

SECTION B:
PROFESSIONAL JOURNAL ARTICLES

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THE VIEWS OF PROFESSIONALS ON FAMILY PLAY THERAPY WITHIN THE CONTEXT OF CHILD SEXUAL ABUSE IN SOUTH AFRICA

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ABSTRACT

This article reports on the *information gathering and synthesis phase* of an intervention research process. The aim was to accumulate information on family play therapy from professionals working in the field of child sexual abuse in South Africa. This article outlines the findings based on data gathered from a focus group, and discussion groups as the participants in these groups were all professionals in the field of CSA. The information obtained during the focus and discussion groups, was thematically analysed and functional elements of family play therapy were identified and described in the form of themes, which were integrated with literature control. The research findings in this study will inform the *Design* phase of the intervention process, which will lead to the early development and the refinement of a family play therapy model for families affected by child sexual abuse.

Keywords: child sexual abuse, family play therapy, intervention research

1. INTRODUCTION

South Africa's historic legacy of violence, extreme inequality and social dislocation often translates into social problems that affect children. Within this context, social problems include high levels of domestic violence, substance abuse, sexual abuse, neglect and poverty (Djeddah, Facchin, Ranzato & Romer, 2000:906; Kaminer & Eagle, 2010:123, 126; Lalor, 2004). Sexual offences such as rape and sexual abuse prevent many South African children from experiencing their childhood as a time of innocence, comfort and security. The high incidence of sexual abuse in South Africa, as emphasised by the South African Survey (2012:691), indicates that the number of reported sexual offences against children in South Africa, during 2011/2012, were estimated to be 25 862. It must be taken into account that many sexual offences against children are never disclosed or reported (Kaminer & Eagle, 2010:19). Townsend and Dawes (2004) state that it is difficult to know whether there is a real increase in child abuse, or whether an increase is occurring because of the heightened levels of awareness. Waterhouse, Porter and Butt (2009), indicate in their annual report that a total of 39% of sexual offences committed against children affect those aged 15 to 17; whereas 13.2% of these sexual offences involve children from birth up to age five and 27% affect children between the ages of six and eleven. This study focused on the last mentioned group, including the families of such children who were affected by child sexual abuse (CSA). Children in primary school are more or less between the ages of six and eleven and play is a natural medium for children in this age group.

The mentioned statistics paint a grim picture, which is not expected when taking into account the macro-level structures that have been put in place to support child protection and

children's rights in South Africa. According to Rossouw (2011) and Richter and Dawes (2008), services to children and youth in South Africa are underpinned by policy documents, charters and legislation outlining children's rights. These documents, guidelines and pieces of legislation include the Constitution of the RSA (Act 108 of 1996), the Children's Act, No 38 of 2005 (RSA, 2005), and the ratification of the United Nations Convention on the Rights of the Child (UNCRC) (United Nations, 1989). Despite such macro-level structures, the provision and monitoring of interventions aimed at vulnerable children still prove to be a critical challenge in South Africa (Kaminer & Eagle, 2010:153; Richter & Dawes, 2008).

2. MOTIVATION FOR THE RESEARCH

Effective service provision in the helping professions is not a new challenge. Already in 2004 Pierce and Bozalek (2004) and more recently Hall, Woolard, Later and Smith (2012) stated that budget constraints in government led to the retrenchment of professionals in many areas of service, which negatively affected victims of CSA. Discussions between the researchers and professionals working in the field of child care and child sexual abuse point to the gap between needs and service delivery. The first author worked as a case manager for the Children are Precious (CAP) programme of RAPCAN (Resources Aimed at the Prevention of Child Abuse and Neglect) in Lavender Hill, Cape Town. Here, it became clear that the high incidence of CSA versus the under-provision of services required innovative approaches to optimise services to children and families impacted by CSA. The second author provided supervision and consultation to social workers in organisations specialising in sexual abuse intervention in the Western Cape. For these organisations, it was a constant challenge to meet the need for services, where a discrepancy between the services provided and the need for services resulted in long waiting lists.

The disclosure of CSA leads to an immediate crisis for victims and their families. They are faced with the challenge of legal and forensic processes while struggling with a range of multidimensional effects (Van der Merwe, 2009; Wilson & van Wyk, 2009). The immediate crisis after the disclosure of sexual abuse needs to be addressed as soon as possible as delays in service delivery, which include being put on a waiting list, can lead to disillusionment and resistance to intervention. Timeous services should be cost effective and should leverage the non-tangible resources inherent in families in order to facilitate processes that will continue to be effective between therapeutic sessions and after termination of interventions. According to Fraser, Richman, Galinsky and Day (2009) the social work profession faces the challenge to ensure effective practice with best available change strategies despite limitations in service provision and budget constraints. The focus of this study is to use intervention research to develop and refine a family play therapy model for families affected by CSA in South Africa, in an effort to face this challenge for effective social work practice.

It is clear from literature that there is a need to expand interventions to include the family, as stated by Ferreira, Ebersöhn and Oelofsen (2007). In their opinion, research needs to be conducted in order to develop practical guidelines for the assessment and treatment of children and their families who are victims of sexual abuse. According to Christensen and Thorngren (2000), professionals have struggled to actively integrate children's ways of communicating in family therapy. This emphasises the importance of widening the scope of interventions in order to include families in the process. Based on the above, the research question is, *What are the views of professionals on family play therapy in the context of child sexual abuse in South Africa with special reference to core components of the intervention?*

3. RESEARCH DESIGN AND METHODOLOGY

As part of the development and refinement of a family play therapy model, this article outlines the results of one phase of the intervention research process, namely the information gathering and synthesis phase (Du Preez & Roux, 2008; Fawcett, Balcazar, Balcazar, White, Paine, Blanchard & Embree, 1994; Fraser & Galinsky, 2010; Hayes, 1994; van Rooyen, 1994). The input of professionals working in the field of CSA and a literature review contributed to the identification of themes and functional elements of interventions others have used, as suggested by Gilgun and Sands (2012). These themes and elements will be described in this article and will form the foundation of “interventions sensitive to the experiences of the persons for whom the intervention is designed” (Gilgun & Sands, 2012).

3.1 Approach

This qualitative study aimed to build on existing knowledge in order to develop an understanding of child sexual abuse interventions from the perspectives of professionals working in the field. The knowledge accumulated in this article assisted the aim of the research to develop a family play therapy intervention aimed at closing the gap between high incidences of sexual abuse and the need to expand therapeutic interventions for CSA victims, while coping with the limited resources available to help such children and their families (Bailey & Ford Sori, 2005; Dishion & Stormshak, 2007; Geldard & Geldard, 2010; Goldenberg & Goldenberg, 2004). The research was exploratory and descriptive, as explained by Babbie, (2008); Bless, Higson-Smith and Kagee, (2006) and Rubin and Babbie (2009), as it focused on gaining insight into a complex situation and phenomenon. The findings of this research will be applied (Babbie, 2007; Fox & Bayat, 2007) to assist in solving specific problems in practice.

3.2 Design

The blueprint for this research was the intervention research design based on the original Design and Develop (D & D) model of Rothman and Thomas (1994) as also described by De Vos and Strydom (2011); Caspi (2008); Du Preez and Roux (2008); Fawcett, et al. (1994); Fraser (2004); Fraser, et al. (2009); Fraser and Galinsky (2010); and Gilgun and Sands (2012). Intervention research has various components and phases that are mostly described in a linear fashion, but which circles back and forth between the different parts (Gilgun & Sands, 2012; Rothman & Thomas, 1994). In this regard, Rothman and Thomas (1994) refer to intervention research as an integrated perspective to research aimed at developing technology for intervention. Typically, intervention research would provide the process to support the development and refinement of a practice model. Researchers and practitioners often work together to apply research-based knowledge to develop or improve services (Corner, Meier & Galinsky, 2008; Du Preez & Roux, 2008; Fraser & Galinsky, 2010).

Rothman and Thomas (1994) refer to Design and Development as an integral part of intervention research. In 1994, van Rooyen used the term developmental research (as in the 1978 and 1984 work of Thomas) to refer to what is now commonly known as intervention research, as described by Corner et al. (2008). A recent issue of *Qualitative Social Work* focused on intervention research (2012) and it is of interest that the editors, Gilgun and Sands (2012), report that many researchers who submitted articles for the special edition did not have a clear understanding of what intervention research implies. Gilgun and Sands (2012) refer to Shaw who mentioned to them that intervention research in England is commonly seen as evaluation research. It seems as if some researchers who submitted articles for this special journal edition wrongly perceived intervention research to imply outcome or evaluation research. Design and development are an integral part of intervention research, but are not

reflected in the current term. Gilgun and Sands (2012) tentatively suggest that consideration should be given to change the term, *intervention research*, to *developmental intervention research*. Time will tell how this suggestion will be accepted among researchers. In this study, the development of an intervention model is the core aim and the researcher can relate to the suggestion of Gilgun and Sands (2012). Therefore, this qualitative study will incorporate detailed descriptions of the social and professional realities of the professionals included as participants, which will be integrated into the design phase of the intervention model.

3.3 Data collection

Creswell (2007) views data collection in qualitative research as a process during which different activities are used aimed at gathering rich information to answer the research question. The data collection process was supported by field notes and recordings of discussions of focus group and discussion groups. The researcher used an existing database of professionals in the Western Cape that worked in the field of child sexual abuse and have knowledge of play therapy and/or family therapy. Eight participants took part in the first focus group discussion during which information was gathered. For triangulation purposes (Ellingson, 2009), two additional discussion groups were conducted with social workers, working in the field of child sexual abuse. The first discussion group consisted of three social workers, working from a centre for sexually abused children in the Western Cape and the second group consisted of three professionals working in the field of child trauma and CSA in the Western Cape.

An interview schedule was used during the focus group discussions. The researcher used the interview schedule as a support to structure the focus group (Stewart, Rook, & Shamaasani, 2007:11) and to gather data on the functional elements of family play therapy within the

context of CSA in South Africa. The final discussion group was conducted for the purposes of dissemination as part of the intervention research process. Transcriptions were made of all the sessions that were conducted during this study. Functional elements, findings and recommendations obtained from the participants were highlighted and this accumulated information was integrated into a tentative family play therapy model to be implemented with families affected by CSA in the next phase of the intervention research process.

3.4 Data analysis

Analysing data (Babbie, 2007; Creswell, 2007; Rubin & Babbie, 2009) entailed transcribing and coding the information. Transcriptions of the focus group discussions were analysed according to the data-analysis spiral of Creswell (Creswell, 2007) and integrated in the process as described by Marshall and Rossman (2011). Elements of thematic analysis, as described by Braun and Clarke (2006), were used additionally to order and arrange the feedback provided by the participants. Thematic analysis within a social constructionist epistemology is used in this study, as patterns were identified that were socially produced by the focus group participants and the families that were involved in this study. The researcher used thematic analysis as different patterns (themes and stories within the context of CSA) were identified from the data and meaning was given to the information produced by the participants in this study.

3.5 Ethics

As set out by Strydom (2011), Terre Blanche, et al. (2006), and Whittaker (2012), ethical considerations form a core feature of this study. Firstly, the researcher, as a social worker, adheres to the South African Council of Social Service Professions' Code of Ethics. Voluntary participation was understood by and informed consent (Rubin & Babbie, 2008) was given by each participant. This part of the study was deemed as low risk in terms of

causing harm to participants as they reported on their professional practice. The anonymity of participants was respected at all times. The participants were given the opportunity to withdraw from the study at any time. To ensure the correctness of the data analysis, the researcher consulted with her study supervisor, a research assistant and colleagues at an organisation working with CSA victims to verify impressions and conclusions. This corresponds with the peer-review process proposed by Maree and Van der Westhuizen (2009).

4. DISCUSSION OF FINDINGS

The findings presented below are based on the analysis of the transcripts of the focus group, and two group discussions. Added to this is the input from a literature review that formed part of the information-gathering and synthesis phase of the intervention research. Various themes emerged from the data collection strategies (Braun & Clarke, 2006; De Vos & Strydom, 2011; Du Preez & Roux, 2008; Fraser & Galinsky, 2010; Van Rooyen, 1994).

Themes are supported by quotes from the transcribed data and are presented below:

Theme 1: Individual intervention versus family play therapy within the context of CSA in South Africa

The participants recognised the need to expand interventions to include the sexually abused children and their families with the rationale that this will help to expose more affected families to therapeutic interventions. The participants indicated family play therapy as an intervention modality that addresses problems in a systemic way and that involves each family member in the integration process, enabling family members to work together in order to process the trauma of child sexual abuse. Families with children who experienced sexual abuse were identified from an existing client base (of an organisation specialising in CSA) and were engaged in the integrated family play therapy process. More specifically, the focus was on family units where family members acknowledged the abuse and were committed to support the victim.

The participants' views on the need to expand therapeutic services to include the families of sexually abused children were based on their professional experiences in which interventions were mostly focused on individual children as victims of sexual abuse. The need to expand services to include the families is supported by various researchers (Bailey, 2005; Dishion & Stormshak, 2007; Geldard & Geldard, 2010; Goldenberg & Goldenberg, 2004; Miller, 1994; Rotter & Bush, 2000; Gil, 2011: 224). The Annual Report of the Department of Social Development (2011) confirms that interventions and initiatives aimed at vulnerable children in South Africa need expansion. The need for the expansion of services in South Africa is emphasised by the participants who provided descriptive accounts of their professional experiences in terms of interventions to CSA victims in South Africa. They all concluded that the family should be included in interventions:

“It is frustrating to know that the work done with the child during an individual session will stop, knowing that the child's environment has an impact on the emotional status of the child. It is important to broaden our views as to how we can include the family so that the therapeutic input in one hour can be maintained after the session.”

