

**FAMILY RESILIENCE IN RESPONSE  
TO EXTRAFAMILIAL CHILD  
SEXUAL ABUSE**

University of Cape Town

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**FAMILY RESILIENCE IN RESPONSE TO EXTRAFAMILIAL  
CHILD SEXUAL ABUSE**

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of MSocSc (Clinical Social Work)**

**Cape Town  
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This work has not previously been submitted in part or whole, for the award of any degree. It is my own work. Each significant contribution to, and quotation in, this dissertation from the works of other people, has been attributed, cited and referenced.

Signed:

Signed by candidate

Date: 16/06/05

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University of Cape Town

## **ABSTRACT**

This qualitative study explores family resilience in response to extrafamilial child sexual abuse. Family resilience refers to the adaptive pathway along which a family journeys in response to a significant stressor. The theory on family resilience proposes that certain protective family factors and processes serve to mediate the impact of trauma on a family. A gap was found in the literature in the area of family resilience relating to child sexual abuse and theoretical research conducted as part of this study aims to contribute to this area. This research study adopts a strengths perspective which views families as challenged rather than dysfunctional.

The research is conducted in the context of Childline Western Cape and seeks to increase awareness in counsellors of families' internal and external resources for healing and support in the face of trauma. The empirical research includes an exploration of families' emotional responses to extrafamilial abuse, family coping strategies, sources of support, family strengths, the family's meaning-making processes as well as the challenges that impinge on the family's resilience. Data collection consists of semi-structured, in-depth interviews of five sets of parents, as well as the direct observations of the researcher. The data is inductively analysed through a grounded theory approach and the findings are presented and discussed in a theoretical framework. New data is generated by this study and it is hoped that the research findings will be valuable to counselling organizations working with children, families and trauma. The research findings show that factors contributing to a family's resilient process include effective coping strategies (such as talking about the trauma and maintaining a positive outlook), healthy family functioning (such as good communication and mutual support) and access to social support. Spirituality was found to play an important role in family coping. Counselling, the extended family and the church community emerged as significant sources of support. The researcher identified skills and capacities within the families, for example, family self-awareness and conscious parenting, which contributed towards family resilience. The perceived failure of the criminal justice system to protect the child is regarded as a significant risk for families' ongoing trauma.

From both the theoretical and the empirical study findings it is recommended that a family intervention approach be adopted in the treatment of extrafamilial child sexual abuse. Parental support, psychoeducation and searching for strengths should form part of this approach. The counsellor has a vital role to play in facilitating information between the family and the relevant role-players in the criminal justice system and advocacy around the criminal justice process is urgently required.

## **CHAPTER ONE – INTRODUCTION**

This chapter provides the rationale and context for the study, highlighting the relevance of the topic for research. The main research objectives, and the assumptions on which they are based, are stated. These are followed by a brief presentation of the research design and an outline of the remaining chapters.

### **Background and rationale for the study**

This study explores family resilience in the context of extrafamilial child sexual abuse. Child Welfare<sup>1</sup> describes child abuse in South Africa as a “national emergency”. Statistical data from Child Welfare show that sexual crimes against children have increased dramatically in recent years, revealing that child sexual abuse constitutes 57% of the total child abuse figure ([www.childwelfare.org.za/research.htm](http://www.childwelfare.org.za/research.htm)). According to a submission by RAPCAN<sup>2</sup> to the Parliamentary hearing on child sexual abuse in 2002, South Africa has the highest level of reported sexual abuse against women and girls in the world. In 2000, 21 438 charges of rape/attempted rape of children under the age of 18 were reported along with 4140 reports of indecent assault and incest. It is widely accepted that sexual abuse in South Africa is vastly underreported and the real statistics are estimated at 20 times higher than these figures ([www.pmg.org.za/docs/2002/appendices/020312rapcan.htm](http://www.pmg.org.za/docs/2002/appendices/020312rapcan.htm)). Given the prevalence of child sexual abuse in South Africa, it is important to focus attention on this issue. This study sheds light on the ways in which sexual abuse trauma impacts on families, how families cope with the trauma, and how the counsellor can support families, who in turn can support the child victim.

Despite the prevalence of child sexual abuse in South Africa, a comprehensive literature review revealed no literature on family resilience relating specifically to families coping with child sexual abuse. Most related studies have explored family resilience in response to

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<sup>1</sup> Child Welfare is a non-profit organisation committed to promoting the wellbeing of vulnerable children, through providing services such as child protection, community development and adoption services.

<sup>2</sup> RAPCAN (Resources Aimed at the Prevention of Child Abuse and Neglect) is a non-government organisation based in the Western Cape. RAPCAN's activities include advocacy and lobbying around various issues related to child abuse, training of children and adults around child abuse, running court-based child witness projects and housing a resource library on child abuse.

the chronic illness or disability of a child member. In relating family resilience to extrafamilial child sexual abuse, this study therefore generates new data and contributes to the existing literature on family resilience.

The term 'family resilience' is used with some ambiguity in the literature in that it is used to describe both a family's capacity and a family's process. This study adopts the view of family resilience as the adaptive process the family undergoes in response to a significant stressor (Patterson, 2002a). This implies that family resilience involves a journey or pathway rather than referring to a static set of characteristics. Although it is important to examine family stress and family coping strategies when exploring family resilience, the concept of family resilience is broader than family stress and coping theory because it incorporates the family's initial response to the trauma, its coping process over time and its adaptational outcome. When trauma or chronic adversity disrupts the functioning of the family system, there are certain key family processes that can buffer the impact of the stress and assist the family's recovery (Walsh, 2003). These key processes contribute to the family's resilient process. Therefore, family resilience is a dynamic, emergent, multidimensional process that unfolds over time (Patterson, 2002; De Haan et al, 2002; Walsh, 2003). It involves a family's growth and relational transformation. Crises are seen as opportunities for families to "struggle well" (Walsh, 2003:1). Family resilience differs from individual resilience in that the unit of analysis is the family as a whole rather than the individual.

De Haan et al (2002) note that resilience research is important in that it can help the clinician to discover those factors that are instrumental in shaping adaptive pathways and lead to the design of appropriate preventative interventions. Walsh (2003) agrees that understanding family resilience has significant implications for practice. The focus on family resilience represents a shift from a view of families as dysfunctional to families as challenged (Walsh, 2003).

The study was conducted within the context of Childline Western Cape, a non-profit organization providing telephonic and face-to-face counselling to sexually abused children between the ages of 4 and 18. At the time of conducting the research, the researcher was

employed as a counsellor at Childline and therefore had professional experience working in this field. According to Childline Western Cape's records, between 145-195 children are referred to the Wynberg branch of Childline for sexual abuse counselling per year. This is only one of four Childline branches in the Western Cape. The current treatment approach adopted by Childline is predominantly individual counselling for the sexually abused child as well as some groupwork. Family intervention is not offered. This study recognizes the importance of exploring the supportive capacities of families in the face of trauma. It seeks to increase awareness of the role of the family in the child's recovery, and encourage counselling organizations to consider a more inclusive approach to treatment. Counsellors working with sexually abused children need to be aware of the potential healing resources of the family in order to help activate them. A family approach to extrafamilial child sexual abuse treatment that includes support services to parents as well as intervention with the child victims, has been found to be effective in fostering recovery (Grosz et al, 2000).

The study is grounded in a systems framework. The family is a complex socio-emotional system (Freeman, 1992) and from this perspective, it is understood that the sexual abuse of one member of the family is likely to affect the whole family. It is therefore necessary to explore the family's coping and healing capacities as these will impact on the child's recovery. The study is based on the hypothesis that the family is a potential source of support and healing for the sexually abused child. It embraces a 'strengths' perspective, which recognizes that families have internal and external resources for healing and support. The research is applied, as the findings have direct relevance to the therapeutic context of Childline Western Cape and other organizations providing counselling services to children and/or families.

## **Research design**

The research is based on a qualitative paradigm. Qualitative research offers the opportunity for obtaining rich, detailed data and insightful understanding, and providing complex explanations and interpretations (Neuman, 2000). In qualitative research (or field research) the emphasis is on process rather than outcome (Babbie & Mouton, 2001) and reality is regarded as subjective, therefore the social context of the participants is taken into account

(De Vos, 1998). Semi-structured in-depth interviews with five sets of parents were conducted to obtain the data. Thereafter, the textual data was analysed by means of inductive reasoning and the findings presented and discussed within a theoretical framework. The research design will be elaborated on in Chapter Three.

## **Research questions**

The research questions are as follows:

1. How do families respond emotionally to the extrafamilial sexual abuse of a child family member?
2. What coping strategies do families employ in response to child sexual abuse?
3. What sources of support are available to families coping with child sexual abuse?
4. How do families make meaning of the child's sexual abuse?
5. What family strengths and protective family factors exist?
6. What challenges do families face which inhibit their ability to cope?
7. How does theory contribute to an understanding of family resilience in the context of extrafamilial child sexual abuse?

## **Research objectives**

The main research objective is to explore the resilient processes of families in response to a child member's sexual abuse. Related to this main objective are the following objectives:

1. To identify the emotional responses of families affected by the extrafamilial sexual abuse of a child family member.
2. To examine the coping strategies families employ in response to child sexual abuse.
3. To find out what sources of support are available to families coping with child sexual abuse.
4. To find out how families make meaning of the child's sexual abuse.
5. To explore family strengths and protective factors.
6. To ascertain what challenges families face which inhibit their ability to cope.

7. To conduct a theoretical review of family resilience and extrafamilial child sexual abuse.

### **Researcher's main assumptions prior to investigation**

1. That families have inherent resources which aid their recovery and healing.
2. That the family's response to trauma affects the child's recovery from trauma.
3. That focusing on family strengths and adaptational coping is beneficial to families.

### **Reflexivity**

The researcher was aware of her powerful role in relation to the research participants. Her dual role as professional Social Worker and researcher contributed towards these power dynamics. Reflexivity is discussed in more depth in Chapter Three.

### **Concept clarification**

#### ***Family resilience***

For the purpose of this study, family resilience refers to the dynamic process through which a family is able to 'bounce forward' after a crisis or experience of adversity. Family resilience is an emergent, multidimensional process which develops over time, and presents the opportunity for a family to grow and strengthen through adversity rather than simply returning to a previous level of functioning. The process of family resilience incorporates three components: a significant risk, family protective factors/processes and an outcome (family adaptation). The risk and protective factors interact to produce the outcome. The concept of family resilience adopts a 'family strengths' perspective which views families as inherently resourceful and having the potential for promoting the growth and healing of its members.

### ***Child sexual abuse***

Child sexual abuse refers to any acts involving the exploitation of a child or young person under the age of 18 for the purpose of sexual gratification, with or without the child/young person's consent. Child sexual abuse may be perpetrated by adults, young persons or other children (Finkelhor, 1994). Child sexual abuse includes a range of acts including contact and non-contact abuse.

*Extrafamilial sexual abuse* refers to sexual abuse that happens outside the family, by strangers or acquaintances. This can involve single episodes or ongoing abuse (Green, 1996). This type of abuse is also referred to as nonfamilial abuse.

*Intrafamilial sexual abuse* is sexual abuse by a family member, such as a parent, grandparent, sibling or relative, as well as by a nonrelated adult living in the home (Green, 1996). This type of abuse is also referred to as familial abuse or incest.

### **Outline of the dissertation**

Chapter Two provides a review of the literature on family resilience and clarifies the key concepts. Chapter Three describes the methodology of the research, including sampling, data collection, data analysis and limitations. Reflexivity and ethical considerations are also discussed in Chapter Three. Chapter Four provides a sample profile, and presents a discussion of the research findings within a theoretical framework. Chapter Five presents the conclusions of the research and offers recommendations for a counselling organization.

### **Summary**

This chapter presented the context and rationale for the study. The research design, questions and objectives were mentioned and clarification of key concepts was provided.

## **CHAPTER TWO – LITERATURE REVIEW**

### **1. Introduction**

This chapter offers an in-depth discussion of the central themes relating to family resilience, with the focus on extrafamilial sexual abuse trauma as the significant stressor. The chapter begins with an introductory discussion of families and adversity and the family strengths perspective. A theoretical framework for understanding family resilience is then presented. This includes systems theory and family stress theory, within which the concept of family resilience is grounded. The *process* of family resilience – including the concepts of significant risk, protective family factors and processes, and adaptation – is then explored. Protective factors and processes are presented according to a framework of family resilience by Froma Walsh (2003). In conducting the in-depth theoretical analysis, the researcher has identified an intricate overlap between Walsh's family resilience framework and the McMaster Model of family functioning. The similarities and differences of the two frameworks are examined. This is followed by a discussion of extrafamilial sexual abuse as a significant stressor for families and the impact of a traumatised member on the family. A discussion of suggested intervention with the families of sexually abused children is then provided, followed by a presentation of related studies. The chapter concludes with a summary of the main themes relating to family resilience and extrafamilial child sexual abuse.

An extensive literature search (using a combination of methods which included academic search engines, internet searches and a review of the printed literature on sexual abuse, family functioning, family coping, family stress and family resilience) has revealed numerous studies on family coping and several on family resilience. However, despite the prevalence of child sexual abuse in South Africa, no local or international studies relating to families coping with child sexual abuse were identified. Through generating new findings, it is hoped that this study will contribute towards filling that gap.

## **2. Families and adversity**

The family is a dynamic, evolving system which faces ever-increasing challenges and demands. Many South African families exist in a context of multiple socio-economic problems such as poverty, domestic violence and trauma, alcoholism, divorce, unemployment, high crime rate, gangsterism and lack of or limited access to resources and social supports.

The alarming incidence of child sexual abuse is a widespread challenge to South African society. Due to the phenomenon of under-reporting and the absence of one single system keeping track of statistics, it is not possible to ascertain the actual prevalence of child sexual abuse in South Africa. However, according to the South African Police Service (SAPS), more than 40 000 cases of child sexual abuse are reported in a year and it is estimated that child sexual abuse is on the increase (Tsolekile, 2003). As mentioned in the previous chapter, South Africa is known to have one of the highest levels of reported sexual abuse against women and children in the world. Childline Western Cape<sup>3</sup> estimates that one in four children will be sexually abused during their childhood.

Technology, industrialisation and urbanisation have been cited as contributing factors towards a deepening complexity and depersonalisation in daily life, which in turn impact on the quality of family life (McKenry & Price, 1994). In addition, societal shifts such as changing economies, poverty, overpopulation and social alienation also affect family life. In the context of global, social, political and economic upheavals, families are challenged with multiple losses, disruptions and uncertainties (Walsh, 2003). Furthermore, family structures in the 21<sup>st</sup> Century are diverse and changeable, traditional beliefs about families and gender roles have been thrown into question, and there is no uniform family shape. All these factors contribute to the challenges faced by families.

Combrinck-Graham (1989) describes the family as the locus of human development and the primary socializing influence for children. The family can be considered the “headquarters

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<sup>3</sup> Childline Western Cape is a non-government organisation offering face-to-face and telephonic counselling to sexually abused children. Its offices are located in Wynberg, Khayelitsha, Bishop Lavis and Gugulethu.

of human development” (Friedrich, 1990:167). Thus, the family holds the potential for both optimal development of its members, and damage to its members. Families under stress may react in many different ways: while some pull together and find shared strength and hope in the face of adversity, others are derailed and overwhelmed. The ways in which families respond to stress and crises have far-reaching implications for the health and wellbeing of their members. This underlies the importance of understanding how ongoing strains and unpredicted traumas can disturb the family’s equilibrium, and of strengthening the family’s protective resources.

Due to the transitions and disruptions experienced by families in the 21<sup>st</sup> Century, professionals involved in family therapy and research can no longer rely on frameworks of family normality and pathology: diversity in family life needs to be considered and one should approach the study of families with an attitude of curiosity and sensitivity (Barnes, 2004). Over the past two decades there has been a shift of focus in family therapy from family pathology to family strengths (Walsh, 2003). There has been a move towards exploring how families cope with adversity, and a trend towards helping families enrich and develop their internal resources. This way of thinking about and working with families embodies a family strengths perspective. A family strengths perspective recognises that the family is the child’s ‘primary environment’ and draws on concepts such as resilience and family capabilities to enable family members to fulfil their roles adequately (Early & GlenMaye, 2000). An underlying assumption of the family strengths perspective is that families have the capacity for competence. Family members are regarded as experts of their own family (Early & GlenMaye, 2000). This perspective acknowledges that the family is also able to draw on the resources of other systems with which they are connected, such as extended family and social networks. It emphasises the value of ‘searching for strengths’, and offers a more holistic approach to viewing and working with families than traditional family theories which tend to focus exclusively on family pathology. The theory of family resilience is grounded in a family strengths perspective.

This study, which explores family resilience in the face of extrafamilial sexual abuse trauma, is based on the assumption that families have the potential for recovery from crises, and optimally, transformation through adversity. It assumes that families can draw on

internal and external resources to help them cope. However, it acknowledges that certain families have limited access to external supports and services depending on their socio-economic status and geographical location.

### **3. A theoretical framework for understanding family resilience**

A brief background of resilience research is offered, followed by a discussion of the central debate regarding the definition of family resilience. An introduction to family systems theory and family stress theory is then provided, as both these theories are incorporated into the concept of family resilience.

#### **3.1. The background of resilience research**

Resilience research started in the 1970's with a focus on individual resilience. This field of interest arose from the observation that certain individuals showed competence in some aspect of their functioning, despite considerable adversity (Patterson, 2002a). In the early studies of individual resilience or 'hardiness' in children, resilience was viewed in terms of innate attributes that rendered a child invulnerable to stress (Walsh, 2003). The focus then began to shift, and resilience was seen as emerging out of a person-environment interaction. Most early studies looked at how children were able to thrive despite pathological parents, and the family was regarded only in terms of the risk it presented to the child. As resilience research expanded, however, there was a growing recognition of the multiple risk and protective factors at an individual, family and social level (Walsh, 2003). Rather than viewing families as damaged and damaging, the resilience perspective sees families as challenged by adversity. In studies of the different responses of military families to war-related crises, researchers H.I. McCubbin and colleagues found that many families successfully adapted to crises (Patterson, 2002a). The significant difference between individual resilience and family resilience is that in family resilience, the unit of analysis is the family as a whole rather than the individuals in the family. It is only fairly recently that the family unit has been the focus of resilience research (Patterson, 2002a).

Related to the concepts of risks and protective factors is the concept of vulnerability. Vulnerability refers to those internal and sometimes external conditions that amplify the probability of a negative outcome in the presence of a risk (Cowan et al, 1996). Vulnerability is usually understood in terms of internal conditions such as genetic factors, personality traits, depression and low self-esteem, although family factors (such as ineffective parenting) can also be seen as functioning as vulnerabilities. Vulnerability only has an effect in the presence of a risk.

### **3.2. Family resilience: capacity or process?**

There is a lack of clarity in the literature regarding the definition of family resilience. Cowan et al (1996) attribute the vagueness of the language of risk and resilience to the fact that many of the terms and concepts were developed for the study of individuals and are now being applied to the study of the family unit. Specifically, confusion lies around whether resilience is a *capacity* or a *process* (Patterson, 2002ε). When family resilience is understood as a capacity, it refers to family strengths, or a set of characteristics that help the family cope. Family resilience defined in this way is similar to family protective factors. On the other hand, family resilience as a process refers to the process a family engages with in the face of significant risk exposure (Patterson 2002a). This process can be likened to a journey, during which the family makes sense of the significant stressor and evolves as a result of the stressor. This perspective views resilience as the coping and adaptational processes in the family unit (Cohen et al, 2002). It is a broader view of resilience than the capacity perspective in that it incorporates family change over time as a result of protective factors which mediate the impact of the stressor, whereas the view of resilience as capacity has a smaller scope and implies fixed attributes or traits.

This study adopts the view of family resilience as a process for the following reasons: the researcher believes that the significant risk, the family protective factors that mediate the risk, and the adaptational outcome for the family, should all be taken into account in assessing whether a family has engaged in a resilient process. Furthermore, the choice to adopt this definition of family resilience is consistent with the trend that researchers tend to

explore resilience as a process, while clinicians tend to view family resilience as capacity (Patterson, 2002a).

There is further debate over the ways in which family protective factors buffer the impact of the stressor and contribute to successful outcomes or adaptation (Patterson, 2002a). Some researchers postulate that the protective factors have a direct effect on the outcome for the family, regardless of the severity of the stressor. However, others claim that the effect is interactive, in that the impact of the protective factors on the outcome depends on the nature and severity of the risk. This latter view of the relationship between the stressor and protective factors is consistent with R. Hill's early model of family stress, which claims that family outcomes vary depending on risk exposure and protective functions (Patterson, 2002a). Hill's model of family stress will be discussed in more depth in a subsequent section. Cowan et al (1996) state that an isolated factor considered on its own cannot predict individual or family adaptation; instead, a combination of risks, protective factors and vulnerabilities experienced in a family over time, influences family adaptation.

### 3.3. Family systems theory

Family systems theory views the family unit as an open system consisting of subsystems, and interacting with systems outside the family. Examples of family subsystems are the sibling subsystem and the spousal subsystem. Outside systems include the extended family, the school, the workplace and social service systems (Epstein et al, 1978). In working within this framework, the aim is to bring about change in the family system, rather than in the individual members.

#### Characteristics of the family system

1. The family is made up of *subsystems* (Freeman, 1992).
2. The family system is shaped by *boundaries* which determine the separateness or connectedness of subsystems within the family, as well as between the family and the external environment. The rigidity or flexibility of these boundaries determines the fluidity of movement, and flow of information, between subsystems. Family

boundaries are not fixed but shift over time as the family proceeds in its life cycle (Friedrich, 1990).

3. The family has certain *structural and developmental functions* to fulfil. Minuchin (1974:14) describes these as “the support, regulation, nurturance, and socialization of its members”. These functions have also been identified in terms of family formation and membership, economic support, nurturance and socialization and the protection of vulnerable members (Patterson, 2002b). Freeman (1992) describes the family’s developmental functions in terms of supporting both individual members’ development as well as the developmental stage of the family unit.
4. The family system *evolves over time*. It is constantly reorganising itself according to internal and external demands (Freeman, 1992).

According to family systems theory, the family as a whole is greater than the sum of its parts. Individual dysfunction is regarded as emerging from reciprocal interactions between family members, and as serving a particular role within the family. Therefore, dysfunction in any part of the unit should be understood by considering the family in its entirety rather than the separate individual members. Furthermore, change in one part of the system brings about change in the whole system (Freeman, 1992). Similarly, Cowan et al (1996) note that relationships in one area of family life (such as the marital relationship) impact relationships in other areas (for example, the parent-child relationship).

The family context is a powerful organiser or disorganiser of individuals (Colapinto, 1981). Bearing in mind the family’s organising capacity, a child cannot be regarded as isolated from the family unit. In this way, trauma experienced by one family member is experienced by the whole family system. This interconnectedness not only renders the family a potential source of support for the individual members, but also places members at risk for traumatic stress. Figley (1989:12) describes the family as a source of “stress production and reduction”. Families can both perpetuate traumatic experiences (for example, not believing a child’s disclosure of sexual abuse) or act effectively to provide social support, thereby promoting recovery (Figley, 1989). This concept is supported by social learning theory, which purports that children who have supportive parents are likely to develop competence as a result of parental modelling of effective coping (Wills et al, 1996).

The family systems perspective underpins the theoretical framework for family resilience, as the study of family resilience is concerned with the family unit as a whole rather than the individual resources of family members. Furthermore, family resilience is influenced at different levels of the system, from the parent-child dyad to the extended family and wider social networks.

