

**ATTITUDES OF PROFESSIONALS TOWARDS INCEST
CLIENTS IN THE
NORTHERN PROVINCE OF SOUTH AFRICA**

**BY
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DECLARATION

I declare that this research project for a Master's degree in Clinical Psychology at the University of the North hereby submitted, has not been previously submitted by me for a degree at this or any other University, that is my own work in design and execution and that all material contained herein has been duly acknowledged.

Signed : 

Date : 2001-01-09

DEDICATION

I sincerely dedicate this project to my husband Mothiba, a devoted supportive husband who was always by my side throughout the entire project.

To my sons Mahlatse and Neo Ya Kgaugelo as well as Sydney who were the sources of my inspiration.

To my parents Ntlala and Kgaugelo and in loving memory of my mother in law Sekwati, my guiding lights, sources of joy and inspiration.

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ABSTRACT

This study was designed to assess the attitudes of the helping professionals towards incest clients and its impact on professional intervention towards incest clients. The participants were 103 helping professionals, consisting of 39 nurses, 12 doctors, 14 police officers, 15 magistrates, 13 social workers as well as 10 clinical psychologists. The selected areas of the study were Pietersburg, Seshego and Mankweng districts. The professionals were to be working in Pietersburg, Seshego and Mankweng hospitals, Child Protection Units (CPU), Departments of Justice and Health and Welfare. The sample consisted of 31 males (30 %) and 72 females (70 %).

The interview and questionnaires (Treatment Punishment Scale (TPS) and Jackson Incest Blame Scale (JIBS)) were used as measures of collecting data. The quantitative method of analysis included factors such as educational background, incest experience, gender and age as well as emotional involvement in one's client with regard to attribution of blame, treatment and punishments of clients (victims), perpetrators and their families. Each professional had to give a brief incest case description once managed indicating the age of the victim and the relationship between the victim and the perpetrator. The incestuous abuse involved either sexual intercourse or fondling, deep kissing etc.

There were significant differences amongst professionals in terms of perpetrator punishment, family treatment, situational blame and offender blame. The differences amongst professionals indicated that their personal attitudes interfere negatively with management of incest clients. The results further showed that more blame was attributed towards the offender and external factors of the situational subscale followed by societal factors. The police officers, nurses and doctors were found to be more punitive oriented towards perpetrators than magistrates and clinical psychologists. All six professional groups showed no differences in their support for court mandated treatment for both the perpetrator and family.

Incest training and professional experience seemed to have had an influence in incest management and control of professionals' emotions. Professionals (magistrates, nurses, psychologists and police officers) who had training workshops, in-services were better of in terms of objectivity and subjectivity in their professional duties. Training does

not have a significant difference on the blaming attitude among professionals. However, more blame was attributed to victims than the offender on the JIBS by those professionals with incest training. In case of the TPS, incestuously trained professionals are significantly in favour of perpetrator punishment than the untrained ones. On contrary, more experienced professionals oppose the issue of perpetrator treatment more than the less experienced.

Age of the professional was found to be having a significant difference among professionals on the victim and offender blaming. The younger the professional the more attribution of the blame is attributed towards the victim. Older professionals blamed offenders more than younger ones. There was no significant difference found between gender and blaming, treatment and punishment factors. Therefore, gender was not found to influence responses of professionals on either the TPS or JIBS.

The results indicated a mild to moderate correlation between the JIBS and TPS subscales ranging between .21-.68. The results indicated positive association between offender treatment and offender blame ($r = .42$), situational blame and offender blame ($r = .49$), situational and victim blame ($r = .47$) and offender and societal blame ($r = .39$). Negative correlation was also found between age and victim blame as well as family punishment ($r = -.21$, $p < .04$).

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CHAPTER 1

1. INTRODUCTION

1.1. DEFINITION OF INCEST

Incest is defined by Carson, Butcher, and Mineka (1996), Hartmatz (1978) and Wilson, Nathan, O'Leary, & Clark (1996) as sexual relationship between members of the same family such as mother/son, father/daughter, sister/brother and the involvement of other members of the extended family like grandfathers/granddaughters, grandmothers/grandsons. This is also supported by Forward (1978) who defines incest as any overt sexual contact between people who are related or who perceive themselves to be closely related including, step fathers or mothers and step children. Forward (1978) further supports his definition by saying that whenever the special trust that exists between a parent figure and a son/daughter or sibling is violated by a sexual act, that act becomes incestuous. This act of sexual contact includes fondling of genitals, deep kissing and sexual intercourse (Mckenzie and Calder, 1993 and Freet, Scalise and Ginter, 1996). To add on that McIntyer (1981 : 462) defines incestuous act as "any manual, oral or genital sexual behaviour that an adult family member or older sibling imposes on a child".

According to the South African law, incest refers to the unlawful and intentional act in which two persons, male and female, have sexual intercourse or marry each other while they are related within the prohibited degree of consanguinity, affinity or adoptive relationship (Snyman, 1986 & Cronje, 1991). Other South African authors like McKendrick and Hoffman (1990 : 217) further define incest as "any sexual encounter between a child and an older family member (parent, step-parent, or sibling), an extended family member (uncle or grandparent, or surrogate parent figure) and a common law spouse or foster parent, who exploits the child's vulnerability". Moreover, Snyman (1995) defines incest according to the "Abortion and Sterilization Act" of 1975 as the carnal intercourse between two persons who are related to each other, and by reasons of such relationship they are deemed incompetent to marry each other.

The South Africa law only prohibits certain types of relatives from marrying or having a romantic relationship (Snyman, 1995 and Cronje, 1991). The prohibited types of relatives include the following:

- Consanguineal relations in the direct line: blood relatives who share a common ancestor or ascendants in the direct, such as parents, grandparents and grand children. This also include consanguineal relations in the collateral line, that is, blood relatives who share a common ancestor and one of whom is only a generation away from the common ancestor, such as sibling; uncles and nieces and aunts and nephews.
- Affinal relations in the direct line: a man and the blood relatives of his ex-wife or a woman and the blood relatives of her ex-husband, such as a man and his former mother-in-law; a woman and her former grandfather-in-law and a step-parent and step-child.
- Parents and their adopted children.

In the African culture incest is still referred to as a taboo which is worth a severe punishment. It is always believed that something horrible will happen to the perpetrator and is a shame to the family. It is also believed that the offspring of incest will be born with physical and mental deficiencies as a sign of disapproval of the relationship (Monning, 1967). Despite the marriage prohibitions prescribed by culture, there are situations where sanctioned incest is practiced. This occurs in situations where the wife has died or does not bare children. In these situations the sister could be organised to rescue her sister's marriage (Mashego, 2000).

The South African Law does not differ much from the English law in terms of incest. According to Renvoize (1993 : 32), the English Law defines incest "as sexual intercourse between a male aged fourteen or over and a female whom the man knows to be his daughter, sister, half-sister and grand daughter or mother". If the female is less than thirteen the crime carries a possibility of life sentence; the same applies to rape cases. If she is over the age of thirteen, however, the maximum sentence is seven years. Of interest still is that even if both participants are adults and fully consenting, their relationship is still regarded as incestuous and a criminal offence. In 1981 the government of the state of Victoria changed their law to make incest perpetrators, irrespective of their gender, suffer

the same penalties, this includes mothers as possible offenders in relation to their sons (Renvoize, 1993).

1.2. THE PREVALENCE OF INCEST IN SOUTH AFRICA.

In essence, it is hard to tell, with any certainty, the extent of the incest problem. It is also unfortunate that statistics concerning sexual molestation including incestuous cases are often unavailable or unreliable in the sense that most incest cases go on without being reported. It is documented that one out of every three females, and one out of six males experienced some form of sexual molestation at one stage or the other (Russel, 1997). According to Russell (1997) incest has been regarded as “the secret trauma” because the vast majority of survivors do not disclose their abusive experiences to anyone, let alone to the authorities like doctors, police officers and magistrates, among others.

Carson, Butcher & Mineka (1996) argue that in any society incestuous behaviour does occur, but its actual incidence is unknown because it mostly takes place in a family setting and only become known when reported to law enforcement or other agencies. The other issue that makes the prevalence of incest to be unknown or unreliable is that, in many cultures incest is practised as part of the cultural rituals, therefore many victims do not consider themselves being victimized (Meiselman, 1978 and Mashego, 2000).

The South African statistics of crime against children indicate that in 1995 the Child Protection Unit alone dealt with 28484 cases of abuse against children, which represents an average increase of 28% per year since 1993 (Schurink, 1996). It is also contended that during the period 1991-1994 rape cases (including incest) increased from 4736 to 7559 (60%). Schurink (1996) further contends that in 17,1% of such cases the father or the step-father of a child is the perpetrator, while the mother features in 5.1% of the cases of the act. Schurink (1996) adds that since many cases of crime against children (including incest) are usually not reported, the above statistics are just the tips of the iceberg. It is further pointed out that the rate at which crime is increasing in South Africa could predict that by the year 2000 the Child Protection Unit (CPU) would deal with about 1478110 cases of sexual abuse including incest.

Pienaar (1996) also discovered that the CPU of the South African Police Services (SAPS) observed an increasing number of reported cases of incest in the country. For

example, 146 cases (an average of 12, 17 cases per month) were reported in 1993; 156 cases (averaging 13 cases per month) in 1994; 221 cases (averaging 18 cases per month) in 1995 and 125 cases in the first six months (averaging 20, 8 cases per month) in 1996 were reported. It was also discovered that the highest record of the SAPS on incest prevalence in South Africa since 1993 to 1996 was 221 (HSRC; SAPS Report).

The incest statistics in the Northern Province as supplied by the South African Police Services indicate that between 1996 July and 1998 August 54 cases of incest were reported. These cases were reported from different areas of the Province (Bushveld, Far North, Central region and Lowveld). In 1996, 37 incest cases were reported, while for 1997, 17 cases were also reported. From that time the reported cases were as follows: 33 in 1998; 23 in 1999 and 10 in June 2000. These reports show some fluctuating numbers yet increasing (SAPS Report, 2000).

The Northern Province of South Africa, has a population of 5,2 million. According to Madu, Peltzer and Mashego (1998), childhood incestuous abuse has also been identified as a social problem that is increasingly calling for urgent attention in the country. In their study, Madu, Peltzer and Mashego (1998) discovered that the prevalence of childhood incestuous abuse amongst black high school students was 15,2%. This finding is comparable to the 16% of Collings (1997) conducted amongst the South African white female students, and that of Russel (1986) amongst females below eighteen years in USA.

The general impression of incest prevalence in South Africa, especially in the Northern Province show some similarity of incest rates between South Africa and other countries, such as USA. The same problems pertaining to reporting and proper notification of incest cases applies in a more or less the same way in South Africa and elsewhere (Russell, 1997, Carson et al. 1996 and Peltzer & Paswana, 2000) hence the unreliable rates of incest.

As a results of the growing rate of incest in the Northern Province of South Africa, the researcher predicts that the community needs professionals who are well prepared or trained for handling incest clients. However, since different professionals meet different challenges and experiences in the process of handling incest cases, their approach may vary and their attitudes towards clients may be influenced by various factors. Identification and awareness of such factors by professionals is crucial. This is the core of this study.

CHAPTER 2

2. LITERATURE REVIEW

Literature regarding attitudes of professionals will be reviewed in this section. This will include the statement of the problem and the aims and objectives of this study. This part will be divided into different sections which will cover the following issues:

- 2.1. Attitudes of professionals towards incest clients
- 2.2. Blaming attitudes
- 2.3. Child victim culpability and credibility
- 2.4. Professionals' emotional reactions
- 2.5. Knowledge of and management strategies in incest cases amongst professionals
- 2.6. Re-victimization of incest victims by helping professionals
- 2.7. Male survivors of sexual abuse and professionals' attitudes
- 2.8. Problems, errors and opportunities in the treatment of father-daughter incestuous cases
- 2.9. Family stereotypes of incestuously victimized children
- 2.10. Biases often encountered in the management of incest perpetrators
- 2.11. Professionals' fear or discomfort with incest
- 2.12. Professionals' view of who must leave the home
- 2.13. Integrated treatment of incest
- 2.14. Offenders' evaluation of professional service
- 2.15. Statement of the research problem
- 2.16. Aims and the objectives of the study

2.1. ATTITUDES OF PROFESSIONALS TOWARDS INCEST CLIENTS

Attitude studies are often about beliefs, feelings and emotions that professionals bring along to their therapeutic situations which could impact their intervention process. Reidy and Hochstadt (1993) argue that the attitudes of professionals who work with incest cases are sometimes influenced by their perception of incest. They also believe that the process of decision making in incestuous child abuse cases can be highly subjective, influenced by attitudinal factors such as professionals' affiliation, experience and training, gender and age.

Kalichman, Craig, and Follingstad (1988), Saunders (1988), Eisenberg, Owen and Devey (1987) further add that the professionals' attitude can have a major effect on many aspects of the decision making process in incest cases. These may include reporting, investigation of victim's credibility and punishment of offenders, judicial intervention and delivery of mental health services to the victim, offender or perpetrator and family.

2.2. THE BLAMING ATTITUDES AND PUNISHMENT

According Doughty and Schneider (1987) excessive attribution of blame or identification could interfere with assessment of relevant issues and planning of treatment in all professionals working with incest clients. They further advocate that professionals should be objective, unbiased and capable of working with victims, offenders and the rest of the family without being judgmental or bias. It was also stated by Riche-Suttles and Remer (1997) that some psychologists' own life experiences may influence their responses towards male victims. Against this background, their responses may vary from blaming and judgmental, if their own issues have not been resolved, they might be too supportive and empathetic. Other male professionals as cited by Doughty and Schneider (1987) seem to view sexual abuse as less serious than do their female counterparts, who tend to blame sexual abuse victims more.

The professionals' attitude is, according to Leberg (1997), supportive of the offender's tendency to blame victims for their act. Finkelhor (1986) found that as most offenders often blame factors like alcohol for their actions, researchers and helping professionals virtually never view alcohol as the cause of a sexual assault.

According to Doughty and Schneider (1987), Jackson and Ferguson (1988) and Adam and Betz (1993), the higher the therapist's educational level and more years of experience in their working fields, the lesser the blame leveled against victims.

Trute, Adkins and Mac Donald (1996) hold that professionals respond differently to the same person. This is influenced by either their professional duties or their own attitudes and feelings towards those concerned in the matter, such as perpetrators. Police strive to gather evidence for criminal persecution, child welfare officers seeks safety for the victim and need to consider long term implications in the relationship between the perpetrators and victims, while mental health professionals focus primarily on the provision

of clinical services to those concerned.

Furniss (1991) has identified three distinct types of services that need to be maintained by professionals of child sexual abuse including incest. They are the following:

- The primary punitive intervention seeks establishment of responsibility for the sexual assault and punishment of the perpetrator.
- The primary protective intervention focuses on protection of the physical, emotional and moral well being of the victimized child.
- Primary therapeutic intervention concentrates on the amelioration of psychological trauma and the enhancement of a positive family relationship.

These factors, according to Furniss (1991), correspond with the fundamental and priority service mandates of the police, child welfare and community mental health services. Finkelhor (1984) points out that in most communities the service response in situations of incest is marked by interdisciplinary distrust and dependent action. It was further discovered that even though service sectors such as police, child welfare and mental health services are drawn together in service delivery, they often act in a solitary and uncoordinated manner (Finkelhor, 1984).

2.3 CHILD VICTIM CULPABILITY AND CREDIBILITY

It is often believed that many victimized children passively allow events to take place or even take the initiative by going to the offender without any specific seduction or threats. Some legal professionals stress that victims of sexual abuse (incest) are willing participants, often inviting their victimization through provocative behavior (Virkkunen, 1975 & Saunders, 1988). However, Gruber (1981) attributes a child's role in incest not to any systemic or purposeful initiative, but rather to an inappropriate overture to receive affection or situations which force the child to comply with adults demands.

Yet another way according to De Young (1982:93) in which incest victims may be further regarded by helping professionals as being culpable for their victimisation, is by their assumption that "the victim seduced, encouraged, or otherwise attracted this

incestuous victimization". Furthermore Lukianowicz (1972:309) concluded that "the victims were far from being innocent victims, on the contrary, they were willing participants and often provocative seductresses". Such assumptions in South Africa according to Armsworth (1989) and De Young (1981) may arise from these sources, namely:

- Documentation of passivity of incest victims during the incestuous affair
- Researchers' accusations of seduction made against the incest victims
- Rationalization of incest offenders

The credibility of children as stated by Saunders (1988) has historically been a matter that was dismissed by authorities in psychology and legal professions. They subjected that to fantasy due to the oedipal complex. It was further discovered that some judges or magistrates experienced problems in believing the incest reports of children. They contend that many incestuously victimized children act on their mothers' behalf, helping them to get even with men. As a result, judges and magistrates find it difficult to know whether the child is lying or not (Bohmer, 1984). This attitude was affirmed when the majority of professionals in this study mentioned that it is always difficult to believe teenage victims.