“In my experience, working as part of the sexual offences court structure in South Africa, it is horrific to see the number of children and their families in need of emotional support and in the same breath we cannot do anything to change the system. So we as social workers need to look into ways to hold 'ten individuals in one hand instead of holding thousands by the fingertips'.”

“When we as social workers work with the individuals, our work has an impact on one life, so if we could work with the family as a whole, we will be able to touch so many more lives.” “It is time that we start looking beyond the individual work with children.”

“The family is the building blocks of society; it is the foundation of healthy communities. The focus of a social worker is to create healthier communities and including the family in the work of children is the way to do it.”

Family play therapy is not a new mode of intervention. As described by Miller (1994), family play therapy has developed over the years into a more integrated concept of family and play therapy. While play and family therapy are both well-established therapeutic paradigms, family play therapy is an integrated approach that combines elements from play therapy and family therapy, and which includes children, family members and the social worker in the play therapeutic setting (Gil, 2006). In this way the serious effects of CSA can be addressed in a systemic way.

Disclosure of child sexual abuse can lead to intense reactions, such as shock, denial or confusion, all of which may serve to incapacitate caregivers and prevent them from being emotionally available to affected children (Charleston, 2009; Corcoran, 2004; Gil, 2006). In this regard, authors emphasise the need to include families in the play therapy process (Bailey & Ford Sori, 2005; Charleston, 2009; Christensen & Thorngren, 2000; Corcoran, 2004; Geldard & Geldard, 2010; Gil, 1994; Gil, 2006; Gil, 2011; Kaduson & Schaefer, 2006; Keith & Whitaker, 1994; Miller, 1994; Rotter & Bush, 2000; Schaefer & Carey, 1994). Literature supports that the focus of the intervention should shift from the individual to the family system.

Gil (as cited in Christensen & Thorngren, 2000) and Gil (2011) are of the opinion that including the family in the therapeutic process can be highly valuable. Firstly, the victim of CSA is the reason why a family requests intervention. Secondly, by working with the family, the social worker is helping to ensure a more positive and lasting effect on the child by strengthening the supporting role of the family

Theme 2: Limited knowledge and experience in terms of implementing and integrating play therapy in families

Participants indicated that limited knowledge exists in terms of the implementation of family play therapy as a process. This is supported by authors such as Ariel (2005); Christensen and Thorngren (2000); Haslam (2006); Haslam and Harris (2011); McMonigle (2008); and Rotter and Bush (2000), who argue that knowledge about the benefits of integrating family therapy and play therapy does exist. However, little knowledge exists about how to implement family play therapy and how to provide an integrated therapeutic intervention process. According to these authors, there is a gap in the education of social workers in terms of family play therapy. The participants confirmed this void as is clear from their feedback:

“As a gestalt therapy trained social worker, I have worked with the individual, with the inclusion of the parents where needed, but my knowledge, based on the development and implementation of play therapy with families is limited.”

“In my personal opinion, play therapy with families provides a space for all the members to play out difficult situations. I understand the definition and the rationale behind the integrated approach to play therapy, but in my opinion, the implementation of the process lacks knowledge and the know-how.”

“I feel that I am not equipped enough to implement play as part of the family therapy process; I am nervous to do it as I am scared that I will not do the right thing. The whole dynamic changes when we have to work with the whole family, so much more to look out for during each therapy session.”

“In South Africa, there is not a lot of training in this field, but I will benefit from training to include the families in therapy. It definitely is something that would help me in my work.”

The participants elaborated on the need to gain knowledge about the content and the implementation of the family play therapy model and, as a result, information emerged on the possible structure and framework of family play therapy, which is provided below.

Theme 3: Family play therapy framework

The merging of play therapy and family therapy to develop an integrated family play therapy framework was highlighted during the focus group intervention.

Merging two approaches: Play therapy and family therapy

A clear challenge emerged from the discussions, namely to develop a systemic family play therapy framework. The focus group members regarded the establishment of the process of family play therapy as a daunting one due to uncertainty about the framework and the implementation of the therapeutic process. This corresponds with the views of Ariel (2005); Christensen and Thorngren (2000); Haslam (2006); and Haslam and Harris (2011) who ascribe the gap in the implementation of integrated family play therapy to the fact that social workers typically do not feel comfortable working with family play therapy, to the lack of training in this field, and to the negative professional and personal attitudes of social workers towards the integration of play therapy with family therapy. Most of the participants agreed that the play therapy process should include elements of family therapy to underpin the therapeutic framework. This is in line with the opinions of Gil (2006); Haslam (2006); Haslam and Harris (2011); and Gil (2011) who define the process of family play therapy as the integration of two key clinical approaches, namely family therapy and play therapy.

According to these authors, this can be achieved by using play therapy techniques and approaches to encourage the participation of all the family members within the context of child sexual abuse.

According to the participants, the challenge was to integrate the two modalities and to implement one practical framework. Focus group members articulated this as follows:

“As gestalt trained therapists, it is very difficult to think about the implementation of therapy without the foundation of the gestalt principles. The fact that the family is included in the process makes it more daunting. I feel comfortable working within the gestalt framework, but how to integrate it with family therapy seems difficult.”

“It is a lack of confidence that is preventing me from trying to include families in the play therapy process, but I think the benefits of family play therapy are so vast that it should definitely become a priority in South Africa.”

There is a clear need among participants to obtain more information about the integration and implementation of the two modalities. Therefore, the discussion of the importance and use of play as part of family play therapy below:

Using play as medium during the implementation of family play therapy

Participants made it clear that play as a medium should form part of the therapeutic framework. This corresponds with the above-mentioned need for more information about the integration and the implementation of play therapy and family therapy. The benefits of using play therapy when working with families have been acknowledged by various authors (Ariel, 2005; Bailey & Ford Sori, 2005; Christensen & Thorngren, 2000; Geldard & Geldard, 2010; Gil, 1994; Gil, 2006; Gil & Sobol, 2005; Gil 2011; Haslam, 2006; McMonigle, 2008; Rotter & Bush, 2000). Although play therapy is predominantly seen as a child-focused medium,

literature has shown its use in families. Authors such as Ariel (2005); Casado-Kehoe, van der Bleek and Thanasiu (2007); Gil (1994); Rotter and Bush (2000); and Topham and van Fleet (2011) state that play during intervention allows family members to become less defensive, to overcome resistance, to manage their stress, to enhance creative thinking and to explore more acceptable ways of problem-solving and conflict resolution. According to Haslam (2006), symbolic play is a powerful medium to use with children; however, symbolic play can also be effective with adults. When playing, adults are able to use their cognitive ability to translate the symbols of play into expressions in their own lives. This is important when including the family in the process of play therapy. Participants commented on the importance of the inclusion of play in family play therapy sessions:

“Play as a medium should be utilised throughout the family play therapy process, as this will enhance the family members' ability to open up verbally and emotionally as they can focus on identifying their underlying thoughts and feelings in a non-threatening way as play facilitates the engagement of family members in the therapeutic process.”

“Play is part of the way I was trained to work therapeutically with children. I won't exclude it from therapy where children are included”.

“I am used to always incorporate some playful activity in my sessions with children and cannot see any other way when working with families”.

“Play will help the different family members to express what they feel, it will build relationships. It will create a different type of platform for the family members to communicate.”

“Every family member will be able to express their feelings without having to feel like that they have to talk about it.”

Using play techniques during family play therapy as a process can engage children and parents, and improve communication and understanding (Kaduson, 2006). Throughout the focus group discussion which was aimed at identifying functional elements of a family play therapy intervention, it was clear that the principles of gestalt therapy theory should be utilised as a foundation in conjunction with the use of play in family play therapy, as discussed below:

Principles of gestalt therapy theory

The participants agreed that the inclusion of gestalt therapy theory principles in the integrated framework of family play therapy should be investigated further. The principles of awareness and dialogue within a helping process, as described by Yontef (1993) and Yontef (1998) and the gestalt therapy principles should form the foundation of the family play therapy process and of each family play therapy session. Various authors refer to gestalt therapy as a phenomenological-existential therapy that allows each individual in the family system to focus on his/her own perceptions and experiences with an emphasis on awareness in the here and now and the immediate experience (Blom, 2006; Clarkson, 2004; Joyce & Sills, 2010; Latner, 2005; Mackewn, 1997; Magill, Rodriguez & Turner, 1996; Yontef & Jacobs, 2011; Yontef, 1993; Yontef, 2002). One focus group participant articulated this as follows:

“Different gestalt therapy techniques can be used to build relationships, identify different feelings and emotions, communicate, and raise sensory and emotional awareness and to enable family members to tell their story as part of the play therapy process.”

It seems as if the structure of the process should focus on the immediate needs of family members during each session. Keith and Whitaker (1994) and Carson (1999) agree with this point of view and emphasise the importance of the family play therapy structure and a creative approach to intervention without following a rigid and technical approach to the process. The participants agreed that the intervention process of family play therapy should be dictated by the needs of the family of the case in hand because every family is different. Some of the participants expressed this as follows:

“Trained as a social worker in the gestalt therapy field, I would suggest that it is important to focus on the here and now and the foreground needs the family brings to each session by using play as a medium.”

“The sexually abused child brought the family to therapy but we need to focus on the issues the family is dealing with on a daily basis and the issues as a result of the abuse.”

“The gestalt therapy process is not static and can and should be implemented during each session in order to identify and address their unfinished business.”

“I would suggest that the person-focused approach should be extended to the family and the foreground needs of the family should be identified throughout the process. I always make sure that I bring my clients back to the reason they are part of this therapy process; in this case it would be sexual abuse that brought the family to therapy.”

Various researchers conclude that the aim of a family play therapy approach should be to help each individual family member to improve the perceptions of his or her immediate experiences (Blom, 2006; Latner, 2000; Mckewan, 1997; Magill, et al., 1996; Yontef, 1993;

Yontef & Jacobs, 2011). The researcher suggests that it will be the task of the social worker during family play therapy to allow all the family members to talk freely about their emotions and painful issues, and to make use of counselling skills in conjunction with other play strategies. In conclusion, family play therapy could allow family members to objectively look at their family environment, which is burdened by child sexual abuse. During this process, family members can learn more effective ways to deal with trauma within the family by being allowed to focus on their own trauma and experiences and to understand the CSA victim's trauma in a systemic way. Family play therapy could therefore provide a controlled but non-threatening environment in which parents and family members can experiment with change.

Theme 4: Family play therapy process

In intervention research (Caspi, 2008; De Vos & Strydom, 2011; Du Preez & Roux, 2008; Fawcett, et al., 1994; Fraser, 2004; Fraser et al., 2009; Fraser & Galinsky, 2010; Gilgun & Sands, 2012), a prototype must be developed to apply to people who are experiencing the problem under investigation, in this case families affected by child sexual abuse. It was therefore necessary to identify specific techniques and to place them within a preliminary framework in readiness to be used with the next group of participants (families affected by CSA) in the next phase of the intervention research. Carson (1999) and Ariel (2005) emphasise that the structure and process of family play therapy should ideally include a range of creative intervention techniques aimed at making the therapeutic process more attractive and accessible and to raise awareness in the 'here and now'. Family members can be involved in play or supported by media such as hand puppets, sand-tray work, painting, drawing, clay or other forms of creative expression. In this regard, Gil (2011) state that the utilisation of different play therapy techniques can serve as a bridge between the creative, non-verbal world of the child and the verbal world of the adult, which could lead to a new interaction process

that holds benefits for all parties involved. Participants in focus groups mentioned possible techniques that can be incorporated in a family play therapy model. It is beyond the scope of this article to describe these techniques in detail as this will be included in a prototype together with functional elements obtained from literature. However, the literature review focused on the work of Yontef (1993; 1998; 2002) in terms of a gestalt intervention process, combined with the work of Hepworth, Rooney, Rooney, Strom-Gottfried and Larson, (2010), in terms of a social work intervention process and the historical work of Dennison (1989) who offered a structured yet individualised approach. The Dennison model allows for a balanced focus on the helping process as well as on the problems or needs of each family supported by creative techniques. In the next phase of the intervention research, the functional elements described in this article will be incorporated in a prototype that will be applied within the context of family play therapy with families affected by CSA.

5. SUMMARY AND CONCLUSIONS

This article described the information gathering and synthesis phase of intervention research. The input of professionals working in the field of CSA was obtained to identify functional elements which could be included in the development of a family play therapy intervention for families affected by CSA. Data obtained from professionals and a literature review resulted in four themes. The first theme focused on the issue of individual intervention versus family play therapy in the context of CSA in South Africa. Participants clearly indicated that social workers should relook individual interventions where they cannot adequately intervene to meet the needs of the many families affected by CSA. Family members are a neglected population in the field of CSA with the limited service delivery mainly focusing on the children directly affected by CSA. Note should be taken of the view of one participant who said that social workers try to hold thousands of people by the fingertips, instead of ten

individuals in one hand. It is a well-known fact that social workers have high caseloads and often have to follow crisis-based approaches. It seems as if the time has come where service delivery should make provision for social workers in specialised positions to work systemically and strength-based with families affected by CSA. Enabling environments should be created where families can find their own expertise to facilitate trauma integration.