### **3.4. Family stress theory**

The study of individual resilience builds on the theory of stress and coping in individuals. Similarly, the study of family resilience builds on family stress theory (Patterson, 2002b). It is therefore necessary to examine the theory on family stress in this review. While there has been vast research into individual stress and coping, the specific interest in family stress and family coping is fairly recent (McCubbin et al, 1982).

Several different definitions of family stress are found in the literature. For example, McKenry and Price (1994:10) define family stress as “the response of the family to the demands experienced as a result of a stressor event”, while Boss (1988) defines it as a disturbance in the family’s stable state. Family stress is also frequently discussed in the literature in terms of an imbalance between family demands and family capabilities and it is this definition of family stress that the researcher adopts for the purpose of this study. The terms stress, crisis and significant risk will be used interchangeably in this discussion when describing the catalyst event or experience for a resilient process.

#### **Family stress as an imbalance between family demands and capabilities**

A certain amount of stress is inevitable in family life; indeed, reasonable tension is necessary for individual and family growth. However, when family demands considerably outweigh family capabilities, the family experiences stress or crisis. According to Patterson (2002b), a crisis disorganises and disrupts a family, throwing it out of equilibrium. A crisis can affect family functioning positively or negatively and can bring about structural change in the family system. The process a family utilises in restoring balance to the system is

referred to as regenerative power (Patterson, 2002b). Regenerative power is a sign of successful adaptation to stress and is akin to family resilience (Patterson, 2002a).

Patterson (2002b) distinguishes between different types of family stressors – family demands, ongoing family strains and daily hassles. Family demands may be normative (for example, the expected challenges related to transitions in the family's life cycle) or nonnormative (such as unanticipated stressful life events including trauma). Ongoing family strains are the persisting unresolved tensions experienced in a family while daily hassles refer to the day-to-day demands of family life (Patterson, 2002b). These stressors are the risk factors, while family capabilities are the protective factors (such as a family's internal and external resources and its coping strategies). Not all nonnormative events are disastrous, for example, winning the lottery; however these events do cause disruptions in the family's normal functioning (McKenry & Price 1994). Walsh (2003) points out that most major stressors have a past history and future course and are complex in nature (for example, divorce). In addition, current stressors often activate past, unresolved strains or losses, thereby compounding the family's distress.

Many families are vulnerable to 'stressor pile-up', which is a clustering of stressors as opposed to an isolated stressor (McKenry & Price, 1994). Rutter (1987) describes this phenomenon as a cascade of risks in a downward trajectory. Stressor pile-up or cascade of risks, can place enormous strain on a family's ability to cope and may overwhelm a family.

Research has found that the quality of family life prior to the crisis is a strong predictor of the upheaval and distress a family will experience during crisis (Mederer, 1999). According to Mederer (1999), pre-existing problems in finance, health and marital and family relationships place the family at risk for difficulties during adversity. This finding ties in with the notion of stressor-pile up, where multiple stressors contribute towards a family's vulnerability to dysfunction.

According to Aldwin (1994), the ways in which individuals or families cope with stress may be more significant than the nature of the stressful event itself. Cognitive appraisal processes deeply influence the perception of stress. Thus, families that are able to reframe a

stressor more positively are considered to be better able to cope and adapt. Positive reframing allows the family to better manage the stressor so that the family's task of promoting the individual wellbeing of its members is not impeded (McKenry & Price, 1994). Just as individuals have internal resources that mediate the impact of a stressor, families have strengths and vulnerabilities that influence the impact of stress. Cognitive appraisal is an important component of family resilience and will be discussed in greater depth in a later section.

According to McKenry and Price (1994), families are less likely to negatively appraise a stressful event if they have adequate resources. Resources can be defined as "the traits, characteristics, or abilities of (a) individual family members, (b) the family system, and (c) the community, that can be used to meet the demands of the stressor event" (McCubbin et al, 1982, cited in McKenry & Price, 1994:9). An example of a community resource that has been found to protect families from the negative impacts of stressful life events and enhance recovery from crises, is social support (McKenry & Price, 1994). Family resources have also been defined in terms of capabilities, which include the family's material and psychological resources (what the family has) as well as the family's coping mechanisms (what the family does) (Patterson, 2002a).

### The impact of stress on family relationships

Crnic and Acevedo (cited in McKelvey et al, 2002) state that stress hinders the development of positive family relationships and creates tension among family members. Specifically, these researchers find that stress negatively impacts parenting practices; they cite studies that have found a relationship between stress, and parenting that is more punitive, reactive and less supportive (McKelvey et al 2002). Crnic and Acevedo identify two sources of family stress, namely, the quality of the marital relationship, and economic need. They find that stress in the marital relationship negatively affects interactions between parents and children, and that financial stress has been linked to increased levels of family conflict and poorer family functioning. Wills et al (1996) note that economic stress has been linked with deficiencies in parenting behaviour as well as in the quality of the marital relationship. Both these identified sources of stress (the marital and financial

domain) have serious implications for South African families, as divorce and poverty are two of the widespread problems facing families in South Africa.

### Hill's Model of family stress

In 1949, Reuben Hill developed a model of family stress to describe how a family responds to a stressor (De Haan et al, 2002). Hill observed that a family follows a pathway in its response to a crisis. This observation has been embraced and elaborated on in subsequent years of research. Researchers today agree that family resilience involves a family's adaptive pathway over time (De Haan et al, 2002; Walsh, 2003; Patterson, 2002b).

Hill's original model, the ABC-X Model, describes a family's developmental process when it is confronted by a stressor: A (the stressor) interacts with B (the family's resources) which interacts with C (the family's appraisal of the event) to produce X (the crisis). The crisis or stress experienced by the family develops as a result of the family's response to the stressor (McKenry & Price, 1994). The model outlines stages that a family will go through when encountering a stressor – firstly, a period of disorganisation marked by increased conflict, confusion, and anger, during which time a family searches for ways to cope; secondly, a period of recovery during which the family adjusts to the crisis; and thirdly, a period of reorganisation in which a family situates itself above, below or at the same level of precrisis functioning (De Haan et al, 2002).

The ABC-X Model assumes that all families pass through similar stages after encountering a stressor. However, when tested in a subsequent study by Burr and Klein (1994) it was found that there were a variety of patterns that families followed in the aftermath of a crisis (De Haan et al, 2002). Walsh (2003) supports this notion that each family follows its own unique pathway to resilience.

McCubbin and Patterson (1982) developed the Double ABC-X Model which expanded on Hill's original model. The Double ABC-X Model includes the family's adaptation to the stressor over time. In other words, it stretches the original model to include the postcrisis factors that influence adaptation. The model therefore begins with the family crisis, then

moves to the family's adjustment to the crisis over time, and concludes with the family's adaptation - the outcome (McKenry & Price, 1994). The Double ABC-X Model is helpful in that it offers a more comprehensive way of exploring family stress by moving beyond the result of a family crisis, to look at the outcome of that crisis for the family. Various possible outcomes are considered, ranging from maladaptation to bonadaptation.

#### **4. The process of family resilience**

“Resilience refers to a dynamic process encompassing positive adaptation within the context of significant adversity” (Luthar et al, 2000:543).

Family resilience can be described as the path a family follows over time as it responds to stress (De Haan et al, 2002). According to this process model of family resilience, three components need to be considered in assessing a family's resilience: the significant risk exposure, the mediating or protective factors and the adaptational outcome. This section examines these three components in depth. To begin with, a discussion of what constitutes significant risk is provided. This is followed by a discussion of protective family factors and processes. These include the processes as described in Froma Walsh's framework of family resilience, as well as certain aspects of family functioning such as cohesion, flexibility and family coping strategies. Lastly, family adaptation is discussed as an outcome of the family resilience process. In a separate section, the researcher explores how Walsh's framework of family resilience overlaps with the McMaster Model of family functioning. Both models offer valuable contributions in terms of considering family strengths and protective processes.

##### **4.1. The concept of significant risk**

If a family is to be regarded as resilient there is an assumption of some challenge, stressor or adverse experience that the family faced and mastered. However, a controversy exists in family resilience literature regarding what constitutes a significant risk. Two distinct perspectives are identified: the 'life as risk' perspective and the 'significant risk' perspective (Patterson, 2002a). According to theorists and practitioners who adopt the 'life

as risk' perspective, the general challenges of life that families face are regarded as significant enough to regard the overcoming of these challenges as resilient. In contrast, supporters of the 'significant risk' perspective maintain that significant risk is a precondition for resilience (Patterson, 2002a). Therefore, a family would only be considered resilient if their competent functioning followed a significant risk or stressor, whereas for the former perspective, any family showing competence would be considered resilient. Patterson (2002a) suggests that a risk can be regarded as significant when an expected reaction to it would be dysfunctional behaviour, while Cowan et al (1996) propose that risks are processes which predispose individuals and families to negative outcomes.

For the purpose of this study, the 'significant risk' perspective is adopted as the study examines family resilience as it relates to a specific trauma, that of a child member being sexually abused. Identifying child sexual abuse as a significant risk for a family is consistent with the definition of significant risk provided by Masten and Coatsworth, 1998 (cited in Patterson, 2002a), where significant risk emerges from:

- a) high-risk status as a result of chronic exposure to adverse social conditions, such as poverty;
- b) exposure to a traumatic event or severe adversity or
- c) a combination of high-risk status and exposure to trauma.

It could be argued that the families in this study meet the third definition of significant risk in that they were exposed to the trauma of child sexual abuse, as well as being exposed to chronic adverse social conditions such as financial hardship, gangsterism and limited access to resources.

#### **4.2. Family protective factors and processes**

Protective factors and processes are those which moderate the relationship between the stressor and the adaptational outcome (Patterson, 2002a). Protective factors, or buffers, diminish the likelihood of a negative or undesirable outcome despite the presence of a risk (Cowan et al, 1996). They include individual factors, aspects of family functioning, social/community factors, family meanings, family coping strategies and spirituality.

#### **4.2.1. Individual factors**

Individual factors such as personal strengths and qualities play a role in operating as protective factors in the family context (Mederer, 1999; De Haan, 2002).

#### **4.2.2. Family factors**

Family factors include those aspects of family functioning that contribute towards family health. Family functioning refers to the relational processes within a family (Patterson, 2002a). These relational processes are multidimensional, and shape the family unit and relationships within it. Throughout the literature, the three family processes identified as central to healthy family functioning, are cohesion, adaptability and effective communication. These are internal family resources that bolster a family's resilience in times of stress. Family cohesion refers to the degree of emotional connectedness and separateness of family members while adaptability refers to the flexibility of the family system and its ability to change (Cohen et al, 2002). Effective communication refers to clear and direct patterns of communication in a family. These three dimensions will be discussed in greater depth in the following section which looks at a framework for family resilience.

According to Hansen and L'Abate (1982), other healthy attributes and styles of family functioning that can be described as protective include the ability to show respect for the views of its members, a strong parental subsystem, flexibility, spontaneous interactions that show initiative and vary in emotional intensity, openness to change, permission to express anger and sexual feelings, and management of loss and change. In contrast, dysfunctional families are described as having repetitive interactions and experiencing minimal changes within the unit, in addition to having intrusive relationships, high levels of hostility, incongruent family myths and difficulties coping with loss, change and separation.

Boundary flexibility is also a protective factor. In healthy families, boundaries are flexible, and shift as the family moves through different life stages (Colapinto, 1981). For example, in a healthy family during a time of crisis, the roles of supporter and supported within the parental unit are shared. Rigid boundaries and hierarchies are maladaptive in that they create stress in the family system. At the same time, the capacity to maintain sameness and

stability during a crisis is also a family strength. Patterson (2002b) observes that maintaining routines and rituals during times of upheaval can help a family retain its sense of identity and contribute towards family health.

Family factors also include the stage of the family life cycle at which the family finds itself. At each stage of transition in the family's development, the equilibrium shifts between the stressors that increase the family's vulnerability and the protective processes that foster resilience (Walsh, 2003).

#### **4.2.3. Social factors**

A systems framework places the family within the context of a broad social system (McKenry & Price, 1994). This wider environmental and social context deeply influences the ways in which families perceive and respond to stressors and develop adaptive pathways (De Haan et al, 2002). Many protective factors can be found within the social and community contexts of families, for example, health and education services and social support. Thus, family resilience stems not only from the family's internal processes, but is also influenced by the social context in which a family lives. However, while the social context has the potential to support family resilience, it can also play a large role in undermining families' capacities for resilience, for example, adverse social conditions such as crime and poverty.

Social support has been cited as one of the most important types of community resources that positively influence family resilience (Mederer, 1999; McKenry & Price, 1994).

#### **4.2.4. Family meanings**

A family needs to make sense of their experiences in order to understand them and manage them. Making meaning of stressful events is also referred to as the family's cognitive appraisal, subjective appraisal, perception, assessment and reframing (Patterson, 2002b; McKenry & Price, 1994). Patterson (2000b) describes family meanings as collective constructs made up of beliefs and interpretations of life experiences. They arise out of a family's shared experience and process. Family meanings are relevant to family resilience because they shape the family's expectations of both the stressor and their anticipated

responses, and thus influence how they cope (Patterson, 2002a). Meaning-making is fostered through interactions within the family as well as interactions between the family and community, for example, with other families who may have experienced a similar stressor.

An example of how positive family meanings can contribute towards a family's resilience can be found in a study cited in Patterson (2002b). The study explored family coping in families where a child member had special medical needs. It was found that many families coped with the child's illness by changing the way they think about the situation, such as focusing on the new skills they had learnt, gaining a deeper appreciation of the child's positive attributes and reflecting on how they had grown as a family.

When a family has an experience of coping successfully in one situation, this creates a sense of mastery, and a family belief that they can cope in other situations. These family beliefs, along with family rituals, daily routines, and the values and meanings that shape family relationships, contribute to a family identity (Patterson, 2002a).

#### **4.2.5. Family coping strategies**

Family coping strategies can be regarded as protective family resources when they are adaptive in their function. The adaptive or maladaptive nature of coping strategies often depends on the situation. For example, a coping mechanism employed immediately in the aftermath of a crisis could become maladaptive if it persists over time (Walsh, 2003). This notion is supported by De Haan et al (2002) who state that a family may appear to be coping adequately at a certain point in time, however, the family's initial coping strategies can become damaging or dysfunctional in the long-term. Furthermore, there are times when the coping strategy itself becomes the source of stress. For example, when a family member engages in substance abuse or violence as a way of coping, or where a family member denies the existence of a problem.

McKelvey et al (2002) define coping as any strategy utilised to manage stressful events. This definition implies that coping strategies include both cognitive processes (for example, altering a perception) and behaviours (for example, seeking help). In studies of families

coping with a child's chronic illness, certain family coping strategies have been identified as fulfilling a protective function. These include the ability to balance the illness with other family needs, maintaining clear family boundaries, attaching positive meaning to the situation, maintaining social contact and family flexibility (Patterson, 2002).

The family systems perspective regards coping as a process rather than an outcome, as family coping strategies fluctuate and develop over time (Lazarus & Folkman, 1984). A family's capacity to draw on a range of coping responses indicates flexibility, and this is considered to be much more effective than applying one coping response to all situations (McKenry & Price, 1994). Flexibility can therefore be regarded as a key characteristic of adaptive family coping.

Wills et al (1996) argue that different types of coping mechanisms cannot be labelled good or bad. Rather, the degree to which the coping mechanisms facilitate or hinder adaptation determines their effectiveness (Wills et al, 1996). Figley (1989), on the other hand, distinguishes between functional and dysfunctional family coping. These characteristics are described below:

#### Functional family coping

- Acceptance of stressor – the family is temporarily in crisis but able to quickly recover and mobilise resources
- Family-centred locus of problem – able to quickly shift focus of problem away from one individual and recognises the challenge to the whole system
- Effective problem-solving – may initially engage in blaming but then is able to approach the problem as a family unit
- Shows high tolerance for each other – recognises that heightened patience, teamwork and co-operation are called for
- Committed to each other – able to show praise and affection towards each other
- Open communication – discussions are of high quality and quantity
- High family cohesion – enjoys each other's company
- Family roles are flexible – roles are shared
- Able to access resources inside and outside family

- Absence of violence
- Absence/infrequency of substance abuse

In contrast, *dysfunctional family coping* is characterized by:

- Denial or misperception of stressor
- Problem is located within an individual
- Problem-solving is blame-oriented
- Low tolerance for each other
- Indirect or absent expressions of affection
- Closed or ineffective communication
- Low family cohesion
- Rigid family roles
- Inefficient resource utilisation
- Use of violence
- Frequent use of substances to reduce stress

#### **4.2.6. Spirituality**

Lastly, spirituality can be considered a protective family process in that it has the potential to provide comfort in times of stress and can facilitate the meaning-making process in families. Family process research has found that spirituality plays a significant role in family functioning: spiritual beliefs and practices help families accept the challenges and strains of family life. A survey in the United States conducted by Gallup Surveys found that 75% of respondents reported strengthened family relationships in the home due to the family's religion (Walsh, 2003).

#### **4.3. Adaptation**

The term *adaptation* in family resilience theory is used in a broad sense: firstly, it describes a positive outcome of stress and coping for the family; in this way, it is concerned with the family's postcrisis recovery (Shu-li, 2000). Secondly, adaptation describes the extent to which the family has been able to restore homeostasis; in this way, it describes the family's ability to achieve a balance between environmental demands and family system resources

(McCubbin et al, 1982). McCubbin et al (1982) refer to the concept of a 'system-environment fit' whereby environmental resources meet the needs of the family system, and the family system satisfies the demands of the environmental resources. When these reciprocal needs are met in a balanced way, adaptation is achieved. In addition, a 'fit' must also be achieved between the needs of individual family members and the family unit. Therefore, adaptation involves restoring equilibrium between the demands and resources at these two levels (McCubbin et al, 1982).

A distinction is made between the terms *adjustment* and *adaptation* in that adjustment is seen as a temporary change in response to a stressor while adaptation is viewed as evolving over a longer period of time and bringing about long-lasting changes in the family system (McKenry & Price, 1994).

In assessing adaptational outcomes for families, some theorists suggest examining the family's ability to perform certain essential family functions, namely nurturance and socialisation, family membership, economic support and protection of vulnerable family members (Patterson, 2002a). However, it is emphasised that the ways in which these functions are met are influenced by cultural context, and that there is no single model of family health (Walsh, 2003; Patterson, 2002a). Most families are both functional and dysfunctional in different aspects (Hansen & L'Abate, 1982). Furthermore, resilience fluctuates; a family may be resilient in certain domains and not others. Boss (1988) cautions that adaptation should not be viewed as a definitive end product because a family will always be changing and growing. Boss argues that an enduring state of serenity and calmness in a family may not be optimal for a family due to the necessary growth inherent in conflict and change.

A successful adaptational outcome is referred to as bonadaptation as opposed to maladaptation, which is a poor adaptational outcome. A family has achieved bonadaptation when it is able to continue to promote individual members' development as well as fulfil its appropriate functions as a family (Patterson, 2002a).

In order to explore the extent to which families fulfil their various functions, it is necessary to explore family functioning processes as they are the means by which the family fulfils its functions. Therefore, in considering adaptation, it is necessary to consider family functioning. For this purpose, the McMaster Model is proposed as a useful framework.

#### **4. The interplay between Walsh's framework for family resilience and the McMaster Model of family functioning**

Froma Walsh incorporates the protective factors mentioned above, in a comprehensive framework for family resilience. The framework, which was developed for clinical practice, is built on the findings of a number of studies on individual resilience and effective family functioning (Walsh, 2003). The framework describes "the key processes of family resilience", which are organised under the headings of family belief systems, family organisational patterns and communication processes. The researcher finds this framework worthwhile for examining family resilience in that it is comprehensive and offers a holistic view of family functioning in different areas.

Similarities were noted between Walsh's framework for family resilience and the McMaster Model of family functioning, as many of the protective factors described by Walsh are also seen in the McMaster Model. The McMaster Model is a conceptual model for assessing family functioning in six key areas: problem solving, communication, roles, affective responsiveness, affective involvement and behaviour control. Consistent with a process view of family resilience, the model is based on a systems theory approach. The McMaster Model is built on a set of assumptions of families, namely, that families have specific functions to fulfil concerning the social and emotional development of family members and that they do this through performing specific tasks. Epstein et al (1978) identify three family tasks: basic tasks – meeting basic needs such as food and shelter; developmental tasks – supporting the development of the family unit and individual members; and hazardous tasks – such as crises and unforeseen trauma. The McMaster Model is a helpful model to consider in exploring family resilience as it offers a framework for assessing the strengths and weaknesses of family functioning in significant areas.

Following is a visual breakdown of both frameworks, followed by a discussion of how the models overlap or deviate from each another, using Walsh's framework as the frame of reference:

**Walsh's framework for family resilience (2003)**

**Family belief systems:**

- Make meaning of adversity
- Positive outlook
- Transcendence and Spirituality

**Organisational patterns:**

- Flexibility
- Connectedness
- Social and economic resources

**Communication/problem-solving:**

- Clarity
- Open emotional expression
- Collaborative problem-solving

**The McMaster Model of family functioning (1978)**

**Problem-solving (7 stages):**

1. Identifying the problem
2. Communicating problem to appropriate resource
3. Developing action alternatives
4. Deciding on one alternative
5. Action
6. Monitor that action is taken
7. Evaluate success

**Communication:**

1. Clear vs. masked
2. Direct vs. indirect

**Roles:**

1. Provision of resources
2. Nurturance and support
3. Adult sexual gratification
4. Life Skills development
5. Systems maintenance and management

**Affective responsiveness:**

Welfare emotions and emergency emotions

**Affective involvement:**

1. Lack of involvement
2. Involvement devoid of feelings
3. Narcissistic involvement
4. Empathic involvement
5. Over-involvement
6. Symbiotic involvement

**Behaviour control:**

1. Rigid
2. Flexible
3. Laissez-faire
4. Chaotic

**Walsh's framework of family resilience:****5.1. Family belief systems**

Walsh (2003) states that a family's belief system shapes the family's internal organisation and affects how the family responds to crisis. Resilience is facilitated through shared beliefs that increase the chances of problem-solving. Incorporated under this heading are the following key processes:

- *Making meaning of adversity*

This is a highly significant aspect of family resilience because a family's appraisal of a stressor and of their available resources will impact how they respond to the stressor. A resilient family approaches adversity with a sense of togetherness and shared challenge. Family distress is normalised, and blaming and shaming are minimal. By reframing a crisis as a challenge that is surmountable or meaningful, families gain a sense of coherence. Families attempt to make sense of a stressful event when they ask why and how the event happened. This meaning-making process is an important aspect of recovery.

- *Optimism*

The capacity for hope is an important component of resilience. The ability to hope prevents a family from becoming defeated and helps them strive to overcome obstacles. However, in order for hope to be realistically sustained, a family needs to have enough experience of mastery, success and support. This reflects the concept of learned optimism, whereby optimism can be learned through experiences of mastery and confidence-building (Seligman, 1990, cited in Walsh, 2003). Initiative and perseverance are other qualities of resilient families; the family's conviction that they will make it through the tough times helps family members to actively seek opportunities for problem-solving. Taking stock of demands and resources and accepting limitations, can move a family beyond a sense of powerlessness.

- *Spirituality*

Many families gain solace and guidance from spiritual beliefs and practices; spirituality can help a family see beyond their immediate situation. Spiritual rituals help families through transitions and often provide a sense of community. Prayer is considered by many to be a source of support and nourishment and can inspire feelings of hope and calmness. Spiritual beliefs influence the experience of suffering and hardship and assist the process of making sense of adversity (Walsh, 1999).

