



UNIVERSITY of the
WESTERN CAPE

THE DESIGN OF AN INTERVENTION TO REDUCE VIOLENCE IN THE FAMILY: A FAMILY-CENTRED APPROACH

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ABSTRACT

Violence occurs in different environments, however, it is often found in the family with family members being the perpetrators. Family violence, as an integrative concept, is defined by few researchers or theorists, let alone conceptualised as a theoretical grounding for family-centred interventions aimed at violence in the home. However, family members are all affected in the act of any violence in the family, thus any intervention should include the whole family. A family-centred approach focuses on all family members to be included in the intervention and is acknowledged as the best method when trying to create an intervention for family violence. Thus, the aim of this study was to design an intervention programme for families experiencing family violence in order to reduce violence in the family.

To create such a programme, intervention mapping was the chosen design for this study. Intervention mapping has five steps, 1.) Specify the programme's goals into proximal programme objectives. In this stage, needs are identified; 2.) Selection of theoretical and practical strategies; 3.) Design the programme, 4.) Implementation of the programme, and 5.) Focus on anticipating process and effect evaluation. However, this study only focused on the first 3 steps of intervention development, namely, Phase I, a family violence needs assessment done to identify the problem, Phase II entailed a review done to determine appropriate theoretical and practical approaches for the intervention regarding family violence, and lastly, Phase III had been a Delphi study which aided in the design and development of the intervention. This study showed promising results with proven long-term positive effects in implementing a family-centred approach, and when coupled with a collaborative network of support services, political will, and community support, and has the ability to ensure continuity of care and improved functioning for families experiencing violence in the home.

KEYWORDS

Family violence

Family-centred intervention

Intervention mapping



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LIST OF ABBREVIATIONS

GST	General Systems Theory
IPV	Intimate Partner Violence
NGO	Non-Governmental Organisations
NPO	Non-Profit Organisation
PFVA	Prevention of Family Violence Act
PIP	Pillar Integration Process
PREMIS	The Physician Readiness to Manage Intimate Partner Violence Survey
RE-AIM	Reach, Effectiveness, Adoption, Implementation, Maintenance
SAVI	Safety and Violence Initiative
UNICEF	United Nations International Children's Emergency Fund
USAID	United States Agency for International Development
WHO	World Health Organization

DECLARATION

I, **Jill Ryan**, declare that the thesis entitled, “**The Design of an Intervention to Reduce Violence in the Family: A Family–Centred Approach**”, submitted for the PhD degree at the University of the Western Cape, is my own work. All the sources that I have used, or cited, have been indicated and acknowledged by means of complete references. This research project has never been submitted, previously, for any degree to any other institution.

Jill Ryan

Student Number: 2839413

Date: 18 December 2018



Signed:

Jill Ryan
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DEDICATION

This work is dedicated to all the participants who have contributed greatly to the field of family violence, by selflessly committing to service excellence and continue having the passion and drive to make a positive difference for the families they aid and assist. Secondly, this work is aimed to uplift and empower families enduring violence, so they may reach fulfilment in their family life and enjoy a functioning and supportive family environment. Lastly, and most importantly, my efforts and persistence in navigating the many challenges, and inspirational moments within this PhD journey has only been possible through the mercy and grace of God the Almighty, of whom all praise and success belong to Him and all errors are my own.



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Family

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Supervisor

My supervisor, Prof. Nicolette Roman, has been with me on my academic journey for the past 7-8 years (Masters and PhD) and has enriched my every way of thinking and conducting research, but also in being hardworking and committed to every project taken on. Prof. you have not only been my supervisor, but my mentor in many ways, helping me navigate through every triumph and challenge. I will never be able to thank you enough for all you have done, in all the ways you have supported me and my growth, but I am forever grateful and I thank you sincerely.

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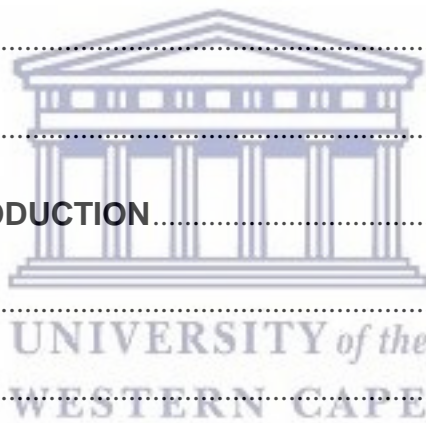
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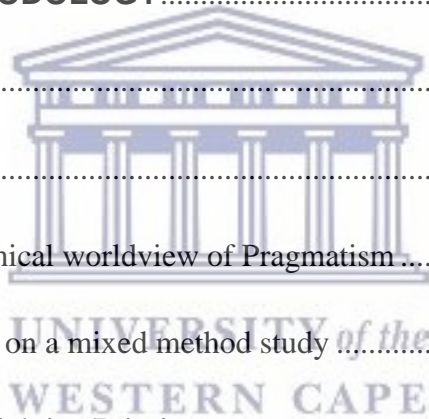
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CHAPTER ONE

INTRODUCTION

1.1. Background

Violence, as defined by the World Health Organization (WHO), is the “intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation” (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002, p. 5). Additionally, violence can entail aggressive acts; not only intended to physically hurt someone, but also purposely limit human needs, such as hampering bodily needs and psychological integrity, as well as hampering human rights (freedom of expression, need for mobilization, need for work, etc.) and non-material needs (solidarity, friendship, happiness, self-actualisation) (Gelles, 1985; Galtung, 1988; Honderich, 2003; Confortini, 2006).

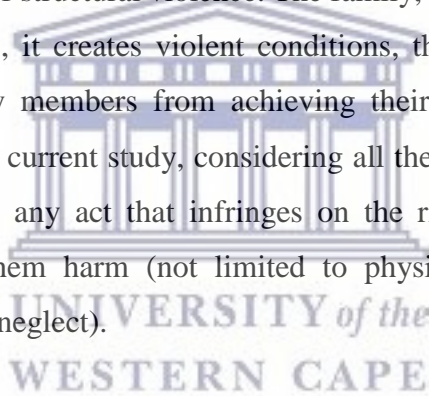
Violence occurs in different environments; however, it is often found in the family, with family members being the perpetrators (Thorpe, 2013). The idea of family violence, or family members purposely inflicting harm on one another, has perennially been a challenging concept to understand, or accept. Family is considered to promote and provide care, stability, dependability and positive development, not purposely inflict harm (Jouriles, McDonald, Norwood, & Enzil, 2001; Amoateng, Richter, Makiwane, & Rama, 2004; Wallace & Roberson, 2016; Waite, 2000).

Family violence, as a concept, is difficult to define because often, when any violence occurs in the family, the specific act of violence is seen as a subset. Subsets are sets, which make up a larger set, or smaller items that make up a larger group (O’Neil & Summers, 2015). Throughout this current study, subsets refer to elder abuse (which includes child-on-parent violence), intimate partner violence (used interchangeably with domestic violence), as well as child abuse and neglect (which includes sibling-on-sibling violence), all of which constitute family violence. Family violence is divided

into these subsets because currently, family violence is not perceived as an integrative concept (Tolan, Gorman-Smith, & Henry, 2006).

Family violence, as an integrative concept, is defined by very few researchers, or theorists. Of the few researchers, Wallace and Roberson (2016) define family violence as “any act or omission by persons who are cohabiting or living together as a family that results in serious injury to other members of the family. Serious injury refers to physical or emotional harm, or a violation of another family member’s rights and freedom of choice” (p. 5). Tolan, Gorman-Smith, and Henry (2006) state that family violence includes violent acts, psychological aggression, coercive and intimidating aspects, such as fear felt, or the intent to commit violent acts.

However, family violence embraces diverse abstract ideas of violence in the home, particularly as a form of structural violence. The family, as a structure, facilitates more than mere violent acts, it creates violent conditions, through fear and intimidation, which prevents family members from achieving their full potential of well-being (Absher, 2012). In this current study, considering all the definitions presented, family violence is defined as any act that infringes on the rights and freedom of family members or causes them harm (not limited to physical, psychological, spiritual, economic, sexual, and neglect).



Family members are all affected by the act of any violence in the family; therefore, any intervention should include the whole family (Thorpe, 2013; Tolan, Gorman-Smith, & Henry, 2006). A family-centred approach to family violence intervention allows for a better understanding of the interrelatedness and effects of all forms of violence in the family. When children are exposed to, or experience family violence, the consequences of the effects may extend into adulthood. Exposure to IPV often co-occurs with child abuse and maltreatment, resulting in greater aggression and delinquency, difficulty in regulating emotions, as well as managing social interactions (Haselschwerdt, Savasuk-Luxton, & Hlavaty, 2017).

Potentially, the co-occurrence of IPV and child abuse affect the child’s attitude and belief about the significance of violence in relationships, and also as a form of conflict

resolution (Grogan-Kaylor, Stein, Clark, Galano, & Graham-Bermann, 2017; Haselschwerdt, Savasuk-Luxton, & Hlavaty, 2017). Boys are twice as likely to become perpetrators of abuse in adulthood, compared to boys from non-violent homes, with girls being more tolerating of abusive marriages, than girls from non-violent homes would be (United Nations Children's Fund [UNICEF], 2007).

Involvement in one form of family violence becomes a risk factor for other types, as often, perpetrators of family violence would have been victims of some form of family violence in childhood, or later (Graham-Bermann & Edleson, 2001; Tolan, Gorman-Smith, & Henry, 2006). Research indicates that early exposure to family violence places children and youth at risk of continued violence, either towards themselves or others, as families fulfil an important role in socialising young people (Burton, Leoschut, & Bonora, 2009; Holborn & Eddy, 2011; Thorpe, 2013).

In South Africa, there are subsets of family violence that are perceived to be more prevalent than others, for example, South Africa has the highest rate of gender-based violence, for a society not engaged in armed conflict (Wood & Jewkes, 2005). Regarding children, South Africa has the highest rate of child abuse in the world, as well as twice the global estimate rate for child homicide (Seedat, Van Niekerk, Jewkes, Suffla, & Ratele, 2009; Mathews, Abrahams, Jewkes, Martin, & Lombard, 2013).

In a lifestyle study, Leoschut (2009) revealed that 53% of young people had seen family members lose their tempers, 24% had been punished by their parents, 18% had family members who argued often, 11% had witnessed family members intentionally hurt one another, while 7% stated that their family members hit one another when angry. Youth, having witnessed violence in the home, were more likely to carry weapons, fight, as well as threaten or injure others, as opposed to youth, with no experience of violence in the home (Holborn & Eddy, 2011).

Similarly, 27% of offending youth stated that their family members would often hit each other, compared to 9% of non-offending youth (Burton, Leoschut, & Bonora, 2009). The prevalence of young people being raised in violent family environments reveals that violence, not only becomes a normative way of interaction but also a

contributing factor to family dysfunction and violence in communities. These findings include the possibility that young people learn violent behaviour, observed in their homes, as a way of resolving issues. In addition, South African research on elder abuse is limited; however, it is noted to be widespread, with international literature revealing family members as the most likely perpetrators (Berkman, 2006; Ferreira & Lindgren, 2008; Soares et al., 2010).

In South Africa, legislative attempts have installed mechanisms to address family violence. The Prevention of Family Violence Act (Republic of South Africa [RSA], Act No. 133 of 1993) was an early attempt to deal with violence in the family; however, the legislation encountered many obstacles (Mathews & Abrahams, 2001; Usdin, Christofides, Malepe, & Maker, 2000; Vetten, 2005). The Prevention of Family Violence Act (RSA, 1993) limited its definition to, physical aggression towards a spouse or child, dismissing other forms of violence, such as psychological aggression, maltreatment, and neglect. Besides, it is only directed at male and female married couples, failing to acknowledge cohabitation, as well as same-sex couples. The regulation over socially accepted forms of violence, such as corporal punishment (domestic setting), also lacked acknowledgement, ubiquitously (Cousineau & Rondeau, 2004; Mathews & Abrahams, 2001; Usdin, Christofides, Malepe, & Maker, 2000).

South Africa, therefore, adopted other updated forms of legislation to address the three family violence subsets, respectively, which also encountered obstacles, because, holistically, it was not perceived as an issue that affected the family. These legislative responses to family violence are discussed in a later chapter (See Chapter 5: Legislative response to family violence in South Africa: A family-centred perspective). Interventions or services to address family violence often focus on one or two aspects of violence in the family only, and, therefore, are often fragmented in approach and outcomes (Nagia-Luddy & Mathews, 2010).

Few studies have explored family-based interventions concerning IPV (Chaudhury et al., 2016), and child abuse, which is addressed mainly through child-centred strategies, aligned to the legislative mandate of “best interest of the child” (Ryan, Esau, & Roman, 2018, p. 5). Additionally, elder abuse has been divorced from family-centric insights

due to the focus on bolstered social services and awareness-raising (Daly, Merchant, & Jogerst, 2011; Jagielska, Łukasik, & Pikuła, 2015; Pillemer, Mueller-Johnson, Moch, Sutor, & Lachs, 2007). Organisations, such as Resources Aimed at the Prevention of Child Abuse and Neglect¹ (RAPCAN) argue that the heterogeneous effect of abuse should be acknowledged, and, instead of creating generic, uniform treatment programmes for all forms (subsets) of abuse, each one should be treated separately, as any form of violence in the family, affects the whole family (Nagia-Luddy & Mathews, 2010; Parliamentary Monitoring Group, 2013).

Throughout this chapter, the researcher highlights that family violence affects all members of the family, while early exposure to violence places them at risk of perpetration/victimization in future domestic settings, or violent crime, which, with no adequate intervention, could result in premature death. Additionally, the researcher presents corroboration that individuals, involved in one form of family violence, could be affected by other forms, later in their lives.

The prevalence of family violence, currently seen, shows that addressing violence within the silo-like subsets, fails to integrate the need families have, to adequately address the challenges they face, with skills, ensuring positive functioning and well-being. The need would be to address violence within the family, from an integrative family-centred perspective; an intervention would have to be family-centred in its approach, in an attempt to reduce violence within the family. A family-centred approach focuses on all family members to be included in the intervention, and is regarded as the best-suggested method, when trying to create an intervention for family violence (Lock & Le Grange, 2013; Tolan, Gorman-Smith, & Henry, 2006). A family centred-approach not only includes all members of the family affected by the violence in the home, but also creates collaboration between the family and the practitioner. The family-centred approach aims to balance the family needs with the best interest of its members; encourage family input on the plan of care, and have each family treated as

¹ A national organisation in South Africa aimed at child protection through intervention, as well as advocacy.

unique, instead of being viewed as prescriptive to a specific group (Burns, Dunn, Brady, Starr, & Blosser, 2008).

A family-centred approach allows the challenges presented to provide contextual explanation, rather than individual blame, as the emphasis is placed what is *happening* in the family, rather than what is *wrong* with the family; therefore, adequate support is provided through this approach (Bromfield, Sutherland, & Parker, 2012; Burns, Dunn, Brady, Starr & Blosser, 2008). Consequently, in this current study, the researcher aimed to develop an intervention to reduce family violence, utilizing a family-centred approach.

1.2. Problem statement

To date, violence in the family has been focussed on its subsets, namely, elder abuse, intimate partner violence, and child abuse. In addition, it has been viewed as occurring fragmentally, rather than as a whole, integrative concept (Nagia-Luddy & Mathews, 2010). Focusing on subsets does not contemplate the shared risk factors and commonalities between and among the subsets, in interventions, as well as theories used to explain family violence; however, the interventions focus more on power and control (Tolan, Gorman-Smith, & Henry, 2006; Hyde-Nolan & Juliao, 2012; Nagia-Luddy & Mathews, 2010). Additionally, conceptualising family violence has been marked by a narrow understanding that it merely involves physical violence, instead of including unmet basic needs and psychological aggression, which could be just as damaging, for example, child neglect (Tolan, Gorman-Smith, & Henry, 2006). This was evident in the early attempts in South African legislation, such as the Prevention of Family Violence Act (RSA, 1993). However, this act failed to acknowledge cohabitation, same-sex couples, and psychological aggression, as well as the regulation over socially accepted forms of violence, such as corporal punishment (Cousineau & Rondeau, 2004).

Recent reforms around family violence legislation still reveal a divorce from family as a delivery mechanism, as well as failure to acknowledge the impact that violence in the home has on all members of the family. As mentioned previously, interventions or

services offered to address family violence often focus only on one or two aspects of violence in the family, and are frequently fragmented in their approach and outcomes; however, interventions should focus on the family, instead of individuals (Nagia-Luddy & Mathews, 2010; Tolan, Gorman-Smith, & Henry, 2006).

1.3. Research questions

- What is the perception of family violence?
- What is the current South African legislation used to address family violence?
- What do the stakeholders feel are the factors contributing to violence within the family?
- What effective intervention approaches were used in family-centred interventions in previous studies?
- What factors are needed to design and develop a successful family intervention program regarding family violence?

1.4. Aim of the study

The aim of the study was to design an intervention programme for families experiencing family violence, in order to reduce violence in the family.

1.5. Objectives

The objectives of the study were to:

- Explore the perceptions of family violence;
- Review the current South African legislation used to address family violence;
- Conduct reviews to identify family-centred strategies used for family violence;
- Develop objectives for the design of a family intervention by using a Delphi Study.
- Design an intervention for families experiencing violence within the family

1.6. Significance of the study

This current research project is the first known study in South Africa that attempts to create one intervention, aimed at all subsets of family violence, to reduce it, by using a family-centred approach. The researcher regards this intervention as a first step response, utilising a strength-based approach for families experiencing family violence. It is also anticipated that well-trained community healthcare workers, or NGOs/NPOs in any area (rural or urban), would be able to implement this intervention.

Consequently, the intervention is aimed at building capacity, enriching skills and knowledge, as well as developing a collaborative relationship between families and support services. Through the iterative engagement with stakeholders, the researcher strove to design the intervention in a manner that would be effective to meet the needs of families experiencing violence in the home, yet simple enough to be implemented by community stakeholders, who had assisted in its thought generation and ultimate creation.

South African legislation dealing with family violence, states that service providers should strive to assist in the protection of family members, especially the vulnerable, such as women and children, to create an environment of safety and security, which has been the motivation for this current study, in its multi-layered engagement with family, community, and policy level factors. Examining and exploring the needs of families experiencing violence in the home at various levels, ensured that the intervention would not only highlight the lived experiences of these families, but also the environment (legislative/service-level) required to implement the skills learnt, and ultimately, enable these families to thrive, function, and experience well-being.

1.7. Definition of Keywords

Table 1.1 summarises the keywords and their definitions, as used in this current study. These terms have been operationalized within the chapters, either by being directly engaged in terms of legislative understanding; framing practitioners' scope of practice, understanding, and recommendations; or as points of reference in the chapters.

Table 1.1: Definition of keywords

Family	Family can be characterised by how it is structured, the organisational patterns of the structure, as well as the interactions and transactions occurring within the organisational structure, which determines and shapes behaviour, and how well the family functions (Miller, Ryan, Keitner, Bishop, & Epstein, 2000).
Violence	Refers to an aggressive act intended to physically hurt someone and purposely limit human needs, such as hampering bodily needs and psychological integrity, as well as hampering human rights (freedom of expression, need for mobilization, need for work, etc.) and non-material needs (solidarity, friendship, happiness, self-actualisation) (Gelles, 1985; Galtung, 1988; Honderich, 2003; Confortini, 2006).
Family violence	“Any act or omission by persons who are cohabiting or living together as a family that results in serious injury to other members of the family. Serious injury refers to physical or emotional harm or a violation of another family member’s rights and freedom of choice” (Wallace & Robertson, 2016, p. 5).
Child abuse	All forms of physical/emotional ill-treatment, sexual abuse, neglect or negligent treatment, commercial or other forms of exploitation, resulting in the actual, or potential harm to the child’s health, survival, development, or dignity, in the context of a relationship of responsibility, trust or power (World Health Organization [WHO], 2002).
Elder Abuse	The single or repeated act, or even the lack of appropriate action, occurring in any relationship that has an expectation of trust, which causes harm or distress to an older person (WHO, 2002).
Domestic violence	Relates to physical, sexual, emotional, verbal and psychological abuse, economic abuse, intimidation, harassment, stalking, damage to property and entry into the complainant’s residence without consent, within the domestic setting (Vetten, 2005). [Term used interchangeably with IPV].
Intimate Partner Violence (IPV)	Abuse (physical, sexual, psychological attacks) occurring between two people in a close relationship, with partners, including current or former spouses/dating partners, and the violence existing on a continuum from a single episode of violence to ongoing battering (Tjaden & Thoennes, 2006; McClennen, 2010).
Family systems theory	A framework in which all parts of the system are interconnected. The family, as a system, is the unit of analysis with violence displayed, for example, domestic violence, an expression of the conflict within the system, instead of a pathology of only one individual (Lawson, 2012; Wallace & Robertson, 2014)
Family-centred approach	The focus of the intervention is on the whole family; therefore, in order to assist families, or reduce violence in the family, all family members are included in the intervention (Lock & Le Grange, 2013).
Systematic review	Collated empirical evidence that fit pre-specified eligibility criteria by using a methodology that can be reproduced, in order to minimise bias and increase validity and reliability of results (Green, Higgins, Alderson, Clarke, Mulrow & Oxman, 2011).
Scoping review	A review done to provide a broad overview of the available evidence on a particular topic. A scoping review maps or charts out key concepts underpinning a research area, clarifies working definitions and/or boundaries of a research topic, but also identifies gaps in research (Joanna Briggs Institute, 2015).
Narrative review	“A narrative review is a scholarly summary along with interpretation and critique. While principles and procedures may diverge from the classic methodology of systematic review, they are not unsystematic (in the sense of being ad hoc or careless), and may certainly be conducted and presented in a systematic way, depending on purpose, method and context.” (Greenhalgh, Thorne, & Malterud, 2018, p. 2).

1.8. Chapter Layout

In this section, the content layout pertaining for each chapter is presented. Chapters that have been published in peer-reviewed journals have their citations placed below the chapter title. Articles under review have also been indicated.

1.8.1. Chapter 1: Introduction

In this chapter, the background of violence in the family (family violence), its prevalence and the introduction of a family-centred approach to reduce violence in the home is provided. In addition, the study aim and objectives are provided, as well as the significance of the study.

1.8.2. Chapter 2: Conceptual framework

The use of Family Systems Theory is explained in this chapter, in unison with Bronfenbrenner's Ecological approach, as this current study's framework in eliciting a more holistic response, sensitive to the needs of the family, which is expected to thrive within a systemic interplay of context. Additionally, subsequent to understanding the concept of family violence, the researcher discusses violence and the manner in which it creates conditions for legitimation, conceptualisation of defining family, and lastly the marriage of these concepts as family violence, touching on available interventions that are discussed later.

1.8.3. Chapter 3: Methodology

Mixed methods are discussed in this chapter, as the overall methodology, the use of pragmatism as the paradigm within the mixed methodology, and the types of mixed methodology available. Moreover, the current study is described with intervention mapping as the overall study design.

Ryan, J. & Roman, N. V. (2017). An application of intervention mapping as a phased approach in developing a family-centred programme to reduce violence in the family. *The Open Family Studies Journal*, 9(1), 15–20.

The processes of each phase and stage is briefly described, as more detailed

process information is provided within each chapter, to avoid excessive duplication of information, while still providing sufficient information to explain the methodological steps and processes undertaken.

1.8.4. Chapter 4: A review of family-centred interventions aimed at family violence

Ryan, J. & Roman, N. V. (2019). Family-Centred Interventions for Elder Abuse: a Narrative Review. *Journal of cross-cultural gerontology, none(none)*, 1–12. Retrieved from <https://link-springer-com.ezproxy.uwc.ac.za/article/10.1007/s10823-019-09377-5#citeas>

The current strategies and approaches that address family violence are reviewed in this chapter, which is the amalgamation of three reviews, conducted separately, as family violence is still dealt with in its subsets. The three reviews have been appended for a more detailed description of each review process per subset.

1.8.5. Chapter 5: Legislative response to family violence in South Africa: A family-centred perspective (Article 1)

Ryan, J., Esau, M. V., & Roman, N. V. (2018). Legislative response to family violence in South Africa: a family-centred perspective. *Aggression and Violent Behaviour, 42(none)*, 1–8.

As part of the needs assessment, Chapter 6 forms part of a legislative analysis that was done to determine the perception of family within law and policy, as well as what legal recourse and resources are available to families affected by violence in the home.

1.8.6. Chapter 6: A needs assessment of families experiencing violence in a South African context

In this chapter, the researcher describes the mixed method process employed to determine the perceptions of family violence, as well as the needs of families

affected by violence in the home. The pillar integration process is utilised as a way to integrate the findings for the purpose of interpretation. In the discussion section, the researcher highlights vital points, later included in the proposed intervention programme.

1.8.7. Chapter 7: A Delphi Study to develop a family-centred intervention to reduce violence in the home

The two-round process of stakeholder engagement in defining the scope and range of the proposed family-centred intervention is illustrated in this chapter, providing input regarding intervention implementation and focus. This chapter is finalized with the presentation of a format for the family-centred intervention programme.

1.8.8. Chapter 8: Discussion, Limitations, Recommendations and Conclusion

In this chapter, the summarised main chapter outcomes are discussed, regarding the implications of a systemic strategy on reducing violence in the home. In addition, the study limitations and recommendations are presented, not only for future studies, but also for intervention implementation.

1.9. Chapters presented at conferences (Peer input)

Ryan, J., Esau, M. V., & Roman, N. V. *Legislative Response to Family Violence in South Africa: A Family-Centred Perspective*. Oral presentation: International conference on violence prevention titled ‘Violence Prevention, Safety Promotion and the Sustainable Development Goals’ by UCT Safety and Violence Initiative (SAVI) and SaferSpaces, 15-16 October 2018, Cape Town, South Africa.

Ryan, J. & Roman, N. V. *Family-Centred Interventions Addressing Child Abuse: A Scoping Review*. Oral presentation: International conference on violence prevention titled ‘Violence Prevention, Safety Promotion and the Sustainable Development Goals’ by UCT SAVI and SaferSpaces, 15-16 October 2018, Cape Town, South Africa.

Ryan, J & Roman, N. V. *Family centred interventions for intimate partner violence: A systematic review*. Oral presentation: International conference on violence prevention titled 'Preventing Violence: From Scientific Excellence to Effective Practice' hosted by UCT SAVI and the Global Campaign for Violence Prevention, 8-9 September 2016, Cape Town, South Africa.

Ryan, J., & Roman, N. V. *Protocol for creating family-centred interventions for family violence*. Oral presentation: International conference on violence prevention titled 'Preventing Violence: From Scientific Excellence to Effective Practice' hosted by UCT SAVI and the Global Campaign for Violence Prevention, 8-9 September 2016, Cape Town, South Africa.

Ryan, J. *The design of an intervention to reduce violence in the family: A family-centred approach*. Oral presentation: First South African Conference on Violence: Mobilising Science, Community and Policy for Prevention, 15-17 August 2016, Boksburg (Gauteng), South Africa.

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CHAPTER TWO

CONCEPTUAL FRAMEWORK

2.1. Introduction

In this chapter, the researcher outlines the theories that underpin the current study, and briefly explores legislation aimed at family violence; how violence is conceptualised, how family is defined, and lastly, what encompasses family violence as a concept, as well as the type of intervention best suited to address it.

2.2. General Systems Theory

Taking into account the integrative concept of family violence, Wolfe (2003) denotes that the common characteristic among the subsets of family violence, such as child abuse, domestic violence, and elder abuse, is the close, interdependent relationship between them. The core foundation of General Systems Theory is that all parts of the system are interconnected, and the family, as a system, is the unit of analysis, with violence being an expression of the conflict in the system, instead of a pathology of only one individual (Lawson, 2012; Wallace & Roberson, 2016).

The assumptions usually highlighted of General Systems Theory are:

- i.) All parts of the system are connected;
- ii.) Systems can be understood when viewed as a whole;
- iii.) Systems affect themselves through environmental feedback; and
- iv.) Systems are not reality, but simply a means to understand what the researcher intends to study (White & Klein, 2008).

However, seven commonly recognised features are associated with General Systems Theory [GST], as illustrated in Table 2.1 (Von Bertalanffy, 1969; Laquer, 1969; Whitchurch & Constantine, 2009; Becvar & Becvar, 2014).

Table 2.1: Features associated with the General Systems Theory [GST]

Holism (non-summativity)	The whole is greater than the sum of its parts. The system is understood as a whole (e.g., victim and perpetrator cannot be solely focused on, but family must be investigated).
Hierarchy	The part must obey the rules of any whole to which it belongs. The hierarchy is mostly embedded within the subsystems (e.g. sibling subsystem obedient to parental subsystem).
Mutuality	The parts of the system are so interconnected that cause-and-effect is impossible to determine (e.g. at times difficult to clearly define victim and perpetrator, as these roles are fluid among family members, and complex, in the context of family violence).
Boundaries	The system regulates what can pass between them and the environment. Family's rules/boundaries act like a gatekeeper for the flow of information. Information from outside the system is screened for compatibility, in line with family values and maintenance of family identity. This process determines how open, or closed the family system is. A family can become entropic, in which the system heads towards maximum disorder, as too little, or too much, info is allowed in; therefore, family loses identity; the family can also become negentropic where maximum order is sought in screening info by avoiding change, even if in an appropriate manner. Balance between the two is regarded as healthy functioning.
Equilibrium	A system will seek a steady state between two opposing forces. This is done through a feedback process, in which past behaviours are fed back into the system, in a circular manner (circular causality), which becomes a self-regulating or self-correcting process. Positive feedback is an error-activated process, in which deviation was responded to in an appropriate manner (change occurred and has been accepted by the system). Negative feedback is linked to resistance, as change was detected and rejected; therefore, stability is maintained. This feedback process in a family illustrates that change is processed by the entire family and not just a single family member. The process determines if the family becomes morphostatic (pull towards stability), or morphogenetic (allows growth and change through system enhancing behaviour → health functioning).
Equifinality	Equifinality denotes more than one way to reach a goal. However, a system can become 'stuck', through redundant patterns of behaviour (habitual ways of behaving/communicating, regardless of topic), for example, arguing when problem-solving or discussing, in which case, the results stay the same. This becomes ineffective and requires new ways of communication and behaving.
Equipotentiality	Predictions cannot be made about the developmental process, as one cause could have different results (e.g. survivor of family violence can become revictimised/perpetrator, or not).

However, GST is a transdisciplinary field of study, which indicates that GST is used more as a programme of theory construction, in creating concepts, postulates, principles or theorems, for universal application across any domain (Whitchurch & Constantine, 2009). Therefore, GST is viewed as a theory of systems, in general, which is why some scholars consider GST broader than a theory, but more of a 'weltanschauung' or worldview, in which systems thinking is a way to see objects in the world as all interrelated (Whitchurch & Constantine, 2009). Additionally, GST provides a

theoretical framework for the creation of various micro-level approaches, known as *systems theories* (Whitchurch & Constantine, 2009). One of those systems theories is a Family Systems Theory, as applied by Murray Strauss (1973), which explains the family system, in the context of family violence, and utilised in this current study.

2.2.1. Family Systems Theory as applied by Murray Strauss

Murray Strauss was an influential sociology scholar in the field of family violence theory, research and interventions, as well as the first scholar to apply General Systems Theory to family violence (Lawson, 2012; Strauss, 1973; Whitchurch & Constantine, 2009). Although Family Systems Theory may be applied differently to the context of family violence, Strauss argues that family violence was a response to conflict in the family (Lawson, 2012; Strauss, 1973). Strauss clarifies this by stating that conflict among family members is universal and inevitable, with causes being diverse; however, violence between family members is only one method of resolving the predicted conflict (Lawson, 2012; Strauss, 1973).

An attempt at understanding the reason why this violence is maintained in the system is made by Strauss (1973) in eight propositions, namely:

- i.) Violence between family members are a result of various causes, ranging from role expectation to personality traits;
- ii.) The actual occurrence rate of family violence is higher than what is publicly known, which may be due to underreporting, or uncertainty of what constitutes abuse;
- iii.) Most violence in the home is either denied, or not labelled as a deviance, for example, parental use of corporal punishment;
- iv.) Stereotyped imagery of family violence is learned in early childhood from parents, siblings and other children. Strauss refers to it as parental use of corporal punishment, sending the message that physical force is an effective means of controlling behaviour;
- v.) Stereotypes of family violence are continually being re-affirmed either through social interaction, or mass media;

- vi.) Violent persons may be rewarded for their results, in that the violence produces the desired results;
- vii.) The use of violence that is contrary to family norms, and secondary conflict is created, for example, when a husband and wife are arguing, and one of them hits, or throws something at the other, which is contrary to what the norm is within the family, which further escalates the current conflict being experienced; and
- viii.) Persons labelled as violent may be encouraged to play out that role as a self-concept may have been created.

Strauss (1973) states that propositions iii (most violence within the home is either denied, or not labelled as a deviance, for example parental use of corporal punishment), vi (violent persons may be rewarded for their results in that the violence produces the desired results), vii (use of violence that is contrary to family norm, secondary conflict is created), and viii (persons labelled as violent may be encouraged to play out that role as a self-concept may have been created), are what constitutes positive feedback (deviation affirming), in terms of violence experienced in the family (Strauss, 1973).

In a review of interventions covering domestic violence, child abuse and elder abuse, Tolan, Gorman-Smith, and Henry (2006), revealed that domestic violence, as well as child abuse interventions are focused on shelter placements, mandatory prosecution, treatment of perpetrators and counselling/therapeutic services. For domestic violence, interventions are preventative, while for child abuse and elder abuse interventions, the interventions are more reactionary (parenting aid programmes, caregiver programmes), focusing on the victim and the perpetrator. Additionally, it would seem that interventions aimed at child abuse are the only interventions that include family preservation and improved family functioning (Tolan, Gorman-Smith, & Henry, 2006). Programmes or interventions in South Africa, aimed at these forms of family violence, have followed a similar trend in its structure, with elder abuse services more focused on residential/shelter (Nagia-Luddy & Mathews, 2012; Ferreira & Lindgren, 2008).

A critical factor is that there needs to be a collaboration between sectors that deal with these issues, as stated in the national roundtable on the multi-sectorial interventions and actions on gender-based violence, for an effective response to gender-based violence, which includes other forms of family violence, such as child abuse. In order for such a collaboration to transpire, an ecological perspective of the family and its needs must occur. Specifically, the heterogeneous effect of abuse must be acknowledged, instead of the creation of generic, uniform treatment programmes for the various forms of abuse (Nagia-Luddy & Mathews, 2010; Parliamentary Monitoring Group, 2013).

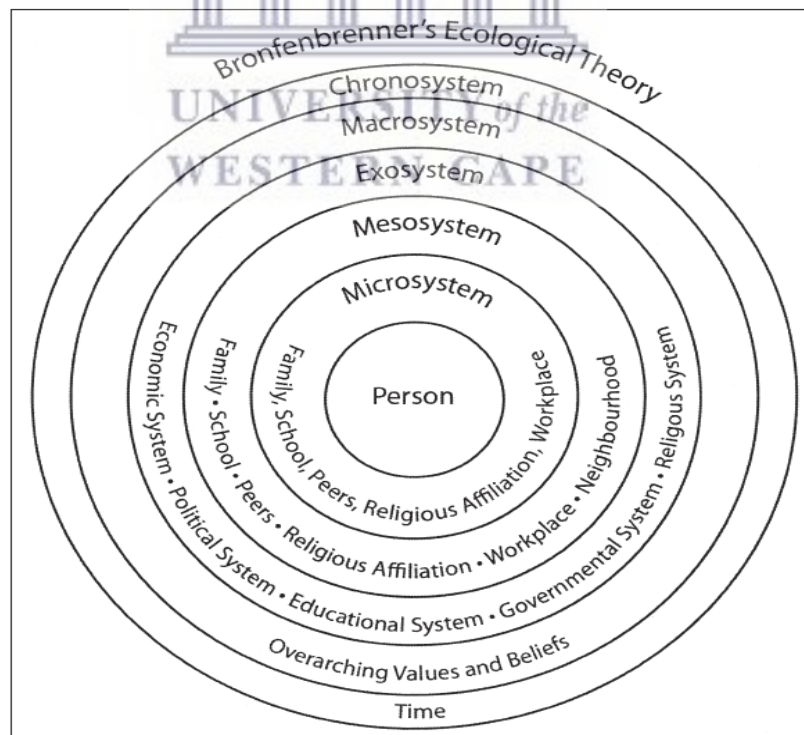
Historically, the delivery of services for family violence has been fragmented, specifically for domestic violence and child abuse. These fragmentations included having different philosophies and mandates, using different professional terminology, and lastly, indicating that the sectors have different missions (Nagia-Luddy & Mathews, 2010). However, family violence policies guiding service delivery and intervention implementation have all used the ecological approach to establish which individual, familial, as well as communal factors should be considered (Australia's National Research Organization for Women's Safety [ANROWS], 2017; Nagia-Luddy & Mathews, 2010). The ecological approach, used within policy, reflects risk, resulting from the interplay of personal, individual, situational, as well as socio-cultural factors, at various levels in the social environment (Nagia-Luddy & Mathews, 2010). Consequently, to narrow down the focus of family violence into its subsets, not only narrows the understanding of family violence, but over simplifies it (Tolan, Gordon-Smith, & Henry, 2006). The risk, therefore, is that, if the focus is on a subset of family violence, family members, exposed to the violence, may not necessarily be part of the healing process, as the focus may be on the victim and the perpetrator only, or negate the systemic interplay of influencing factors in relation to the family.