Theme two indicated that social workers need additional training to be skilled to implement family play therapy. They will also need specific supervision as they hone their skills in family play therapy. It was interesting in theme three that Gestalt therapy theory was strongly indicated as a framework for family play therapy. Gestalt therapy theory accommodates the foreground needs of clients and dialogue aimed at enhanced awareness. Combined with play techniques this can provide a powerful intervention aimed at the integration of CSA.

Participants generally valued play and play media in the process of family play therapy. The tentative family play therapy process outlined in theme four, points to the inclusion of a Gestalt framework, a social work helping process and a model that was developed in the 1980's which offers an individualised and goal-directed approach. This Dennison therapy practice model (Dennison & Glassman, 1987; Dennison, 1989:9-20) has a deliberate primary and secondary goal focus in the different phases of the helping process. Family play therapy interventions with families affected by sexual abuse should never lose sight of the dynamics of the helping process and the Dennison model offers a practical framework which will help social workers to be mindful of the helping process. In the next phase of intervention research the elements outlined in this article will be integrated into a prototype to be applied to families affected by CSA.

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Article 2: Article 2 will be submitted to Journal: CARSA - Child Abuse Research: A South African Journal - Publishing Policy (Appendix 2)

The experiences of families affected by child sexual abuse as expressed in a family play therapy context

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This article focuses on the experiences of four families who were engaged in a family play therapy process as part of intervention research within a qualitative framework. The following themes were identified, namely Theme 1: Reactions of caregivers; Theme 2: Other traumas: Vulnerability factors in the community; Theme 3: Change in family dynamics; and Theme 4: Experiences of pending court process. The research findings in this study will inform the *Design* phase of an intervention research process, which will lead to the early development and the refinement of an integrative family play therapy model.

INTRODUCTION

Child sexual abuse (CSA) is an ever-increasing problem in South Africa (Djeddah, Facchin, Ranzato & Romer 2000:906; Kaminer & Eagle 2010:19; Lalor 2004:439; Wilson & Van Wyk 2009:1). Kaminer and Eagle (2010:19) indicate that CSA is typically underreported and they estimate that only about one in twenty cases are reported to the South African Police Service. According to the South African Survey of 2012 (2012:691), there were a total of 25 862 reported cases for the years 2011/2012.

Already in 2004, Pierce and Bozalek (2004:820) indicated that the high incidence of sexual abuse in South Africa puts pressure on the government to ensure the safety and emotional well-being of affected children and their families. Then already, the monitoring of interventions for vulnerable children and their families proved to be a critical challenge in South Africa (Pierce & Bozalek 2004:820). More specifically, the escalation in reported rape and CSA cases led to an increase of cases present on the caseloads of social workers in South Africa (Ferreira, Ebersöhn & Oelofsen 2007:69; Richter and Higson-Smith, 2004:252-255). The challenge that child protection services are faced with in this country is the number of cases in need of appropriate interventions that exceed the available resources (social workers, psychologists, counsellors) for the delivery of interventions to families affected by CSA (Britz & Joubert 2003:27; Pierce & Bozalek 2004:820; Richter and Higson-Smith 2004:252-256; Townsend & Dawes 2004:91-92).

Intervention research was conducted to develop an integrated family play therapy intervention for children and families affected by CSA. Functional elements of other models and practice were obtained from focus groups and discussions with experts in the field and elements identified by means of a literature review. It was important to obtain information on the experiences of CSA of the families, as it outlined typical aspects to be taken into account during a family play therapy process. A prototype was developed and while it was applied to families affected by CSA, the experiences of family members emerged of how the sexual abuse affected them.

The subjective experiences of families and children affected by CSA are probably often available in confidential case files of social workers. It does not often emerge in the field of research. In this article, the focus is then on such experiences to enhance the understanding of the effect of CSA. It will also enhance the understanding of how such experiences are verbalised and played out within the context of family play therapy. Before outlining the experiences of participant families, a systems perspective will be briefly outlined as this article focuses on the child victim of CSA as part of the family system.

Family systems within the context of CSA

From a postmodern perspective, a certain amount of criticism emerges regarding systems approaches that can be seen as mechanical, and expert driven. Furthermore, the impact of researchers and practitioners on systems is not always taken into account. Care should also be taken not to make assumptions based on systems theory where the individuality of individuals and families can be missed (Du Preez & Eskell-Blokland 2012:53; Rasheed, Rasheed & Marley 2011:25). With this in mind, the systems theory has value in terms of understanding the dynamics of families. Visser (2012:25-26) outlines characteristics of systems such as the interrelated relationships within a network of systems. In this regard, the work of Bronfenbrenner (1977, 1988) is still relevant with the focus on microsystems, mesosystems, exosystem and macrosystems. The family system as microsystem cannot remain unaffected by CSA. Family members have to face their own difficulties, dealing with this traumatic event that could impact the way in which they will support the child victim. In order to understand the distress the child victim is enduring, it is important to understand what the rest of the family is experiencing regarding the CSA. This corresponds with the opinions of Blom (2006:19), Latner (2000:20), Parlett and Lee (2005:442), Yontef and Jacobs (2008:332) and Yontef (1998:82) that it is important to understand the field or context people live in, in order to understand their behaviour and experiences.

The family and immediate environment, in other words the close microsystem of children (Bronfenbrenner 1977:513-531; Bronfenbrenner 1994:37-43; Bronfenbrenner 1979:3; Bronfenbrenner & Morris, 2006:793; Richter & Higson-Smith, 2004:75) are expected to provide structure, safety and support to children. Social support from the family can serve as a major protective variable for direct

victims of CSA (Van der Merwe 2009a:290-298). In this regard, Geldard and Geldard (2010:77) state that every member of the family could add to the social support and form a support system with their own resources, such as their perceptions, ideas, and understanding, which can have a positive and strengthening influence on child victims and the family as a whole. This will be especially true if dialogue between family members can be facilitated through family play therapy so that they can verbally support each other and show understanding of their respective processes of integration of CSA.

RESEARCH METHODOLOGY

After obtaining information from existing sources and identifying functional elements of other intervention models, the design phase of intervention research followed where a prototype was developed and applied to four participating families.

Approach

Intervention research was used within a qualitative framework (Babbie 2004:22; Creswell 2003:15; Creswell *et al.* 2007:252; Fouché & De Vos 2011:95; Fouché & Schurink 2011:316) and based on the original design and developed model of Rothman and Thomas (Fawcett, Balcazar, Balcazar, White, Paine, Blanchard, & Embree (1994:31), as also described by Caspi (2008:575), Corner, Meier and Galinsky (2004:251), De Vos and Strydom (2011:475), Du Preez and Roux (2008:78), Fraser and Galinsky (2010:459), and Hayes (1994:103). These authors indicate that intervention research entails that researchers, professionals and participants work together to create interventions that improve and develop research knowledge and services.

The focus of this article is on their experiences of family members of CSA as it emerged within the context of family play therapy. The information was utilised to develop an integrated family play therapy intervention for families affected by CSA.

Sample

Sixteen participants from four different families were engaged in family play therapy processes, including six sessions for three families and four sessions for another family. The ages of the direct victims varied between the ages of six and thirteen years. Non-probability sampling (Ritchie, Lewis & Elam (2009:100) with elements of the purposive sampling method, as described by Maree (2007:79), Ritchie *et al.* (2009:100) and Strydom (2011b:232) was used in this study. Families with children who experienced sexual abuse were identified from an existing client base (of an organisation specialising in CSA) and were engaged in the integrated family play therapy process. More specifically, the focus was on family units where family members acknowledged the abuse and were committed to support the victim. Families with high levels of conflict and divided loyalties regarding perpetrator versus victim and also families where the perpetrator was still living in the household were excluded from

this study. It is the opinion of the researcher that family play therapy will not be the intervention of choice for such families. Members of the extended family were included according to the needs of each family and young victim.

Each family's composition, structure and dynamics differ. One of the families was an extended, foster care family, one was a single parent family with a grandmother who forms part of the family, and two of the families were nuclear families, with both a mother and a father. The sexual abuse of a child victim was identified in all four families, while three of the families were still subjected to sexual offences court procedures during the implementation of the therapeutic process. All four families were Afrikaans and English speaking. Due to financial constraints, Family 4 withdrew from the therapeutic process after the fourth session.

Data collection

In the design phase of intervention research, data collection was supported by family play therapy sessions with families affected by CSA. Each family play therapy session lasted approximately one to two hours, depending on the process and the needs identified by the specific family. An average of twenty-four hours was spent with families 1, 2 and 3. A total of five hours were spent with family 4, who withdrew after the fourth session. Data collection adhered to the typical qualitative data collection process where different data collection strategies were used to obtain in-depth information, in order to answer the research question (Creswell 2007:118). Family play therapy sessions, were guided by a prototype developed from information gathered from focus and discussion groups with professionals and, integrated information gathered from an in-depth literature analysis. The family play therapy sessions conducted with families affected by CSA afforded the opportunity to refine the prototype. Rich data emerged as family members engaged in dialogue through words and play. Data collection was supported by field notes and video recordings of each family session.

Data analysis

Interviews were transcribed and subjected to thematic analysis (Braun & Clarke 2006:87-88). The researcher worked according to the six phases of Braun and Clarke (2006:86-93). The aim is therefore not simply a descriptive summary of the content, but a combination of different methods of data analysis. In this study, the researcher became familiar with the transcribed data and general ideas of the data were identified and written down. After reading and re-reading the data, the researcher identified different categories. Several themes and sub-themes emerged from the different categories. In order to categorise different themes, the researcher looked for stories, narratives and individual experiences from participants. Braun and Clarke (2006: 82) explain that a simple way to organise data is to describe and discuss each theme referring to examples from data and using direct quotes to help characterise the themes.

ETHICS

Ethical considerations were guided by the researcher's profession as a social worker where she adheres to the South African Council of Social Service Professions code of ethics. Ethical clearance and an ethics number were allocated to the study by North-West University. Ethical considerations as set out by Brinkmann and Kvale (2008:297), Welman, Kruger and Mitchell (2005:11), and Whittaker (2012:114) were a core feature from the onset of the research in terms of the research process, selection of participants, interviewing and data analysis. Aspects such as no harm, informed consent, confidentiality, the role of the researcher and the possible consequences of the research as described in Brinkmann and Kvale (2008:297) and Strydom (2011a:115-119) were crucial in this study.

The researcher was aware of the participants' emotional responsiveness during the sessions and she responded respectfully towards such situations by allowing and facilitating family members to serve as support for each other during the sessions. The researcher continuously acted as an additional support and mediator for the family members to limit possible emotional harm. The researcher is an experienced social worker who has worked in the field of CSA. She used her skills and experience in the family play therapy interventions. The name of the organisation where the research was conducted will remain confidential as additional measure to protect participants. A social worker was assigned to each case, prior to the start of the research process and after the completion of the research process, families had the opportunity to receive individual intervention from the social workers at the organisation they have been referred to in the first place.

FINDINGS

Four main themes emerged from the thematic analysis of transcriptions of sessions, reflecting the experiences of CSA of participating family members. Typical to qualitative research and also due to the small sample size and the nature of the research, the data collected is not generalised to the wider population, but rather to literature that supports the findings. The following themes were identified, namely Theme 1: Reactions of caregivers; Theme 2: Vulnerability factors in the community; Theme 3: Changes in family dynamics, and Theme 4: Experiences related to court process. These themes are discussed below:

Theme 1: Reactions of caregivers

The participants voiced their frustration and feelings of inadequacy in supporting the child victim and each other, partially as they were working through their own shock, denial and sense of disbelief. Walker-Descartes, Sealy, Laraque and Rojas (2011:438) state that the dynamics surrounding CSA disclosures are complex and impact a child victim's actions and behaviours after the disclosure, while Cook *et al.* (2005:395), Hubel *et al.* (2011:361), Klingman and Cohen (2004:69), and Malloy and Lyon (2006:98) posit that the exposure to sexual abuse has a traumatic effect not only on the victim, but also on the family system, especially the caregivers. Furthermore, Hobfoll, Dunahoo and Monnier

(1995:37), and Lewin and Bergin (2001:365) suggest that individual coping patterns play a significant role in how people will manage stress.

Elliott and Carnes (2001:321) emphasise that the adjustment of child victims is related to the reactions and the support they receive, pointing to the important buffering and protective function of the family. Based on clinical experience and the findings of this research, the researcher proposes that the 'well' of support for the individual lies embedded within the family structure. This implies that the family and caregivers should take responsibility for supporting the victim, in order to strengthen the adjustment process after disclosure, as emphasised by Deblinger, Stauffer and Steer (2001:333). However, feelings of disbelief and shock can hamper the protective function of caregivers. In this regard, Marcha (mother of victim, family 2) had the following to say:

I am still so shocked and in a sense I don't want to believe what has happened, which makes it difficult for me to be there for my daughter (Marcha, mother of victim, family 2).

Klingman and Cohen (2004:68) indicate that parents of the victims of child sexual abuse feel inadequate to protect their children due to their own reactions. The participants mentioned reactions such as shock, denial, over protectiveness, guilt and a loss of control that limit appropriate responses to their children's trauma. This is in line with similar caregiver reactions mentioned by Klingman and Cohen (2004:69). Cook *et al.* (2005:395) emphasise that when caregivers deny the children's experiences of the CSA, it can cause children to feel that they also need to suppress their reactions to the CSA-related trauma. Johanna (foster mother, family 1) said the following in which she expressed her feelings of inadequacy to deal with the CSA:

I know I am the one that should be strong for her and the rest of my family, but it is difficult as I don't know how to deal with this situation that life has put us in (Johanna, foster mother, family 1).