2.4 PROFESSIONALS' EMOTIONAL REACTIONS AND INCEST

There are many troublesome emotional reactions experienced by professionals involved in the sexual abuse field like incest. The responses experienced by most professionals might involve violent or sexual fantasies about paediatric victims, non-offending parents and offering positive feelings towards the offender and/or toward the abused child or a non-offending parent (Lyon, 1993).

Shapiro, Burkey, Porman and Welker (1996) note that working with incestuous clients can be emotionally demanding on the professionals because of its focus on painful experiences and the emotional intensity of the interaction between care providers and clients. These professionals, according to Shapiro et al. (1996), face problems that may have the potential to produce difficult job experiences. Eventually, these types of engagements might bring the professionals in less contact with the betrayal and suffering of the child and unable them to be sensitive and objective to families and perpetrators.

McCann and Pearlman (1990) postulate that working with traumatized victims such as incest victims might expose the professionals to the danger of vicarious traumatization in which the professionals incorporate their clients' traumatic memories and experiences into their own. Shapiro, et al. (1996) contend that with all the experiences professionals go through, the end products of it could be increased job dissatisfaction, burnout syndrome, judgmental behaviour, blaming and blunted emotions, and over identification towards self and clients.

It is also perceived that the professionals' past experiences, feelings and gender may impair their professional intervention with incest clients. Hence Pence (1995) states that professionals ignoring these reactions and feelings may not be able to effectively serve incest clients. However, awareness and ventilation of thoughts, emotions, feelings and fantasies are believed to be desired responses whose aim is to assist professionals in maintaining their identity as caring professionals and to facilitate their intervention (Pence, 1995).

Fargason (1995) stresses the fact that the countertransference problem affects the care delivered not just by psychologists and other therapists, but also the care delivered by nurses, physicians, judges and magistrates, police, child protective service workers, and other professionals involved in the sexual abuse field as well. Mouton (1981) points out that when previously victimized professionals work as treatment providers the dilemma of who is receiving treatment arises whereupon the need to resolve their own issues during therapy sessions with clients persists. In most cases these feelings consequently become barriers to effective intervention.

Horton, Johnson, Roundy and Williams (1990) further stress that the treatment provider should feel comfortable working with the perpetrator, which often means resolving angry feelings towards an incest perpetrator. In addition, Giarretto (1981) stresses that it is common for professionals to respond to the perpetrator with disgust or anger; however, such feelings should not continue, they should rather be replaced with productive intervention.

Fargason (1995) further argues that other (non-experienced) therapists do not have necessary training in handling or managing countertransference. He further argues that positive countertransferences in medical situations can lead to unconscious bias in assessment of physical findings and the use of subtly leading questions during client

interviews, or over identification with a particular party in a custody case. Eptein (1994) and Peterson (1992) stress the issue of violation of professional boundary which occurs in most professional interactions. They argue that empathetic identification with clients should not cause professionals to confuse their separate roles as advocates for victims and objective professionals.

According to Fargason (1995), professionals should be clear about the role they assume at any particular time. He further contends that other professionals might not be able to manage their own feelings and attitudes, therefore they need the support of mental health professionals who together will form a multi-disciplinary team to protect each other from inappropriate action resulting from positive or negative feelings towards clients, perpetrators and their families. This situation might be equally applicable in the Northern Province of South Africa because the few professionals available are over-worked and often work under stressful conditions of the reality of incest in the province. Therefore, professionals might find their roles as service providers contaminated by their subjective feelings and attitudes towards clients.

The selected areas for this study has been utilizing the once a week psychological services for a long time until in 1999 when the University of the North Department of psychology started with the masters training. Students of which I was part of, were allocated among the nearby hospitals for practicals. I have personally observed and worked under these situations while working in the hospitals both as a nurse and an intern psychologist. The same situation was observed while interacting with other professionals during data collection. The Child Protection Unit was also newly introduced in the Northern Province, while the Justice Department was also in the process of allocating and training female magistrates to deal child sexual cases.

2.5. KNOWLEDGE OF AND MANAGEMENT STRATEGIES IN INCEST CASES AMONG PROFESSIONALS

According to Doughty and Schneider (1987) the clinicians' attitudes towards incest are vertical to effective involvement and handling of incestuous families in treatment. Hertman (1981) and Herman and Hitchman (1977) argue that professionals are poorly prepared to offer appropriate help and support. They often make judgements about the guilt and innocence of family members, and such attitudes are likely to interfere negatively

with the intervention processes. This behaviour might result in victims experiencing guilt and self-blame for the abusive episode and the consequences of disclosure or reporting.

According to Attias and Goodwin (1985), the issue of interest here is focussed on assessing the professionals' knowledge about incest and management strategies applied in incest intervention. The core of their investigation revolves around the following issues:

- Strategies chosen for evaluating a family in which an incest accusation has been made
- Information about the epidemiology of incest
- The amount of the kind of experience with incest cases
- Sources of information about incest and felt needs for further training
- The most common problems encountered in these cases

As the cases of incest increases and the family secrete of incest is gradually exposed in South Africa, (see Chapter 1 pages 3 to 4) more children and adults will seek treatment for ongoing sexual abuse and the after effects of incestuous abuse. It becomes important to know what skills and knowledge practitioners bring into this increasing case load.

According to Goodwin (1982), this is critical because it has been shown that the initial handling of a case may influence the entire long-term course. It is for this reason that Attias and Goodwin (1985) believe that more precise information about levels of knowledge and expertise among professionals will allow for better design of continuing education about incest. De Young (1983) and Dietz and Craft (1980) in the studies conducted in Boston (USA) revealed that social workers express a need for more training, with more than 70 % workers rating as deficient in their preparation for managing incest cases. The South African social workers also express almost a more or less similar situation when coming to knowledge about reporting and management of incest cases (Peltzer & Paswana, 2000).

Pearson (1994) agrees that mental health professionals need to be increasingly prepared to facilitate healing and growth for adult incest survivors. Groth (1978) asserted that treatment providers have not been well prepared in their academic training to work with incest perpetrators. Overall, in addition to lack of preparation, allegations have been made that these helpers are unmotivated and have little desire to work with incest clients, especially the perpetrators.

According to Horton et al. (1990), the dynamics involved in dealing with incest cases are very complex. Therefore professionals in this service should be alert and have a clear understanding of the incestuous system. This was observed in (Mashego, 2000) where instead of mothers supporting and trusting their daughters, they tended to blame the victims and accused them of fabricating the abuse. He adds that, professionals with limited experience and understanding of incest are very disadvantaged and may be misled. Furthermore Dietz and Craft (1980) reveal that professionals believe their training and skills to be lacking for working with incestuous families. This could lead to failure to observe important factors surrounding the abuse. Most of them indicate the need for more information, training and skills to help in incestuous cases.

According to Edgar (1986), the training and experience of professionals such as doctors and social workers against their accepting the full impacts of social forces, and they mostly see the problems in individual, psychological terms. He further points out that counselling or medication, can only be temporary measures. Without changing underlying social structures, there will never be sufficient workers, time or money to cope. The move towards self-help through networks is growing in response to the need, but community networks cannot provide the answer alone (Edgar, 1986).

Recently attention has been focussed on professionals' reluctance to report either physical or sexual abuse of children including incest. Silver, Barton and Dublin (1967) further discovered that more than 20% of physicians would not report child abuse even if they suspected it. Anglin (1983) reported that pediatricians who had been trained during residency to manage sexual abuse cases are more likely to recommend appropriate interventions. Swaboda, Elwork, Sales and Levine (1978) and Finkelhor (1979) found that other professionals, in addition to physicians have difficulty complying with the legal mandate to report physical or sexual abuse including incest in children.

Practitioners might have some difficulties looking beyond incest allegations to make a problem list for the entire family. However, as a discipline, pediatricians seem to have much to teach the other disciplines about sensitivity of incest and the necessity for physical examination as part of a comprehensive approach to the child together with the hazards of venereal disease in this particular cases. Non-pediatricians are less likely to recommend physical examination, they also tend to underestimate the frequency of positive physical findings, which is expected to be more with new developments coming. Therefore cross-disciplinary training and collaboration are obviously needed (Attias and Goodwin, 1985).

However, in South Africa all reported cases of sexual abuse (incest) routinely go through physical examinations with the purpose of collecting evidence for court process not necessarily for the emotional aspect of the victim(own experience in the hospitals as an intern psychologist).

2.6. RE-VICTIMIZATION OF INCEST VICTIMS

In many ways, incest victims have been further victimized, and in some of those ways they have been victimized by the very helping professionals who are expected to assist them. One of the most notable ways in which this has occurred is refusal (by some helping professionals) to believe that the person who makes an allegation on incest might actually be telling the truth (De Young, 1983 & Armsworth, 1989).

According to Sgroi (1979:9) "one of the basic hurdles for the helping professionals to overcome is to change the mental attitude that, patients routinely make allegations of sexual abuse. This attitude implies that patients either lie about the sexual abuse or fantasize about its occurrence or both". Peters (1976) maintains that such attitudes on the part of therapists may be easier and more interesting for the therapist, but may also be counterproductive to the most efficient resolution of symptoms, since they may encourage brief superficial techniques. Therefore, the helping professionals' refusal to believe a report of incest cases is expedient for the therapist, but ultimately victimizes the patient who is denied the opportunity to share her or his experience and to receive therapeutic assistance and intervention which may be desperately required (De Young, 1983).

When the incest victim is believed, he or she may yet be victimized by those helping professionals who refuse to actively intervene in the victimization by refusing to report the case (De Young, 1982). The refusal by some helping professionals like medical doctors, social workers, and so on, to intervene when a patient discloses an ongoing incestuous relationship is once again expedient for the professional who then never becomes entangled in the complexities of the protective and legal systems. However, for the patient such non-intervention and non-advocacy may be perceived as victimization by the very same person who could help the most. In my clinical experience as a psychology intern in the hospital, I was told about an incest case involving a prominent figure and his daughter; this was known to legal and welfare professionals. The abuse went on until the daughter left home for tertiary education with no effective intervention. Other incest clients referred to the

hospital were treated medically and discharged before proper referral to other professionals was followed, for example referring clients to the social workers and psychologists, among others.

According to Section 42 of the Child Care Act 74 of 1983 in South Africa, it is a criminal offence for any person who examines, treats, attends to, advises, instructs, and cares for any child not to report suspicions of abuse (DuPlessis,1996). Peltzer and Phaswana (2000) discovered that non-reporting of abuse cases amongst social workers in the Northern Province as perceived by social workers, was due to different factors including, the insensitivity of police personnel (59%), CPU staff's poor training, while other reasons were purely due to their ignorance. Non reporting an abuse case is contrary to the stipulations of the South African Child Care Act 74 of 1983. This does not only lead to under recording of incest cases in the Province, it also encourages a form of re-victimization of the client by fostering a attitude professional non-advocacy.

Hansson and Russell (1990) report that there are many factors which contribute towards silencing rape and incest survivors. The following are some of those reasons and fears expressed by survivors for not reporting their incestuous abuse to the police as indicated in Hansson and Russell (1990):

- Fear that their abusers will retaliate if they report combined with the knowledge that police are not likely to protected her
- The belief that her particular abuse is not likely to be prosecuted
- Fear that the police will not believe that she has been incestuously abused
- Fear that others will blame her for causing the abuse
- Wanting to protect the loved ones from the anguish of knowing that she has been abused or from the consequences thereof
- Being psychologically traumatized by the abuse to the extent that she consciously denies its occurrence
- Fear of being stigmatized, and so on

The helping professionals often overlook the dynamics of incestuous families, like the coercive techniques used by the offending parent to convince the child victim to keep the incest secret. Some helping professionals may further victimize the incest victims by believing that incest is not harmful, or that it may even be beneficial to victims. The study

conducted by the so-called “ pro-incest” researchers insisted that, incest is a little more than “neutral and dull” for the child victims, while others insisted that it is actually positive and even beneficial for the child (De Mott, 1980 & De Young, 1981). The same discoveries were made in (Mashego,1999) who revealed that, in some cultures fathers should sexually prepare their daughters for marriage by sleeping with them.

De Young (1981) feels that such assumptions by professionals are unscientific, since they are rooted in a highly romanticized notion of family love that coldly undercuts the experiences of countless incest victims who feel much less loved than exploited. Permeation of such an attitude into the helping professionals could result in a mind set which deems that helping services to the incest victims are inappropriate, or that such services should be given low priority.

Edgar (1988) discovered that lawyers still have some difficulty in accepting child sexual abuse as a fact. Counsellors dealing with disputes over custody or access in family courts have been psychologically trained, but the judges, registrars, lawyers and prosecutors have not, hence their experience of great difficulties in accepting the counsellor’s report as being reliable. Others argue that if the abuse ever happened it was probably provoked and therefore excusable on that score (Edgar, 1988). In the South African Law, incest is prohibited and punishable by law, however, enough evidence is always required for the conviction of the perpetrator (Snyman,1995).

Some of the incestuously abused teenage victims referred to me (as an intern psychologist) for therapy, reported to have been harassed by some police personnel when reporting cases (especially accused of having seduced their offenders by their way of dressing). To add on that, the police and magistrates hold that the modus operandi in their profession is to suspend the act of believing or drawing conclusions as to whether or not the victim is telling the truth until the offender has been proven guilty by the court. This is supported by Hansson and Russell (1990) who discovered that, according to the South African Abortion Act (1975) section 6(4), the assumption that survivors lie about being raped or incestuously abused in order to obtain legal abortions is widely held by the professional within the legal fraternity. In fact there is a rule of evidence, known as the Hue and Cry Rule, which states that the court may take the complainant’s failure to report the alleged offence soon after its occurrence as an indication that the complainant is lying.

Renvoize (1993) contends that people who are most frequently accused of

abstractive attitudes in the past are the police. In the study conducted amongst the London police officers, the discoveries were made that, although there are some police men or women holding negative attitudes, most of them are sufficiently trained to handle child sexual abuse cases including incest. He further stresses that there are still extreme cases where policemen report that the victims often deserve what they get. Another factor which is said to be still common amongst the police is that if a woman does not have bruises she must have enjoyed being raped (Renvoize, 1993). These were some of the Renvoize's discoveries done among the London policemen.

2.7 PROFESSIONALS' ATTITUDES TOWARDS MALE SURVIVORS OF SEXUAL ABUSE

According to Richey-Suttles & Remer (1997) as supported by Betz & Fitzgerald (1987), psychologists' responses to male survivors could be influenced by societal expectations of men, as well as their own attitudes towards men, and their own life experiences. The cultural stereotypes towards males influenced them to deny, minimize or fail to recognize important things that may serve as evidence of sexual abuse in their male clients. They might expect male victims to conform to traditional male sex roles, as such have negative reactions to male survivors who did not respond to the abuse or do not respond in therapy in a manner consistent with traditional male sex roles (Betz & Fitzgerald, 1987).

Concerning therapists' attitudes towards sexual abuse, males were found to view sexual abuse as less serious than do females. It was also discovered that the degree of victim blaming by therapists was influenced by the sex of the perpetrator, the age of the victim, and the victims' response to the abuse (Attias & Goodwin, 1985, Doughty & Schneider, 1987, Wagner, Aucoin and Johnson, 1993). However, Wagner, Aucoin & Johnson (1993) and Adams & Betz (1993) argue that the sex of the victim does not influence the degree of victim blaming by the therapists.

2.8 PROBLEMS, ERRORS AND OPPORTUNITIES IN THE TREATMENT OF FATHER-DAUGHTER INCESTUOUS CASES

Ryan (1986) has discovered that treating the father-daughter incestuous cases could be difficult under the best circumstances. Therapists who work with the network to gain control of defining those circumstances, such as obtaining juvenile court protection orders and leaving the child in the house, stand a better chance of success in the treatment than those who do not. Once the family is referred for treatment, as Ryan (1986) observes, a dichotomous treatment situation present itself. Hence the control of sexually abusive behaviour is of paramount significance in warranting direct behavioural means of treatment.

Ryan (1986) has also discovered that the behavioural methods of treatment alone are inadequate to ensure the safety of the victim, her siblings and other potential victims. Therefore the important skill in the treatment of incest cases, is the manner in which professionals behave as parents and the skills they use in obtaining information from the concerned parties (Giarretto, 1982).