## 5.2. Family organizational patterns

Flexibility in the family structure, connectedness and social and economic resources are ways in which family organisational patterns can foster resilience.

- *Flexibility*

This is a central process in family resilience. Walsh (2002b, in Walsh 2003) coins the term “bouncing forward” to describe how a family changes and moves forward through crisis, rather than bouncing back to its original functioning. A family that has ‘bounced forward’ has reorganised its structure and interactions and is better able to meet new challenges. The resilient family is open to change; however, it is also important for the family to maintain a certain degree of stability and sameness during times of disruption. Firm yet flexible leadership is necessary to guide a family through a crisis. Parents need to provide nurturance, predictability and protection to their children during times of stress and transition.

- *Connectedness*

Connectedness is often referred to as cohesion; it refers to the sense of “mutual support, collaboration and commitment to weather troubled times together” (Walsh, 2003:11). At the same time, a cohesive family respects individual members’ need for separateness and observes boundaries. Family cohesion is often disrupted by crisis, after which family members need to re-establish their connection with one another.

Walsh’s concept of connectedness is comparable to the McMaster dimension of family functioning named affective involvement, because both relate to support between family members within appropriate and respectful boundaries. Affective involvement refers to the family’s level of investment, interest and concern for one another. The McMaster Model considers the type of affective involvement as well as the degree of involvement. Types of affective involvement are situated on a continuum with lack of involvement at one extreme and disturbed symbiotic involvement at the other. In between are involvement without

feeling, narcissistic involvement, empathic involvement and over-involvement. Empathic involvement is considered to be the most supportive and healthy style of affective involvement. Affective expression refers to the way in which affective involvement is demonstrated within a family (Epstein et al, 1978).

Similar to Walsh's concept of connectedness and the McMaster dimension of affective involvement, is the concept of family cohesion. Throughout the literature on families, family cohesion is cited as an important indicator of family health. It can therefore be described as a protective factor. Family cohesion has been described by McKenry and Price (1994:9) as the "bonds of unity" within a family. Differentiating self from other is a vital infancy and childhood developmental task, however the need for independence co-exists with the need for emotional connection (Patterson, 2002b). A family's task is to support the individual members' need for both separateness and connection. This emotional connection fulfils the family unit's nurturing role. The necessary degree of separation and connectedness varies according to the family's life cycle. It also varies across different cultures and religions and even from family to family (Patterson, 2002b). Minuchin (1974) describes the extremes of cohesion at either end of the continuum as enmeshment and disengagement. Differing needs within a family regarding the degree of connectedness or separateness required often lead to tension in a family and families need to strike a satisfactory balance between these two states (Patterson, 2002b). Some families find that a crisis increases their sense of connection as they 'pull together' to overcome the challenges. In keeping with Walsh's view of connectedness, Patterson (200b) notes that a sense of closeness within the family may help members through a difficult time and heighten their appreciation of one another.

- *Social and economic resources*

Social support from the community and extended family network plays a significant role for a family in terms of offering practical help and emotional support. In addition, financial resources play a significant role in family resilience – for example, loss of income through a crisis, or situations of chronic poverty, can have a deleterious effect on a family's ability to cope (Walsh, 2003).

### 5.3. Communication processes

Communication processes are highlighted by both Walsh (2003) and the McMaster Model. Walsh (2003) states that communication processes are integral to family resilience in that they clarify crisis situations, encourage open expression of emotions and facilitate shared problem-solving. Communication patterns take many different forms, from verbal to nonverbal, and can be examined at many levels, from gestures, clarity and consistency, to who speaks to whom, who dominates and who withdraws (Patterson, 2002b). The McMaster Model distinguishes between affective and instrumental communication, where affective communication refers to feelings while instrumental communication refers to tasks (Epstein et al, 1978). The Model also measures two specific aspects of communication, firstly whether the meaning is clear, and secondly, whether it is direct (that is, whether the message reaches the person to whom it is sent). Communications should ideally be passed directly from one member to another rather than via a third party (Barker, 1986). According to Wills et al (1996), families that practice effective communication foster the development of coping skills and competence amongst their child and adolescent members.

Both the McMaster Model and Walsh's model focus only on communication in terms of verbal exchange. Other forms of communication would be very difficult to measure.

- *Clarity*

Clarifying and sharing essential information about a crisis situation is very important as it reduces ambiguity and anxiety and fosters meaning-making and decision-making in families. In contrast, ambiguity and secrecy inhibit closeness, understanding and mastery. Clear communication also allows families to share their experiences of pain and loss whereas denial can lead to estrangement. Walsh (2003) observes that frequently, well-meaning families will avoid discussing stressful situations with children out of a belief that they are protecting their children from worry. This can create enormous anxiety in children; the crisis that can be named and discussed is much more manageable than the situation that is unspeakable. Epstein et al (1978) state that families that are able to communicate clearly

generally function more effectively than families in which communication is vague and indirect. Communications that are vague or ambiguous lend themselves to distortions and confusion and are likely to heighten anxiety (Barker, 1986). The ability to communicate well profoundly influences the way a family is able to make meaning of events, which, as discussed, is such an important element of family resilience.

- *Emotional expression*

Crises evoke emotional reactions, and open expression of these emotions in an atmosphere of trust and empathy can be helpful. The sharing of emotions can foster a sense of support and comfort in the family. The suppression of strong emotional reactions may lead to estrangement or conflict in the family, or may result in certain family members becoming symptomatic. Walsh (2003) notes that family members may try to control each other if they feel out of control of a situation. Sharing moments of pleasure or humour is also important and offers a respite from stress and worry.

While Walsh discusses the need for open sharing of emotions, the McMaster Model assesses how the family responds to emotions. This is referred to as affective responsiveness. This dimension explores whether the family responds appropriately to emotional stimuli, and the quality and quantity of that response. The Model postulates that healthy families demonstrate a range of affective responsiveness whereas less healthy families are limited in their repertoire of responsiveness (Epstein et al, 1978).

Epstein et al (1978) caution that cultural factors influence the ways in which people respond emotionally in families. This is an example of how the McMaster Model may not be applicable across cultures as it is based on Western Judeo-Christian values. This is a shortcoming of the model.

- *Collaborative problem-solving*

Collaborative problem-solving that involves shared decision-making, brainstorming and managing conflict is a vital component of family resilience (Walsh, 2003). This process

implies that the family is able to negotiate differences and accommodate one another. Resilient families are able to set clear goals and outline the steps that need to be taken in order to reach the goals. They recognise their successes and learn from their mistakes. These processes help a family become proactive rather than reactive and better equips them to work through future challenges.

The McMaster Model highlights problem-solving as a central dimension of family functioning and defines it as “a family’s ability to resolve problems to a level that maintains effective family functioning” (Epstein et al, 1978:21). It identifies specific steps to be taken towards resolving a problem, which include identifying the problem; communicating the problem to those who need to know (for example, internal and external resources); exploring different approaches and selecting one; taking action; and evaluating the results (Barker, 1986). It overlaps with Walsh’s framework in that it also regards correctly identifying the problem as a crucial step. It also includes elements of communication in that the problem needs to be communicated to appropriate resources, and discussed within the family. According to the McMaster Model, healthily functioning families are able to achieve more steps in the problem-solving process while dysfunctional families may not manage to master the first step of correctly identifying the problem (Epstein et al, 1978).

The McMaster Model also differentiates between affective and instrumental problems. Affective problems are those involving emotions, such as distrust or hostility between family members. Instrumental problems are practical issues such as inadequate food, shelter or clothing (Barker, 1986).

#### **5.4. Differences between the models**

The similarities between the two models have been previously mentioned. There are also several differences between the models that need to be discussed. Specifically, two dimensions of family functioning which are highlighted in the McMaster Model, are not referred to by Walsh (2003), namely, family roles and behaviour control.

Family roles are the patterns of behaviour through which the family fulfils its functions. The McMaster Model explores how roles are allocated in a family, and the extent to which members are held accountable for the roles that have been allocated. Role allocation involves how responsibilities are assigned, whether they are appropriate for the family member, whether they are shared and whether allocation is obtained through discussion or through orders. Role accountability refers to a member's commitment to a particular role and the effectiveness of that function (Epstein et al, 1978). Most families allocate roles informally, however, it is sometimes important for family members to get together and jointly decide how tasks should be accomplished and by whom (Barker, 1986). A healthy family allocates roles appropriately and clearly, and accountability of those roles is high. A healthy family is able to adequately fulfil its functions (Epstein et al, 1978).

With regards to the functions of the family, the McMaster Model distinguishes between necessary family functions and other family functions. The family's functions include both instrumental and affective functions. Necessary functions consist of providing material resources, nurturance, sexual gratification of the marital unit, life skills development and maintaining and managing the family system. Other family functions are the idiosyncratic roles unique to each family, such as the role of scapegoat or idealised family member (Barker, 1986). These unique 'other' family functions can be adaptive or maladaptive (Epstein et al, 1978).

Behaviour control refers to the influence that family members have on each other (Barker, 1986). The McMaster Model highlights four basic styles used by families to control their members' behaviour: rigid, flexible, laissez-faire and chaotic. Rigid styles of control are highly predictable but poor in adaptability. This style may elicit passive-aggressive behaviour, displaced anger and power struggles. Flexible styles are predictable, constructive and adaptive while laissez-faire styles are disorganised. Tasks may not get accomplished and communication tends to be poor in families that use the laissez-faire style of behaviour control. Chaotic styles are neither predictable nor constructive, creating instability and inconsistency in family functioning. Flexible styles are considered to be the most effective as they are reasonable and consistent, whereas chaotic styles are considered the most dysfunctional, due to the random shifting of styles along the continuum from rigid

to laissez-faire (Epstein et al, 1978). The dimension of behaviour control is not comparable to any of the protective processes referred to in Walsh's framework, although it fits in most closely with her discussion of flexibility.

Both Walsh's framework and the McMaster Model make valuable contributions in terms of exploring a family's competent and resilient functioning. However, the most striking difference between the two is that Walsh's framework includes aspects of the family's belief system, such as family identity and meanings, positive outlook and the family's spiritual life. Walsh's framework appears to focus more on family strengths than pathology. One of the shortcomings of Walsh's framework is that it identifies key processes but does not offer dimensions of functioning within the framework whereas the McMaster Model allows the clinician to locate the family's functioning in each particular domain on a continuum of health to pathology.

A criticism of models of family functioning such as the McMaster Model is that these models do not necessarily allow for cultural and ethnic variations in the ways families function (Patterson, 2002b). Walsh (2003) notes that due to the diverse natures of families, there can be no single model of family health. Family competence can be achieved through a wide range of family relational patterns and a framework of family functioning should be applicable across cultures.

## **6. Child sexual abuse and the family**

### **6.1. Sexual abuse as significant risk**

Sexual abuse can be considered a significant risk as it is a complex trauma that disrupts the child's functioning at many levels, which in turn, is likely to pose serious challenges to the family. Childhood sexual abuse is recognised as placing children at major risk for a variety of problems (Briere & Elliott, 1994). While there is no 'sexual abuse syndrome' and reactions to sexual abuse vary widely, a number of potential immediate and long-term effects of sexual abuse have been documented. Sexual abuse also involves a response from parents and society which could lead to further trauma, as well as dealings with sociolegal

systems, which may be even more traumatic than the abuse itself (Friedrich, 1990). According to family systems theory, no part of the system can be understood in isolation (Hansen & L'Abate, 1982). Therefore, when a child in the family is sexually abused or traumatised, the family unit as a whole is affected and may become traumatised.

This study focuses on extrafamilial child sexual abuse, which refers to those situations of abuse where the perpetrator is not a family member, while intrafamilial sexual abuse refers to sexual abuse of a child by a family member, extended family member or a person acting in the capacity of a parent figure. Intrafamilial sexual abuse is an extreme example of how the family unit itself can be the source of trauma.

## **6.2. The impact of sexual abuse on the child**

The extent of the negative impact of sexual abuse on the child is determined by a range of factors including the severity of the abuse, degree of intrusion, duration of abuse, child's relationship to perpetrator, use of threat or violence by the perpetrator, the child's personal strengths and the family's response (Grosz et al, 2000). Abuse-related distress also arises from individual, family and environmental variables that existed prior to the abuse or occurred subsequent to the abuse (Briere & Elliott, 1994). In order to understand the presenting symptoms of the sexually abused child, it is important to explore how the family as a unit has responded to the trauma.

In a 1985 study, Finkelhor and Brown identified the sources of trauma in child sexual abuse as the traumatic sexualisation, stigmatisation (for example, the child's negative self perception, or the parental reaction to disclosure), betrayal, and powerlessness. These factors are named 'traumagenic factors' (Friedrich, 1990).

A comprehensive coping model for sexual abuse was developed by Friedrich (1990). This model can be applied to both intrafamilial and extrafamilial sexual abuse. The model examines four components:

- 1) Functioning prior to the abuse – including risk factors, preconditions of abuse and family variables.

- 2) The nature of the trauma – including the traumagenic factors as described by Finkelhor and Brown (1985).
- 3) Initial response by child and family – including child's coping resources and parents' coping resources.
- 4) Long-term reactions – including degree of fixation, development and triggering events.

Unlike physical abuse, there are no identifiable variables that act as clear markers for child sexual abuse (Finkelhor, 1994). Some research highlights gender, age and low socio-economic factors as markers for sexual abuse but these have not received widespread empirical support. The variables that have shown up most consistently in research as markers for sexual abuse however, are factors in the child's family environment. These factors include emotional estrangement or physical separation from a parent, parental conflict, parental substance abuse and emotionally unstable parents. These family dynamics place children at increased risk for sexual abuse, as supervision of children in these families is low, and families with these dynamics are likely to produce emotionally needy children who may be vulnerable to the attentions of sexual abusers (Finkelhor, 1994).

In a critical review of studies conducted on the short-term effects of child sexual abuse, Beitchman et al (1991) found that parental addictions and depression were commonly reported in families of sexually abused children and well as frequency of separation and divorce. For the most part, research findings do not tend to distinguish between intrafamilial and extrafamilial child sexual abuse. However, Beitchman et al (1991) did find differences with regards to family composition: it was found that victims of intrafamilial sexual abuse were more likely to come from families with divorced or separated parents than victims of extrafamilial sexual abuse. Overall, the review of literature by Beitchman et al (1991) noted that family breakdown and dysfunction were prevalent in families of sexually abused children.

With regards to extrafamilial sexual abuse, the question emerges as to whether the abuse was totally unpredicted or whether the family in some way failed to protect the child. If one is to regard extrafamilial sexual abuse as an accident, research around childhood accidents

strongly suggests that a stressful family environment is a key implicating factor. Studies of repeated accidents in children found that family dysfunction frequently played a role (Friedrich, 1990). Subsequent studies also established a relationship between severe parental punishment and childhood accidents.

### **6.3. The impact of a traumatised member on the family**

Sexually abused children may or may not reach a diagnosis of Post Traumatic Stress Disorder (PTSD). Finkelhor, a sociological researcher who has made far-reaching contributions to understanding child sexual abuse, argues that a PTSD formulation for sexual abuse is too narrow, and is applicable for only a small subset of sexually abused children. However, a diagnosis of PTSD is sometimes helpful for the clinician and can direct treatment appropriately (Friedrich, 1990).

Figley (1989) observes that the costs of caring for the traumatised family member are high for the family, and that as they support and care for the traumatised member, they too will experience emotional pain. He identifies four ways in which family members become traumatised:

- 1) Simultaneous effects – for example, in the case of a natural disaster, the whole family and wider community is affected; there is minimal blaming.
- 2) Vicarious effects – for example, indirectly learning that a loved one has been traumatised, such as for the families of hostages.
- 3) Chiasmal effect – whereby the family develops secondary stress symptoms as a result of helping the traumatised member.
- 4) Intrafamily trauma - as in the case of familial abuse, where the family is the context for the trauma.

Carlson and Ruzek (2000) note that trauma symptoms can make a family member difficult to live with. In their “online fact sheet”, the authors discuss common reactions that families experience when dealing with a traumatised family member, including sympathy, depression, fear and worry, avoidance, guilt and shame, anger, negative feelings, drug and

alcohol abuse, sleeping problems and health problems. A summary of these reactions is provided below:

- Sympathy – feeling sorry for the traumatised member is a normal reaction. However, a possible negative effect of sympathy is that a family may ‘overprotect’ the trauma survivor, thereby sending the message that they do not believe that the trauma survivor is strong enough to overcome the trauma. This could be interpreted as a lack of confidence in the survivor’s ability to cope and resume normal activities.
- Depression – the actual event of the trauma could evoke depression, as it shatters basic trust in the world as well as the assumption that people are essentially good and well-meaning. Furthermore, the depression may be related to loss. The trauma inevitably brings about changes in family life; often the traumatised member behaves in ways which may evoke feelings of pain and loss in the family. The family may struggle to retain hope that the traumatised member will ever return to normal. Loss is an integral component of trauma.
- Fear and worry – these feelings arise out of the knowledge that terrible things can happen to people. Furthermore, if the traumatised member is concerned about safety, this can make other family members feel unsafe too. A traumatised child’s anger or aggression can also cause worry for the family. For example, parents may worry about the child engaging in fights and exposing him/herself to further harm.
- Avoidance – family members may avoid talking about the traumatic event, especially if it is associated with shame. Often the traumatised members themselves hope that their difficult feelings will go away if they don’t talk about what happened to them. In addition, the family may avoid talking about the trauma in an attempt to spare the survivor more pain, or out of fear that the survivor will react badly.
- Guilt and shame – this is a common reaction to trauma, especially if a family member feels responsible for the trauma of another member. Guilt and shame may be exacerbated if family members feel that they cannot adequately help the traumatised person.
- Anger – family members commonly feel angry about the trauma and the ways in which it has impacted on their lives. They may feel angry towards the perpetrator, as well as the trauma survivor for not recovering quickly enough. Furthermore, they

may experience anger in response to the irritable or angry feelings directed at them by the survivor.

- Negative feelings – family members may have negative feelings about the trauma survivor, even if they realise that their assessment is unfair. They may feel negatively towards the survivor due to the survivor's changed behaviours or because they no longer recognise the qualities they used to enjoy in the survivor. They may feel negatively about the way in which the survivor dealt with the actual trauma.
- Substance abuse – this can be used by family members as a way of escaping difficult feelings and may have something to do with avoiding being at home.
- Sleeping problems - sleep is often disrupted as a result of depression or worry. If the traumatised member is having sleep problems, this may also interfere with other family members' sleeping patterns.
- Health problems – illnesses and health problems can develop due to extreme stress. Family members may adopt unhealthy habits as a way of coping, such as drinking, smoking and over- or under-eating.

A family is often unable to link the presenting problem with the trauma and should be helped to understand this relationship. The family should have the opportunity to openly discuss their own reactions to the child's trauma (Catherall, 1997).

#### **6.4. Intervention with the families of sexually abused children**

Catherall (1997:1) states that "a supportive family is the best recovery environment for a trauma survivor" and that the goal of intervention with traumatised families is to mobilise the family's natural recovery process.

No universal models of intervention with the families of sexually abused children were found in the literature. However, a helpful model of treatment for child victims of extrafamilial sexual abuse and their families is presented by Groz, Kempe and Kelly (2000). These authors describe a treatment project which adopted a multiple treatment family approach that included family crisis counselling, individual treatment for the child and/or parent, group treatment for the children and support groups for the parents. The

authors conclude that the parents' ability to resolve their own feelings about the abuse, and their ability to support the child, were significant factors in the child's recovery.

The family intervention project documented by Grosz et al (2000) found that parents reported similar symptoms to the child victim in response to the child's disclosure, such as sleep disturbances, nightmares, emotional distress, low frustration tolerance and feeling overwhelmed. The anxiety they experienced caused significant disruptions in their normal functioning. Their belief in the safety of the world was shattered and the betrayal of trust caused them to doubt their own judgement with regards to the caregivers and friends they had chosen. The parents went through a process of grief and mourning as they dealt with the loss brought about by the sexual abuse. They often experienced shock, rage and guilt. They also felt immobilized and helpless and needed support around the judicial process. Common parental fears regarding the impact of the abuse on their child were that the child was permanently damaged and that the child may perpetrate or become homosexual as a result of the abuse. Some parents became very overprotective and this had a negative effect on the child's coping and normal development. Parents who themselves were survivors of childhood sexual abuse tended to be more distraught as they had made special efforts to protect their children (Grosz et al, 2000).

Although some parents maintained that the victim's siblings did not know about the abuse, it was found that siblings sometimes knew about the abuse or had even observed it (Grosz et al, 2000). Older siblings tended to feel guilty that they had not been able to protect the younger sibling.

The victims themselves often experienced the disclosure of the abuse as more problematic than the abuse itself. They blamed themselves for the distress their families experienced, worried about the disruption caused to the family's normal routines and about what would happen to the perpetrator (Grosz et al, 2000).

As the children's symptoms diminished, and as the parents worked through their own reactions, the parents started to gain hope that the family could recover and move on. The experience of successfully negotiating several crises instilled a sense of confidence and an

acknowledgement of strengths. Anniversaries of the sexual abuse provided an opportunity to reflect on their progress (Grosz et al, 2000). This project clearly highlights the benefits for the child of offering supportive services to the whole family.

Figley (1989) believes that the family has the capacity to heal its members as they know each other best and are therefore often in the best position to help each other. According to Figley (1989), ways in which a family is able to help a traumatised member are identifying traumatic stress (through noticing the emotional and behavioural changes), confronting the trauma (through linking the behaviour to a recent stressful event), encouraging the working through of the trauma (through helping the member to reconsider the traumatic event) and helping the member come to terms with the trauma (through reframing the event and offering different ways of viewing the event). However, Figley (1989) acknowledges that a high degree of social support within a family is required in order to overcome a traumatic stress and this is often the point at which families need assistance.

In situations where one member of the family is suffering from PTSD, Catherall (1997) states that the individual locus of the problem must be shifted away from the traumatised member. He points out that families that cope best are those that view individual problems as problems facing the whole family. He believes it is counterproductive to view the problem as residing in one member of the family, and advocates that the therapist confronts any scapegoating that the family may be engaging in. When a family member is traumatised, families need to establish a climate of physical and emotional safety. As trauma evokes powerful feelings of shame and alienation, family members can easily resort to blaming as a way of distancing themselves from these uncomfortable feelings. Blaming can result in a family member either internalising the shame or acting it out. Catherall (1997) advocates that all instances of shaming and blaming in a family must be interrupted to avoid potentially damaging effects for some of the family members.

In the case of a family member suffering from acute PTSD, the family's primary task is to provide support to the member and to protect that member from additional everyday stresses. The main therapeutic tasks are to educate the family through psychoeducation, normalise the affected member's reactions and help the family to be supportive (Catherall,

1997). After a period of time however, the family should encourage the traumatised member to resume normal activities in order to prevent that member from becoming stuck or immobilised.

In the case of chronic PTSD, Catherall (1997) points out that the family's primary concern is around survival, rather than providing support for the traumatised member. One of the important therapeutic tasks is to help the family overcome the "traumatic sequelae", which include myths, rules, distorted worldview and reenactments of the trauma.

According to Catherall (1997), the longer a family lives with a traumatised member, the greater their chances of being affected by the trauma. This point has serious implications for service delivery. In South Africa, the waiting lists for counselling at both non-governmental counselling organisations and state-provided mental health facilities are often lengthy. Where a child or family is traumatised, prompt intervention is advocated.