It was significant to note how inadequate caregivers felt in supporting the victim and other family members. This was partially due to them being caught up in their own processes and dealing with their own feelings, and also due to a lack of knowledge and skills in handling this complicated extreme stress. This links with the view of Cook *et al.* (2005:395) who emphasise that caregivers' distress and inability to deal with their own reactions to the CSA can cause children to believe that they should rather not communicate their emotional needs to their parents in order to avoid the anguish of the caregivers. Participants in this study were clearly not always sure how to deal with the CSA. They also indicated how difficult it was to balance their own emotions and reaching out appropriately to the affected children:

I know that Nicci is unhappy, but how do I ensure that she is okay if I myself am not okay? (Jacoba, foster mother of victim, family 1)

I am not Nicci's real mother, but she and her brother and sister are like my own; their mother is dead, but she asked me to care for them and provide the best for them, so I will use everything

available to me to help them. I just need to first get my own head together (Johanna, foster mother of victim, family 1).

I am not sure if I am strong enough to go through this and be emotionally strong for my family, only time will tell if we will get through this nightmare (Marcha, mother of victim, family 2).

How do I do this? How do I make myself strong for her and her stepfather who is also struggling? (Marcha, mother of victim, family 2).

I have been feeling so much pain over the past few weeks that I can't, I don't know how to handle it and I broke down in church last Sunday (Gertrude, grandmother of victim, family 3).

As identified by the participants, Deblinger *et al.*(2001:333), Hubel *et al.* (2011:361); Kim, Trickett and Putman (2011:499), Klingman and Cohen (2004:64); Lewin and Bergin (2001:365) support the fact that the levels of distress that are experienced by the caregivers impede their ability to provide support to the children's emotional needs caused by CSA. This is a sad reality given that the support of the caregivers can serve as a buffer against the emotional trauma that children experience due to sexual abuse.

Furthermore, caregivers indicated that they felt responsible and blamed themselves for the sexual abuse of their children. This is a heavy burden to carry when they already have so much to deal with in the aftermath of CSA. Four participants from families 2 and 3 made comments pertaining to the experience of self-reproach.

I blame myself, why did I not just end it. That makes it even worse, being the mom and not aware what is happening. I could have helped her earlier, but I was too busy with work” (Jacoba, mother of victim, family 3).

I feel a great sense of responsibility as a mother, as I have put her in this situation, by thinking that my best friend will look after her while I was in hospital. Now, I have to make it better for her and my family (Marcha, mother of victim, family 2).

If I think back on the decisions I have made, it consumes me. It makes me feel guilty (Marcha, mother of victim, family 3).

We have always tried to protect her by not allowing her to sleep at friends' houses, but look what happened in our own home (Jacoba, mother of victim, family 3).

In the face of trauma, it seems to be quite common for direct victims and their families to consider what they could have done differently to prevent the trauma. However, if caregivers spend a great deal of their emotional energy on self-reproach and feeling responsible, it may hamper their ability to provide supportive networks for their children.

Furthermore, Cook *et al.* (2005:395), Cyr, McDuff and Hebert (2013:211), and Elliott and Carnes (2001:314) assert that the complex childhood histories of caregivers might affect their parental personality. The child's reaction to the trauma may provoke feelings of loss, rejection and abuse experienced by the caregivers, which may weaken their parental ability. In this study, caregivers were clearly affected by their own life histories and in particular their own sexual abuse experiences.

Both the biological parents in family 4 (caregivers) elaborated on their own negative feelings and emotions associated with their own personal experiences of sexual abuse, which hamper their ability to provide emotional support to the victim and the rest of the family. Elliott and Carnes (2001:319), and Leifer, Kilbane and Grossman (2001:354) indicate that there is limited research on the influence of parents' history of sexual abuse on their ability to provide emotional support for CSA victims. In contrast, Kim *et al.* (2011:500) argue that, in fact, there is a connection between the caregivers' experience of their own personal sexual trauma and the extent of support and insight that is shown to the child victims, as sexual abuse is associated with the general psycho-social functioning of the parent. Both of these participants stated that they have not had closure on their own personal experiences, which has a significant impact on the way they support the victim. Their expectations about how to work through the trauma (sexual abuse) as stated below, put pressure on the victim, because the victim cannot focus on his/her own personal processing and he/she is not receiving the emotional support he/she needs: Their comments were as follows:

I would like him to move on, it will never be forgotten, but it happens, it happened to me, it happened to my wife (Ben, father of victim, family 4)

He must move on from it, I did it, so can he (Ben, father of victim, family 4)

I went through something similar but more on a larger scale. Why I am saying Peter's is not severe, because it happened only in one day, mine was on-going you know. So I just feel sad and I hope it doesn't interfere in his life one day (Ben, father of victim, family 4)

I am grateful that he has the help, I did not get any help and that is why I am still suffering (Shaya, mother of victim, family 4)

What makes me more emotional is that I know what he is going through but in my case it was closed doors, I could not talk about it, but he has the chance to talk about it here (Ben, father of victim, family 4)

According to Follette, La Bash and Sewell (2010:228), early disclosure of CSA is important to afford victims the opportunity to work through the trauma caused by the CSA and in doing so, the effect on them as adults can be moderated. If they had time to integrate their childhood traumatic experiences, there is a better chance that they will be able to support their children exposed to CSA. This is in line with the view of Kim *et al.* (2011:500), who affirm that the caregivers' own histories of sexual abuse and the way they were dealt with, have a significant impact on the way the caregiver will be able to offer support to the victim.

In summary, the participants indicated that they find the sexual abuse disclosure of their children difficult within the context of their own experiences. Furthermore, they find it hard to provide support as their own feelings, emotions and processes are difficult to manage. While family play therapy is the focus of this research, it seems important that caregivers should receive additional therapeutic input to help them work through their own processes, while also having access to psycho-education to enable them to support children.

Theme 2: Other traumas: Vulnerability factors in community

Cohen, *et al.* (2006:1403) indicate that factors present before the sexual abuse, such as psychiatric, emotional and social conditions in children and their parents, as well as stressful living conditions, correlate with heightened emotional and behavioural problems after the abuse has taken place. In other words factors on meso and exo levels can complicate the process of dealing with CSA. The families included as participants were exposed to factors in the community such as community violence which increased their vulnerability. Three out of the four families attested to the fact that their existing living conditions and external influences negatively affected the processing of the sexual trauma. For example, family 1 strongly emphasised that their daily experience of, and exposure to gang violence in the community and poverty is keeping them from functioning optimally. These external factors are relevant in terms of their impact on the functioning of families, especially when taking into account the view of Lewis (2009:14), who states that the functioning of the family within their environment after abuse is a good indication of the manner in which the individual's symptoms will be handled.

Cumulative stress and trauma can complicate families affected by CSA's integration of a specific traumatic event, in this case CSA. Cook-Cottone (2004:128) refers to cumulative trauma as the experience of a sequence of traumatic events, with every incident causing the individual to become more vulnerable. The participants indicated that stressful life events (cumulative stress), such as gun shootings, drugs and on-going violence in the community have an additional negative effect on their behavioural and emotional status and coping strategies, after abuse. The following conversations were shared with the researcher:

There are so many confusing feelings, so many drugs, gun firing and ugly things, I cannot even send my son to Shoprite, and they will think he is a gangster, they will hurt him. To work through their daily problems in the community leaves no time for discussions about Nicci's condition (Johanna, foster mother of victim, family 1)

This past Friday they pressed a gun to my head. It makes me feel as if I cannot set foot outside the house (Errol, older brother of victim, family 1)

Even on my way to this session we were caught up in-between a gang shooting. It makes us feel very unsafe and scared (Errol, older brother of victim, family 1)

When the children get out of school, they are robbed. Cell phones or money are taken and most of the time they are also beaten. How can they even think about what has happened to Nicci; there is too little time to become quiet (Winnie, sister of the victim, family 1)

Cohen *et al.* (2006:738) indicate that the child's handling of the trauma might be influenced by exposure to other violence and threats in the community. More so, Cook *et al.* (2005:390) talk about cumulative impairment, which can be caused by psychiatric illnesses, family problems and the on-going experiencing of trauma. These authors furthermore state that one should not view the trauma framework of the families of sexual abuse in a one-dimensional manner, but that the victim and the

family's living conditions should be viewed holistically. Figley and Figley (2009:173) define trauma as follows: “trauma is by nature interpersonal and is, therefore, a systemic entity”. In this article, the family is seen through a systemic lens and the influence of society has a significant influence on how traumas are handled. More specifically, the knowledge pertaining to the manner in which the emotional system functions within the family reveals new and more efficient options for problem-solving in the families.

Other mediating variables that can influence the response to CSA are economic status, living conditions and basic day-to-day needs of the family. This concurs with the view of James and MacKinnon (2012:190), who introduced the 'trauma lens' that should be included in interventions in order to get a holistic image of all the traumas that the family experiences, and not only the trauma caused by the sexual abuse. When looking at families holistically, the families are seen as a unit that forms part of a holistic and interactive environment (field). The 'field theory' provides a framework wherein any event, experience or system can be studied and it is a way of understanding the experience of the individual as part of his or her context (Yontef & Jacobs 2008:333). The Lewinian approach, as described by Robine (2008:116-117), considers the field as a field of forces that are forced onto a certain given subject, with subjectivity as highly regarded in the way that every entity that is part of the field perceives his/her field. In other words, Yontef (1993:295) defines the field as follows: “A totality of mutually influencing forces that together form a unified interactive whole.” Seemingly personal traumas and vulnerabilities that the families have to live with on a daily basis can have a negative impact on the ability to provide support to one another, as the individuals are overshadowed by their own personal trauma processes. The field consists of multiple factors with complex inter-relationships that have a significant impact on the individuals (Clarkson & Mackewn 2006:42). Therefore, when working with families that have been subjected to CSA, it is important to look at all the different levels in the eco-systemic perspective that might play a role in the way the family members will respond to the trauma caused by CSA.

Family 1 (foster care family) indicated that, even before the sexual abuse incident, they had experienced trauma because of the death of their biological mother. They talked about the emotional load that they already had to process before the sexual abuse. Van der Merwe (2009a:292) states that the trauma event that is experienced by an individual can evoke a series of other memories and complex trauma moments. For example, the emotional vulnerability, caused by the mother's death and the fact that they have no contact with their father, may be exacerbated by the trauma of the sexual abuse or can place renewed focus on their fragile states. Participating family members in family 1 commented on their bereavement:

How should they feel? Their mother passed away and their father wants nothing to do with them (Johanna, foster mother of victim, family 1)

The children's father is dead to them; he does not even know what is going on in their lives. He does not even know what had happened to Nicci (Johanna, foster mother of victim, family 1)

I have not even really cried about my mother, and now this thing with Nicci, it just makes it worse (Errol, brother of victim, family 1)

Participants from family 2 indicated that, before the abuse, they had experienced trauma because of the serious life-threatening illness of their mother. The illness of the mother already had a negative impact on the family as a system, prior to the abuse. In addition to this, the mother trusted the perpetrator and his family to take care of her daughter while she was hospitalised due to cancer. Instead, she was betrayed by them, as this was when the abuse occurred. The views of participants of family 2 are as follows:

I was in hospital; I could not attend to her needs. I made the decision to move in with a friend to look after her as I was a single mom, but I could not protect her (Marcha, mother of victim, family 2)

I was bed-ridden and so ill and needed help for my child. While I was fighting for my life, he was doing it. How can anyone forgive someone for that? (Marcha, mother of victim, family 2)

While this happened to me, my mom was in hospital with cancer. I felt so scared and lonely (Cayla, victim, family 2)

I had this feeling and thought that my mom was dying, and he took advantage of me in a time when I was vulnerable. That makes what happened to me, even worse (Cayla, victim, family 2)

Stressful life events, such as CSA, loss or terminal illness of a caregiver in a family can have a negative influence on the family's way of communication, as described below:

Theme 3: Change in family dynamics

Participants indicated that the dynamics within the family changed drastically after the disclosure of CSA. Nine participants attested to the fact that the way they communicated within the family has been influenced after the abuse. These participants commented that their relationship with one another and specifically the victim changed in a negative way after the revelation of the sexual abuse.

Their comments in this regard are as follows:

When we found out about Nicci, everything changed; no-one could speak to each other. I did not know how to react; it was very uncomfortable (Errol, brother of victim, family 1).

We did not know what to ask her (Cindy, sister of victim, family 1).

Everything just became too much and now everyone just does their own thing, almost as if nothing had happened. No-one really speaks of it (Cindy, sister of victim, family 1).

After what happened, I don't always know how to react on normal day to day things, e.g. managing her going out with friends or schoolwork issues (Derrick, stepfather of victim, family 2).

I am almost a teenager and I want to live a normal life. They make me feel caged-in most of the time (Kayla, victim, family 2).