In addition, for a comprehensive response, a collaborative environment would need to be created, to address, holistically, the needs of a family experiencing violence; a collaboration that could only be initiated by identifying the various systemic services which are available to the family, and have been encountered

by them in their community. Consequently, Bronfenbrenner’s Ecological Theory was also used to frame the needs and scope of this current intervention study.

2.3. Ecological Theory

Ecological Theory provides concepts that are useful to empower relations with families (Swick & Williams, 2006). Bronfenbrenner supposed that advocacy and support of families should embody a caution of *do no harm*, in which categorizing, stereotyping, or hampering families are avoided, by whatever is developed in partnership with them (Swick, 2004; Swick & Williams, 2006). Understanding families through Bronfenbrenner’s ecological approach aids the inclusion of systems in which families are enmeshed, helps to reflect the dynamic nature of family relations, and empowers families to understand their strengths and needs, as well as characteristics inherent to the ecological approach (Garbarino, 1992; Swick & Williams, 2006). Bronfenbrenner explains that, in the world of an individual (a child), five systems of interaction exist, namely: the (i) Microsystem, (ii) Mesosystem, (iii) Exosystem, (iv) Macrosystem, and (v) Chronosystem (Figure 2.1).



Stanger, 2011, as adapted from Berger, 2007

Figure 2.2: Bronfenbrenner’s ecological framework

2.3.1. The Microsystem

An individual's immediate environment (physically, socially and psychologically) is referred to as the microsystem. This system contributes to an individual's initial learning about the world, and therefore, becomes a reference point of the world (Swick & Williams, 2004). The microsystem has the capacity to be a centrepiece for positive child development, or trauma, through an individual's earliest encounters with violence (Rogoff, 2003). The microsystem, essentially, teaches an individual *how to live*, as the experience of the family-child relationship is the first trust-building experience s/he has, and will later shape future significant relationships of mutuality and trust; consequently, a determinant of an individual's personality (Stanger, 2011; Brazelton & Greenspan, 2000; Pipher, 1996; Swick, 2004).

2.3.2. The Exosystem

Exosystems are the contexts individuals experience vicariously; however, they have a direct impact on them, and therefore, are more psychological than physical (Stanger, 2011). For example, children may realize the stress of their parent's workplaces without ever physically being in these workplaces (Galinsky, 1999). Exosystems can be empowering – similar to the effect a high quality child-care programme has on entire family, or debilitating – similar to the effect excessive stress at work has on the total family ecology (Stanger, 2011).

2.3.3. The Macrosystem

The macrosystems that an individual lives in influences what, how, when and where s/he conducts his/her relationships, and consist of cultural and societal values, political trends, and *community happenings* (Bronfenbrenner, 2005; Stanger, 2011). Without the aid of beliefs, services, and support, families are open to many adversities and deterioration, for an example, a mother and child programme that equips young mothers with health care, essential medication, support, and educational resources; she may feel empowered, and in turn, become more affective and caring towards her newborn (Stanger, 2011; Swick, 2004; Garbarino, 1992).

2.3.4. The Mesosystem

Mesosystems connect two or more systems in which the child, parent and family live, and are, in essence, a system of microsystems (Bronfenbrenner, 1979; Bronfenbrenner, 1994). This can be seen when a parent attends a parent-teacher conference, as both the parent and teacher are part of the child's microsystem, or when a parent's close friend babysits the child while the parent is away; loving adults, other than merely the parents, interacting caringly with children can be seen as a powerful mesosystem agent (Stanger, 2011).

The mesosystem functions by creating a sense of community and expanding circles of interactions, without which familial dysfunction may be instigated (Pipher, 1996; L'Abate, 1990). This concept can be seen in a uniquely South African concept of *Ubuntu*, which is an *all-for-one-and-one-for-all* mentality that draws on community as a form of bonding, and a source of social, emotional, and material security for children and families during crisis periods (Atilola, 2014).

2.3.5. The Chronosystem

All family dynamics are framed within a historical context, as it occurs within the different systems (Bronfenbrenner, 1989). Notably the chronosystem, therefore, is characterised by the passage of time, or chronological age that shapes the historical context in which a family functions (Bronfenbrenner, 1994). For example, the *history* of relationships in families may explain more about parent-child relations than is evident in existing dynamics, as historical influence holds strong sway over a family's macrosystem, and determines how they respond to stressors within the societal parameters present in their lives (Bronfenbrenner, 1979; Ford & Lerner, 1992; Stanger, 2011).

A stark example of this system would be contextualizing South African family life with the backdrop of Apartheid. The system of Apartheid segregated Black South Africans into *homelands*, designated territories allocated to Black South Africans once forced removals had occurred. Due to this displacement, Black men had to seek work in cities and towns, leaving their families behind in the

homelands, a migrant system that facilitated a legacy of single-parent households, with present-day South Africa having the highest rate of absent fathers in Africa (Holborn & Eddy, 2011; Louw & Louw, 2009; Ritcher, Chikover, & Makusha, 2010). Apartheid's political culture was undoubtedly interwoven with themes of violence and political intolerance through decades of state legitimization of violence, in order to maintain state power and control (Simpson, 1993; Boonzaier, 2003). As a result, violence became an apparent mechanism in resolving conflict that was socially sanctioned, and even accepted, inevitably spilling into other dimensions of society, where people sought to resolve their social, economic and domestic disputes (Simpson, 1993). The trauma accompanying such political turmoil lead to displaced aggression, an example of which could be seen in South African men, who had trouble reconciling definitions of masculinity, as well as roles associated with it.

The powerlessness and emasculation of Black men, created and maintained by the Apartheid regime (by referring to them as *boys*), added to the displaced aggression; an aggression often directed towards society's most vulnerable, namely, women and children (Simpson, 1993). In directing their aggression towards women, women ultimately became victims of symbolic power reassertion, as men were unable to reconcile the masculine expectation of *breadwinner* in light of a dwindling economy and high unemployment rate. Black women ultimately faced multiple forms of oppression, in terms of race, class and gender, with violence against them a manifestation of a complex dynamic of inequality and domination, as part of the legacy of Apartheid (Boonzaier, 2003; Simpson, 1993).

Family life in South Africa, presently, is directed according to guiding principles laid out in the White paper on Families in South Africa (Republic of South Africa [RSA], Department of Social Development [DSD], 2012). The White paper on families is a policy used to direct all ratified international declarations, regional commitments, as well as national legislation that define what a family should be, the protection and support the family is entitled to, and how equality in marriage and commitment to care of children, should be the basis within these families

(RSA, DSD, 2012). Through this paper, the government sought to emphasize the support South African families should be receiving, in light of the nation's socio-political upheaval of family life, in terms of the migrant system and its effects on the family unit (RSA, DSD, 2012). In addition to supporting family well-being, legislation had also been introduced to protect the family from violence occurring in the home, namely legislation aimed at child abuse (Republic of South Africa [RSA], 2005, *Children's Act, Act No. 38 of 2005*; Republic of South Africa [RSA], 2007, *Children's Amendment Act, Act No. 41 of 2007*), intimate partner violence (Republic of South Africa [RSA], 1998, *Domestic Violence Act, Act No. 116 of 1998*), and lastly elder abuse (Republic of South Africa [RSA], 2006, *Older Persons Act, Act No. 13 of 2006*; Republic of South Africa [RSA], 2000, *Equality Act, Act No. 4 of 2000*). This examination of family legislation aimed at family violence is discussed later in Chapter 5 of this thesis. However, before studying family violence as a concept or phenomenon, how violence is conceptualized needs to be understood, as well as how it extends beyond mere physical acts, and the conditions it creates for its legitimation.

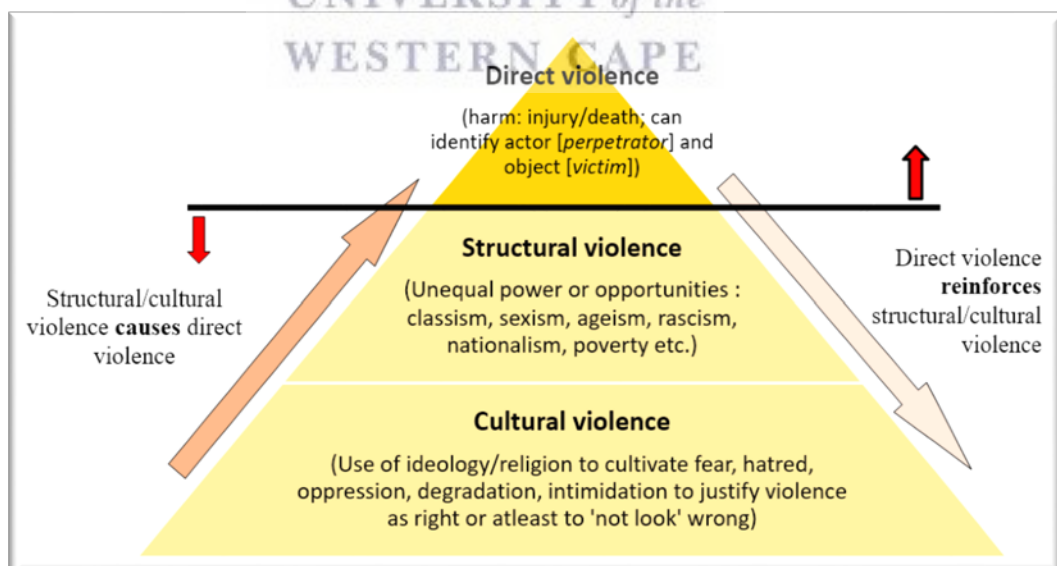
2.4. Defining violence

Violence is often described as the intentional use of physical force or power (forceful), threatened or actual (coercive), self-inflicted, against another person, or against a group or community, that either results in, or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation (Honderich, 2003; Confortini, 2006; Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002; Galtung, 1969). However, to narrowly define violence as merely doing harm to a person/persons, severely inhibits the understanding of the extent of violence, as well as the role of violent conditions.

Johan Galtung, founder of *Peace Studies*, and a vanguard in violence conceptualisation, emphasised that violence is not merely the *killing*, but also the *letting die*. As much as violence can be attributed to *direct* acts of violence against a person/persons, it is caused by social structures/institutions (structural violence), or culture (cultural violence), which create the conditions, where violence is enforced, or reinforced, through symbolic aspects (ideology or religion), thereby legitimating, or justifying the acts of

violence (Laurie & Shaw, 2018; Galtung, 1969; Galtung 1990; Absher, 2012). Galtung, therefore, broadened the concept of violence, stating that any force or influence that creates a massive rift between an individual's actual realisations (somatic, mental, psychological), and their potential realisations, is viewed as violent (Laurie & Shaw, 2018; Galtung, 1969; Galtung 1990; Absher, 2012). Put differently, if any structure, influence, or force is preventing an individual from reaching their full potential in obtaining an optimal state of well-being; or the individual can only obtain what that force, or influence allows, which is disparate to what they could achieve, that force or structure is viewed as violent. This definition exposes acts of degradation, oppression and other subtle forms of harm as acts of violence (Absher, 2012). This is evident in a situation of family violence, where not only the direct or overt forms of harm are inflicted on the family member, but also the environment of fear and intimidation, which denies the victim to reach his/her full potential (Absher, 2012).

Galtung shapes violence into 3 distinct types, namely: *direct* – earlier described as direct harm to a person/persons; *structural* – social structures/institutions reinforce violent ideologies such as classism, ageism, racism, sexism, nationalism to name a few; and *cultural* violence – symbolic aspects used to justify violence, making it look/feel right, or at least not wrong [See fig. 2.2] (Galtung, 1969; Galtung 1990; Galtung 2014).



Adapted from Galtung (1990)

Figure 2.2: Diagrammatic display of the triangle of violence

As much as direct violence is noted to be caused by cultural and structural violence, with these same factors reinforcing direct violence, structural violence is noted to be the most avoidable, as the harm it inflicts indirectly, is built into the social structure, and results in unequal power and unequal *life chances*, constraining an individual's agency to meet fundamental basic needs, as well as fulfilling their potential [See fig. 2.2] (Ho, 2007; Galtung, 1969; Galtung 1990). Drawing from the example posited by Galtung (1990) that inspired later understandings (Ho, 2007, Absher, 2012), this triangulation of violence can be viewed as an example in the access to health care. If an individual died from contracting TB in the 18th century, such a fate would have been viewed as unavoidable. However, if an individual were to contract TB present day, with all medical advancements and treatment available, and influences or forces prevent access to these, resulting in death, such an action would be viewed as violence.

The focus of this current study is *family violence*, namely violence occurring in a particular place – the family. Family is notably the location where the most prevalent forms of violence occur (Abrahams, Mathews, Jewkes, Martin, & Lombard, 2012; Leoschut & Kafaar, 2017; Carmona-Torres, López-Soto, Coimbra-Roca, Gálvez-Rioja, Goergen, & Rodríguez-Borrego, 2018); family interactions comprising the single greatest determinant of violence outside the home (Barnett, Miller- Perrin, & Perrin, 2011). Family, as a social institution, is noted to be integral for socialization and as a building block of society; however, the concept of family requires further clarification. Family has been classified as married/cohabitating individuals, or individuals bonded through blood/kinship, revealing an *elastic band* term, which expands to include diverse people in many types of relationships (Loseke, 2005). Examining definitions of family is vital to understand violence, as the different forms of relationships are associated with different characteristics, issues and possibilities (Loseke, 2005).

2.5. Defining family

Family is a social phenomenon, notably pervasive, but also difficult to define (Floyd, Mikkelson, & Judd, 2006). As difficult as defining family may be, family researchers, however, have attempted to conceptualise family, either through their structure, interdependence, interactions, or relationship.

2.5.1. Family defined as an interpersonal experience

Researchers have defined family as a group that engages in organized, relational transactions, occupying the same living space over an extended period of time, while having merged interpersonal images, which evolve over time, in their exchange of meaning (Pearson, 1993). An expanded understanding suggests that family, though a group occupying the same living space, is a multigenerational social system, consisting of at least two interdependent people, who share a common history and an emotional bond with one another (Yerby, Buerkel-Rothfuss, & Bochner, 1998). A broader definition conceptualises family as a self-defined group of intimates, who create, define, and maintain themselves and their interactions through relationships, which consist of boundaries that may evolve over time (Turner & West, 2013). Floyd, Mikkelson, and Judd (2006) consider these definitions of family to be explicit, but striking, in not only their focus on the interpersonal aspect of family, but the outright neglect to acknowledge family structure and processes, such as genetic and legal ties, for example reproduction, child development, marriage, parent-child relationship, siblings.

Floyd, Mikkelson, and Judd (2006) argue that, by defining family solely through interaction and interdependence, an attempt is made to be inclusive and acknowledge diverse families. However, family researchers and stakeholders, who may benefit from their work, are at risk of an indistinct concept of family, if family structure is dismissed, ignoring socially, or genetically ingrained motivations for behaviour.

2.5.2. Family defined through its structure

First conceptualisations of family defined it by its structure. Early understandings viewed family as two or more people related by blood, marriage, or adoption, residing together (Nye & Bernardo, 1973). Later, the purpose of family was added, which was creating and maintaining a common culture, and promoting the development of each of its members (Duvall, 1977). However, these imaginings of family, explained through traditional forms of kinship, such as marriage or *nuclear families* (denoting a two-parent family with children in one dwelling), is

perceived, largely, as western ideals (Levine, Sato, Hashimoto, & Verma, 1995; Manning, Brown, & Stykes, 2014; Tam, Findlay, & Kohen, 2017). Various forms of family structures occur in other cultures. However, what is regarded as common place, and condoned, may be illegal in Western nations, for example, polygamous marriages, which are controversial and illegal in Canada, although still practiced in countries such as, Malawi and South Africa (Andrews, 2008; Bailey, Baines, Amani, & Kaufman, 2005; Bartholomew, 1964; Limaye, Bablola, Kennedy, & Kerrigan, 2013; Nyathikazi, 2013; Rehman, 2007; Tam, Findlay, & Kohen, 2017). Therefore, the westernized concept of family, in terms of structure, may not be applicable to all cultures, or nations (Tam, Findlay, & Kohen, 2017); a depiction noted for its heteronormative belief in the stable, unified, yet nuclear family structure, rather than how well the family functions (Rabe, 2017a; Rabe, 2017b; Morison, Lynch, & Macleod, 2016).

Confining family strictly to its structure, promotes prescriptive understanding towards particular groups, instead of embracing families as unique, holistically, not only in structure, but also in processes and functioning (Isaacs, Roman, & Savahl, 2018; Rabe, 2017a; Rabe, 2017b; Morison, Lynch, & Macleod, 2016; Soliz, Thorson, & Rittenour, 2009). Therefore, families should be understood beyond mere structure, encompassing interrelated relationships between community and broader societal systems, the quality of which strongly predict adjustment and well-being (Isaacs, Roman, & Savahl, 2018).

2.5.3. Families understood through its functioning

Human beings can only be understood and helped within the context of their intimate and powerful human systems, one of which is family (Hartman & Laird, 1983). Family is constructed and developed through its generations and has far-reaching effects on all its members (Hartman & Laird, 1983). Family members are shaped through mutual interaction and influence that create habitual ways of behaving and communication (the manner in which problem-solving, arguments or discussions occur), as well as relationship patterns, which govern these actions (Becvar & Becvar, 2006). All these mentioned activities create a family that promotes and provides care, stability, dependability and positive development, as

families are expected to provide (Amoateng, Richter, Makiwane, & Rama, 2004). As such, the family is logically modeled after a system, owing to the interdependence observed through these relationship patterns and the networks they create between the family and the social environment (Connard & Novick, 1996). From a systemic perspective, family members cannot be understood in isolation from each other; therefore, to obtain an authentic depiction of family life, the concepts of structure, organisational patterns, as well as the interactions and transactions that occur within the organisational structure have to be married, to not only determine behaviour and what shapes it, but also how well the family functions (Miller, Ryan, Keitner, Bishop, & Epstein, 2000).

Family functioning, as a result of organisational structure and the interaction/transactions that occur within them, is determined by 7 dimensions in family life. Although these dimensions not encompass all components of family functioning, they were observed to be important dimensions affected in at-risk families, and were indications of healthy, or unhealthy, family functioning (Epstein, Baldwin, & Bishop, 1983; Miller, Ryan, Keitner, Bishop, & Epstein, 2000). The seven dimensions identified were:

- 1.) Problem Solving: the ability of family members to address and resolve issues which threaten the integrity or functional capacity of the family;
- 2.) Communication: the exchange of information between family members, in terms of clarity of message content conveyed and clarity for whom the message is intended;
- 3.) Roles: established patterns of behaviour for handling a set of family functions, such as provision of resources, nurturance and support, personal development and maintaining the family system;
- 4.) Affective responsiveness: the ability to express appropriate affect, which implies capacity and manner in which family members show welfare emotions;
- 5.) Affective involvement: the degree to which the family shows an interest in and values the activities and interests of family members;

- 6.) Behaviour control: expectations and rules that the family have for dangerous situations and interpersonal relations with consequences for not meeting these expectations; and
- 7.) General functioning: instrumental and affective functions common to the family's daily life.

(Epstein, Baldwin, & Bishop, 1983; Miller, Ryan, Keitner, Bishop, & Epstein, 2000).

To ensure healthy family functioning, families are observed to be cohesive, flexible and self-reflective, which become resilient in adversity, and facilitate positive development (Benzies & Mychasiuk, 2009; Walsh, 2003; Isaacs, Roman, & Savahl, 2018). However, such positive development can be disrupted through the occurrence of family violence, when harm is purposefully inflicted by family members (Jouriles, McDonald, Norwood, & Ezell, 2001), resulting in a dysfunctional, entropic family system.

Currently, South Africans still endure unprecedented violence, experiencing a murder rate of six times the global estimate for the year 2012-2013. These murders include the highest rates of child and intimate partner violence (IPV) related female homicide in the world (Africa Check, 2013; Mathews, Abrahams, Jewkes, Martin, & Lombard, 2013; Seedat, Van Niekerk, Jewkes, Suffla, & Ratele, 2009; Wood & Jewkes, 2001). In order to equip South African Families to deal with violence occurring in their home, effectively, a family-centred intervention that is cognizant of the contexts in which these families exist, will be more beneficial, to aid these families to thrive with the strengths they possess, as well as the resources available to them.

2.6. Family violence

Family violence refers to cohabiting persons performing any act, or omission that results in serious injury (physical, emotional harm or rights violation) to other members in the family (Wallace & Roberson, 2015). Family violence characteristics further extend to include psychological aggression, coercion or intimidation to incite fear, or

intent to commit violent acts (Tolan, Gorman-Smith, & Henry, 2006). However, family violence is usually divorced from the concept of family, and is explored and understood in its various subsets, as if it is a separate, independently occurring phenomenon, with no shared qualities (Tolan, Gorman-Smith, & Henry, 2006). These subsets include:

- i) Intimate partner violence (IPV), where the focus is on abuse occurring between current/former spouses or dating partners;
- ii) Child abuse and maltreatment, where the focus usually is abuse or neglect, carried out by a parent or caregiver on the child, as well as abuse between siblings; and
- iii) Elder abuse, where the focus is on abuse on a caregiver, or persons in a position of trust, who inflict harm on the elderly.

(McClennen, 2010).

Recent findings have established that all subsets of family violence share an interconnected relationship, and all family members are affected by any act of violence occurring in the family. However, few scholars have identified family violence as an integrated concept (Tolan, Gorman-Smith, & Henry, 2006).

When violence is the prevailing factor in the family, limited development occurs in social competence (Stanger, 2011). For children and adults the emotional trauma caused by family violence is undoubtedly influential, as an individual's emotional fabric is impacted by social and emotional experiences. Healthy development occurs when early experiences are positive, nurturing, and enriching. In contrast, early experiences of chronic abuse provoke young children learn violent behaviour toward others, when parents, or other relatives, prominently display such behaviours in their presence (Stanger, 2011; Berger, 2007; Perry, 1997).

Globally, 275 million children are exposed to violence in the home, with a strong correlation revealed between violence against women and children, and negative psychosocial challenges that span generations (United Nations Children's Fund [UNICEF], 2007). As mentioned previously, Youth, who had witnessed violence in the

home, were more likely to carry weapons, fight, as well as threaten or injure others, as opposed to youth who had not witnessed violence in the home (Holborn & Eddy, 2011). In the case of elder abuse, family members are noted as being the most likely perpetrators (Berkman, 2006; Soares, Barros, Torres-Gonzales, Ioannidi-Kapolou, Lamura, Lindert, de Dios Luna, Macassa, Melchiorre, & Stankūnas, 2010).

Family violence alters the mindset of the family into one that focuses on who is in control, as opposed to one, which seeks to share and help each other, producing a pattern of self-centred behaviours by the abuser, ultimately dominating the entire family environment (Bancroft, 2004; Stanger, 2011). Therefore, elements such as control, abuse, disrespect, manipulation, intimidation, isolation, and degradation characterise the family relationship system (Bancroft, 2004; Gelles, 1994; Stanger, 2011).

2.7. Family-centred interventions aimed at family violence

With family members, evidently, either witnessing, being victims of, or perpetrating family violence, violence in the home affects all family members; therefore, it is imperative that interventions aimed at reducing violence in the home should embody a family-centred approach. A family-centred-approach includes all members of the family, affected by the violence in the home, yet also creates collaboration between the family and the practitioner. In addition, a family-centred approach balances the needs of the family with the best interest of its individual members, encourages family input on the plan of care, and treats each family as unique, instead of prescriptive to a specific group (Burns, Dunn, Brady, Starr, & Blosser, 2008).

A family-centred approach facilitates a partnered environment, where the challenges presented provide a contextual explanation, rather than individual blame. What is happening in the family is focused on, rather than what is *wrong* with the family; therefore adequate support is provided through this approach (Bromfield, Sutherland, & Parker, 2012; Burns, Dunn, Brady, Starr, & Blosser, 2008). A family-based intervention is known to reduce violence in the family, and enhance family functioning (Chaudhury et al., 2016).

In South Africa, it has been noted that family-centred intervention is vital when dealing with family violence and many legislative pieces have been created, to outline family-centred interventions. However, its implementation has had many challenges, namely: the lack of training; confusion around implementation due to unclear guidelines; inadequate leadership; unrealistic expectations of the Department of Social Development; lack of resources or funding; and low salaries; factors that have caused strained relationships between overworked social workers and uncooperative families (Nhedz & Makofane, 2015). In the South African context, exactly what family-centred services entail should be clarified (whether to remove a child or not; whether it refers mainly to intensive family preservation services). Even if the concept is understood, practitioners do not have the time to implement it, due to the priority given to their high statutory caseloads (Nhedz & Makofane, 2015; Strydom, 2014).

However, when family-centred services are introduced, they would most likely be short-term, family-centred crisis interventions that would focus largely on educational resources (life skills), rather than also linking families to long-term family-centred interventions services, such as counselling, or referring to formal/informal services, namely support groups or play dates (Strydom, 2014). By not linking families to formal or informal services, fails to expand the families' social network to minimise their social isolation. In addition, this lack of referral, however, has been linked to the limited available time, due to heavy caseloads (Strydom, 2014).

Globally, the family-centred interventions introduced, either follow a family conferencing format, or use restorative justice, while others may ensure that all the family members are in the same programme, just not together. New Zealand mostly utilises the latter approach, regarding adult protected persons, under their Domestic Violence Act (New Zealand [NZ], 1995, *Act No. 86 of 1995*). Perpetrators, women, and children are all included in empowerment programmes; however, perpetrators are the only individuals who are court-mandated to attend. The programme is contextually grounded within the foundations of Māori culture, extending to include Māori facilitators. Although all family members are included in the programme, members do not attend as family collectives, but within groups, for example: perpetrators with perpetrators; children with children; etcetera (Cram, Pihama, Jenkins, & Karehana,

International Research Institute for Maori and Indigenous Education, University of Auckland, & the New Zealand Ministry of Justice, 2003; Chetwin & Gregg, 2013).

Following a combination of both the family conferencing format, as well as restorative justice framework, the United Kingdom utilises a *whole family approach*, which brings all disputing parties together in a solution-focused, strength-based manner. The focus of the conferencing sessions, however, have a strong emphasis on bringing families in contact with coordinated, existing service structures (Stanley & Humphreys, 2017; Malin, Tunmore, & Wilcock, 2014).

However, as seen in the above examples, as well as what has been mentioned in literature, most of the family-centred interventions are directed mostly at domestic violence or child maltreatment, which are already noted as limited. Rare mention of elder abuse has been made, as family-centred interventions for elder abuse are sparse (Chetwin & Gregg, 2013). In addition, few studies are noted to explore family-based interventions, in relation to IPV (Chaudhury et al., 2016), which when also viewed with child abuse, addressed mainly through child-centred strategies, aligned to the legislative mandate of the “best interest of the child” (Ryan, Esau, & Roman, 2018, p. 5). Additionally, elder abuse has been divorced from family centric insights owing to the focus on bolstered social services and awareness raising (Daly, Merchant, & Jogerst, 2011; Jagielska, Pikuła, & Łukasik, 2015, Pillemer, Mueller-Johnson, Moch, Suitor, & Lachs, 2007). Family-centred interventions aimed at family violence is discussed later in Chapter 4.

2.8. Conclusion

Systems influence the family and their functioning, as these systems are not only dynamic, but also interactive, and underpin activities present in daily family life. For researchers, practitioners, as well as various other beneficiaries and stakeholders of family well-being, being conscious of the contexts, in which inhibiting or progressing factors of family functioning occur, enables them to create effective and responsive interventions that holistically address the needs of at-risk families.

2.9. References

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CHAPTER THREE

METHODOLOGY

3.1. Introduction

Family violence, due to its pervasive nature and health implications, has developed into a major public health concern (World Health Organization [WHO], 2013; Devries et al., 2013). Consequently, family violence has been addressed through health promotion programmes at various levels, such as individual, school-based and community (Harvey, Garcia-Moreno, & Butchart, 2007). Health promotion programmes have proved to be effective, when developed and implemented in a systematic manner, with effective planning and evaluation (Nyembezi et al., 2016).

In this chapter, the researcher outlines the mixed methodology used to conduct this current study, which translates into a pragmatic, real-world philosophy inherent in the methodology that is discussed. In addition, the researcher delineates the various mixed methodological designs used, as well as the process and steps followed for this current study. The chapter is concluded with reflections on the trustworthiness of this current study, as well as the researcher's reflexivity during the research process.

3.2. Methodology

In this current study, the researcher employed a mixed methodology, which is a combination of qualitative and quantitative approaches in a single research study, to gain a comprehensive understanding of an incident, or phenomenon (Johnson, Onwuengbuzie, & Turner, 2007; Johnson & Onwuegbuzie, 2004; Wisdom, Cavaleri, Onwuegbuzie, & Green, 2012). The health sciences use mixed methods to explore various methods of viewing, hearing, and understanding the social world of an individual, to procure the clearest picture of a phenomenon (Creswell & Plano Clark, 2007; Evans, Coon, & Ume, 2011; Shaw, Connelly, & Zecevic, 2010).

Therefore, the employment of mixed methods legitimates the use of multiple

approaches, in order to answer the research question effectively, rather than restrict the researcher in his/her choice. It ultimately requires the researcher to not only be creative in his/her approach, but knowledgeable in the methods and planning (Andrew & Halcomb, 2009; Johnson & Onwuegbuzie, 2004).

When implementing a mixed methodology, the strengths and weaknesses associated with the approach need to be acknowledged. The drawbacks are that this approach could be time consuming, and may require a team, as multiple methods will be used, which may be too much for one researcher to complete in time. In addition, the researcher needs to be knowledgeable about multiple methods and the study may require varied resources, which could be expensive, as illustrated in Table 3.1 (Johnson & Onwuegbuzie, 2004).

Table 3.4: Advantages and disadvantages of mixed methodology

Advantages	Disadvantages
Narrative (quali) adds meaning to numbers	Time-consuming
Numbers (quanti) adds precision to narrative account	May require research team
Strengths used from both methodologies cancels out weaknesses found	Researcher has to learn about multiple methods
Can answer broader range of questions	Expensive
Provide stronger evidence	
Add insights and understanding	
Increase generalizability	
Produce knowledge relevant to theory and practice	

However, the strengths far outweigh any shortcomings, for example, thorough explanation of the findings can occur, as the narrative component adds meaning to the numbers, and the numbers add precision to the narrative account. Mixed methods utilizes the strength of both quantitative and qualitative approaches; thereby cancelling out the inherent weaknesses in each approach. Through the use of multiple methods, a broader, or wider range of research questions can be answered. In addition, stronger evidence can be concluded through the convergence and corroboration of the findings;

the findings can add to insights and understandings, which may have been missed by using a single methodology; the findings can be generalizable; and more complete knowledge, needed to inform both theory and practice can be produced, as illustrated in Table 3.1 (Johnson & Onwuegbuzie, 2004).

When conducting research, various paradigms or worldviews are considered. A worldview is a set of basic assumptions, or beliefs that guide the research inquiry (Andrew & Halcomb, 2009). A worldview is the researcher’s view the world, which will guide the research being conducted. There are various types of worldviews that can be considered (see Table 3.2). Firstly, *post-positivism* is associated with quantitative research, in which researchers are interested in the cause-and-effect, as well as theory testing, of which observations are detailed and variables are measured. *Secondly, constructivism*, usually associated with qualitative methodology, uses a bottom-up approach, in which the participant’s subjective view of a phenomenon is explored, as well as how social interactions have shaped the experience of that particular phenomenon, which are later linked to broader patterns, and ultimately theory.

Table 3.5: Summary of different worldviews

Postpositivism	Constructivism	Advocacy	Pragmatism
<ul style="list-style-type: none"> - Deterministic - Reductionist - Empirical observation and measurement - Theory testing / verification (top-down approach) 	<ul style="list-style-type: none"> - Understanding - Multiple participant meanings - Social and historical constructions - Theory generation (bottom-up approach) 	<ul style="list-style-type: none"> - Political - Focus on empowerment - Collaborative - Change orientated 	<ul style="list-style-type: none"> - Consequence of action - Problem-centred - Pluralistic - Orientated on real-world solutions

(Adapted from Creswell 2003; Creswell & Plano Clark, 2007)

Thirdly, advocacy worldviews, also dominantly associated with qualitative research, rather than quantitative, focus the inquiry on issues of empowerment, marginalization, patriarchy, and other forms of disenfranchisement, and collaborate with the participants, who experience these forms of injustices, with a focused outcome on positive social change, lessening social injustice. Lastly, *pragmatism*, which is

associated with mixed methods research, focuses on the question being asked, rather than method being used, resulting in multiple methods being used to answer the questions, in terms of *real-world*, practical solutions. Therefore, the focus is on the consequence of the research (Creswell & Plano Clark, 2007).

The four above-mentioned worldviews have commonalities, as all are understood in terms of similar elements, namely: ontology (nature of reality); epistemology (how knowledge is gained/sources of knowledge); axiology (judgements made about value – assessment of the role of the researcher’s own value at all stages in research process); methodology (process of research/approach to inquiry); and rhetoric (language used) (Creswell & Plano Clark, 2007; Denzin & Lincoln, 2005; Guba & Lincoln, 2005). However, the purpose of each worldview is different, as is the stance that each worldview takes, in relation to the aforementioned elements, as illustrated in see Table 3.3).

3.2.1. Philosophical worldview of Pragmatism

In searching for an individual’s personal experience of reality, mixed methods employs a pragmatic worldview. Pragmatism emphasises the importance of understanding reality, and the influences that shape an individual’s inner social world, in which s/he experiences growth and development; an understanding that will allow the researcher to examine and answer the research questions in the real world (Creswell & Plano Clark, 2007; Creswell & Plano Clark, 2011; Johnson, Onwuegbuzie, & Turner, 2007). However, a perennial critique from purists is that pragmatism lacks the clearly delineated differences, as seen in postpositivism, or constructivist philosophical underpinning, as illustrated in Table 3.2 (Morgan, 2014).

Additionally, a well-known pragmatists, John Dewey, highlights that pragmatism is not confined to philosophical abstractions, such as the nature of reality, or the relationship of the knower with what is to be known, because pragmatism is grounded in life itself, which is contextual, emotional and social, and creates a centrality around the human experience (Morgan, 2014).

Table 3.6: Worldview elements and their practical implications

Worldview element	Postpositivism	Constructivism	Advocacy	Pragmatism
Ontology (Nature of reality – namely a system of belief that reflects an interpretation by an individual about what makes a 'fact')	Singular reality (Knowable, can be verified or nullified through hypothesis testing)	Multiple realities (shown through various quotes to illustrate various perspectives)	Political reality (one's version of reality determined by one's social positioning)	Single reality with multiple interpretations of it (hypothesis can be tested and multiple perspectives provided)
Epistemology (sources of knowledge/ relationship between researcher and what is being researched)	Objective; making use of empiricism	Subjective; close/interactive link with researcher and participant	Interactive and collaborative; participants are involved as collaborators	Practical (data collected according to 'what works' in relation to the research question); relationship of researcher determined in relation to what is appropriate to the study
Axiology (judgements about the value/role of researcher's value on all stages of study)	Unbiased; value-free	Biased; value-bound (researcher part of what is being researched)	Biased and negotiated; value-laden	Multiple stances
Methodology (process of research inquiry)	Deductive (a priori hypothesis testing; quantitative)	Inductive (a posteriori/ theory generating; qualitative)	Participatory (can be mixed methods)	Combination (Mixed methods)
Rhetoric (language used)	Formal	Informal	Advocacy; change orientated	Formal or informal

(Adapted from Creswell & Plano Clark, 2007; Denzin & Lincoln, 2005; Guba & Lincoln, 2005)

The research process, utilising a pragmatic approach, does not limit what can be known or understood through one approach, such as the world existing apart from an individual's understanding of it (post-positivism), or the world being constructed by an individual's understanding of it (constructivism), as this is a false dichotomy. Instead, pragmatists see these distinctions as two sides of the same coin, as they both feed into the nature of human experience (Dewey, 2008; Johnson & Onwuegbuzie, 2004; Morgan, 2014). Pragmatism implies that, by looking at actions and their consequences, unlike constructivist, individuals are not free to believe anything they want about the world, especially, if they care about the consequences linked to acting on those beliefs. Experiences, to an

extent, are constrained by the nature of the world, and an individual's understanding of the world is limited by the interpretations of the said experiences (Morgan, 2014). Therefore, the focus of pragmatists are not to determine whether the results are context-bound, or generalizable, but to investigate factors that affect whether the knowledge gained could be transferred to other settings, or circumstances, consequently, examining transferability (Morgan, 2007).