Patterson (2002a) states that the practitioner's belief in the family's inherent strengths and abilities lies at the heart of the resiliency approach. Engaging with the family from this perspective allows families to experience themselves as capable of finding solutions, developing resources to cope with challenges and achieving a sense of mastery.

## **7. Findings from related studies**

Many studies have explored family coping and resilience in families where a child has a disability or chronic illness and it is upon these studies that the literature of family resilience has been built. Despite an extensive search of the relevant literature, no studies were found that examined family resilience in families where a child has been sexually abused. It is reasonable to expect that the dynamics of families having to cope with child sexual abuse may differ from those families coping with a child's illness. Coming to terms with the how's and why's of a child's abuse may be a particularly challenging process for the family, where the importance of meaning-making would be high.

Cohen et al (2002) conducted a qualitative study exploring Israeli mothers' perspectives of family resilience, where the family had experienced a trauma in the previous year. The traumas were varied and included sudden death, accidents, divorce, illness and death in hostile acts.

Five themes relating to family resilience emerged:

- expressiveness-disclosure: the ability to express their feelings within the family encouraged a sense of family resilience.
- connectedness: families that were perceived as resilient showed the ability to relate to the needs of their members, demonstrated readiness to help and were able to share emotional processes, which fostered a sense of connectedness.
- flexibility: this was experienced in families that were able to share the roles of 'supporter' and 'supported'; the opposite scenario was emotional rigidity which was associated with low family resilience.
- optimism-positive outlook: interpersonal relationships that incorporated humour and optimism facilitated a sense of family resilience.
- family values: participants defined family resilience in terms of two values, trust and a sense of security – the presence of these values contributed to a feeling of family strength and coping.

The findings of this study are consistent with many of the key processes of family resilience that have been highlighted by other researchers such as Walsh (2003) and Patterson (2002).

Family stress research in families with children who have chronic medical conditions has established that the family's perception of the condition is the key factor influencing how the family copes with and adapts to the condition (Garwick et al, 1999). Garwick et al (1999) adopted a cross-cultural perspective in exploring the differences in families' explanations about chronic childhood conditions. In keeping with family coping theory, they state that the way a family cognitively processes their experiences critically impacts their adaptation to life events. Finding an explanation for the chronic condition that is consistent with their beliefs and worldview, and coming to terms with the condition, are

important tasks for the family. They also found that the dynamic of blaming oneself or another family member was a risk factor that hindered the family's healthy adaptation and prevented the family from working together. Furthermore, they found that a family's ability to move beyond the question 'Why did this happen?' to focusing on managing the demands, was a characteristic of family resilience.

In a quantitative study exploring the relationship between coping and adaptation in families of children with cerebral palsy, Lin Shu-Li (2000) found that family coping was related to positive family meanings of the cerebral palsy, social support, spiritual support, personal growth and advocacy and positive social interaction. The instruments used in the study were the Family Demographic Form (FDF); a modified form of the Family Crisis Oriented Personal Evaluation Scales (F-COPES) and the General Functioning Scale of the McMaster Family Assessment Device (FAD). The findings revealed that family coping and adaptation varied according to the family's stage in the life cycle. For example, families with infants and preschoolers tended to use more coping behaviours related to information-seeking and seeking external support, than families with young adults. The two factors relating to family coping that were found to predict family adaptation were positive family appraisal and positive social interaction.

In a study which explored the impact of stress on parent-child interactions, McKelvey et al (2002) examined the mediating role of coping. The study was based on the hypothesis that stress negatively impacts the quality of the parent-child relationship. Three types of stress were focused on: marital dissatisfaction, family conflict and financial need. The findings of the study indicated that mothers with lower stress levels had more positive interactions with their infants. The study also found that the mothers who perceived lower stress in their life were making more use of the coping strategies of seeking social support and cognitive reframing. However, the results of this study did not support the mediating role of coping on the mother-infant relationship under stress.

In other similar studies focusing on coping and parent-infant attachment, cognitive reframing (of the stress of parenting) was found to mediate the impact of parenting stress on parent-infant attachment (McKelvey et al, 2002).

## **8. Concluding remarks**

The family resilience approach is based on two premises – that crises affect the whole family, and that there are several key protective processes which mediate the impact of crises on families and facilitate healthy adaptation (Walsh, 2003).

The resilient process involves a significant risk to the family which then interacts with multiple potential protective factors to influence adaptation. From this perspective, family resilience implies far more than simply managing a stressful situation. Each family navigates its own journey through adversity and develops its unique resilient pathway depending on the situation, the cultural and social context and their own strengths and abilities (Walsh, 2003). Family resilience is enhanced through experiences of mastery (Cowan et al, 1996).

Walsh's framework of family resilience was used to examine the protective processes that contribute towards family resilience, including positive family meanings, clear and direct communication processes, spirituality and a family's ability to work together to find solutions. The six dimensions of family functioning according to the McMaster Model were also discussed. Healthy families are those which foster a sense of closeness and emotional support while respecting individual needs for separateness. They are open to change and share family roles. Blaming is a risk factor for families while social support is protective.

The trauma of sexual abuse was presented as a challenge to the whole family and understood from a family systems perspective. Certain features of the family environment, such as physically or emotionally unavailable parents, can place a child at risk for sexual abuse. Parental support plays a crucial role in the child's recovery from sexual abuse and this highlights the need for a family-centred approach to sexual abuse treatment.

The main limitation of family resilience research thus far seems to be the lack of clarity in the definition of key concepts. For example, the different theoretical interpretations of the concept of resilience, and the lack of distinction as to whether family competence is a protective factor or a resilient outcome. Patterson (2002) emphasises the need to give more

focus to the role of social systems, such as community resources, on family resilience. The impact of the socio-economic context on family resilience seems to be understated in the literature. With regards to studies, some theorists highlight the need for longitudinal studies so as to explore the unfolding of the family resilience process over time (Patterson, 2002).

A focus on family strengths and resilience has significant implications for intervention – Walsh (2003) notes that building resilience is a preventative measure as it empowers families to ‘struggle well’ with the inevitable and unanticipated challenges of family life. Building family resilience benefits all family members as it fosters a healthy family environment. A focus on ‘family strengths under stress’ affirms the healing potential of families and makes room for shared hope.

## **Summary**

This chapter presented a review and discussion of the literature pertaining to family resilience and extrafamilial child sexual abuse. The perspective of family resilience as a process was presented and the systems framework within which it is rooted, was mentioned. An introduction to family stress and coping theory was also provided. The impact of sexual abuse on the child and family was discussed, along with suggestions for intervention.

## **CHAPTER THREE – RESEARCH DESIGN AND METHODOLOGY**

### **Introduction**

This chapter outlines the research design, sampling method, data collection and data analysis. Limitations of the study, reflexivity and ethical issues are also discussed.

### **Research design**

The research design can be described as the logical steps that link the research findings to the study's initial research questions, and to its conclusions (Yin, 1994). A qualitative research design is used in this study. Due to the exploratory nature of the study, the findings are best captured through a qualitative paradigm. Qualitative research designs involve a "detailed encounter" with a small selection of cases (Babbie & Mouton, 2001:279). The style of the qualitative researcher is involved, as opposed to the detached style of the quantitative researcher (Neuman, 2000). This was indeed demonstrated in this study, where the researcher moved in and out of her researcher role and adopted an empathic listener role where appropriate, due to the sensitive subject matter. The qualitative approach lends itself to interpretive enquiry and allows for depth and richness of understanding (De Vos, 1998). In this study, the researcher aimed to gain a rich understanding of the families' coping experiences with regards to sexual abuse, and to explore their resilient processes. Patterson (2002a) recommends qualitative studies for examining family resilience in order to best understand the subjective family meaning-making processes.

An aspect of qualitative research that is noted as both an advantage and a disadvantage is the subjective nature of the approach. The disadvantage is that this presents the potential for errors and researcher bias, while the advantage is that the qualitative paradigm best captures the personal meanings and experiences of the participants. Potential errors and biases are discussed later in this chapter.

## **Sampling**

In this study, a purposive sampling method was used whereby the researcher selected participants who were most likely to elicit the information that was sought. Purposive sampling is an example of a non-probability sampling method, where the sample is not representative of the wider population and the findings cannot be generalized. In purposive sampling, cases are selected for their relevance to the research topic rather than their representativeness of the population (Neuman, 2000). Babbie (1998) notes that purposive sampling is often used in exploratory research, where cases are selected with a specific purpose in mind, usually to deepen an understanding of a particular domain of social life. Purposive sampling is used when the researcher aims to acquire a deep understanding of a particular topic rather than to generalize to the wider population (Neuman, 2000). In purposive sampling, cases are often selected gradually, which was the case in this study, as described below.

A sample of 5 sets of parents was used, comprising 8 parents in total. The sample was small, firstly due to the difficulty in accessing cases which met the criteria for this research. Secondly, to allow for an in-depth exploration, in keeping with the clinical nature and purpose of this study. Neuman (2000) notes that a case-oriented approach is the preferred style of qualitative researchers. This approach allows for a broad and in-depth examination of a few cases.

The sampling strategy for this study occurred in the following steps:

### **1. Selecting the sample**

The sample needed to meet specific criteria for inclusion in the study. These criteria included:

- a) A child in the family had been subjected to extrafamilial sexual abuse (ie. not by a member of the family, household or extended family)
- b) The child had received counselling at Childline - preferably in the past year
- c) In the counsellors' opinion, the family appeared to cope well (i.e. no obvious family dysfunction; able to support child)

d) The family could communicate in English

Families who had been the researcher's clients at Childline were excluded from the sample, as were those families who did not have telephones. Language also reduced the potential sample. The Childline counsellors were then invited to suggest families that met the above criteria. The researcher initially attempted to select the whole sample from the head office in Wynberg but as there were insufficient cases at this branch which met the minimum requirements, the researcher also approached the Bishop Lavis branch and asked for the counsellors at this branch to suggest potential participants from their caseloads. Thus, it can be said that the sample was collaboratively selected, using the judgement of experts in the particular field. Purposive sampling is sometimes referred to as judgemental sampling because the sample is selected based on the researcher's judgement and the purpose of the study (Babbie & Mouton, 2001). An interesting pattern emerged which indicated that the families who were regarded by the counsellors as those who had coped well, were those who had followed through with their child's counselling sessions.

The majority of cases seen at Childline Western Cape are intrafamilial sexual abuse cases (R. Fransman, personal communication, September 27, 2004)<sup>4</sup>, however the researcher decided to focus only on extrafamilial abuse. This was because abuse by a family member implies a different set of family dynamics and circumstances from extrafamilial abuse. For example, where a child had been sexually abused by a family member, the family structure might have changed since disclosure or there might be loss of income or the family functioning could simply be dysfunctional. The researcher wanted to focus on families that were relatively stable or healthy. The decision to only include families where the child had already received therapeutic intervention, was an ethical one; it would have been unethical to expect a family in trauma who was needing therapeutic intervention, to participate in a study. It was also hoped that the time period since disclosure had allowed for some healing and resolution of trauma to take place, which might render the families more able to reflect on their experiences. However, it was recognized that the families may still be in the process of coping. Aldwin (1994) notes that the process of coping with traumatic stress takes longer than coping with everyday stressors.

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<sup>4</sup> R. Fransman is the manager of Childline Western Cape

## 2. Gaining access to the sample

The researcher was initially provided with the names and contact details of eight families. In December 2003, all eight families were contacted telephonically and five were available and willing to participate in the study. The other three did not respond to the invitation to participate or to subsequent messages. Two participants were single mothers and three were married couples. The process of gaining access to the sample was guided by ethical principles. At the initial telephone contact, the researcher informed the parents about the research, including why the researcher was contacting them (the reason given was that their counsellor had identified them as coping well); what the research was about; that it would be tape recorded and anonymity protected and that participation was voluntary. At this stage, the researcher requested the parents' permission to look at the child's file. The researcher also informed the parents that they would be referred for further intervention if this became necessary and that the cost of transport to the interview would be covered and refreshments provided.

Once the parents expressed their verbal willingness to participate, a detailed letter was sent to the family along with a consent form. (See Appendix A and B for a copy of the letter and consent form). At the beginning of January 2004, the researcher contacted the families to arrange appointment times for the interviews.

Several difficulties were encountered during sampling. Firstly, it was difficult for the counsellors to identify cases where the perpetrator was not a family member. Secondly, the counsellors struggled to identify families that had coped well. Furthermore, sample selection was a slow process as the researcher had to rely on the counsellors to come forward with potential cases to use in the study.

## **Data collection**

Data was gathered through qualitative interviews and the researcher's direct observations. Five semi-structured in-depth interviews with parents were conducted over a period of two weeks. Children were not included in the interviews. Babbie and Mouton (2001) note that interviews are the most commonly used methods of qualitative data gathering. The

interviews were tape-recorded. The researcher's observations were recorded in the form of field notes. The field notes, which were jotted down after each interview, included the researcher's observations, thoughts and impressions. The researcher observed the physical environment (when the interviews were conducted at the participants' homes) as well as expressive movements such as eye contact, body language, tone of voice, gestures, language and interactions between the two parents. These field notes were subsequently referred to during data analysis. This type of observation can be referred to as "simple observation" as opposed to "participant observation", where the researcher is a member of the group that he/she is studying (Babbie & Mouton, 2001:310). Thus, the participant observer is not merely a passive observer, but engages in the activities appropriate to the social phenomenon he/she is studying as well as observing them, while simple observations (also referred to as "casual" or "direct" observations) are made in the field during interviews (Yin, 1994:87).

Two interviews were conducted at the Childline counselling center in Wynberg and three were conducted at the participants' homes. The interviews lasted between one and one and a half hours each. A research schedule was used to ensure that important themes and topics were covered. Mostly open-ended questions were asked, to allow for detailed responses. Please see Appendix C for the interview schedule.

Studies referred to in the literature review found it adequate to interview just one member of the family to explore family coping and resilience. However, De Haan et al (2002) state that interviewing one member of the family about family resilience poses the risk of assessing that member's perceptions of the family, rather than directly observing and assessing the family. These authors suggest the conjoint family interview as a more useful methodology as it would elicit more accurate data about family processes. In contrast, Barnes (2004) believes it is possible to work systemically with individual family members or subsystems, provided the whole family is 'held in mind'. Cowan et al (1996) identify the lack of appropriate measuring instruments for measuring family-level processes. However, there are practical difficulties to interviewing the family unit, such as the availability of all family members, as well as the challenge of including children of varying ages in the interview. Ethical issues also exist – the sensitive nature of the subject matter raises the

question of whether it is appropriate to include children in the interview. Due to these practical and ethical issues around interviewing the whole family, this study adopted the compromise of interviewing the parental subsystem, which comprised either a single parent or a parental couple. This allowed the researcher to assess the family members more directly and observe some interactions between members where both parents were present.

Due to issues surrounding sexual abuse, such as the sensitivity of the topic as well as privacy and protective issues, the researcher decided to conduct in-depth interviews rather than focus groups. The spread-out geographical locations of the participants would also have contributed towards practical difficulties in conducting focus groups. Thompson (1999:191) notes that semi-structured interviewing is often used in qualitative research; the advantage is that it allows for “flexibility in scope and depth”, while at the same time, is organized around key subjects. The interviewer does not need to adhere rigidly to the questions in a specific order, and is free to explore new themes that emerge in the interview. The semi-structured interview allows for the flexibility of obtaining unanticipated responses (Bailey, 1994). Babbie (1998) describes the qualitative interview as an interaction between researcher and participant that is similar to a conversation, but one in which the participant does most of the talking. The researcher guides the general direction of the conversation so that specific topics are covered. Babbie and Mouton (2001) describe the interviewer as a ‘naturalistic investigator’, whereby he or she adopts a position of ignorance about the subject under investigation and needs the participants to describe, explain and ‘teach’ him or her about the subject. The in-depth interview as a research method has both advantages and disadvantages: although the interview is a highly useful measurement tool for exploring sensitive material, its disadvantage is that it is expensive and time-consuming, and limits the researcher to a small sample (Aldwin, 1994). One of the advantages of the in-depth interview is that it allows the researcher to make observations of nonverbal behaviour and to note spontaneous responses (Rubin & Babbie, 1989). In interviews there is less standardization of question-wording than in a mailed questionnaire, for example, the interviewer may phrase a question differently with different participants. In qualitative research, however, this is generally regarded as an advantage because it allows the researcher to be flexible and adaptive. Qualitative interviewing introduces the possibility of interviewer bias, which is discussed in a subsequent section of this chapter.

The main difference between the qualitative interview method used in this study, and the case study approach used in other qualitative studies, is that most case studies rely on multiple sources of data while the qualitative interview is simply one method of data collection (Yin, 1994). Furthermore, the case study is an in-depth examination of a single unit, while the qualitative interview explores the experiences of several participants. In multiple case studies, a replication logic is followed whereby each case is examined fully and written up separately and then similar or contrasting results are noted. Each case can be regarded as a single experiment (Yin, 1994). As there was no information about the family on the case file besides the concrete details of the actual abuse, it was decided that in-depth interviewing would be the most appropriate data collection technique to use in this study, as opposed to a multiple case study approach. There were insufficient alternative sources of data available to warrant a case study approach.

Babbie and Mouton (2001) note that being a good listener is an important skill for the qualitative researcher conducting interviews. In this study, the researcher's familiarity with interviewing, as well as an established foundation in counselling skills as a result of her clinical experience, was a distinct advantage to the researcher.

### **Data analysis**

The tape-recorded interviews were transcribed and analysed according to Tesch's 8-step approach (De Vos, 1998). Tesch's approach outlines 8 steps in which the researcher familiarizes herself/himself with the data and arrives at a truthful and thorough interpretation of the data. In this study, the researcher began with a close reading-through of all the transcripts. Ideas and impressions were jotted down during this reading. The researcher then selected one transcript for closer analysis. She selected the transcript of the first interview conducted, on account of it being the longest. While reading through the transcript, a list of topics arising were made, which were abbreviated by codes. The researcher then returned to the reading of the other transcripts, applying these codes next to the appropriate pieces of text, thereby building on and adding to the list of topics. The topics were then categorized into major topics, unique topics and topics of lesser relevance. Some of the categories were collapsed into one. The categories were assigned descriptive

names. The categories were then alphabetized and the researcher manually put all the text belonging to a particular category, in one pile. She then meticulously examined the material in each category, highlighting themes for elaboration.

The analysis occurred by means of inductive reasoning, whereby the researcher allowed the data to speak for itself as opposed to fitting the data into an existing conceptual framework. The researcher allowed themes and categories to emerge and searched for the similarities and relationships between them. The data was then synthesized into a coherent textual framework. This is referred to as a grounded theory approach, whereby a theory is built out of the evidence collected (ie.inductively), in order to make sense of the evidence and observations (Neuman, 2000). The grounded theory approach offers the opportunity to discover new theory, as it allows for the investigation of topics about which not much is known, as was the case in this study (Babbie & Mouton, 2001). In analyzing the data, the researcher made use of the technique of bracketing, whereby existing knowledge and preconceptions of the topic are set aside, allowing the 'new' data to be the sole focus (De Vos, 1998). In both qualitative and quantitative research, the adequacy of the investigation is important. Adequacy refers to the volume of data collected rather than the number of subjects (Neuman, 2000).

During data analysis, attention was paid to the participants' actual words and phrases, as recommended by De Vos (1998). Field notes were also referred to during data analysis as they contained the researcher's thoughts and observations of the family at the time of interviewing.

The research results are presented and discussed in Chapter Four.

### **Limitations of the research and potential sources of error**

The researcher is aware of limitations and possible sources of error relating to the research design, sampling method, data collection and data analysis. These limitations are described below.

### Research design limitations:

One of the draw-backs of qualitative research is that it is time-consuming to carry out, and, depending on the size of the sample, could be costly, especially where travel costs are involved. In addition, the external validity of this qualitative study is low. External validity refers to the generalisability of findings to a wider population. The results can only be said to apply to a small and specific context (Neuman, 2000). Babbie and Mouton (2001) note that as the researcher is the main instrument in the qualitative research process, he or she has a responsibility to be as unbiased as possible in his/her investigation.

### Sampling limitations:

As mentioned above, one of the main limitations of this study is that due to the non-probability sampling method, the sample is not representative of the wider population and the research findings are not generalizable. However, the study is valuable in terms of raising pertinent issues relating to family resilience and providing an organization with key recommendations pertaining to intervention with sexually abused children and their families. The small sample allowed for an in-depth investigation of the topic and the value of the rich data gathered is considered to outweigh the disadvantage of not being able to generalize the results of the study.

Rubin and Babbie (1989) observe that non-probability sampling methods are less reliable than probability sampling methods. Therefore, a study is likely to produce slightly different results if it were to be replicated. This is due to the contextual nature of qualitative research and the interactive nature of data collection (Neuman, 2000). It is recognized that the evolving context and process of qualitative research reduces reliability. Neuman (2001) notes that the authenticity of the qualitative research (that is, the fairness and honesty of the accounts of the participants' experiences) is of utmost importance.

Language was also a limitation for the participants in this study for whom English was their second language. They may not have been able to accurately express their thoughts and experiences. However, this limitation was somewhat controlled in that the participants felt free to switch back and forth between English and Afrikaans.

### Data collection limitations:

The interview method introduces the impact of interviewer bias. This includes research expectancy effect, whereby the researcher subtly conveys a certain expectation that the participants fulfill, and social desirability effects, whereby the participants try to please the researcher (Mouton, 2001). Furthermore, the interviewer's physical and social characteristics such as race, religion, gender, physical appearance, age, accent, dress and social class, can influence participants' responses (Bailey, 1994). However, a good rapport established between the researcher and participants can minimise interviewer bias to some degree (Bailey, 1994). In this study, the researcher adopted a warm, friendly and sincere manner. It is hoped that this contributed towards the participants feeling at ease. It is also important to be aware that the participants' perceptions of the interviewer may produce caution in answering certain questions (Bailey, 1994). The researcher's affiliation with Childline and with the University of Cape Town is likely to have introduced a power dynamic which may have influenced participants' responses due to the perception that the researcher occupies a different social status to the participants.

The interview situation also presents the risk of inaccuracies and inconsistencies. For example, participants may say one thing but do another (Bailey, 1994). This particular inconsistency was noted in this study, and is commented on in Chapter Four. The researcher's ability to observe and listen closely and carefully, helped to some extent to pick up these inconsistencies. Other possible errors that may be caused by the participants include giving inaccurate accounts due to lying, unconscious mistakes, misunderstanding the question or memory failure (Bailey, 1994). In this study, the researcher was interested in the participants' perceptions - there was no way of monitoring how realistic these perceptions were, therefore the risk of unreliability of sources was present. The researcher may also make errors, such as omitting questions, asking irrelevant or biased probing questions, or simply falsifying data (Bailey, 1994).

The social setting in which the interviews took place may have influenced the data gathered in that some participants may have felt more comfortable talking about their experiences at the Childline office, while others may have felt freer to speak from home.

### Data analysis limitations:

Firstly, the actual transcription of the recorded data is open to human error. Secondly, the subjectivity of the researcher's interpretation of the data poses the risk of biases. For example, in analyzing the data, the researcher may overemphasize some findings and underemphasize others, drawing conclusions that are not accurately supported by the data. Mouton (2001) refers to this phenomenon as research selectivity effect. This could be due to the researcher's personal biases, where particular themes hold more importance for the researcher than others.

The researcher's relative inexperience in the field of research was also a potential limitation. This potential was monitored through the regular use of supervision.