Van der Merwe (2009b:32) indicates that the change in relationships after disclosure of CSA can be caused by the feeling of betrayal of trust that is experienced by the victim. This feeling of mistrust that the victim experiences can serve as protection from other relationships that can prevent further opportunities for violation. On the other hand, Cook *et al.* (2005:395) focus on the inability of caregivers to manage their own trauma appropriately, which can cause the child victim to not communicate about the abuse and other related incidences, to protect their caregivers from being exposed to the hurt they are experiencing. In their words, “the victim has to act as if the abuse never occurred” (Cook *et al.* 2005:395). This inability to trust by the child victim can lead to parents' mutual mistrust in the child that can cause the child victim to feel secretive and removed from the rest of the family (Davies 1995:404). The victim from family 2 indicated that she no longer feels as comfortable to have her family members so emotionally close to her, as she feels more removed and isolated from her family than before the abuse. The victim indicated that she is aware of the fact that she is withdrawing from the family, but that she does not know how to share her 'new' world with them. Herman (2001:96) describes the impact of trauma on the child as follows:

“Repeated trauma in adult life erodes the structure of the personality already formed, but repeated trauma in childhood deforms the personality. The child trapped in an abusive environment is faced with formidable tasks of adaptation”. Therefore, the goals of the broader study, to include the family in interventions within the context of Scathe participants made the following statements based on the changes in their family dynamics and patterns of interaction:

I am really sad, because it changed me and everyone else. We used to be happy. We used to talk about everything (Johanna, foster mother of victim, family 1)

We used to do more stuff together, like riding our bikes or flying the kite, but now I don't feel comfortable if anyone comes into my space, especially not Derrick, because he is a man (Kayla, victim, family 2)

I feel so different, I don't know myself anymore. And I know my mom and step dad do not always know how to be around me, that makes me feel sad (Kayla, victim, family 2)

I don't even play outside with the boys anymore. I am too scared that something will happen to me again. Everything is different now (John, victim, family 4)

The participants attested to the fact that their lack of knowledge about the correct manner to address the problem and their anxiety and uncertainties around what to expect from the forthcoming court experiences negatively affected the dynamics within the family system, which are discussed in the next paragraph of this study.

Theme 4: Experiences of pending court process

Participants clearly experienced **uncertainty, nervousness and stress** related to the court proceedings. Participants indicated that the post-disclosure criminal procedures (investigation and court procedures) had a negative impact on the victim and the rest of the family. Plummer and Eastin

(2007:784) posit that, from their study, it was clear that especially mothers of victims of sexual abuse voiced their dissatisfaction with the way in which the child protection system handled the matter.

All four families involved in this research still await completion of court cases and experience high levels of uncertainty pertaining to the court procedures, dates and what is expected of them as well as the victims. The court processes were drawn out and it was not possible to put therapeutic intervention on hold while these court processes could take years to conclude. The uncertainty about what to expect was clearly voiced by them in the following:

The court case has been going on for nearly two years and still we do not know where in the process we are. Each time there is another investigations officer who has taken over the case (Johanna, foster mother of victim, family 1)

If only we could know what date it will happen, it will already make our lives better. This waiting is killing me (Wendy, sister of victim, family 1)

I wish we knew what to expect, but no one seems to be communicating things to us. I would like the closure for myself, but more so for Kayla, so that she can move on with her life (Peter, step father of victim, family 2)

Jenna is scared, she has no idea of what to expect (Jacoba, mother of victim, family 3)

The court date might be next year, who knows. This time waiting is the worse (Gertrude, grandmother of victim, family 3)

I can't imagine myself standing in front of all those people talking about this. I don't know if I can handle this. I don't even know him that well (Gertrude, grandmother of victim, family 3)

If only they knew what this waiting and uncertainty is doing to us, they will understand how we are feeling (Marcha, mother of victim, family 2).

From the concerns and uncertainties about the court procedure and process, as stated by the participants, it was clear that the **lack of communication from court officials and uncertainty about the time frames** of court processes had a negative impact on the victims and their families. Families 1, 2 and 3 reflected on the uncertainty that was caused by the poor communication between themselves and the investigative system (investigating officer). Jones, *et al.* (2007:1070) and Jones *et al.* (2010:302) concur that poor communication between the investigating officers and the families can have a negative influence on the trauma integration process of the victim and the families.

Families 1 and 3 reflected on their high levels of uncertainty about the set court date, as it constantly changes. In the one instance that they attended court, the court case was postponed for reasons that made them feel uninformed. They mentioned that they were not informed about the expectations of the court procedure, and this caused feelings of anxiety and fear that impeded the ability to work through the trauma. The participants' feedback in this regard is as follows:

I am so worried about the court proceedings, not sure what will happen. How would Kayla know if she is a good enough witness? (Mother of victim, family 2)

I am very nervous about the court procedure. Nicci does not know what to expect (Foster mother of victim, family 1)

I want the case to go ahead, but I just want to know what is happening, as they don't inform us (Shaya, mother of victim, family 4)

We are very nervous about the court case; no-one knows what to expect, but no-one tells us either, and that makes it worse (Jacoba, foster mother of victim, family 1)

Linked to the above, Plummer and Eastin (2007:776), from their study, indicate that:

“Mothers who had had no prior contact with the police, CPS or courts were particularly stunned by the attitudes they encountered and the lack of services provided. Many expressed that after the abuse occurred, they expected that justice would quickly follow and that they would be treated with concern and sensitivity”. Based on the experiences of families regarding their involvement in court proceedings, it seems pertinent that families exposed to CSA need guidance, psycho-education and support from professionals for them to understand the criminal process. Serious changes in the justice system are necessary to limit the time of such proceedings and to make sure that families are fully informed about what is happening. Although, Jones, *et al.* (2010:292) offer a different view from the above research by suggesting that, from their studies, it was found that most caregivers' experiences of sexual abuse investigations and processes were experienced as positive, little positive experiences were evident in the participating families.

Fear of the perpetrator is often linked to court procedures. From the researcher's practical experience it is clear that family members and children exposed to CSA have had contact with perpetrators at courts in unexpected ways, i.e. in the toilets. Even if children testify through intermediaries in the child-friendly room, just knowing that the perpetrator is in the same building can lead to intense anxiety. All the families involved indicated fear of the perpetrator and therefore were uncertain as to how it would be if they see him again, at court or even in their community. The victims from families 1 and 2 revealed strong feelings of fear with regard to the perpetrator, despite the fact that contact between the victim and perpetrator has been suspended. The feedback from the participants is as follows:

I am really afraid to see him; he is nothing of me any longer (Nicci, victim, family 1)

Each time I see him, he looks at me as if to kill me. That was also what he did when he abused me, but now it is worse (Nicci, victim, family 1)

What must I do if I see him again? I will be fine to tell my story, but am scared when I am in court and he is right in front of me. I am not sure if I will be able to do it then (Kayla, victim, family 2)

No-one tells us what to expect at the court, so I hope she does not run into him, because then she will refuse to speak (Johanna, foster mother of victim, family 1)

All the participants expressed the need to distance themselves emotionally and physically from the perpetrators, but they find it difficult to do this because of the court procedure that lies ahead. Members from family 1 mentioned that they were physically exposed to the perpetrator at the court, as there was gun fire at the court and chaos ensued.

It was terrible. The next moment he was walking past her, how will she now again go through this? (Johanna, foster mother of victim, family 1)

Contact with the perpetrator has a negative impact on the victim's integration process and it is necessary that the family and victim should reach a point where they can get closure. In many instances, and as confirmed by one of the participants, the finalisation of the court case adds a degree of closure of the process that can allow the victim and the family to move on with their lives, away from the negative experience caused by CSA.

CONCLUDING REMARKS

This article focused on gaining an understanding of the experiences of CSA of child victims and their family members. It is clear that family members face their own difficulties, dealing with this traumatic event that has an impact on the way in which the child victim is supported. Caregivers indicated that initially after disclosure they experienced shock and disbelief. They also did not feel competent to deal with the trauma and to help their children. They indicated a strong sense of blame and felt responsible for what happened. It seems as if this sense of responsibility took quite a bit of emotional energy away from their supporting role. It was also clear that where parents were also subjected to sexual abuse when they were children, they will need alternative interventions either before or in conjunction with family play therapy, especially if they have not integrated their own experiences. On the one hand, such experiences may become reactivated when they have to deal with the abuse of their children. On the other hand, they may expect the child to react and cope as they had or minimise the child's abuse by thinking or even saying that it was not as severe as their own. It was clear that other traumas, such as bereavement and illnesses and vulnerabilities in their community, such as drugs, gun shootings and gang violence exacerbated the trauma caused by CSA. Changes in the family dynamics appeared significant, as most of the families revealed that the way they were communicating with each other has changed dramatically in the aftermath of the CSA. It was clear that, in most cases, the victims' relationships with their family members changed due to the victims' physical, social and emotional fluctuations that appeared to be misunderstood by the rest of the family members. In most cases, the victims felt isolated and misunderstood. It was significant to notice that all four families were still involved with investigations and court processes. The relentlessness and the constant postponement of the cases caused the family members to feel nervous and exposed. They were unsure of what will happen, which caused feelings of apprehension and uncertainty. Limited knowledge of the court proceedings and a lack of communication from court officials caused anxiety. It was clear that specifically the victims were anxious and fearful to engage in any way with the perpetrator during or after the court proceedings. More studies are needed to understand the effect of CSA on families and direct victims. The complicated dynamics in the aftermath include the challenging forensic processes that can evoke feelings of powerlessness, health issues where aspects such as testing for HIV/AIDS is needed and managing life cycle stages. In order to support families

affected by CSA, social workers and other professionals should take time to enter into dialogue with such families where the complexities of their fields can be heard and understood.

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Article 3: Article 3 will be reviewed by the Journal, Families in Society (Appendix 3)

An integrated family play therapy model within the context of child sexual abuse in South Africa

Fourie, A

The aim of this article is to provide an overview of the framework of an integrated family play therapy prototype as part of the *design and early development and pilot testing phase* of an intervention research process which was implemented with families affected by child sexual abuse (CSA). The families' reflections on how they experienced the family play therapy process and the specific techniques implemented as part of the intervention process will be described in this article.

IMPLICATIONS FOR PRACTICE

- The family play therapy intervention offers an opportunity for families who have been subjected to child sexual abuse, to express and understand their own and each other's experiences and processes, by engaging in the family play therapy process.
- Intervention research is aimed at developing tools for the helping professions. This article highlights the process of intervention research and also outlines a family play therapy intervention for a vulnerable population.

Motivation for the study

The research, of which this article is a product, focused on the development and refinement of a family play therapy model within the context of child sexual abuse (CSA). The systemic nature of this family play therapy intervention affords a holistic perspective on the participant families within the framework of ecological systems theory. In family therapy literature, there was a distinct shift from viewing the so-called individual self as autonomous. As

understanding developed in the dynamics of the family and society, the self was seen as relational and embedded in systems. Important for this study is the postmodern notion that families construct their own life narratives (Rasheed, Rasheed, & Marley, 2011) in an effort to master traumatic events (van der Merwe, 2009a:296). Rasheed et al. (2011:16) value the psychosocial and ecological contexts in understanding individual and family dynamics. Based on the experience of the researcher in practice, and on discussions with social workers specializing in child sexual abuse interventions, it seems as if the direct victim more often has access to intervention than the family members. However, even children who are victims of CSA often cannot be helped immediately, but their names are placed on waiting lists. It seems crucial that the scope of therapeutic interventions with victims of child sexual abuse should be broadened to include family members in the process. This links with the opinion of Ferreira, Ebersöhn, and Oelofsen (2007) that social work interventions that focus on the development of practical guidelines for the assessment and treatment of children and their families who are victims of child sexual abuse need to be expanded. Britz and Joubert (2003) remarked in their study on CSA in South Africa that a pressing need for effective, structured and therapeutic interventions for victims of CSA exists. They furthermore affirmed that the need to expand services in South Africa is required by the pressing numbers of victims of CSA, limited human resources and the high costs of individual interventions. Therefore, the aim is to satisfy or reduce the demand for effective and innovative intervention structures by expanding interventions to include the family.

Research design and methodology

As part of the development and refinement of a family play therapy model, this article outlines the results of the design and early development and pilot testing phase (De Vos & Strydom, 2011; Du Preez & Roux, 2008; Fawcett, Balcazar, Balcazar, White, Paine, Blanchard, & Embree, 1994; Fraser & Galinsky, 2010; Hayes, 1994; Van Rooyen, 1994) of the intervention research process. The families understood the purpose of the research and were willing to provide feedback on their experiences of the sessions. Their feedback was incorporated into the process of refining the prototype and the development of an integrated family play therapy model within the context of CSA in South Africa. More specifically, the focus of the study was on family units where family members were committed to supporting the victim, irrespective of the status of the perpetrator, where individuals in the household acknowledged the abuse and supported the child. The perpetrator or alleged perpetrator was not included in family play therapy.

Approach

In this qualitative study (Creswell et al., 2007; Fouché & Schurink, 2011), theoretical frameworks with possible therapeutic techniques were identified. This was supplemented with input from a literature review and compiled into a prototype. The prototype was implemented with four families affected by CSA. The research was exploratory and descriptive, as explained by Babbie, (2013), Bless, Higson-Smith, and Kagee, (2006), and Rubin and Babbie (2009). The focus was on obtaining input from families exposed to CSA and to describe a preliminary model for integrated family play therapy.

Design

The plan for this research was the intervention research design based on the original Design and Develop (D&D) model of Rothman and Thomas (1994), as also described by Caspi (2008), Corner, Meier, and Galinsky (2004), De Vos and Strydom (2011), Du Preez and Roux (2008), Fawcett et al. (1994), Fraser (2004), Fraser and Galinsky (2010), Fraser et al. (2009), Gilgun and Sands (2012), and Mouton (2001).