In the following parts are some of the common problems, errors and opportunities often committed by professionals in the treatment of father-daughter incestuous cases:

- 2.8.1 False promises
- 2.8.2 Non- probationable charges
- 2.8.3 Bargaining away court involvement
- 2.8.4 Confrontation of perpetrators
- 2.8.5 Failing to recognise the mother's treatment needs and expecting too much too soon from them

Brief discussion of the above problems, errors and opportunities is as follows;

2.8.1 False promises

Often when professionals need to gain information from children and parents alike they will just imply or not discredit the inference that telling it all will be rewarded with leniency. Offenders who are often misled into compliance through professionals' false promises prove bitter, resentful, and very resistant to the treatment process. They often

view themselves as being victimized. If similar promises have been made to their children only to see their fathers later jailed or imprisoned, they may become extremely distrustful of social services or the entire helping system. In this sense, the solution is to tell the truth so that the family can benefit from knowing both the good intentions and the limitations of the interviewer, thus enhance cooperation (Ryan, 1986).

2.8.2 Non-probationable charges

In Illinois there have been cases where the law exercises the specific law regulations which require incarceration and no probations with the minimum of four years sentence. When faced with such charges, fathers often find it difficult to admit to the molestation in court. This shifts the burden of proof onto the shoulders of the child victim, meaning that she/he should testify in court, and the results might be catastrophic for the family (Ryan, 1986).

Recently in South Africa, mild to severe sentences have been passed on perpetrators for charges of child sexual abuse (including incest), if the victim is under the age of seventeen. There is a case of a girl who was sexually abused by her mother and step father, the girl was assaulted, sexually and physically abused and also used as a sex worker. The step-father received a maximum sentence of 50 years imprisonment while the mother was given 39 years imprisonment by Pietersburg high court (Sowetan, 2000, October: 31 p3). There was also a case of brother/sister incest who were married for 16 years, with 3 children others died. The remaining children are kept in a place of safety. The case is still continuing (SABC TV News, 2000 :28). One more case of brother/sister incest has been recently reported in Pietersburg. The couple has been in love for 15 years and had two children of which this man also incestuously abused. They both pleaded guilty, however the man was sentenced to five years with three years suspension, while the mother got one year sentence for child molestation. When handing out judgement the magistrate urged the two to mend their ways, but warned them that they would be send to jail should they commit the same offence again (Sowetan, 2000, November: 16 p4). These could be an example of how the South Africa courts deal with incest cases, by not only concentrating on the punishment of perpetrators but also considering the victim and the family's needs and also considering complexities involved in the family or the case.

The above could be in line with what Ryan (1986) and Giarretto (1982) suggest, they argue that in the interest of the victim, professionals should persuade the legal system to file probationable charges that give offenders the possibility of pleading guilty. This will relieve the child victim from the burden of fear, indecision and possible hurt. Longer sentence in case of father-daughter incest have both positive and negative impact on the victim and the family, therefore, many factors should be considered before the sentence is passed. The victim might feel guilty for disintegrating the family unit, and contributing to the financial and social bankruptcy of the family.

2.8.3 Bargaining away court involvement

Often professionals expect resistant and hostile behaviour from the families reported for abuse. When an incest complaint is discovered in a respected family with a good social reputation, social workers often offer to keep the whole issue out of court, provided the family voluntarily agrees to enter into treatment programme. In such cases, if the offender is the father, he will usually remain at home and is likely to influence the attitudes and feelings of other family members towards the victim. Thereafter, he might make attempts to shift blame onto the child and gain sympathy towards himself as a victim. After winning over the support of other family members the perpetrator is most likely to leave the treatment and continue with the abuse. That could be why Ryan (1986), argues that all sexual abuse cases should be court ordered for treatment. The offender is often ordered to leave home to allow opportunity for the healing process in the family, for both the offender, mother and the child victim (Ryan, 1986).

In cases of father-daughter incest as contended by Mashego (2000), the mother is often under pressure from her family and In-Laws, to bail out or persuade the victim to drop charges against the father so as to avoid imprisonment and the scandal in the community.

2.8.4 Confrontation of perpetrators

Ryan (1986) maintains that professionals have a tendency of looking at incestuous abusers as offenders or perpetrators, the terms often used amongst criminal justice professionals. The label is often weighted with judgement which fits the terminology of the

law. However mental health professionals have the responsibility to avoid getting angry with clients for being as sick as they are. Incestuous abusers are believed to be psychologically damaged themselves, often as a result of own sexual victimization or experiences. This therefore, makes them proper subjects of treatment just like their victims. Therefore, they need to be approached rather than confronted (Ryan, 1986 & Giarretto, 1982). A positive approach from the care providers could ensure positive intervention outcomes.

2.8.5 Failing to recognize the mothers' treatment needs and expecting too much too soon from them

Most clients often go through a lot of emotional outburst during intervention processes. At times they might flee from their own feelings of guilt by refusing to be involved in therapeutic programs. Even if they believe that the abuse has occurred, they may deny their role in failing to protect their daughters or in supporting their husband's pathology. Professionals might be annoyed by this denial and defensive behaviour with demands that women victims be strong on behalf of their children or become critical and impatient with their self-preoccupation. By so doing they may lose their opportunity to provide treatment for their clients (mothers), and ultimately to their daughters and the family at large (Ryan, 1986).

In some instances as noted by (Mashego, 2000), mothers expressed the fact that they blamed themselves for incest, feeling that they were not caring enough for their families, while on the other hand, some mothers reacted with complete denial of the situation, such that they ended up siding with the partner and blamed the victim. Such a position put pressure on the mother-daughter relationship and create a discord in the family.

Ryan (1986) further postulates that successful treatment of fathers' molestation behaviour, in the absence of maturational gains in the mother, leaves the child with no adequate identification figure, thus continue with the responsibility to maintain the pseudo-mature behaviour in order to support her mother's inadequacy. The mother should be treated as though she is in one of the stages of the grieving process. Full support and understanding for her behaviour are necessary. By the time she quits understandable numbness and resistance to the reality of incest she will give way to attempts directed at

supporting her child (Giarretto, 1982).

Keen and Keen (1995) and Elbow and Mayfield (1991) argue that professionals often have unrealistic expectations of the victim's mother when she is confronted with the crisis of disclosure of incest. The mother has to confront questions about herself, her sexuality, partner, and their relationship. The mother is expected to assess the accuracy of the allegations, and make life changing decisions about her family life, and negotiate her way through many new systems such as police and courts. This is further reported by Freet et al. (1996) who notes that incest when compared with other categories of sexual abuse, represents a situation in which the conditioning of the family is so intense and pervasive that even though all the members of the family are fully aware of a relationship, they react to it with complacency, and lack of motivation or interest in either reporting the relationship to the community and/or seeking professional help.

Mashego, (2000) contents that, in the process of incest disclosure, there are many factors that mothers are often worried about, these include; pressures from home to keep the incest issue a secret, a pressure of having to lay charges against the perpetrator who might be the husband, the fall into the economic problems and the anger from the perpetrator's (husband's) family and the community. Despite pressures experienced by mothers in this study, the police and social workers's professional intervention were said to have been helpful and appreciated. This indicates that mothers are always faced with difficult choices to make. Therefore, mothers needs professionals who will support them and intervene appropriately.

Ryan (1986) is further concerned about professionals who tend to expect too much too soon from the mothers of the abused child. He states that as the treatment processes go on, the mother recovers from her initial shock state and begins to work on issues from her own life, as well as her role as a mother. She may start by showing dramatic behavioural gains and surprising capacity for insight. Often professionals might regard these changes as substantive and start arranging mother-daughter sessions without adequate discussions and planning. In a way, Ryan (1986) implies that it is possible for professionals to misjudge her strength and weaknesses. Often the mother might feel threatened by inclusion of the daughter in the sessions and may regress to self-absorption and hostility towards her. It was therefore discovered that experiences in incest case management and confidence in the aspects for improvements in the long term make it easier for therapists to be patient in the process (Giarretto, 1982).

Keen and Keen (1995) argue that the handling of mothers of incest victims by many professionals opt for a more objective view as far as their role in incest is concerned. This led to the discovery of the fact that many professionals feel inadequately trained to deal with intra-familial sexual abuse and that they most rely on the literature for guidance.

According to (Mashego, 2000) there are needs among the mothers which must be dealt with by the professionals in the intervention programs, these include the following:

- Mother's need to gain insight into their own emotional reactions and find away of speaking out their problems within the cultural limits
- mother's need to develop an understanding of themselves and their roles as mothers
- Mothers' needs to appreciate support system put into place by their culture which may help them cope with incest crisis.
- Mothers need some help to deal with the process of grief.
- Mothers need to see adaptive and maladaptive sides of the use of avoidance
- Mothers need to realise that incest is not their fault
- Mothers' needs to be empowered on how incest impacts on their lives
- Mothers' need to be empowered from the they are forced to take in the patriarchal culture

2.9 FAMILY STEREOTYPES OF INCESTUOUSLY VICTIMIZED CHILDREN

Professionals who approaches incest from the systemic model often view incest as a symptom of a dysfunctional family, whereby everyone in the family forms part of the whole non-functioning unit that contributes to incest (Mashego, 2000). However, professionals according to (Finkelhor, 1979) hold stereotypical beliefs about incestuous families. In an attempt to help understand the perpetrators and the victims, professionals often examine their family functioning. This focus enables the professionals to analyse the victims' interaction, and their family values about sexual issues.

In the next part of this section some family stereotypes about incest will be discussed, these include; marital conflict and disruption theory and the role of mothers in incest.

2.9.1 Marital conflict and disruption theory

Finkelhor (1979) holds that the stereotype that quickly comes to many professionals' mind is that of the Oedipal triangle. They often believe that incest occurs because a husband and a wife become estranged, and so the father turns to his daughter for sexual outlet. However, marital conflict is far more common than the father-daughter incestuous relationship, hence Finkelhor (1979) argues that it takes much more than just marital conflict for incest to occur.

When children grow up in families marked by parental conflicts, they receive contradictory messages, especially about sex which might leave them confused and unclear about appropriate sexual values. They could also be less capable of handling themselves in potential situations of abuse. As such they may be particularly vulnerable to older persons, who entice them into sexual situations with offers of advice and instruction and assurances about the appropriateness of the behaviour. Furthermore, it is argued that in conflictual and disrupted families children are less well supervised, and thus more vulnerable to sexual victimization (Finkelhor, 1979).

2.9.2 The role of mothers in incest

Most of the incestuous families seems to portray patterns of enmeshment within the family and disengagement from outside the family, hence the increased rate of marital conflicts and dysfunction. According to Finkelhor (1979), mothers somehow contribute to the incestuous victimization of their daughters because they abdicate (to a certain extent) their maternal responsibilities. Mothers are often accused of allowing their daughters to be victimized because they are seen to be exchanging roles with their daughters, and by being weak and unable to protect their daughters from their fathers. In other situations mothers are seen as responsible because sometimes they know about the incest but refrain from doing anything about it.

According to Mashego (2000) the mother's role in an incestuous family is seen by the systemic model as that of a collaborator who sees incest occurring but ignores it. She further contents that this happen because "the mother is according to this theory trying to bring about homeostasis in the system, and has to do this by keeping secrets within the family, to restore the family 's dignity and its subsequent functioning" (Mashego, 2000:87).

Furthermore, mothers of incestuously abused children are perceived by Finkelhor (1979) as those who might have married young, had less education, more intimidated by their husbands and had fewer powers in the family. Heavy drinking and ill mothers are also seen as responsible for their children's incest abuse. Incestuous families according to Mashego (2000) exhibit an inter-generational boundary confusion in that the mother is said to be continuously ill and absent. Therefore, the daughter takes over the mother's role to become a parentified child, this makes the daughter to move from the sibling subsystem to the parental subsystem where she should not be.

Seeing that there are many factors within the family unit which contribute towards incest, it would be unfair for professionals to regard the non-reporting of incest by mothers to be solely due to the fact that they are colluding without taking into cognisance their vulnerability that is caused by factors such as their lack of self esteem, unassertiveness and lack of motivation as well as their cultural background (Mashego, 2000).

2.10 BIASES OFTEN ENCOUNTERED IN THE TREATMENT OF INCEST PERPETRATORS

The part will focus on the helping professionals' biases which influence their attitudes towards those who need help from them. These include the following: cultural biases, professional biases, personal biases and gender biases.

2.10.1 Cultural biases

The following issues are common prejudices regarding incest that will likely be encountered by treating professionals:

- Society's unwillingness to accept what the presence of incest among the normal population may suggest about that society. This implies the reluctance of the society to acknowledge the prevalence of incest in the society (Renvoize, 1993).
- If you are not part of the solution then you are part of the problem. This is common in a society where the only solution to incest is incarceration, preferably for life. In this situation therapist who attempts to thwart this process by diverting

offenders into treatment may be perceived as another part of the problem (Horton et al. 1990).

- Lack of faith in the value of psychotherapy as a cure for incest especially for perpetrators. Alternative solution to this might be incarceration.
- Biases based on the socioeconomic status of offenders and their family. Children from lower socioeconomic families are more likely to be removed than those from high class. This lessens the risk of continued victimization. Incest in high class families is less likely to be reported. If they do, professionals are inclined to trust the judgment of offenders more than the situation itself (Horton et al. 1990).

In the African culture mothers are often blamed for the occurrence of incest because they are expected to be protectors of their children. It is also believed that incest occurs as a results of inadequate guidance of the daughters by their mothers on the code of conduct and manner of dressing (inappropriate dressing of girls said to make them vulnerable for incestuous abuse). In case of father-daughter incest, it is believed that any closeness between the father and his daughter in the absence of the wife and the mother, promotes a risky situation between the two. This is regarded as another factor for the occurrence of incest (Mashego, 2000). Professionals are likely to approach their intervention from their cultural believes which exert more responsibility on mothers.

2.10.2 Professional biases

The professionals' biases in this case include the following:

- Dilemmas regarding the development of trust in a therapeutic relationship. Professionals involved with incest clients often find themselves in trust battle. Failure to resolve this dilemma might result in retardation of the therapeutic progress and premature reunion of the offender with his family which exposes the victim to further victimization. Lack of trust in therapy is regarded as counter-therapeutic event.
- Dilemmas resulting from models of treatment that are based on unconditional positive regard are situational where the offender is using denial as a way of

shielding himself from his responsibilities. In these cases professionals might find it difficult to comply with this principle of unconditional acceptance.

- Professionals who treat incest are subjected to negative feedback from a section of the clinical community. This could be from their colleagues who support the fact that a natural process in resolving oedipal complex, most children engage in incestuous fantasies involving the parent (Horton et al. 1990).
- Pedophiles (often perceived as all child sexual offenders, including incest perpetrators) are considered by many professionals in the therapeutic fields to be incurable. Therefore the professionals who believe that perpetrators can be curable are likely to meet resistance from those professionals who believe in incarceration, jailing and life sentences to perpetrators (Roundy & Horton, 1990).

2.10.3 Personal biases

According to Horton et al. (1990), dealing with incest effectively requires professionals to examine their own biases, which may create blind spots for them unless they are forced and appropriately dealt with. Strano and Kelly (1988) further add that therapists too are not always free from personal biases, despite agreeing in principle that they must not be judgmental in therapeutic transactions.

Ambivalence regarding the responsibility of children who behave seductively or appear to have willingly participated in sexual contact with offenders. It is perceived that professionals with unresolved issues regarding sexuality and seductivity might be biased in favour of offenders if the victimized children's seductive nature becomes known. Rather than looking beyond the victim's behaviour to the responsibility of the perpetrator not to respond, they may fix part of the blame for the incest on the children.

2.10.4 Gender biases

Herman and Hirschman (1977) argue that there is a gender difference in how professionals perceive incest and their judgement about responsibility and blame. To add on that their gender is also revealed to be strongly influencing their reaction in intra-familial

child sexual abuse. They believe that if the male therapist identifies with the male offender and is judgmental to the victim, then he will have difficulty validating her experiences and responding therapeutically. However, the female therapist may identify with the female victim and become judgmental in therapy with male offender limiting her effectiveness and her expertise in resolving the case.

Professionals might find themselves bringing their gender biases to the helping sessions. For example, male therapists siding with female victims, might attack offending males, while presenting nurturing or rescuing response to their helpless victims. If male professionals are unwilling to accept that males are capable or guilty of an incest act, they may side with the perpetrators, displacing the blame for the sexual behaviour onto seductive typical females. Female professionals might also find themselves responding in a nurturing way towards the victim while perpetrators and the victim's mother for failing to protect the child (Horton et al. 1990).

Biases suggesting that non-offending spouses such as wives may be partially responsible for the abuse of their children as a result of their failure to perform their wifely duties to meet their spouses' sexual needs. This perception might, to a certain degree, be used as the natural reaction of offenders in turning to their daughters if their spouses are not providing them with adequate affection (After all man has to have it, and if his wife is not there for him he will have to go elsewhere), (Horton et al. 1990).

2.11 THE PROFESSIONALS' FEAR OR DISCOMFORT WITH INCEST

Helping professionals are as human as their client, hence they may experience varying degrees of discomfort in working with child sexual abuse. Rather than dealing directly with the pain, guilt and problems associated with incest, they may choose to focus on the secondary effects like low self-esteem and related others.