Awareness of the potential sources of bias and errors mentioned contributes towards trustworthiness of data (de Vos, 1998).

### **Reflexivity**

As researcher, I was particularly aware of the power dynamics of myself in relation to the participants. I am a white female South African, and represent the profession of Social Work. The participants were so-called Coloured, working class families living in low socioeconomic circumstances. Furthermore, I was being supervised by the University of Cape Town. This powerful combination of roles, that of professional and researcher were however somewhat mitigated by my role as a Childline counsellor, as all the participants had had positive experiences of their Childline counsellor. This helped the participants relate to me and allowed me access to their experiences. My awareness of this power dynamic also helped minimize the potential for exploitation.

I was aware that as a researcher I was not entirely neutral. The topic of child sexual abuse was familiar to me as I was a Childline counsellor, and therefore had certain experiences, beliefs and opinions about families, sexual abuse trauma and related issues. It was important that I remained as objective as possible and suspended my own personal thoughts and opinions.

Due to the sensitive nature of the interviews, there was a thin line between my role as researcher and as counsellor. At times, I had to move in and out of the two roles, as was necessary. It was not appropriate for me to remain an objective researcher when the participants were visibly distressed or when they were asking for specific guidance or information. In addition, I had to carefully manage the participants' expectations of me. It was not possible for me to meet some of their hopes and expectations, for example, that I would see the child or be able to provide answers to questions about the court case.

The research was a valuable learning experience for me. I was deeply inspired by the resilience and capacities of the participants. At the same time, it was distressing to learn how the criminal justice system had failed to adequately play its role in protecting children and respecting the integrity of families.

### **Ethical considerations**

Ethical issues in research revolve around the dilemmas and conflicts that arise during the process of conducting research. Issues of power and trust are paramount in considering research ethics: by virtue of his/her professional and academic role, the researcher has power relative to the participants (Neuman, 2000). Neuman (2000:91) warns that with the authority to carry out research, comes the researcher's responsibility "to protect the interests of those being studied". As previously mentioned, the researcher needs to be aware of power dynamics; by virtue of being a clinician, researcher and postgraduate student of a tertiary institution, the researcher was in a position of power over the participants. Care must be taken not to exploit this power and efforts should be made to reduce the power difference.

This study was guided by ethical principles. One of the minimum ethical requirements is that the researcher obtains the participants' voluntary informed consent prior to conducting the research (Neuman, 2000). Participants in this study were initially informed about the study over the telephone. They were informed that the research was being conducted on behalf of Childline Western Cape and that the researcher was a student at the University of Cape Town. The participants were subsequently sent an information sheet about the

research, outlining what the research was about and what was being requested of them, as well as a consent form to sign. Issues of confidentiality were laid out. They were informed that the interview would be tape-recorded, and that the tapes would be destroyed at the completion of the research. They were aware that their participation was voluntary and that they could withdraw their participation at any time. Permission for the researcher to view their child's file was requested.

Another minimum ethical requirement is that the researcher does not harm the participants physically, emotionally or legally (Neuman, 2000). In conducting this research, the researcher was aware of the potential emotional harm to the participants. Due to the sensitive nature of the investigation, the potential existed for the research questions to evoke psychological stress or anxiety on the part of the participants. Therefore the researcher clearly informed the participants that she would refer the family for additional counselling if this became necessary. Participants were also informed that they did not have to answer any question they didn't want to.

Proper closure of the interview was essential - time was allocated at the end of each interview for 'debriefing'. Participants were asked how it had felt to talk about their experiences and to share what was hard for them in talking about their experiences. This allowed for appropriate containment, and gave the researcher the opportunity to ascertain whether the family needed further intervention. In one situation, the participants requested a referral for marriage counselling and the researcher contacted their Childline counsellor to arrange for this.

Ethical consideration must also be given to the processes of data analysis and reporting. The researcher must present the findings truthfully and avoid falsification of data (Babbie & Mouton, 2001). Research shortcomings and methodological limitations should be acknowledged.

Another ethical consideration is the researcher's professional conduct and competence. The researcher did not carry out this research in isolation, but consulted with her supervisor at each step. The research proposal was approved by the Department of Social Development,

UCT. The research was well-planned and systematically carried out. Privacy was ensured in that no names were used in the research report.

The focus of this study was on strengths rather than dysfunction. The researcher approached the families from the perspective that they had valuable experiences that others could learn from. This approach was empowering in that it was assumed that the family had coped well enough and had achieved some mastery over their traumatic experience.

As a follow-up to the research and a sign of respect for the participants who courageously shared their experiences, the researcher wrote each participant a letter of thanks for their involvement, reflecting briefly the issues that had been raised by that particular participant. Upon completion of the final research report, the findings will be presented to the Childline staff in a formal presentation. A copy of the final research report will be made available to Childline Western Cape should the participants wish to view the report.

## **Summary**

This chapter presented the research design and methodology. A discussion of the qualitative paradigm was offered, followed by a description of the non-probability sampling method employed in the study. Steps taken in selecting the sample were outlined. Qualitative data collection, in the form of in-depth interviews, was discussed and the advantages and limitations thereof were presented. The process of data analysis was described. This was followed by a discussion of the limitations of the research and potential sources of error. The chapter concluded with a reflection of reflexivity and ethical issues.

## **CHAPTER FOUR – RESEARCH RESULTS AND DISCUSSION**

### **Introduction**

The research data was inductively analysed according to Tesch's 8-step approach, as outlined in De Vos (1998). After drawing themes from the data, the researcher looked for relationships and connections between themes, and developed a theoretical framework. Field notes were also consulted during the data analysis as they contained the researcher's thoughts, impressions and reflections during the data gathering process. The research findings discussed in this chapter are the outcome of the research objectives outlined in Chapter One.

The five in-depth interviews were conducted over a two-week period in January 2004. The length of the interviews varied from one to one and a half hours. Two of the interviews took place at the Childline Centre in Wynberg and the other three took place at the participants' homes. Conducting the interviews at the participants' homes helped the researcher gain a feel for the daily living environment in which the families exist, and contributed towards a more vivid understanding of the families' realities.

An interview schedule served as a guide for the in-depth interviews. The researcher prompted the participants through asking open-ended questions related to family resilience and coping and allowed the participants to respond as they wished. In designing the interview schedule, the researcher broke down the concept of family resilience into its different components, guided by the literature findings. However, throughout all five interviews, the researcher was aware that family resilience was a broad and complex concept to capture through an interview schedule and it seemed that at times the questions could not adequately cover the scope of the concept. All information shared by the participants about their coping and related experiences around the abuse, was regarded as valuable. For some of the participants, English was their second language. This is taken into account as it may have hindered their ability to accurately express themselves. Despite the potential drawbacks of this language issue, however, the participants responded capably in

English and broke into Afrikaans when they felt they could better express themselves that way.

At times during the interviews, when it was evident that the participants were struggling emotionally with certain aspects of their experience, it was necessary for the researcher to step aside from her neutral researcher role in order to respond as a counsellor. In these situations, the researcher used counselling skills such as empathic responding, normalizing and psychoeducation.

Two of the interviews required some follow-up action by the researcher. In one situation, the family asked for information regarding the court process. In this case, the researcher subsequently phoned the prosecutor involved to find out why the case was delayed, and then informed the family of the relevant information. In the other case, the parents requested a referral for marital counselling. With the couple's permission, the researcher relayed this request to their child's counsellor at Childline, asking her to refer the parents to FAMSA. Furthermore, the researcher informed the counsellor that the perpetrator was breaking his bail conditions and this was having a negative impact the family. The researcher asked the counsellor to communicate this to the investigating officer.

All five sets of parents were considered by their Childline counsellor to have coped fairly well or to have displayed strengths. This was why their names had been suggested to the researcher. The main strength which conveyed to the Childline counsellor a certain level of coping that was not apparent in other cases, was the families' ability to bring their child in regularly to counselling, despite practical difficulties such as financial hardship, transport difficulties or work commitments.

During the interviews, there were times when disparities arose between what the researcher heard and what she observed. These contradictions are discussed in the data analysis and efforts are made to understand them.

## Sample profile

The sample consists of eight parents, including three sets of married couples and two single mothers. The families reside in Bonteheuwel (2), Mitchell's Plain (1), Hanover Park (1) and Ocean View (1). Their geographical location is relevant as they are all situated far from the Childline counselling centres and live in communities with low socioeconomic status, limited resources and social problems such as gangsterism and violence. The children in Family #4 and #5 were abused by the same perpetrator. Of the child victims of sexual abuse in the sample families, four were male and one was female. This differs from the trend at the Wynberg branch of Childline Western Cape, where more girls than boys are referred for sexual abuse counselling.

**TABLE 1: FAMILY #1 (Residing in Mitchell's Plain)**

Interviewed:	Mother and father (married)
Age of the child at time of abuse:	11
Living in the household:	Mother and father, child, two siblings
Gender:	Male
Perpetrator:	Family friend (young adult)
Type of abuse:	Sodomy <sup>5</sup> and sexual assault <sup>6</sup>
Frequency:	More than once
Where abuse occurred:	At child's home and elsewhere
When abuse occurred:	Jan-Aug 2001 (approx. 2 ½ years prior to interview)
Court case:	Ongoing
Counselling:	Child attended seven sessions
Who referred child to Childline:	Family friend

<sup>5</sup> Sodomy refers to anal penetration

<sup>6</sup> For the purpose of this research, sexual assault refers to a range of sexual abuse acts (such as verbal, touching, oral sex, flashing) excluding rape (vaginal or anal penetration).

**TABLE 2: FAMILY #2 (Residing in Ocean View)**

Interviewed:	Mother (parents separated)
Living in the household:	Mother, maternal grandmother, mother's two sisters, child
Age of the child at time of abuse:	5
Gender:	Male
Perpetrator:	Teenage boy in neighbourhood
Type of abuse	Sodomy
Frequency:	Once
Where abuse occurred:	Unknown
When abuse occurred:	Oct 2002 (one year and three months prior to interview)
Court case:	None
Counselling:	Child had attended six sessions at time of interview
Who referred child to Childline:	Red Cross Child and Family Unit

**TABLE 3: FAMILY #3 (Residing in Hanover Park)**

Interviewed:	Mother (parents separated)
Living in the household:	Mother, child, mother's parents
Age of child at time of abuse:	6
Gender:	Female
Perpetrator:	Teenage family friend
Type of abuse:	Sexual assault
Frequency:	Once
Where abuse occurred:	At house where child attended creche
When abuse occurred:	Jan 2002 (two years prior to interview)
Court case:	None
Counselling:	Yes, number of sessions unknown
Who referred child to Childline:	Relatives

**TABLE 4: FAMILY #4 (Residing in Bonteheuvel)**

Interviewed:	Mother and father (married)
Living in the household:	Mother, father, child and sibling
Age of the child at time of abuse:	9
Gender:	Male
Perpetrator:	Adult male in neighbourhood
Type of abuse:	Sodomy and sexual assault
Frequency:	More than once
Where abuse occurred:	At perpetrator's home
When abuse occurred:	Approx. one year prior to interview
Court case:	Ongoing
Counselling:	Child attended six sessions
Who referred child to Childline:	Unknown

**TABLE 5: FAMILY #5 (Residing in Bonteheuvel)**

Interviewed:	Mother and father (parents married)
Living in the household:	Mother, father, grandfather, child
Age of the child at time of abuse:	9
Gender:	Male
Perpetrator:	Adult male in the neighbourhood
Type of abuse:	Sodomy and sexual assault
Frequency:	More than once
Where abuse occurred:	At perpetrator's home
When abuse occurred:	Approx. one year prior to interview
Court case:	Ongoing
Counselling:	Child attended ten sessions
Who referred child to Childline:	Child's aunt

## Theoretical framework

Several themes arose which have been organized into the following framework. Participants' responses are quoted throughout the discussion to illustrate these themes. The quotations are referenced by a number in brackets – this number refers to a particular family, according to the sample profile (ie: (1) refers to Family #1). Due to the small sample, and the qualitative nature of the study, it was recognized that it was important to bear in mind the context of the participants' responses. To aid the discussion of the findings, the researcher makes reference to the literature reviewed in Chapter Two, where relevant.

### 1. Initial reactions to finding out about the abuse

#### 1.1. Parents' reactions

The participants reported a range of emotional reactions upon finding out about the abuse. These included, firstly, a sense of shock; a feeling of it being unreal and of not knowing what to do. *"Actually we were very shocked. I didn't realized what was happening at the moment because everything happened so quickly"* (2). The sense of shock was very strong and lingered. One parent reported feeling on edge for a while after she first found out; *"I would jump when the phone rings"* (2). She was afraid of further bad news. Related to the shock was the theme of being unprepared for such a trauma. *"I didn't know what to do"* was a reaction that was repeatedly recalled. One set of parents reported feeling puzzled as to what to do first, whether they should report it to the police or find out more (5).

Secondly, there was a sense of betrayal that someone the parents had trusted, had sexually abused their child. *"...and I felt that you can't actually trust your friends because you think that they're your friends, but when the thing like that happen. Its just unbelievable..."*(3) One family was caught in an uncomfortable ambivalence about the perpetrator, as he was someone of whom they had been very fond, and whose company they had enjoyed. In this situation, the sense of bewilderment, betrayal and hurt was strongly felt. *"He was like a homely type of person and when we heard that he did this then it was such a shock to us that a close friend of ours that done this to our child..."*(1)

The feelings of shock and betrayal experienced by the parents in the study are referred to by Grosz et al (2000) in describing parental reactions to extrafamilial child sexual in a family intervention project.

Thirdly, a theme of self-blame was present for some parents. This was expressed by one mother as 'disappointment' in herself: "...I felt so disappointed in myself that to think that I didn't evens take note of things that happened. That it happened in my own home. And it was almost like I was more interested in having fun than to take note of the hurt that was happening to my son, and he's my only boy. I just ran out here and I just cried"(1). Another mother expressed regret at having initially felt sorry for the perpetrator and his wife: "...for the moment I thought that I put my son aside and took their feelings into consideration, which was wrong...I guess that was the part that ate on me the most. That I was considering his children and his family first but not thinking what damage he has done to my kid"(5). These feelings of regret and disappointment in self can be likened to the feelings of guilt and shame that Carlson and Ruzek (2000) refer to in describing common reactions of family members to a traumatized member of the family.

One couple were struggling with a dynamic whereby one spouse was blaming the other for the child's abuse (4). In this case, the wife had spent a lot of time at the friend's house where the abuse had taken place. This family is the one that was not able to come to terms with what had happened, and whom the researcher experienced as being immobilized by grief, loss and anger. The spouse who was blamed, responded with silence when asked about her initial reactions. She was unable to articulate her pain regarding her child's abuse, even though it was now a year later. The husband also expressed self-blame and helplessness in his feeling that he had failed to protect his child. This dynamic of blaming is referred to in the literature as a scapegoating mechanism which locates the problem in one member of the family (Catherall, 1997; Figley, 1989).

Fourthly, parents grappled with feelings of anger and of wanting to hurt or punish the perpetrator. One parent recalled the following dilemma after finding out about the abuse: "*I just couldn't take it, because if I was going to grab him, I was going to kill the guy*"(1). For certain families, concerned friends or relatives offered to harm the perpetrator. The parents

had to think through the consequences of taking the law into their own hands. For some, their spouse was able to persuade them to let the justice system take its course. This finding of anger as a reaction to the sexual abuse disclosure is consistent with the theory of Carlson and Ruzek (2000) who cite anger as a common reaction of family members where one family member has been traumatized.

One couple's anger was directed at their child for not telling them what had happened. Over time, however, they came to accept that the perpetrator had groomed the group of children he had abused, and had manipulated them into keeping it a secret. They later understood that their child had not realised that what had happened was sexual abuse. "...he didn't tell us about what happened in that period of time. Like one night, he reckoned to me I wasn't there to help him and that cut me down totally"(5). This parent was disappointed that his son had not disclosed the abuse to him, as he claimed that his child can come to him with any problem and that he would sort it out for him. A contradiction was noted here, in that the father repeatedly stated that he had forgiven the perpetrator for what he did, saying that he would still greet the perpetrator if he saw him in the street. Thus, this appeared to be a situation in which the parent perceived his attitude to be supportive of the child, but was not experienced by the child as supportive. Furthermore, in this family, the child had previously attempted a disclosure to the mother when he told her that his private parts were sore. However, his mother did not pick up that anything unusual was going on.

Initial feelings of hurt and hopelessness were also reported. Several parents used the expression 'cut up' to describe how they and other family members felt. One parent initially felt ashamed of what happened, but with the support of her family, was able to recognise that blaming herself or her child was not helpful (3). While recalling their initial reactions, the researcher noticed that the participants frequently repeated the word or phrase that best described their emotional response. These repetitions impressed upon the researcher the intensity with which the emotions were experienced by the participants.

Feelings of anger and disappointment stayed with the parents for a long time. As one parent comments, "*It stood by me for a very long time, it took about a year and a half*"(1).

### 1.2. Sibling reactions (as reported by parents)

In one case, the older sibling was reportedly very upset and angry about her brother's abuse; she told her parents that she could have guessed something like that was happening because the perpetrator and her brother would always lie in the room and watch TV together (1). With younger siblings, some parents told the child what had happened to their sibling, while others decided not to tell them exactly what had happened. *"I didn't actually inform [them] of what really happened. I only told them that something bad happened because I didn't want to upset their emotion...but they knew that...I was going to get some help"*(3).

### 1.3. Extended family reactions

Extended family members went through similar emotional reactions as the parents, such as shock, disappointment, anger and feeling betrayed. A parent describes the cousins' shock: *"And basically they were just shocked and they didn't know what to do. So they just sat there. Normally they would play outside, but they just sat there shocked and everybody was in shock"* (2). These cousins also became very protective of the abused child, making an effort to fetch him to come and play and bring him home again. They were reluctant to leave him on his own. One cousin wanted to go and look for the perpetrator. When the parent saw how troubled this boy was, she brought him along to a counselling session.

The overriding theme was that all the parents felt totally unprepared to deal with the sexual abuse of their child. Several parents stated that they knew it happens out there but they never thought it could happen to their own child. In most cases, it took a while for the shock to wear off. For four out of the five families, this was the first time they had gone through anything like this.

## **2. Child's symptoms**

### 2.1. Initial symptoms:

The parents observed the sexually abused child suffering from the following symptoms in the initial stage after disclosure:

- Aggressive behaviour. One child went through a stage of fighting with his family members and becoming very aggravated (1)
- Nightmares
- Child not wanting to take off his clothes in order to bath
- Physical symptoms such as pain when going to the toilet

## 2.2. Lingering symptoms:

Two common lingering symptoms that were reported were the child's fear of people (especially men) and falling behind with schoolwork.

- Fear of people

Some of the parents said that their child was afraid of people and of being alone. This fear of people, especially of men, extended to family members such as uncles, and family friends. This was hard for parents to see. *"He would just sit in the corner...even when my sister's husband come and see him, he would be very afraid...ja, my brother also..."*(2)

- Decline in schoolwork

Some parents noticed a marked decline in the child's schoolwork.

Other longer-term symptoms that were reported by parents were:

- The child feeling unsafe at home, as the abuse happened in the neighbourhood and the abuser was still at large. *"He don't want to come home any more"*(4). In this case, the child was choosing to stay with a grandmother who lived in another area, which caused considerable sadness and distress for the mother.
- Headaches and feeling sick. One child was experiencing mysterious headaches and frequently complained of feeling sick (1).
- Sad, hurt and withdrawn. *"He would just start crying and he would come to his daddy and he would sit on his daddy's lap and he would tell daddy "Daddy I'm feeling so hurt inside. Every time it just plays back into my head"*(1). Another child became withdrawn: *"...but ever since this happening, it is almost like he closed up, he's not that open anymore..."*(4)

The finding of these symptoms, which describe a range of problems that the child experienced as a result of the sexual abuse trauma, concurs with the theory of Briere and Elliott (1994) who state that child sexual abuse places a child at risk for a wide range of problems but that there is no single sexual abuse syndrome.

Some parents talked about behaviours that they noticed before the child disclosed the abuse; these were like clues as to what was happening, but were not picked up on by the parents. For example: *"But what I picked up during that time is that his school was going down so...Everybody can see it in the house that something was wrong, how can you say it, he was so strange. Things he do, how can I say, he never do before. He like closes the door, the bathroom door..."*(5). This child also told his mother that his private parts were sore and she suggested that he drinks more water, without realizing that he was being abused. In another situation, the teacher had noticed that the child had become anxious and that his grades were dropping. She called the parents to a meeting at school but they were unable to attend until after the disclosure, whereupon the teacher's observations could be understood in light of the abuse. *"His teacher always said to me she wants to speak to me about [child's name] but I never had a chance to go up to the school..."*(1).

### 2.3. Child's strengths:

Some of the parents talked about the child's own personal strengths, such as managing to get on well with schoolwork despite the trauma (4). Another child was able to ask his family not to mention the perpetrator's name in the house (1). Therefore, certain children had innate strengths or competencies that contributed to their individual resilience. According to Mederer (1999), these individual factors can act as buffers to moderate the negative impact of the stressor.

### 3. Parents' coping strategies

In dealing with their child's sexual abuse, the parents employed the following coping strategies. These can be considered shared or common coping mechanisms as they were used by more than one parent. These coping strategies can also be regarded as adaptive in that they contributed towards family health, thus were beneficial to the child.

### 3.1. Talking about it

This coping mechanism came up the most consistently as parents reflected on how they coped. Talking about the experience with others was felt to be very helpful. This finding concurs with the characteristic of functional family coping identified by Figley (1989) as open communication. *"I think actually what helped is we spoke about it very often...and I think that helped by speaking, by talking about it, how you feel and what you are going to do about it"*(3). Other parents commented *"...we had to speak, if you don't speak you are going to get sick"*(1) and *"I think the more you talk about it, the less you think of it"*(1).

For some, talking to their spouse about their feelings helped, for others it was their extended family and for others it was the Childline counsellor. For the parents whose children were sexually abused by the same perpetrator, it was helpful for them to speak about it with other parents in the neighbourhood (4&5).

In contrast, there was one parent who did not find it helpful talking about what happened. His way of coping was rather to not talk about it. *"...I won't go tell my friends, or sit with a friend and talk about it...but for me to talk about it with other people, how can I say...I don't bother, man, I just switch myself off"*(1).

### 3.2. Positive thinking

Most of the parents found it helpful to think positively. This seems to have been a way for them to gain control over the traumatic experience. As one parent put it: *"...I think it is mostly as I was saying, mind over matter, if you can put your mind on that, stay positive, then I believe it come out for you, you and your child"*(3).

Staying positive was a conscious decision some parents made for the sake of their child. *"I just thought that its not going to happen this way. I want my son to be happy, and it made things a little bit easier..."*(2). Staying positive however, was not something that necessarily came naturally, but rather was an attitude that the parent had to learn. One parent reflected that it was important for her to stay focused. *"...I persevered and I trusted that my child is going to make it and I stayed positive and focused on if I don't help her*

*now, what is she going to be like when she grows up*"(3). This parent's determination to make it through provided her with the impetus to go on.

Positive thinking implies an acceptance of the stressor, which Figley (1989) refers to as a healthy characteristic of family coping. The finding of positive thinking as a coping strategy also ties in with Walsh's (2003) concepts of optimism and hope as necessary protective processes for family resilience.

### 3.3. Seeking help and taking action

Seeking help and taking action were another important coping strategies adopted by some of the parents. "*...from there onwards it started to, things started to fall in place but I took action, I spoke to my child, I spoke to my other children*"(3). What helped this parent was taking control of the situation, playing an active role in it rather than feeling she was a helpless victim.