The researcher explored the way the participant families reacted to the process and the techniques used during the early development and pilot testing phase of intervention research (De Vos & Strydom, 2011; Du Preez & Roux, 2008; Fraser & Galinsky, 2010; Van Rooyen, 1994). The preliminary family play therapy model is not static, as it forms part of the development and the refinement process.

Participants

Sixteen participants from four different families were engaged in family play therapy processes.

See table 1 for the participant's family members who took part in this study.

Table 1: Participant family members who took part in this study

Family	Age composition of families	Number of sessions
Family 1 Extended foster care family	Biological brother of victim – 17 years Biological brother of victim – 12 years Biological sister of victim – 22 years Biological brother of victim – 4 years Girl cousin of victim – 16 years Foster mother of all 4 children – 56 years Girl victim – 8 years	6 sessions

Family	Age composition of families	Number of sessions
Family 2 Step-family	Stepfather – 47 years Biological mother – 44 years Girl victim – 13 years	6 sessions
Family 3 Single-parent extended family	Biological grandmother – 69 years Biological mother – 41 years Girl victim – 6 years	6 sessions
Family 4 Nuclear family	Biological father – 55 years Biological mother – 46 years Boy victim – 8 years	4 sessions

Each participant family was involved in six sessions of integrated family play therapy, except family four, who withdrew after four sessions due to time and financial constraints. Non-probability sampling (Ritchie, Lewis, & Elam, 2009) with elements of the purposive sampling method, as described by Maree (2007), Ritchie et al. (2009), and Strydom (2011) were used in this study. The identified families were all families with children who experienced sexual abuse, who were identified from an existing client base (of an organization specializing in CSA). Each participant family's composition, structure and dynamics are different. One of the families was an extended, foster care family, one was a single parent family with a grandmother as the primary caregiver and two of the families were nuclear families, with both a mother and a father (one, stepfather). All participating families were at the time of the research still subjected to sexual offences court procedures. All four families were Afrikaans- and English speaking.

Data collection and analysis

Creswell (2007) views the data collection process of the qualitative researcher as a *circle* of interrelated activities aimed at gathering in-depth rich information to answer the research question. Creswell (2007) furthermore states that the data collection method consists of

multiple phases, not just focused on one method. During this data collection process, the researcher was able to observe the process, awareness levels and the dialogue that took place between different individuals that took place during each session. During each family play therapy session, a non-directive approach was followed, during which the researcher focused on each family member's subjective reality and response to the preliminary family play therapy prototype. In total, 22 family play therapy sessions were conducted with families affected by CSA. Rich data could be gathered and used to describe the preliminary family play therapy intervention described in this article. Field notes and video recordings of each family session supported the data collection. A guideline was used as the outline of the application of the preliminary family play therapy model. (See Figure 1). A questionnaire was utilized as a guideline during the evaluation and termination phase of the intervention process.

The work of Braun and Clarke (2006) supports the process of *flexible* thematic analysis that allowed for coding to take place throughout the data analysis process. The rich data gathered during the family play therapy process consisted of the family members' subjective realities of CSA in the form of narratives, in-depth descriptions of their experiences and the responses of the family members to the preliminary family play therapy prototype. After each family play therapy session, the family participants reflected back on their experiences of the session, which was supported by field notes of the researcher. The 22 sessions conducted with the families as well as their constant evaluations of the intervention were transcribed and different categories were identified, viewed and re-viewed. The experiences of the family participants of the techniques were highlighted and described in this article. The information gathered allowed the researcher to further develop and refine the structure and the process of the preliminary family play therapy model, as illustrated and described in this article.

Ethics

Ethical considerations were guided by the researcher's profession as a social worker as she adheres to the South African Council for Social Service Professions code of ethics. Ethical considerations as set out by Babbie (2013), Brinkmann and Kvale (2008), Welman, Kruger, and Mitchell (2005), and Whittaker (2012) were a core feature from the onset of the research in terms of the research process, selection of participants, interviewing and data analysis. Aspects such as no harm to participants, informed consent, confidentiality, the role of the researcher and the possible consequences of the research as described in Strydom (2011), and Brinkmann and Kvale (2008) were crucial in this study.

Participants disclosed intimate details of their experiences of CSA, which caused some participants to get emotional. The researcher responded respectfully towards such situations by allowing and facilitating family members to serve as a support for each other during the sessions and acted as an additional support. She also made use of her skills and experience as social worker. The information provided by the participants was handled as confidential as the researcher made sure that the details of the participants were kept anonymous. No participant was in any way forced to part take in the study. All participants voluntarily signed a consent form to participate in the research and reassurance was given by the researcher that they could end their participation in the study at any time. The social workers at the organization were willing to follow up, where needed.

Integrated family play therapy model

The theoretical paradigm for the family play therapy intervention as it emerged from the literature review and discussions with professionals working in the field of CSA, guided the researcher to integrate elements of a gestalt intervention process (Yontef, 1993, 1998, 2002)

with particular emphasis on the constructs awareness and dialogue within an intervention process. This was combined with the work of Hepworth, Rooney, Rooney, and Strom-Gottfried (2013) in terms of a social work intervention process and the historical work of Dennison (1989), who offered a structured yet individualized approach to intervention. The Dennison model allows for a balanced focus on the helping process as well as on the problems or needs of each family supported by creative techniques. Van der Merwe (1991, 1999) applied the Dennison model respectively within the contexts of divorce and trauma. Dennison (1989) allows for a focus on process- and problem-related goals where process goals are the primary focus in the beginning and final phases of intervention (See Table 1). In the change-oriented phase, the primary goal is to address needs and problems while still attending secondarily to the helping process with process goals (Van der Merwe, 1999). This fluctuation between goals allows for individualization according to the needs of each client system.

The helping process as described by Hepworth et al. (2013) was used as a framework (initial, change-oriented and final phase), which shaped the process to support the attainment of therapeutic goals relating to the problem (van der Merwe, 1999), in this case child sexual abuse. (See appendix Figure 1). Using the helping process of Hepworth (2013), Johnson and Yanca (2010), and Lowery (2002), allowed for the inclusion of other perspectives such as the Dennison model (1989), the sequentially planned integrative counselling for children (SPICC) model (Geldard & Geldard, 2010) and gestalt therapy theory (Parlett & Lee, 2005:440; Yontef, 1993: 283-343). This will ensure that family members will be motivated to take part, that relationships with the social worker will be formed and those aspects such as contracting and limits in intervention will receive adequate attention. Process goals are typically supported by techniques aimed at relaxation and fun, but also on contracting. Towards the end of a session, the process goal of reducing therapeutic intensity can be achieved by

techniques such as hitting newspapers and blowing bubbles. It was therefore necessary to identify specific **techniques** and to place them within a preliminary framework in readiness to be used with families affected by CSA. Carson (1999), and Ariel (2005) emphasize that the structure and process of family play therapy should ideally include a range of creative intervention techniques aimed at making the therapeutic process more attractive and accessible and to raise awareness in the 'here and now' as part of the gestalt therapy process (Blom, 2006). Family members can be involved in play with media such as hand puppets, sand-tray work, painting, drawing exercises, clay or other forms of art. In this regard, Gil (2006) and Gil (2011), state that the utilization of different play therapy techniques can serve as a bridge between the creative, non-verbal world of the child and the verbal world of the adult, which could lead to a new interaction process that holds benefits for all parties involved. Thus, the goals and therefore the techniques that will be used will be different during each session and cannot be included in the systematic description of the family play therapy model. A manualised intervention is not indicated as individualization is a primary concern. The choice and forms of play and techniques for each family were determined by specific variables in their direct environment. In essence, the techniques were based on each family's unique process and foreground needs and the processes of the individual family members. This is typical to the gestalt approach as well as the social work principle of individualization and self-determination of the clients (Van der Merwe, 1999:430-431). Therefore, the table and figure included here serve as a broad structure that will be adapted to each family, although the broader process will stay the same.

Fundamentals of family play therapy model

The fundamentals of a social work practice model, such as the beginning, change-oriented and termination phases, as presented by Hepworth et al. (2013), provided the ground structure for a family play therapy intervention. It is important to remember that social workers should

use all their micro-skills when applying family play therapy. This is not outlined further, but includes aspects such as reflective listening, empathy, verbal following and exploring skills (Hepworth, 2013). The SPICC model, developed by Geldard and Geldard (2010), was incorporated alongside the social work practice model (Hepworth et al., 2013) throughout the family play therapy process, and serves as one of the directive/guiding theoretical approaches. The SPICC model is integrated and allows for the incorporation of different therapeutic approaches, e.g. person-centered approach; narrative interventions; cognitive behavior therapy, and gestalt therapy to support the already defined process. Figure 1 illustrates the family play therapy prototype that served as structure for intervention

Figure 1: Application of the preliminary family play therapy model

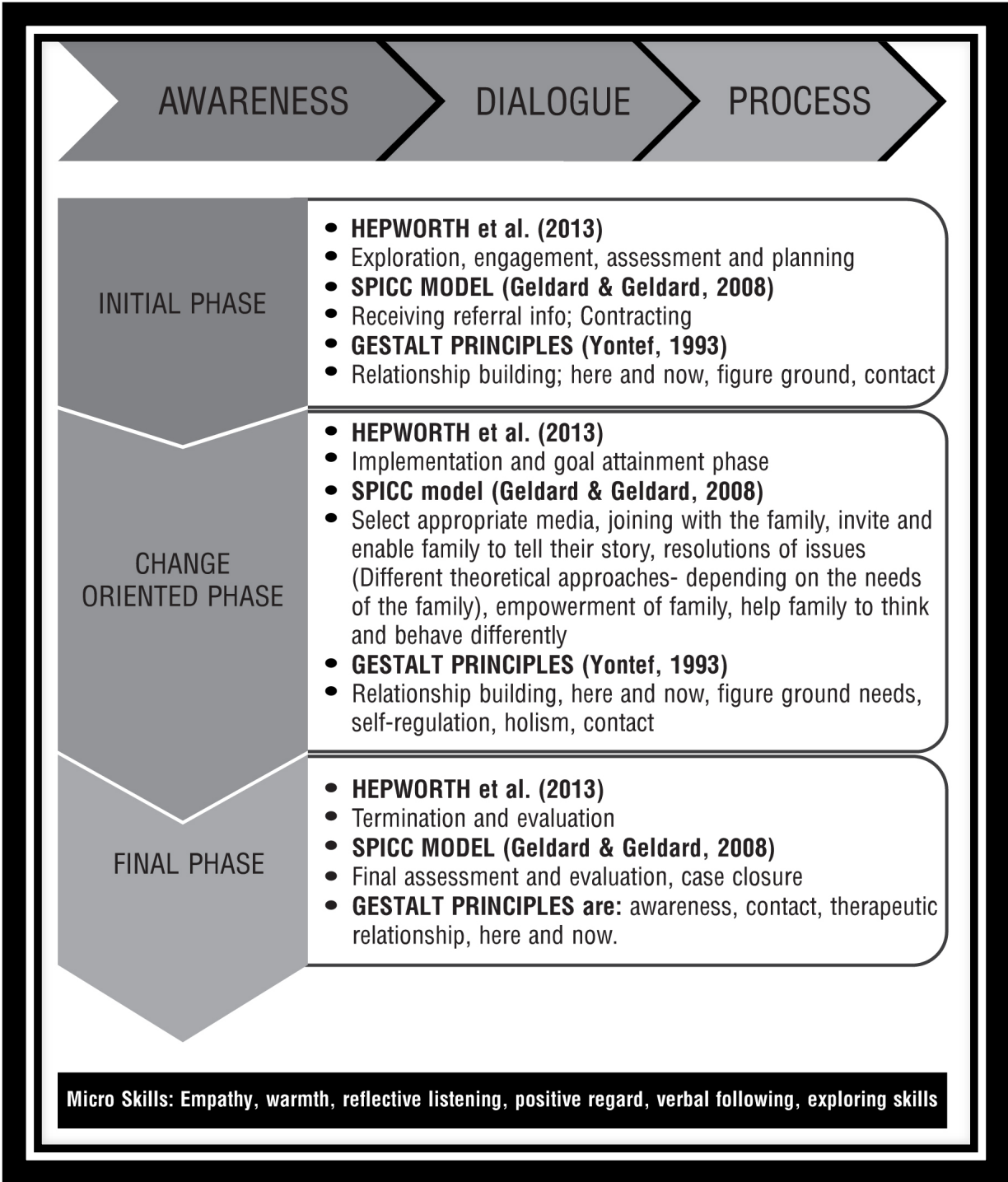


Table 2: Process and problem goals based on Dennison practice model (1989)