Factors related to the intense nature of incest may become an obstacles to objective interventions by therapists (Horton et al. 1990). These factors include the following :

- Pain associated with the incestuous behaviour
Incest victims experience pain and fear which negatively impact their lives as well

as their families. Professionals who have fears of addressing these issues may fall in their attempts to provide effective treatment.

■ Emotional intensity

Emotional reactions such as anger, hatred, hostility, and so on expressed by victims, their families and other people towards incestuous offenders or during the therapy sessions might be threatening to certain professionals. This might lead professionals to avoid talking about certain issues that could evoke such feelings (Horton et al. 1990).

2.12 WHO MUST LEAVE THE HOME: THE ABUSER OR THE VICTIM?

This is a controversial issue since the offender in most cases is discovered to be the father or father figure. This question is fraught with difficulties (Renvoize, 1993).

Most professionals today agree that for the child's sake it is the father/offender who should leave home, except under exceptional cases whereupon the child would actually choose to leave. This is possible in cases where the victim is older or independent age-wise, or where the victim is being seen as a scapegoat or totally rejected by the rest of the family (Renvoize, 1993). However, the reactions of the non-offending spouse or family members during the crisis of disclosure is of vital importance. Apparently, it is inevitable to the said spouse (if the father is the offender) to see her loyalty being torn between the partner and child. Therefore, nothing can be taken for granted. The victim might end up being traumatized almost as much by the eventual outcome of the revelation of her abuse as by the abuse itself. As they make their choices, professionals should always guard against the possible victimization thereof (Furniss, 1991 & Renvoize, 1993).

Jorgensen (1991) further adds that the child can and must be made safe by removal from home at times, but he believes that this should be made as the last resort. He further stresses that every effort should be made to reunify the child with his family in a manner that is consistent with the child's safety.

2.13 INTEGRATED TREATMENT OF INCEST

According to Trute et al. (1984), integrated services for all sexually abused cases have not been easily implemented or maintained within community settings. There is still lack of service coordination persisting in most areas. However, there has been an increasing awareness, in professionals, of the deleterious effects of their fragmented and disjointed efforts to collect evidence, ensure family safety and provide treatment. Often in the intervention process, the treatment progress can be disturbed and delayed by proceedings of the judicial system. Trute et al. (1996) also believe that a major block to functional and consistent service collaboration may be due to the absence of a mutually understood service ideology which makes it easier to maintain coordinated professional intervention across service sectors. However, it does seem that attitudes held by professionals such as the police officers, child welfare workers and mental health professionals, among others, do differ particularly in terms of what manner of investigation and treatment services will serve in the best long term interest of the victims of incest and their families.

There is no direct communication existing among the South Africa professionals who handle incest clients. Sometimes clients are even not referred for other professional services (personal experience as a psychologist working in the hospital).

Trute et al. (1996) observes that the psychological trauma experienced by child victims of incest and their family members could be seriously exacerbated by service fragmentation. Without such a collegial appreciation of professional function and service view, it would be difficult to promote any development of coordinated investigations and treatment services, and to reduce the inter-agency service fragmentation which prevails amongst professionals. It is against this background that this study seeks to alert professionals of their attitudes towards clients and encouraging the formation of an integrated body consisting of different professionals who will be responsible for coordination of services pertaining to incest and other forms of child sexual abuse. It is believed that service coordination could be acquired through awareness of incest rate and its impact on the victim and other family members, encouragement of referral system of clients as well as case discussions among professionals.

Furthermore, Horton et al. (1990) reveals that legal, judicial and law enforcement personnel often do not act on the basic promise that the child victim is best served if she

is returned to her family when the incest case is resolved. The police and prosecuting attorneys, in particular, are found to be likely to believe that the victim is betrayed by both parents, thus put the family beyond repair. They often view the mother to be salvageable while the father is believed to have abdicated his rights as a parent, being beyond treatment and worthy of punishment. These professionals further believe that incarceration of the perpetrator will protect other potential victims, teaching the victim and other family members to become law-abiding people (Horton et al. 1990).

The problem encountered by professionals in the treatment of intra-familial child sexual abuse has led to the development of the Child Sexual Abuse Treatment Program (CSATP) of San Jose, California in 1971. The CSATP is based on the following premises:

- The child victim is best served if she can be returned to her own family
- To accomplish this aim, the family system must be changed from abusive to a nurturing one
- To expedite the return of the child to a healthy familial environment, system collaboration is required among the police, legal-judicial personnel, social workers, therapists and the family members themselves (Horton et al. 1990). It was discovered that the CSATP became increasingly effective as more different professionals including the legal-judicial and human services interveners integrated, and oriented their services towards the goal of returning the victims to their own families to restore normal family functioning (Horton et al. 1990)

There are few resources available in South Africa which focusses on sexual abuse cases. Unfortunately most of them focus on the legal aspects of abuse than the preservation of family and individuals in the abusive families. The usual procedure in South Africa is that, abuse cases are reported to the police who then decide to refer the victim to the hospital for physical investigation in order to confirm the abuse. In most instances the services of other professional are less regarded by the legal system, even in court proceedings. This gives an impression that the legal system is only interested in the punishment of perpetrators (Tower,1996) than in the welfare of the victims and their families.

The few abuse prevention and treatment centres in South Africa include the following:

- Resources aimed at prevention of child abuse and neglect (RAPCAN)
- Child protection unit (CPU)
- National Institute of Crime Prevention of Offenders
- Life line centres
- Trauma centres in hospitals, etc.

There are critics that , most of these services have taken a Western approach and are only rendered in the urban areas of South Africa. The language usage has been always a problem for these population, especially in the Northern Province due to its high rate of illiteracy (Mashego 2000). To combat this problem the local radio talk shows (Turf FM and Thobela FM) presented by professionals (nurses, doctors, psychologists, social workers) to reach out to the community has been introduced. The psychological services are coordinated by the Department of psychology, University of the North (Northern Province, South Africa).

Elliot (1997) stresses the importance of the therapists' capacity to model non-judgmental, accepting attitude towards persons who are sexually abused by female perpetrators. He further states that the clinicians should be able to separate their own feelings and possible conflicts regarding perpetrators. The clinicians should be able to give the client permission and freedom to process these issues for himself/herself without being negatively influenced or burdened by the clinicians' unresolved conflicts in the same area. Therefore, for clinicians working with incest cases, especially female perpetrators, according to Elliot (1997), it will be necessary to do some self-examination, and perhaps, work on some of their own unresolved issues before or during their work with incest.

2.14 PROFESSIONAL SERVICE AS EVALUATED BY INCEST OFFENDERS.

Incest offenders according to Horton et al. (1990) have made the following evaluations about the services provided by the helping professionals:

- Professionals do not know enough about its dynamics and causation, for they lack understanding of the problem and those involved

- They help many myths about incest and some express open hostility towards the perpetrators
- Others simply do not know what to suggest, at times they deny or minimize the incest problem. Often they assume that recognition or expressed remorse contributes a cure

There are new services suggested by perpetrators for helping professionals which are believed to be important in incest prevention as well as helping the affected families and incest offenders too as stated in (Horton et al. 1990). These include the following:

- Train more qualified professionals to work with incest perpetrators and increase research efforts in incest
- Have more cooperation between services and professionals in the community
- Provide legal services for perpetrators at all times in the legal process, perpetrators need to be advised on their rights, options and legal responsibilities
- Arrange with legal system, a treatment program or alternative that can be used without the threat of jail
- Offer family therapy to perpetrators in jail that could deal with incest issues
- Develop training materials and programs on the dynamics of incest for couples to study even before marriage or remarriage
- Locate group services for perpetrators and their families immediately following arrest or involvement with the legal Child Protection Services. Group and/or individual therapy should be offered to incestuous clients before conviction and involvement with court proceedings (Horton et al. 1990).

2.15 STATEMENT OF THE RESEARCH PROBLEM

The Northern Province is the most rural province in South Africa. About 91% of the inhabitants of this province are scattered in the traditional rural areas of the former Lebowa, Gazankulu and Venda homelands where access to facilities is still inadequate (Alberts, 1995). Like other South Africans, inhabitants of this province have different belief systems and attitudes which might have an influence on their professional services.

Looking at the statistics of incest in the Northern Province (see Chapter 1.2, pages 10 to 11), it is evident that most incest cases are not reported to the court of law, but dealt with traditionally at home or somewhere else without court or proper channels of intervention. This type of incest management could be contributing to the low statistics and faulty estimation of incest in the province. Nevertheless, the present statistics require professionals who are well trained and experienced to serve the incest clients effectively. I therefore, believe that the insensitive handling of incestuous clients and the emotions involved in incest management as reported by other clients and professionals, and observed during my clinical experiences as a nursing sister and intern psychologist, motivated me to conduct this study. This could be a way of encouraging awareness of attitudes, thus allowing professionals to deal with their unresolved feelings and at the same time improving management of clients.

Most of the previous researches conducted on incest in South Africa and elsewhere by Madu, Peltzer and Mashego (1998); Mashego (2000); Russell (1997); Finkelhor (1979); Horton et al. (1990) and others focussed on different aspects of incest, that is victims, prevalence, offenders and so on, while few focussed on the non-offending family members and helping professionals. There is very little incest data available or documented in South Africa particularly in the Northern Province, which focuses on the attitudes and feelings of professionals involved with incestuous clients and how that affect or influence their services in incest intervention or impact their professional judgement.

To determine the feelings and attitudes of professionals, e.g., psychologists, social workers, police officers, nurses, doctors as well as magistrates towards incest clients in the Northern Province, a study of such attitudes is required. Therefore, this research focuses on the investigation of feelings and attitudes of different professionals towards incest clients and how that interfere with their professional services to such clients, especially the offender and the victim and not excluding the family. Emphasis is placed on

the influence of feelings and experiences on professional judgement (Fargason, 1995).

Characteristics of service providers such as ethnicity, gender, educational level, preparedness of the professionals, and others will be explored to investigate their influence on the attitudes of professionals, especially that these factors are believed to have an impact on the objectivity of professionals with regard to judgement, blame, punishment and treatment of clients (Reidy & Hochstadt, 1993, McKenzie & Calder, 1993).

Considering that countertransference reactions and feelings experienced by professionals during therapeutic sessions impact on intervention process, the study will look into how these reactions affect their attitude towards the incest victim, perpetrator or the family. The study seeks to come up with a strategy towards possible solutions to the problems experienced by professionals, with a view of working towards encouraging some feedback and referral system amongst professionals handling incest.

2.16 THE AIMS AND OBJECTIVES OF THE STUDY

This study intends to explore the awareness of attitudes, feelings, emotions and experiences of different professionals which are likely to interfere with services rendered to incest clients. It also seeks to identify factors which contribute to the manner in which professionals interact with incest victims, families and offenders, and to establish the outcomes of such interactions in a professional setting, thus highlight problem areas.

The study further intends to explore professional attitudes in relation to the treatment, punishment, and attribution of blame during intervention processes. The focus is on how these attitudinal factors interfere with professionals' services toward incest clients. Furthermore, this research will also highlight the need and importance of incest training and experience on incest intervention among different professionals. That is, identifying the relationship between incest training and experience against professionals' attitudes of blaming, treatment as well as punishment.

Lastly, the study also seeks to identify factors which tamper with empathetic identification with incest clients, consequently causing professionals to confuse their separate roles as advocates for victims and objective professionals. Factors could include among others the age and gender of the professionals.

CHAPTER 3

3. METHODOLOGY

This section of the study consists of data collection and sampling, sample size, data collection instruments used and methods of data analysis used.

3.1 DATA COLLECTION AND SAMPLING

The data was collected amongst different professionals in the Northern Province: Seshego, Pietersburg and Mankweng. Data was collected in hospitals, child protection units as well as the magisterial offices of the selected areas. The selected areas were given a high preference for data collection of this study because of their proper services of all professional categories involved in the study. For example, there are clinical psychologists permanently based in the Pietersburg / Mankweng complex collaborating with Seshego hospital. In addition there are also clinical psychologists and four senior clinical psychologists giving part-time services in these hospitals. The Mankweng/Pietersburg hospital complex serves as a referral centre for complicated medical cases and sexually abused cases including incest from the peripheral hospitals of the Northern Province. In essence, there is higher expectation of contact with more incest clients for different professionals who are involved in this study. The Mankweng/Pietersburg hospital complex is also a training complex for intern psychologists, social workers and nurses from the University of the North, medical students from the Medical University of Southern Africa and nurses from Mankweng nursing college. Therefore this makes proper referral of patients to be followed so that students can get appropriate exposure.

There are also proper Child Protection Units (CPU) services rendered in these selected areas of the Northern Province. Seeing that this is still a newly established unit in the country, the numbers of personnel are few in the selected areas, but the service is been rendered. The magisterial and social work services have been functioning well in the selected areas of the study so far.

There were 157 professionals of different categories proposed to participate in this study. The number of each professional category in the sample depended on the overall total of such professionals in the areas selected for the study. Information about total

numbers of professionals was taken from the following departments, Department of Health and Welfare, Department of Justice and Safety and Protection and Psychological Society of South Africa.

There are 180 nurses of different categories working in gynaecology, pediatric and casualty departments of Mankweng, Pietersburg and Seshego hospitals. All nursing categories were included in the study as long as they satisfied a requirement of having been exposed to incest client/s. Sixty (60) nurses were intended for inclusion in the sample with twenty (20) nurses selected from each of the three departments on a random basis. However, only 39 nurses (gynecology 14, pediatric 16, and casualty 9) could manage to complete both the interview and the incest blame, as well as the treatment punishment scales. Professionals were approached individually and at their convenient times. Twenty one nurses refused to be involved in the study process.

In the case of medical doctors there were 29 doctors in gynaecology, paediatric and casualty departments of Mankweng, Pietersburg and Seshego hospitals who were all to be included in the study. Each one of them was approached at different times, but only 12 of them managed to complete both the interview and the two scales.

There were 17 police officers working in the child protection units of the selected areas who were all supposed to have been included in the study, however, 14 officers complied with the requirements. There were also 21 magistrates in the three areas selected for the study, 15 of them agreed to participate in this research process.

All 12 clinical psychologists in the selected areas were to be included in the sample, eventually 10 of them were available for the study.

In the case of social workers, there are 18 of them working in the selected areas for the study, only 13 completed the research process. In total, a group of 54 professionals was not available for complete participation in the study (see Table 1 for details).

The collection of data was completed over a three month period. All respondents were assured of confidentiality and anonymity, and these were maintained. Permission for carrying out the study was granted from different departments concerned.

A group of professionals from different categories mentioned before was utilized to gather data for this study. An important requirement was that a participant should have had contact with incest clients; victim or perpetrator and/or their family. There was no specific number of clients set for professionals in order to be included in the sample, as long as one has been exposed to at least one client. As to the medical participants (nurses and doctors) of all categories, they should also be working in either gynaecology, pediatric departments as well as casualty. Each professional had to give a brief description of one case they have managed.

Almost all clinical psychologists in the Northern Province were included in the study, so too were the police officers working in the CPU and other female police officers who often help with sexually abused cases, as well as almost all magistrates in the selected areas of the Northern Province. The last group of participants included social workers working in the hospitals and judicial offices of the selected areas for the study.

3.2 THE SAMPLE SIZE

The final sample consisted of 103 professionals of different categories.

- 13 social workers who are involved in the CPU and custody services
- 14 police men and women working in the CPU
- 39 nurses working in casualty department, pediatric and gynecological wards
- 12 doctors working in casualties, gynecological and pediatric wards who are expected to examine incest victims and give reports
- 15 magistrates who are expected to listen to the testimonies of the parent/s and victims and/or even to pass sentences to perpetrators
- 10 clinical psychologists who deal with the emotional aspects of the victims and their families, and later also to assess and give therapy to offenders

3.3 DATA COLLECTION INSTRUMENTS USED

Two questionnaires and a semi-structured interview were used to collect data measuring experiences, attitudes and feelings of professionals towards incest clients and how that affect their professional judgement, intervention and personally. An interview

was first conducted with each subject followed by the administration of both the Treatment Punishment Scale (TPS) and Jackson Incest Blame Scale (JIBS).

The summary of data collection tools used:

Jackson Incest Blame Scale (JIBS) is a 20-item self-report measure of the attribution of incest blame. The JIBS is categorized according to four subscales, namely: the victim, societal, situational, offender/offender mental status subscales (Jackson & Farguson, 1983). The scale measures four constructs and attribution of blame according each subscale. Items are scored on a 1-5 point continuum (from 1- strongly agreed to 5- strongly disagree). The internal reliability of the scale was measured by means of Cronbach alpha at .79, while the split half reliability range between .65 and .75. The mean scores of each subscale will be used to determine the relative extent to which each factor is endorsed. Higher scores represent a greater attribution of blame. Refer Appendix D for arranged subscales.