Following through with the criminal justice system helped one parent feel she was at least doing something constructive: "*And I am not going to get tired of walking to court after him and seeing that justice is there and prevails*"(5). One can also hear in her words, a perseverance and determination to ensure that justice is achieved. This was a case where the perpetrator had a history of abusing many children but was never convicted. This parent was motivated to take action as she did not want the same thing to happen to another person's child.

For other parents, taking their child for counselling and getting help for the child gave them a sense that they were taking action to make things right. "*I think that [counselling] was actually the thing that gave me, you know, more freedom to talk about it and if anything should happen, what must you do, what is the procedure to take, where must we go*"(3).

Seeking help and taking action are ways of accessing and mobilizing resources, which are cited by Figley (1989) as functional family coping strategies.

### 3.4. Keeping strong for the child's sake

Some parents were able to stay 'strong' as they believed this is what their child needed. Thinking about their child's needs helped them cope. *"I had to keep myself strong for the sake of him [husband] and my son. And this is why we could have communicated so well with one another in this time that we were in, so a traumatic time"*(1). Another parent did not want her son to worry about her feelings and this helped her keep her own feelings in check and *"make things look better for him"* which consequently helped her to cope better (2). This finding reflects elements of the concepts of family cohesion and appropriate family boundaries, which are both referred to in the literature as protective family factors (Cohen et al, 2002).

### 3.5. Prayer

Prayer and a relationship with God was a comfort to many of the parents and aided their coping with the trauma. While Figley (1989) does not include spirituality in his discussions on family coping, Walsh (2003) identifies spirituality in her framework for family resilience, and identifies it as a source of solace, guidance and hope.

The following coping strategies were used individually by parents, thus cannot be seen as common coping strategies amongst the participants. The last two listed can be regarded as potentially maladaptive in that they hold possible negative consequences for the child's recovery.

### 3.6. Thinking through and not acting impulsively

Carefully thinking through his response to finding out about the sexual abuse was important for one of the parents, as his friends and community were encouraging him to respond with violence (5). This parent thought through the consequences of retaliating violently against the perpetrator and decided against it despite considerable pressure from the community, as he decided that it would not be worth going to jail himself, and that violence was not his way. However, this parent could not seem to find a balanced approach, as he swung from this 'thinking' position to blanking it out completely and forgiving the perpetrator. This seemed to be his way of coping with the trauma.

### 3.7. Taking things day by day

Adopting this approach helped one couple who were still struggling to come to terms with the abuse (4).

### 3.8. Parents working through it together

One of the things that helped a single mother to cope was to work through what happened to her child with the child's father. It helped her to think that the child was seeing his parents work together and that the child would not have to worry about his mother carrying the burden on her own. The father's involvement and availability was experienced by the mother as a significant support (2). This sense of mutual support and collaboration is identified by Walsh (2003) as family connectedness, which needs to be re-established in a family after the disruption caused by the stressor.

### 3.9. Blanking it out

One parent's coping mechanism was to choose not to think about what happened to his child and not to participate in the child's counselling or legal procedures, leaving these roles for his wife to fulfil (5). *"Actually I forgot about it, really forgot about it". He elaborated "...for me I can't bother me anymore really. Really I can't bother. For me to put my mind on that, its going to bugger up my life".* Once he knew that his son was not infected with HIV, he decided to put everything behind him. *"...after the AIDS test, like I wanted to calm down and I just, how can I say, blank all this stuff that happened to him, I just blank it out of my mind...After that I said no more for me, now he can do whatever he wants to do, I'm not going to force him. I don't want to listen about it. Its klaar for me now, I'm just going one way now".* In hearing these words, one can also see that the parent was using avoidance as a way of dealing with a very painful experience. Rather than engaging in anger, this parent decided to forgive the perpetrator. *"I mean I already forgave him for what he did to my son".*

### 3.10. Minimising

The same parent who blanked out his son's traumatic experience from his mind, also minimised the extent of the damaging impact of the sexual abuse on his son. *"There was nothing that wrong with my son and he didn't kill him or hurt him, or do anything besides*

*the abuse... ”(5). There is also an element of denial apparent here, whereby this father was denying the emotional consequences of the abuse for his son and also perhaps denying his own strong feelings about the abuse.*

Avoidance and minimizing are manifestations of denial, which Figley (1989) includes as an aspect of dysfunctional family coping. Walsh (2003) notes that denial of a problem in a family can lead to estrangement.

#### Parents’ reflections on coping

While reflecting on coping, parents had different views. Some had a pragmatic approach whereby one must go forward and deal with the problem. *“Each day everyone face a problem in his life, whether it is so small, so big, you have to deal with it, you can’t go around it, you can’t go kill yourself with it...I said to myself, no, this is one thing I’m just going to stop it here, right now. That’s how I coped with it”*(5). A discrepancy was observed here however, because this parent didn’t seem to ‘deal with the problem’ in a healthy, realistic sense, but instead, used denial as a way of coping. Others saw themselves at the mercy of the trauma, feeling powerless and overwhelmed (4).

Reflecting back, a parent attributes the fact that she has coped to the support she’s received from her family. *“I am shocked still, but I have coped with my family’s help, I am coping very well now. And I don’t know, if they wasn’t there, I don’t know what I would have done”*(2).

Contradictions were observed. For example, a family who was clearly actively struggling and experiencing marital conflicts, would conclude by saying *“but other than that we are still coping”*(4). These parents needed to perceive themselves as coping despite their obvious difficulties.

Coping with the child’s symptoms was also difficult – one family coped with their son’s distress by buying him TV games to keep him busy and help take his mind off things (1). For this family, one year passed before they sought help for the child.

### On forgiveness

The theme of forgiveness is not referred to in the literature on family resilience, possibly because the literature that was reviewed did not focus on specific traumas such as sexual abuse. In this study however, one of the parents did speak about forgiving the perpetrator (5). However, this was the parent who had blanked it all out, and one wonders whether his forgiveness is not premature, as there doesn't seem to have been a sincere resolution on his part. He appears to have jumped from deciding not to harm the perpetrator, to blanking it out and forgiving the perpetrator. *"What happened, why I forgive him so quick because he did it so many times with different people's children. And I said to myself, no man, I'm not going to...run around for lawyers and court cases and all this s--t because my son is not the guilty one"*. This parent believed that the perpetrator would get his justice one day. In this family, the parents had adopted very different ways of coping; while the father had blanked it out and was having nothing to do with the court or counselling process, the mother was determined to take action and see the court case through. She had not made peace with what had happened and she continued to ensure that the child attended counselling

**TABLE 6: PARENTS' COPING STRATEGIES**

<p><u>Common coping strategies (adaptive)</u></p> <ol style="list-style-type: none"><li>1. Talking about it</li><li>2. Positive thinking</li><li>3. Seeking help and taking action</li><li>4. Keeping strong for child's sake</li><li>5. Prayer and relationship with God</li></ol> <p><u>Individual coping strategies</u></p> <ol style="list-style-type: none"><li>6. Thinking through and not acting impulsively</li><li>7. Taking things day by day</li><li>8. Parents' working through it together</li></ol> <p><u>Potentially maladaptive coping strategies</u></p> <ol style="list-style-type: none"><li>9. Blanking it out</li><li>10. Minimising</li></ol>
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#### 4. Sources of support

Being able to draw on a variety of supports played a major role in how the parents coped. The parents' perceptions of these supports as available and sufficient, were also important. The three main sources of supports reported were extended family support, counselling support and support from the church/faith community. Other supports included support from a spouse or co-parent, friends, neighbours, school and employer. These are discussed in more detail as follows.

##### 4.1. Extended family support

All the participants felt that their extended family (that is, parents, brothers and sisters) were extremely supportive, and that this support is what carried them through. Ways in which family members were supportive included:

- Providing practical support such as looking after the child
- Taking the child to appointments and passing on important telephone numbers and information. *"...like my brothers, they showed a lot of support in the situation and they advised me and well they went all out to get some source of help getting numbers and stuff like that..."*(3)
- Emotional support such as reaching out, showing care, concern and understanding *"...when I feel suddenly I am sad and everything is just coming back to me...then my mom and my sister would see that I am not myself and they would ask me why and I would tell them. And they would normally give me some good advice and do something with me"*(2).
- Being available to share decisions and discuss the situation with them.
- Being able to draw on expertise in the family. For example, one couple had a niece who was a lawyer and her special advice and interest in the situation was felt to be very helpful (5).

*"Without the family and without the love and without the help I don't think that I would have survived this thing..."*(2). A close bond between family members was also felt to be supportive. Only one parent stated that his family was no support at all (4).

The McMaster Model identifies this closeness and emotional support under the dimension of family functioning referred to as affective involvement. In the cases mentioned above, the affective involvement of family members was of an empathic nature (Epstein et al, 1978).

#### 4.2. Counselling support

Although the counselling was offered primarily to the sexually abused child, the parents felt that it also benefited them. The contact they had with the Childline counsellor through their child was experienced by all the parents as a significant support. The parents were generally full of praise for the counsellor. "*[Counsellor] didn't actually counsel [child] alone, but she actually counselled me and [father] also and when he went for help, we also received help at the same time so*"(1).

Specific ways in which the counsellor was experienced as a major support to the parents:

- The counsellor was someone who listened, and to whom the parents could talk. She helped contain parents' anger and made suggestions as to how the parents could handle the child and how they could help the child. Parents felt that the counsellor's advice and direction about what to do, was very helpful. "*I used to get very angry easily with [child] because I didn't know how to handle the situation ...until [counsellor] spoke to me...Like she said what I must do, I mustn't hit him...and that is what helped me also along*"(1). This parent added "*...she helped me a lot because there was times that I felt like picking up [child] and lifting him up and running him against a wall, that's the way I used to get. But with her help and her support I had to sit down still, I had to work on myself...*" Another parent reflects "*..me and she had a talk and that's all the thing that helped me. To see which is the right way and what to do and when to do the right thing...*" (5). One parent perceived the counsellor as someone neutral who asks the right kinds of questions and is helpful in this way (4).
- Through supporting the child the counsellor indirectly supported the parents, especially where the counselling helped to relieve a child's symptoms, such as sleep disturbances. One parent acknowledges how the counselling helped her child: "*Because he is going on his own outside. But he is now playing outside...all the*

*counselling he has got has helped him. And I must say that I am very proud to see that he is actually trying to do things alone”(2).*

- It was helpful for parents to observe how the counsellor speaks to and interacts with their child. In this way, the counsellor modelled for the parent new ways of relating to the child. “...*actually I have seen what she’s doing and then I’ve tried it at home and it really works. I mean, there are some tips that I didn’t know about that the counsellor can give ...*”(2).

All the parents held the belief that counselling would benefit their child and aid their child’s healing. “...*by taking them to the place where they are going to get help, also I think that also sets a mindset in that child that my mommy is here to bring me here to get some help and she is not just sitting back and just thinking it must go away or she can cope on her own or whatever*”(3).

One of the parents made an initial phonecall to an NGO that deals with child abuse, and found this phonecall to be very supportive, at a time when she was bewildered and upset. “...*I couldn’t imagine that someone just speaking over the phone to you can really have brought some relief...They made me actually see the light through all this. They really helped, they really helped me*”(5).

#### 4.3. Support through the church and faith

For four out of the five families, the church community and parents’ faith in God, played a major supportive role in their coping with the trauma. Three helpful aspects were:

- The advice, guidance and prayers from their minister as well as the church community. It was supportive knowing that people cared about what had happened and were remembering the family in their prayers. “...*our priest will always speak to me, speak confident in me and tell me what to do and how to handle [child]*”(1). The availability of the support was important: “*We can have any problems or whatever and we just call up on them, then they will be here for us*”(1).
- The parents’ personal faith and relationship with God was a significant support from which strength, comfort and courage were drawn. “*I believe that the only thing and the only person at that time that is near to you is God and I believe that you can talk*

*to Him whenever you want to...And I believe that the people that are doing the counselling here, they will be put there by Him and through them, He can also work”(3). Another parent expresses this same support as such “...I knew that God was there, with me all the way...”(2).*

- a) Attending church and sitting with friends and family who knew what had happened, in what was perceived as a caring environment, was supportive for parents. *“I could see the love and care in everybody’s faces and it actually helped me...”(2).*

#### 4.4. Support from spouse or co-parent

For the two single mothers, the support received from their child’s father was significant. What was helpful in this was having the child’s father take responsibility for getting the child help, providing practical support such as taking the child to the doctor, checking in, popping in, and being someone to talk to. *“I’m divorced but I had her dad involved..and he also gave me support from his side. And gave me advice what to do, how I must go about it...”(3).* For these single mothers, it meant a lot that the child’s father made a special effort to visit and help out. *“But he is always there, every step of the way he’s with me...not letting me do things alone...We’re still friends, nothing more, but at least he accepts his responsibilities towards his son”(2).* One married couple also cited spousal support as a significant helping factor for them. *“Me and my husband will speak about it when we lay down in bed at night...”(1).* Being able to share the experience with one’s spouse or co-parent allowed the parents to feel that they weren’t struggling alone; that they could overcome the trauma as a unit.

#### 4.5. Support from friends

Friends also played an important role in supporting the parents through their ordeal. Friends showed their support through being someone to talk things through with, making an effort to visit the family and find out how they are coping, and talking to the child.

#### 4.6. Support from school

In two cases, the school’s response to the child’s sexual abuse was experienced by the parents as caring, protective and supportive (1&5). For example, one school organized an awareness presentation on sexual abuse while keeping the child’s experience confidential

and offering to take action should they discover that the child was being teased at school (5).

#### 4.7. Support from employer

One of the parents had a supportive employer who gave the parent time off when she needed to attend appointments (2). This helped the parent considerably.

#### 4.8. Support from neighbours

For one family, the support from neighbours was a big help. In this situation, the same perpetrator abused several children in the community. Standing together as parents was a source of support. *"We did a lot of stuff together. We stood together, took the children to counselling; went together to court, everything. We didn't get tired of anything or difficult about anything"*(4). In this case, the parents also held meetings to talk about what had happened. This contact was helpful for the mother but unfortunately her husband was unable to connect with this source of support. *"...I wasn't in that meetings...I couldn't talk about, you know, about it. It was too hurtful"*(4). This parent suffered in isolation and has been unable to come to terms with what happened to his son.

The finding of the importance of the above-mentioned sources of social support is consistent with the theory on family resilience, which identifies social factors as having the potential to serve important protective functions for families (De Haan et al, 2002). This finding is supported by McKenry and Price (1994) who observe that social support enhances families' recovery from crisis. This is also reflected in the study by Shu-Lin (2000) which found that positive social interaction was one of the factors linked to family coping. However, the findings of this study differ slightly in terms of the overwhelming positive impact on family coping by extended family support and the church community.

Again, Walsh's (2003) concept of spirituality as a protective process in family resilience is reflected in these findings. An aspect of spirituality that emerged strongly is the sense of community in the church environment, which was experienced by the participants as supportive.

### Reflections on support

A notable theme about sources of support was the parents' perceptions of not being alone in their struggle. Thus, supports from various sources which decreased their sense of having to go through it on their own, were very important. The sense of sticking together as a family or community was beneficial. "...we stood together and the family stood together with us... Our strength actually came from them and through our ministries. We came through it. I won't say easily but we did come through it"(1). For the couple who did have the experience of struggling alone without their spouse's support, coping was difficult and resolution of painful feelings was slow or inhibited (4).

The nature of the supports was also important – most significant were those supports that were perceived as being available or on-call (such as a friend at the end of the line; a minister to call on; or family members to rely on) as well as accessible, which is where practical help offered was vital as this helped parents to get their child to their appointments. " ...we got help all over so. We were never left behind, you know...Everybody was there to help us..."(1). It was also important that those who were helping, had a caring and interested attitude.

**TABLE 7: SOURCES OF SUPPORT**

1. Extended family support
2. Counselling support
3. Support through the church and faith
4. Spouse or co-parent
5. Friends
6. School
7. Employer
8. Neighbours

## 5. Ongoing challenges for the family

The ongoing challenges that the families are currently facing can be discussed under four headings: persisting emotional distress; the frustrations of the court process; the failure of the criminal justice system to protect the child and reminders and anniversaries.

### 5.1. Persisting emotional distress

At the time of interviewing, some parents were still struggling with difficult emotions such as despair, feeling defeated, grief, loss and marital conflicts. This persisting distress was particularly evident for the couple where the husband continues to blame the wife for the child's abuse. This couple has not been able to discuss what happened, and have resorted to silence and arguing. *"Because since this happened, ooh, we argue a lot. Mainly because I feel that she's partly to blame, because I was forever the one warning her don't go sit that much, don't...Its her friends...I know its wrong for me to blame my wife but I trusted her with my children's innocence..."*(4). This father is also struggling with his own sense of having failed to protect his child. *"There are days when I feel like I'm useless. I can't protect my family"*. This parent further commented that he is still grieving. The theme of loss was also evident for another parent, who is grieving the loss of her close friendship with the woman whose son abused her child (3).

The dynamic of blaming in a family after a trauma, is understood by Catherall (1997) as a mechanism whereby family members can distance themselves from the uncomfortable feelings such as shame and alienation that the trauma evokes. It can have a damaging effect on the family as it prevents the family from sharing the problem and facing it together. Garwick et al (1999) found that the dynamic of blaming oneself or another family member was a risk factor that hampered a family's healthy adaptation.

As will be seen in the following subsection, the inadequacies of the criminal justice system contributed significantly to the families' ongoing distress. These findings arose due to the specific nature of the trauma that the families in the study had experienced. These aspects are therefore not covered in the literature on family resilience that was reviewed.

### 5.2. The court process

Delays and postponements of the court case are frustrating and bewildering, and a source of ongoing stress for several of the parents, making it hard for them to move on and put the experience behind them. For one family, *"This will now be the third year that this case is going on now and it just cannot seem that this case can be finished"*(1). An additional source of stress for parents is the lack of information they receive regarding their child's court case, resulting in them feeling dependant upon yet alienated from, this process. They do not have a sense of ownership over the process. *"...it is very long and I don't know how to go through the channels to find out what is really happening to the case or whatever so that we can know when is the next court date"*(1). These frustrations result in families feeling disillusioned by the system, and distrustful of the system. In one case, the parents attributed the delays to the fact that the perpetrator's brother had joined the police force (1). They suspected that someone was tampering with the case. Another parent describes her experiences of the system: *"I wouldn't say I've found peace with it [the abuse] because...this justice system is throwing us all over the show, thats why I don't really have that peace of mind with him"*(5).

This finding is significant in terms of family resilience, because, as Catherall (1997) notes, the longer a child lives with trauma, the greater the chances are that the family will be traumatized. In turn, the longer the family is traumatized, the longer it takes for the child to recover. Delayed court proceedings therefore contribute to both the child and family's prolonged traumatization.

### 5.3. Failure of the system to protect the child

In the case involving two children in the sample families, the perpetrator was released on bail and had broken his bail conditions. The investigating officer had not responded to this. *"That's also stuff that breaks you down"*(4). The perpetrator was therefore walking around in the community. Not only did this leave the parents feeling concerned, angry and helpless, it made the child feel unsafe. This poses a serious impediment to the child and family's recovery. The child in this family preferred to go and live with his grandmother in another area. *"Because they still feel scared so they can't, its hard for them to feel better. So that's the other reason why that person should be in jail, so at least the children and the families*

*can get on with their lives”*(4). Perceptions of the investigating officer as unavailable (out of touch), uninterested and unsupportive contributed to family stress. *“But we didn’t even see him [investigating officer]. He’s not supportive, you know. He don’t come around, you know, to investigate properly”*(4). This leaves parents feeling they are at the mercy of a system over which they have no control, but which is centrally important to them. *“They talk about children’s rights, but they don’t get them. Children don’t get their rights”*(4).

#### 5.4. Reminders/anniversaries

For three families, the interview coincided with the one-year anniversary of their child’s abuse (2,4,5). One set of parents is reminded of their son’s trauma when they hear about abuse in the media as well as each time they have to appear in court (1). The lingering court cases therefore make it very hard for parents to ‘move on’. Another significant and traumatic reminder for parents is seeing the perpetrator in the neighbourhood (as in the case of Families 4 & 5).

### 6. Making sense of the child’s sexual abuse trauma

It was not easy to obtain an in-depth understanding of how the parents had made sense of the sexual abuse of their child. Somehow this was a difficult question to formulate and a difficult understanding to reach. However, the parents’ perceptions of the changes that the trauma brought about in the family, offered clues as to the ways in which the families had made sense of their traumatic experience. Those perceptions are discussed in a subsequent section. The following responses arose in terms of how parents have managed to come to terms with the abuse and their feelings towards the perpetrator:

- Two parents had come to think of the perpetrator as being sick, having an emotional problem or perhaps having been abused themselves as a child (3&5).
- One parent’s perspective was that the abuse happened for a reason, and that was to bring the family closer together. In other words, this person could find a positive and unexpected consequence for the traumatic event (2).
- Some parents were unable to make sense of, or understand, why the abuse happened to their child. *“I don’t think I ever come to understand it. I don’t think so. Because*

*whenever I see his family I feel like I want to hurt them.”(4). Another father responds “I can’t understand why he did it. I can’t tell you”(5).*

It seems as though the parents who have attributed some meaning to the trauma then have some explanation to work with which aids the integration and resolution of the traumatic experience. This, in turn, instills a sense of mastery, which increases the family’s expectation that they can overcome future challenges. The finding of these meaning-making processes reflects the theory on family coping and family resilience which maintains that making meaning of adverse experiences is an important aspect of recovery (Walsh, 2003; Patterson, 2002b). The researcher notes that the two sets of parents who struggled to come to terms with the traumatic event, had difficulty reframing the trauma in a way that assisted their recovery. Aldwin (1994) points out that a family’s cognitive appraisal processes deeply influence their perception of a trauma.

## **7. Parents’ perceptions of how the family changed as a result of the trauma**

Several parents commented that their family had never been through anything like this before. Again the theme of being unprepared for this trauma emerged. Some of the parents acknowledged that now, when they hear in the media of an abuse or rape case, they know how those parents feel, whereas previously it was not an experience they could relate to.

### **7.1. Initial changes in the family**

Some parents recalled that initially, things changed in the family as a result of the abuse. For example, communication became a bit strained in one family, as the extended family did not want to ask or say anything that might upset the parent. *“It was almost like they were scared maybe they were going to hurt my feelings”(3).* This change in communication was temporary and shifted into open and supportive communication as time went on. Another couple also experienced an initial strain on their relationship. *“At first it brought us apart a little bit from one another”(1).* This was due to the mother feeling that she was to blame. However, through the influence of the child’s counselling, this couple overcame these tensions.

## 7.2. Longer-term changes in the family:

Positive changes perceived as a consequence of the traumatic experience included the following:

- Several parents felt that the experience had a positive effect on their family's closeness, and had strengthened family bonds (the marital bond as well as extended family ties). *"I think actually the bond was closer, it was tightened...that was also a great help in that situation..."*(3). One family now makes an effort to come together once a week and speak about problems, whereas previously they were leading their separate lives (2). These are examples of families who, according to Walsh (2003), have been able to 'bounce forward' after the crisis to new ways of functioning. Reflecting on the trauma and how it enhanced family closeness is also an example of positive reframing, which has been found to enhance family coping (McKenry & Price, 1994).
- Some parents commented that they are more cautious about supervising their child as a result of the abuse – they are more aware of where their child is, as well as teaching their child basic safety measures.
- For some parents, there had been an increased awareness of the child's needs and increased observation of the child's behaviours. One parent described how her sister and her husband were careful not to fight in front of the child, and took his feelings into consideration. *" Yes, they were really thinking about his feelings before they did [fight]. Normally they would just go ahead, but because of what happened they would think about what they were doing"*(2). Other parents made an effort to do more with their child in order to make him feel included. Another parent noticed that her family was much more aware of the children's emotions and behaviours, taking note if there were any unusual behaviours or changes in sleeping patterns (3).
- Some parents did not think that they do anything differently as a family and said that family life went on as usual after the disclosure.