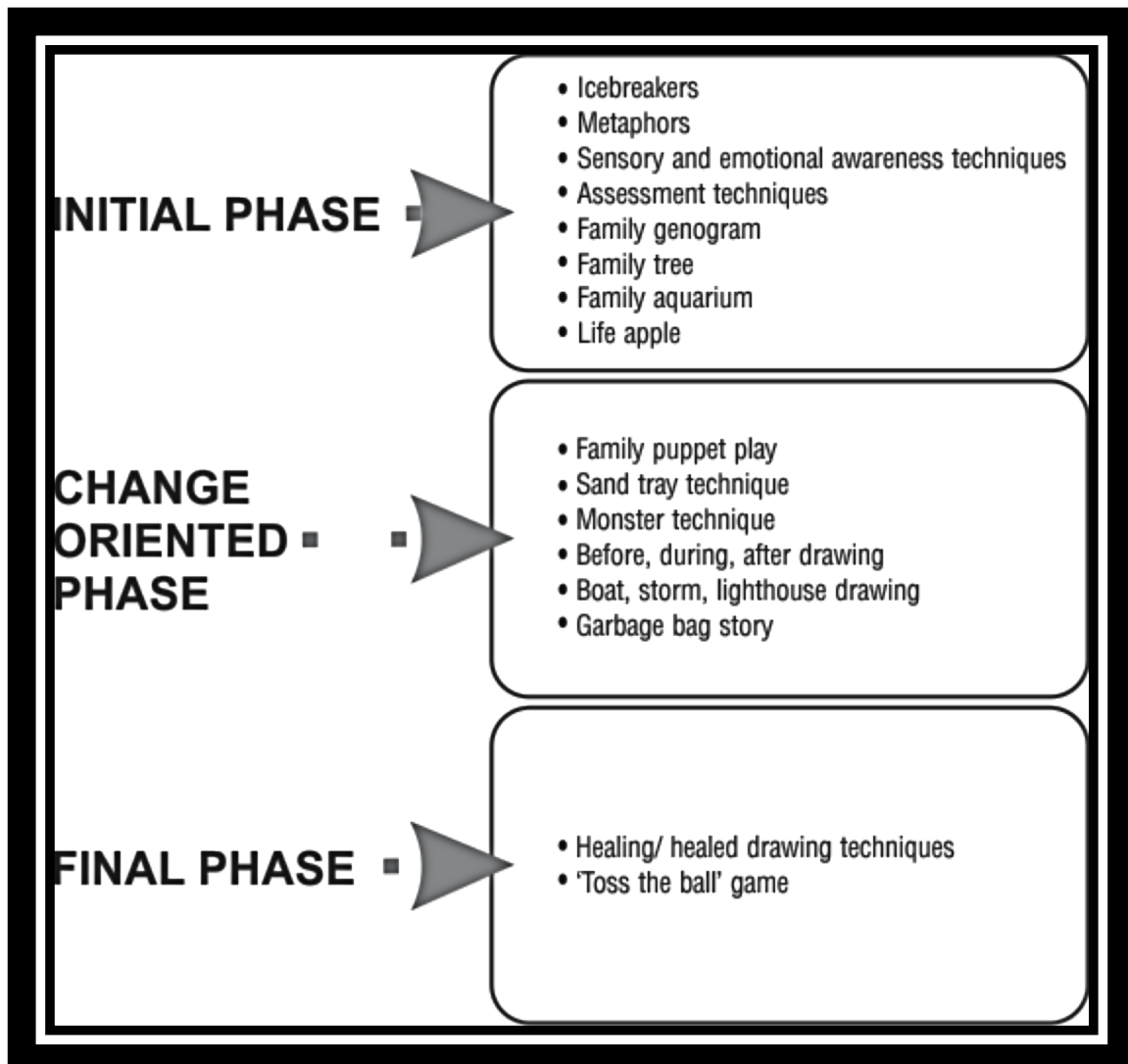
INITIAL PHASE	CHANGE ORIENTATED PHASE	FINAL PHASE
<p>PROCESS GOALS</p> <ul style="list-style-type: none"> • Establish contact • Motivate to become involved • Building relationship • Contracting • Create safe, fun environment • Boundary setting 	<p>PROCESS GOALS</p> <ul style="list-style-type: none"> • Encourage problem focused play • Work through traumatic experience • Resolve problems • Work- solution focused • Focus on strengths and abilities of family 	<p>PROCESS GOALS</p> <ul style="list-style-type: none"> • Assess progress & Experiences of process • Deal with feelings and emotions re. termination
<p>PROBLEM GOALS</p> <ul style="list-style-type: none"> • Gather information of family Identify needs; foreground needs • Assessment work 	<p>PROBLEM GOALS</p> <ul style="list-style-type: none"> • Address problems, using play, problem solving skills and process 	<p>PROBLEM GOALS</p> <ul style="list-style-type: none"> • Referral to appropriate source • Discuss open door policy

Table 2 is an indication of the different problem and process goals that aided as a guidance for the researcher during each phase and session.

Family play therapy techniques

Techniques (Figure 2) are explained below as part of the different phases integrated in family play therapy model. This is an overview of possible techniques to indicate how such techniques can be used within the helping process. Social workers will be able to add techniques from their repertoire of techniques for play interventions. Techniques should, however, never be implemented in a recipe book way, but should be grounded in therapeutic processes embedded in theoretical approaches. Important here are the experiences of the participant families when they were involved in family play therapy sessions. They reflected after each session on how they experienced the process and the specific techniques. Some of the techniques that stood out during the family play therapy process and the family participants' experiences of the techniques are described in more detail below. These techniques were aimed at achieving the goals mentioned in Table 1.

Figure 2: Family play therapy techniques in different phases



INITIAL PHASE

Icebreakers and assessment techniques (Lowenstein, 2008) are used in the beginning and the end phases of each session and can be used during the initial and final phases of the intervention, as stated by Van der Merwe (1999). It creates a fun, non-threatening environment that is safe and non-judgmental in which the family members can share, learn, and explore their personal experiences. It facilitates the building of the therapeutic relationship that may lead to the family members being more open to communication, which

supports the attainment of process goals, e.g. to encourage participants to take part in the activities. Some of the suggested icebreakers and assessment techniques are described as follows:

Icebreakers

Blom (2006), and Joyce and Sills (2010) define contact-making (sensory techniques) as an important part of the gestalt process and as a good indicator of the individual's process. They furthermore propose that nothing in a session can take place without contact. This resonates with the gestalt approach, which focuses on the development of sensory and emotional awareness and, according to Blom (2006), and Joyce and Sills (2010), add specific value to the holistic (thoughts, body, mind and emotions) functioning of the individual, which could create contact. The social worker should allow family members to use their own creativity and space in these activities. Activities such as finger painting, the use of sand, water and clay, walking barefoot on different textures, such as sand, stones, feathers, pillows or smelling and tasting different flavors (oranges, lemons etc.) can be applied to have fun and for the family to experience positive touch and to get into contact with the process. It facilitates open communication, lowers defenses, reduces anxiety, incorporates humor, creates playfulness, and provides insight into individual and family dynamics (Gil, 2006; Lowenstein & Post-Sprunk, 2010; Ariel, 2005). Care should be taken regarding possible traumatic reactivation for victims, as the senses capture possible triggers. When this is interpreted by the primitive brain (amygdala), such input is typically responded to without context, time and place as traumatic memory. However, reclaiming the senses should also be part of post-trauma intervention and can be helpful when integrating traumatic memories (Van der Merwe, 2009).

Family 1, specifically, responded well to the techniques as it allowed the family members to express their positive feelings, which formed part of the feeling work. The techniques

supported process goals such as grounding individuals, facilitating relationship building and creating communication between family members.

The **Dustbin metaphor** was used when the negative feelings that the family members felt were compared to *rubbish* in a bin. The goal is to remove the lid and to *clean* the bin out. The rubbish bin was used as an analogy of the current state of their heart, soul and minds. The family members reacted to the metaphor, agreeing that the *rubbish* in the bin is the same as the *yukky* stuff (feelings and emotions) in their lives, caused by CSA. It created the opportunity for the family members to understand the concept of the helping process (that they are here to be helped and guided to reach trauma integration) and to identify the *rubbish* in their lives, for goals to be formulated accordingly. This metaphor was used by the researcher with three of the families with young victims. Families 3 and 4 responded well to this metaphor and the analogy served as a *safe* word for the victims to use every time they had to talk about hurtful content. Within the context of strengths-based work, it will also be pertinent to work with the positives and to involve families in processes where they can make sunshine bags where strengths and assets will be explored.

Assessment techniques

During the initial phase of the social work model, the process goals of establishing a relationship, creating a safe space and motivating family members to get involved in the intervention process can be attained, while the use of different assessment play techniques, as defined by Van der Merwe (1999), will determine the needs of the family. Gitterman (2011), Germain and Gitterman (1996), Watson and West (2006) emphasise that it is important for the social worker to obtain information of the problem, in this case, sexual abuse in relation to the functioning of the family as part of their environment. In contrast with the view of Gitterman (2011), Grant and Cadell (2009), and Graybeal (2001) affirmed the importance for

social workers to move away from the *pathological worldview* (Grant & Cadel, 2009), which focuses on 'what is wrong with me' and needs to be replaced it with, 'what is going well in my life'. In other words, social workers are challenged to focus on alternative strength-based assessments (Graybeal, 2001) and to move away from the use of assessment processes based on the medical model. Therefore, assessments should be adapted to reflect a more holistic strength-based social work perspective. Graybeal (2001) outlines the ROPES model, which can be used as an acronym for the assessments of strengths, namely **R**esources, **O**pportunities, **P**ossibilities, **E**xceptions and **S**olutions. In this case, the content goals in relation to sexual abuse might change over time, as the needs of the family can change throughout the process. This links with Watson and West (2006), and Hepworth et al. (2013), who state that assessment is a process that does not always have to be seen in a logical manner. Therefore, assessment play should be used in the initial phases of the helping process as it will help determine the intervention strategies that are suitable for the needs of each family. In the final phases of intervention, assessment play can be used to evaluate the progress toward trauma integration (van der Merwe, 1999).

The **family gift** technique was also used for assessment and started with the family being instructed to make a *gift* (Lowenstein & Post-Sprunk, 2010). The family members were then asked to explain their own experiences of creating the gift together as a family. The process goals of establishing a therapeutic relationship and to make the family members feel safe and comfortable were obtained through the dialogue that was established between the family members and the researcher. It provided a tool with which the researcher could observe the family interactions and dynamics as identified by Lowenstein and Post-Sprunk (2010). From the information gathered, specific process and content goals that should address the identified needs of the family could be developed. In Family 2, the tension between the victim and the

stepfather was apparent. This technique created the opportunity for the researcher to get a broad overview of the miscommunication, conflict issues and alliances in the family.

During the **family puppet interview**, the researcher instructed the family to create a story with different hand puppets. The **family puppet interview** (Irwin & Malloy, 1975, 1994; Christensen & Thorngren, 2000; Sori, 2006; 2010 and storytelling process created the opportunity for the family members to create a dialogue in the form of narratives during which the social worker could make meaning of the family's stories and related issues. Such dialogue emerged in this study when the family puppet show with family 4 (a family that does not naturally communicate easily) created a dialogue between puppets depicting a very angry father and a very quiet son (victim). It was as if the safe environment and the fact that it was the 'puppets talking' provided the opportunity for the father and son to interact verbally. The victim in the puppet show even verbalized his feelings of anger and resentment towards the perpetrators who hurt him. It is this metaphor or the fact that the family stayed within the characters, which made it easier to talk and to express feelings and emotions as also mentioned by Christensen and Thorngren (2000). The family puppet interview technique encouraged projection and helped the family members gain insight into the dynamics and interpersonal relationships between family members through the puppet characters (Gil, 2006; Christensen & Thorngren, 2000; Gil, 1994; Lowenstein & Post Sprunk, 2010; Sori, 2010).

The **family genogram** (McGoldrick, Gerson, & Petry, 2008) provides a graphic picture of the family history and enhances the understanding of patterns in families. The genograms are used to assess the family situation, dynamics and role division (Gil, 2006; Rotter & Bush, 2000). Through symbols it creates a basic structure of three or more generations. This tool could link with the ecological and gestalt field approach, as an illustration is provided of the family as part of the environment they form part of. Gil (2006) developed the play genogram in which miniature toys are used to play out the structure of the family. The family is asked

to draw their own genogram and is then asked to use miniature objects to represent positive and negative attributes of each family member in the genogram. With this, a pattern emerges of different family members and the dynamics between them. Geldard and Geldard (2010:51) mention that the genogram provides the opportunity for family members to tell their story and to classify their experiences within their system. Related to the genogram is the eco-map, which was also originally explained by Hartman (1995) with roots in the work of Satir (Minuchin, 1974). Eco-maps could be applicable within the context of family play therapy, especially when used with small play items used to portray the embedded, nested systems in which the family functions. The heartstring exercise (Hobday & Ollier, 1998 as cited in Newby, Coetzer, Daisley, & Weatherhead, 2013) ties in with the eco-map techniques and is useful to gather relational information on families and children. This technique entails that each family member draws circles to indicate which persons in their life space are emotionally close to them. They can also indicate people with whom there is not a close relationship. Family sculpture was used years ago by Satir as a tool to help families portray relationships, rules, roles, communication and general family dynamics. One member would use facial expression, body movement, gestures and would place different family members in different positions to portray relationships (Rasheed, Rasheed, & Marley, 2011). In a sense, this is an eco-map springing to life with real family members. Within the context of CSA, it could be helpful if family members visually portray their support for the victim with variations of family sculpting.

During the **feelings tree** activity (Kaduson & Schaefer, 2006), family members were asked to draw a picture of a tree and to proceed to create an illustration of their feelings and emotions, using different colored clay balls in the picture. In family 4, where the victim was reluctant to talk about anything, this technique created the opportunity for him to create his world of feelings and emotions. He created a tree of the clay color, blue (sad), white (frustrated) and

green (anger). This visual illustration of his own creation of his inner feelings and emotions that he finds so difficult to express verbally, raised his awareness about what he felt and the technique allowed him to express and share his feelings and emotions in an unthreatening way. It also created the opportunity for the father to get involved in the process and to observe the expression of the victim's emotions as is evident from the following excerpt.