The Treatment Punishment scale (TPS) consists of 10 items with Likert type response (from 1- strongly agree to 5 - strongly disagree) with internal reliability of .44. The test assesses attitudinal differences focussing on treatment and punishment between professional groups on these factors:

1. Perpetrator treatment e.g. perpetrator mentally ill rather than a criminal
 2. Perpetrator punishment e.g perpetrator to be arrested and jailed
 - 3 The family treatment (the victim and the non-offending spouse should be treated)
 4. The family treatment (the victim and the non-offending spouse should be punished)
- (Wilk and McCarthy, 1986). Refer Appendix D for arranged subscales.

A semi-structured interview with both closed and open-ended questions was conducted with each professional (for example, what is your view about abusive men/ women? Do you find yourself emotionally involved when handling incest cases? And why? Do you feel comfortable when treating incest clients especially perpetrators? And why? Do you need more information about incest? etc refer Appendix A). The questions included a real case description by the professionals which assisted the researcher in evaluation. The case was also used to assess the frequencies of the father - daughter incestuous relationship. In addition, the case served as a tool to discriminate the age of victims and to exclude those professionals who were never exposed to either incest victim or perpetrators.

This was used in collaboration with the questions which required the actual numbers of incest cases managed by each professional.

The personal data information comprised of items surveying participants' demographic information, theoretical orientations, years of experience in their department, and their own sexual victimization. The number of sexual abuse cases treated and highest gender treated were also covered here. The biographical data included the sex, age, marital status, and qualification as well as the occupation of each professional. The professional training and types of incest training and in-service training provided within the department were also investigated in the study. Significantly, questions about the professional's emotional involvement during intervention and their attitudes and interest towards treating perpetrators, victims and their families were also evaluated in an open-ended way (refer Appendix A).

3.4. DATA ANALYSIS

Different statistical methods were used to analyse data. The SPSS was utilized. For analysis the descriptive statistics (frequencies and percentages etc.) were used. Both qualitative and quantitative analysis of data were executed. Pearson's correlations were performed on all predictor variables and on all criterion variables to determine any correlations.

An analysis of the variance (ANOVA) and the Post hoc test were performed to indicate professional differences. T-test and the *f*-test were also performed on subscales of Treatment Punishment Scale and the Jackson Incest Blame Scale to assess variances amongst professional groups.

The content analysis approach was used to interpret specific themes of incest (Jick, 1983). Data obtained from the interview was systematically analysed (arranged in pairs according to similarities) to discover patterns of meaning and experiences common to professionals, to formulate suggested answers to research questions, and to develop conclusions derived from the range of data given above.

CHAPTER 4

4. RESULTS

The findings of this study will be presented in different parts. The parts division will be done as follows:

- 4.1 The socio-biographic characteristics of participants
- 4.2 Themes on attitudes towards offenders and victims
- 4.3 The need for more information and training
- 4.4 Treatment punishment factors as well as blaming attitudes of the professionals
- 4.5 Correlation of blaming and treatment / punishment factors

4.1 THE SOCIO-BIOGRAPHIC CHARACTERISTICS OF THE PARTICIPANTS

There were 157 professionals from different categories proposed to participate in this study, however, the final sample consists of 103 participants (see Table 1). All participants were exposed to either incest victims or perpetrators and their families.

Table 1 indicates the numbers of targeted and actual professionals of this study. It also shows the different professional groups according to gender.

Table 1: Number of participants from the six professional groups by frequency and gender

PROFESSIONALS	TARGETED TOTAL	GENDER		ACTUAL PARTICIPANTS
		MALES	FEMALE	
Nurses	60	0	39	39
Doctors	29	7	5	12
Policemen /women	17	10	4	14
Magistrates	21	9	6	15
Clinical Psychologists	12	5	5	10
Social Workers	18	0	13	13
TOTAL	157	31	72	103

Since the number of nurses working in the selected areas for the study was higher (38%) than other professional categories, the data over represents nurses and under represents other professionals, especially clinical psychologists.

4.1.1 The age and gender factors of professionals, victims and perpetrators.

The mean age of the participants was 36,02 years with a standard deviation of 6,41. The minimum age of subjects is 24 years, while the maximum age was 50 years.

From each case described, participants were asked to give an estimate of the victim's age and also to specify the relationship between the victim and the perpetrator. Ages of the victims range between 4 and 18 years with the mean of 9.28 years. Perpetrators were adults (most of them were fathers or stepfathers of the victims). The ages of the victims were also used as a predictor variable on attitudes of professionals on blame, treatment and punishment of perpetrators.

The sample of the study consisted of 31 male professionals (30%) and 72 female professionals (70%). Females are over represented in this sample than males (see Table 1).

4.1.2 Ethnicity and marital status

Out of the sample for this study, 61 respondents (60%) were Northern Sotho speaking; 10 Tsonga speaking 9,7%, 2 Venda speaking (1,9%) and 2 from the Southern Sotho speaking (2%). A total of 28 professionals (27,2%) were included in the collective category of others consisting of whites, Ndebeles and Tswanas. Of all the nurses who responded, 29 (74,4%) were Northern Sotho speaking. In the category of others the medical doctors formed 50% (6) of the respondents. Of all the Police personnel who responded, 10 of them (71,4%) were Northern Sotho speaking. The Northern Sotho speaking psychologists formed 70% (7) while the social workers who are Northern Sotho speaking were 4 (30,8%). Obviously, the results indicate that the sample over represented Northern Sotho speaking professionals than others.

Of all the respondents, 74 (72 %) were married, while 23 (22,3%) were single. The divorced group formed 2,9 % (3) of the respondents. This group shared the same percent with the widowed. Almost all professionals (99%) who participated in the study had children.

4.1.3 Reported levels of education, training and experience

The findings indicate that the highest qualified category was that of psychologists with all of them (100%) having the masters degree while the lowest were the police with 9 diplomas (70%) and 4 (30%) had other lower qualifications. Ten medical doctors (83%) and 13 magistrates (87%) had junior degrees with few of them holding senior qualifications. The results further indicated that 9 participants (9%) had a master's degree while 2% had a doctorate degree.

Fifty-four professionals (54%) reported to have had no incest training while 49 of them (49%) had received some training on incest. Among those who had training, the sequence was 9 psychologists (90%), 10 magistrates (67%), 8 social workers (62%), 6 doctors (50%), 5 policemen/women (36%) and 11 nurses (28%). Of the 28 nurses who had incest training, 40,9% acquired their incest training through readings and 9,1% through workshops. From the 50% of medical doctors, 25% accumulated their incest knowledge through reading and 25% through individual means. Amongst the 36% of the policemen/women who agreed to have had incest training, 41,7% attended workshops. Twenty-two percent of the professionals acquired their incest knowledge through training, 19% through readings and 19% through individual means.

Seventy-nine professionals (77%) denied having any incest in-service training within their disciplines. This was more common among social workers, medical doctors, nurses and police officers. That is, their disciplines do not offer specific training on incest at all. Sixty-three professionals (61%) reported not to have had prior professional experience preparing them to work with incest clients, whereas only 39 professionals (38,2%) consented to have had practical experience of incest during their training. Professional experience was also acquired through classroom training (80%), internship (45%) and workshops (30%). About 35% of the professionals were inexperienced in working with incest clients. Eight clinical psychologists (89%) and 12 magistrates (80%) were found to have had prior experience in working with an incest client through classroom training and

practical experience. Seventy percent of psychologists enhanced their incest-based knowledge through workshops, whereas 33,3 % of magistrates regularly have in-service training on care about incest and rape clients.

Professionals' years of experience working as professionals were assessed on various levels ranging from zero to ten years;

- 0-1 years, 36 professionals (35%), common among medical doctors, psychologists and social workers
- 1-5 years, 27 professionals (26,2%), common among nurses, and social workers
- 5-10 years, 29 professionals (28%), common among magistrates and police officers
- 10 and above 11 professionals (10.7%), common among magistrates

4.1.4 Personal experience of incest

Regarding personal experience on incest in one's own family, 84 professionals (81,6%) denied having had experience in this regard, whereas 19 (18,4%) confirmed their experiences. Eight nurses (42%) amongst all professionals have had incest experience in their families, hundred percent of these nurses were females. All clinical psychologists had no incest experience in their own families. Eight professionals (8%) were once sexually abused, while 5 professionals (92%) reported to have had no history of sexual abuse. Fifty percent of those who have had abuse experience were magistrates. Of significance is that this factor did not seem to show noticeable impact on their professional attitudes.

4.1.5. Numbers of incest cases managed and the interest or desire in working with incest clients.

All professionals (100%) were exposed to incest clients. Nurses had a maximum of 100 incest victims, 4 perpetrators and 60 family members. It was also discovered that other professionals especially the medical personnel had little experience with offenders and their families. In average the medical practitioners treated a maximum of 25 incest victims, 2 offender and 5 family member. The police officers had contacts with 20 incest victims, 25 incest offenders and 16 families. The magistrates were experienced with 50 incest victims, 50 incest offenders and 8 families. Clinical psychologists had a maximum of 52 incest victims assessed, 8 offenders and 28 families. Lastly, social workers assessed a

maximum of 33 incest victims, 5 offenders and 30 families.

Summary of incest clients seen by professionals:

	Mean	SD
Victims	= 8.30	4.68
Perpetrators	= 4.41	8.79
Families	= 4.64	8.44

Professionals showed different levels of desires or interests in working with incest clients (see Table 2). The following table indicates their (professionals') levels of desire or interest in working with victims, perpetrators as well as their families.

Table 2: Professionals' desire or interest in working with incest clients by percentage

Levels	Nurses	Doctors	Police	Magistrates	Clinical Psychologists	Social Workers	TOTAL %
Victim							
High	79.3	58.3	71.4	60	100	69.2	73
Moderate	15.8	17	27	40	-	16	20
Low	8	25	-	-	-	16	8
Perpetrator							
High	16	17	50	20	20	46	26
Moderate	29	8	22	67	30	23	31
Low	55	75	29	15	50	31	45
Family							
High	63	42	100	74	100	62	71
Moderate	24	34	-	27	-	23	20
Low	13	25	-	20	-	16	10

When determining the interest or desire of professionals working with incest clients, 72,5% of them (professionals) indicated a high interest of working/helping the incest victims, while 70,6% of them indicated a high interest in helping the family. It was also discovered that only 25,5% of professionals indicated a high interest in working with perpetrators. This was more common among the police officers with 27%, while 8% was

constituted by both the medical personnel and clinical psychologists. Generally, 45% of all professionals showed a low interest in helping perpetrators.

From the case descriptions each professional gave, it was discovered that 95% of incest victims were females with the highest severity of the abuse (83,9%) being sexual intercourse. The study further discovered that incest offenders ranged from biological fathers, brothers, uncles to grandfathers. Both biological fathers and step-fathers counted 78,6% (see Appendix A).

4.2 THEMES ON ATTITUDES TOWARDS VICTIMS AND OFFENDERS

Analysis of responses on this part of the study is based on the open-ended questions from the interview section. Follow-up description of responses was required by the researcher.

4.2.1 Thoughts on abusive women and men

In attempt to answer the question “*(What do you think about abusive men or women?)*”, different responses from professionals were elicited, this included the following; (a) the view that incestuous abusers are mentally unstable, (b) abusers are victims of abuse, (c) abuser are insensitive and cruel, uncaring and stupid, (d) over-possessive. Fifty seven professionals (55,3%) argued that incest abusers are mentally unstable (this included impulsiveness, low self-esteem, low frustration tolerance), for example, “I think they are sick, cannot control their impulses, and they seem to have feelings of inferiority complex (low self esteem) ”.

Thirty-eight professionals (27%) showed a lot of anger against abusers, and further stressed that they need to be jailed. The response was found to be more among nurses and police than other professionals in the sample. Amongst the professionals who mentioned that abusers are mentally unstable (this ranged from 30,8% to 80%), it was discovered that 12 magistrates (80%), followed by 7 psychologists (70%) and the least were 4 social workers (30%) agreed with this factor. Only 4 participants (4%) believe that abusive men and women are victims of abuse themselves. However, 5 respondents (4,9%) contended that abusive women are uncaring and stupid. These responses are more or less similar for both men and women.

4.2.2 Transfer of responsibility for the abuse

It is contended that 78 professionals (75,7%) stressed the fact that victims are never responsible for the abuse, while only 24 (23,3%) mentioned that they are sometimes responsible though. More than half of magistrates argue that victims are sometimes responsible. Seventy-six professionals (74%) believed that in most cases perpetrators are responsible for the abuse, while only 3 participants (2,9%) were contrary to the idea. Forty-seven percent of magistrates argue that perpetrators can only take responsible for the abuse sometimes. Seventy-four professionals (71,8%) believe that mothers are in one way or another responsible for the victims abuse, whereas only 28 (27,2%) contend that mothers are never responsible for their children's abuse.

The study also discovered that 66 participants (64,1%) believed that the victims' responses are always realistic. To add on that, the victims' responses, 94 participants further mentioned that in most instances victims are either passive or resistant. In order to evaluate perceptions of professionals about victims' responses regarding the abuse, this question was asked, *"how do you as a professional feel about the responses of your client/s?"* The majority of professionals believed that victims are forced to comply to perpetrator's actions due to various reasons. Reasons for their responses were mostly attributed towards threats and fear elicited by their abusers. For example, victims are threatened with their lives, that no one will believe them or people will blame them for the act and so on. Victims therefore, become afraid and keep silent about the abuse. However about 7,8% of victims comply with the abuse due to the incentives promised by the perpetrators (for example "children are sometimes promised money and some special favours for their compliance").

Furthermore on the same question, respondents argued that victims should react more actively, though they are sometimes unable to do so because the society treats incest as a secret or taboo (8,7%). In certain situations the victims are made by abusers to view incest as a normal sexual act (12,6%). This is for example, reflected in the statement: "other people practice incest, therefore, they will not take you seriously if you tell them." About 5 professionals (4,9%) demonstrated a more sympathetic response towards the victims. For example: "I always feel pity for the victims for having been betrayed by people they trusted most."

4.2.3 Believing versus not believing

The study further discovered that 70 professionals (68%) indicated that they do not have problems believing that the victim had been sexually abused. Only 33 professionals (32%) agreed that they are often doubtful about the reports of incest abuse. About 13 nurses (39%), 6 social workers (18%), 4 police officers, 4 magistrates and 4 medical doctors all with (12%) respectively, agreed to be having problems believing the victim's report of abuse. It was further stressed that certain professionals such as magistrates and police believe in first investigating the report before they could believe or pass any sentences about the abuse, arguing for example that "in cases of parent-child incest reports, children might be used to fulfil the needs of the non-offending spouse". In most instances professionals indicated that they experience problems believing the victims, especially when the latter are teenagers (years unspecified in this study). One of the participants said ("I have problem in believing teenagers unless I have evidence to prove their reports of abuse").

4.2.4 The degree of comfort and emotional involvement when treating incest cases

Forty-two professionals (40,8%) indicated to be comfortable when treating incest perpetrators. It was also interesting, however, to discover that 61 professionals (59%) were not comfortable at all around incest perpetrators. About 11 doctors (91,7%), 29 nurses (74,4%), 7 social workers (53,8%), 4 magistrates (40%) and 4 psychologists (40%), 4 police officers (28,6 %), all mentioned that they experience or could experience discomfort while managing incest perpetrators.

Twenty-seven professionals (26%) attributed their comfortability before the incest perpetrators to training and knowledge acquired prior to their transactional exposure to incest cases. The feeling of training and experience was predominant among the magistrates, psychologists and police officers. When answering this question, (*do you / would you feel comfortable when treating incest perpetrators, and why?*), one psychologist argued that "if you are trained you automatically become more relaxed and comfortable during the intervention process." Seven professionals (6,8%) stressed the fact that knowing that incest perpetrators are sick and need help, make them feel comfortable and eager to help.

Of all professionals (59%) who experience discomfort working with incest perpetrators, 51 of them (50%) reported that they feel too emotional and angry during interventions. These feelings are common amongst social workers (77%) and nurses (72.7%). About 2% of the nursing professionals stated that the main reason for their discomfort when helping incest clients could be due to lack of incest training and knowledge on their part. This reason was cited by only 5,1 % of the nurses. Fifteen percent of all the professionals, mostly doctors with eight of them (67%) consenting that incest perpetrators are dangerous, hence their discomfort when around them. One of the female doctors said “I always feel as if they can rape me too, sometime perpetrators can be threats to those who want to intervene, I always feel vulnerable in their presence.”

In terms of emotional involvement of professionals with their victims, various reasons for such involvement were tapped out. Table 3 will illustrates reasons why professionals say they are emotionally involved during encounters with incest clients.