Perceived negative changes in the family as a result of the trauma:

One couple felt that the marital relationship had come under noticeable strain as a result of the trauma; they argue a lot more since finding out about the abuse. *"Now every time we have an argument it's almost like I'm blaming her..."*(4). Figley (1989) refers to this

dynamic as blame-oriented problem-solving. This finding reflects Patterson's (2002b) discussion of families who have not been able to establish equilibrium after the disruption of the crisis.

### **8. Previous family functioning**

Previous family functioning was not the focus of this research, however, the families were asked how they were managing before the sexual abuse disclosure. All sets of parents perceived their family to be managing adequately before the trauma, with the normal ups and downs of family life. It was not possible to assess previous family functioning in further depth; however, it is probable that those families that communicated well and stood together during the challenging time, had open communication and supportive patterns in their family prior to the trauma.

With regards to how the family normally dealt with problems, the following responses emerged:

#### **8.1. Open communication**

Three of the families reported that open communication was practiced in their family, whereby family members could talk to one another about problems, disagreements were allowed, and things were dealt with as they came up (1,3&5). As one parent stated, in her family of origin, children could be free to speak about things without being afraid to raise a certain topic (3). Another comments "*..we will call them [children] together and then we will speak to them and then I will ask them, what is bothering you? Or how can we help one another in a situation like this? And we will discuss it and then come to a decision*"(1). This is an example of a family that shared problem-solving as a family unit, as mentioned in Walsh's (2003) framework for family resilience as well as the McMaster Model of family functioning. Communication in this family is also spontaneous, whereby children will discuss things with their parents, and share their good and bad experiences. The effective communication (including sharing of emotions) reported in these three families reflects the theoretical concepts of open emotional expression (Walsh, 2003) and affective responsiveness (Epstein et al, 1978).

## 8.2. Thinking about problems

In dealing with difficult things that happen in life, one parent would think through what had happened and try to reach a solution that way. This parent reflected on the cause of the problem, whether she had some responsibility for it, and searched for ways to make positive changes. *"I would just think of what happened, whatever the situation is. I will just think about why it happened, or where did I maybe go wrong, or was it my fault or whatever and then look into it and see maybe I can do something that can maybe improve it..."*(3). This parent also cited positive thinking as a habitual way of coping with problems.

Communicating openly and the thinking about problems are examples of families' internal resources that can be drawn on in times of crisis, as discussed by McKenry and Price (1994).

## 8.3. Silence

One couple acknowledged that the way they normally dealt with problems was with silence (4). This silence was observed during the interview, especially on the part of the mother. The father repeatedly said that he was struggling to express himself, although he did manage to articulate his feelings aptly. This couple was the one that was struggling to come to terms with the abuse.

Certain literature on family stress states that the degree of upheaval experienced by a family during a crisis is influenced by the quality of family life prior to the crisis (Mederer, 1999). The literature cites pre-existing problems in finance, health or the marital relationship as placing the family at risk for increased difficulty during adverse times. None of the participants reported pre-existing problems in these areas although the couple who were struggling to communicate openly after the disclosure were possibly previously struggling in their marital relationship. The findings of this study deviate from the theory in that issues around pre-existing financial problems were not named as challenges to the family's recovery from trauma.

## **9. Parents' perceptions of family strengths**

When the participants were asked to reflect on their family's strengths, they highlighted the following positive aspects of family functioning:

### **9.1. Good communication**

Three parents cited good communication as a positive aspect of their family life. By good communication they meant family members can talk freely with one another, discuss things together, can disagree with each other and can voice their point of view. *" And I think that is also, the door is always open, if you feel that you don't like something...or you don't feel easy then you can speak about it and then you got the liberty to come to them and speak to them about anything"(3).*

This finding has implications for the family's ability to make meaning of the traumatic experience, as Walsh (2003) states that a family's capacity for effective communication powerfully impacts their ability to make meaning of an event.

### **9.2. Capacity for mutual support**

Several parents identified their family's support as a strength, in that family members support each other, stand together and are there for each other in times of need.

The above two findings are consistent with those of Cohen et al (2002) who found that open and expressive communication and the readiness of family members to help each other emerged as two of five themes relating to family resilience.

### **9.3. Spirituality**

For two parents, their extended family's spiritual life was cited as a family strength – the fact that they believe in God, go to church, pray and have firm values, was seen as creating a strong and positive family (2&3). Besides the writing of Walsh (2003), spirituality is generally not mentioned in the literature as a family resource, although it emerged as a strong theme in this study.

#### 9.4. Family closeness

One family felt that the closeness in the mother's extended family and the help they offered, was a positive attribute of the family (4). When asked about family strengths, only one family identified strengths in their immediate household (1). The others looked to the extended family for strengths. Thus most of the parents did not recognise the individual strengths that they themselves bring to their families but were aware of supportive resources in their extended families.

**TABLE 8: PARENTS' PERCEPTIONS OF FAMILY STRENGTHS**

- |  |
|--|
| <ol style="list-style-type: none"><li>1. Good communication</li><li>2. Capacity for mutual support</li><li>3. Spirituality</li><li>4. Family closeness</li></ol> |
|--|

#### 10. Observed/inherent family strengths

As the researcher listened to the participants recalling their coping experiences, certain implied family strengths became apparent through what the parents were saying and the ways in which they spoke about their family experiences. For example, the way in which they were able to think about the child's needs was noted as a strength. These strengths were therefore not explicitly stated by the family, perhaps not even recognized by the family, but were observed by the researcher, inherent in the family's words.

The following family strengths were observed:

##### 10.1. Family's ability to help the child ('what the family did to help the child')

Parents performed the following functions, which helped the child recover:

##### 10.1.1. Soothing, comforting and supporting the child

*"And he would lay there and he tell me, Daddy, this thing is playing on my mind. And I must now let him lay in my arm and I talk and rub his hair and I would tell him 'Try to forget it, my boy, it happened, its in the past'"*(1). This parent was able to appropriately

soothe and comfort his child, helping to contain the child's distress. Another parent would talk to his child when he saw the child was feeling hurt and upset, and could see that this was comforting to the child (4). One set of parents supported their child through the court process by talking through the child's fears, reassuring the child and encouraging the child to speak out (1). Similarly, another parent supported her child through the counselling process by explaining to the child what the counsellor's role was. "*...when I get home I will tell him that lady is there to help him and she is not going to hurt him...*"(2). This parent also encouraged her child to speak about his experiences through not interrupting him when he talked to her and not asking too many questions.

#### 10.1.2. Reframing the experience for the child

One set of parents helped to reframe their child's experience as the abuser had bribed and manipulated the child. The parents had to re-educate their child about what had happened so that their child would understand properly. "*And we made [child] understand what really happened to him. That it was something wrong that uncle did to him*"(5).

#### 10.1.3. Bringing the child to the counselling appointments

It was a strength of all five families that at least one member of the family ensured that the child attended the Childline counselling appointments, despite considerable odds such as distance, money and work schedules. "*He's still going. Every date I'm there and if I can't go then I phone her to get me another date*"(4).

#### 10.1.4. Communicating the child's needs to extended family members.

For example, one parent had to educate her sister that she should not scream and shout in front of the child as it was upsetting for the child (2).

#### 10.1.5. Making a special effort

Some parents made a special effort with the child, such as taking him to the park to cheer him up, involving the child in activities and spending more time with him/her.

The family's ability to help the traumatized child reflects the ability of a family to care for and protect its vulnerable members. This is mentioned by Patterson (2002a) as a measure of

the family's bonadaptation. The family's ability to adequately fulfill its function of nurturance is also referred to in the McMaster Model and is considered to be a sign of healthy family functioning (Epstein et al, 1978).

### 10.2. Family self-awareness

Some parents demonstrated a self-awareness of their family's functioning in that they were able to acknowledge and articulate their difficulties in coping, as well as in some cases, reflect on their positive aspects. This finding was not anticipated as this concept was not discussed in the theory on family resilience. The closest theoretical concepts appear to be those of flexibility (openness to change) and adaptability (Walsh, 2003; Cohen et al, 2002).

The couple who was struggling to come to terms with the traumatic experience, showed insight into their needs by voicing their desire to get help in the form of marriage counselling (4). For other families, their self-awareness was evident in the ability they showed to reflect, learn and grow from their experiences. *"And I used to skel a lot but I come off it now; I had to sit still; I have to pull back and sit now. Now I just sit and I thought 'what I'm doing is wrong'..."*(1). The way some parents spoke about their children and their experiences indicated that they were engaging in 'conscious parenting' in that they were thinking about the type of parenting they wanted to employ, the impact they as parents were having on their children as well as showing openness to change. *"I feel that a child should feel free to talk to their parents. I think that is the kind of relationship that I have got with my parents. And I think that is the same relationship I would like my children to have with me..."*(3). Another parent demonstrates the ability to reflect on his parenting through the following thoughts: *"Like I always say to my wife sometimes the child can also teach us. There are times when we do wrong things. This is also my wish for the New Year, is like to involve my children, to sit with them...get different opinions from them. That's my wish to grow more closer to my family. You know, we must build a nice unit, forget about the sisters and brothers-in-law, they are a family on their own. We must start in our own home..."*(1). The ability to think of different approaches to parenting and take responsibility for one's role as a parent indicates a healthy flexibility.

### 10.3. Ability to think of the child's needs for healing

This family strength was evident where parents were able to consider their child's feelings and think about what the child needed in order to recover. For one set of parents, this was giving the child the option of staying with his grandmother and attending another school, if that was going to help him get over the traumatic incident (4). Another parent decided not to let her son start primary school as she could see that he was fearful and not ready, and would benefit from another year at preschool (2). This family strength again demonstrates a family's ability to promote the individual development of its members, which, according to Patterson (2002a) is an example of family health and successful adaptation.

### 10.4. Relationship with the child

The parent's good relationship with the child was observed as a strength. This was seen, for example, where a parent had established good communication with the child and the child was able to disclose the abuse to her mother, despite her young age, due to the good relationship they shared. *"...she was young but she could tell me what happened. And she had the freedom to talk to me, because I always talk to my children"*(3). Furthermore, some parents were able to recognize their child's strengths and abilities, and took pleasure in their child's unique characteristics and recovery from the trauma. *"...I must say, she is still a lovely little girl...all the good results that I got from her pre-school showed me that she had developed well in life and she coped with this. And I am actually thankful that she turned out to be that child. And I wouldn't have something else in place of that"*(3).

### 10.5. Ability to maintain good co-parent relationships

In the two cases where the parents were divorced or separated, the parents managed to maintain good relationships when it came to parenting the child, and this is regarded as a strength as it is assumed to be beneficial for the child for him/her to see both parents co-operating together. In one situation, the separated parents were managing to bring up the child in his Muslim faith, while the mother was Christian (2). This would require a certain degree of flexibility and connectedness, both which are concepts that Walsh (2003) refers to as family organizational patterns that form key processes in family resilience.

**TABLE 9: OBSERVED FAMILY STRENGTHS**

1. Family's ability to help child	1.1. Soothing, comforting & supporting child 1.2. Reframing traumatic experience for child 1.3. Bringing child to counselling appointments 1.4. Communicating child's needs to family members 1.5. Making a special effort
2. Family self awareness	E.g. 'Conscious parenting'; Can think about their role as parents
3. Ability to think of child's needs for healing	E.g. Allowing child extra year before starting primary school
4. Relationship with child	E.g. Recognizing child's strengths
5. Ability to maintain good co-parent relationships	E.g. Divorced parents share responsibility for raising child

## **11. Parents' thoughts on what would assist the child's recovery**

### **11.1. Counselling**

All the parents interviewed shared the belief that counselling was a central factor in assisting their child's recovery from the sexual abuse trauma. They could see the benefits of counselling, for example, it helped the child talk about what happened and helped to clarify for the child what happened. Furthermore, they could observe the counsellor's caring manner towards the child, as well as the child's attachment to the counsellor. One set of parents recalled how their child would look forward to counselling: he would lay out his best clothes the night before his counselling appointment and would remind his father to take him to Childline the following day (1).

Some of the parents offered suggestions as to how a counsellor could be a support to parents. These included the suggestion that the counsellor invite the parent to bring somebody with them to the counselling who could also benefit, and that the counsellor could give advice about what to do and what not to do in the circumstances. Furthermore,

parents believed that the counsellor should be someone professional rather than someone in the family, and should listen, support and not judge the parents.

#### 11.2. The belief that parents should be strong for the sake of their children.

*“As parents we have to be strong for our son because he went through a very traumatizing time and I can’t be weak nor can my husband be weak for him otherwise he is going to get sicker...”*(1). Related to this is the belief that parents should work together as a team for the sake of the child. *“I mean, I’m his mother and he has to feel his mom and dad working together”*(2).

#### 11.3. Justice should be served

Parents held the belief that the child will feel more secure when the perpetrator is sentenced.

### 12. Advice to other parents

As a result of their own coping experiences, the participants had the following advice for other parents going through a similar situation:

#### 12.1. Do’s:

- Go for counselling
- Get help immediately. Report the case to the police; go through the right channels and accept all the help you can get. Think of the long-term, of your future and your child’s future; don’t be afraid or ashamed. *“Take all of the support, advice you can get, take it. Because that is what makes you stronger at the end of the day”*(5).
- Take time for yourself; be still; think things through. *“You must be able to think straight”*(5).
- Stick together as parents; support each other.
- Talk about what happened with family and friends so that others can learn about sexual abuse and be aware.
- Build a good relationship with your children. Communicate openly with your children so that your child will feel free to talk to you if something happens; be

observant and aware. *"You mustn't just let things go past and think its normal..."*(3).

- Put your child first. Think of your child; don't worry about what other people will think.
- Do things together as a family.

#### 12.2. Don'ts:

- Don't blame the child for what happened. *"That is the worst thing that you can do"*(3).
- Don't abuse alcohol during the traumatic time.
- Don't carry on as though nothing has happened
- Don't be harsh with your spouse.

#### 13. The experience of talking about coping

While parents had mixed responses to how it felt to talk about their coping experiences, the general experience was that they felt better after talking about it and that it brought some relief. For several parents, this was either the first time that they were talking about it with a third person, or the first time they were talking about it in a long time. One father had never spoken to a counsellor before, and also had not spoken about his experiences without being under the influence of alcohol (4). It was noted that the two male participants found it hard to express themselves and both struggled to come to terms with the trauma. This finding may support the claim by some theorists that there are gender differences in the ways that individuals respond to stress (Cohen et al, 2002).

The parents' experiences of talking about it included the following:

- Relief. Several parents felt much better after talking about their coping experiences; it brought relief, and they found it was helpful. *"...I felt good speaking about it. It helped me again, in another way, speaking about it"*(1).
- Difficulty expressing self. Two fathers found it hard to talk about their experiences as they felt they couldn't express themselves well (4&5). *"The words don't want to*

*come out*”(5). It is noted that there may be a gender difference in the participants’ ability to express their thoughts and feelings, as well as possibly in their emotional reactions to the abuse – perhaps due to gender socialization.

- **Painful**. Some parents also found it hard recalling their experiences. For one mother, it was hard talking about when she first found out about her child’s abuse (2). Another parent expressed feeling nervous prior to the interview (3).
- **Comfortable**. Some parents felt comfortable talking about their experiences.

It was an ethical decision to include time for reflecting on how it felt to talk about their coping experiences. The interview was requiring participants to recall painful experiences and it was important to offer an opportunity for debriefing. The researcher was struck however, by the visible relief and lightening of mood observed at the end of the interviews. This points to the benefits of talking in a structured way to a neutral objective listener. Furthermore, the interview was structured in such a way that there was a deliberate searching for strengths. This angle highlighted how the parents had coped (thus implying that they *had* coped), the things they had done well, things they had learnt and explore family strengths. Asking the parents what advice they would give to other parents implied that they had valuable experience and expertise as a result of having gone through their experiences. Getting the parents to think about their own positive coping and family strengths, allowed them to explore positive aspects of their family functioning that they may not have been aware of. ‘Taking stock’ of limitations and successes and developing confidence that difficulties can be overcome, instills a sense of hope in families, which Walsh (2003) refers to as optimism, a key process in building family resilience. Furthermore, the researcher’s interest in the families’ strengths and successes allowed the family to experience itself as masterful, as discussed by Patterson (2002a).

### **Concluding discussion of findings**

In conclusion, talking about the trauma, taking control, being optimistic, and using prayer, were some of the coping strategies the parents made use of. Extended families, friends, the church community and counselling were significant sources of support. All the families were able to seek help and to follow through with counselling for the child. Also important

was the perception of not being alone in the traumatic situation; of being able to share it with people who are available, who care and are willing to help.

The researcher observed family strengths which were not articulated by the families but were apparent in the ways in which the families thought and spoke about their experiences. The parents' ability to think of their child's needs, their ability to reflect, grow, learn, and parent consciously, as well as their ability to maintain open communication in the family were considered to demonstrate positive family resources that enhanced a resilient process. Close family ties, flexibility and spirituality were also regarded as protective factors contributing to family resilience.

It is interesting to note that neither the type of abuse the child was exposed to nor the frequency of the abuse were raised as significant in terms of severity – all five situations, although different to each other, were experienced by the family as traumatic.

The next section offers a summary of each family's coping responses, allowing the researcher to conclude the extent to which the participant families engaged in a resilient process:

### **Family #1**

#### **Strengths and sources of support:**

- ❑ Secure, mutually supportive marital relationship
- ❑ Support from school
- ❑ Church support significant
- ❑ Generally healthy family functioning – open communication; family discussions; child able to voice fears and needs; parents able to soothe and comfort child
- ❑ Parents' ability to learn, reflect and grow
- ❑ Sense of having survived the trauma; able to find something positive in the whole experience
- ❑ Perception of having been helped by many sources

Known challenges/risk factors:

- Court case going into its third year<sup>7</sup>; parents' suspicious of the criminal justice system
- Decline in child's schoolwork
- Child's psychosomatic symptoms

**Family #2**

Strengths and sources of support:

- Extended family support
- Co-operative relationship with ex-spouse
- Support from personal spirituality and church community
- Supportive employer
- Family able to consider child's needs
- Mother's ability to 'think positive' and support the child
- Mother able to find her own meaning of the abuse
- Mother's individual strengths

Known challenges/risk factors:

- Child's persisting symptoms (fear of men and generally fearful)

**Family #3**

Strengths and sources of support:

- Extended family support
- Mother's positive thinking
- Support from ex-spouse
- Relationship with God significant source of support

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<sup>7</sup> According to the Senior Prosecutor at the Children's Court at Wynberg Magistrates Court in Cape Town, there is no average duration of a court case – they can vary from three months to three years. Cases tend to be delayed when several role-players are involved and where there are numerous sources of evidence. Cases are also slowed down by the Legal Aid system due to lawyers not always being readily available. The length of each court case depends on the circumstances of that particular case (J.Kellerman, personal communication, 27 September, 2004).

- ❑ Healthy family functioning: open communication; family observant of children's behaviours and needs
- ❑ Ability to reflect and learn
- ❑ Ability to find something positive in the experience (closer family bonds)
- ❑ Mother takes responsibility for her role as parent; searches for solutions
- ❑ Young child's disclosure believed by mother

**Known challenges/risk factors:**

- ❑ Mother still grieving loss of friendship with mother of boy who abused her child – this is not seen as a risk factor as mother's sense of betrayal and loss is appropriate; however it is challenging to mother

**Family #4**

**Strengths and sources of support:**

- ❑ Support from neighbours significant (for mother)
- ❑ Child managing with schoolwork
- ❑ Parents taking things 'day by day'
- ❑ Father talks to child when sees child is distressed or withdrawn
- ❑ Parents recognize need for marriage counselling

**Known challenges/risk factors:**

- ❑ Dynamic of father blaming mother for child's abuse
- ❑ Communication difficulties in marital relationship – silence as coping mechanism
- ❑ Marital conflicts (arguing)
- ❑ Parents' sense of powerlessness
- ❑ Unable to come to terms with the traumatic experience
- ❑ No support from paternal extended family
- ❑ Persisting grief and despair
- ❑ Child feeling unsafe in neighbourhood and wants to live with grandmother
- ❑ Significant risk: Perpetrator at large; perception of investigating officer's involvement as inadequate

## **Family #5**

### **Strengths and sources of support:**

- Support from school
- Mother's personal strengths (not giving up, following through with court case)
- Parents ability to reframe experience for the child

### **Ambiguities and contradictions:**

- Parents report open communication in family but researcher observed ambiguous communication in family, e.g. perpetrator openly forgiven by father; child's attempted disclosure not picked up by mother.
- Father's perception of self as supportive to child but not experienced as such by child

### **Known challenges/risk factors:**

- Significant risk: Perpetrator at large; child unsafe in neighbourhood
- Decline in child's schoolwork
- Father's coping strategy - not talking about it; avoidance and denial

It is concluded that three of the five families (1,2,3) had the sense of having come through the ordeal and of having survived it. For these families, there was a sense of movement through the trauma and out of it. The researcher notes that these families were able to access multiple sources of social support and practised a range of coping strategies. In the case of Family #5, their process was ambiguous – contradictions existed and the parents had very different ways of coping. It is unclear as to whether this family has engaged in a resilient process. It can be concluded that Family #4 had engaged in a resilient process to a lesser extent – they felt powerless and defeated by the trauma; at the time of interviewing, their pain was still very raw. The dynamic of blaming was seen as significantly preventing the family from working together towards recovery.

The families that journeyed along a more resilient pathway were those that were able to work together as a family to support their child, and who experienced themselves as

survivors of the trauma rather than victims. For these families, the elements of hope, faith and control over the way they decided to cope with the circumstances, were present. Their ability to make sense of the trauma through meaning-making processes aided their resilient journey. All these factors contributed towards a successful adaptational outcome. On the other hand, the families that experienced themselves as victims of the trauma operated from a sense of helplessness and despair, whereby the circumstances felt bigger than them.

The failure of the criminal justice system to protect the child and the presence of the perpetrator in the community is regarded as a significant risk for families' ongoing trauma. The ability to bring the child to regular counselling sessions is noted as a strength for all five families.

The act of recalling one's coping behaviours and exploring family strengths was beneficial in that it brought about a certain catharsis and relief. It was also empowering because the 'positive' angle from which the participants were asked to reflect, helped them to identify positive family resources which they may not otherwise have recognised.

## **Summary**

This chapter comprised the data analysis, beginning with a brief description of the method of analysis used. A sample profile was then provided, followed by a synthesis of the research findings presented and discussed within a theoretical framework. The chapter concluded with a summary of the strengths and risk factors of each family in the sample.

## **CHAPTER 5 – CONCLUSION AND RECOMMENDATIONS**

### **Introduction**

This chapter presents the conclusions of the research by relating the key findings to the original research objectives. The significance of the findings for practice are discussed and recommendations for a counselling organization are provided. Considerations for future research are also mentioned.