Family 4: R: *I can see that the overall feeling on your tree is sadness? I see a lot of blue clay balls. What makes you feel sad?*

Victim: *When I get hurt. R: In what way do you get hurt? V: When I fall or when someone pushes me. R: Then it is sore on your body? V: Yes. R: And it makes you feel green and blue? V: Yes. It is all the 'yukky' stuff'. R: All the 'yukky' stuff' you want to shake off? V: Yes, I don't want to feel sad anymore. R: What else makes you feel blue? V: When I think of what happened. R: What colors do you feel then? V: White R: Frustrated? What makes you feel frustrated? V: When I think of the boys who did it to me, I want to get back at them and I want these feelings to go away.*

The change-oriented phase is the next phase of the family play therapy process and will be described in combination with the detailed description of the techniques used in this specific phase:

Change-oriented phase

According to Dennison (1989), and van der Merwe (1999), process goals are secondary in the change-oriented phase. It is important to make sure that the helping process is still supported by process goals especially in the beginning and end of each session, where it is for instance necessary to ensure that therapeutic intensity of sessions is managed appropriately. However,

in the change-oriented phase of intervention, the problem, in this case child sexual abuse, will be the focus with discussions and techniques aimed at the problem. Techniques discussed with focus and discussion group participants and literature, such as the following, can be considered:

The **garbage bag technique** (Kaduson, 2006) allowed the family to display rubbish bags filled with different types of *rubbish* that they had to create from colourful paper and different miniature objects. The family collectively picked out the *garbage* in their lives, following a display of a rubbish bin. A conversation (dialogue) of the identified *garbage* followed. Family 2 utilized this technique as they struggled in the beginning as apprehensiveness came from the stepfather who thought that it was *child's play*'. It appealed to the victim and the mother and in the end the stepfather verbalised that he had a great experience and emotional expression during the activity. It took time for him to lower his guard and to become part of the process that the victim and the mother were deeply engaged in. The aim was to raise the family's awareness about the negative feelings and experiences in their lives (Kaduson, 2006) and to motivate them to find appropriate solutions. In the case of family 2, the social worker developed the content goals by focusing on their trauma responses to the sexual abuse and to guide them through the expression of their feelings during the garbage bag activity. This tool fits in with the contextual approach of this study as part of identifying the life spaces of the traumatized family members.

Some of their own words during the use of this technique are provided below:

***Family 2: Mom:** Most of this 'yukky stuff' in our lives is caused by the sexual abuse. It was never like this before. **Dad:** We can handle the day-to-day problems with C (victim), but the biggest problem in my life at the moment is the perpetrator, who was a very good friend of mine. The fact that it happened to her, and the fact that I don't always understand how she feels and also the feelings of guilt. **Mom:** Everything has changed between us [family], we are not as close as we used to be. **V:** I feel distant from my mom and dad and it is the sexual abuse that I can't always share with them. They won't understand. **F:** Now to hear that makes me feel extremely sad and helpless...*

During the **boat, storm and lighthouse drawing technique** (Lowenstein, 2011), family 4 drew a picture of a storm, lighthouse and a boat. The family members proceeded to create a story from the picture drawn. The researcher found it difficult to build a relationship with the victim and the father, as they were both resistant and reluctant to engage in the process as the father was not open to communication in the beginning of the process. It was clear that the mother in this family was completely isolated and *not heard* by the father and the son (victim). The researcher created a dialogue with the family members by *entering* the story dialogue formed between the family members and the researcher, to help them engage in the process and to enable them to tell their story as they identified problem areas in their lives. Content goals, as defined by Dennison (1989) in Van der Merwe (1999), should focus on the identified needs, e.g. feelings and emotions and risk areas and negative dynamics in the family. More specifically, these goals should be obtained in order to empower the family, and to help them resolve issues (Post Sprunk, 2010a) by using different activities based on the specific need. In this case, the family was empowered as an opportunity was created for them to communicate in a safe space, without judgment. Each family member had a chance to

express their foreground needs and complexities in their lives. A brief description of the story that was created by the family members during this technique follows:

Family 3: Father: *It was a dark stormy night, a boat went boating, and it was full moon. V: A boat went boating, and then a big wave came and almost knocked the boat over. Then he saw a lighthouse calling him, flashing his lights on him. It was a rainy, dark night. The boy turned into a werewolf and felt stronger than anything going on around him, he fell out of the boat and swam away, towards the lighthouse. R: What happened in the story? V: Someone rescued him. Mom: The sea rescue. Like the help we are getting from you and this organisation. R: That is right, but dad, how would you help the boy in the stormy sea? D: I will try my best to prevent the boat from tipping and to keep everyone afloat, especially my children. R: It is a great analogy for what is happening in your lives regarding the CSA? Think about real solutions for the situation your family is currently in, regarding the CSA. (The researcher then placed the focus on the positive things that came from the story and with the family members discussed solutions for the problems identified).*

Family sand play technique. The family was instructed to create a story in the sand tray by using different miniature objects. In the dialogue that ensued, family members and the researcher co-created a mutual story as suggested by Carey (2009). Each participant had a chance to tell or change the storyline. In the case of family 2, the victim *directed* the story in the sand, as also described by Carey (2006), and the mother completed it, by changing the story in a positive and solution-focused way. During this session, the family members had the opportunity to identify and express their feelings in the sand, while the rest of the family could get a sense of their emotional expressions of CSA. The solution portrayed in the sand by the mother was to create an environment that is safe, protective and nurturing for the victim. Some aspects of the *story* created by family 2 are described below:

Family 2: Victim: *My mom, stepdad and their dog are on the one side and she is placed on the complete opposite side on a little boat with a rock on it, busy sinking with lots of sharks and dangerous sea creatures swimming around her. Mom then intervened and changed the creation/story by taking all four sharks and put their heads in the sand and placed the victim back on the one side of the sand tray with the rest of the family on the boat, without the rock and with dolphins swimming around the boat. The researcher then explored the replacement of the sharks with dolphins and mom answered that it is put there to protect their family against the sharks.*

The **monster technique** is used to help the family or individual family members to express a feeling that they deem as unacceptable in their lives. It is a way for the individuals to express what they feel, to raise their awareness levels and to enhance self-nurturing (Blom, 2006). Family 2 was instructed to draw a *monster* in their lives together on a big sheet of paper. They drew a black monster, with a black heart, with red around the teeth, lips and red eyes. This was a clear expression of their feelings of anger and hatred towards the perpetrator. The collaboration of the family provided a space for the victim to express emotion reflective of her own process. The victim continued expressing her feelings of anger as she became more in contact with the process by scribbling continuously over the drawing, while everyone else observed her process in silence (See appendix 5-photo evidence). She showed anger, which can be indicative of pent-up emotion. It was interesting to note the family dynamics here. As the victim became more and more involved in the drawing, writing words of anger and hate towards the perpetrator, the family members provided a holding environment together with the researcher. In this lengthy session, the family members also reacted emotionally and became involved again in the drawing process. The researcher asked them to engage in dialogue with monster drawing. The family members were then given the opportunity to

express their negative feelings and emotions onto the monster drawing. This session was profound as the emotional expression towards the perpetrator was raised and all the family members were deeply involved and in contact with the process. Some of the family members reacted emotionally during this stage as they started crying and showing empathy towards the child victim. The victim continued until the researcher urged all the family members to tear or cut the piece of paper and to collectively express their anger towards the perpetrator. Thereafter, the session was closed with a relaxation technique. For family 3, the monster technique created the opportunity for the family as a whole to collectively express feelings and emotions. The technique created the chance for every family member to observe the different feelings and emotions as they were verbally and visually expressed by the different family members. It also gave them the opportunity to relate to the feelings of others; in this case, the feelings of hatred, anger, resentment and frustration towards the perpetrator. For the first time, the grandmother and the biological mother observed the emotional expression of the victim, which caused the family members to get emotional. This observation allowed the family to develop a greater understanding of the feelings towards the perpetrator.

The final phase of the family play therapy process entails the termination and the evaluation of the process. Van der Merwe (1999) explains that the final phase is where the clients should reach a stage where the traumatic experience is managed, where the traumatic memories are less reactive and the event can be viewed as a painful part of the life history that does not cloud every day, but that can be openly discussed as needed.

Final phase

In the final phase of the intervention, it is important to focus on the process goals, such as creating a safe space in which the experience of the family therapy process can be evaluated and to help the family feel comfortable and to manage emotional intensity. Authors such as Lockhart and Danis (2010) describe evaluation as the discussion with the clients about the attainment of their goals and objectives during the intervention process.

The **healing drawing activity** (Lowenstein, 2010) was utilized with three of the four families. Each family member was asked to draw a picture of the family before and after the intervention process. The two illustrations were discussed with the researcher. After the drawing was completed, the families were asked to identify the differences and similarities in their drawings. Families 2 and 3 responded well to this technique as their input during this phase was substantial. The technique helped to evaluate how the family felt before and after the therapeutic process, as it helped the family to assess the changes that have taken place throughout the intervention process. During these sessions, the awareness levels of the families were raised on how they overcame their adversity and it gave the opportunity for the family members to evaluate their own experiences to trauma integration. It helped the families to identify the growth, strengths and endurance of the family as different changes took place during the family play therapy process. The researcher focused on the positive reinforcement of this change in the lives of the families (Lowenstein & Sprunk, 2010; Gil & Sobol, 2005). The feedback from the family members in family 2 was as follows:

Family 2: R: *What similarities and differences in the two pictures can be identified? Mom:* *The healed family drawing [after intervention]: blue skies, colourful flowers, hearts, and sunshine. R: And from the healing [before intervention] family drawing? V: Dead people, black skies, broken hearts, graves and blood. R: Describe the wounded family picture in three words. V: Death, crying and dark. R: And the healed family drawing: Love, happiness and brightness. Where are you as family in the process? Mother:* *More the healed family side, as we have come so far and have stuck together through the hard times. V: We as a family have definitely learnt to listen to each other and have started to understand each other's feelings. Dad:* *Yes, before we started this process, we could not even talk about what happened; now we are more comfortable to talk about it. Mom:* *Also, being here made me realise how extremely sad the [victim] is and how much pain she is carrying with her. R: What advice can you give to another family that is suffering from trauma caused by CSA? V: Tell them to come to you!! M: Tell them to hang in there and to know that things will get better.*

Other techniques such as the '**toss the ball game**' (Post Sprunk, 2010b) can also be utilized during the final phase of family play therapy interventions. This entails that the ball is tossed from one family member to another. The person who catches it must give feedback about the therapeutic session and process. This turns the ball game into a tool to get feedback on the process. It helps to identify the emotions of family members in terms of the therapeutic process and each session. Families 1 and 3 utilized this technique during the termination of the family play therapy process. The family members were open to expressing their feelings and to identify their experiences of the process. It also created a fun space with laughter and happiness. Some of the feedback provided by the family members when catching the ball was as follows:

Family 1: Sister: *I loved coming every week. Brother:* *It made me realise how important our family is. Mom:* *My family has opened up and I have learned so much about them all. About where they all are in their lives. Victim:* *I enjoyed talking about it. I feel better now. Sister:* *My family loves me and that feels good. Brother:* *I want to protect my family, especially N [victim]. Mom:* *This therapy has changed my life and the lives of my family for the better.*

Implications for social work

The serious under provision of social work services in South Africa emphasized the need for innovative approaches that could include the family. The need for such innovative approaches is based on the high incidence of child sexual abuse, and the under provision of resources to this vulnerable group in South Africa. The need for social workers to expand their interventions dates back as far as the 1960s, during which the social worker, Virginia Satir (Neukrug, 2011; Rasheed, et al., 2011), played an important role in the inclusion of the family (communication) in therapy (Neukrug, 2011). When working from a postmodern approach, the social worker should use systems approaches critically in order to not fall into the trap of seeing families in a mechanical way and the helper is the expert (Neukrug, 2011; Rasheed et al, 2011). The responsibility should be on the family to make the change. In other words, social workers should place less emphasis on the causal factors by focusing on the context of the family. Allowing the family to co-construct the meaning they give to their experiences, perceptions and ideas within their environment can occur through ongoing dialogue and non-verbal interaction during intervention and by including narrative and gestalt approaches. The preliminary family play therapy intervention offers an opportunity for families who have been subjected to child sexual abuse, to understand their own and each other's experiences and processes, by engaging in the family play therapy process.

CONCLUSION

In this study, the family play therapy prototype was implemented with four families subjected to child sexual abuse. During each phase and session of the process, the social work process as described by (Hepworth et al., 2013) was integrated with components of the SPICC model (Geldard & Geldard, 2010) and the gestalt therapy process, which included different gestalt principles, depending on the process of each family. The gestalt process of dialogue, process and awareness (Yontef, 1993) guided the researcher during each session. The techniques were specifically chosen according to the specific therapeutic goal (problem or the content goals, Table 1), specific phase, session and the foreground needs of the family. Important here were the experiences of the participating families when they were involved in family play therapy sessions. They reflected after each session on how they experienced the process and the specific techniques. The process as described in Figure 1 is an illustration of the total intervention process; however, it was differentially applied during each specific session. Family members reported that the family play therapy process was helpful. More research on this will be necessary, but it can be indicated that family play therapy with a basis of Gestalt therapy theory, ecological systems theory and the framework afforded by the SPICC model shows promise in terms of intervening with families subjected to CSA.

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