Table 3: Reasons of professionals for being emotionally involved when helping victims by percentages

Reasons	Nurses	Doctors	Police	Magistrates	Clinical Psychologists	Social Workers	TOTAL %
Physical Trauma	15.4	8.3	2.4	26.7	40	-	18
Minor children	5.1	16.7	14.1	-	-	15.4	7.8
Sympathy	66.7	66.7	50	53.3	50	69.2	61
Anger	12.8	-	7.1	6.7	-	-	6.8

It was also discovered by the study that, only 16,5% of the professionals reported that they do not become emotionally involved when treating incest cases, while almost all (86) professionals (83,5%) said to be inevitably emotionally involved in their clients.

Reasons for their emotional involvement include cases where physical trauma (17,5%) like vaginal tears, venereal diseases and a host of related others are involved, especially when the victim was a minor child (7,8%) mostly less than 10 years of age. This feeling is more common amongst psychologists (40%). Sixty-one percent of all

professionals noted that their emotional over involvement could be due to too much sympathy towards the victim (see Table 3), as reflected by one of the female participants, “I sometimes associate the victim with my own child or someone close to me, this makes me feel very emotional, I see victims being pressured against their will. I always ask myself, how is this child’s future going to be ?” This feeling was predominant among all professionals in this study. Other professionals (6,8%) stated that they inevitably became too angry with the perpetrators.

4.3 THE NEED FOR MORE INFORMATION AND TRAINING ON INCEST

Almost all 93 professionals (92%) responded affirmatively to the question “*Do you require more information or training on the incest treatment?*” Almost all professionals indicated the need for more training about incest, percentages were as follows; police 100%, magistrates 100%, and clinical psychologists 100%, social workers (91,7%) nurses (89,7%), and medical doctors (72,7%). Most of the professionals maintain that training is essential if one has to handle the situation objectively, in order to control their emotions. They stated for example, that they “I still need more information and experience on managing incest clients As well as my own feelings.” The areas which 85 professionals (90%) felt that they need more attention on were mostly the management strategies of incest as a whole. These include information about identification and diagnosis of incest, treatment options, intervention skills and control of ones emotions. Only 2 professionals (9,5%) indicated the need for more knowledge about an incestuous family and on handling of the perpetrator.

The methods of training suggested by 85 professionals (90%) on how their knowledge of incest can be improved included, workshops and in-service training provided by trained and experienced professionals.

4.4 TREATMENT/PUNISHMENT AND BLAMING OF INCEST CLIENTS

The Jackson Incest Blame Scale (JIBS) and Treatment Punishment Scale (TPS) were both quantitatively and qualitatively analysed. Following is the analysis thereof.

4.4.1 Perpetrator punishment

Table 4 illustrates the professional's differences on perpetrator punishment subscale of the Treatment Punishment Scale. Responses on perpetrator punishment are presented in table 4.

Table 4: Responses of professionals who agreed with punitive items of Treatment Punishment Scale of perpetrators by frequencies and percentages

Items	Nurses	Doctors	Police	Magistrates	Clin Psychologist	S.Worker	Total %
Perpetrator: arrest	(35)89,7	(12)100	(13)92,9	(10)66,7	(10)100	(9)69,3	(89)86,4
Perpetrator jail	(33)84,6	(13)100	7 (92,9%)	(6)46,7	(8) 60	(8) 61,6	(79)76,7

Eighty-six percent of all professionals again supported the arrest of perpetrators. Hundred percent of both doctors and clinical psychologists supported the arrest of perpetrators. Seventy-seven percent of all professionals opted for or agreed to jail sentence for incest perpetrators. Almost all professionals supported the issue of arresting the perpetrators with 100% of doctors and psychologists as well as 93% of police officers.

However, on the jail sentence, almost all professionals opted for jailing of perpetrators as a solution to incest, except for more than half of magistrates (54%) and 40% of the psychologists. On the jail sentence for perpetrators 100% of doctors sided with the idea, followed by police officers with 92,9%, and nurses 85%, lastly social workers with 61,6%. This indicates that police officers, doctors followed by nurses are the most punitive oriented professionals towards perpetrators than clinical psychologists and social workers with the least being magistrates.

The above findings further show consistency on both arrest and jail sentences favoured by professionals as desirable solutions for perpetrators. There was also evidence of consistency on responses of both nurses and social workers about their decision on arresting and jailing perpetrators which counted 90%, 84,6% and 69,3%, 61,6% respectively. The same support of arrest and jailing is still found between doctors and police officers.

The above responses were similar to those from the interview open-ended question which required that professional indicate what they would regard as the best treatment for perpetrators. On this question 53 professionals (52%) supported rehabilitation of perpetrators than punishment. One of the responses which cropped up was that *“perpetrators should get a life imprisonment because they are cruel and will never change, they can never be rehabilitated.”* Other professionals favoured the arrest of perpetrators without being too punitive when it comes to jail sentence. The psychologists and social workers with 60% as well as magistrates with 46,7% on the question of jailing, indicated some leniency on sentences of perpetrators than other professionals.

The ANOVA was performed on the Jackson Incest Blame Scale and Treatment Punishment Scale to determine any significant differences among professionals groups (see Table 5 for illustration of the results).

Table 5: Total ANOVA values of JIBS and TPS subscales between occupations

Sub-scales		Sum of Squares	df	mean squared	F	P
Jackson Incest Blame Scale						
Victim blame	between groups	54.917	5	10.98	1.003	.42
Societal blame	between groups	316.276	5	63.26	3.612	.005***
Situational blame	between groups	157.247	5	31.45	2.011	.08
Offenders blame	between groups	81.153	5	16.23	3.090	.01*
Blame total	between groups	1611.431	5	322.29	3.264	.009***
Treatment Punishment Scale						
Perpetrator punishment	between groups	67.490	5	13.50	6.264	.000***
Perpetrator treatment	between groups	20.813	5	4.16	1.293	.27
Family punishment	between groups	49.456	5	9.90	2.214	.06
Family treatment	between groups	67.005	5	13.40	4.350	.001***

P is significant at .05, .01, .001.

Looking at Table 5 it is clear that there are significant differences on certain subscales of both the JIBS and TPS. The ANOVA indicates that there is a significant difference between the professional groups on the societal subscale ($f = 3.612$, $p < .005$) and on the offender subscale ($F = 3.09$, $P < .01$) of the JIBS. The total blame shows that there is a significant difference between professionals on the blaming attitudes ($f = 3.264$, $p < .009$).

However, the ANOVA shows significant differences between professional groups on the JIBS and TPS subscales, but does not indicate between which professionals does the difference lie. To indicate the specific or actual differences among professionals, the Post hoc test was performed. Table 6 illustrates the Post hoc test differences of professionals on the JIBS and TPS subscales.

Table 6: The Post Hoc test of the JIBS and TPS subscales showing the differences amongst professional groups.

Dependant variable	Occupation		Occupation		F	P
	M	SD	M	SD		
Treatment Punishment Scale (TPS)						
Perpetrator punishment	Magistrates		Nurses		6.243	.000***
			11.2	2.4		
	2.9	1.5	Doctors	11		
			3.0			.006**
	-		Police	2.4		
			5.13			.001***
Family treated	Social Worker		Nurse		4.35	.01**
			6.9	1.9		
	3.9	2.4	Doctors	1.2		
			6.2			.003**
	-	-	Magistrates	1.2		
			6.3			
			6.3	1.8		.01**
Jackson Incest Blame Scale (JIBS)						
Societal Blame	Doctors		Police		3.612	.001***
	11.8	4.7	18.5	3.8		
Offender Blame	Doctors		Magistrates		3.09	.05*
	8.8	1.5	11.4	2.2		

Societal Blame	Total blame 14.9	4.5	Police 18.50 Doctors 11.8	3.8 4.7	3.612	.002**
Situational Blame	Total blame 15.0	4.1	Police 17.9	3.8	2.011	.002**
TOTAL BLAME	Total blame 61.71	10.47	Police 70.2	10.8	3.264	.002**

P is significant at the .05* .01** and .001*** level.

The treatment punishment subscale indicate that there is a significant mean difference between magistrates and doctors, nurses and the police officers in terms of perpetrator. While most of the professionals support perpetrator punishment, magistrates were found to be less punitive than others. These professionals tend to opt for more punishment for perpetrators than the magistrates. On the other hand, the significant difference amongst social workers and other professionals such as doctors, nurses, magistrates and psychologists. This indicates that social workers show little support towards family treatment than other professionals. On the JIBS, a significant difference is found between doctors and police in terms of societal subscale. The police officers particularly attribute more blame of incest towards societal factors than do the doctors. Evidently, the police attributes more blame towards societal and situational factors and contribute more blame on the total blame than other professionals. There is also a significant difference found between the doctors and magistrates in terms of offender blame. Magistrate attributes more blame towards offenders than doctors.

4.4.2 Perpetrator treatment

Items of the TPS on perpetrator treatment were illustrated on table. This table shows professionals' responses on perpetrator treatment subscale by frequencies and percentages. The table shows responses of professionals who agreed to perpetrators as being mentally ill than criminal, and the responses of professionals who disagreed to the court ordered counselling for the perpetrator.

Table 7: Positive responses of professionals on perpetrator treatment by frequencies and percentages

Items	Nurses	Doctors	Police	Magistrates	Clin. Psych	S Workers	Total %
Offender mentally disturbed	9 (23)	2 (16.7)	2(14)	4 (27)	5 (50)	2 (14)	24 (23)
Remove victim from home	8(25.6)	0	2 (14)	3 (20)	0	2 (15.4)	17 (16.5)
Offender court counselling	30 (79)	8(66.7)	12(86)	15 (100)	10 (100)	10 (77)	85 (83.3)

The fact that the perpetrator is rather mentally disturbed than a criminal, was approved by 24 professionals (23%). Twenty-seven professionals (26%) showed uncertainty about the mental status of the perpetrators, while 52 of them (51%) stated their disagreed to the issue of mental disturbance as an excuse for the offender's action. Five psychologists (50%) and 4 magistrates (27%) had the highest members who supported the fact that the perpetrator could be mentally ill, while 50% and more of professional categories disapproved the issue of mental illness as the reason behind the perpetrator's incestuous act. While only 16,5% of all the professionals agreed to the issue of removing the (victim) daughters from home, not the perpetrator, 74 professionals (71,8%) disagreed to this fact.

However, in terms of treatment for perpetrators, 85 professionals (83,3%) agreed that the perpetrator could be helped through court ordered counselling, while 9 professionals (8.8%) disagreed to the possibility of behavioural changes for the perpetrators through court ordered counselling. All magistrates and psychologists believed that the court ordered counselling could be useful for perpetrators.

4.4.3. Family punishment or treatment

Sixty-four professionals (62%) disapproved the fact that the family (mother and victim) should be punished. It was also discovered that 91 professionals (88,3%) also disapproved the accusation of guilt on the part of the victim. However, there was no

significant mean difference relating to the professionals' responses on family punishment. Concerning family treatment, 51 professionals (50%) indicated that they have limited confidence on mental health therapy "without court" intervention for helping the family. Moreover, 7 psychologists (70 %) and 10 police (72 %) officers were not agreeable to the fact. However, it was noticed that 13 magistrates (87%) also chose to support the issue of mental health therapy of families with court intervention. Furthermore, 81 of all professionals (80 %) opted for the removal of the perpetrators from home and further supported the fact that the victim and non-offending spouse (family) might thus be helped through mental health therapy. All doctors and psychologists opted for the removal of the perpetrator from home in support of family therapy. Eighty-nine professionals (86%) believe that the court-ordered mental health therapy can help the incestuous family. All the doctors (100%) and the police officers (100%) with 36 nurses (93%) also supported the court-ordered mental health therapy. In conclusion, it is evident that professionals support the court-ordered mental health therapy for both the perpetrator and their families more than the treatment without court intervention.

4.4.4 Age and blaming attitudes and treatment punishment

The *t*-test evaluations in this study show that there are significant mean differences among professionals who are 35 years and less, and those who are above 35 years. The mean values of the professional's age differences on the Jackson Incest Blame Scale and Treatment Punishment Scale will be illustrated in table 8.

Table 8: An Illustration of age differences on the blame and treatment punishment subscales

Sub-scales	< 35 years M (SD)	> 35 years M (SD)	T- test	P
Jackson Incest Blame Scale (JIBS)				
Victim Blame	22.9 2.5	21.31 3.6	2.42	.02*
Societal Blame	14.5 4.9	15.10 4.1	-0.6	.52
Situational Blame	15.0 3.6	15.0 4.4	0	1.0
Offender Blame	9.13 2.5	10.5 2.2	-2.9	.000*
Blame Total	61.5 9.4	61.9 11.3	-0.2	.87
Treatment Punishment scale (TPS)				
Perpetrator treatment	3.47 3.6	3.66 1.7	-0.6	.57
Perpetrator punishment	5.44 2.2	5.26 1.4	0.52	.56
Family punishment	12.2 2.1	11.5 2.2	1.87	.07
Family treated	7.2 2.2	6.8 2.0	1.23	.26

Significant at <. 05, <. 01 and <. 001

There is a significant difference between professionals' age and victim and offender blame. This indicate that the younger the professional the more the victim blame (M 22.9/ 21.3). However, there is no mean difference among professionals on the issue of situational blame (M = 15.0). The *t*-test also indicated that older professionals blame the offenders more than younger ones, hence the former are seen to contribute more blame to the total blame. The younger group attributes more blame to the victim, while the older ones attribute more blame to the society, and offenders.

The Treatment Punishment Scale indicates that younger professionals support the fact that offenders should be punished for their acts, while older ones support offender treatment. Although older professionals evidently prefer a punishment approach, especially towards the family (the mother and the victim) they however, support treatment approach for the family.

4.4.5. Gender versus blaming and punishment \ treatment

There is no significant difference in the mean scores of males and females on the Jackson Incest Blame Scale (JIBS) and Treatment Punishment Scale (TPS). However, the pattern of responses shows that males scored higher than females on three subscales of the JIBS, except the victim subscale. The total blame for gender indicates the following mean scores ($M = 64.52$, $SD = 12.33$ for males and $M = 60.93$, $SD = 9.56$ for females).

Sex differences are evident in the ratings of the victim subscales. The mean scores show that females attribute more blame to the victim subscale than men, while males tended to attributes more blame to situational factors than females.

In terms of the Treatment Punishment Scale (TPS), the *t*-test scores indicate that more male professionals are strongly in favour of the fact that perpetrators should be punished while the female professionals strongly support that the family should be treated. However, the difference is very small and insignificant.

4.4.6 Incest training and blaming and treatment \ punishment attitudes.

The Treatment Punishment Scale shows that work experience is negatively associated with perpetrator treatment ($t = -2.26$, $p < .03$). It is thus hardly surprising to note that the mean score for professionals with more experience differs from the mean scores of professionals with less experience, especially on perpetrator treatment. An interval difference between the experienced is (-1.5 and -.10). This further shows that professional experience has an influence on blaming and treatment punishment attitudes.

Table 9 indicates the scores of professionals who had incest training and those without incest training.

Table 9 Responses of the professionals who had incest training and those without incest training

Subscales	Training	Mean	SD	T-test	P
Jackson Incest Blame Scale (JIBS)					
Victim Blame	Yes	22.16	3.27	0.5	0.61
	No	21.83	3.36		
Societal Blame	Yes	14.65	4.68	-0.44	0.66
	No	15.04	4.26		
Situation Blame	Yes	15.47	3.80	1.17	0.24
	No	14.54	4.25		
Offender Blame	Yes	10.12	2.55	0.97	0.34
	No	9.67	2.27		
Blame Total	Yes	62.41	10.98	0.65	0.52
	No	61.07	10.06		
Subscales Treatment Punishment Scale (TPS)					
perpetrator punished	Yes	3.94	1.59	2.2	.03*
	No	3.24	1.65		
Perpetrator Treated	Yes	5.24	1.94	-0.54	0.61
	No	5.43	1.69		
Family Punished	Yes	11.63	2.18	-0.73	0.47
	No	11.94	2.18		
Family Treated	Yes	7.04	1.89	0.41	0.68
	No	6.89	1.91		

P is significant at <.05

The *t* test scores for professionals shows no significant differences on the four subscales of the JIBS. However, it was discovered that the professionals' blame attribution followed a particular pattern as influenced by incest training. The pattern is as follows; victim blame, situational blame, offender blame and societal blame (see Table 9)

In the case of Treatment Punishment Scale (TPS), there is a significant difference between the mean scores of professionals on perpetrator punishment subscale for the two groups with incest training and those without incest training ($t = 2.185$, $p < .03$) see Table 9. This implies that, the trained professionals are more in favour of perpetrator punishment

than professionals who lack incest training.