In this current study, the above-mentioned is evident when exploring family violence in different contexts (familial, community, and political/policy). In pragmatism, action and belief work in tandem with each other (linked in a cycle), where actions are found in beliefs, and our beliefs arise from our prior actions. Put differently, actions have predictable outcomes, and individuals build their lives around those experiences, which link their actions and outcomes. Researchers are neither objective, nor subjective, but instead work within intersubjectivity, in which shared understandings/meanings are created (between researcher and participant, as well as researcher and peers). The alternative is oscillating between a forced and unproductive summarised view of a phenomenon being objective or subjective, and instead accepting that there is a single *real* world, but with multiple interpretations of it (Morgan, 2007; Given, 2008). Through this understanding, concentration lies on beliefs directly linked to actions, rather than a commitment to abstract philosophical beliefs, as such research is influenced by historical, cultural and social factors. In addition, pragmatism moves beyond procedural, practicality issues of *what works*, and is broadened to consider how such factors influence the choices made by the researcher, as well as the way in which the results of those choices are interpreted [not just *what* a researcher does, but *why* it was done in a particular way] (Morgan, 2007).

Overall, pragmatism shifts the focus from the nature of reality, to the nature of human experience, and consequently, allows the researcher to move iteratively between different inductive and deductive approaches, to end up with the best possible results, making use of abductive reasoning (Morgan, 2007). This is evident in this current study, as the researcher makes use of qualitative methods,

quantitative methods, as well as policy analysis in Phase I of the study, various forms of reviews in Phase II, and a modified Delphi study in Phase III. To effectively implement an abductive approach, allow transferability of the results, as well as employ intersubjectivity, the researcher makes use of the various types of mixed methodology.

3.2.2. Deciding on a mixed method study

The decision to conduct a mixed method study depends on three factors; weighting, timing and mixing (Creswell, Fetters, & Ivankova, 2004).

3.2.2.1. Weighting/Priority

The main consideration in a mixed method is determining which methodological form requires more emphasis (quantitative data or qualitative data), or whether equal emphasis should be placed on both forms of data (Creswell, Fetters, & Ivankova 2004). To answer the research questions of the study, importance is *weighted* against quantitative or qualitative methods, while the availability of resources is also a consideration (Creswell, 2003).

3.2.2.2. Timing/Sequence

This refers to whether data collection and analysis of quantitative and qualitative data will be conducted simultaneously (concurrently) and/or at different times (sequentially). Plano Clark, Huddleston-Casas, Churchill, O'Neil Green, and Garrett (2008) assert that concurrent timing combines mixed method results during the interpretation stage. However, sequential timing entails collection and analysis of quantitative and qualitative data in a particular sequence.

3.2.2.3. Mixing

This refers to how the quantitative data and results are related to the qualitative data and results, producing understandings that exceed what is garnered from the separate components of the study (Plano Clark et al., 2008). Mixing generally occurs in one of three ways; the two data sets are

either merged, connected, or embedded (Creswell & Plano Clark, 2007). *Merged* studies integrate the two data sets either during data analysis (when one type of data is transformed into the other data type), or during the final interpretation and discussion (Plano Clark et al., 2008). *Connected* studies link one type of data to the results of the other type; the initial results are inadequate and call for the other data type to build on, or follow up the initial results in studies (Plano Clark et al., 2008). *Embedded* studies use one type of data in the context of a design, based on the other data type (Plano Clark et al., 2008). Therefore, *embedded mixing* occurs at the design level, not just at the data level (Plano Clark et al., 2008). Consequently, the mixed methods approach tends to resonate with a pragmatic worldview (Morgan, 2007; Johnson, Onwuegbuzie, & Turner, 2007).

3.2.3. Types of mixed methodology

Mixed methods has five main functions (Greene, Caracelli, & Graham, 1989; Johnson & Onwuegbuzie, 2004) as depicted in Table 3.4.

Table 3.4: Main functions of mixed methods

1. Triangulation	Seeking intersections or corroborating the results from the different methods and designs employed in studying the same phenomenon.
2. Complementarity	Aims to elaborate, enhance, or clarify the results of one method with results from another method.
3. Initiation	Relates to paradoxes or contradictions that may lead to reframing the research question.
4. Development	Entails using the findings of one method to help inform another method.
5. Expansion	Expanding the breadth and range of the research by using different methods for different enquiry components.

According to Creswell, Plano Clark, Gutmann, and Hanson (2003), mixed methods are conducted in two main categories namely, sequential and concurrent. In *sequential designs*, either the qualitative or quantitative data are collected in

an initial stage, followed by the collection of the other data type during a second stage; data is collected in this manner to use one method's findings to elaborate, or expand the findings of the other method (Creswell, 2003; Castro, Kellison, Boyd, & Kopak, 2010; Leavy, 2017). There are three types of sequential mixed methods designs, as depicted in Table 3.5.

Table 3.5: Types of sequential mixed methods designs

<p>1. Sequential explanatory</p>	<p>This entails as quantitative method is conducted first (priority), followed by the qualitative method. This is done as the quantitative aspects take precedence and the qualitative aspect is used more to explain the relationships and differences found in the first phases. A sequential explanatory design does not use an explicit advocacy lens.</p>
<p>2. Sequential exploratory</p>	<p>In this design, the qualitative method is conducted first (priority), followed by the quantitative method. Similarly to the explanatory design, this design does not make use of an advocacy lens.</p>
<p>3. Sequential transformative</p>	<p>Here priority can be given to either method but an explicit advocacy lens is used.</p>

On the contrary, concurrent designs are characterized by quantitative and qualitative data collected during the same stage, although priority may be given to one form of data over the other. Concurrent mixed methods designs are grouped in three categories (Creswell et al., 2003; Castro et al., 2010), as summarized in Table 3.6.

Table 3.6: Categories of concurrent mixed methods designs

<p>1. Concurrent nested</p>	<p>Both qualitative and quantitative data are collected at the same time (same stage), although one form of data is given more weight over the other</p>
<p>2. Concurrent transformative</p>	<p>This design is theoretically driven to initiate social change or advocacy.</p>
<p>3. Concurrent triangulation</p>	<p>Makes use of both qualitative and quantitative data to accurately define relationships among variables of interest.</p>

3.2.4. Mixed method typology of this current study

In this current study, the researcher utilised concurrent triangulation, discussed in more detail during the needs assessment stage (Phase I). Concurrent triangulation uses separate quantitative and qualitative methods to offset the weaknesses, inherent in one method, with the strengths of the other method (Creswell et al., 2003). Triangulation could also include the use of more than one type of qualitative method, as triangulation, generally, indicates the use of more than one method (Flick, 2018).

In the concurrent triangulation design typology, the quantitative and qualitative data collection are concurrent, occurring during one phase of the research study, with the integration of the results from the two methods, occurring during the interpretation phase (Creswell et al., 2003). Concurrent triangulation was selected for this current study to extend the range of insight and knowledge produced, a quality deemed necessary, as the families the intervention aimed to assist were unique, as were the contexts in which they functioned.

Various forms of triangulation occurred in this current study, namely, families experiencing violence in the home were observed, at different times (as data collection was conducted during 2015 to 2017), in different places (urban and rural locations, detailed under *Recruitment*), as well as with different persons (individuals and groups); all factors linked to *data triangulation* (Carter, Bryant-Lukosius, DiCenso, Blythe, & Neville, 2014; Flick, 2018). In addition, more than one theory was used in this study, for the purpose of result interpretation (family systems approach/ecological theory), which indicates *theory triangulation* (Carter et al., 2014; Flick, 2018). Finally, multiple methods of data collection were conducted in this current study, namely, individual interviews, group discussions, questionnaires, as well as document analyses, which is referred to as *methodological triangulation* (Carter, Bryant-Lukosius, DiCenso, Blythe, & Neville, 2014; Flick, 2018). These triangulation processes occurred concurrently in this current study.

3.2.5. Research design

3.2.5.1. *Intervention mapping*

Intervention mapping was the chosen design for this study. Intervention mapping utilises knowledge from literature, as well as key stakeholders to develop, implement and evaluate an intervention in five stages, as the assertion of intervention mapping is that there is collaboration between individuals, who would make use of the intervention, and the intervention developers (Van Oostrom et al., 2007). While exploring family and family violence, especially within its influencing environments, parallels to the theoretical grounding of intervention mapping, which is the social ecological approach (Kok, Peters, & Ruiters, 2017), are aligned to the conceptual framework of the study. Simply put, to assist families, who are experiencing violence in the home, would require an intervention developer to use intervention mapping, to incorporate available family violence literature, discussions with family violence stakeholders, as well as an analysis of the systems that influence those families, to develop the most appropriate family intervention. This use of multiple sources to create cross verification of the intervention scope and content, illustrates the concurrent triangulation used in this current study, as these processes may have occurred, simultaneously, as parallel processes.

Therefore, intervention mapping plots the pathway from the recognition of a need, to the identification of a solution, particularly, it is a tool that assists in planning and implementing health-promoting interventions (Kok, Schaalma, Ruiters, Van Empelen, & Brug, 2004). Intervention mapping has five steps:

1. Specify the programme's goals into proximal programme objectives. In this stage, needs are identified;
2. Selection of theoretical and practical strategies;
3. Design the programme,

4. Implementation of the programme, and
5. Focus on anticipating process and effect evaluation

(Kok, Schaalma, Ruiter, Van Empelen, & Brug, 2004).

In this current study, the researcher only focused on the first 3 steps of intervention development, as depicted in Figure 3.1. The phases were, **Phase I**, a family violence needs assessment conducted to identify the problem, thereby creating a comprehensive depiction of what issues were present in the communities experiencing family violence. Additionally it provided a scope for possible change, regarding the target population’s perceptions of the issue (Nutbeam, 1998; Kok, Schaalma, Ruiter, Van Empelen, & Brug, 2004).

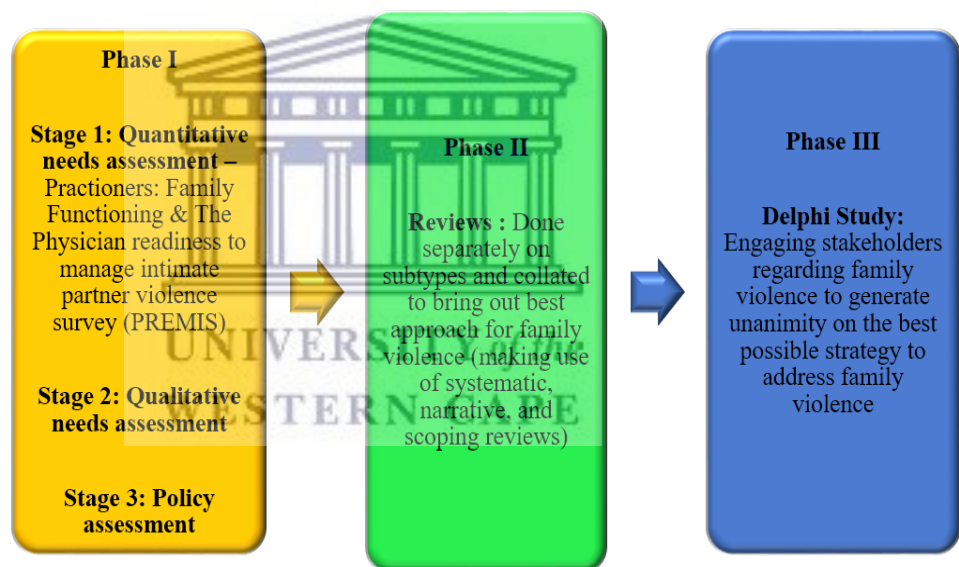


Figure 3.2: Overview of study design

Phase II entailed a review to determine appropriate theoretical and practical approaches for the intervention with family violence (Kok, Schaalma, Ruiter, Van Empelen, & Brug, 2004). A review was viewed as a means to provide the best quality, theoretically sound basis, to assist in explaining and predicting change in the personal, social and environmental characteristics at which the intervention was aimed (Nutbeam, 1998).

Phase III was a Delphi study that aided in the design and development of the intervention. This was a vital part of intervention formation, as active participation of the individuals and communities the intervention is intended to benefit, was essential in the decision-making (Nutbeam, 1998).

3.2.5.2. Recruitment

Families were initially sought for the purpose of the study, to reduce harm and enhance benefit, in accordance with the ethics, outlined nationally and internationally (Ellsberg & Heise, 2002). Organisations that were already working with families, who were experiencing violence, were approached. Permission was sought from the various national offices to approach the regional offices; however, it was at the discretion of the incumbent social workers and counsellors of the organisations, to decide whether they could assist, or not. When permission was granted by the national head offices, invitation letters were sent to regional offices within the area, inviting existing clients and their families to participate; however, after one-and-a-half years, only one participant was recruited.

After much interaction, attending regional shelter forum meetings for further recruitment, and checking up with the organisations, this non-participation was still the status quo. Apparently, this non-participation was due to either non-responsiveness, or the lack of time of already limited staff. Additionally, the contacted organisations that particularly worked with the elderly, claimed that their clients were not prepared to participate, as the topic was of a sensitive nature. Evidently, this scenario is quite common with elder abuse, as underreporting was due to a sense of protecting the family, a sense of shame, or helplessness (Kwiatkowski, 2015).

Therefore, the sampling and data collection were restructured to focus on family practitioners. It was observed that organisation staff were more comfortable to relay their own experiences, as well as insight about families, who were experiencing violence, than allow access to their client

base. For this reason, only practitioners were consulted.

NGOs were approached, as they were situated in static locations. In addition, they encountered many families who were experiencing difficulties (families known to experience instability, and chaotic households that were familiar to such difficulties) in areas such as Facticeon, Elsies River, Dunoon/Joe Slovo, Observatory, Khayalitsha, Bellville and Mitchells Plain (Evans, 2003; Lupton & Power, 2002; Families South Africa, Western Cape [FAMSAWC], 2015). However, due to the limited staff members in the NGO settings, many of the case workers, who participated in this current study, were working in broadened services areas, such as the Cape Town metropole, Boland, Cederberg, Overberg, and Lamberts Bay areas, while others had work duties that included the Western Cape Province, as a whole. This current study, therefore, drew information from urban, as well as rural areas of the Western Cape.

3.2.6. Phase I: Family violence needs assessment

In Phase I, a family violence needs assessment was conducted with practitioners, to identify the problem, creating a comprehensive depiction of what issues were present in a family experiencing violence. Additionally, it was anticipated that the assessment would provide a scope for possible change, regarding the target population's perceptions of the issue (Kok, Schaalma, Ruiters, Van Empelen, & Brug, 2004; Nutbeam, 1998). This phase followed concurrent triangulation in which to conduct a quantitative and qualitative needs assessment. Subsequently, a policy assessment was added to this phase, to ascertain, holistically, whether current policy and law provided a legislative environment that met the needs of families experiencing violence in the home. This analysis also sought to determine whether policy provided a supportive setting for the practitioners, who worked with these families, to execute their duties, effectively, as well as whether adequate guidance was offered in these legislative acts.

3.2.6.1. Sample

In total, nine participants were recruited for the quantitative phase. The

mean age of the participants was 33.14 (SD=11.60) years, most of whom were female [7 (77.8%)]. All of the participants were employed [9 (100%)], with most being in the Afrikaans-speaking [6 (66.7%)], and Coloured [4 (44.4%)] demographic. The majority of the participants were social workers [7 (77.8%)], working in the low income [6 (66.7%)] areas of Lamberts Bay [5 (55.6%)] in the Western Cape. The participants considered that they had sufficient government stakeholder support [5 (55.6%)] to address family violence; however, they did not presume to have adequate community support [5 (55.6%)], resources [7 (77.8%)], and referrals [7 (77.8%)], for and from families, who were experiencing violence. These demographics appear in Table 1, Appendix A.

3.2.6.2. Stage 1: Quantitative needs assessment

3.2.6.2.1. Data collection instrument

A questionnaire was administered to NGO practitioners, who worked with the families who were experiencing violence in the home, to determine their perceptions of these families. Their perceptions were integral for the purpose of programme design and development. Interventions directed at most forms of family violence sought to improve family functioning, through the control of impulses, as well as other behaviours and affects related to family violence; whichever interventions provided the most positive outcomes, and were the most promising (Tolan, Gordon Smith, & Henry, 2006). The questionnaire (Appendix C) was divided into three sections.

- **Section A: Biographical information**

The biographical details of the practitioners (gender, age, race, and language), as well as information regarding the work area/community, and the resources available to them in the community were required. In addition, the aim was also to determine their perceived support from the community, as well as the government.

- Section B: The questionnaire of family functioning

The family functioning, self-administered questionnaire was created to verify the core aspects of the family's interpersonal functioning, an aim usually focused on and addressed in family psycho-educational programmes (Casacchia & Roncone, 2014; Roncone et al., 2007). Although the McMaster Family Assessment Device [FAD] (Epstein, Baldwin, & Bishop, 1983) is notably popular in assessing how family members perceive the family environment and interaction, the family functioning (FF) questionnaire focussed on the skills that family members should possess, to help each other (Casacchia & Roncone, 2014).

An example provided was that the FAD's communication scale related to the clear and direct exchange of information among family members, and not much on the skills required to communicate, such as expressing pleasure/displeasure and active listening, which is part of psycho-educational treatment (Casacchia & Roncone, 2014). The FF is a 24 item questionnaire that measures:

- a) *problem-solving*, based on six steps of structured problem solving, which is: to identify the problem; list possible solutions; discuss pros and cons of each proposal; choose the best or most satisfying realistic solution; plan the solution; and review implementation;
- b) *communication skills*, which entails the expression of positive and negative feelings, making requests, and active listening; and
- c) *personal goals*, which is each family member's ability to identify personal everyday goals, as well as how to express those goals (Casacchia & Roncone, 2014; Roncone et al., 2007). Example:

Statement	Always	Often	Sometimes	Never
Families experiencing violence, collaborate together to find the best way to solve their problems.	1 (Always)	2 (Often)	3 (Sometimes)	4 (Never)

The family functioning questionnaire investigates the positive qualities of the family and not the negative, in order to augment the skills needed to reinforce family functioning and life satisfaction (Casacchia & Roncone, 2014). This questionnaire has been adjusted for the purpose of this current study, as originally, it was directed towards caregivers of schizophrenic family members (Casacchia & Roncone, 2014; Roncone et al., 2007).

Validity and Reliability

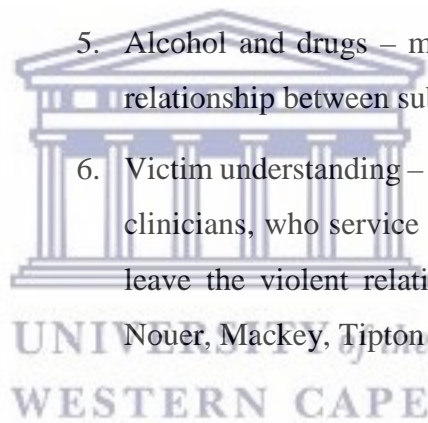
Psychometric properties: The questionnaire initially included 60 items, and was later scaled down to 38 items, as a result of focus groups and preliminary investigations (Roncone et al., 2007). After two additional studies, as well as rewording/removing certain items, and aligning questions more thoroughly to the core domains, the questionnaire was scaled down to 24 items (Roncone et al., 2007). The 24-item questionnaire achieved an over-all Cronbach Alpha score of .84, with the three sub-scales: Problem-solving indicating $\alpha = .83$, Communication showing $\alpha = .71$ and Personal goal presenting $\alpha = .66$ (Roncone et al., 2007).

- Section C: The physician readiness to manage intimate partner violence survey (PREMIS)

The PREMIS is a survey questionnaire developed to measure clinician knowledge, beliefs and self-reported behaviours (KABB) of physicians in four parts, namely: background; intimate partner violence knowledge; opinions; and practice issues (Connor, Nouer, Mackey, Tipton, & Lloyd, 2011;

Short, Alpert, Harris, & Surprenant, 2006). However, for the purpose of this current study, only the opinions subscale has been used, which observes 6 dimensions, namely:

1. Staff preparation – which observes the clinician’s skills in discussing domestic violence (DV) with men, women, and people from different backgrounds;
2. Legal requirements – which measures awareness of legal requirements in reporting cases of DV;
3. Workplace issues – measures adequate time to respond to service users experiencing DV;
4. Self-efficacy – determines comfort in discussing DV with service users;
5. Alcohol and drugs – measures knowledge about the relationship between substance misuse and DV, and
6. Victim understanding – determining the opinion of the clinicians, who service users experiencing DV, could leave the violent relationship at any time (Connor, Nouer, Mackey, Tipton & Lloyd, 2011).



For this current study, however, the questions were adapted to address family violence in a more holistic sense, and all questions that seemed to be directed at physicians, explicitly, were removed. This was done so that non-clinical paraprofessionals, as well as non-medical professionals, would be able to answer the questions, which has not yet been done with this instrument before (Connor et al., 2011; Short et al., 2006). The seven-response options were reduced to four category response options, as the seven responses would still have to fall under the four-response categories, as per the example below.

Statement	Strongly disagree	Disagree	Agree	Strongly agree
I ask all newclients about abuse in their relationships.	1 (Strongly disagree)	2 (Disagree)	3 (Agree)	4 (Strongly agree)

Validity and Reliability

Psychometric properties: According to Short et al. (2006), the developers of PREMIS, the opinions scales initially contained 54 items, which were later scaled down to 31 items, by means of factor loadings and testing the Alpha coefficients. Through this process of validity testing, the opinions scales were reduced from 8 to 6 core scales, namely:

i. Staff preparation, which contained 5 items, displayed an $\alpha = .85$;

ii. Legal requirements, which contained 4 items, displayed an $\alpha = .82$;

iii. Workplace issues which contained 6 items, displayed an $\alpha = .79$;

iv. Self-efficacy which contains 6 items, displayed an $\alpha = .69$;

v. Alcohol and drugs which contains 3 items, displayed an $\alpha = .70$; and

vi. Victim understanding which contains 7 items, showed an $\alpha = .69$

(Short et al., 2006).

3.2.6.2.2. Data Collection Procedure

Data were collected from practitioners who worked in various regions of the Western Cape, South Africa. These regions include the Boland, Cederberg, Overberg, and Lamberts Bay areas, as well as the greater

Cape Town. Each practitioner was handed a self-report questionnaire to complete, with the researcher present to clarify any queries regarding the questionnaire.

3.2.6.2.3. Data Analysis

The data were entered, cleaned and analysed, using the latest version of SPSS (Statistical Package for the Social Sciences), documenting the results in descriptive statistics, such as mean scores and frequencies.

3.2.6.3. Stage 2: Qualitative component of family violence assessment

Immediately after the questionnaire, the participants were asked if they would participate in an interview, regarding their experiences with families who were experiencing violence in the home. In this stage, the participants were afforded the opportunity to narrate their experiences with these families, descriptively, as well as elaborate on what should be included in a family-centred intervention.

3.2.6.3.1. Data Collection Tool

For a more contextual gauge, regarding the occurrence of family violence in the home, semi-structured interviews were used to qualitatively explore the practitioners' perceptions of the family members' experiences of family violence, family life, as well as recommendations for programme development. The questions used in the interviews were adapted from a lethality risk assessment designed by McCloskey and Grigsby (2005), usually conducted as part of the procurement of a family violence history from a client. The aim was to assess, as far as possible, the dangerousness and level of risk of the home environment, an insight into which was vital for safety planning, risk assessment, and intervention (McClennan, 2010). As the aforementioned, the questions elicited practitioner perceptions around:

✚ 1. The family members' experience of family violence

Regarding the families that you have encountered, who were experiencing family violence, did they ever described how arguments usually started in the home? *Prompt:* If so, could you describe the incident? /What usually happens during these arguments?

✚ 2. Experience of family life

How did a family member describe what had been happening in the home?

✚ 3. Recommendations for programme development

Have the family members ever mentioned to you what, in particular, they would want changed in their families? *Prompt:* What would you as a practitioner like to see implemented? Would a family violence intervention that includes all the family members be helpful?

As seen in the examples above, questions further included open-ended prompts, when the initial responses were vague, required elaboration, or the questions needed clarification (Appendix D).

3.2.6.3.2. *Data collection procedure*

- In the same session as the quantitative assessment, individual face-to-face interviews were conducted with eight of the nine participants.
- These interviews were conducted in Afrikaans or English individually with each participant.
- The organisation's facilities were used to conduct the interviews. The participants were notified that the session was to be recorded on a digital recorder, with no personal descriptors used in the interview. They were also reminded that the interviews were voluntary; therefore, they could withdraw from the interview at any given time, without

negative consequences.

3.2.6.3.3. Data Analysis

The digital recordings were transcribed verbatim and analysed using thematic analysis. Thematic analysis is a 6-stage process of data emersion, codifying and thematisizing to extract relevant themes that would build on the quantitative findings (Braun & Clark, 2006). This 6-stage process includes:

- i. Familiarizing oneself with the data by reading and re-reading the transcribed data,
- ii. Generating codes by means of organizing the data into meaningful groups,
- iii. Searching for themes by re-focusing the codes into an overarching theme,
- iv. Reviewing themes by refining it either by breaking the themes down further or merging them,
- v. Defining and naming the themes by identifying the essence of each theme, and
- vi. The final analysis and writing up of findings

(Braun & Clark, 2006). The analysis of the above can be found in the second part of Appendix B.

3.2.6.4. Stage 3: The family policy analysis

Family is rarely addressed in violence related policy, as the focus is placed on the victim/perpetrator, and the alignment of the justice system with this relationship. However, the normalization of violence begins in the family and could be further exacerbated by community violence, which leads to the desensitization of violence, as well as violence being viewed as socially appropriate to resolve interpersonal conflict (Leoschut, 2009). Therefore, the researcher was of the opinion that, in order for the family to gain more

focused attention in policy, and to garner a more holistic response when faced with violence, attention needs to be directed at what was currently available, to address violence occurring in the family. Firstly, the theoretical framework inspiring the direction of a family-centred focus in legislation was explored. Secondly, international and regional commitments, from which South Africa had drawn to shape family focused legislation, were reviewed, as well as how it had influenced South Africa's response to families at risk of violence. Thirdly, the need for an integrated strategic framework for violence, as the best means to co-ordinate resources and stakeholder responses, was discussed, as well as how to harness political will, in directing efforts towards violence prevention. Lastly, South African legislation directed towards family violence was examined, and the implications of putting families at the forefront of legal consideration, was discussed, as well as health promoting interventions.

Policy analysis is grounded in pragmatism in its inquiry, aimed at the creation, assessment and communication of policy-relevant information, as this analysis aimed to clarify and improve practical problems, which were observed to be complexly political, cultural, economic and ethical, simultaneously (Dunn, 2015).

3.2.7. Phase II: Selection of theoretical and practical strategies for intervention

In order to assess development, as well as the delivery and evaluation of the identified family-centred interventions, the RE-AIM framework was used to structure the analysis of the interventions revealed. The use of the framework is not dependent on which methodology the study employed, but rather focusses on the core elements of the intervention. The RE-AIM acronym denotes five elements, namely:

- i.) **Reach** – refers to the target population that will be reached by the intervention, and determines whether the intervention was used on the intended target population;

- ii.) **Effectiveness** – refers to the intervention achieving its objectives/outcomes;
- iii.) **Adoption** – refers to target staff or organisation adopting the intervention;
- iv.) **Implementation** – refers to consistency and adaption of intervention protocol to practice;
- v.) **Maintenance** – refers to intervention effects on participants over time (Matthews, Kirk, MacMillan, & Mutrie, 2013).

Family violence is not regarded as a holistic term, but addressed in its silo subsets (IPV, child abuse, elder abuse). Individuated reviews were conducted requiring different processes, due to the availability of studies (Table 3.7). These reviews were later collated as a narrative review of family-centred interventions, aimed at family violence, presented later in Chapter 4.

In this stage, the researcher drew on the theoretical underpinning of the family systems approach, as discussed in the conceptual framework, to guide the implementation of these reviews. The individual processes can be viewed as appendices (Appendix E- Systematic review of IPV family interventions; Appendix F – Scoping review of child abuse family interventions; Appendix G – Narrative review of elder abuse family interventions). As aforementioned, this current study presents a collated display of the processes used and the results revealed as a family violence narrative review (See Chapter 4: *A Review of Family-Centred Interventions Focusing on Family Violence*).

3.2.8. Phase III: Design the programme

3.2.8.1. Research design

This current study utilised a modified Delphi method, a combined process of a self-administered questionnaire, followed by a physical meeting of the experts to discuss the results (Boukdedid, Abdoul, Loustau, Sibony, & Albert, 2011).

Table 3.7: Reviews done to collate family-centred interventions aimed at family violence

Focus of review	Type of review	Review method and process
Family-centred interventions aimed at intimate partner violence	Systematic	<p>The search protocol was discussed with the fellow reviewer (NR). The full search examined titles and abstracts matching the selection criteria; were done by the first reviewer (JR) and the second reviewer (NR). Due to limited family-centred interventions addressing IPV, broad search terms were used. Data bases utilized were PubMed, BioMed Central, SABINET, SocIndex, PsycArticles and Academic Search Complete. Limiters were adapted where necessary (certain databases needed specificity, e.g. 'Humans only' studies). Search terms included family-centred, family-based, interventions, strategies, programs, intimate partner violence, gender-based violence, partner violence, domestic violence and community-based.</p> <p>All publications that implemented interventions that were family centred and aimed at IPV, were included. Articles were searched for within a 10-year span to date of the study being done (2005-2015) and in English. A 10-year span was decided upon in order to elicit latest trends and interventions used at family level for IPV. The search protocol was developed using the PICOS framework for systematic reviews, specifically: i) Population- Family members affected by IPV; ii) Intervention: interventions aimed at reducing IPV and its effects, yet inclusive of family members; iii) Context: interventions that were community-based, offered via NGOs, primary health care; iv) Outcomes: based on the RE-AIM framework (Reach, Effectiveness, Adoption, Implementation or Maintenance) of the intervention; v) Study Design: This was not defined to a specific study design but the studies, however, had to report on an intervention including process data.</p> <p>Exclusion criteria included protocols, interventions focused only on one individual and, hence, not inclusive of the family, case studies, interventions not aimed at IPV, systematic reviews, reviews, and also studies which had not reported on interventions inclusive of process data.</p> <p>Data extraction and quality appraisal for IPV articles</p> <p>Data relating to study characteristics and findings were extracted and tabulated and was performed by one reviewer (JR) and reviewed by the second reviewer (NR). Inclusion and exclusion criteria were used to clarify difference of opinion. The RE-AIM Framework evaluation (Adapted from Glasgow 1999; Glasgow, McKay, Piette & Reynolds, 2001; Blackman, Zoellner, Berrey, Alexander, Fanning, Hill & Estabrooks, 2013) was used to evaluate the interventions fitting selection criteria as illustrated in Table 1. A total of 18 038 potential articles were found via the electronic databases through the various search terms. After duplicates were removed and article titles were screened, 25 abstracts were retrieved. A further 18 articles were removed due to studies not fitting selection criteria as they were either reviews, case studies or only directed the intervention at one member of the family. Six articles had met the desired score of 67%-100% as per methodological quality.</p>
Family-interventions aimed at child abuse	Scoping	<p>Data was systematically collected from databases namely, Health Source: Consumer Edition; PUBMED, PsychArticles; SocIndex, and Academic Search Complete. Additionally, child relevant; peer-reviewed journals were also searched; such as African Safety Promotion: A Journal of Injury and Violence Prevention, South African Journal of Psychology; as well as Child Abuse and Neglect (Elsevier). Searches were done for the period 2007-2017, which was within the 10-year period of relevant literature to the date of study.</p> <p>Search terms included child maltreatment, child abuse; child neglect, family intervention/s; parent-child centred, family wellness; family approach, and community-based. The titles and abstracts of the literature identified for this study were screened by two researchers independently, using the inclusion criteria as stated below. The full text</p>

		<p>articles that were potentially relevant to the systematic study were retrieved and screened by one researcher (JR) with secondary screening done by another researcher (NR) using the same inclusion criteria in order to determine eligibility of the studies for this study.</p> <p>Inclusion criteria were i) English, intervention studies, ii) full text articles, iii) from 2007-2017, iv) intervention studies about humans only and v) studies must speak to addressing child abuse specifically from a family-centred approach. Exclusion criteria included consensus studies, studies using secondary data, studies which did not show a programmatic layout beyond just screening, protocols, interventions focused only on one individual and, hence, not inclusive of the family, case studies, interventions not aimed at child abuse, systematic reviews, and reviews. Initial search was conducted by one researcher, yielding a total of 10 654 prospective articles, which had the search terms in their titles, keywords and abstracts. Titles and abstracts were screened by the same researcher. After 320 duplicates were removed in searches, 29 titles were screened as eligible of which 5 abstracts were deemed relevant to the study. The search process, titles, and abstracts underwent secondary screening by another researcher who acted as first reader.</p>
<p>Family-centred interventions aimed at elder abuse</p>	<p>Narrative</p>	<p>Databases searched included Google Scholar, Academic Search Complete, PubMed, SocIndex, MEDLINE, PsychARTICLES and Research Gate. Search terms included elder abuse and neglect, community-based, family, family interventions, family-centred and family-based interventions. The interventions sought were in English as well as searched from within an 11-year time frame from date of study (2006-2017) to elicit latest trends.</p> <p>Articles seen to relate to the search terms, were assessed via titles, abstracts as well as article content. Articles sought for this review had to be family-centred interventions with a primary aim to address elder abuse. The interventions had to have included the elderly and at least the family caregiver. Furthermore, the intervention was to go beyond screening but also include a program referral plus a description of the program layout, with the program potentially to be implemented at community level. Furthermore, a systematic review of citations for elder abuse (Erlingsson, 2007) had been referred to in order to identify specific journals that would yield results in offering more articles in terms of family-based interventions.</p> <p>In total 34 929 hits were found via the databases. This total excludes Research gate results, as Research gate does not provide an exact number of hits. Only 3 articles were identified via title with 1 identified through Research Gate. Of the 4, 1 was later excluded due to the intervention not aimed primarily at elder abuse. In total, only 3 articles were identified as family-centred interventions aimed primarily at addressing elder abuse. The family-centred interventions were conducted in Israel, Iran and in the United States with the Native American community.</p>

Both the questionnaire process, as well as the physical meeting of the experts were considered separate rounds in the modified Delphi method (Boulkedid et al., 2011; Custer, Scarcella, & Sterwart, 1999). The round in which the experts engaged with the items face-to-face in a physical meeting, coincides with a popular Delphi technique, noted as the estimate-talk-estimate, or nominal group technique. In this technique, the experts provide individual, independent judgments, followed by a group discussion, which, consequently, is followed by independent judgements drawn from the group discussion, until consensus is reached (Custer, Scarcella, & Sterwart,

1999; Armstrong, 2001; Avella, 2016; Green, Armstrong, & Graefe, 2007). The current Delphi study consisted of 2 rounds, which is supported by Keenay, Hasson, and Mckenna (2006), who state that the number of rounds depends on the time available and the exhaustion incurred after two rounds, as experts tend to be busy.

3.2.8.2. Process

On 30 November 2016, invites for the Delphi participation were sent to 29 potential participants from the local and international backgrounds. These participants were sourced and selected based on their contribution to the academic field of family violence, identified through their biography. In addition, the participants were also located via national and international conferences on violence prevention and safety attended, workshops attached to these conferences, family violence seminars, provincial shelter forum meetings, local government forum meetings on child protection and family services (which would also included NGOs invited to attend). Networking was also conducted with the attendees of all the above-mentioned events, in a snowball effort to assess other contacts, who might be eligible to participate in the Delphi study, but were not present at these events. Responses were received within the first two weeks, after which re-invites were sent every two weeks. Consent forms were received during December 2016. The participant demographics are presented in Table 3.8.

3.2.8.3. Round 1

The participants were asked to comment on the preliminary findings of the study (Phases I and II), as well as the proposed layout of the intervention programme. Feedback was given according to three questions adapted from Van Oostrom et al. (2007), namely:

1. What does the target population need to learn or acquire regarding family violence to achieve an optimal family environment or functioning?
2. What needs to be changed in the environment for the target

population to achieve an optimal family environment or functioning?

3. What are your thoughts on the scope, content, possible approaches used, implementation, resources needed and cost of this proposed programme? In your experience, what do you think needs to be considered?

3.2.8.4. Pilot Workshop

Building on the findings of round 1, a pilot workshop was hosted 2 weeks before the main workshop (round 2) as a test run for the efficacy of the workshop layout and content. A faculty, as well as department level invite was sent to staff and post-graduate students to participate. The workshop was hosted, with the feedback session digitally recorded.

Table 3.8: Round 1—Participant demographics

Gender	Age	Employment title	Specialization
Female	47	Academic/Clinical psychologist	Traumatic stress
Female	52	Clinical services coordinator/Psychologist	Perinatal mental health
Male	45	Psychologist/Academic	
Female	56	Researcher	Gender-based violence (GBV)/violence against children/health consequences of violence
Male	56	Academic/Clinical psychologist	Trauma, violence intervention with children and families
Female	39	Project Manager	GBV (mostly intimate partner violence)
Female	60	Social work educator/Academic/Private practitioner	Interpersonal and sexual violence (risk assessment, intervention, & programme development)

3.2.8.5. Round 2

Invites were sent to various stakeholders; however, owing to a low response rate, the invite was later circulated via the department of social development (Western Cape), and later forwarded to their specific divisions of family services and victim empowerment. A vast response was received, with

departmental lists submitted each day for possible attendees.

A diversified selection was conducted of potential attendees, to create, as much as possible, a balanced mix of stakeholder backgrounds, to garner varied inputs and perspectives. A total of 15 participants participated in the workshop, as shown in Table 3.9.