The aim of the research was to explore the resilient processes of families in response to a child member's sexual abuse. This was achieved through the following objectives:

1. To identify the emotional responses of families affected by the extrafamilial sexual abuse of a child family member;
2. To examine the coping strategies families employ in response to child sexual abuse;
3. To find out what sources of support are available to families coping with child sexual abuse;
4. To find out how families make meaning of the child's sexual abuse;
5. To explore family strengths and protective factors;
6. To ascertain what challenges families face which inhibit their ability to cope; and
7. To conduct a theoretical review of family resilience and extrafamilial child sexual abuse.

### **Conclusions**

The research conclusions will be discussed in terms of each of the objectives listed above.

1. The emotional responses of families affected by the extrafamilial sexual abuse of a child family member

Families reacted with shock, anger, disappointment, bewilderment, helplessness, a sense of betrayal, and in one case, scapegoating (or blaming), in response to a child family member's sexual abuse. This emotional distress was sometimes complicated by the family's ambivalence towards the perpetrator, especially where the perpetrator was a trusted friend of the family. A theme that emerged consistently for all five families was the element of being unprepared for such a trauma. The initial reactions were hard to get over. Participants made reference to the time it took to come to terms with the trauma. Long-term reactions such as loss, grief and disillusionment with the criminal justice system were also experienced. The emotional reactions reported by the participants in this study are consistent with those reported in the study by Grosz et al (2000), referred to on page 44. In many ways, the families' reactions mirrored the child victim's response to the trauma. The reported emotional reactions of the siblings, parents and extended family support the premise of the theory on families coping with trauma, namely, that trauma to one family member affects the whole family (Figley, 1989). The findings indicate that these emotional reactions can be expected in the families of sexually abused children, therefore the counsellor has a role to play in normalizing these emotions and preparing the family for a process of time during which the emotional reactions will be experienced. Due to the intensity of these reactions, the need for emotional containment is high. Where dynamics of blaming or scapegoating become apparent, these should be addressed and the family encouraged to view the problem as one that is shared by the whole family, rather than it residing in an individual member.

2. The coping strategies families employ in response to child sexual abuse

Talking about the abuse, maintaining a positive attitude, taking action and prayer were common family coping strategies used by the participants in response to child sexual abuse. Perseverance and taking initiative were also found to be helpful coping strategies for parents. The parents who were able to take action as opposed to feeling powerless and overwhelmed, and who were able to draw on a range of coping strategies, were better able

to engage in a resilient process. Some couples coped by using avoidance, denial and blaming. These are considered to be maladaptive coping strategies as they prevent an acceptance of the stressor, and thus, resolution of the trauma.

Given the above findings, it is important that families facing the particular trauma of child sexual abuse are given the opportunity to talk about it, either with a supportive friend or family member, a counsellor or with other parents who have been through a similar situation. Furthermore, the finding of a positive outlook as a helpful coping strategy, supports the need for a model of counselling that is supportive and strengths-focused rather than problem-focused. Family members should be empowered to mobilize resources. Prayer is an aspect that is not always included in a counselling framework but these findings suggest that it is a helpful coping strategy. The counsellor could therefore explore the family's rituals around prayer and the role of the faith community in family life.

Many of the family characteristics reported and observed in the families that engaged in a more resilient process, are included in Figley's (1989) list of the characteristics of functional family coping. For example: family-centered locus of the problem, commitment to each other, open communication, flexible family roles, access to resources both inside and outside the family and absence of violence and substance abuse. Therefore healthy family functioning is an important contributing factor to family resilience. This is useful knowledge for the counsellor, as maladaptive aspects of family functioning can signal potential difficulties in the family's capacity to engage in a resilient process. Thus, in order to strengthen family capacity for resilience, attention must be given to family functioning.

### 3. The sources of support available to families

The findings show that a wide network of social supports is potentially available to families, including support from spouses, friends, school, neighbours, counselling, church and employers. While the support of counselling emerged strongly, many of the families also found support in informal, non-professional domains, such as the neighbourhood and the church. Therefore there are rich supportive resources in the community which families should be encouraged to access or explore. The finding in this study of the extended family

as such a highly significant source of support deviates from the literature on family coping and resilience which underestimates extended family support. Despite the multiple problems experienced by South African families, the existence of the extended family and the potential support it offers is a significant strength. The American and British literature on family resilience neglects this important aspect of family life and one is reminded that the availability of the extended family is a unique strength of South African families. The counsellor treating the sexually abused child should recognize this, and be open to working with members of the child's extended family where it is appropriate and helpful.

Counselling support was also found to be significant. Even though the counsellor was primarily there to support the child, parents found the contact with the counsellor to be very helpful. This has implications for practice, as the finding shows that the family members of a traumatized child can benefit from intervention themselves. The support obtained from the caring environment of the church community, including the prayers and guidance of the community as well as the parents' personal relationship with God, emerged as a significant source of support.

The parents' perceptions of the social support as available, sufficient, accessible and non-judgmental were also important, as was the experience of not being alone in the crisis. It can be concluded that families who have access to a variety of social supports, will be better supported to engage in a resilient process.

#### 4. The families' meaning-making processes

The ability of a family to make meaning of a trauma is related to the family's acceptance of the trauma, their problem-solving abilities as well as their communication skills. This study found that those families that were able to reframe the trauma in a more positive way (for example, that it has brought the family closer together) or come to their own understanding of the perpetrator's actions, were better able to move forward in the process of resilience and recovery. Several families did report positive changes as a result of the trauma, for example, that the family had grown in closeness or that parents were more aware and observant of their child's behaviour. The literature on family stress, coping and resilience

emphasizes that a family's perception of the trauma influences the ways in which the family reacts to and copes with the trauma. Professionals working with families in trauma therefore need to promote the healthy family functioning that allows the meaning-making processes to occur.

##### 5. Family strengths and protective processes

Family self-awareness, the ability to think of the child's needs for recovery, a strong parent-child relationship as well as a strong parental subsystem, were identified by the researcher as family strengths that played a role in the families' resilient processes. The concept of family self-awareness is a relevant new finding. Family self-awareness refers to a family's ability to reflect on its own strengths and weaknesses, its awareness of parental roles and responsibilities and its capacity for adapting and learning. Self-awareness in families can be nurtured, for example, by means of life skills and exercises that require individuals to reflect on their families of origin and the family forces that have shaped their growth and development. Stable, secure family life is likely to produce individuals who are in touch with their inner life and are able to reflect on their own behaviour and that of others.

The above-mentioned family strengths were identified in the more resilient families through the direct observation and listening of the researcher. The ability to think about the child's needs for recovery and respond appropriately to these needs, was identified as a sign of family health that demonstrated a family's capacity to fulfill its nurturing function for its vulnerable members. All the families in the sample demonstrated the strength of being able to sufficiently organize themselves in order to bring the child to regular counselling sessions despite obstacles.

The protective family factors that were identified as mediating the negative impact of the trauma and enhancing resilience, included open communication and emotional expression, family closeness, the ability to make sense of the trauma, spirituality and a positive outlook. The social supports mentioned in a previous section also performed a protective function for families in the face of adversity. The families that were able to engage in a more resilient process reported open communication as an existing family strength, a tool in

family problem-solving, as well as a source of support. Thus, open communication in families can be regarded as an important contributing factor towards family health, and paves the way for family resilience.

Spirituality was a theme that emerged strongly in this study. This is consistent with the recent literature on family resilience that cites spirituality as playing an important role in family functioning, acting as a source of comfort and guidance and facilitating meaning-making in times of stress (Walsh, 2003). Furthermore, individual parental strengths, such as determination, faith in God and the ability to seek and accept help, were also found to serve important protective functions for families.

The family strengths, along with the protective family factors mentioned, served to buffer the impact of the trauma on the family. This finding supports the researcher's initial hypothesis that families have inherent resources which aid their recovery and healing.

#### 6. The challenges families face which inhibit their ability to cope

The challenges that were identified as a threat to family resilience included both internal and external factors. Firstly, it was found that the sexual abuse trauma created a series of related stressors for the family that they needed to cope with. These included the child's persisting symptoms, the frustrations of the court process, perceived failure of the criminal justice system to protect the child, the child's lack of safety in the neighbourhood, marital conflict and reminders of the abuse. These stressors that are associated with the significant risk, can be seen as contributing towards 'stressor pile-up' as described by McKenry & Price (1994). The study revealed that stressor pile-up was not present for the families prior to the child's sexual abuse. This research did not explore in depth the quality of family life before the sexual abuse stressor; all the families reported 'normal' family life with its usual ups and downs. However, the sexual abuse trauma introduced a chain of additional stressors which presented as challenges to the families' coping.

Secondly, it was found that involvement in the criminal justice system contributed significantly towards a family's persisting emotional distress and impeded resolution of the

traumatic experience. The court process was a source of ongoing stress for the three families whose children were testifying in court. The families had to cope with a lack of information about the court case, delays and postponements, distrust of and disillusionment in the system, experiences of a lack of support and interest from the investigating officer and a sense of alienation and lack of control over the process. These factors threaten to negatively impact the family's adaptational outcome. Thus, a family whose child is involved as a primary witness in a court case can be expected to be more vulnerable and may take longer to recover from the initial trauma as a result of the court involvement.

Thirdly, the dynamic of blaming was found to be an impediment to a family's ability to work through the traumatic experience. Blaming prevents realistic acceptance of the stressor. This was seen in the couple where the father blamed the mother for the child's sexual abuse. It was seen how the family became 'stuck' due to this dynamic. Figley (1989) cites blaming as an example of dysfunctional family coping as it locates the problem within an individual. In addition, in the case of Family #4, the father alluded to his use of alcohol. According to Figley (1989), the use of substances to reduce stress is also an example of dysfunctional family coping.

Lastly, it was found that when the perpetrator was a family friend, this presented a particular challenge to the family in terms of coming to terms with their sense of betrayal. The counsellor can be alert to this and anticipate that the family may experience particular difficulty where the perpetrator is a family friend.

Walsh (2003) and Mederer (1999) identify financial stress as placing a family at risk during adversity. However, despite the low socioeconomic status of the five participant families in this study, the aspect of financial strain did not emerge as a risk to the families' coping. This could perhaps be due to the families not identifying financial hardship as a risk factor, as it is a reality they live with every day. This study found that regardless of financial hardship, families were able to engage in a resilient process. Family support, along with other sources of social support far outweighed the potential negative impact of financial strain on their coping capacity.

## 7. A theoretical review of family resilience and extrafamilial child sexual abuse

The theoretical review of family resilience highlighted a lack of South African literature on the subject. Furthermore, there was a gap in the literature in terms of family resilience in the context of child sexual abuse, despite the prevalence of this problem in South Africa. Related international studies tend to focus on family coping with regard to a child with a disability or chronic illness. These studies are helpful in that they highlight functional family coping strategies such as cognitive appraisal and family cohesion and identify the positive impact of social support for families in crisis. However, the study of family resilience is a broader topic than family coping. The literature raises the dilemma of the lack of an appropriate instrument for measuring family resilience, as well as for assessing the family unit. Because family resilience can be viewed as process, many theorists advocate the use of longitudinal studies rather than capturing data at one point in time.

The study of family resilience is a recent phenomenon; resilience was previously only considered in terms of individuals. Terms and concepts that were traditionally applied to the study of individual resilience are now being applied to family resilience and this raises some ambiguities in the literature.

Family resilience can be described as “the phenomenon of doing well in the face of adversity” (Patterson, 2002a:350). This study adopted the view of family resilience as a process, whereby a family is confronted by a significant stressor and in responding to the stressor, certain family strengths and protective processes are activated which mediate the potential negative impact of the stressor. This moves the family forward towards an adaptational outcome.

In sum, this study found that family resilience is not necessarily related to material resources; rather, it has to do with attitudes (e.g. positive thinking and perseverance), personal strengths (e.g. taking responsibility for the parenting role), healthy family functioning (e.g. open communication in the family), protective factors (e.g. spirituality) and access to social support (particularly from the extended family, friends and church). In the case of child sexual abuse trauma, access to counselling support is crucial. Involvement

in the criminal justice system is likely to significantly enhance a family's vulnerability. Advocacy around the criminal justice process is urgently required to ensure that this process becomes one which protects and empowers children and families, rather than one which disempowers them.

This study revealed that family resilience is a process which unfolds over time. Resilience does not immediately emerge in the face of a trauma nor does it protect the family from emotional distress. Rather, it is a journey the family embarks on in response to trauma. Equipped with adequate family functioning and access to sufficient social support, families can overcome traumatic experiences and develop their own adaptive and resilient pathways.

## **Recommendations**

In light of the findings of this study, which presents a multi-faceted view of family resilience, the preventative efforts of mental health practitioners should be focused on strengthening families in different areas. For example, strengthening family functioning, encouraging reflection of one's family of origin, teaching effective parenting skills and strengthening adaptive coping strategies. Offering the family an opportunity to talk together about their experiences will enhance family closeness and understanding. A focus on family strengths allows the family to experience a sense of mastery and survival.

The finding that counselling played a vital role in the participant families' coping experiences has important implications for non-governmental organizations, social services departments and private clinicians offering counselling and support services to children recovering from sexual abuse trauma. Counselling is a significant support not only to the child but to the whole family. The parents in this study indicated that their contact with the child's counsellor was of great benefit to them. It is therefore of value to include parents and other family members in the child's treatment in a deliberate, structured manner. Furthermore, this study highlights the need for prompt intervention, as the longer a family lives with trauma, the greater their chances of being affected by the trauma.

The emotional support that one of the participants received when she made a phonecall to a child abuse helpline when first finding out about the abuse, is a reminder of how important this first contact is and what far-reaching effects it can have for a family member in terms of guiding the person through the initial shock of the disclosure.

A family intervention approach is recommended. Parents that feel supported are more likely to mobilize themselves into taking action and access different sources of help. They are in a better position to support the child and siblings if their own feelings are contained.

**Specific recommendations for a counselling organization offering sexual abuse counselling and support:**

1. A family intervention approach should be adopted. This would include:

□ Guidance to the parents

When the parent makes or attends the first counselling appointment, they are often still in a state of shock. They don't know what counselling will involve. The counsellor needs to educate parents as to the number of sessions required, the weekly appointments, what will happen during the appointments and what is expected of the parent by the organization. The counsellor needs to repeat this information as necessary.

□ Psychoeducation

The counsellor should educate the child and family about trauma, the expected human responses to trauma and the possible effects of a traumatized member on the family. Normalising feelings and reactions is important. The counsellor should try to activate the family's natural supportive resources.

□ Inviting parents and siblings to one/more sessions

It is suggested that parents and family members are included in the child's treatment in a structured way. The counsellor should invite both parents to a session as well as anyone else in the family who feels they would benefit from attending a session or whom the family is concerned about with regards to their response to the abuse.

□ Searching for family strengths

Searching for strengths has therapeutic value for the family. Offering the family an opportunity to reflect on their strengths and positive coping strategies is worthwhile for the family as it encourages a sense of mastery and helps the family to recognize their resources, both within and outside the family unit. It allows the family to talk together about their experiences and share their struggles and successes, thus fostering a sense of cohesion in the family. The counsellor should explore the family's sources of support, as the family may not have thought through all their potential supports. The counsellor should also ask about the family's spiritual life and church community.

2. The counsellor should facilitate communication between the family and the criminal justice system. While prosecutors and police officers are expected to communicate with the family, in reality this often does not happen. The counsellor has an important role to play in passing on information to the family and adopting an advocacy role on behalf of the family. It is important for the family's healing and recovery that they are included in the otherwise-alienating process of court. The counsellor is often the only link between the family and the systems with which it must interact. Included in this role of communicator is the counsellor's role of educating the family about what to expect from the court process, for example, reasons for postponements, potential frustrations, who they can phone for an update, and so on.

3. The counsellor should be alert for potential maladaptive coping mechanisms such as blaming, scapegoating, alcohol abuse and violence.

4. It is recommended that a follow-up session with the parents and child is offered six months or one year after the conclusion of counselling. This will allow the family to reflect on their coping, family changes and growth. The counsellor can use the interview schedule from this research as a guide.

5. A parents 'group meeting' could be offered, where parents who have coped and survived, and are willing to share their experiences, can talk to other parents who are going through similar traumas.

## **Considerations for future research**

In general, there is a need for more research in the field of family resilience, specifically in the South African context. In addition, as the family unit is the focus of resilience research, there is a need for data collection methods that can capture the experiences of the family unit. This study focused on the parental unit for data and observations regarding family resilience. Other studies have simply relied on one family member's perceptions of family resilience. Researchers need to find ways to gather data from the family-as-a-whole. In exploring family resilience, the researcher's observations of family interactions constitute important data.

With regards to research on family resilience as it relates to child sexual abuse, the researcher suggests that the following factors are taken into consideration:

### **1. Intrafamilial child sexual abuse**

There is a need for future research in the area of family resilience as it relates to intrafamilial child sexual abuse, as this type of abuse is prevalent in South Africa.

### **2. A larger, more representative sample**

A larger sample, which represents different types of sexual abuse should be used in future research. Different cultural groups should also be represented in the sample. However, concepts of family functioning differ across cultures, therefore any research on family resilience needs to be culturally sensitive, recognizing that families of different cultural and ethnic backgrounds have unique ways of functioning and that a single model of family functioning cannot be applied across cultures

### **3. Longitudinal research designs**

Researchers should make use of longitudinal designs in investigating family resilience.

De Haan et al (2002) note that in most resilience research, data is collected at a single point in time. However, the authors suggest that a resilient pathway can be best captured by longitudinal studies. Luthar et al (2000) also advocate longitudinal studies for resilience research due to the dynamic nature of resilience.

## **Summary**

This chapter summarised the key findings of the research, showing how they relate to the research objectives and highlighting their significance for practice. Recommendations for a counselling organization were made and points to consider for future research were provided.

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## **APPENDICES**

University of Cape Town

## **APPENDIX A: LETTER OF INFORMATION**

Name

Address

Date

Dear

Information sheet about Childline research project

Thank you for your interest in helping us in our research. This letter is to tell you more about the project.

I am doing a research project through UCT, where I would like to find out how families cope when one of their children is sexually abused. The project focuses on the positive ways that families cope and the things that help families cope and make them stronger. You have valuable experiences that will help us help other families.

I will be interviewing parents and asking them about how they coped. The interview will take about one and a half hours. You could either meet with me at the Childline office in Wynberg or I could come to your home. If you come to Wynberg, we will contribute R50 towards your transport fare. Tea, coffee and biscuits will be offered.

You can choose whether or not you would like to be part of this research – it is VOLUNTARY and if you decide not to take part, there will be no hard feelings from Childline. Your involvement would be ANONYMOUS – your names will not be identified. Although the interview would be tape-recorded, only myself and the person who is transcribing the tapes will listen to them. After this, the tapes will be erased.

It may be painful to talk about things relating to your child's sexual abuse. You are free to stop the interview at any point if you wish. If, after the interview, you feel distressed or feel you need further counselling, I can refer you to a counsellor. If you feel that your child is still traumatized, I can refer your child to a counsellor.

Your help is very valuable to this project and would be much appreciated. You will find a consent form enclosed, which you are requested to sign if you decide to take part.

I will phone you shortly and if you are willing to be interviewed, we can set up an appointment for next year, between January 5 – 15<sup>th</sup>.

Thank you for considering this request. Please feel free to ask me if you have any questions.

Yours sincerely,

---

Monica Robertson  
Social Worker  
Childline

**Contact details:**

**Phone: 761 8198 (w) 8.30am-4.30pm, Monday to Friday**

**671 7277 (h) after hours**

**Fax: 762 7467**

Childline Counselling Centre  
38 Fleming Road  
Wynberg, 7800

University of Cape Town

**APPENDIX B: CONSENT FORM**

I understand that by signing this form I am agreeing to talk to Monica Robertson about how my family coped with my child's sexual abuse. I understand that this is part of research for the University of Cape Town and Childline. I understand that I will be able to get assistance if I find that I need further counselling.

I understand that if I take part in the research, it is voluntary, and anonymous (my name will not be identified). I agree to the interview being tape recorded and understand that the tape will be erased after the research is completed.

I give permission for Monica to read my child's file at Childline.

1. Parent's name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

2. Parent's name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

3. Name of witness: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

University of Cape Town

## **APPENDIX C: INTERVIEW SCHEDULE**

### **1. WELCOME/ORIENTATION**

- Thank you for coming today.
- Offer coffee and biscuits; give transport claim money
- Receive signed consent form
- This interview will take about an hour and a half
- I invited you here today because I want to know more about how families cope when one of their children is sexually abused; you have valuable experiences that can help me understand the things that help families cope with this trauma – this will help us to know how to draw out the strengths in a family
- I have some questions which I will ask, but the interview will be like a discussion; there are no right or wrong answers
- The discussion will be tape recorded but the only people that will hear it are myself and the person who transcribes the tapes; the tapes will then be destroyed
- This discussion is confidential; your input is anonymous; I will not be using your names. – I have a supervisor who has access to my work
- When I listen to the tapes, I will be listening for general themes about how families cope
- You may stop at any point in the interview; you don't have to answer questions if you don't feel comfortable
- You will hear me sometimes using the word 'trauma' when I refer to the sexual abuse; this is because sexual abuse can be a traumatic experience for the child and for the family

### **2. DISCUSSION:**

To begin with, I'd like to ask you to please take your mind back to the time when you first found out that your child was sexually abused. I'm interested in how your family coped at that time and since then.

#### **□ Coping and adaptation:**

- ❖ What were your family's initial reactions when you first found out that .....had been sexually abused? Explore *feelings, ideas, behaviours*.
- ❖ Did your reactions change as time went by?
- ❖ What helped your family cope with the trauma? And with your *feelings, ideas and behavioural reactions*?
- ❖ How did this event compare to anything your family has been through before?

#### **□ Meaning-making:**

- ❖ What did the sexual abuse trauma mean for your family?
- ❖ Has your understanding of what happened changed as time has passed?
- ❖ Were you able to hold onto the belief/hope that your family would recover? How?

#### **□ Social supports:**

- ❖ Who helped you to help you cope the most?
- ❖ How did they help you cope?

#### **□ Spirituality:**

- ❖ Did your religious/spiritual beliefs help you cope? How?

**Cohesion:**

- ❖ How did the trauma affect your family's sense of closeness/togetherness?

**Adaptability:**

- ❖ What changes did your family have to cope with as a result of the trauma?
- ❖ Did your family do anything differently as a result of the trauma?  
[Is your family different as a result of the sexual abuse trauma?]

**Communication:**

- ❖ To what extent were you able to share your feelings about what happened, with your family?
- ❖ What helped you talk to one another? What made it hard to talk to one another?

**Problem-solving and functioning prior to the crisis:**

- ❖ How do you think your family was managing before this happened? *E.g. solving problems, dealing with challenges and difficult times.*
- ❖ How do you usually deal with problems in your family?

**Family life cycle:**

- ❖ What else was happening in your family at the time that helped you cope, or made it harder to cope?

**Family strengths:**

- ❖ What would you say are your family's strengths? (or, what are the positive aspects of your family?)

**Concluding the discussion:**

- ❖ What advice would you give to other families who are going through a similar experience? *Are there things they should not do? What should they focus on?*
- ❖ How do you think the counsellor can help to support a family in this situation?
- ❖ What else would you like to say about the abuse and how you coped?

3. **ENDING/DEBRIEFING**

- We've reached the end of the discussion.
- Thank you for sharing openly.
- Would you each like to say how it felt for you to talk about these things?
- What was the most helpful part of this discussion for you?
- What was the hardest part of this discussion?