These could imply that professionals with incest training believe that perpetrators should take some form of responsibility for their action through punishment. What is interesting about them, however, is that they support victim and family therapy. On the other hand, professionals with insufficient incest training believe that perpetrators should not be punished, but they had rather be given treatment.

4.5 CORRELATION OF BLAMING AND TREATMENT/PUNISHMENT FACTORS.

Pearson's correlation coefficient for JIBS and TPS subscale were calculated in order to explore associations amongst subscales of the two scales on professional attitudes towards incest. Illustration of the correlations coefficients for the subscales of JIBS and TPS are summarized in table 9.

Table :10 Pearson's correlations between subscales of JIBS and TPS.

Sub scales	1	2	3	4	5	6	7	8	9
Pearson's correlation for JIBS									
1. Societal	.27**	1000							
2. Situational	.47***	.38***	1000						
3. Offender	.29**	.39***	.49***	1000					
4. Blame total	.68***	.75***	.81***	.68***	1000				
Pearson's correlation for TPS									
5. Offender punishment	-.17	-0.17	0.05	0	-0.1	1000			
6. Offender treated	0.001	0.05	0.14	.42***	0.17	-0.21	1000		
7. Family punishment	.26**	0.09	0.16	0.04	.19 *	-0.1	0	1000	
8. Family treated	.22**	-0.03	0.19	.34***	.21**	-0.1	.40***	0	1000

***r is significant at < .001 **r is significant at < .01 *r is significant at < .05

Pearson's correlations indicate mild to moderate interrelationship between the attitudes scales (JIBS and TPS), ranging from .21- .68. The two scales are positively associated on several subscales and negatively correlated to age of the professionals (not shown on the table). Discussion of the correlations of the blame scale and the treatment punishment scale will be discussed in the following section. This includes situational blame and offender blame, situational blame and victim blame, offender treatment and offender punishment, age and gender.

Situational blame and offender blame correlation. The two subscales indicate a positive correlation ($r = .49$, $p < .000$). These factors also appear to have an influence on the attitudes of professionals on incest. That is, although professionals often blame the situational factors for incest, their blame for offender is just as high as that of the situations. This implies that 25% ($r^2 = .49$) of the effect of change in situational blame is due to offender blaming.

Situational blame and victim blame correlation. There is a positive correlation between situational blame and victim blame ($r = .47$, $p < .000$) implying that 24% of the effect of change in situational blame is associated with victim blame. Professionals' attribution of blame to situational factors is often associated with victim blaming.

Furthermore, the JIBS indicates that people who attributes blame to the offender have the tendency to blame the societal factors for incest ($r = .39$, $p < .000$). In this case the change is only 15%. However, the JIBS shows that the blame of incest abuse is more attributed to the offender and the situational factors than other subscales.

Offender treatment and offender blame correlation. There is a positive correlation between offender treatment and offender blame ($r = .42$ and $p < .000$). This therefore implies that 18% of the effects of changes in offender treatment is associated with offender blame. Although the majority of professionals attribute blame of incest to the offender, they also support the fact that offenders should be given treatment rather than stricter punishment.

The Pearson's correlations indicate that a large proportion of variance 66 % ($r^2 = .810$) squared, in total blame can be accounted for by the variation in situational factors. This correlation is followed by societal factors ($r = .745$) squared which is = 56%,

offender blame ($r = .677$) squared = 46%, and lastly, victim blame with ($r = .681$) squared = 46 %.

Age of the professional was found to be having a significant negative correlation with victim blame on the JIBS ($r = -.38$, $p < .000$), so attributing more to the victims is associated with older professionals. Conversely, the victim blame is associated with younger professionals. On the TPS, age is associated with family punishment ($r = -.21$, $p < .04$). Lastly, there is no gender correlations between subscales of both the JIBS and TPS.

CHAPTER 5

5. DISCUSSION

This study used both quantitative and qualitative methods to explore the attitudes of professionals towards incest clients. The methods were also used to provide insight into how professionals' external and internal factors (emotions) interfere with their management of incest clients, and on how professional groups differ in their attitudes. The discussion of the results was divided into different parts, each focusing on a specific theme.

5.1 DEMOGRAPHIC PROFILE OF PROFESSIONALS

The mean age of professionals is 36 years, this therefore indicates that studied professionals are matured. Most of them are married with children of their own. Almost all professionals studied have a Christian background, which may be dictative of their moral behaviour. Furthermore, the study indicated that most professionals, especially medical doctors and clinical psychologists, have had less years of experience working with incest clients, thus they fall within the one to five years category of years of experience. However, despite their fewer or no years of experience in the given field, majority of them had good intervention experience with incest clients. On a different note, it is also worth noting that the sample of this study was dominated by female professionals.

There were also gender differences in terms of TPS subscales for perpetrators and the family. On the JIBS more males than females tended to attribute more blame to four blame subscales except the victim subscale. In fact, more males supported punishment for the perpetrator while females supported family counselling approach for both the victim and the mother. This indicates that gender also has an influence on attitudes towards incest clients. Apart from that, male professionals tended to attribute more blame to situational factors than females did while the males had a tendency of attributing more blame to situational factors. These findings corresponded with those of Herman and Hitchman (1977) and Horton et al. (1990) who argue that gender differences may affect the way professionals perceive incest as well as their judgement about responsibility and attribution of blame. This indicates that gender biases might influence one's attitude to a limited extent and could also interfere with professional intervention.

5.2 PROFESSIONAL EXPERIENCE AND TRAINING

As indicated in the data analysis, incest training for professionals has been a problem despite the good educational background of professionals, whereupon most of them hold diplomas, bachelors' degrees as well as masters degrees. Incest knowledge and training appear to be a problem especially amongst nurses, police officers and doctors as compared to other clinical psychologists and magistrates. There is also evidence in the study to suggest that despite the background training these professionals received, they were still lacking in continued training on incest-based issues within their disciplines. This was found to be more common among social workers, doctors and nurses as well as the police officers than magistrates and psychologists. This goes to show that while most professionals may be well educated and experienced in their fields, individual and ongoing departmental training on incest are very important for changing attitudes and proper management of incest clients. Unlike other means of data collection, the JIBS did not confirm the influence of training on the blaming attitudes of professionals.

Apparently, workshops have shown how important and helpful they can be in imparting knowledge to professionals, especially among the magistrates, psychologists and the police. These professionals were the people who showed a more positive attitudes towards clients as compared to nurses, medical doctors and social workers. Incest training and experience also show that they have a positive impact on the professionals' attitudes towards treatment and punishment of incest clients. This factor is supported by Renvoize (1993) on his observations done on the London police officers. The findings states that the police have moved forward a lot in their attitudes towards victims, however, although there are still some police officers with negative attitudes, most of them are sufficiently trained to handle child sexual abuse cases including incest. Occasionally, professionals who have not been specifically trained to deal with incest come into contact with clients, with unfortunate results. Recently moves has been made in South Africa to try and use more female police officers and magistrates in child abuse cases and to try to have them specially trained for such cases.

Continuous knowledge update seemed to have been effective even when it is the treatment provider's own responsibility. Some professionals reported acquiring their knowledge of incest through individual means and self readings. However, proper training has been indicated in this study as a successful method of helping professionals to control their emotions from interfering with their work and also to be able to make themselves

comfortable as well as helpful when assisting incest clients. These findings of insufficient incest training and exposure of professionals correspond with the findings of previous studies. In this regard, Herman and Hitchman (1977) and Pearson (1994) argue that professionals are poorly prepared to offer appropriate help and support to incest clients. This lack makes them unmotivated and to have little desire to work with incest clients. Attias and Goodwin (1982) further believe that the precise information about the levels of information as well as about levels of knowledge and expertise amongst professionals will allow for better design for continuing education about incest. Professionals like doctors, social workers and police officers, according to De Young (1983) and Dietz and Craft (1980), have acknowledged that their training and skills for working with incest are lacking. Therefore, most of the professionals indicated the need for more information about incest. There is evidence in this study to suggest that almost all professionals need more incest training, especially on the management skills and techniques of incest clients as well as management of their own feelings and emotions.

This study has also established that classroom training and field experience are important in preparing professionals for proper incest intervention. In addition to poor interdisciplinary training, the majority of professionals still lack pre-professional preparation and practical experience with incest clients. Few professionals with prior experience (mostly amongst the psychologists and magistrates followed by social workers) indicated that practical experience of incest was part of their classroom training as well as practical requirements. This indicates that this type of exposure is helpful in practical situations. Therefore, incest knowledge and training, practical experience and management skills have proved to be important contributory factors in impacting attitudinal change of professionals' towards incest clients (Attias and Goodwin, 1985; Herman and Hitchman, 1977; Groth, 1978 and Pearson, 1994).

Significant differences were also found between incestuously trained professionals and those without incest training. Professionals with incest training (psychologists, magistrates and social workers) are more in favour of perpetrator punishment than their counterparts (medical doctors, nurses and police officers). These professionals also support the fact that the victim and the non-offending spouse (family) should be treated. The difference could be due to fact that the former professionals believe that perpetrator should take some responsibility for their actions through punishment as a form of rehabilitation. On the contrary, untrained professionals are against treatment for victims and mothers (families), while on the other hand supporting treatment for perpetrators. This treatment

punishment attitudes of professionals in this study does not correspond with the findings on JIBS where trained professionals blame the victims more than the offenders. These findings correspond with those of Mashego (2000) whereby professionals blame offenders and mothers (untrained) blaming victims more. On the contrary, Adam & Betz (1993) and Doughty & Schneider (1987) discovered that the higher the professional's level of education and years of experience in their working fields the lesser the blame against victims.

The study further discovered that professionals (magistrates and police officers) with more years of experience opposes perpetrator treatment as compared with those having less years of experience (clinical psychologists, medical doctors, social workers and nurses). The difference could be due to the fact that the former spend their years maintaining law and order. The findings concurs with those of Trute et al (1996) who maintain that the police consistently hold attitudes that are more likely to give priority to punishment rather than treatment because they are agents of law enforcement.

5.3 EFFECTS OF EMOTIONS AND FEELINGS ON INCEST MANAGEMENT

It was clear from the study that during the intervention processes both the care provider and the client could become affected by their encounters. Issues of transference and countertransference cannot always be avoided, hence the need for a more specially trained or well experienced professionals to handle this emotional situation effectively. Although the majority of professionals in the study denied having personal or family history of incest abused, but the few who had this experience demonstrated more anger directed towards the perpetrator than their counterparts. This supports the fact that there is a relationship between gender and history of sexual abuse of either own or one's family. Most nurses (females) with this history tend to blame offenders more and to react with more anger towards them. Furthermore, the issue that apparently brings about countertransference reactions for the professionals is their emotional involvement when managing incest perpetrators and victims. These feelings occur for various reasons including; too much sympathy towards victims, the physical trauma sustained by the victim, or if the victim is a minor and the possible physical and psychological danger that the victim could be facing..

These findings correspond with those of Mouton (1981), who contends that when previously victimized professionals who are now handling an incest case as service providers, faces the dilemma of attempting to solve their client's problem from their own point of view, which is tantamount to a case of trying to solve their own problems rather than their clients' during the therapy. Pence (1995) also adds that if these feelings are ignored or entertained during therapy, the therapeutic process might be hampered.

Furthermore, some professionals reported that their reasons for being uncomfortable when helping incest clients especially perpetrators are influenced by their lack of knowledge and training on how to handle them. The discomfort was mostly among social workers, nurses and medical doctors. This naturally evokes the feelings that these people might be dangerous or might victimise them. Once more the significance of training and knowledge within the professionals is further emphasized as professionals who reported to be comfortable and better able to control their feelings were among psychologists, magistrates and police officers. This difference helped distinguish between trained and untrained professionals in incest. Dietz and Craft (1980) as well as Horton et al. (1990) also support these findings, arguing that the dynamics involved in incest are very complex, therefore professionals should be alert and have a clear understanding of incestuous system. The discomfort was discovered to be due to the perceived danger of being attacked, or professionals did not know how to handle perpetrators and that professionals become too emotional in the process of helping,

In addition, own sexual abuse and history of incestuous abuse in own family do not seem to be the only factor that evokes countertransference feelings amongst professionals. Actually, it was prominent from this study instead, that factors such as the age of the victim, the extent of physical trauma suffered by the victim, anger towards the perpetrator and too much sympathy from professionals towards clients, have some influence on professionals' attitudes and their professional intervention. It was discovered in this study that, the younger the child victim the more the negative emotional outburst towards the perpetrator, and the more the physical trauma suffered by the victim, the more the anger and the blame attribution towards the perpetrator. Situations of mounting emotions among the professionals corresponded with options of severe punishment of perpetrators such as jailing, life or death imprisonment etc. This further confirms that emotions have a major impact on attitudes of professionals. It could be further stressed that incest training could be used as a tool to assist professionals learn the ability to control their emotions during the process of intervention.

The issue of countertransference feelings among the professionals is supported by Pence (1995) who states that professionals ignoring these feelings may not be able to effectively serve incest clients. Furthermore, Horton et al. (1990) add that, these countertransference feelings may become obstacles to objective intervention. It is therefore further contended that it is necessary for treatment providers to feel comfortable working with incest, meaning that they should be able to resolve their personal feelings towards clients, in order to be as objective as possible. Giarretto (1981) also contends that anger and hateful reactions of professionals towards the perpetrators should be replaced with a more neutral attitudes which could facilitate a productive interventions.

The fact that the highest gender treated by professionals in this study was females, with the severity of abuse being sexual intercourse and most of the perpetrators being males (fathers/stepfathers) could have somehow influenced the professionals' attitudes. Considering that females are over-represented in this study, majority of them expressed a lot of anger and distrust towards males, hence the negative attitudes towards perpetrators. This could also have contributed to professionals' attitudes in terms of punishment, treatment and blaming which is common among the nurses, doctors, and social workers.

Furthermore, the findings show that the majority of offenders are often males as well as fathers of the victims. This corresponds with the findings of Finkelhor (1979), Alter-Reid et al. (1986) who discovered that the majority of child sexual abuse offenders are males with three quarters of them targeting female victims. The study also established that the age of victims influenced the attitudes of professionals. That is, the age of the victims as the determinant of the severity of the abuse, influences the objectivity of professionals with regard to treatment, punishment and attribution of blame. So, the younger the child the more severe and traumatic the abuse will be, so it suggestively follows that, for a solution to this problem, the blame and punishment of the offender should determine the severity of the punishment. This is more common in cases where small children are victimized and eventually contract venereal diseases or suffer genital trauma. In these cases most professionals suggest jailing, incarceration and other strict punishment for the offenders.

The age of the victim also proves to have an impact on either believing or not believing the victim. Most of professionals in this study stated that they are always cautious when dealing with teenagers. This correlates with Sgroi's (1979) discovery that "many professionals believe that clients routinely make allegations of sexual abuse or they

either lie or fantasize about its occurrence". This attitude, according to De Young (1983), may prevent the professionals from imparting proper therapeutic assistance to clients. In addition to this, professional orientation also seems to have a bearing or influence on believing or not believing on the part of the victims. While nurses, doctors, social workers readily believe the victims, the legal professionals (police officers and magistrates) are professionally compelled not to draw conclusions until enough convincing evidence has been gathered. However, Dale (1999) argues that the adoption of broad definition of victimization by helping professionals within which almost any form of subjective experience of dissatisfaction may be included, is problematic and confusing.

5.4 ATTITUDES TOWARDS OFFENDERS AND VICTIM

Most of the professionals in the study showed ambivalent feelings about the mental status of the perpetrator. While almost half of the professionals agreed that incest offenders are mentally unstable, another half still viewed incest as a criminal offence whereby offenders need to take some responsibility for their action. Surprisingly, this perception is true with the magistrates than the mental health professionals (psychologists and social workers). Hence majority of professionals support a court ordered-mental health therapy than mental health therapy without court intervention. In this study, no much differences were found amongst professionals regarding the utility of court mandated treatment for incest clients. All the six professionals were equivalent in their modest positive support for court mandated treatment of both the family and the perpetrators. These results are the same as those of Trute et al. (1996).

Despite the professionals' feelings about incest and offenders, most professionals support the usefulness of court-ordered mental health therapy in helping the offender and his family. This demonstrates that although most professionals support the idea that offenders should be arrested and jailed, the fact that an offender and his/her family need help is still important to them. In this study medical professionals (doctors, nurses) and police officers support the issue of arrest and jailing of the offenders more than other professionals (magistrates, psychologists and social workers), while more than half of the magistrates disapprove of jailing as the solution. To this end, magistrates could still remain objective in their judgement as they concentrated not only on helping the victim and his/her family but also on helping the offender as part of the family. These results are similar to those of Saunders (1988: 89) who maintains that "judges, as mediators within

the system, hold more neutral attitudes about both victims and offenders than other groups". Findings of this study suggest that police officers and doctors tend to consistently hold attitudes that are more likely to give priority to punishment than treatment. Since all professional categories expressed views that tend to support a general treatment orientation in their services, it is worth noting that most professionals seem to be concerned with correcting the behaviour than punishing it. These findings are consistent with those of Trute et al. (1996) in supporting a court mandated treatment for clients and their families. However, the results seem different from those of Wilk and MacCarthy (1986) whereby law enforcement professionals are seen to be the ones who are more punitive while the health professionals are more non adversarial approach (treatment oriented).