Table 3.9: Round 2—Participant demographics

Gender	Profession	Work title/area	Work focus	Work description
Male	Law enforcement	Gender Based Violence and Victim Empowerment Safe Schools Coordinator	Non-specific	-
Male	Social Worker	Manager/Welfare	Children and families	-
Female	-	Centre Manager at a Family Counselling Centre	Women and children	Manage a Trauma Counselling Clinic, residential care facility for women and their children, after-school care. Responsible for all governance and clinical aspects of the organisation. Mentor emerging non-profit organisations (NPOs).
Female	-	Director of NGO aimed at gender base violence (GBV), domestic violence and HIV/AIDS	Women, children and families	Strengthening family structures in communities by strengthening the women within them. Done through door-to-door visits and awareness programmes.
Female	Clinical Social Worker	Director at NGO aimed at family services	Families	Manage services such as training and counselling services provided. These services also include community outreach.
Female	Social worker	Welfare	Families	-
Male	Social worker	Welfare	Families	-
Female	Social worker	Welfare	Families	Foster care
Female	Social worker	Welfare	Families	Family interventions with foster families, reunification services with biological parents whose children were removed from their care due to multiple social problems, e.g. domestic violence, substance abuse, physical, sexual, psychological abuse, neglect etc. Also mediation and parenting plans for the children's court.

Female	Social worker	Welfare	Families	Early intervention
Female	Social Worker	Welfare	Families	Foster care, reunification, counselling and supervision.
Female	Social Worker	Welfare	Children	After hours Child protection.
Male	Health and Safety Officer/Counsellor/manager of work integration programme	Child and Youth Care / Drug Counselling	Children, Youth, Men.	Counselling/Mentoring/administration
Female	Paraprofessional	Child and Youth Care	Boys	-
Female	Paraprofessional	Child and Youth Care	Boys	-

3.3. Trustworthiness

Shenton (2004) states that trustworthiness comprises four elements, namely, *credibility* (internal validity), *transferability* (external validity/generalisability), *dependability* (reliability), and *confirmability* (objectivity). These concepts were integrated in this current study as follows:

3.3.1. Credibility

The research methods employed in this current study were derived from, and referenced from empirical bodies of work, to ensure that well-established research methods were used. Triangulation was utilized, as more than one organisation was approached to conduct data collection. The researcher ensured an honest process in data collection by reminding the participants that the process was voluntary and anonymous. Collaborative sessions were held with the supervisor, for the researcher's ideas and interpretations to be tested and broadened. Lastly, a thick description of the findings obtained was provided, in an attempt to promote credibility.

3.3.2. Transferability

Transferability is the extent to which the findings of the study could be generalized (Shenton, 2004). A mixed methodology was implemented for this current study, to tap into a broad range of participants, for a full contextual description.

3.3.3. Dependability

This relates to how the study could be repeated (Shenton, 2004). A detailed description of the data gathering process was provided, and a reflective process was embarked on, as explained under heading of *Reflexivity*.

3.3.4. Confirmability

Confirmability denotes that the findings of the study should reflect the thoughts and experiences of the participants, and not the characteristics, or preferences of the researcher (Shenton, 2004). Therefore, the Delphi study section of this current study was implemented, that, through the stages of engagement with relevant stakeholders, as well as participants, information was representative of needs assessed.

3.4. Reflexivity

Introspective reflexivity was employed, in which the researcher engaged with personal meanings, personal insights and experiences drawn from the research process, by means of a reflective journal (Finlay, 2002). Reflexivity and introspective insights are discussed under the following section, *Reflections of the data collection process*".

3.4.1. Reflections of the data collection process

The study design described in this chapter was a way forward to create a holistic intervention that is family-centred, to reduce violence in the family. However, family violence is an intricate topic, and when researched, proved to be quite challenging, especially when attempting to engage with families experiencing violence, as well as interview the practitioners, who assisted them. The recruitment process that was initially conducted for families, proved to be quite challenging.

Research in the field of violence have more defined ethics than any other sensitive topic, as the conducted research could put both participant and researcher at risk, if safety concerns were ignored (Ellsberg & Heise, 2005). To reduce harm and enhance benefit, in accordance with ethics outlined nationally and internationally

(Ellsberg & Heise, 2005; Republic of South Africa [RSA], Department of Health [DoH], 2015), organisations, which were already working with families experiencing violence, were approached.

Permission was sought from the various national offices to approach regional offices. However, even with this permission, the discretion to assist or not, rested with the individual social workers and counsellors of the organisations. After permission was granted, invitation letters were sent to offices in the regional area, inviting existing clients and their families to participate; however, after a year and a half only one participant was recruited. Even after much interaction, attending regional shelter forum meetings for further recruitment, and following up with the organisations, it was either through non-response, or the already limited staff members' lack of time that non-participation resulted.

Additionally, the contacted organisations, who particularly worked with the elderly, claimed that their clients were not prepared to participate, as the topic was sensitive and they did not want to talk about it. This scenario was quite common with elder abuse, as underreporting was a way of protecting the family, or a sense of shame and helplessness (Kwiatkowski, 2015). Organisations, as gatekeepers of the community and the clients, fulfilled a major role, not only regarding the initial family recruitment, but organisation resistance contributed much to the challenges experienced. However, when restructured, and the data collection was conducted, the organisations played a valuable role in networking.

The data collection process was restructured, as the organisation staff appeared to be more comfortable to relay their own experiences and insight of families experiencing violence, than allow access to their client base. Therefore, only practitioners were used in the needs assessment phase, in addition to the policy analysis. However, this also proved to be challenging, as the organisations present for the initial family recruitment, withdrew due to fears that approaching staff to participate, would add to the burden of already overworked, time-constrained, limited staff. All the organisations approached, though, confirmed that a family-centred intervention, aimed at reducing family violence, was vital.

3.5. Ethics Statement

Permission to conduct this current study was sought from Senate Higher Degrees and Ethics committees. After permission was granted, contact was made with the managers/directors of organisations registered, in accordance to the Non-profit Organisations Act 71 of 1997, for permission to conduct the study. The participants were informed about the study through an information sheet (Appendix H).

Informed consent was obtained for the prospective participants through signed consent forms. Consent forms were provided at the quantitative stage (Appendix I for the questionnaire) and for the qualitative stage (Appendix J for the interview) in Phases I and III, completed by the individuals, who were willing to participate. The reason for separate consent forms was that qualitative inquiry required more vivid detail into such a sensitive topic; the potential risks differed to the quantitative aspect of the study. Additionally, due to the sensitive nature of the topic, qualitative interviews were done separately with individual participants, and on different days best suited to the participant's availability.

These interviews were conducted at the organisation's facilities. Participation was voluntary and the participants were informed that they could withdraw from the study at any time, with no negative consequences. The participants were informed that they would remain anonymous, as all the questionnaires were numbered for identification purposes, and all information obtained from the interviews remained confidential, as assured in the consent form, and was only shared between the researcher and the supervisor. All ethical considerations stipulated, was in accordance with the revised declaration of Helsinki (World Medical Association [WMA], 2002), and research methods for social work (Rubin & Babbie, 2001; Smith, 2009). Although the above precautions were taken, trained staff members and resource lists were made available to the participants, in the event that distress was experienced and debriefing was required. Sensitivity and respect was maintained by the researcher, to ensure that the participants' self-esteem was not undermined, and show consideration for the topic's sensitivity (Ellsberg & Heise, 2002).

3.6. Conclusion

The concept of family violence is quite disparate in its representation of all the forms of abuse, as it is still divided and addressed in its subsets (child abuse, elder abuse and intimate partner violence). It is anticipated that family violence will be viewed as a holistic phenomenon that affects all members of the family. Consequently, all future interventions, or approaches should be promoted to address family violence in this manner, being cognizant of its effects on all family members, with its solution grounded in family-centred strategies.

3.7. Layout of the results chapters

The following results chapters are structured so that the theoretical chapters (review and policy analysis) are presented first to introduce the conceptual foundation of the study. Subsequently, the primary research (needs assessment and Delphi) follow, to provide the practical application of the concepts that define the programme scope and content. Therefore, the chapters are as follows:

- **Chapter 4:** A review of family-centred interventions focusing on family violence
- **Chapter 5:** Legislative response to family violence in South Africa: A family-centred perspective
- **Chapter 6:** A needs assessment of families experiencing violence in a South African context: The perspectives of professionals
- **Chapter 7:** A Delphi study to develop a family-centred approach to reducing violence in the home

All chapters were written in a manuscript format, as they are, currently, either under review, or published in a peer-reviewed journal.

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CHAPTER FOUR

A REVIEW OF FAMILY-CENTRED INTERVENTIONS FOCUSING ON FAMILY VIOLENCE

4.1. Introduction

The effect of family violence on family members is documented in studies on intimate partner violence (IPV), child abuse, and elder abuse (Tolan-Gorman, Smith, & Henry, 2006). Yet most studies fail to coalesce commonalities among family violence subsets, especially its effects on the family, an understanding needed for an effectively integrated response (Gracia, Rodriguez, Martín-Fernández, & Lila, 2017; Ryan & Roman, 2017). Notably, the common characteristic among family violence subtypes is the close, interdependent relationship between the family members (Wolfe, 2003), with family members (parents, in-laws, siblings, and children) often present when violence occurs in the home (Bassadien & Hochfeld, 2005; Rasool, Vermaak, Pharoah, Louw, & Stavrou, 2002).

Therefore, family violence affects all family members present in the home/abusive setting, the very effects of which are known to hold intergenerational consequences (Ryan, Rich, & Roman, 2015). The co-occurrence of IPV and child abuse potentially affects a child's attitude and belief about violence, regarding its place in relationships, and as a form of conflict resolution (Grogan-Kaylor, Stein, Clark, Galano, & Graham-Bermann, 2017; Haselschwerdt, Savasuk-Luxton, & Hlavaty, 2017). Youth witnessing family members intentionally hurt one another, were thrice as likely to carry weapons, twice as likely to be in a fight, and four times more likely to have threatened/injured someone with a weapon, than youths who had not been exposed to violence in the home (Holborn & Eddy, 2011).

Women exposed to family violence in childhood, are at risk for adult revictimization (Gass, Stein, Williams, & Seedat, 2011; Ryan, Rich, & Roman, 2015), with another study stating that 27% of IPV would not have occurred, if boys had not been exposed to IPV (Abrahams & Jewkes, 2005). These findings hold the possibility that young

people are learning violent strategies to cope with current and future domestic life.

Regarding the elderly, family members are identified to be the most likely perpetrators of elder abuse (Berkman, 2006; Soares et al., 2010), with research documenting an interconnected relationship between the elderly and their family, with the family not only being a source of care but also abuse (Bookman & Kimbrel, 2011; Berkman, 2006; Soares et al., 2010). About 4-6% of seniors experience abuse in the home, and over a third of family carers report perpetrating the abuse (Cooper, Selwood & Livingston, 2008; Sethi et al., 2011). With family members evidently either witnessing, being victims of, or perpetrating family violence, it must be acknowledged that violence in the home affects all family members present; therefore, it is imperative that interventions aimed at reducing violence in the home should embody a family-centred approach. A family-centred approach not only includes all members of the family affected by the violence in the home, but also creates collaboration between the family and the practitioner. The purpose of a family-centred approach is to balance family needs with the best interest of its members; encourage family input on the plan of care, and have each family treated as unique, instead of being seen prescriptive to a specific group (Burns, Dunn, Brady, Starr, & Blosser, 2008).

A family-centred approach allows challenges presented to provide contextual explanation rather than individual blame; focus is given to what is happening in the family rather than what is *wrong* with the family; therefore, adequate support is given through this approach (Bromfield, Sutherland, & Parker, 2012; Burns et al., 2008). A family-based intervention is known to reduce violence in the family and enhance family functioning (Chaudhury et al., 2016). However, few studies are noted to explore family-based interventions in relation to IPV (Chaudhury et al., 2016), which is also seen with child abuse, addressed mainly through child-centred strategies, aligned to the legislative mandate of *best interest of the child* (Ryan, Esau, & Roman, 2018). Elder abuse also has been divorced from family centric insights, owing to the focus on bolstered social services and awareness raising (Daly, Merchant, & Jogerst, 2011; Jagielska, Piłkuła, Łukasik, 2015; Pillemer, Mueller-Johnson, Moch, Sutor, & Lachs, 2007). This paper, therefore, aimed to map out what family-centred intervention programmes are available to address family violence.

4.2. Methodology

Family violence is not discussed as a holistic term, but addressed within its silo subsets (IPV, child abuse, elder abuse); therefore, individuated reviews were conducted requiring different processes due to availability of studies. The individual review processes can be seen as appendices (Appendix E - Systematic review of IPV family interventions; Appendix F – Scoping review of child abuse family interventions; Appendix G – Narrative review of elder abuse family interventions). This current study presents a collated, tabular display of the processes used, as well as the results in Table 4.1.

In order to assess development, but also the delivery and evaluation of the identified family-centred interventions (A family centred programme includes all members of the family affected by the violence in the home, however when not always possible due to logistics, search criteria also included interventions which had at least more than one family member part of the intervention), the RE-AIM framework was used to structure the analysis of the interventions found, as the framework is not dependent on which methodology the study used but rather hones in on core elements of the intervention.

The RE-AIM acronym denotes five elements, namely:

- i.) Reach – which refers to which target population will the intervention reach and was the intervention used on the intended target population,
- ii.) Effectiveness – refers to the intervention achieving its objectives/outcomes,
- iii.) Adoption – refers to target staff or organisation adopting the intervention,
- iv.) Implementation – refers to consistency and adaption of intervention protocol to practice,
- v.) Maintenance – refers to intervention effects on participants over time

(Matthews, Kirk, MacMillan, & Mutrie, 2014).

Table 4.6: Reviews done to collate family-centred interventions aimed at family violence

Focus of review	Type of review	Review method and process
Family-centred interventions aimed at intimate partner violence	Systematic	<p>The search protocol was discussed with the fellow reviewer (NR). The full search, examined titles and abstracts matching the selection criteria; were done by the first reviewer (JR) and the second reviewer (NR). Due to limited family-centred interventions addressing IPV, broad search terms were used. Data bases utilized were PubMed, BioMed Central, SABINET, SocIndex, PsycArticles and Academic Search Complete. Limiters were adapted, where necessary (certain databases needed specificity, e.g. 'Humans only' studies). Search terms included, family-centred, family-based, interventions, strategies, programmes, intimate partner violence, gender-based violence, partner violence, domestic violence and community-based.</p> <p>All publications that implemented interventions that were family-centred and aimed at IPV, were included. Articles were searched for within a 10-year span to date of the study being done (2005-2015) and in English. A 10-year span was decided upon, in order to elicit latest trends and interventions used at family level for IPV. The search protocol was developed, using the PICOS framework for systematic reviews, specifically: i) Population-Family members affected by IPV; ii) Intervention: interventions aimed at reducing IPV and its effects, yet inclusive of family members; iii) Context: interventions that were community-based, offered via NGOs, primary health care; iv) Outcomes: based on the RE-AIM framework (Reach, Effectiveness, Adoption, Implementation or Maintenance) of the intervention; v) Study Design: This was not defined to a specific study design but the studies, however, had to report on an intervention including process data.</p> <p>Exclusion criteria included protocols, interventions focused only on one individual and, hence, not inclusive of the family, case studies, interventions not aimed at IPV, systematic reviews, reviews, and also studies, which had not reported on interventions inclusive of process data.</p> <p>Data extraction and quality appraisal for IPV articles</p> <p>Data relating to study characteristics and findings were extracted and tabulated and was performed by one reviewer (JR) and reviewed by the second reviewer (NR). Inclusion and exclusion criteria were used to clarify difference of opinion. The RE-AIM Framework evaluation (Adapted from Glasgow 1999; Glasgow et al., 2001; Blackman et al., 2013) was used to evaluate the interventions fitting selection criteria as illustrated in Table 4.2. A total of 18 038 potential articles were found via the electronic databases through the various search terms. After duplicates were removed and article titles were screened, 25 abstracts were retrieved. A further 18 articles were removed due to studies not fitting selection criteria as they were either reviews, case studies or only directed the intervention at one member of the family. Six articles had met the desired score of 67%-100% as per methodological quality as seen in Table 4.3. The data extraction of the six articles is shown in Table 4.4.</p>
Family-interventions aimed at child abuse	Scoping	<p>Data was systematically collected from databases namely, Health Source: Consumer Edition; PUBMED, PsychArticles; SocIndex, and Academic Search Complete. Additionally, child relevant; peer-reviewed journals were also searched; such as African Safety Promotion: A Journal of Injury and Violence Prevention, South African Journal of Psychology; as well as Child Abuse and Neglect (Elsevier). Searches were done for the period 2007-2017, which was within the 10-year period of relevant literature to the date of study.</p> <p>Search terms included child maltreatment, child abuse; child neglect, family intervention/s; parent-child centred, family wellness; family approach, and community-based. The titles and abstracts of the literature identified for this study were screened by two researchers independently using the inclusion criteria as stated below. The full text articles that were potentially relevant to the systematic study were retrieved and screened by one researcher (JR) with secondary screening done by another researcher (NR) using the same inclusion criteria in order to determine eligibility of the studies for this study.</p>

		<p>Inclusion criteria were i) English, intervention studies, ii) full text articles, iii) from 2007 to 2017, iv) intervention studies about humans only and v) studies must speak to addressing child abuse specifically from a family-centred approach. Exclusion criteria included consensus studies, studies using secondary data, studies that did not show a programmatic layout beyond just screening, protocols, interventions focused only on one individual and, therefore, not inclusive of the family, case studies, interventions not aimed at child abuse, systematic reviews, and reviews. Initial search was conducted by one researcher, yielding a total of 10 654 prospective articles, which had the search terms in their titles, keywords and abstracts. Titles and abstracts were screened by the same researcher. After 320 duplicates were removed in searches, 29 titles were screened as eligible of which 5 abstracts were deemed relevant to the study. Data extraction of the 5 articles can be seen in Table 4.5. The search process, titles, and abstracts underwent secondary screening by another researcher who acted as first reader.</p>
Family-centred interventions aimed at elder abuse	Narrative	<p>Databases searched included Google Scholar, Academic Search Complete, PubMed, SocIndex, MEDLINE, PsychARTICLES and Research Gate. Search terms included elder abuse and neglect, community-based, family, family interventions, family-centred and family-based interventions. The interventions sought were in English as well as searched from within an 11-year time frame from date of study (2006 to 2017) to elicit latest trends.</p> <p>Articles seen to relate to the search terms, were assessed via titles, abstracts as well as article content. Articles sought for this review had to be family-centred interventions with a primary aim to address elder abuse. The interventions had to have included the elderly and at least the family caregiver. In addition, the intervention was to go beyond screening, but also include a programme referral plus a description of the programme layout, with the programme potentially to be implemented at community level. Additionally, a systematic review of citations for elder abuse (Erlingsson, 2007) had been referred to in order to identify specific journals that would yield results in offering more articles in terms of family-based interventions.</p> <p>In total 34 929 hits were found via the databases. This total excludes Research gate results, as Research gate does not provide an exact number of hits. Only 3 articles were identified via title with 1 identified through Research Gate. Of the 4, 1 was later excluded due to the intervention not aimed primarily at elder abuse. In total, only 3 articles were identified as family-centred interventions aimed primarily at addressing elder abuse. The family-centred interventions were conducted in Israel, Iran and in the United States with the Native American community.</p>

Table 4.7: RE-AIM Framework evaluation used for IPV family-centred interventions – Appraisal sheet (Adapted from Glasgow, 1999; Glasgow et al., 2001; Blackman et al., 2013)

RE-AIM Dimensions	Questions	Scoring
REACH	Indicate who the programme is intended for (Inclusion and exclusion criteria)?	Y= 1 / N=0
	Report on the representativeness of the target population?	Y=1 / N=0
	Report on participation rate?	Y=1 / N=0
Effectiveness	The programme achieves the intended objectives?	Y=1 / N=0
	Report on the limitations of the intervention?	Y=1 / N=0
	Reports on at least one outcome of the intervention?	Y=1 / N=0
	Reports on attrition?	Y=1 / N=0

Adoption	Is the setting clearly described?	Y=1 / N=0
	Report on the adoption of the intervention by the participants/organisation?	Y=1 / N=0
	Reports on who delivered the programme?	Y=1 / N=0
Implementation	Describes duration and frequency of the intervention?	Y=1 / N=0
	Has the staff / participants of the organisation / intervention been involved in delivering the programme?	Y=1 / N=0
	Reports on intended and delivered interventions?	Y=1 / N=0
Maintenance	Report on long term effects of the intervention (after 6 months)?	Y=1 / N=0
	Report on the indicators used for intervention follow-up?	Y=1 / N=0

Table 4.8: Scoring sheet of selected abstracts for IPV

Author(s)	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	Score
Becker, Mathis, Mueller, Issari, & Atta (2008)	1	1	1	1	1	1	1	1	0	1	1	0	0	1	1	80%
Ermentrout, Rizo, & Macy (2014)	1	1	1	1	1	1	1	1	1	1	1	1	0	0	1	87%
Graham-Bermann, Lynch, Banyard, DeVoe, & Halabu (2007)	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	100%
Graham-Bermann & Miller-Graff (2015)	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	100%
Grip, Almqvist, & Broberg (2012)	1	1	1	1	0	1	1	0	1	1	1	0	1	1	1	80%
Kan & Feinberg (2015)	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	100%
McWhirter (2011)	1	1	1	0	0	1	0	1	1	1	1	0	0	0	0	53%

Table 4.9: Data extraction table of final studies included

Author(s)	Ermentrout, Rizo, & Macy (2014)	Grip, Almqvist, & Broberg (2012)	Graham-Berman & Miller-Graff (2015)	Graham-Bermann, Lynch, Banyard, DeVoe, & Halabu (2007)	Kan & Feinberg (2015)	Becker, Mathis, Mueller, Issari, & Atta (2008)
Study design	Multimethod qualitative design	A repeated-measure design without comparison group.	Randomized-control Trial (RCT)	Randomized-control Trial (RCT)	Randomized-control Trial (RCT)	Not clear
Country	USA	Sweden	USA	USA	USA	USA (Hawaii)
Reach	Of the current follow-up study, 8 were child participants (demographics not collected) 18 adult participants (62.50% Black/African American) M=2.25 children, and 7 staff participants (all White, 85.71% female).	Mother-child dyads were sought with 34 mothers and 46 children present at pre-assessment, 23 mothers and 31 children present at post assessment and 17 mothers and 24 children present for follow-up. Inclusion criteria: 1.) help was sought for mother and child at the unit, 2.) reports of physical, psychological or sexual violence.	Women participants were 33 years old (SD 5.29), largely 57% White, Monthly income varied considerably and was generally low (M \$1,366, SD \$1,315). The women's children ranged in age from 6–12 years (M 8.49, SD 2.16).	Children ranged in age from 6 to 12 years (M 8.49, SD 2.16). There were 110 boys and 111 girls. Child ethnicity was largely 52% Caucasian. Mothers' mean age was 33.10 years (SD 5.29 years), with 57% Caucasian. Monthly income varied (M \$1,366, SD \$1,315).	Participants were 169 heterosexual couples. At baseline, 91 % of mothers and 90 % of fathers were Non-Hispanic White. Median annual family income was \$65,000.00 (SD = \$34, 372.79). Attendance ranged from 0 to 8 sessions.	A sample size of 106 children (37 boys, 69 girls) between the ages of 3 and 17 (M = 8.64, SD = 3.72). Ethnically, 52.8% identified as multi-ethnic. Of the 106 participating parents, 104 were mothers (98.1%). The majority of families participating in the program had an annual income of less than \$13,000.
Efficacy	The study aimed to test the feasibility of a child program concurrent with the MOVE program. Attrition showed 33% for children attended 8 or more sessions.	The intervention had achieved its aim in reducing behavioral problems and social impairment. Limitations include no comparison group and using the mother only as an adult informant. Attrition was reported as being high with no percentage given.	The aim was to assess intervention efficacy for women exposed to IPV and was achieved. Limitations include the study represented few minorities, frequent moves, loss of housing, custody issues, and lack of consistent contact info.	The overarching aim of the present study were to assess the efficacy of a group intervention for children and their mothers exposed to IPV and to identify factors associated with treatment efficacy. Limitations include loss of housing, custody issues, and lack of consistent contact info.	The program aimed to inoculate parenting from the effects of pre-birth IPV that was noted as being met. Limitations included a largely White sample, selection bias, and only focusing of physical IPV through triadic observation. Attrition reported loss of 2 couples before intervention and 37 couples at follow-up.	The intervention is noted as meeting its goals in improving child and parent outcomes. Limitations of the intervention were inconsistent information, lack of no-treatment control as well as e report bias. Only 30.1% of the children completed all 12 sessions.

Adoption	Private space was used at one of the partner agencies. The groups were co-facilitated by a clinician with a master's level and a student intern or volunteer.	The research setting stated to be Swedish communities psychiatric assistance was sought through community-based services. Facilitators were 2 female social workers.	The research setting only been noted in the Michigan area. The program is an evidence-based and community-based program. Facilitators were 2 trained co-leaders, or therapists.	The research setting only been noted in the Michigan area. Facilitators were clinical psychology and social work graduates and community mental health providers.	Intervention setting not made clear. The group sessions involved 6–10 couples and were led by a male–female co-leader team in order to offer a role model for each partner.	Setting not clear. Facilitators were counselors with a minimum of a high school degree and 1 year experience.
Implementation	The program consists of 12 weekly group sessions, each session lasting two and a half hours. Facilitators were clinicians at master's level. The intervention had been noted as being successfully implemented.	A group program of 15 structured 90-min weekly sessions.	The program is noted as being 10 sessions with mothers and their children attending 7 out of the 10 on average. Duration of each session is not given. The program seems have its own group facilitators recruited by the organisations running the community-based intervention.	The program is noted as being 10 sessions with mothers and their children attending 7 out of the 10 on average. Duration of each session is not given. The program seems have its own group facilitators recruited by the University of Michigan.	There were 8 sessions of which an average of 5 was attended. Male -female co leaders were recruited as facilitators	The curriculum was 12 weekly session run parallel for all groups but varied on age-appropriate topics.
Maintenance	Follow up period not clear. Results show improved family functioning. Parents able to communicate effectively and children participating in pro-social activities and reporting better emotion management. Indicators included program satisfaction and program efficacy.	Post assessment was 6 months with follow up sessions conducted 1 year post assessment. Outcomes were not sustained at 1yr follow-up attributed to pre-existing disorders. Indicators included general functioning and relationship to the perpetrator. Additionally, the Strength and Difficulties Questionnaire (SDQ) and Impact of Event Scale (IES) were used to assess parents as well as the mother's trauma symptoms.	Post assessment occurred at 10 weeks with follow-up conducted 8 months post intervention. Indicators used: The Beck Depression Inventory, the Anxiety and Parental Child rearing Styles Scales. Results show reduced depression and improved parenting, and improved child behavioral outcomes.	Post assessment conducted after 10 weeks and follow-up conducted 8 months post intervention. Indicators used: The Conflict Tactics Scale, the Attitudes about Family Violence Scale and the Child behavior Checklist. Results show children in the CM [child-plus-mother-] condition continued to make significant improvement in externalizing problems relative to the CO [child only] condition.	Follow-up was conducted 4-8 months post-natal using questionnaires (Time 2), home-based interviews, and video recorded interactions at 13 months postnatal (Time 3). Results show intervention families experiencing no significant associations between IPV and parenting over time.	Post-intervention assessment occurred on the last session of the program. No long term follow up (6 months +) reported. Results show decreased child psychopathology and improved parenting practices. Indicators were program participation, DV knowledge and awareness, behavior control (Child behavior checklist), parenting practices, and appropriate coping skills.

Table 4.10: Data extraction of included studies for child abuse family-centred interventions

Author(s)	Jouriles et al. (2010)	Linares et al. (2015)	Schneider-Muñoz, Renteria, Gelwicks, & Fasano (2015)	Kan & Feinberg (2014)	Travis, Heyman, & Smith (2015)
Reach	<p>A total of 35 families participated in the study, with n=17 families allocated to the project support intervention and n=18 families allocated to services-as-usual comparison condition. Families recruited from child protection service referrals.</p> <p>Referrals were mostly for physical abuse (63%), with roughly 50% of families referred have had one previous referral to child protection services. The average age of the mother was 28.7 years old (SD= 5.4); and 5.4 years old (SD=1.5) for the children.</p> <p>Ethnicities included Black (47%), Hispanic (26%), White (23%) and other (3%). The mothers averaged with 10.6 years (SD=2.1) of education with 69% being employed at baseline. Of the 35 families that participated, 23 were noted to be single-mother families.</p>	<p>Twenty-two sibling pairs and their foster parent (13 pairs in the intervention group/9 pairs in the comparison group) participated. Children were between 7.2 & 9.7 years old [No SD given]. Of the sibling pairs, 26% were both male; 37% both female, and 37% had mixed genders.</p> <p>Participants were majority African American (45%) with over 90% of the children being placed in foster care due to neglect.</p> <p>None participation of eligible families were due to time constraints, lack of interest; feeling program was not needed, and accessibility.</p>	<p>The study had 308 participants of which 131 (children and one of their caregiver) completed the intervention. The remaining 177 had been the comparison group. No other characteristics had been provided such as age, race, socio-economic status etc. with the sampling method described as convenient.</p>	<p>Participants were 169 heterosexual couples, all of whom were living together, over 18 years old, and expecting their first child. At the prenatal interview (Time 1), 91 % of mothers and 90 % of fathers were Non-Hispanic White.</p> <p>Median annual family income was \$65,000.00 (SD = \$34, 372.79). Mean age were 28.33 years old (SD=4.93) for mothers and 29.76 years for fathers (SD=5.58).</p> <p>At postnatal phase, 56% of participating children were male and on average aged 36.82 months (SD=1.47).</p>	<p>Family Advocacy Program (FAP) is aimed at military families that exhibit partner and child maltreatment.</p> <p>Upon allegation of maltreatment, the family is mandated for intake interview.</p>
Effectiveness	<p>The study reported meaningful effects on mothers parenting which showed greater reductions in perceived inability to manage their children's behaviour, harsh parenting and ineffective parenting.</p> <p>Limitations include small sample size, possible bias as most participants were</p>	<p>The study aimed to develop and test a short-term, multicomponent, ecological intervention to reduce sibling conflict, enhance sibling interactions, and strengthen the foster parent's ability to nurture positive sibling relationships. The</p>	<p>The study aimed to test the outcomes of those who participated in the intervention, in comparison to families who were invited to participate but refused. The study showed positive results in intervention group. Limitations</p>	<p>The program aimed to inoculate parenting from the effects of pre-birth IPV, an aim that was noted as being met. Limitations included majority White sample, selection bias, and only triadic observation being done, and not observing one</p>	<p>The study ascribes its program efficacy to the Central Registry Board (CRB) that conducts child maltreatment investigations after the assessment has begun. The CRB consists of the vice wing commander,</p>

	referred for physical abuse and neglect. Furthermore, staff who collected data were not adequately blinded as to who were in the intervention and who was in the control, which may have affected data collection. Feasibility may be questionable as home visitation was used by a trained therapy team to carry out the intervention, which most agencies will not be able to carry out due to lack of resources for such an intensive intervention. Of the 17 participating families, 11 families completed 11 out of the 12 parenting skills with the remaining 6 families completing 6 parenting skills. In 7 of the families, the mother's partner has had also participated in the sessions with a mean attendance of 82 %.	study is described as meeting its aim. However, the intervention group was noted in having parents which were younger, less educated, and had more children than the comparison; which may impact findings in an 'unknown manner'. Additional limitations include a small sample size that limits generalizability. The program was offered as a 3-component package yet the study states it is unknown which particular component is responsible for positive results.	include convenient sampling as well as only legally verified maltreatment was tracked, and not reported maltreatment.	parent and the child without the presence of the other parent. Attrition reported loss of 2 couples before intervention and 37 couples at follow-up.	family advocacy officer, an attorney, law enforcement officer, and a rep. from the family's unit leadership. The CRB is noted in engaging available resources and making informed decisions based on social service recommendations . Since the CRB's establishment, recidivism had decreased by 50%.
Adoption	Setting described as home visitation. The country, state or community intervention and recruitment carried out was not mentioned. Referrals received from Child protection services – Family based safety services unit. Not state if intervention had been adopted by the state or community. The intervention team consisted of 11 master's level licensed mental health service providers; hired, trained and supervised by a registered clinical psychologist.	The program had taken place in New York city with the assistance from 3 foster care agencies providing recruitment. The study does not indicate if any organisation had officially adopted this program. Two masters- level clinicians facilitated the sessions. Attrition rates show 11 children (85%) and 8 foster parents (62%) attended 6 out of the 8 sessions. Overall, average attendance was 73%.	Participants were referred from the Florida child welfare system and the community of Brevard County. Each family was assigned a facilitator and a family support partner. Facilitator training had not been stated or if the program was implemented at community or state level.	Intervention setting not made clear. Couples and were led by a male–female co leader team in order to offer a role model for each partner. Facilitators received 3 days training as well as supervision and observation throughout intervention.	Intervention setting is unclear as it may occur through FAP or the state's child protective services. If FAP cannot provide the needed service to the family, a civilian provider of clinical services is used. However, the FAP retains primary responsibility to monitor child safety and treatment progress.
Implementation	The intervention was weekly, home-based 1 -1½ hours long	Promoting sibling bonds (PSB) program consisted of 3	Noted as a community-based intervention styled after the "Family	There were 8 sessions of which an average of 5 was attended.	Specific information regarding treatment or

	<p>session for the duration of 8 months. The intervention was tailored to family needs and not limited to a set number of sessions or weekly attendance schedule. However, 12 parenting skills (further elaborated on in 'Results) had to be delivered. Intervention activities included role-plays and written materials.</p>	<p>components (sibling pair, parent and joint sessions). The program ran 8, 90min, weekly sessions that focused on cooperation, consequences for aggressive behaviors; emotive self-regulation, problem solving, and barriers in the home. Techniques used included live demonstrations, role-playing, coaching and positive feedback.</p>	<p>team conferencing" format. The format allows for an individualized process that caters towards the family's specific needs. The process includes a wider circle of support directed towards a wraparound family plan. Through the conferencing format, the family (assisted by support members) outlines the family needs, challenges; barriers, resolution action steps,; responsibility, time frame, and outcome.</p>	<p>Male -female co leaders were recruited as facilitators</p>	<p>program info. Is not clearly stipulated as incidences are dealt with on a case-by-case basis. Additional steps are noted to be taken if the child maltreatment resulted in mortality.</p>
<p>Maintenance</p>	<p>Assessments had been home-based questionnaire and observational data. Assessment had been done at baseline, and then repeated every 4 months for 16 months. Assessment indicators included subscales from Parental Locus of Control Scale and the Revised Conflict Tactic Scale. Observational data had been 45-minute videotapes sessions conducted within a 2-week span. Results were maintained during follow-up period yet at the 20-month follow-up period; new reports of child maltreatment did show a vast difference in relation to the comparison (5.9% in Project Support vs. 27.7% in the comparison). However, these percentages failed to show statistical significance.</p>	<p>Post-intervention assessment occurred yet time frame not stated. Assessment indicators included Sibling Indication Quality Scale that assesses dyadic quality of sibling interaction and conflict; videotaped sessions of sibling group; Conflict Checklist and the Sibling Aggression Scale.</p>	<p>Follow-up conducted 6 months post-intervention. Indicator used was the Florida Safe Families Network to check if new cases of maltreatment occurred.</p>	<p>Follow-up was conducted 4-8 months post-natal using questionnaires (Time 2), home-based interviews, and video recorded interactions at 13 months postnatal (Time 3). Results show intervention families experiencing no significant associations between IPV and parenting over time.</p>	<p>A case is closed once recommendations are carried out or if offenders are non-compliant, the case is closed as unresolved. No follow-up is explicitly stated.</p>

4.3. Results

4.3.1. Reach

Across the subsets, the majority of the interventions recruited parent-child dyads (Ermentrout, Rizo, & Macy, 2014; Graham-Bermann, Lynch, Banyard, DeVoe, & Halabu, 2007; Graham-Bermann & Miller-Graff, 2015; Grip, Almqvist, & Broberg, 2012; Linares et al., 2015; Schneider-Muñoz, Renteria, Gelwicks, & Fasano, 2015), while the remaining interventions sought families (Becker, Mathis, Mueller, Issari, & Atta, 2008; Jouriles et al., 2010; Travis, Heyman, & Smith, 2015), or couples (Kan & Feinberg, 2015; Kan & Feinberg, 2014).

Where participant demographics were provided, the majority of participants were White (Graham-Bermann, Lynch, Banyard, DeVoe, & Halabu, 2007; Graham-Bermann & Miller-Graff, 2015; Grip, Almqvist, & Broberg, 2012; Kan & Feinberg, 2015; Kan & Feinberg, 2014); followed closely by African American (Ermentrout, Rizo, & Macy, 2014; Jouriles et al., 2010; Linares et al., 2015), with only one study having participants of multi-ethnic descent (Becker, Mathis, Mueller, Issari, & Atta, 2008). Within the IPV studies, most participants entered the family interventions voluntarily (Graham-Bermann, Lynch, Banyard, DeVoe, & Halabu, 2007; Graham-Bermann & Miller-Graff, 2015; Grip, Almqvist, & Broberg, 2012, Kan & Feinberg, 2015); of which the remaining studies indicated that the participants were court mandated to attend (Becker, Mathis, Mueller, Issari, & Atta, 2008; Ermentrout, Rizo, & Macy, 2014).