When coming to treatment and punishment for non-offending parents and victims, all professionals opted for more treatment oriented perspective for their clients. On this matter, training and experience seems to play an important role since trained professionals believe that even though punishment is recommended for offenders, the family must still go through family counselling. In this study, the general feeling of professionals towards perpetrators is rehabilitation with the intentions of uniting the family rather than mere punishment.

5.5 ATTRIBUTION OF BLAME AS AN INFLUENTIAL FACTOR

The study established that there are positive significant differences between the age of professionals and blame especially with the victim subscale. It was discovered that younger professionals tend to blame victims more than the older ones while the younger ones blame societal factors more. This could be due to the elders's belief that, as a results of the social changes that has taken place, the society is immoral and valueless, as such regarding people as sex objects. As far as older professionals are concerned, this could be a reflection of an unhealthy society. In other instances victims could be blamed if their responses are perceived as encouraging, seductive or passive, this concurs with previous research findings (De Young, 1882, Armsworth, 1989,& Mashego, 2000). In the African culture incest is a taboo and is expected to be treated as such, whenever the secret is exposed, victims are more blamed by their mothers than perpetrators (Mashego, 2000). The differences indicate that the age factor has an influence on the professional's attitudes. There is no correlation, however, between gender and blame subscales, which suggests that the sex of the professionals does not have a significant influence on their attitudes, the

findings are similar to those of Trute et al. (1996).

Looking at the JIBS in general, it was found that the blame was less likely to be attributed towards the victims by almost all the professionals. Blaming the victim was associated with societal blaming by the professionals. This could indicate that as much as the incest victims are regarded as being responsible for their victimisation, certain professionals believe that there are more societal factors such as societal immorality, societal values, societal stereotypes and media influence which could influence the victim's behaviour. It was however, discovered that more blame was attributed to offenders and situational factors such as alcohol and drugs, poor home environment and poor interpretation offender blaming is followed by societal blaming. These findings were consistent with those of Mashego (2000) who contends that it seems as if people feel better when they project blame to external factors which make offenders victims of situational and cultural factors. She further discovered that professionals in her study attributed more blame to offenders than the non professionals (mothers). The findings differ from that of Finkelhor (1986) who discovered that unlike offenders, the helping professionals never view alcohol and drugs as the causes of incestuous abuse.

5.6 CONCLUSION

In conclusion, the study has established that professional differ in terms of perpetrator treatment, punishment and blaming attitudes. Some professionals tend to opt for more strict punishment of perpetrators than others. This is more evident among medical personnel, magistrates and police officers. The implication could be that these professionals hold a more negative attitude and approach towards incest perpetrators than others. Apparently, there are some different opinions on whether punishment of incest perpetrators should be considered as the only solution for the incestuous family. Although attitudes differences found between professional groups did reach statistical difference, it should be noted that the differences were relatively small in absolute terms. Almost all professionals expressed views that tended to support a court ordered mental health therapy for the whole family more than the one without court intervention. This indicates that while other professionals such as nurses, doctors and police officers were more punishment orientated, on the other hand the majority of professionals were in favour of psychotherapy and rehabilitation for clients.

Looking at the results, one could deduce that there is a fundamental problem and confusion amongst professionals who deal with incest clients whereby they cannot seem to conclude whether incest is a mental health sickness, criminal offence or just a family problem as well as the proper approach to the situation. This stresses the need for incest training and awareness among professionals.

It was also established that professional attitudes are also influenced by their professional and educational background. That is, training and experience proved to have an impact on professional, attitudes regarding treatment and punishment of incest clients. More blaming attitude of perpetrators was found to be common among incestuously trained professionals (magistrates, psychologists and social workers). Essentially, the study confirms that severe punishment of perpetrators could be a reflection of emotional involvement with clients which often impede professional objectivity. Therefore, workshops and in-service training seem as essential methods in equipping professionals with necessary knowledge and skills for professionals' attitudes control and effective incest intervention.

The study further established that age is an important factor on key items of the blame scale and treatment and punishment scale. It further proved that professionals' attribution of blame is more projected towards the offender and situational factors than to the victim. Adding to this is the emotions of professionals which also show a tremendous impact on the intervention process and effective handling of incest especially, amongst professionals such as nurses, doctors as well as police personnel.

Therefore, given the situation in the study whereby professionals differ in terms of factors such as age, professional affiliation, emotional outbursts, training and experience, affecting their attitudes, it could be concluded that collaboration of services amongst the legal, medical, and the psycho-social professionals, is necessary in order to ensure attitudinal change and effective and appropriate management for incest clients (victims, offenders and their families).

5.7 LIMITATIONS OF THE STUDY

One of the weaknesses of this study could be gender limitation because there is an over representation of females than males. Another limitation relates to the generalization

of the study. This could spark problems in view of the fact that only professionals in the selected areas of the Northern Province (Seshego, Pietersburg and Mankweng districts and hospitals) were used in the study, therefore, generalizing the findings to represent the whole of the Northern Province, might not offer a true reflection of professionals' attitudes towards incest clients in the Province. However, due to lack of studies about attitudes of professionals regarding incest, the study can contribute much to change of attitudes among professionals.

The third limitation may follow from the way in which some professionals responded to both the questionnaires and interview sections of this study, some were mostly too busy and hard pressed for time to go through the study.

Northern Province of South Africa have a limited number of professionals than other Provinces in the country, such as clinical psychologists, Child Protection Units (CPU) police officers and social workers, which therefore contribute to the limitation of numbers of professional groups in the sample. This accounts for why there is an unequal distribution of the number of professional in the sample. This factor made comparing professional groups a bit difficult.

5.8 RECOMMENDATIONS

This study has indicated that incest training and continuous education are important in assisting professionals and improving their knowledge and intervention skills. The differences discovered among professionals in this study therefore, suggest that continued research and education focussed on improving intervention skills, understanding incest clients, awareness of one's emotions and how to control such emotions is required. This will lead to less blaming attitudes and to more effective management of incest clients.

It is further recommended that the differences observed amongst professionals in this study suggest the need for a more integrated approach of incest management and proper referral system of incest clients amongst different professionals. Given this situation, cross-disciplinary training and collaboration of services are obviously needed. This could be achieved through workshops and regular in-service training of sexual abuse and incest for care-providers in various departments of the Province. This will therefore, conscientise professionals of the sensitivity of incest and the different treatment needs clients deserve,

as well as to improve professionals' intervention skills.

Future research is required to identify the impact of different professionals training programs and their influences on attitudes towards incest clients. This follows the fact that the incestuous family is a unit comprising of the victim, perpetrator, as well as other family members, such as non offending spouse/siblings, therefore focussing on one party of the system might not be an effective solution for this family. The system theory advocates for family oriented management of incest as the most important approach that professionals should adhere to for a positive outcome when handling incest clients. This is also supported by the findings of Mashego (2000) on the perceptions of incest in father-daughter incestuous cases, considering that incest is a symptom of a dysfunctional family.

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APPENDIXES

APPENDIX A

GUIDING INCEST ATTITUDES INTERVIEW SCHEDULE

[Please answer the following questions as honestly as possible]

A. PERSONAL PROFILE

Age :

Gender	Male	Female
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Marital status	Married	Single	Divorce	Widowed
-----------------------	---------	--------	---------	---------

Ethnic group	N. Sotho	Venda	Tsonga	Others
---------------------	----------	-------	--------	--------

Religion	Christian	Non-Christian
-----------------	-----------	---------------

Occupation	Nurse	Medical Doctor	Police	Magistrate	Clinical Psychologist	Social Worker
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B. EDUCATIONAL BACKGROUND

EDUCATION

1. Highest grade completed

2. Highest qualification achieved :

Diploma

Degree

Masters

Doctorate

Others

C. THEME ON INCEST TRAINING.

1. Did you receive any skill in incest training? Yes \ No

2. What type of incest training is provided within the discipline?

- | | |
|--|-------------------------------------|
| ☐ Orientation | ☐ In-service |
| ☐ Team meetings | ☐ Workshops |
| ☐ Readings | ☐ Individual |
| ☐ Others | |

3. Is there any regular in-service training within your department?

Yes / No

If yes specify

.....

.....

.....

D. THEME ON INCEST EXPERIENCE

EXPERIENCE

1. Do you have prior professional experience / preparation for working with Incest perpetrators?

yes / no

If yes specify

.....

.....

.....

2. Do you have a specific type of incest experience? Yes / no

If yes tick the relevant one from the following:

- Workshop
- Internship
- Classroom
- Prior work experience
- Other

- 84-

10. Give a brief description of one incest client that you have treated and indicate the relationship between the client and the perpetrator as well as the estimated age of the victim.

.....

.....

.....

.....

.....

11. How would you rate the victims' response to the abuse? Ascending

Passive

Resistant

12. Do you think the victim's response to the abuse was realistic? Yes \ no

13. How do you as a professional feel about the responses of client /s (victims)?

.....

.....

.....

E. THEME ON ATTITUDE TOWARD VICTIM /PERPETRATOR

1. What do you think about abusive men?

2. What do you think about abusive women?

3. The victims are totally responsible for the abuse : always
sometimes
never

4. The perpetrators are totally responsible for the abuse :

- . Always
- . Never
- . Sometimes

5. The mother is totally responsible for the abuse :

- . Always
- . Never
- . Sometimes

6. Do you often experience problems believing the victims? Yes \ no

Why?.....
.....
.....

7. Do you or would you feel comfortable treating the incest perpetrator? Yes \ No

Explain why

.....
.....
.....

8. Do you find yourself emotionally involved when treating incest clients? Yes \ No

Explain why

.....
.....
.....

9. What do you think is the best treatment for perpetrators and explain why?

.....
.....
.....

10. Do you require more information about incest ? Yes /No

If yes, is there any type of training that would be most useful to you as a professional working with incest clients? State your opinion

.....
.....

11. Do you have any opinion as to how the professionals' knowledge can be improved ?

Yes / No

If yes state your opinion
.....
.....

APPENDIX B

F. TREATMENT PUNISHMENT SCALE (TPS)

TICK THE APPROPRIATE ANSWER AS HONESTLY AS POSSIBLE.

1. The family can be helped by mental therapy without court intervention :

Strongly agree	Uncertain	Agree
Disagree		Strongly disagree

2. The father should be arrested :

Strongly agree	Uncertain	Agree
Disagree		Strongly disagree

3. The father is a mentally disturbed person not a criminal :

Strongly agree	Uncertain	Agree
Disagree		Strongly disagree

4. The father should serve a jail sentence :

Strongly agree	Uncertain	Agree
Disagree		Strongly disagree

5. The court should remove the daughter from the home, but not the father

Strongly agree	Uncertain	Agree
Disagree		Strongly disagree

6. If the father is removed from the home, the daughter should stay with the mother with mental health therapy.

Strongly agree	Uncertain	Agree
Disagree		Strongly disagree

7. The mother should be arrested

Strongly agree	Uncertain	Agree
Disagree		Strongly disagree

8. The father could be helped by court ordered mental health counseling

Strongly agree	Uncertain	Agree
Disagree		Strongly disagree

9. Court ordered mental health therapy can help this family

Strongly agree	Uncertain	Agree
Disagree		Strongly disagree

10. The daughter is as guilty as the father

Strongly agree	Uncertain	Agree
Disagree		Strongly disagree

APPENDIX C

JACKSON INCEST BLAME SCALE (JIBS)

1. There is a strong connection between the current morality and the crime of incest.

Strongly agree	Uncertain	Agree
Disagree		Strongly disagree

2. The amount of sex and violence in the media today strongly influences the father to commit incest.

Strongly agree	Uncertain	Agree
Disagree		Strongly disagree

3. When incest occur it is the father's fault.

Strongly agree	Uncertain	Agree
Disagree		Strongly disagree

4. There is a strong relationship between people being regarded as sex objects by our society and the crime of incest.

Strongly agree	Uncertain	Agree
Disagree		Strongly disagree

5. The prevalence of incest is directly related to our societal values.

Strongly agree	Uncertain	Agree
Disagree		Strongly disagree

6. A father who commits incest should be locked up for the act.

Strongly agree	Uncertain	Agree
Disagree		Strongly disagree

7. Fathers who commit incest are mentally ill or psychologically disturbed

Strongly agree	Uncertain	Agree
Disagree		Strongly disagree

8. Incest can be mainly attributed to peculiarities in the father's personality.

Strongly agree	Uncertain	Agree
Disagree		Strongly disagree

9. It is the daughter who entices the father to commit incest.

Strongly agree	Uncertain	Agree
Disagree		Strongly disagree

10. Incest is a product of a sexually unhealthy society.

Strongly agree	Uncertain	Agree
Disagree		Strongly disagree

11. Daughters provoke the act of incest by using bad judgement, acting seductively, etc.

Strongly agree	Uncertain	Agree
Disagree		Strongly disagree

12. Daughters are victims of incest because they deserve it.

Strongly agree	Uncertain	Agree
Disagree		Strongly disagree

13. Incest can be avoided by the daughter.

Strongly agree	Uncertain	Agree
Disagree		Strongly disagree

14. Incest is more likely to occur in broken homes.

Strongly agree	Uncertain	Agree
Disagree		Strongly disagree

15. Alcohol and drugs are significant factors in the occurrence of incest.

Strongly agree	Uncertain	Agree
Disagree		Strongly disagree

16. Incest is more likely to occur in families with poor interpersonal relationships.

Strongly agree	Uncertain	Agree
Disagree		Strongly disagree

17. There is a certain type of person who becomes a victim of incest.

Strongly agree	Uncertain	Agree
Disagree		Strongly disagree

18. Incest is more likely to occur in slum or bad areas.

Strongly agree	Uncertain	Agree
Disagree		Strongly disagree

19. Fathers are driven to incest by internal factors.

Strongly agree	Uncertain	Agree
Disagree		Strongly disagree

20. Incest is more likely to occur in families that are socially isolated from the community.

Strongly agree	Uncertain	Agree
Disagree		Strongly disagree

[THANK YOU FOR YOUR PARTICIPATION]

APPENDIX D

GROUPED SUBSCALES FOR JACKSON INCEST BLAME SCALE

1. VICTIM SUBSCALE

- 9. It is the daughter who entices the father to commit incest.*
- 11. Daughters are provoke the act of incest by using bad judgement, acting seductively, etc*
- 12. Daughters are victims of incest because they deserve it.*
- 13 Incest can be avoided by the daughter.*
- 17. There is a certain kind of person who becomes a victim of incest.*

2. SOCIETAL SUBSCALE

- 1. There is a strong connection between the current morality and the crime of incest.*
- 2. The amount of sex and violence in the media today strongly influences the father to commit incest*
- 4. There is a strong relationship between people being regarded as sex objects by our society and the crime of incest*
- 5. The prevalence of incest is directly related to our societal values.*
- 10. Incest is a product of a sexually unhealthy society.*

3. SITUATIONAL SUBSCALE

- 14. Incest is more likely to occur in broken homes.*
- 15. Alcohol and drugs are significant factors in the occurrence of incest.*
- 16. Incest is more likely to occur in families with poor interpersonal relationships.*
- 18. Incest is more likely to occur in slum or “bad “ areas.*
- 20. Incest is more likely to occur in families that are socially isolated from the community.*

4. OFFENDER SUBSCALE

- 6. A father who commits incest should be locked up for the act.*
- 19. Fathers are driven to incest by internal factors.*

- 7. *Fathers who commit incest are “ mentally ill “ or psychologically disturbed.*
- 8. *Incest can be mainly attributed to peculiarities in the father’s personality.*
- 3. *When incest occurs it is the father’s fault.*

GROUPED ITEMS ON THE TREATMENT PUNISHMENT SCALE (TPS)

1 . perpetrator treated

- 3. *The father is a mentally disturbed person not a criminal.*
- 8. *The father could be helped by court ordered mental health counselling.*
- 1. *The family can be helped by mental health therapy without court intervention.*

2. Perpetrator punished

- 2. *The father should be arrested.*
- 4. *The father should serve a jail sentence.*

3. Family punished

- 7. *The mother should be arrested.*
- 10. *The daughter is as guilty as the father*
- 5. *The court should remove the daughter from the home, but not the father.*

4. Family treatment

- 9. *Court ordered mental health therapy can help this family.*
- 6. *If the father is removed from the home, the daughter should stay with the mother with mental health therapy.*