4.3.2. Effectiveness

The participants completed most of the programme sessions with most studies stating their aims were achieved (e.g. 11 out of 12 sessions, 5/6 out of 8 sessions or 95% of programme described as complete) (Becker, Mathis, Mueller, Issari, & Atta, 2008; Ermentrout, Rizo, & Macy, 2014; Graham-Bermann, Lynch, Banyard, DeVoe, & Halabu, 2007; Graham-Bermann & Miller-Graff, 2015; Holkup, Salois, Tripp-Reimer, & Weinert, 2007; Kan & Feinberg, 2015; Jouriles et al., 2010; Linares et al., 2015; Kan & Feinberg, 2014).

The included studies show the family-focused interventions improved parent-child interaction, sibling interaction, and decreased abuse over a long term period [6-12 months] (Becker, Mathis, Mueller, Issari, & Atta, 2008; Ermentrout, Rizo, & Macy, 2014; Graham-Bermann, Lynch, Banyard, DeVoe, & Halabu, 2007; Graham-Bermann & Miller-Graff, 2015; Kan & Feinberg, 2015; Kan & Feinberg, 2014; Linares et al., 2015; Schneider-Muñoz, Renteria, Gelwicks, & Fasano, 2015; Jouriles et al., 2010; Travis, Heyman, & Smith, 2015; Holkup, Salois, Tripp-Reimer, & Weinert, 2007; Khanlary, Maarefvand, Biglarian, & Heravi-Karimooi, 2016; Lowenstein & Naim, 2015).

However, physical violence within the elder abuse review showed no change post-intervention (Khanlary et al., 2016), with one study showing outcomes not sustained at 1 year post-intervention follow-up due to no screening done at baseline for pre-existing disorders, which may have needed an intense, individualized therapeutic process (Grip, Almqvist, & Broberg, 2012).

Limitations noted by the child abuse review were small samples sizes; bias related to participants, staff, and sample selection; and the use of home-visitation which may not be feasible for resource-strapped agencies (Jouriles et al., 2010; Kan & Feinberg, 2014; Linares et al., 2015; Schneider-Muñoz et al., 2015); IPV studies were limited by custody battles which greatly affected child participant attrition (Ermentrout, Rizo, & Macy, 2014; Graham-Bermann, Lynch, Banyard, DeVoe, & Halabu, 2007; Graham-Bermann & Miller-Graff, 2015), loss of housing/moving (Graham-Bermann, Lynch, Banyard, DeVoe, & Halabu, 2007; Graham-Bermann & Miller-Graff, 2015); inconsistent contact information (Becker, Mathis, Mueller, Issari, & Atta, 2008; Graham-Bermann, Lynch, Banyard, DeVoe, & Halabu, 2007; Graham-Bermann & Miller-Graff, 2015), all of which created challenges in sample attrition, session planning and rapport building. Limitations were not clarified within the elder abuse studies.

4.3.3. Adoption

Recruitment for the programmes within the IPV and elder abuse family-centred interventions, occurred through community-based organisations, health care

facilities or the courts (Becker, Mathis, Mueller, Issari, & Atta, 2008; Ermentrout, Rizo, & Macy, 2014; Grip, Almqvist, & Broberg, 2012; Kan & Feinberg, 2015; Graham-Bermann, Lynch, Banyard, DeVoe, & Halabu, 2007; Graham-Bermann & Miller-Graff, 2015; Holkup, Salois, Tripp-Reimer, & Weinert, 2007; Khanlary, Maarefvand, Biglarian, & Heravi-Karimooi, 2016). The intervention setting was either the community-based organisations, or linked to community-based facilities (Graham-Bermann, Lynch, Banyard, DeVoe, & Halabu, 2007; Graham-Bermann & Miller-Graff, 2015; Lowenstein & Naim, 2015; Holkup, Salois, Tripp-Reimer, & Weinert, 2007), with families determining exact setting suitably accessible for all participating (Holkup, Salois, Tripp-Reimer, & Weinert, 2007). Intervention settings in the child abuse review revealed home-based visits (Jouriles et al., 2010).

Facilitators used for the interventions were either practitioners in the field of mental health or social services (Jouriles et al., 2010; Linares et al., 2015; Ermentrout, Rizo, & Macy, 2014; Grip, Almqvist, & Broberg, 2012; Graham-Berman & Miller-Graff, 2015; Graham-Bermann, Lynch, Banyard, DeVoe, & Halabu, 2007), who were also specifically sought at masters level (Jouriles et al., 2010; Linares et al., 2015; Ermentrout, Rizo, & Macy, 2014); or individuals trained specifically for the programme (Becker, Mathis, Mueller, Issari, & Atta, 2008; Graham-Berman & Miller-Graff, 2015; Graham-Bermann, Lynch, Banyard, DeVoe, & Halabu, 2007), and were either from the community (Holkup, Salois, Tripp-Reimer, & Weinert, 2007), or a female-male co-pair (Kan & Feinberg, 2014; Kan & Feinberg, 2015).

4.3.4. Implementation

The intervention programmes were either conducted as sessions (Ermentrout, Rizo, & Marcy, 2014; Kan & Feinberg, 2014; Kan & Feinberg, 2015; Linares et al., 2015), in stages (Holkup, Salois, Tripp-Reimer, & Weinert, 2007; Khanlary, Maarefvand, Biglarian, & Heravi-Karimooi, 2016), or according to themes (Jouriles et al., 2010; Schneider-Muñoz, Renteria, Gelwicks, & Fasano, 2015). One intervention used a multi-systemic model formed by various national agencies, to create interventions on a case-by-case basis (Lowenstein & Naim,

2015). Of the interventions that followed a session format, the duration ranged from 8-12 sessions, with frequency noted as 2 hours for both parent and child groups, or 90 min, weekly sessions (Ermentrout, Rizo, & Marcy, 2014; Linares et al., 2015).

Of the theme focused interventions, time was not incumbent on the process, but catered to the needs of the families involved (Holkup, Salois, Tripp-Reimer, & Weinert, 2007; Jouriles et al., 2010); however, where duration was provided, the revealed themes were covered over a period of 8 months (Jouriles et al., 2010).

The themes covered in the interventions, across the subsets, included family violence education, beliefs and attitudes; emotional affect; communication; conflict management; decision-making; focus on the self; 12 parenting skills [such as attentive/non-directive play; listening to and comforting the child; contingent praise and positive attention; appropriate instructions/commands; contingent negative consequences for noncompliance/aggressive behaviour]; co-operation; problem-solving; self-regulation; addressing barriers; neglect and alternative behaviors, and principles of care giving (Becker, Mathis, Mueller, Issari, & Atta, 2008; Ermentrout, Rizo, & Macy, 2014; Graham-Bermann, Lynch, Banyard, DeVoe, & Halabu, 2007; Graham-Bermann & Miller-Graff, 2015; Grip, Almqvist, & Broberg, 2012; Kan & Feinberg, 2015; Kan & Feinberg, 2014; Linares et al., 2015; Schneider-Muñoz, Renteria, Gelwicks, & Fasano, 2015; Jouriles et al., 2010; Holkup, Salois, Tripp-Reimer, & Weinert, 2007; Khanlary, Maarefvand, Biglarian, & Heravi-Karimooi, 2016). Only one study in the IPV review explored the role of gender stereotypes (Becker, Mathis, Mueller, Issari, & Atta, 2008); one study explored parenthood transition (sample was pre-natal parents) (Kan & Feinberg, 2015). Another study revealed that 52% of their family-centred programme was focused on parenting, specifically problem-solving and decision-making (Jouriles et al., 2010).

Techniques used to carry out themes included role-plays; written materials; coaching and positive feedback; modeling; ice-breakers; cognitive restructuring; guided discovery (reflections), and brainstorming (Kan & Feinberg, 2014;

Khanlary, Maarefvand, Biglarian, & Heravi-Karimooi, 2016; Jouriles et al., 2010; Schneider-Muñoz, Renteria, Gelwicks, & Fasano, 2015).

Where stated, organisation/staff members were active in training facilitators, providing technical support for organisations adopting the programme, as well as in conducting post-assessment (Becker, Mathis, Mueller, Issari, & Atta, 2008; Ermentrout, Rizo, & Macy, 2014; Grip, Almqvist, & Broberg, 2012; Graham-Berman & Miller-Graff, 2015; Graham-Bermann, Lynch, Banyard, DeVoe, & Halabu, 2007; Kan & Feinberg, 2015; Khanlary, Maarefvand, Biglarian, & Heravi-Karimooi, 2016). In other instances, services were outsourced to health and welfare service providers (Lowenstein & Naim, 2015; Travis, Heyman, & Smith, 2015).

4.3.5. Maintenance

Follow-up ranged from 4, 6, 12, and 16 months post-intervention across studies (Graham-Bermann, Lynch, Banyard, DeVoe, & Halabu, 2007; Graham-Bermann & Miller-Graff, 2015; Grip, Almqvist, & Broberg, 2012; Kan & Feinberg, 2015; Jouriles et al., 2010; Kan & Feinberg, 2014; Schneider-Muñoz et al., 2015). Short-term follow-up included 30 days post-intervention (Khanlary, Maarefvand, Biglarian, & Heravi-Karimooi, 2016), to the last day of intervention (Becker, Mathis, Mueller, Issari, & Atta, 2008). Indicators used to track process progress were through observational data, interviews and assessment tools.

Observational data were obtained through interviews, as well as video-taped interactive sessions, between parent and child, where noted, and lasted 45 minutes (Jouriles et al., 2010; Kan & Feinberg, 2014; Linares et al., 2015; Ermentrout, Rizo, & Macy, 2014; Grip, Almqvist, & Broberg, 2012; Kan & Feinberg, 2015). Assessment tools included Beck's Depression Inventory; The Anxiety and Parental Child Rearing Styles Scales, and rating checklists (Graham-Bermann, Lynch, Banyard, DeVoe, & Halabu, 2007; Graham-Bermann & Miller-Graff, 2015; Grip, Almqvist, & Broberg, 2012; Becker, Mathis, Mueller, Issari, & Atta, 2008). Children's outcomes were assessed through interviews with children (Ermentrout, Rizo, & Macy, 2014), interviews with parents (Grip, Almqvist, &

Broberg, 2012; Kan & Feinberg, 2015), and using questionnaire assessments, specifically, the Child Behavior Checklist (Graham-Bermann, Lynch, Banyard, DeVoe, & Halabu, 2007; Graham-Bermann & Miller-Graff, 2015; Becker, Mathis, Mueller, Issari, & Atta, 2008). Additionally, assessments included subscales from the Parental Locus of Control Scale and the Revised Conflict Tactic Scale (Jouriles et al., 2010); as well as the Sibling Indication Quality Scale, Conflict Checklist, and Sibling Aggression Scale (Linares et al., 2015). One study used their referral source to establish whether any new cases of maltreatment had been reported (Schneider-Muñoz et al., 2015). For the elderly, the Domestic Elder Abuse Questionnaire (DEAQ) was used to assess progress (Khanlary, Maarefvand, Biglarian, & Heravi-Karimooi, 2016).

4.4. Discussion

Most of the interventions targeted parent-child dyads. Parent-child dyads and parents are sought, when examining positive or negative experiences in the family. The parents' relationship, as well as the parent-child relationship, are considered to be connected, due to the spillover hypothesis. The hypothesis indicates that if one part of the family system (for example, parents) experiences discord/conflict, it may affect the other parts of the family system (parent-child relationship) (Leyendosky, Leahy, Bogat, Davidson, & Von Eye, 2006). Mother-child dyads, which were seen more in the IPV and child abuse reviews, notably display a parent-child relationship, indicative of positive, or negative child outcomes (Renner & Boel-Studt, 2013).

The reviewed interventions had a majority White sample, which may be problematic in providing an inclusive picture. Literature notes that Blacks, specifically African Americans, are mostly at risk for IPV, as well as at-risk for child maltreatment linked to harsh parenting (Capaldi, Knoble, Shortt, & Kim, 2012; Cho, 2012; Langhinrichsen-Rohling, Selwyn, & Rohling, 2012; Dubowitz, Kim, Black, Weisbart, Semiatin, & Magder, 2011; Gershoff, Lansford, Sexton, Davis-Kean, & Sameroff, 2012). Additionally, the interventions were observed to be well attended across the reviews, with participants completing most of the intervention sessions, which is encouraging, as high-risk families often show low retention rates in intervention programmes

(Pereira, D’Affonseca, & Williams, 2013).

Interventions were revealed as largely community-based, in both their recruitment and intervention setting, and, as observed in the elder abuse review, the original research team assisted the community-based organisation with technical assistance, regarding their intervention, a collaboration noted to have a bolstering effect on interventions, as it contributed to high attendance rates (Spath, Clair, Greenberg, Redmond, & Shin, 2007).

The facilitators, who were utilized, were either tertiary level educated, or trained specifically for the programme. However, to provide tertiary educated facilitators with additional training, would capacitate them, not only with expertise, but the ability to translate those experiences and knowledge to respondents, while being grounded in best practice (Lee & Nichols, 2010). In addition, when facilitators are provided with supervision, they are more prepared to deal with expected, and unexpected challenges, concerning programme delivery (Lochman & Van Den Steenhoven, 2002).

The interventions noted specific amounts of sessions; however, others were themes-, or needs-focused, spanning over 8 months. The interventions that were structured according to sessions, were no different to trends set by short-term family interventions, which ranged from 6-10 sessions, averaging 1.5 to 2hrs in length (Barry, 1999). These sessions were not conducted more than twice a week, to allow time to practice new behaviors and experience change (Barry, 1999), equating to what is observed in the findings. Generally, there is no prescribed time duration for interventions, due to flexible implementation, regarding family violence (Eckhardt, Murphy, Whitaker, Sprunger, Dykstra, & Woodard, 2013). Though not time prescriptive, facilitators would, however, necessitate that at least one risk topic is covered in a session (Katz et al., 2008).

Additionally, the reviewed interventions revealed themes commonly addressed in family violence (Tolan et al., 2006). However, interventions assume a large portion of the session devoted to parenting or parenting skills. This may be linked to maltreating parents who actively participate in family-centred interventions, revealing lower rates

of re-abuse; as opposed to child-centred interventions devoid of acknowledging the complex and multiple needs of the family, for example: unemployment, substance abuse, violence, to name a few (Bromfield, Sutherland, & Parker, 2012; Kemp, Marcento, Hoagwood, & Vesneki, 2009).

Only one study reviewed addressed gender (Becker, Mathis, Mueller, Issari, & Atta, 2008), contrasting the body of knowledge that shows gender, integral to interventions at individual/community level (Whitaker et al., 2006). This may be linked to a growing trend towards a gender-neutral framework regarding family violence. Gender neutral family violence frameworks stem from the American context of bringing parity to the female perpetration/male victimization cases of violence (Reed, Raj, Miller, & Silverman, 2010). This may prove challenging as women and girls are still the most likely to be killed/injured by a male intimate partner, the most at risk more than any other class of individual (Reed et al., 2010). Disregarding gender inequality within family violence is a missed opportunity to explore deeply entrenched gender-power abuses occurring in the lives of women and girls (Reed et al., 2010).

Most of the reviewed studies showed sustained long-term positive results that resonate with outcomes associated to the family-centred approach; showing a collaborative partnership between family and professional. As stated earlier, a family-centred approach allows the challenges presented, to provide contextual explanation, rather than individual blame. Focus is given to what is happening in the family rather than what is “wrong” with the family; therefore, through this holistic engagement, adequate support is given (Bromfield et al., 2012; Burns et al., 2008).

4.5. Implications for practice

Interventions that include the family needs are observed to be culturally sensitive, as well as adaptive to the family context (Gillum, 2008; Sumter, 2006; Yasui & Dishion, 2007). Interventions are usually fixed, manualised programmes, following a European American perspective of development; an etic approach examining universal/pancultural principles, where differences are revealed at individual level, and not group level (Yasui & Dishion, 2007). Creating interventions, which link cultural diversity

issues to empirically supported interventions, implies that they are tailored towards the needs of the individual, as well as the family; an emic approach providing flexibility to cater for diversity, whilst retaining the etic science (Yasui & Dishion, 2007). Families provide vital information, essential to valid assessments and appropriate intervention planning (Kemp, Marcenko, Hoagwood, & Vesneski, 2009).

This vital information refers to parental knowledge of children, family circumstances and cultural context (Kemp et al., 2009). Implementing a family-centred approach will create strengthened partnerships between family and caseworker/practitioner, which, in turn, will facilitate sustained positive change (Bromfield et al., 2012; Kemp et al., 2009). In addition, the strengthened partnership between practitioner and family could assist families to navigate their way around other needed social services, as well as comply with caseworker expectations, for positive outcomes (Bromfield et al., 2012; Kemp et al., 2009).

4.6. Conclusion

A family-centred approach in addressing family violence, not only becomes needs-sensitive, in terms of family context and culture, but also allows for a collaborative partnership between the practitioner and the family. Through this strengthened partnership, the practitioner would have a better understanding of the context, in which the family is expected to function, and could implement a better informed intervention plan. Families, therefore, have a better understanding of their support services, as well as the practitioner's expectations, and are able to comply with the intervention plan and associated commitments, more effectively.

4.7. References

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CHAPTER FIVE

LEGISLATIVE RESPONSE TO FAMILY VIOLENCE IN SOUTH AFRICA: A FAMILY-CENTRED PERSPECTIVE

5.1. Introduction

South Africa has made a concerted effort legislatively in a bid to reduce violence and the future eradication thereof, especially regarding gender-based violence (GBV). According to Mofana (2015), since 1994, South Africa has undergone drafts, and introduced several policies and legislation, aimed at gender-based violence, such as the Domestic Violence Act (Republic of South Africa [RSA], 1998, Act No. 116 of 1998), Sexual Offences Amendment Act (Republic of South Africa [RSA], 2007, Amendment Act, Act 32 of 2007), and the National Action Plan to End Gender Violence. The South African Government has also ratified various international and local protocols to show its commitment to address gender-based violence (Mofana, 2015). These commitments, not only imply violence reduction through equality, but also, largely, family well-being enhancement.

However, South Africa has some of the most endemic rates of violence in the world. This is not only reflective of violence at national or community level, but specifically at familial level, targeting the vulnerable members of society, namely, women, children and the elderly. According to Africa Check (2013), the statistics provided by the South African Police Service (SAPS), revealed that the South African murder rate was six times the global estimate for the year 2012-2013. Of these murders, South Africa has the highest rates of child and intimate partner violence (IPV) related female homicide in the world (Mathews, Abrahams, Jewkes, Martin, & Lombard, 2013; Seedat, Van Niekerk, Jewkes, Suffla, & Ratele, 2009; Wood & Jewkes, 2005). South Africa has displayed the highest incidence of rape for a country not engaged in armed conflict and twice the global estimate for child homicide (Mathews et al., 2013; Seedat et al., 2009; Wood & Jewkes, 2005). Youth exposed to family violence are more likely to commit violent acts or acts of intimidation, than youth not exposed to family violence

(Leoschut, 2009).

Though research on elder abuse within South Africa is noted as sparse (Ferreira & Lindgren, 2008), international literature notes family members as the most likely perpetrators of elder abuse (Berkman, 2006; Soares, Barros, Torres-Gonzales, Ioannidi-Kapolou, Lamura, Lindert, De Dios Luna, Macassa, Melchiorre, & Stankūnas, 2010). Overall, 46% of all injury related deaths in South Africa are linked to interpersonal violence (Republic of South Africa [RSA], Department of Health [DoH], 2014).

If such progressive legislative transformation has taken place, why do the statistics show family violence to be the overriding experience of the South African citizen? In examining this question, the aim of this paper is to promote a family-centred approach as a primary point of intervention for the various legislations used to address family violence and enhance family well-being within the South African context. A family-centred approach has been a missed opportunity due to the oversight in much family focused legislation. The main concern of legislation aimed at families, was to either address the victim/perpetrator relationship or addressing family prescriptively through legislation without considering structure, context and functioning unique to the family. In understanding this, we will firstly engage the theoretical framework inspiring the direction of a family-centred focus within legislation. Secondly, we will review international and regional commitments South Africa had largely drawn from in shaping family focused legislation and how it has influenced South Africa's response to families at risk due to violence. Thirdly, the need for an integrated strategic framework for violence will be addressed, as the best means to co-ordinate resources and stakeholder responses as well as harness political will, in directing efforts towards violence prevention. Lastly, we will look at South African legislation directed towards family violence and the implications of putting families at the forefront of legal as well as health promoting interventions.

5.2. Theoretical Framework

Human beings can only be understood and effectively aided, within the context of their intimate and influential human systems, one of which is family (Bronfenbrenner &

Morris, 2006; Hartman & Laird, 1983); as family is constructed and developed through its generations, having an extensive effect on all its members (Hartman & Laird, 1983; Ryan, Rich, & Roman, 2015). Family members are shaped through mutual interaction and influence (Bronfenbrenner & Morris, 2006).

These mutual interactions and influences, create habitual ways of behaving and communicating (the manner in which problem-solving, arguments or discussions occur), as well as establishing relationship patterns which govern these actions (Becvar & Becvar, 2006). As such, the family is logically modeled after a system, owing to the interdependence seen through these relationship patterns and the networks they create between the family and the social environment (Connard & Novick, 1996). Through Bronfenbrenner's ecological systems theory, we begin to understand that as individuals are influenced by family, so too are families influenced and affected by other external factors, notably work, community but also legislation and public policy (Pittenger, Huit, & Hansen, 2016).

Most family violence policies draw from the ecological approach of which individual, familial as well as communal factors are considered (Australia's National Research Organization for Women's Safety [ANROWS], 2017; Nagia-Luddy & Mathews, 2010). The ecological approach used within policy, reflects risk resulting from the interplay of personal, individual, situational as well as socio-cultural factors at various levels in the social environment (Nagia-Luddy & Mathews, 2010). Notably, to tackle the issue of family violence and seek appropriate intervention, we need to understand the ecological framework as a heuristic approach to organize a systemic attempt in disentangling the various levels of influence; as we develop in the context of relationships which serve to sustain, serve, enable or discourage maladaptive behavior (Stormshak & Dishion, 2002). To disregard these relationships and the context they were forged (such as parent-child relationship or family), would inhibit positive change not only in the immediate environment but other contexts such change would extend to (Stormshak & Dishion, 2002).

The ecological approach, therefore, is seen as a beneficial framework that promotes a better, holistic understanding of violence; this is especially observed in the

conceptualization of potential prevention strategies (Heise, 1998; Dahlberg & Krug, 2002; Nagia-Luddy & Mathews, 2010). Evidently, to truly promote holistic prevention or intervention, we must comprehend that families are most at risk, as violence is known to occur more between family members than acquaintances or strangers and have generational transference (Ryan, Rich, & Roman, 2015; Tolan, Gorman-Smith, & Henry, 2006). Therefore, it is important to fully enhance the ecological aspect of family violence policy and legislation, as most interventions may be ideologically driven, most are also policy determined (Tolan, Gorman-Smith, & Henry, 2006). However, in using the over inclusive, earliest version of the ecological framework can be diffuse, making it difficult for clinicians or policy-makers to focus, specifically, on what to study, or when, where, and how to intervene (Eriksson, Ghazinour, & Hammarström, 2018).

In using the latest version of the approach, specifically the Process–Person–Context–Time Model, focus would be more on the individual behaviour and not the contextual assaults that shape it, a criticism linked to the model’s “victim-shaming” ideology (Eriksson, Ghazinour, & Hammarström, 2018; McLeroy, Bibeau, Steckler, & Glanz, 1988). Victim-shaming ideology has been a long-standing deficit in interventions not using the family-centred approach; as families are seen as prescriptive to a specific group instead of unique, differences seen as in conflict with the intervention plan and not as contextual factors to be considered and worked with (Burns, Dunn, Brady, Starr, & Blosser, 2008).

The ecological approach which considers within/between interactions of systems is noted as most effective for health promoting policy; we not only allow for focus to be on intrapersonal as well as environmental needs, we allow policy to reflect this, in being shaped by individual factors but also the lived environment (Eriksson, Ghazinour, & Hammarström, 2018). In promoting a family-centred focus, we efficiently match policy and legislation to what is occurring in the lives of South Africans, as we are able to contextualize risk factors within the ecological framework of the three levels of prevention, namely primary, secondary and tertiary prevention (Nagia-Luddy & Mathews, 2010).

Family life in South Africa is directed according to guiding principles laid out in the

White paper on Families in South Africa (Republic of South Africa [RSA], Department of Social Development [DSD], 2012). The White Paper on Families is a policy used to direct all ratified international declarations, regional commitments, as well as national legislation all defining what a family should be, protection and support the family is entitled to, and how equality in marriage and commitment to care of children, should be the basis within these families (RSA, DSD, 2012). Key features in the White Paper policy will be highlighted.

5.3. International Commitments

Two platforms refer directly to the support that families should receive, namely, the International Conference on Population Development Plan of Action (United Nations Population Fund [UNFPA], 1994) and the World Summit for Social Development, Copenhagen (United Nations [UN], 1995). The International Conference on Population Development Plan of Action (UNFPA, 1994) was a shift of focus, from demographic-specific targets to placing importance on the improvement of individual lives of men and women in order to address inequality at the individual level. Defeating inequality implies providing support and protection to families, as families are the basic unit of society (RSA, DSD, 2012; UNFPA, 1994). Supporting and protecting families was one of the ways inequality, sustainable economic growth, child and mother mortality, as well as access to reproductive health, could be addressed. Adequate protection and support, however, can only be provided to families through family-sensitive policies regarding housing, work, health, social security and education.

However, the elderly were not included under family, but rather under *Population, growth and structure*. The focus on the elderly was more about independence through work opportunities and quality of life; to be self-sufficient through self-determined lives. The Population Development Plan of Action (UNFPA, 1994) maintains that the role of the elderly should be recognized and valued, not only in volunteer work, but also in the care-giving roles they play in family life as member of the family; therefore, addressing the elderly under *population, growth and structure*, instead of *family protection and support*, seems disjointed (RSA, DSD, 2012; UNFPA, 1994).

The World Summit for Social Development, Copenhagen (UN, 1995) aimed to promote social progress and the betterment of the human condition through the participation of all. The summit noted families as integral to social integration. In order to enhance the capacity of families to achieve social progress, the summit asserted the rights of the child to be respected as well as to eliminate violence towards women (UN, 1995). In essence, these gatherings reiterated that families are entitled to support and protection (RSA, DSD, 2012).

5.4. Regional (Africa)

An African specific, family focused initiative, was instituted by the African Union through the Plan of Action on the Family in Africa [PAFA] (African Union [AU], 2004). PAFA was described as an advocacy instrument for strengthening family units, addressing their needs, improving the general welfare and enhancing life chances of family members. The PAFA was aimed at African union states in designing, implementing, monitoring, and evaluating appropriate national policies and programs for the African family, determined by their specific requirements and needs (RSA, DSD, 2012; AU, 2004).

PAFA comprised nine focal areas, of which two, namely rights, duties and responsibilities, as well as protection of families, refer specifically to protecting the family from violence. Family violence is seen as a direct violation of rights and right to protection (UN, 2004). Therefore, surveillance and monitoring mechanisms are seen as important as well as reinforced judicial systems, in order to control violations against women, children and the elderly within the family (RSA, DSD, 2012).

The Social Policy Framework for Africa (African Union [AU], 2008) aimed to be an overarching social policy structure that promoted human empowerment and development. In regards to family, the framework reiterated the PAFA by proposing a minimum package of essential social protection for families, targeting healthcare for vulnerable people (children, elderly, informal workers and unemployed) (RSA, DSD, 2012).

5.5. National legislation

South Africa's national legislation tapped into 30 different constitutional acts that shaped the context of families and specific issues affecting them. The included acts addressed marriage, maintenance, equality, divorce, child care, substance abuse, as well as housing, social and legal assistance. Only 3² out of the 30 legislative acts, identified within national legislation in the White Paper on Families, address violence, and only 1 of the 3 acts, specifically, address the domestic setting, namely the Domestic Violence Act No. 116 of 1998 (RSA, 1998). However, with all South Africa's robust legislation, it appears that not much change has transpire. Statistics reveal alarming rates of family violence, with the leading cause of female deaths in South Africa being due to an intimate partner, at a murder rate of one every eight hours (Abrahams, Mathews, Jewkes, Martin, & Lombard, 2012).

Child abuse and neglect in South Africa comprised nearly half (44.5%) of all homicides for 2009 alone; twice the global estimate for child homicide (Mathews et al., 2013). The various ratified commitments, frameworks, action plans and legislation may indicate what families are entitled to; however, it is not clear whether risk factors, or barriers such as low socio-economic status, limited social networks, breakdown in service delivery, gender inequality, substance use, infrastructure and victimization (Goudge, Gilson, Russell, Gumede, & Mills, 2009; Van Niekerk, Ratele, Seedat, & Suffla, 2014), are being addressed, adequately, through legislation and policy. These risks and barriers need to be addressed, in order to allow access to resources, as well as create an environment where these human rights can be enjoyed in the family setting.

In July 2010, the Injury Prevention in South Africa Policy Project was commissioned by the USAID/Futures Group of which the Integrated Strategic Framework for the Prevention of Violence and Injury in South Africa for 2012–2016 was created (RSA, DoH, 2014). The framework was created by University of South Africa's (UNISA) Institute for Social and Health Science, in collaboration with the National Department

² Criminal Procedure Act (Act 21 of 1977), Domestic Violence Act (Act 116 of 1998), The Sexual Offences Act (Act 32 of 2007).

of Health, with the assistance of a steering committee, consisting of, approximately, 120 representatives from various departments such as Health, Police Services, Justice and Constitutional Development, Social Development, Transport, Basic Education, Trade Development and Industry, Sports and Recreation, Labour, Human Settlements, Women, Children and People with Disabilities, Correctional Services, Economic Development Department, and Public Works (RSA, DoH, 2014).

This framework brings together resources and capacity towards action that address ‘cross-cutting’ risks (these include poverty, socio-economic status, gender inequality, substance use, infrastructure, victimization and service delivery) and various other drivers of violence in order to develop and implement what is known to work (Van Niekerk et al., 2014). In essence, the purpose is to reduce risk factors, create a collaborative environment for support, and to integrate data systems for accurate and collated data to best promote effective evidence-based interventions (Van Niekerk, 2016; Van Niekerk et al., 2014).

A long-standing critique has been the lack of a strategic plan, or framework for South Africa, not only for Gender-Based Violence (GBV³), but violence in general. The South African National AIDS Council Women Sector (SANACWS) issued a press release in 2014 on NGOPulse, as a renewed push towards a strategic plan to address GBV. SANACWS emphasized the necessity for a national strategic plan, as it would demonstrate, not only a political will, but also a commitment, align strategic priorities, and create a coordinated response among stakeholders to address larger social issues, as well as create an accountability mechanism for government (South African National AIDS Council Women Sector, 2014).

³ Gender-based violence can be related to physical, sexual and psychological violence, linked to sex or gender. In South African and international examples, GBV can be observed in intimate partner violence (See femicide in Abrahams, Mathews, Jewkes, Martin, & Lombard, 2012); child abuse (See Leoschut & Kafaar, 2017); as well as in elder abuse (See Carmona-Torres, López-Soto, Coimbra-Roca, Gálvez-Rioja, Goergen, & Rodríguez-Borrego, 2018). The aforementioned examples also reveal violence in the home, perpetrated by family members/partners, to be the most prevalent form of violence experienced, even in cases of gender-based violence.

In addition, it is noted that the hindrance in combating GBV is, not only the lack of political will to do so, but also implementation (South African National AIDS Council Women Sector, 2014). This is exemplified by the 2012 initiative of the South African President Jacob Zuma's administration to create the first strategic plan for GBV, only to have the process halted, 2 years later by, the minister of the Women in Presidency, Susan Shabangu, a move which proved to be discouraging (South African National AIDS Council Women Sector, 2014). Sonke Gender Justice⁴ (n.d) links the halted process to destabilizing political change, as well as a lack in funding to carry out the mandate. In addition, the minister has failed to provide an update on the status of the plan, or plans, to reinstate it (Sonke Gender Justice, n.d.). Genderlinks (2015) stated that learning from the HIV/AIDS response, a national strategic plan was important in the fight against GBV, to garner political commitment, and the funding required to address the social challenges; however, it also requires a coordinated response among diverse stakeholders. A multi-sectoral approach is needed to end the violence or improve the response, as no one department can be held responsible (Genderlinks, 2015).

A sustained push and constant campaigning from civil society endured, and in 2014 an integrated plan was established (RSA, DoH, 2014). However, following this, in 2015 a news report by The Daily Maverick revealed that a more specific strategic plan had been formulated and named the *Integrated Programme of Action Addressing Violence Against Women and Children [POA: VAWC]* (Davis, 2015). However, upon further investigation, it was found that no one from civil society, nor the NGO sector, was consulted when the strategic plan was drafted. In addition, no one was aware that it was being formulated, until it was uploaded on the Department of Social Development's website (Davis, 2015). Sharon Kouta, the gender-based violence programme specialist for NACOSA (the Networking HIV/Aids Community of South Africa) was quoted as questioning the document, as the strategic plan, apparently, indicated that a multi-

⁴ Sonke Gender Justice is a non-partisan, non-profit organisation, which works across Africa in order to strengthen government, civil society and citizen capacity to promote gender equality, prevent domestic and sexual violence, and reduce the spread and impact of HIV and AIDS.

sectoral response was needed, yet no one from civil society was consulted, regarding its formation and implementation (Davis, 2015). In addition, it was observed that vital issues had been overlooked in the new strategic plan, for example, sex workers as part of the target demographic, which funding mechanisms would be used for this mandate, how monitoring and evaluation would occur, as well as how progress will be reported (Davis, 2015).

The disjointed and surreptitious process followed to establish the POA: VAWC could also hint at reasons why possible gaps in implementation were being experienced, such as a mistrust between government structures and civil society organisations (CSO), who are the biggest services providers combatting GBV (Republic of South Africa [RSA], Department of Women, Youth and Persons with Disabilities [DWYPD], 2013). This mistrust has been attributed to inefficient consultation mechanisms and inefficient use of CSO specialist skills (RSA, DWYPD, 2013).

With all the challenges with establishing a coordinated, adequate response to family violence and with specific reference to GBV, experienced in South Africa, it is possible to see as to why plausible interventions or who the focus of the interventions should be, vary across the different sectors addressing family violence. This variation in response and demographic focus is partly due to lack of coordination amongst sectors, owing to competition for funding (RSA, DWYPD, 2013).

However, family can be significantly emphasized within the integrated strategic framework for the prevention of violence and injury. The framework has 3 focal areas of which 12 objectives are spread amongst the action areas. Within action area 1 (cross cutting risk factors), families are directly considered within objective 3, which refers to nurturing safe relationships between children and caregivers (RSA, DoH, 2014).

A key strategy, highlighted in objective 3, is to create evidence-led programs and services for families at risk, of which the intervention stemming from this could be primarily family-focused. At present, intervention aligned to this strategy is spoken about quite generally with specific focus towards youth, unemployed and single caregiver families (RSA, DoH, 2014). In creating evidence-based, family-centred

interventions, objective 12 that deals with effective and equitable resource allocation and utilization for the implementation of evidence-led interventions is also met, and can ensure adequate provision of family-centred interventions.

To effectively engage the root of family violence, holistically, the intervention focus or target population, can no longer be divided. The context in which family violence exists, must be considered. The context is noted to be the biggest contributor to an individual's socialization, self-regulation and even the determinant to the normalization of violence and violent interaction, which is not so much community but the context of family. Family is rarely addressed, or mentioned, when investigating violence related law, as often the focus lies in victim/perpetrator, and the alignment of the justice system to this relationship. However, literature reveals that the normalization of violence begins in the family, and can be further exacerbated by community violence, all of which leads to desensitization of violence, as well as violence being seen as socially appropriate to resolve interpersonal conflict (Leoschut, 2009). In order for the family to receive a more focused attention in legislation and policy, as well as garner a more holistic response when faced with violence, what is currently available to address violence occurring in the family, has to be investigated.

5.5.1. Early legislative attempts towards family violence in South Africa

The last time violence in the family was examined as a legislative whole in South Africa, the Prevention of Family Violence Act 133 of 1993 (PFVA) was being enforced. This was an early attempt to deal with violence in the family; however, there were many drawbacks regarding this legislation (Mathews & Abrahams, 2001; Usdin, Christofides, Malepe, & Maker, 2000; Vetten, 2005). The Prevention of Family Violence Act 133 of 1993 is regarded as a final attempt by the Apartheid regime, as a *face-saving* reform, and was passed swiftly (Usdin et al., 2000). Yet the act was still heavily critiqued as inadequate and flawed (Usdin et al., 2000).

One of the earliest studies, to assessing the newly implemented Domestic Violence (DV) Act 116 of 1998 in relation to the older PFVA, was conducted by Mathews and Abrahams (2001). Family violence according to the PFVA, was

narrowly defined with the definition leaning more towards physical aggression towards a spouse or child and is only directed towards married couples consisting of a man and woman (Mathews & Abrahams, 2001). Additionally, the act failed to acknowledge cohabitation, same-sex couples, or psychological aggression, such as maltreatment or neglect, as abuse (Mathews & Abrahams, 2001). The PFVA was not formulated in consultation with key stakeholders, such as women's organisations, but largely by white males representing the outgoing Apartheid regime (Van Der Hoven, 2001). Additionally, it did not define grounds for a protection order, although it allowed for it, it did not perceive stalking as a form of violence, or make provision for 24 hour help services. It also did not allow for amendments to be made to the protection order, and rehabilitation, or counseling services for the perpetrator was not addressed (Van Der Hoven, 2001).

The PFVA was not only met with much critique, but also avid opposition. The PFVA was opposed by the South African Association of Men (SAAM) (which consisted only of white males), who felt threatened by the new political changes brought on by the post-apartheid democracy (Lock Swarr, 2012). The South African Association of Men stated that men are as much victims to family violence as women and that the PFVA was part of a much "broader feminist assault on men" (Lock Swarr, 2012).

In a newly democratic South Africa, which was pressured to institute the newly ratified Declaration on the Elimination of Violence against Women, change was sought to rectify the shortcomings of the PFVA with the new Domestic Violence Act 116 of 1998, which contained inclusivity and clearer enforcement mechanisms (Mathews & Abrahams, 2001; Usdin et al., 2000; Van Der Hoven, 2001; Vetten, 2005). However, the new DV Act like its predecessor, the PFVA, does not criminalize domestic violence, which has led to unclear prevalence rates of family violence, as these acts are categorized under assault, sexual assault and various other categories (Bendall, 2010; Usdin et al., 2000).

At present, family violence is understood and addressed within its respective subsets of intimate partner violence, child abuse and elder abuse with legal and

legislative responses structured in this way.

5.5.2. Legislation that addresses intimate partner violence

Abuse is physical, sexual, emotional, verbal and psychological abuse, including economic abuse, intimidation, harassment, stalking, damage to property and entering the complainant's residence without consent (Ryan, Rich, & Roman, 2015; Vetten, 2005). Legislatively, The Domestic Violence Act 118 of 1998, Children's Act 38 of 2005⁵, as well Child Justice Act 75 of 2008⁶, all have extensive detail regarding the rights of the individual, the extent to which the state is accountable, as well as the enforcement mechanisms.

The South African Domestic Violence Act (RSA, 1998) encompasses marital or cohabitive relationships, parent-child relationships, as well family membership by means of consanguinity, affinity or adoption. The act relates to physical, sexual, emotional, verbal and psychological abuse, economic abuse, intimidation, harassment, stalking, damage to property and entry into the complainant's residence without consent (Vetten, 2005). The South African Domestic Violence Act (Act 116 of 1998) attempts to address all forms of violence within the home, yet all members of the family are not equally covered within the ambit of this legislation. The Domestic Violence Act (RSA, 1998) does not make adequate provision for elder abuse, in terms of referrals, as, according to Ferreira (2005), as well as Ferreira and Lindgren (2008), older claimants feel marginalized by the judicial process, because their claims are not dealt in the the same urgent way, as IPV or child abuse cases. This ultimately leads to older claimants withdrawing their charges against their perpetrators (Ferreira, 2005; Ferreira & Lindgren, 2008).

5.5.3. Legislation that addresses child abuse

Child abuse/maltreatment is all forms of physical/emotional ill-treatment, sexual

⁵ Section 305 details grounds for enforcement, as well as conviction if found guilty.

⁶ Section 68

abuse, neglect or negligent treatment, commercial or other forms of exploitation, resulting in the actual, or potential harm, to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power (World Health Organization [WHO], 2002). In South Africa, the Children's Act (RSA, Act No. 38 of 2005) is the foundation for early intervention of violence prevention, as well as a means to identify, refer, support, care and rehabilitate children who have endured violence (Proudlock, Mathews, & Jamieson, 2014). The Children's Act provides the Children's Court the ability to mandate parent, caregiver or child to undergo early intervention programs to address issues found to be a threat to the child's safety (Proudlock, Mathews, & Jamieson, 2014).

These interventions include parenting programs, rehabilitation, counseling and mediation (Proudlock, Mathews, & Jamieson, 2014). Because the guiding principle of the Children's Act is to always act in the best interest of the child, most of the interventions mandated by the court would thus be primarily child-focused rather than family-centred. The difference between child focused and family centred, is with child focused approaches, the professional provides the family with a plan of care with one way communication taking place of professional to caregiver, with all differences seen in parents judged as in conflict with the child's best interest (Burns et al., 2008).

This is in contrast to a family-centred approach that creates a collaborative relationship where family needs are balanced with the best interest of the child, parental input on plan of care is encouraged with each family treated as unique instead of prescriptive to a specific group (Burns et al., 2008). In cases of extreme high-risk situations, immediate action is expected, yet for long-term results a family-centred approach is best suited as opposed to a child-focused approach that is noted as a short-term reprieve (Burns et al., 2008).

It is well-known that, especially in areas that have used the family-centred approach, such as HIV/AIDS orphans and other vulnerable children (OVC), children thrive in families (Wakhweya, Dirks, & Yeboah, 2008). Children are

able to better cope with vulnerabilities when their parent/s or caregiver/s are healthy and able to provide love and cognitive stimulation, a notion linked to a central theorem known as Hamilton's rule which was formulated over 50 years ago (Bourke, 2014; Wakhweya, Dirks, & Yeboah, 2008).

Hamilton's rule is a theorem found in evolutionary biology in which biological altruism between parent and child allows the child to thrive, or in other words, the greater the biological relationship between the child/ren and the adult caregiver/s, the better the health, educational and nutritional status of the child (Bourke, 2014; Wakhweya, Dirks, & Yeboah, 2008). Therefore, the family-centred approach has been seen as, not only an important approach, but has also been successfully implemented with children affected by HIV/AIDS (Betancourt, Abrams, McBain, & Fawzi, 2010; Wakhweya, Dirks, & Yeboah, 2008), as well as children with intellectual disabilities, and attention deficit/hyperactivity disorder (ADHD) (Cunningham, 2007; Wade, Mildon, & Matthews, 2007).

The family-centred approach has been shown to make important strides in child welfare when co-occurring issues are taken into account such as parental substance abuse, IPV, parental mental health issues as well as poverty related stressors, yet in other cases, mixed results have been reported whereby no improvement is shown (Kemp, Marcenko, Hoagwood, & Vesreski, 2009; O'Reilly, Wilkes, Luck, & Jackson, 2010).

However, these mixed findings have been linked to the fact that the majority of research around currently used family-centred interventions, used by child welfare (such as home-based visits), were published between the 1980's – 1990's (O'Reilly, Wilkes, Luck, & Jackson, 2010). With the advent of more contemporary intervention methods, such as the evidence-based programs currently sought by government departments like the department of women, children and people with disabilities, a more favorable outcome is foreseen.

5.5.4. Legislation that addresses elder abuse

Elder abuse as a definition has been challenging (Ferreira & Lindgren, 2008), yet

the most agreed upon definition has been the one posited by the International Network for the Prevention of Elder Abuse stating that elder abuse relates to the single or repeated act or even the lack of appropriate action, occurring within any relationship that has an expectation of trust, which causes harm or distress to an older person (WHO, 2002; Tolan, Gorman-Smith & Henry, 2006). Abuse can include physical, sexual, psychological and economic, and in violating the older person's rights enshrined in Chapter 2 (Bill of Rights) of the South African Constitution (Ferreira & Lindgren, 2008).

In contrast to legislation that addresses IPV and child abuse, the Older Persons Act (Republic of South Africa [RSA], (2006), Act No. 13 of 2006) has more of a focus on the state's involvement in residential services of the frail and indigent who do not have family. In addition, it does not stipulate enforcement mechanisms if discrimination or rights violation is experienced, forcing the elderly to seek remedies beyond the Older Person's Act such as in other legislative pieces such as the Equality Act⁷ (Malherbe, 2007).

It is only through the Equality act that, when rights violations can be proven in court, specific provision, such as compensation, interdicts or declaratory orders can be granted to the elderly⁸ (Malherbe, 2007). The Older Persons Act seems to distance the state's role for elderly who have family or community-based initiatives aimed at the elderly, which creates complications if either were in need of the state's assistance, either financially or in terms of resources (Malherbe, 2007).

5.6. Discussion

The aim of this paper was to review the various legislation used to address family violence and enhance family well-being within the South African context and promote

⁷ Equality Act is a commonly used name for the *Promotion of Equality and Prevention of Unfair Discrimination Act* (Republic of South Africa [RSA], 2000, Act No. 4 of 2000).

⁸ S 21 (2)

a family-centred approach as a feasible point of intervention. Legislation or law reviewed on family violence has only focused specifically on the Domestic Violence Act (Vetten, 2005) or the Children's Act (Proudlock, Mathews, & Jamieson, 2014) as gold standards on how well family violence has been addressed through law and services provided.

The necessity in addressing legislation, is that even with a world-renowned constitution, a gap in implementation is felt due to non-integrated services, as family violence is perceived as fragmented. Research reflects IPV, child abuse and elder abuse as inextricably linked to what is occurring within the family (Tolan, Gorman-Smith, & Henry, 2006; Leoschut, 2009), should our legislation and policy not holistically reflect this?

Through an ecological approach, family policy attempts to underlie the interplay of systemic influence and the challenges families face, such as violence in the home. However, the fragmentation in dealing with family violence and its legislative separation from family as the focal point, has in turn led to a fragmentation of sectors and services.

A critical factor was stated at the national roundtable on the multi-sectoral interventions and actions on gender-based violence (GBV)⁹; for an effective response towards family violence and other forms of GBV, collaboration is needed between sectors that deal with these issues (Parliamentary Monitoring Group, 2013). This is reflective of the ecological understanding that as family violence is affected by the systemic risk factors experienced by the family, so too should the various sectors that assist families experiencing violence, collaborate and pool resources to create a holistic response.

Specifically, there should be recognition of the heterogeneous effect of abuse instead

⁹ Gender-based violence is used as a broad term inclusive not only of family violence, but also acts of violence against society's vulnerable members (women and children), not found in the home setting (dating violence, sexual assault, acts of violence from non-intimate partners).

of creating generic, uniform treatment programs for the various forms of abuse (Nagia-Luddy & Mathews, 2010; Parliamentary Monitoring Group, 2013). There has been a historical fragmentation in delivery of services regarding family violence, specifically domestic violence and child abuse. These fragmentations include having different philosophies and mandates, different professional terminology being used, and lastly, these sectors indicating that they have different missions (Table 5.1) (Nagia-Luddy & Mathews, 2010; RSA, DWYPD, 2013). These would all be remedied if all sectors involved in the subtypes of family violence (domestic violence, child abuse and elder abuse) would realize the similarities amongst these subtypes (such perpetrators, shared framework) and create a unified integrative response in dealing with these issues via an integrative family-centred approach. However, this can only be done if reflected in our legislative climate and policy development. An interrelated problem ultimately deserves an integrated response, a response that starts at legislative level.

Table 5.2: Similarities and differences in focus of family violence subset legislation

	Child abuse	Intimate partner violence	Elder abuse
Mandate	Intervene according to the "best interest of the child" which resonates through the Children's Act No. 35 of 2005 and its amendment 41 of 2007 (promulgated in 2010); as well as section 54 of the Sexual Offences and Related Matters Act.	To provide victims (mostly women) with legal instruments (DV act; protection order) to prevent further abuse from occurring and obligating law enforcing bodies to do so as far as possible.	To protect the elder victim first and foremost in alignment to procedures described in the Older Persons Act No. 13 of 2006.
Definition of abuse	All forms of physical/emotional ill-treatment, sexual abuse, neglect or negligent treatment, commercial or other forms of exploitation, resulting in the actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power.	Abuse is physical, sexual, emotional, verbal and psychological abuse, including economic abuse, intimidation, harassment, stalking, damage to property and entry into the complainant's residence without consent.	Abuse can be physical, sexual, psychological and economic, and in violating the older person's rights enshrined in Chapter 2 (Bill of Rights) of the Constitution and any conduct or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress or is likely to cause harm and distress to an older person.
Focus	Child	Mostly women	The elderly
Framework of policy	Ecological	Ecological	Ecological

Abusers/perpetrators	Family/caregiver	Family/spouse	Family carer/professional carer
Response to abuse	Immediate; Multi-sector (social development/ police)	Response time notably linked to protection order; police	Inadequate
Treatment provided	Support programmes (parent-child), foster care/youth homes, legal, medical, counselling	Shelters, legal aid, counselling/support programmes, medical.	Medical, residential services of which only a few have beds set aside for "emergencies". Only 6 shelters in 3 South African provinces available for abused elders.
Mandatory reporting	Yes	No	Yes
<p>Source: ANROWS, 2017; Barnett, Miller-Perrin, & Perrin, 2011; Bendall, 2010; Children's Act No. 35 of 2005 and its amendment 41 of 2007 (promulgated in 2010); Domestic Violence Act No. 116 of 1998; Ferreira & Lindgren, 2008; Nagia-Luddy & Mathews, 2010; Older Persons Act No. 13 of 2006; Ryan, Rich, & Roman, 2015 ; section 54 of the Sexual Offences and Related Matters Act; Vetten, 2005; Department of Social Development, 2012; WHO, 2002.</p>			

5.7. Prevention Implications

The way forward would be to explore how future legislative approaches and interpretation, could lead to family-centred strategies. This would be representative of the effect family violence has on all members of the family, and would advocate family well-being, holistically. In addition, clearly outlined funding and enforcement mechanisms were determined to be vital, as the absence thereof could halt tremendous strides, as observed in the challenges regarding the national strategic plan to address violence.

A strategic framework, therefore, is integral to ecologically co-ordinate all legislative activities towards violence reduction and possible eradication, under unified aims and objectives, inclusive of the family. This, in turn, would elicit clear political will, governmental accountability and guaranteed funding in the fight against family violence and sustainable family well-being.

In essence, this will further assist organisations and practitioners to be supported through a collaborative multi-sectoral climate, with guidelines to assist families experiencing violence through family-centred approaches. Family-centred strategies

that are driven by family-centred legislation will create long-term results, as it is inclusive of all members needed for the enduring outcome of enhanced family functioning and well-being.

5.8. Conclusion

Families, as well as organisations and practitioners, need to be capacitated, in order to reduce violence in the family, a feat that begins with legislative response. Currently, progressive developments cannot be ascertained realistically, due to the unclear status of family protection and support of family violence legislation, as well as the ambiguous nature of the government's response to create coordinated and integrated efforts, across sectors.

Family violence is still addressed and dealt with in isolation, from the concept of family. To narrowly restrict family violence into its subtypes, and have family violence only understood and addressed in its various individuated subtypes, not only narrows the understanding of family violence, but also over simplifies it. Consequently, the risk is that, if the focus is on a subtype of family violence, family members exposed to the violence may not necessarily be part of the healing process, as the focus may only be on the victim and the perpetrator. The way forward, therefore, is to advocate for holistic, family-centred legislation, and translate them into appropriate family-orientated strategies, which may assist South African families effectively, towards better family functioning and enhanced family well-being.

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CHAPTER SIX

A NEEDS ASSESSMENT OF FAMILIES EXPERIENCING VIOLENCE IN A SOUTH AFRICAN CONTEXT: THE PERSPECTIVES OF PROFESSIONALS

6.1. Introduction

The idea of family violence, or family members purposely inflicting harm on one another has perennially been a challenging concept to understand or accept. Family is understood to promote and provide care, stability, dependability and positive development, not purposely inflict harm (Jouriles, McDonald, Norwood, & Ezell, 2001; Amoateng, Richter, Makiwane, & Rama, 2004; Wallace & Roberson, 2016; Waite, 2000). Therefore, the challenge is, not only to understand the concept of violence in the family, but also the needs of such a family, for the purpose of intervention.

Wallace and Roberson (2016) define family violence as “any act or omission by persons who are cohabiting or living together as a family that results in serious injury to other members of the family. Serious injury refers to physical or emotional harm or a violation of another family member’s rights and freedom of choice” (p. 5). Tolan, Gorman-Smith and Henry (2006) states that family violence includes violent acts, psychological aggression, coercive and intimidating aspects such as fear felt or intent to commit violent acts. Family violence is also noted to ascribe to more abstract ideas of violence in the home in that family violence is seen as a form of structural violence. The family as a structure, goes beyond violent acts but also creates violent conditions through fear and intimidation and prevents the family members from attaining their full potential of well-being (Absher, 2012). For the purpose of this study, drawing on all the above-mentioned definitions, family violence is defined as any act that infringes on the rights and freedom of, and causes any harm (not limited to physical, psychological, spiritual, economic, sexual and neglectful) to family members.

The term family violence is a more holistic, all-encompassing term, bringing attention to the violence experienced in the home among family members, and highlights the

interrelatedness of the family relationships, involved in the various forms of violence in the home. Therefore, family violence speaks to the broader context of violence occurring in the home than IPV, elder abuse or child abuse on its own, yet these forms of violence form part of family violence (McClennan, 2010; Gelles, 1999; Tolan, Gorman-Smith, & Henry, 2006; Wallace & Roberson, 2016). The various forms of family violence, namely, IPV, elder abuse, and child abuse, are what is known to be subsets of family violence (McClennan, 2010; Gelles, 1999; Tolan, Gorman-Smith, & Henry, 2006; Wallace & Roberson, 2016). Subsets are sets that make up a larger set, or smaller things that make up a larger group (O’Neil & Summers, 2015).

Ultimately, family members are all affected in the act of any violence in the family, thus any intervention should include the whole family (Thorpe, 2013; Tolan, Gorman-Smith, & Henry, 2006). A family-centred approach focuses on all family members to be included in the intervention and is noted as the best suggested method when trying to create an intervention for family violence (Lock & Le Grange, 2013; Tolan, Gorman-Smith, & Henry, 2006).

A family centred-approach not only includes all members of the family affected by the violence in the home, but also creates collaboration between the family and the practitioner (Burns, Dunn, Brady, Starr, & Blosser, 2008). A family-centred approach to dealing with violence in the family would allow for a better understanding of the interrelatedness and effects of all forms of violence in the family on *all* family members. Interventions or services offered to address family violence often focus only on one or two aspects of violence in the family and are therefore often fragmented in its approach and outcomes (Nagia-Luddy & Mathews, 2010).

Few studies are noted to explore family-based interventions in relation to IPV (Chaudhury et al., 2016), which is also seen with child abuse which is addressed mainly through child-centred strategies aligning to the legislative mandate of “best interest of the child” (Ryan, Esau, & Roman, 2018); elder abuse too has been divorced from family centric insights owing to the focus on bolstered social services and awareness raising (Daly, Merchant, & Jogerst, 2011; Jagielska, Pikuła, & Łukasik, 2015, Pillemer, Mueller-Johnson, Mock, Suitor, & Lachs, 2007).

Notably interventions aimed at family violence not only included family management and training, but also resource knowledge such as where to get assistance, how to get in contact with these service providers and what services are rendered; focusing on family skills and getting in contact with the appropriate service providers were shown to have the best success rate in distress as well as violence reduction (Tolan, Gorman-Smith, & Henry, 2006; Wolfe, 2003). In a South African context, the holistic perspective of family violence, regarding the lived experience of those experiencing violence in the home is lacking, as subsets are still addressed separately, with some subsets garnering more attention than others. The South African Police Service (SAPS) show the South African murder rate to be six times the global estimate for the year 2012-2013, of which child abuse and IPV related homicide rates being the highest in the world, with child homicide rates being twice the global estimate (Africa Check, 2013; Mathews, Abrahams, Jewkes, Martin, & Lombard, 2013; Seedat, Van Niekerk, Jewkes, Suffla, & Ratele, 2009; Wood & Jewkes, 2005).

Of the children surviving the ordeal of abuse on a daily basis, exposure to IPV often co-occurs with child abuse and maltreatment, resulting in greater aggression and delinquency, difficulty in regulating emotions as well as managing social interactions (Haselschwerdt, Savasuk-Luxton, & Hlavaty, 2017), indicating at-risk consequences which may extend into adulthood; risks which include revictimization or perpetration (United Nations International Children's Emergency Fund [UNICEF], 2007; Ryan, Rich, & Roman, 2015).

Boys are twice as likely to become perpetrators of abuse in adulthood in comparison to boys from non-violent homes, with girls being more accepting of abusive married life than girls from non-violent homes (UNICEF, 2007). The involvement in one form of family violence becomes a risk factor for other types, as even perpetrators of family violence have at one point often been victims of some form of family violence in childhood or later (Graham-Bermann & Edleson, 2001; Tolan, Gorman-Smith, & Henry, 2006).

Youth exposed to violence in the family, are more likely to commit violent acts or acts of intimidation, than non-exposed youth (Leoschut, 2009). Moreover, adult survivors

of childhood experiences of family violence currently engaged in filial caregiving (son/daughter looking after aged parent/s), showed a compromised well-being in terms of the adult child (increased depressive symptoms) as well as limited emotional support given to parents (Kong, 2017; Kong & Moorman, 2013; Parker, Maier, & Wojciak, 2018). Though research on elder abuse within South Africa is noted as sparse, it shown to be widespread (Ferreira & Lindgren, 2008); international literature showing family members to be the most likely perpetrators of elder abuse, namely the adult child (Barnett, Miller-Perrin, & Perrin, 2011; Berkman, 2006; Soares, Barros, Torres-Gonzales, Ioannidi-Kapolou, Lamura, Lindert, De Dios Luna, Macassa, Melchiorre, & Stankūnas, 2010).

Elderly who experience abuse are noted to have most likely also experienced child abuse and IPV, further showing the effects of violence in the home extending beyond adulthood and well into old age (Barnett, Miller-Perrin, & Perrin, 2011). Overall, 46% of all injury related deaths in South Africa are linked to interpersonal violence (Republic of South Africa [RSA], Department of Health [DoH], 2014).

As the aforementioned statistics and family violence outcome show, violence in the home undoubtedly affects all members of the family, with early exposure placing greater risk for future perpetration or victimization be it in future domestic settings or violent crime; no adequate intervention potentially resulting in premature death linked to homicide. Additionally, links are highlighted where individuals involved in one form of family violence were involved or affected by other forms of family violence at some point in their life, and how exposure to the various forms of family violence consequently holds maladaptive, at-risk repercussions throughout every phase of one's life.

As family violence is thus shown to be intricately linked to interpersonal relationships and family life, especially within the South African context, a needs assessment is seen as imperative in determining how violence is seen and established by family practitioners, and what the scope of intervention should be. Therefore, the aim of the study was to conduct a family violence needs assessment to create a depiction of what issues are present in a family experiencing violence in the home, but also to provide a

possible scope for a family-centred intervention aimed at reducing violence in the family.

6.2. Methodology

An explanatory sequential design had been implemented using a concurrent triangulation technique. This design has two distinct sequential stages. Firstly, quantitative data was collected (Stage 1) followed by, a qualitative inquiry (Stage 2). These two methods had been implemented concurrently to validate and strengthen the findings (Johnson, Onwuengbuzie, & Turner, 2007; Johnson & Onwuegbuzie, 2004).

6.2.1. Recruitment

Families were initially sought for the purpose of the study. To reduce harm and enhance benefit in accordance to ethics outlined nationally and internationally (Ellsberg & Heise, 2002), organisations that were already working with families experiencing violence were approached. Permission was sought from the various national offices to approach regional offices. However, it was at the discretion of the individual social workers and counsellors of the organisations if they could assist or not. When permission was received from national head offices, invitation letters were sent to offices within the regional area inviting existing clients and their families to participate, after a year and a half, only one participant was recruited. This non-participation was even after much interaction, attending regional shelter forum meetings for further recruitment, and checking up with the organisations. It was through either non-response or lack of time on an already limited staff that resulted in non-participation.

Additionally, organisations contacted, who particularly worked with the elderly, claimed that their clients were not prepared to participate, as the topic was a sensitive subject. This scenario is quite common regarding elder abuse as underreporting was owed to a sense of protecting the family or a sense of shame or helplessness (Kwiatkowski, 2015).

The data collection, therefore, was restructured to focus on family practitioners.

It was noticed that organisation staff were more comfortable in relaying their own experiences and insight of families experiencing violence, than allowing access to their client base. For this reason, only practitioners were consulted.

6.2.2. Sample

In total, 9 participants were recruited for the quantitative phase. The mean age of the participants was 33.14 (SD=11.60) years, most of whom were female (77.8%). All of the participants were employed (100%), with most falling within the Afrikaans-speaking (66.7%), Coloured (44.4%) demographic. Majority of the participants were social workers (77.8%), working in the low-income (66.7%) areas of Lamberts Bay (55.6%) in the Western Cape. The participants felt they had sufficient government stakeholder support (55.6%) to address family violence; however, they did not feel they had adequate community support (55.6%), resources (77.8%), and referrals (77.8%), regarding families experiencing violence. These demographics are broken down in Table 1 Appendix A.

6.2.3. Stage 1 – Quantitative needs assessment

6.2.3.1. Data collection instrument

A questionnaire was administered to NGO practitioners who work with families, to determine their perceptions of families who experience violence in the home. These perceptions are integral for the purpose of programme design and development. Interventions directed at most of the forms of family violence sought to improve family functioning through impulse control and other behaviours and affect related to family violence, which showed the most positive outcome and most promising (Tolan, Gordon Smith, & Henry, 2006). The questionnaire (Appendix B) was thus divided into three sections.

6.2.3.1.1. Section A: Biographical information

The biographical details (gender, age, race, and language of the practitioner) as well information regarding the work area/community

and the resources available to them in the community were sought. In addition, their perceived support from the community as well as the government was determined.

6.2.3.1.2. Section B: The questionnaire of family functioning

The family functioning self-administered questionnaire was created to ascertain the core aspects of the family interpersonal functioning, an aim usually focused upon and addressed in family psycho-educational programmes (Casacchia & Roncone, 2014; Roncone, Mazza, Ussorio, Pollice, Falloon, Morosini, & Casacchia, 2007). Though the McMaster Family Assessment Device (FAD) is notably popular in assessing how family members perceive the family environment and interaction, the family functioning (FF) questionnaire honed directly in on skills family members should have in order to help one another (Casacchia & Roncone, 2014). An example provided was that FAD's communication scale related to the clear and direct exchange of information among family members, but not the necessary skills, which is part of the psycho-educational treatment, to communicate pleasure/displeasure and active listening (Casacchia & Roncone, 2014).

The FF is a 24 item questionnaire which measures the following:

- a) Problem-solving, based on six steps of structured problem-solving to identify the problem, list possible solutions, discuss the pros and cons of each proposal, choose the best, or most satisfying realistic solution, plan the solution and review implementation;
- b) Communication skills, which entailed expression of positive and negative feelings, making requests, and active listening; and
- c) Personal goals which is each family member's ability to identify personal everyday goals and how to express those goals

(Casacchia & Roncone, 2014; Roncone et al., 2007). E.g.:

Statement	Always	Often	Sometimes	Never
2. Families experiencing violence, collaborate together to find the best way to solve their problems.	1 (Always)	2 (Often)	3 (Sometimes)	4 (Never)

The family functioning questionnaire investigates the positive qualities of family and not the negative in order to bolster skills needed to bolster family functioning and life satisfaction (Casacchia & Roncone, 2014). This questionnaire has been adjusted for the purpose of this current study, as it was originally directed towards caregivers of schizophrenic family members (Casacchia & Roncone, 2014; Roncone et al., 2007).

Validity and Reliability

Psychometric properties: The questionnaire initially began with 60 items that was later scaled down to 38 items as a result of focus groups and preliminary investigations (Roncone et al., 2007). After a further two studies and having items reworded or removed and having more thoroughly align questions to core domains, the questionnaire was scaled down to 24 items (Roncone et al., 2007). The 24 item questionnaire showed an over-all Cronbach Alpha score of .84 and the three sub-scales: Problem solving indicating $\alpha = .83$, Communication showing $\alpha = .71$ and Personal goal presenting $\alpha = .66$ (Roncone et al., 2007)

6.2.3.1.3. Section C: The Physician Readiness to Manage Intimate Partner Violence Survey (PREMIS)

The PREMIS was developed to measure clinician knowledge, beliefs and self-reported behaviours (KABB) of physicians in four parts, namely, background, intimate partner violence knowledge, opinions ad practice issues (Connor, Nouer, Mackey, Tipton, & Lloyd, 2011; Short, Alpert, Harris, & Surprenant, 2006). Yet for the purpose of this study, we have only used the opinions subscale, which examined 6 dimensions, namely,

- i) Staff preparation – which looks at the clinician’s skills in discussing domestic violence (DV) with men, women, and people from different backgrounds;
- ii) Legal requirements – which measures awareness of legal requirements in reporting cases of DV;
- iii) Workplace issues – measures adequate time to respond to service users experiencing DV;
- iv) Self-efficacy – determines comfort in discussing DV with service users;
- v) Alcohol and drugs – measures knowledge about the relationship between substance misuse and domestic violence; and
- vi) Victim understanding – determining the opinion of the clinicians that service users experiencing domestic violence could leave the violent relationship at any time

(Connor et al., 2011).

For this current study, however, the questions have been adapted to address family violence in more holistic sense as well as all questions that seemed more directed towards physicians explicitly had been removed. Also the 7 response option had been reduced to 4 category response options as the 7 responses would still had to have fall under the 4 response categories below, e.g.:

Statement	Strongly disagree	Disagree	Agree	Strongly agree
1. I ask all new clients about abuse in their relationships.	1 (Strongly disagree)	2 (Disagree)	3 (Agree)	4 (Strongly agree)

The changes were executed so that non-clinical paraprofessionals, as well as non-medical professionals could answer the questions, which

has not been done with this instrument (Connor et al., 2011; Short et al., 2006). However, reshaping items to speak to mental health practitioners than solely to physicians, had been successfully implemented (Nyame, Howard, Feder, & Trevillion, 2013).

Validity and Reliability

Psychometric properties: According to Short et al. (2006), the developers of PREMIS, the opinions scales initially contained 54 items which were later scaled down to 31 items by means of factor loadings and testing the alpha coefficients. Through this process of validity testing, the opinions scales went from 8 to 6 core scales, namely:

- i) Staff preparation which contained 5 items, showed an $\alpha = .85$,
- ii) Legal requirements which contained 4 items, displayed an $\alpha = .82$, iii) Workplace issues which contained 6 items, showed an $\alpha = .79$,
- iii) Self-efficacy which contains 6 items, showed an $\alpha = .69$,
- iv) Alcohol and drugs which contains 3 items, showed an $\alpha = .70$, and
- v) Victim Understanding which contains 7 items, showed an $\alpha = .69$

(Short et al., 2006).

6.2.3.2. Data collection procedure

The data were collected from practitioners, who worked in various regions of the Western Cape, South Africa. These regions included the Boland, Cederberg, Overberg, and Lamberts Bay area as well as greater Cape Town. All the practitioners were given the self-report questionnaire with the researcher present, in case any clarification was needed regarding the questions.

6.2.3.3. Data analysis

The data was entered, cleaned and analysed, using descriptive statistics such as mean scores and frequencies using the latest version of SPSS. Within the original article, data analysis for section B of the questionnaire (The family functioning) does not denote a specific analysis to be done with the item responses (Roncone et al., 2007). As this questionnaire was only provided to determine prevalence for the purpose of this study, item responses were analysed using descriptive statistics namely means and standard deviation. Furthermore, section C (PREMIS) is a survey tool of which this study analysed using mean scores and standard deviation as well; another study which has used the PREMIS tool, also utilized descriptive statistics in part, as an appropriate analysis for item responses (Nyame et al., 2013).

6.2.4. Stage 2: Qualitative component of family violence assessment

Immediately after the questionnaire, the participants were asked whether they would participate in the interviews, regarding their experiences with families, who were experiencing violence in the home. This stage provided the participants to descriptively narrate their experiences with families, who were experiencing violence in the home, as well as provide an opportunity to elaborate on what should be included in a family-centred intervention.

6.2.4.1. Data collection procedure

Taken from the quantitative sample, individual face-to-face interviews were conducted with 8 of the 9 participants. These interviews were conducted in Afrikaans, or English, with individual participants. Interviews were conducted separately with each participant. The organisation facilities had been used to conduct the interviews. Participants were notified that the session was to be recorded on a digital recorder with no personal descriptors used in the interview and were reminded that the interview was voluntary and the participant can stop at any given time without consequences.

6.2.4.2. Data collection tool

Semi-structured interviews were used to qualitatively explore the practitioners' perception of the individual family member's experience of family violence, experience of family life and recommendations for programme development (Appendix C).

6.2.4.3. Data Analysis

The digital recordings were transcribed verbatim and analysed using thematic analysis. Thematic analysis is a 6-stage process of data emersion, codifying and thematisizing the data to bring out relevant themes that will build on quantitative findings (Braun & Clark, 2006). This 6-stage process include:

- i.) Familiarizing oneself with the data by reading and re-reading the transcribed data,
- ii.) Generating codes by means of organizing the data into meaningful groups,
- iii.) Searching for themes by re-focusing the codes into an overarching theme,
- iv.) Reviewing themes by refining it either by breaking the themes down further or merging them,
- v.) Defining and naming the themes by identifying the essence of each theme, and
- vi.) The final analysis and writing up of findings

(Braun & Clark, 2006).

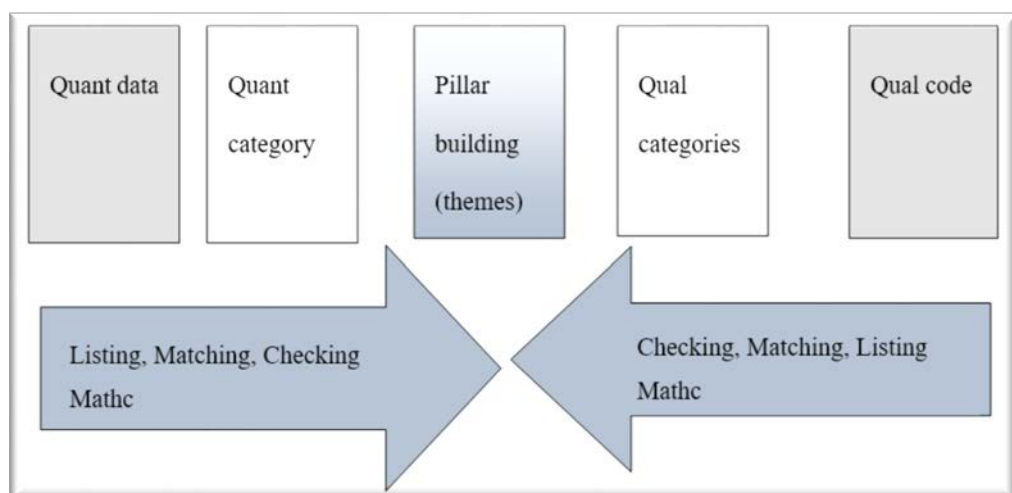
6.2.5. Mixed method integration process: The Pillar Integration Process (PIP)

In order for the results to be integratively interpreted as well as to validate findings of the two methods, the analysed findings underwent a secondary process in order to synthesise results both visually and methodologically. The Pillar Integration Process (PIP) is a transparent, four stage integration process

(Figure 6.1), aimed to merge or combine quantitative and qualitative results at the point of interpretation, after they have undergone an initial separate analysis (Johnson, Grove, & Clarke, 2017). The PIP uses a joint display format that combines and displays textual and numerical data in one visual display. However, PIP can also be used for the purpose of triangulation (Johnson, Grove, & Clarke, 2017), which is utilised in this study. The four stages of PIP followed were:

- 1.) Listing – raw data (percentages/quotations) and coded/grouped data were ‘listed’ in a joint display in the ‘quant data’ and ‘qual code’ columns;
- 2.) Matching – a matching process began with the opposite sides of the joint display. The listed quantitative data in the ‘quant data’ column was matched to the listed qualitative data in the ‘qual code’ column. In this process, data was horizontally aligned, refined and organized into the ‘category’ columns. This process also produced items which did not have a matching counterpart, which was interpreted as a gap in matched data;
- 3.) Checking – matched data was cross-checked for completeness and quality, that it had been relevantly categorized and appropriately matched; and
- 4.) Pillar building – listed categories infer patterns or insights which are then integrated into themes from each row, creating a meaningful narrative from the integrated data

(Johnson, Grove, & Clarke, 2017).



Adapted from Johnson, Grove, & Clarke, 2017

Figure 6.1: Diagram demonstrating the direction of the Pillar Integration Process

6.3. Results

The separate quantitative and qualitative analysis are provided in Appendix A; however, their integrated results are displayed in Table 6.1 in the PIP format; therefore, the results are presented in a tabular configuration.

6.4. Discussion

A family violence needs assessment was conducted to establish, not only what was happening with families, who were experiencing violence in the home, but also to provide a possible scope for a family-centred intervention, aimed at reducing violence in the family. Results themes evolved into systemic levels of possible interventions, such as what could be addressed at individual/family level, what could be linked to communities, and how policy plays a role in how practitioners intervene. These systemic understandings of intervention in family violence are not alien in its concept.

Table 6.1: Data from the needs assessment displayed through the four stage Pillar Integration Format

Quantitative data	Quantitative category	Pillar building themes	Qualitative category	Qualitative code
"Have less time to pursue personal interest, free time spent caring for the family." (M=2.44; SD=0.53) "So many family difficulties, given up on interest." (M=2.22; SD=0.44) "Manage to do things alone without family." (M=2.11; SD=0.60) "Meet friends outside the family." (M=2.44; SD=0.88)	Personal goals	Goal setting	Personal change	R8 "Everyone just wants to be happy. No one wants to work on it. Therefore, if they say what they will do differently, then they say that they just want to be happy. Not anything specific." R6 "So if you willing to change, what has to change? I have to change my lifestyle; I have to change my attitudes... I think it just becomes too much. You know it's easier to stay that way... to change all these things. It's safer... the thing you know, even though it's not nice but it's hard work to change."

<p>“Family members do not speak to one another when angry.” (M=2.00; SD=0.50)</p> <p>“Family never thank one another for something kindly done.” (M=2.33; SD=0.70)</p> <p>“Never let each other know politely if they do not approve of something.” (M=3.67; SD=0.50)</p>	Communication	Communication skills	Lack of communication	<p>R4 “In some families they cannot communicate with one another... some people are in a position where they must be under the influence of substances in order for them to communicate.”</p> <p>R7 “Like emotions...learning how to verbalize it, to acknowledge it ...and to deal with it. To communicate with each other in a proper manner... that’s why there is all this shouting and screaming and hitting because for some people that’s the only way they know how to express themselves.”</p>
<p>“Family members find it difficult to solve problems as they can never agree on anything.” (M=2.22;SD=0.67)</p>	Problem-solving	Problem-solving skills Conflict management	Problem-solving skills Dealing with conflict	<p>R7”problem solving skills...like I have this problem ...do I just focus on this problem? What am I gonna do actually? What are the steps that I’m gonna take? ...What are steps I’m gonna put in place to solve this problem of mine?”</p> <p>R6 “Teach them communication skills and conflict management...to break the cycles, so that the next generation won’t come out of homes that don’t know how to handle this.”</p>
<p>“Participants feel they have sufficient training to deal with family violence.” (M=2.11; SD=0.60)</p> <p>“Have adequate info. to identify family violence (M=2.11; SD=0.60), either through the way clients behave (M=2.56; SD=1.01) or as an underlying cause for health issues such as depression (M=3.00; SD=1.00)”.</p>	Skills and expertise to identify and address family violence	Identifying family violence	Identifying red flags	<p>R3 “One can sense it you know. The non-verbal actions and reactions towards your presence at that moment in the particular area...house...where it happens. And there is a type of anxiety... They can’t communicate really, or they try to cut it very short and they try to get rid of the social worker.”</p> <p>R1 “I knew something was not right with this family. Because you can see, like all over her body... cuts and bruises and all that.”</p>
<p>“Clients who abuse alcohol or other drugs are likely to have a history of family violence.” (M=3.22; SD=1.30)</p> <p>“Alcohol abuse is a leading cause of family violence.” (M=2.89; SD=1.05)</p>	Substance abuse and its link to family violence	Substance abuse	Substance abuse as an aggravator in family violence	<p>R5” Substance abuse is the main cause of it...When they drink; they hurt each other pretty bad. It’s normally the elder people who will abuse alcohol and the younger will use methamphetamine or mandrax.”</p> <p>R7 “They don’t handle emotions. Emotions is being dealt with through substance abuse.” <i>[sic]</i></p>

<p>"Use of drugs is related to family violence victimization."</p> <p>(M=3.22; SD=1.09)</p>				<p>R4 "In some families they cannot communicate with one another. Some people is in a position where they must be under the influence of substances in order for them to communicate." <i>[sic]</i></p> <p>R8"Is very seldom that it is only substance abuse... It's an add on and makes it more difficult. They use because they cannot solve their issues. I will say people are devastated, as they cannot resolve them."</p>
<p>"Are there sufficient resources in the community to assist you in adequately addressing the needs of the families in the community? (No = 77.8%)"</p> <p>"Are there sufficient referrals in the community which aid in assisting families experiencing violence? (No = 77.8%)"</p> <p>"Do you receive support in the community which aid in assisting families experiencing violence? (No = 55.6%)"</p>	<p>Community support and resources</p>	<p>Role of the community in family violence</p>	<p>Community response</p>	<p>R7 "There were neighbours that intervened. When I was interviewing them, they said the wife always went to them afterwards and said that they were okay and it was just a slight misunderstanding. So they would try...they said they just gave up because she didn't want to be helped. ...So people would intervene, but so often it is the victim that didn't want to be helped."</p> <p>R4 "The people will always say that they want to be anonymous...in a case like this it becomes difficult...the perpetrator normally accepts that it is the victim that reported the incident. It is very seldom that the victim will come and report the incident."</p> <p>R2"The community was involved...like in my culture...we used to call the family. The two families come together so that we can solve the matter. But the one family was not willing to come, because the other is accusing the other family...Then we as the community try to...establish a committee on that day so that when there is certain issues like this...we as the committee stand together."</p> <p>R6 "the single girls? No...no one will intervene. The community feels you want to drug? And you want to stay in that relationship? We not going to help you. With the married couples, I would say someone will try and intervene either from the church side or neighbours, because there are children involved."</p>
		<p>Family functioning</p>	<p>Effects of family violence on family functioning</p>	<p>R7" The mother eventually...she became so dead. I don't know if she's so desperate...she actually started harming the kids... The father never abused the kids, he abused the mother."</p>

				<p>R1 "I spoke to her and she was like no, but this is the last time, that this is the last it will happen. So I explained to her the cycle of violence and how that is prevalent in her case."</p> <p>R4 "Look, certain mothers don't realise the impact that family violence has on the children. Sometimes it comes from the perpetrators side and that...he was influenced. In his mind... of the child...this is acceptable because look in their family where they were raised."</p> <p>R6 "The children already know... they know the body language of the father when he comes in 'Now I must go and sit in my room'...I remember this one family, this little girl said when the father comes in the house, then she already knows she must go fetch his <i>kommetjie</i>¹⁰ with warm water for his feet. She was about seven, eight years old. She has to wash his feet, because that relaxes him. So she had her position in the house."</p> <p>R1 "The grandmother... she told me...Her grandchild tried to commit suicide...because she couldn't take it with her family...being so dysfunctional. I think she's twelve... twelve or thirteen years old. "</p> <p>R6 "I'm thinking of the couples now...the wives are all on anti-depressant. What do you call it? They don't say trepiline, they say 'trempline'...They all go for 'trempline' at the clinic. Like an anti-anxiety...depression cover-up I don't know." [sic]</p>
<p>"Interventions for family violence need to be more family-centred." (M=3.44; SD 1.01)</p>	<p>Need for family-centred approach</p>	<p>Family-centred approach and community linkage.</p>	<p>The need for family-centred approach.</p> <p>Linking family-centred approach to community.</p>	<p>R8 "The entire family should be there. Yes. It's like you've seen at the rehabilitation centre. The family must be involved. Because if that person should come back then the family know what to do. He's no longer the same person. He's a different person...This is the most important...for the family to be involved."</p> <p>R1" If you can maybe look at integrating it from all the different</p>

¹⁰ Afrikaans for a *small basin* (pronounced *cawma-key*)

				levels like...community work and individual case work...In the sense that you can look at how can we stop the violence happening in the family and then create a community development programme or look at violence or awareness..."
"Are there sufficient referrals in the community which aid in assisting families experiencing violence? (No = 77.8%)"	Community referrals	Referrals	Working with referrals	<p>R4 "The one case that stands out to me the most is the one of last year... the incident of a woman who stabbed a man to death. She reported it five times and nothing came of it... They have now realized that there was attempts made to do something to the situation, but it wasn't correctly followed through from her side. The woman had an interdict against the perpetrator, but then she never used it... Or they use it... but they use it... like we would say for a 'special weekend'. They go the Friday to make a case so the person can be imprisoned for the weekend. But when it's Monday and they have to take the matter further ... then they go and say no, they are dropping the case. This is what happens in most cases."</p> <p>R6 "I would say when there are children involved...I get the idea that there is a quicker response. When it comes to the intimate partner violence or basically partner abuse... I think the police are a bit hesitant because of all the paper work and then on Monday morning... then the cases are withdrawn. And we usually tell these women this... That you are responsible for this slow response from the police because you do this all the time... How many times have you gone on a Friday and opened a case? And by Monday you go and you withdraw the case or pay the bail? To tell you the truth, you know, with the elder abuse I got a bit more co-operation from the police...I think the people are just more open for the older persons and the children."</p>
"Are there sufficient resources in the community to assist you in adequately addressing the needs of the families in the community? (No = 77.8%)"	Community resources	Resources	<p>Lack of resources in the community.</p> <p>Inadequate resources, if resources are available in the community.</p>	<p>R1 "I actually saw the whole family, but not the perpetrator... The guy... cause I was so scared of him. Because this guy... I don't know if it's... if he has an anger management problem... what it is... but he has like this... you know people with schizophrenia right?... They feel like people are constantly watching them... and then when</p>

				<p>I did the whole visit... the guy was like ...but 'who's this?'...and then the lady told him...but ...I'm her friend... And to that extent she put my life in danger because what if this guy knows that I'm a social worker? And the stuff that he does... he doesn't care about interdicts or all of that... and he will still go to your house and give you a beating."</p> <p>R3 "Where people get so frustrated... when the victim and the perpetrator are aware of each other or become aware of each other because of the living space. And everything... one tries to do deal with it as confidential as possible, but it's not always easy. So there might be times that they listen into discussions and stuff, especially with us having no satellite offices...our own offices in the regions where we operate. So I've... I end up sometimes also talking to...to do clients... getting... into the car... you know that that... we don't have to sit in the house where everybody listens into the discussion."</p> <p>R6 "Okay we've got the trauma room at the police station... very nice room, fully equipped but not functional... Those are for the rape victims and so on. So it's not fully functioning... it is there! But if they are too scared to go home, they can go there. But that's only for 24 hours."</p>
<p>"Do you receive support from government stakeholders in assisting families experiencing violence? (Yes = 55.6%)"</p>	<p>Government support</p>	<p>State policy and support</p>	<p>Role of policy in adequately addressing family violence</p>	<p>R6 "Like there worked a few years ago... where you had this whole basket of service... You worked on all levels and they were all involved. So that worked nice... and then all of a sudden we got three different programs and now we all just working on our little bits... You know, we work fragmented like this because this is the way the government is funding us. " [sic]</p> <p>R1 "I only know... for this one lady I explained the cycle of violence and how it happens and she was like oh ok I'll do it next time and all of that you know... Because we only focus on child protection, that is the main thing, keeping that child safe. There's no time for you to actually do intervention with the parents you know... if there's violence happening."</p>

<p>“If victims of abuse remain in the relationship after repeated episodes of violence, they must accept responsibility for that violence”</p> <p>(M=1.67; SD=0.87)</p> <p>“Victims of abuse could leave the relationship if they wanted to.”</p> <p>(M=2.89; SD=0.93)</p>	<p>Victim response to family violence</p>	<p>The victims and family violence</p>	<p>Victim describing and responding to family violence intervention</p>	<p>R1 “I knew this one... this other case... this girl actually said that ‘my mother would throw around plates, and she will start to hit my father, but then my father will just give her any attention. Then she took it out on us...’ so then she would start beating the children, hence, the father didn’t give her any attention. So that is how she described violence in her perception... or ‘my mother was standing in the road and she threw me with a glass’ or something like that, but they won’t classify... as violence per say.”</p> <p>R4 “With children it’s normally easier. Believe it or not... they will just say that ‘my mommy did this’ and ‘my daddy did that’ and this is how it normally happens, but not the grownups. With them, it will normally be ‘what do we actually tell the social worker? And what do we keep to ourselves?’ ... They will only say that they fought. The children will say in depth what happened.”</p> <p>R7 “...It has taken a long time uhm... for the mother to actually say what was going on. You know, she kept making excuses for what was happening...trying to blame it all on her own... the mother would tell the stories ... as if she is the cause of how the arguments began. You know she... she’ll try to put all of the blame on if herself to keep it away from the father to prevent him from being upset, getting angry... which would later result in violence.”</p>
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Most interventions are policy determined, and family violence policies draw strongly from an ecological approach in which family, community and governmental factors are considered (Australia’s National Research Organization for Women’s Safety [ANROWS], 2017; Nagia-Luddy & Mathews, 2010; Tolan, Gorman-Smith, & Henry, 2006).

Identifying family violence and the victims’ response to violence were seen as themes from the findings. Practitioners dealing with family members affected by violence had stated they were perceptive in identifying red flags around family violence and had the

necessary skills to address it. Furthermore practitioners state that victims of violence were free to leave whenever they want and aren't to be held responsible if they stay in the abusive environment, even though respondents note victims do not see violent acts as 'abuse'.

However, these factors are quite important as practitioners' knowledge on family violence and willingness to enquire about violence being experienced by the client, determined if the client would not only disclose incidents of abuse but seek assistance; an uncertainty of which has led to distrust of practitioners and under reporting within IPV and elder abuse (Alvarez, Fedock, Grace, & Campbell, 2017; Kwiatlowski, 2015). However, the longer an individual stays in such an abusive environment, the greater the impact on the functioning of the individual in the family setting, as seen in the family functioning theme.

The theme around family functioning emphasised more strongly through the qualitative enquiry, showed family violence not only determining family roles (in order to 'keep the peace') but the impact it had on general functioning within the family setting such as depression and suicide attempts. These thematic findings are not unusual regarding family violence as youth exposed to parental IPV or experiencing a comorbidity of abuse and neglect, are at a significant risk to exposure-related psychopathology such as depression (Menon, Cohen, Shorey, & Temple, 2018); an outcome also shared by women experiencing family violence (Cody, Jones, Woodward, Simmons, & Gayle Beck, 2017).

Therefore, the importance of efficiently trained practitioners, and those 'on the ground', who understand family violence and are not only able to identify family violence risk through a relatively small subset of risk factors, such as physical violence, but are able to consider other factors, which may evaluate risk (Robinson, Pinchevsky, & Guthrie, 2018). This need to extend beyond evaluating high-risk, solely based on physical violence, is highlighted in a study conducted by Robinson, Pinchevsky, and Guthrie (2018), who evaluated the police, as well as what they use to identify risk factors among victims of family violence. The police were noted to use mostly physical violence as an indicator of high risk; however, the police who received training on family violence

were significantly more likely to view jealousy/controlling behaviours and spying/stalking/harassing/threatening messages as salient in evaluating victims' future risk.

These findings are important given that these two risk factors are reflective of coercive control (Stark, 2007), considering the criminal justice system fail to acknowledge non-violent, yet controlling behaviours linked to domestic abuse (Burke, 2007; Stark, 2007; Tuerkheimer, 2004). The point of police, or those on the ground, being not only equipped, but also sensitive to the nature of family violence is an important one, as these form part of the referral network practitioners utilize in providing efficient services to individuals and families affected by violence. The impact of a referral system as seen in the results highlights the plight of those seeking aid within the judicial system, in regards to family violence.

In Africa, young girls seeking assistance from law enforcement for sexual assault, are either ostracised or dismissed as it is usually neighbours or family implicated in the assault; the organisation of family life placing these young girls in a dependency cycle which render their experiences as inevitable and invisible (Aderinto, 2010). Women reporting family violence to police would have their accounts of abuse trivialised as no physical violence took place (therefore "not serious") (Douglas, 2012). Women would also have to act as investigators to 'prove' family violence had taken place, locating and collating tangible evidence, presenting it to police and demanding action; work marginalised by those employed by the state to investigate family violence (Douglas, 2012).

This agency in self-advocacy may be commendable but can be challenged, especially when the judicial process is prone to revictimization (Postmus, Severson, Berry, & Yoo 2009). The elderly too, have experienced difficulties in reporting to police and have been known to withdraw cases of family violence, not only due to pressure from the family, but law enforcement not treating their case with the same urgency as in the case of the other forms of family violence (child abuse/IPV) (Ferreira & Lindgren, 2008). The experiences of seeking assistance can be remedied through adequate policies that guide these services, allocate functional resources, create avenues for community

mobilisation and ensure a sustainable funding mechanism; all of which are points highlighted in the study's themes. A long-standing critique within South Africa had been the lack of a strategic plan or framework for violence, which could co-ordinate policies and general legislation directed at violence.

An Integrated Strategic Framework for the Prevention of Violence and Injury had been established in 2012 for the period 2012-2016 and was supposed to bring together resources and capacity towards action that address 'cross-cutting' risks (these include poverty, socio-economic status, gender inequality, substance use, infrastructure, victimization and service delivery) and various other drivers of violence in order to develop and implement what is known to work (RSA, DoH, 2014; Van Niekerk, Ratele, Seedat, & Suffla, 2014). The purpose of such a framework was to reduce risk factors, create a collaborative environment for support, and to integrate data systems for accurate and collated data to best promote effective evidence-based interventions (Van Niekerk, 2016; Van Niekerk et al., 2014).

However, regardless of these attempts in creating integrated, broad-based goals in combating family violence, services remain fragmented in South Africa and abroad, owing to the belief that each sector holds different mandates and philosophies regarding family violence (Nagia-Luddy & Mathews, 2010; Ross, Frere, Healey, & Humphreys, 2011). These would all be remedied if all sectors involved in addressing family violence would embrace the similarities among these the family violence subtypes and create a unified, integrative response in dealing with these issues; a response which can only be through a holistic, family-centred approach. A family centred-approach not only includes all members of the family affected by the violence in the home, but also creates collaboration between the family and the practitioner. The purpose of a family-centred approach is to balance family needs with the best interest of its members; encourage family input on the plan of care, and have each family treated as unique instead of being seen prescriptive to a specific group (Burns, Dunn, Brady, Starr, & Blosser, 2008).

According to the results, the family-centred approach should include focus areas such as goal-setting, communication skills, conflict management and problem solving, themes common in family violence intervention (Tolan, Gormon-Smith, & Henry,

2006). These focus areas typically denote healthy or unhealthy family functioning and therefore are usually the focus in assessment and interventions aimed at family well-being (Epstein, Baldwin, & Bishop, 1983; Miller, Ryan, Keitner, Bishop, & Epstein, 2000; Tolan, Gormon-Smith, & Henry, 2006). Additionally, assistance for substance abuse is noted to be one of the most helpful support services to have by those affected by family violence (Douglas, 2012), but also lowered recidivism rates in perpetrators when integrated as part of family violence intervention (Stover, Meadows, & Kaufman, 2009).

6.5. Implications for practice

The needs assessment informs vital focus areas for a family-centred intervention to take place, which include an environment where such an intervention can thrive. Such an environment is shaped by legislation, community and a referral system that is not only aware of the nature of family violence but also sensitive to needs of families experiencing it. Awareness and sensitivity around family violence can be achieved through appropriate training and seeing families as the best starting point to reduce violence and increase well-being holistically. In addition to this, a much broader understanding on family violence risk factors needs to be fostered. Family violence is not only apparent through tangible signs insulated within 'abuse'. Family violence can have comorbid issues such as substance abuse, issues that must be factored into the intervention as they too add to the risk of violence and its escalation.

6.6. Limitations and future study recommendations

Limitations include a small sample size considering the quantitative aspect of the study, but an aspect hopefully compensated through the qualitative enquiry. Furthermore, different needs may have been emphasised if family members experiencing violence had participated. These points should inform future research as a greater sample size of family members participating could yield more salient areas of focus.

6.7. Conclusion

A family-centric movement around family violence would not only require political

will, but commitment from those on the ground to create awareness amongst the community and their referral networks, for the need of family focused services. If a family violence approach can be utilised, inclusive of a collaborative multi-pronged strategy linking family, community and the public sector; we would not only begin to address family violence holistically, but create an environment sensitive to family violence and the needs of families experiencing it.

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CHAPTER SEVEN

A DELPHI STUDY TO DEVELOP A FAMILY-CENTRED APPROACH TO REDUCING VIOLENCE IN THE HOME

7.1. Introduction

Families continue to grow and diversify in the structures and systems in which they function (Seccombe, 2002). However, families are still understood, or defined, solely based on structure, specifically as a societal group, related by blood, adoption, foster care, marriage or civil union/cohabitation; a depiction noted for its heteronormative belief in the stable, unified yet nuclear family structure, rather than how well the family functions (Republic of South Africa [RSA], Department of Social Development [DSD], 2012; Rabe, 2017a; Rabe, 2017b; Morison, Lynch, & Macleod, 2016).

The constriction of family only to its structure, may have caused short-sightedness in family well-being interventions, being prescriptive towards particular groups, instead of embracing families, as holistically unique, not only in their structure, but also their processes and functioning (Isaacs, Roman, & Savahl, 2018; Rabe, 2017a; Rabe, 2017b; Morison, Lynch, & Macleod, 2016; Soliz, Thorson, & Rittenour, 2009). Families, therefore, would need to be understood beyond just mere structure, but as a family, encompassing interrelated relationships between community and broader societal systems, of which the quality of these relationships strongly predict adjustment and well-being (Isaacs, Roman, & Savahl, 2018).

However, many challenges affect family well-being and the interrelated relationships found in the family, as well as their relationships with these broader societal systems; the biggest challenge of which being family violence. In South Africa, 46% of all injury related deaths is attributed to interpersonal violence (Republic of South Africa [RSA], Department of Health [DoH], 2014). With the South African murder rate at six-times the global estimate for the period 2012-2013, South Africa also holds the highest rates of child and female homicide rates, linked to the domestic setting (Africa Check, 2013; Mathews, Abrahams, Jewkes, Martin, & Lombard, 2013; Seedat, Van Niekerk, Jewkes,

Suffla, & Ratele, 2009; Wood & Jewkes, 2005).

International literature further purports the main perpetrators of elder abuse to be family members (Berkman, 2006; Soares, Barros, Torres-Gonzales, Ioannidi-Kapolou, Lamura, Lindert, De Dios Luna, Macassa, Melchiorre, & Stankūnas, 2010). Most studies fail to consolidate commonalities among family violence subsets (Child abuse, Intimate partner violence, Elder abuse), especially its effects on the family, an insight integral for an effective, holistic response (Gracia, Rodriguez, Martín-Fernández, & Lila, 2017; Ryan & Roman, 2017). Notably, the common characteristic among the subtypes of family violence is the close, interdependent relationship between the family members (Wolfe, 2003).

In order to create interventions that, not only holistically address family violence, but also enhance family functioning, requires a family-centred approach. Family members are all affected in the act of any violence in the family; therefore, any intervention should include the whole family (Thorpe, 2013; Tolan, Gorman-Smith, & Henry, 2006). A family-centred approach in dealing with violence in the family, would allow for a better understanding of the interrelatedness and effects of all forms of violence in the family on family members.

A family centred-approach not only includes all members of the family affected by the violence in the home, but also creates collaboration between the family and the practitioner. The purpose of a family-centred approach is to balance family needs with the best interest of its members, encourage family input on the plan of care, and have each family treated as unique, instead of being seen prescriptive to a specific group (Burns, Dunn, Brady, Starr, & Blosser, 2008). In addition, interventions aimed at family violence included education, such as family management and training, and resource knowledge, such as where to obtain assistance, how to get in contact with these service providers and what services are rendered, were shown to have the best rate in distress as well as violence reduction (Tolan, Gorman-Smith, & Henry, 2006; Wolfe, 2003).

Essentially 13 family-centred interventions aimed at family violence were identified within the period of 2005-2017, eliciting latest trends within family centric strategies

addressing family violence (See Chapter on Family Violence Narrative Review). These family-centred interventions, however, had to separately be identified within intimate partner violence (IPV), child abuse, and elder abuse as family violence is largely understood within these distinct categories. The IPV interventions mainly focused on family violence education, beliefs and attitudes of family violence, emotional affect (expressing feelings, understanding feelings, emotional adjustment, defence mechanisms, empathy), communication, conflict management (anger management, non-violent conflict resolution), decision-making, and focus on the self (self-esteem, self-awareness, self-blame, trust building) (Becker, Mathis, Mueller, Issari, & Atta, 2008; Ermentrout, Rizo, & Macy, 2014; Graham-Bermann, Lynch, Banyard, DeVoe, & Halabu, 2007; Graham-Bermann & Miller-Graff, 2015; Grip, Almqvist, & Broberg, 2012; Kan & Feinberg, 2015). The interventions were aimed at parent-child dyads, with sessions being held separately. Parents and children covered the same topics except for one session with parents who had parenting skills added.

Within child abuse interventions aimed at families, the interventions included parent-child dyads. The interventions made use of therapy sessions or workshop sessions with facilitators or masters-level therapist or clinicians with both parent and child and other times conducted separately. Session themes included child behaviour management, providing instrumental and emotional support to mothers, implementing consistent consequences for aggressive behaviour, emotive self-regulation, problem solving, addressing barriers within the home, collaborative family action planning, family strengthening, co-parenting and postnatal classes (Kan & Feinberg, 2014; Linares, Jimenez, Nesci, Pearson, Beller, Edwards, & Levin-Rector, 2015; Schneider-Muñoz, Renteria, Gelwicks, & Fasano, 2015; Jouriles, McDonald, Rosenfield, Norwood, Spiller, Stephens, Corbitt-Schindler, & Ehrensaft, 2010; Travis, Heyman, & Smith, 2015). The interventions included children from postnatal phase to pre-teens.

Lastly, family-focused elder abuse interventions were either community-based or later became community based initiatives which worked with families in a collaborative manner either through family conferencing or facilitated workshops. Topics covered the interventions reviewed related to conflict management and principles in taking care of the elderly, awareness raising, knowledge sharing and action planning with all

concerned family members. Ages of the elderly participating in the interventions were 60 years and over (Holkup, Salois, Tripp-Reimer, & Weinert, 2007; Khanlary, Maarefvand, Biglarian, & Heravi-Karimooi, 2016; Lowenstein & Naim, 2015). Across the board these studies show family-focused interventions improve parent-child interaction, improve sibling interaction, and decrease abuse over a long term period [6-12 months] (Becker, Mathis, Mueller, Issari, & Atta, 2008; Ermentrout, Rizo, & Macy, 2014; Graham-Bermann, Lynch, Banyard, DeVoe, & Halabu, 2007; Graham-Bermann & Miller-Graff, 2015; Grip, Almqvist, & Broberg, 2012; Kan & Feinberg, 2015; Kan & Feinberg, 2014; Linares, Jimenez, Nesci, Pearson, Beller, Edwards, & Levin-Rector, 2015; Schneider-Muñoz, Renteria, Gelwicks, & Fasano, 2015; Jouriles, McDonald, Rosenfield, Norwood, Spiller, Stephens, Corbitt-Schindler, & Ehrensaft, 2010; Travis, Heyman, & Smith, 2015; Holkup, Salois, Tripp-Reimer, & Weinert, 2007; Khanlary, Maarefvand, Biglarian, & Heravi-Karimooi, 2016; Lowenstein & Naim, 2015).

Family-centred interventions show long-term promise in reducing violence. However, if long-term positive change is sought at a societal level, family violence needs to be addressed systemically by creating collaborative networks between all service providers that aim to aid families experiencing violence. The benefits of creating a collaborative environment and being family centric in doing so, has been explored as a critique regarding engagement between family courts and advocacy groups, who note various benefits in working together, rather than as stand-alone initiatives. In a paper by Salem and Dunford-Jackson (2008), benefits of collaborating within the family violence service sector include:

- i.) Eliminating mixed messages sent to leadership by various groups of similar interests, but who act as standalone initiatives;
- ii.) Answers in determining risk but also safety for child and family can be sought collaboratively;
- iii.) Expertise from family violence service providers are needed to develop effective interventions, as multiple perspectives are invaluable but not as standalone ideas;
- iv.) With shrinking budgets and scarce resources, working within such a

challenged environment without the appropriate tools can create potential dangers, which highlights the need to work together for effective use of available resources.

In creating a family-centred intervention programme aimed at reducing violence in the home, it was imperative to thus engage the various stakeholders who work with these families and who might potentially benefit from such a programme, and explore shared insights stakeholders have on implementing such a programme. Therefore, the aim of this study was to describe the development of family-centred intervention programme aimed to reduce violence in the home, in collaboration with those working and contributing to the field of child and family well-being with specific focus on family violence and its effects.

7.2. Methodology

7.2.1. Research Design

This study utilised a modified Delphi method. A modified Delphi method refers to a combined process of a self-administered questionnaire followed by a physical meeting of the experts to discuss the results (Boulkedid, Abdoul, Loustau, Sibony, & Albert, 2011). Both the questionnaire process as well the physical meeting of experts are considered separate rounds within the modified Delphi method (Boulkedid et al., 2011; Custer, Scarcella, & Sterwart, 1999). The round in which experts engage items face-to-face, in a physical meeting, coincides with a popular Delphi technique noted as the estimate-talk-estimate or nominal group technique, relating to experts providing individual, independent judgments, followed by group discussion, which is then followed by independent judgements drawn from the group discussion until consensus is reached (Custer et al., 1999; Armstrong, 2001; Avella, 2016; Green, Armstrong, & Graefe, 2007)

The Delphi study in this current research consisted of 2 rounds, which is supported by Keenay, Hasson, and Mckenna (2006), who assert that the number of rounds depends on the time available, and exhaustion could occur after two

rounds, as experts tend to be busy.

7.2.2. Process

On the 30 November 2016, invites for the Delphi participation were sent to 29 potential participants from the local and international backgrounds. These participants were chosen mainly based on their contribution to the field of family violence.

Participants were sourced from their contribution to the academic field of family violence that were identified via their biography. Furthermore, participants were also located via national and international conferences attended on violence prevention and safety, workshops attached to these conferences, family violence seminars, provincial shelter forum meetings, local government forum meetings on child protection and family services (which would also include NGOs invited to attend). Networking had also been done with the attendees of all the above stated events, in a snowball effort to gauge other contacts who might be eligible to participate in the Delphi study, but who were not present these events.

Responses began within the first two weeks after which re-invites were sent every 2 weeks. Consent forms were received during December 2016. Participant demographics for round 1 are shown in Table 7.1.

Table 7.5: Round 1 – Participant demographics

Gender	Age	Employment title	Specialization
Female	47	Academic/Clinical psychologist	Traumatic stress
Female	52	Clinical services coordinator/Psychologist	Peri-natal mental health
Male	45	Psychologist/Academic	-
Female	56	Researcher	Gender-based violence (GBV)/violence against children/health consequences of violence
Male	56	Academic/Clinical psychologist	Trauma, violence intervention with children and families
Female	39	Project Manager	GBV (mostly intimate partner violence)
Female	60	Social work educator/Academic/Private practitioner	Interpersonal and sexual violence (risk assessment, intervention, & programme development)

7.3. Results

7.3.1. Round 1

The participants were asked to comment on the preliminary findings of the study (Phase I and II), as well as the proposed layout of the intervention programme. Feedback was delivered to the three following questions, adapted from the study of Van Oostrom, Arema, Terluin, Venema, De Wet, and Van Michelen (2007), namely:

- i.) What does the target population need to learn or acquire with regards to a family violence to achieve optimal family environment/functioning?
- ii.) What needs to be changed in the environment for the target population to achieve optimal family environment/functioning?
- iii.) What are your thoughts on the scope, content, possible approaches used, implementation, resources needed and cost of this proposed programme? In your experience, what do you think needs to be considered?

The participants provided largely similar responses though placed under different questions (i.e. “access to resources” would be an answer for either questions ii or iii or the same respondent would use it as an answer for question ii and again under iii). For this reason feedback was collated and presented in a concept mapping format, highlighting salient points mentioned across questions asked, pertaining to “family”, “community”, “socio-economic/politico environment” and then specifically to the programme itself as “programme considerations”. This structuring of the findings is done instead of grouped feedback relating to the questions, as concerns regarding family, environment and programme was referred to interchangeably between questions.

Responses were coded and grouped, using Atlas.ti version 8.22, according to thematic analysis, with concepts displayed through Atlas.ti’s default, diagrammatic network display in the format of an orthogonal tree.

7.3.1.1. Family

7.3.1.1.1. Family Needs

Across the questions, largely noted that families, experiencing violence, firstly, need to understand what family violence is, as well as what effects it could have on the family, as indicated in the following selected quotes:

“Understand what constitutes violence (types and examples); the complex dynamics of how it plays out between individuals and within families and how it’s been allowed to thrive...” **R6**

“Understanding of violence, power, how family functions together, and understand each other’s roles and responsibilities.” **R4**

Subsequently, the participants thought certain skills/activities (such as communication, problem solving, conflict management, teamwork in care activities, appropriate coping mechanisms), family support (parenting focus) and learning how to be self-aware (being congruent in feeling and action, focus on personal growth) were integral for the family to create an important change in their immediate context. In addition, families need to know how to create a nurturing home environment that encapsulates boundaries, safe spaces to air views and have appropriate affect shown, appropriate forms of discipline and consistent rules. These aforementioned factors would facilitate pro-social behaviours, clearly defined family roles and responsibilities, facilitating a healthy attachment style between family members (see Figure 7.1).

“Family members to have an understanding of themselves firstly and then of others in the family structure – different personality types and how they

operate – and then how as a whole all these “personalities” engage with each other.” **R6**

“Allow for individuality; each member is encouraged to pursue his or her own interests, and boundaries between individuals are honored.” **R3**

“Healthier ways of communicating need to be learned developing out of a healthy attachment style – perhaps modelled and engaged in with those who are doing the interventions and engaging with the families.” **R2**

“Rules tend to be made explicit and remain consistent, but with some flexibility to adapt to individual needs and particular situations.” **R3:**

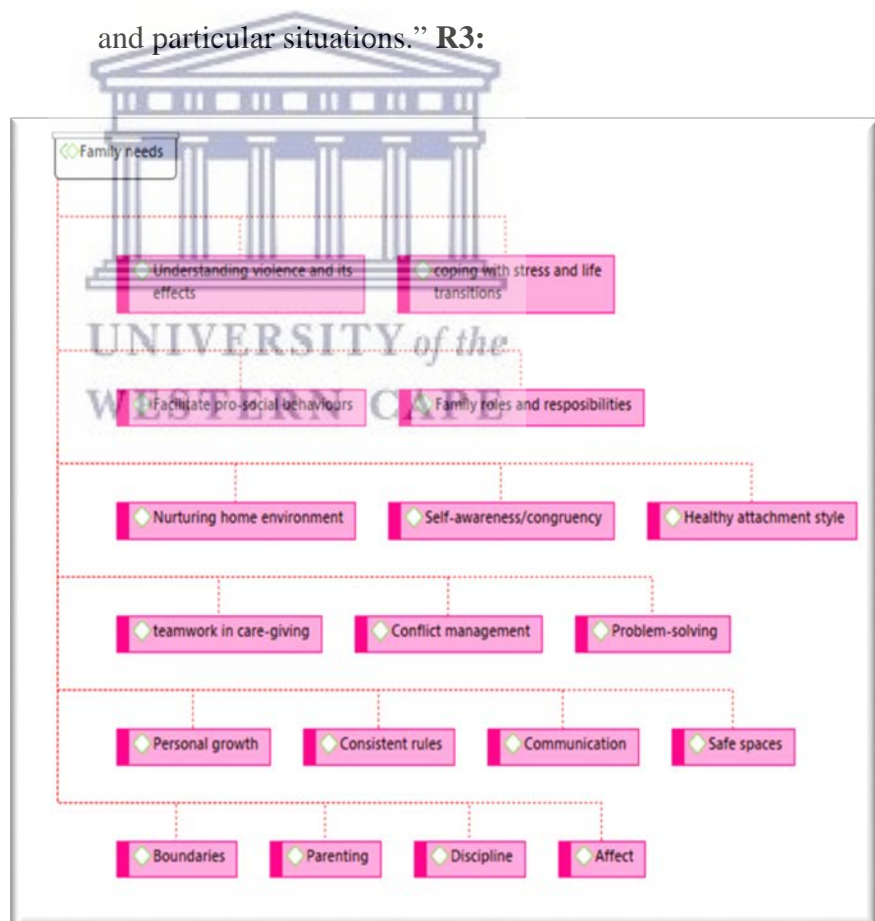


Figure 7.2: Concept map of family needs

7.3.1.1.2. Potential barriers for family and programme

Besides the skills, which families would need to acquire, for positive change in their environment, to reduce violence, the potential barriers that they might encounter in the process of implementing such change (see Figure 7.2) also need to be explored. One such barrier could be the way families would react to being by the court mandated to attend session.: The following extract refers:

“Motivation/resistance might be an issue if families are referred by social workers or courts.”

Another barrier would be how costly it would be to train facilitators to deliver the programme, which has an effect on the quality of the facilitation that the families will receive.

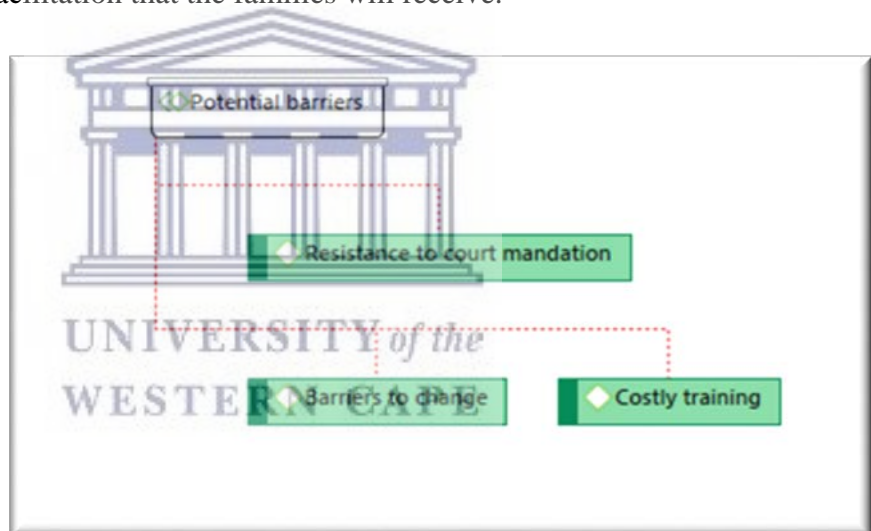


Figure 7.2: Concept map of potential barriers to family change

7.3.1.2. Community

7.3.1.2.1. Community Factors

For community, “awareness of family violence” and “community awareness” may be interchangeable, so the attached verbatim quotes have been presented for clarity (see Figure 7.3). Awareness of family violence relates to individuals that can positively affect community

perception (non-violence ambassadors; workshop facilitators etc.) where as community awareness relates specifically to the community itself and being aware as to what norms within it contribute to family violence and what can be done to counter this at community level. Participants noted that a community support programme needs to be linked to the family intervention either through an awareness raising campaign or the use of ambassadors for non-violent families. This would be integral in focusing on prevention in equipping communities and their families with knowledge on what family violence is, its contributing factors, and what to do and where to go if it is being experienced (Figure 7.3).

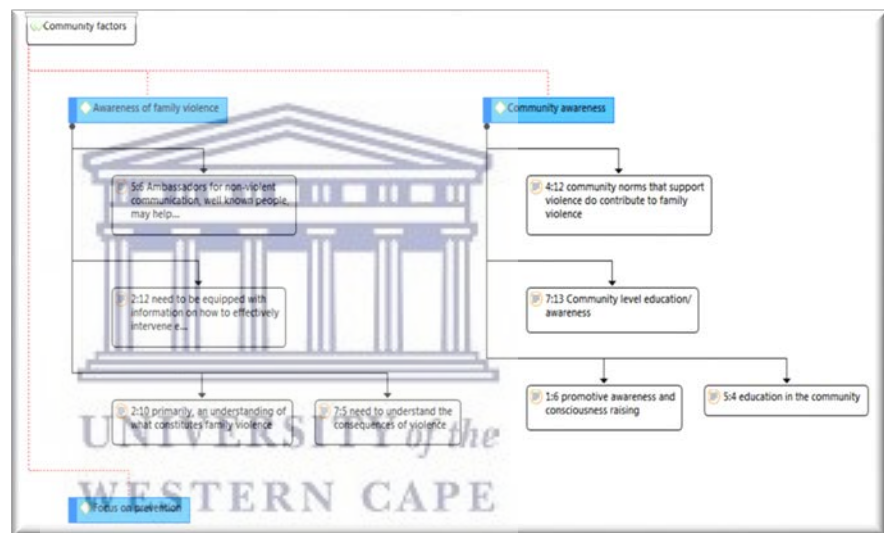


Figure 7.3: Concept map of community factors needed for programme implementation

7.3.1.2.2. Programme resources

Although resources are inherent to the programme logistics itself, the resource needs, specific to the community, are highlighted, namely these resources need to be visible and accessible in the community and should be able to provide continuity of care, once the programme has concluded. In addition, these linked resources should form part of the follow-up process, and if the programme is truly to meet the needs of families in the community, referral should be open to multiple sectors that operate in the community (see Figure 7.4). The following

extract refers:

“Enabling environment with a responsive and effective social service, as poor referral networks and responses from services will be a huge barrier.” **R4**

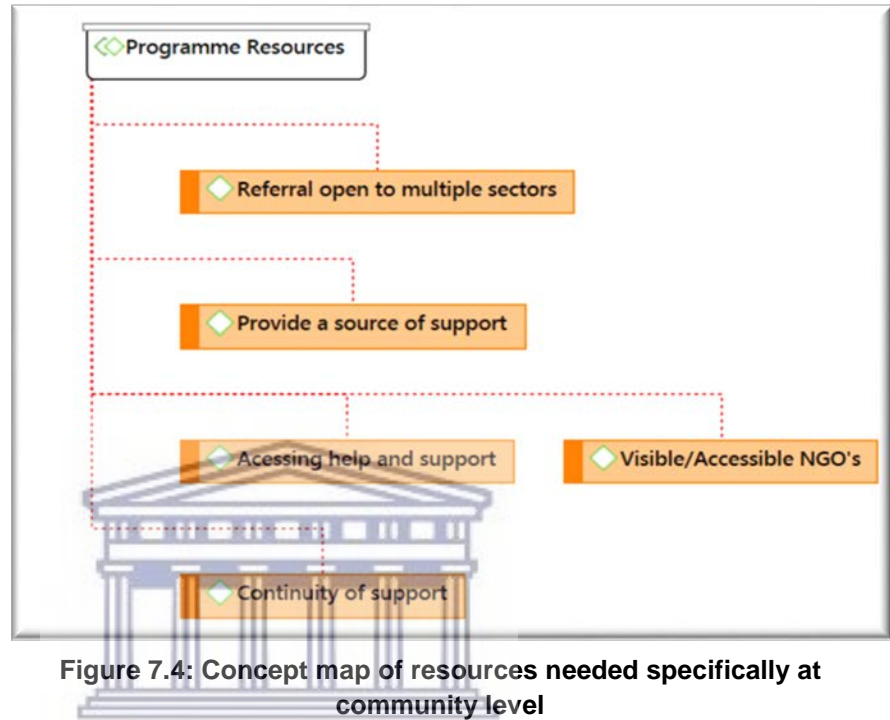


Figure 7.4: Concept map of resources needed specifically at community level

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7.3.1.3. Socio-economic/politico factors (Macrosystem factors)

The family as a unit does not operate in isolation to its environmental surroundings and influence. For this reason, participants pointed out that “contextual drivers” of family violence need to be understood and how multi-sector collaboration would be needed, in order to comprehensively address family violence (see Figure 7.5 for the visual breakdown of these aforementioned factors).

7.3.1.3.1. Contextual drivers of family violence

Participants noted that issues of culture, gender, as well as the availability of substances, are external factors that may also impact violence experienced in the home. In understanding the context in which these families find themselves, may allow programmes to

address issues directly, which if left unexamined may inhibit the family's progress within the programme.

“The subsequent access and availability of illicit substances further aggravates the development of a healthy, stimulating environment for the entire family.”

R7

“Poverty, lack of resources, unemployment, all those factors that mitigate against functionality. Economic challenges often result in the roles and power differentials undergoing change in a family as well as a community.”

R7

“...cultural/traditional perceptions and their impact on society/families is [sic] also important e.g. domestic violence may be seen as the fault of the women if she does not conform to traditional gender roles and expectations (e.g. “doesn't obey her husband). In other instances, family members may place pressure on the abused women to remain in the relationship – again this relates to perceptions of what the role of the wife is [sic], what marriage entails and perceived “disgrace” of a failed marriage, staying in the relationship for the well-being of the children etc.” **R6**

7.3.1.3.2. The need for multi-sector collaboration

The participants noted that many family programmes have failed in the past, as it did not collaborate with other programmes offering similar services, nor had they reached out to other sectors dealing with family violence. In doing so, programmes will share the responsibility with other sectors, as well as share the costs and resources of running the programme. However, as much as collaboration among sectors must occur, the government needs to

step up, in terms of a clear political will, to tackle the issue of family violence.

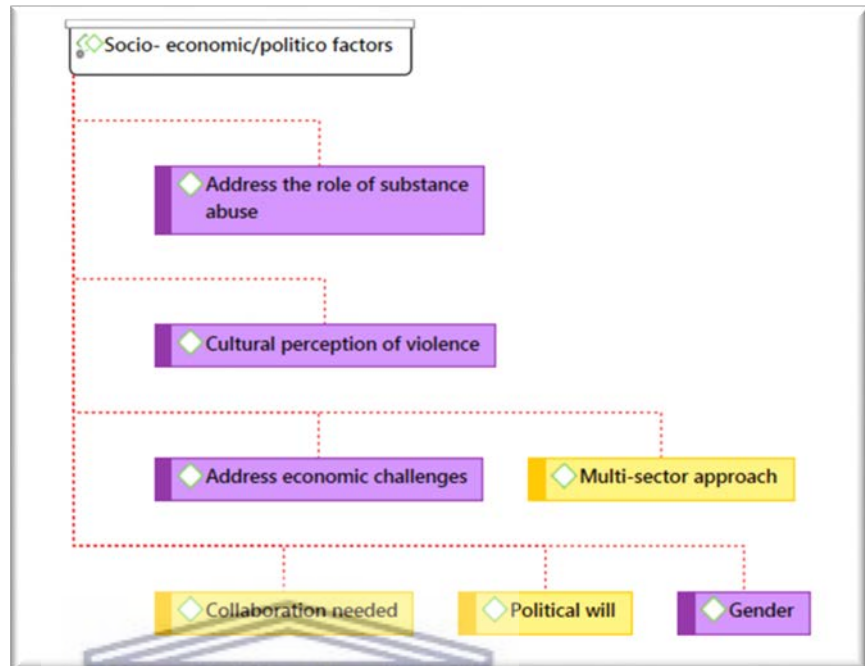


Figure 7.5: Concept map of the influence of macrosystem factors.

“Many NGOs already receives money from DSD (Department of Social Development) to work with families. If this programme become part of their existing work it will deal with the cost of the programme.” **R3**

“Comprehensive family services are often well intended, with a good ‘blue sky approach’ yet often fail because it fails to collaborate with appropriate partners or to engage in shared responsibility campaigns with other service providers.” **R7**

7.3.1.4. Programme considerations

The participants provided feedback specific to the programme itself, regarding its logistics, range and overall feasibility (see Figure 7.6). In the proposed layout provided to the respondents on how the programme will be delivered, in terms of frequency (proposed sessions per week) and duration

(length of session and programme). The participants commented on the fact that, although the family conferencing session (family action planning) is the last session of the programme, assessment needs to occur within the screening phase, and pressing issues addressed as soon as possible. The following extract refers:

“...for example, if the “cause” of violence and general disharmony in a family unit is attributable to one family member’s drug addiction, waiting till week 9 of the programme to address that core issue may not be the most effective strategy for this family. I suppose, however, that in this instance, the family may be considered “high risk” or it may depend on the family and whether they would all like to participate in the programme. All-in-all it is important that the programme be structured but it needs to be flexible enough to respond to the needs of particular families.” **R6**

The extract above also taps into a very important point raised in the literature, regarding how high-risk families are identified and their necessary process determined. The following quotations refer:

“There is the concern that the intervention itself (e.g. some family members disclosing things to the counselor) could increase the risk of harm to family members...” **R1**

“...someone merely observing the family as they engage with each other over the course of a day or two, thereafter a more comprehensive plan would be developed.” **R6**

In addition, the participants considered that those involved in the programme needed to be aware of policy and legal obligations attributed to family violence, especially, when dealing with children. In addition, they should ensure that the programme participants were aware of these protection structures for future use, as per the following extracts:

“...program must take into account the legal obligations of interventions of specific types of abuse for example, child abuse – the issue of mandatory reporting and it should have the mechanisms to address these.” **R7**

“...they need to be aware of the support systems and state protection mechanisms and structures that can be activated for their well- being.” **R5:**

More specific to the programme layout, operation, and its expected outcomes, respondents felt if the range of a 9-session programme is comprehensive enough to address the needs of diverse families. And even so, how would buy-in be created for families to participate for 9 weeks, considering the denial around family violence but also the practical part of transport costs to venue or child care? In addition, when referrals are required, the participants queried whether a case-file management system would be in place, as per the following extracts:

“...how to get families at risk to join the programme, given the level of denial and secrecy about family violence, the degree to which family violence is considered ‘normal family functioning’ by many family members, and the level of resistance that is going to be displayed by the main perpetrators of violence in the family.” **R1**

“...logistics of getting all family members to come in 9 times (not clear from the description of the intervention if they all come for every session)? In my experience, there is always at least one family member who can’t come due to work commitments, studying for exams, caring for a sick family member etc. Also, will the interventions be close to where families live? If not, transporting all the family members to the venue is a huge barrier due to transport costs.” **R1**

“Would family members need to keep repeating their “story” at

each level/point of intervention or will a consolidated case file management system be used so that this isn't required?" **R6**

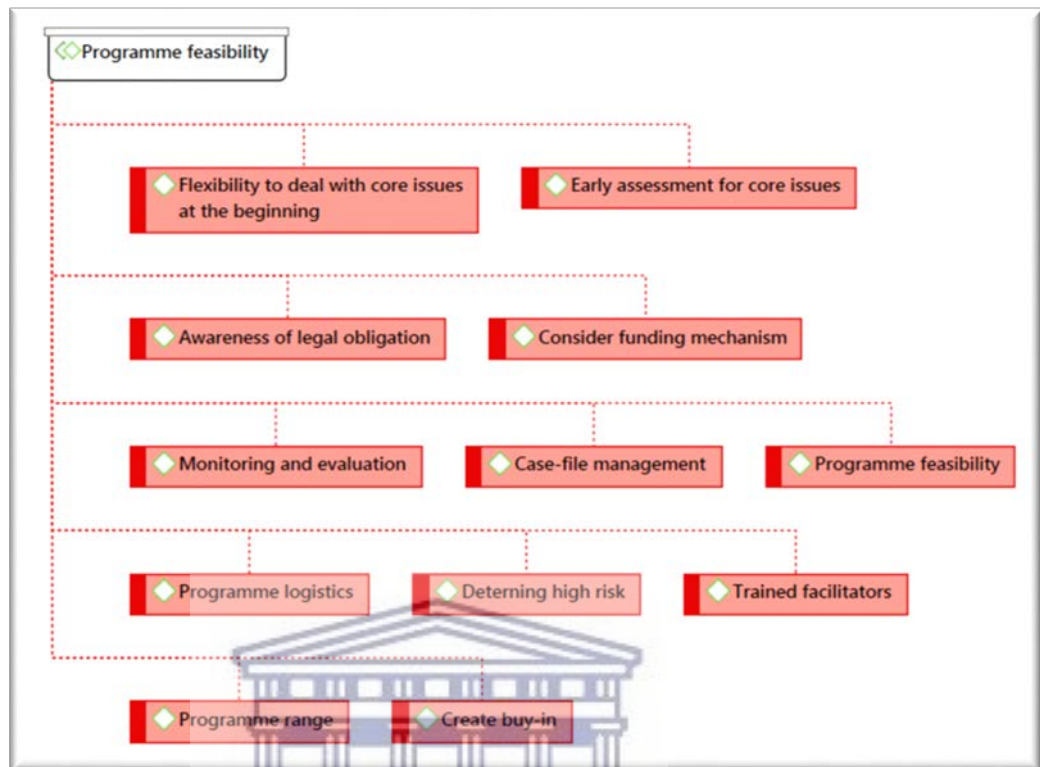


Figure 7.6: Concept map of factors related to the programme feasibility

7.3.2. Pilot Workshop

Building on the findings of round 1, a pilot workshop was hosted, two weeks before the main workshop (round 2), as a test run for efficacy of the workshop layout and content. A faculty as well as department level invite was sent to staff and post-graduate students to participate. The workshop was hosted with the feedback session digitally recorded. Feedback had been summarised as salient points listed below, which were later integrated into the main workshop.

Feedback of the workshop layout and content included:

- Simplified presentation of information (create diagram).
- To clarify perspective of family violence.
- Present/show findings of previous phases.
- Specific to the participants, feedback related to:

- Explaining the purpose of the workshop simply and clarifying participants' role in the workshop.
- When brainstorming themes, attach activities to themes to allow participants to decide how each session could be conducted, so as not to impose a type of theoretical thinking onto participants who will have different schools of thought. This was also posited as a way for simplified engagement (even for non-professionals) but also allow participants to take ownership of content.
- Have questions unanswered in literature (i.e. Determining high risk, type of facilitator used, create buy-in, should perpetrator be included in the family sessions, separate therapeutic process for historical trauma, etc.) attached to each session theme for participants to brainstorm.
- Pose the question to workshop attendees if programme participants should attend ALL sessions? i.e., sessions on elder abuse, which they might not be experiencing in the home.

7.3.3. Round 2

Invites were sent to various stakeholders, yet owing to low response, the invite was later circulated via the department of social development (Western Cape), and later forwarded to their specific divisions of family services and victim empowerment. A vast response was received, with departmental lists submitted each day of possible attendees. A diversified selection was done of potential attendees to create, as much as possible, a balanced mix of stakeholder background to garner varied input and perspective. A total of 15 participants took part in the workshop as shown in Table 7.2. The workshop participants were welcomed and received a general introduction as to the purpose of the workshop and the overview of workshop session and its activities. As an ice-breaker but also as a way to determine the participants' own understanding of family violence, participants were provided with about 6 post-its and a koki. On the first 3 post-its, they were asked to write down whichever words sprung to mind when thinking about "family" violence.

Table 7.6: Round 2 – Participant demographics

Gender	Profession	Work title/area	Work focus	Work description
Male	Law enforcement	Gender Based Violence and Victim Empowerment Safe Schools Coordinator	None specific	-
Male	Social Worker	Manager/Welfare	Children and families	-
Female	-	Centre Manager at a Family Counselling Centre	Women and children	Manage a Trauma Counselling Clinic, residential care facility for women and their children, after-school care. Responsible for all governance and clinical aspects of the organisation. Mentor emerging non-profit organisations.
Female	-	Director of NGO aimed at gender base violence (GBV), domestic violence and HIV/AIDS	Women, children and families	Strengthening family structures in communities by strengthening the women within them. Done through door-to-door visits and awareness programmes.
Female	Clinical Social Worker	Director at NGO aimed at family services	Families	Manage services such as training and counselling services provided. These services also include community outreach.
Female	Social worker	Welfare	Families	-
Male	Social worker	Welfare	Families	-
Female	Social worker	Welfare	Families	Foster care
Female	Social worker	Welfare	Families	Family interventions with foster families, reunification services with biological parents whose children were removed from their care due to multiple social problems, e.g. domestic violence, substance abuse, physical, sexual, psychological abuse, neglect etc. Also mediation and parenting plans for the children's court.
Female	Social worker	Welfare	Families	Early intervention
Female	Social Worker	Welfare	Families	Foster care, reunification, counselling and supervision.
Female	Social Worker	Welfare	Children	After hours Child protection.
Male	Health and Safety Officer/Counsellor/manager of work integration programme	Child and Youth Care / Drug Counselling	Children, Youth, Men.	Counselling/Mentoring/ administration
Female	Paraprofessional	Child and Youth Care	Boys	-
Female	Paraprofessional	Child and Youth Care	Boys	-

The second set of post-its were used to write down whichever words came to mind when *Domestic violence* was mentioned. The words were placed up on a whiteboard for all to see and compare. The words generated from this activity were analysed in Atlas.ti Version 8, through Word Cloud to illustrate the most dominant words associated to each term (see Figure 7.7).

These comparisons depicted how *Domestic violence*, as a term, was not enough to illustrate the extent of violence that occurs in the home, as different, broader connotations are elicited when mentioning family violence. This activity clarified why family violence was used as a holistic term, and why a family-centric perspective was advocated in this programme (see Figure 7.8).



Figure 7.7: Free word association linked to domestic violence

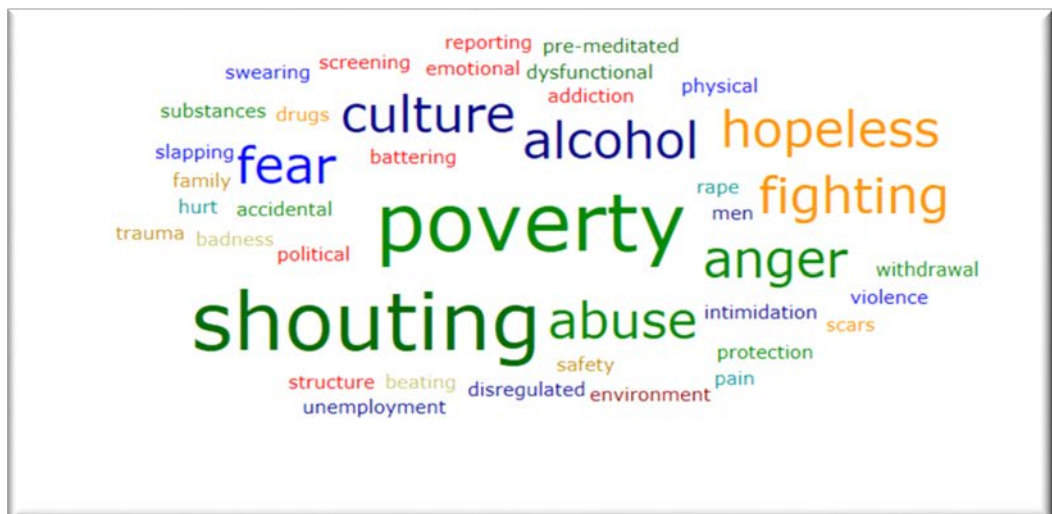


Figure 7.8: Free word association linked to family violence

The participants were later shown a PowerPoint presentation entailing how family violence is understood according to literature, and a proposed programme layout formulated from findings from the previous phases (mixed methods, reviews, policy analysis, Delphi round 1 and pilot). The programme layout is illustrated in Figure 7.9.

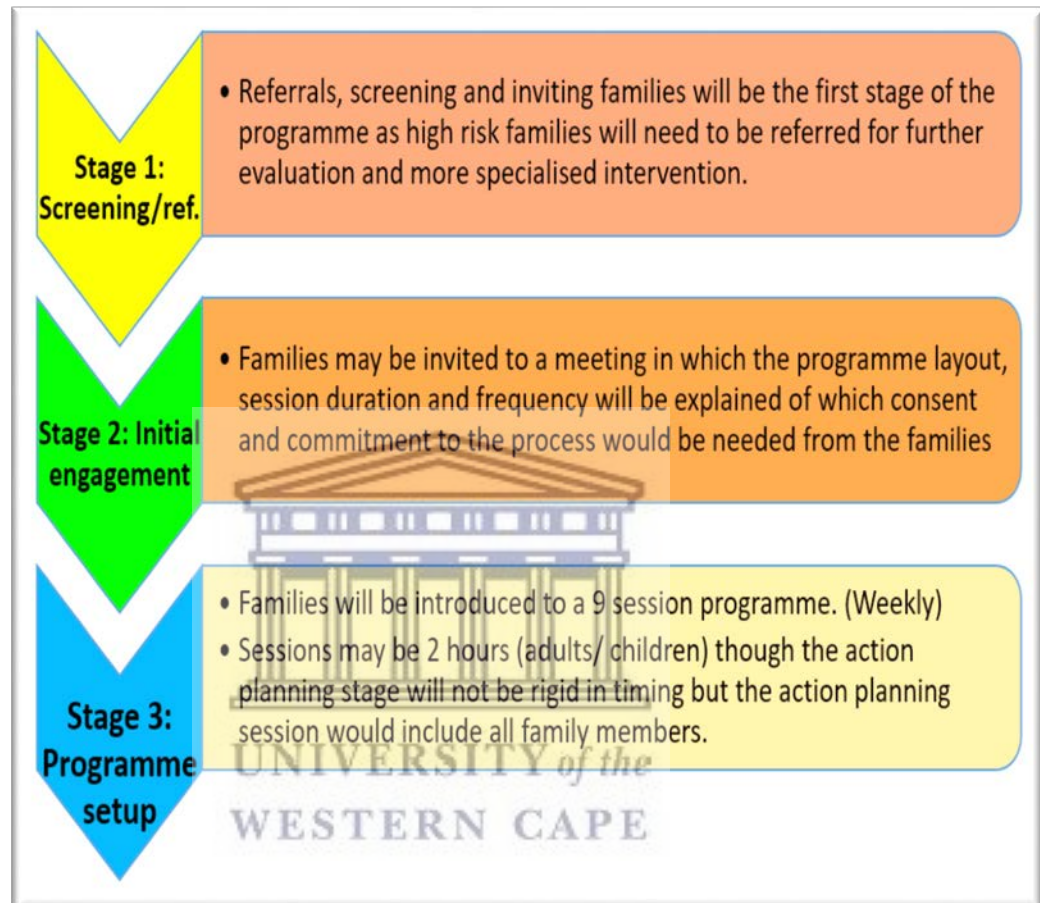


Figure 7.9: Programme layout and process

Sessions (as part of stage 3) were introduced to participants with each session containing a theme and session objectives (Table 7.3). Additionally, the role of facilitators within the programme had also been highlighted such as the need for trained facilitators. Following the presentation, participants were divided into 3 groups of 5 members. Each group was requested to draw a folded piece of paper from a bag. On each piece of paper were the session themes highlighted in table 3. Groups could draw more than 1 piece of paper if they felt they had enough time to address the questions for each session chosen.

Table 7.7: Session themes and objectives

No.	Session theme	Session objective
1	Introduction	Explain what the programme aims to do, what the programme sessions will entail, to establish ground rules, and explore what participants' expectations are in what they would like to take from the programme.
2	Knowledge and perceptions of family violence	To describe and identify family violence.
3	Emotional affect	Becoming aware of thoughts, emotions and physical feelings and choosing the appropriate response.
4	Communication skills	Identify and understand ways we communicate such as verbal and non-verbal communication.
5	Conflict and conflict management	Understand conflict, the different ways we react to it, styles of communication, and choosing a response appropriate to a circumstance.
6	Care of the elderly	Understanding basic care and care principals regarding the elderly and explore how context/culture can influence perceived abuse.
7	Parent skills and building healthy relationships	Understanding rules, routine, consistency, responsibility, rewards, punishment, time out and how a healthy relationship can foster family management.
8	Barriers to change	Exploring barriers to change and how what was learnt so far in the programme and strengths discovered, can assist in being solution-focused.
9	Family Conference	Family action planning. This session will include a relevant professional who may assist with pressing issues needed for effective planning (access to housing, rehab, legal aid etc.).

Groups had to brainstorm possible activities for their chosen session theme but also answer the same 7 questions for each theme, namely:

1. How will programme participants be organised? (Family on its own or in groups/ should the programme have children and parents together or apart in concurrent session?)
2. What will be the process for family members displaying historical trauma [*cumulative emotional and psychological wounding of an individual or generation caused by a traumatic experience or event.*] or in need of a separate therapeutic process?
3. When is a family high risk? How will this be determined?

4. Should the perpetrator be included with the rest of the family members in the programme? If not, what classifies the person as the main perpetrator?
5. Which facilitators should be used and how should they be chosen?
6. How will one create buy-in from participants to attend a 9-week programme?
7. Can participants skip care for the elderly session if elder abuse has not been an issue for their family? [For all to answer even if they did not get elder abuse theme]

Subsequently, the groups were then given newsprint and markers to illustrate answers that they later presented. Feedback has been collated and presented according to question themes.

7.3.3.1. Organisation of programme participants

Participants felt that through assessment, a clearer plan can be made on how to organize participants and which type of intervention would be best-suited dependent on their emotional readiness (see Figure 7.10).

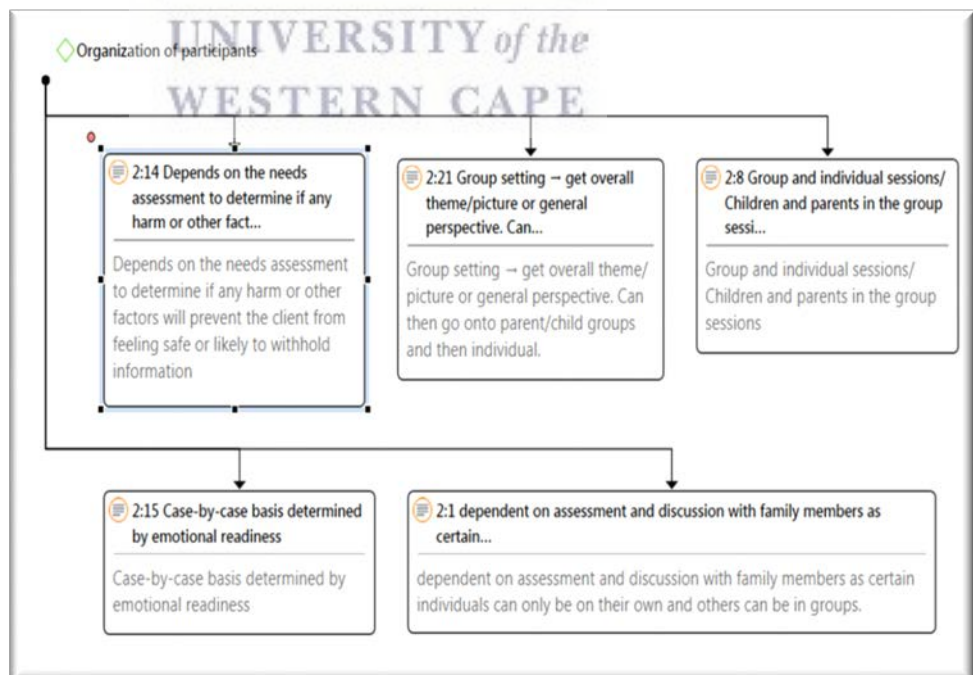


Figure 7.10: Feedback regarding placement of programme participants

7.3.3.2. *Separate process for participants who have historical trauma*

Workshop participants noted that an assessment could be done to determine trauma, but also to identify appropriate referral. If a separate process of counselling is needed, participants' note that can be a parallel process to the programme (see Figure 7.11).

7.3.3.3. *Determining high risk*

Participants agreed that an assessment tool would be needed to determine high risk with the addition of establishing precursors to violence such as prior acts of aggression or substance abuse see (Figure 7.12).

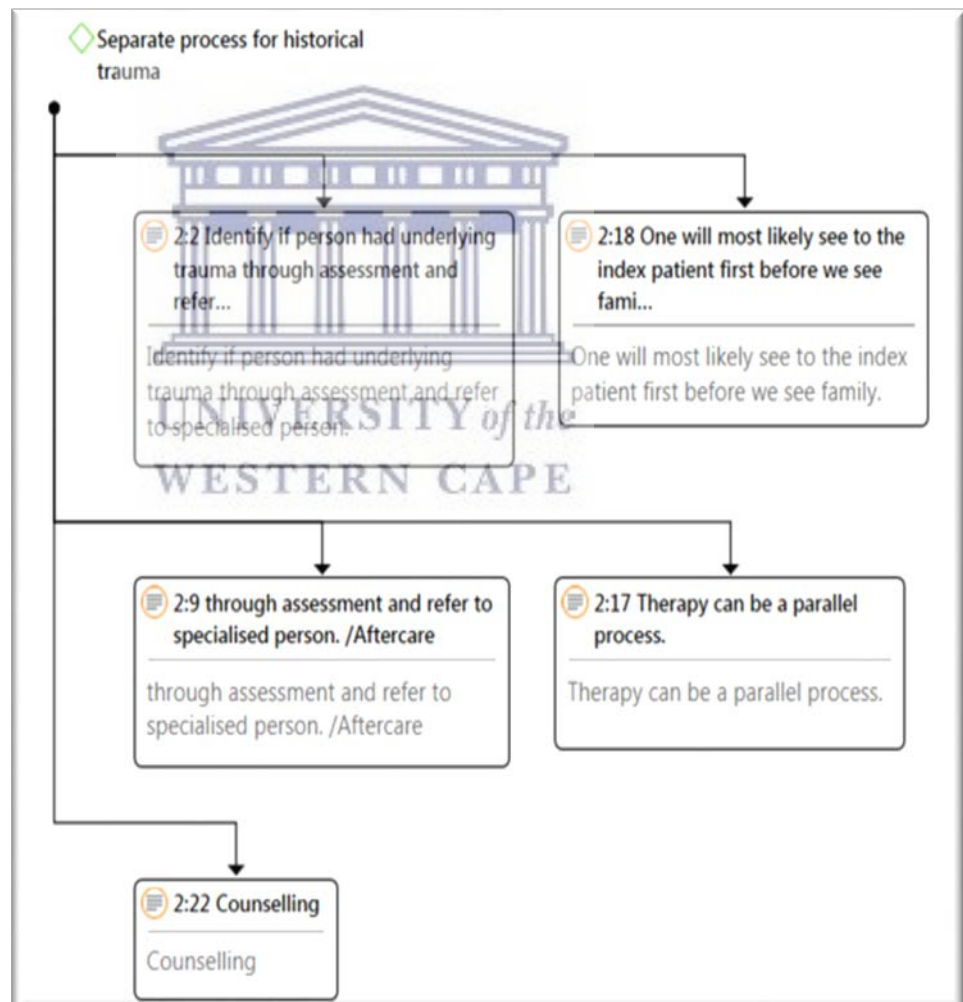


Figure 7.11: Feedback on participants experiencing historical trauma

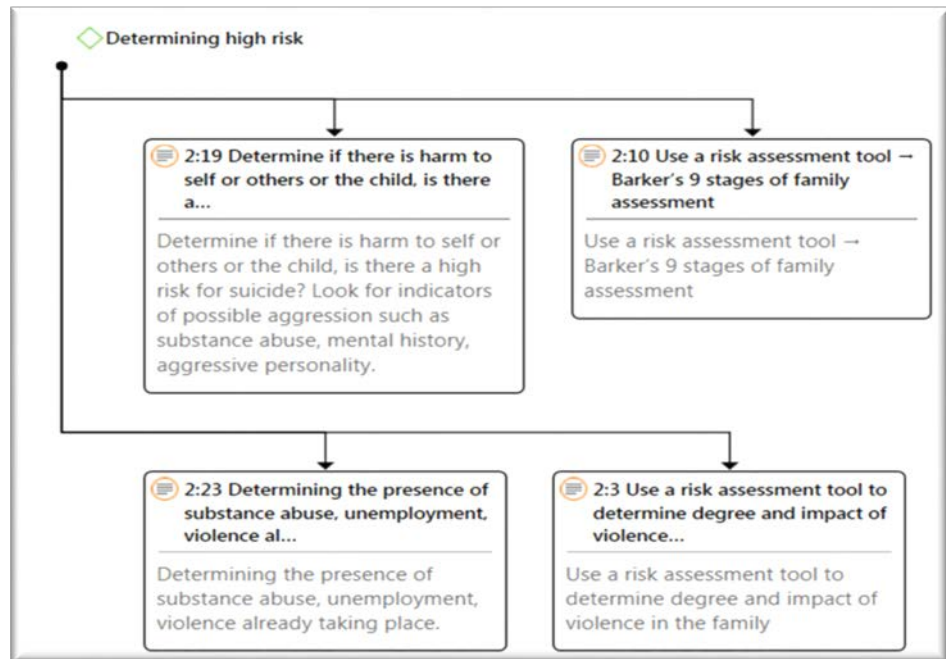


Figure 7.12: Feedback on determining high risk

7.3.3.4. The use of facilitators

Participants commented that facilitators should have the necessary skills such as a therapeutic background, in order to create an environment built on trust and which ensures confidentiality. It would also be preferable if the facilitators were a male-female co-pair (see Figure 7.13).

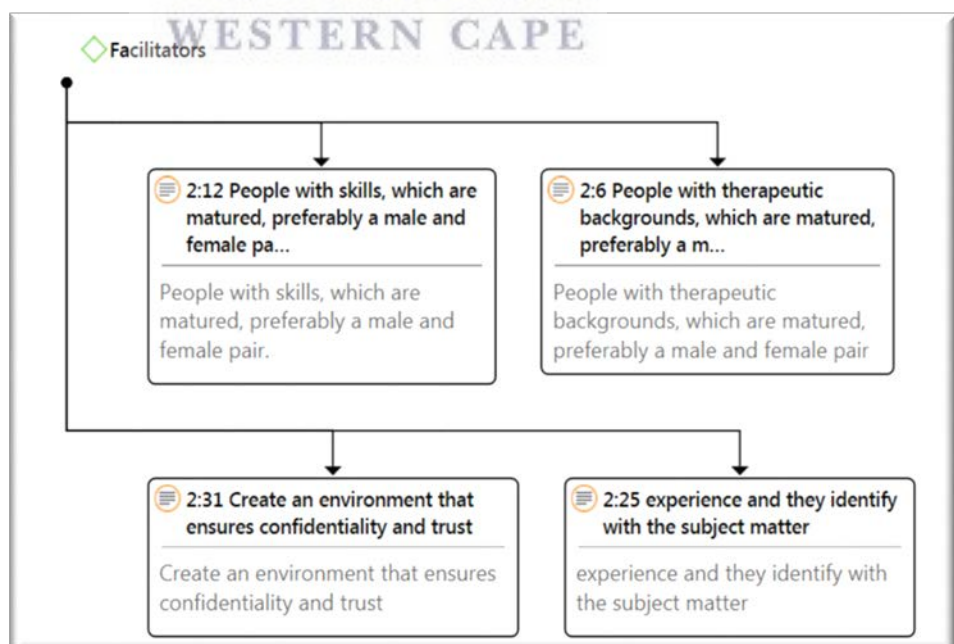


Figure 7.13: Feedback on ideal programme facilitators

7.3.3.5. *Creating buy-in from programme participants*

It was noted that to expect programme participants to unfailingly commit to a 9-week programme would be a feat unto itself, especially considering families who experience multiple challenges such as taking care of sickly family members, no one available to take care of young children, or to even arrange transport. For this reason, workshop participants suggested the use of court mandating, but also to motivate programme participants by creating a vision of improved well-being and quality of life (see Figure 7.14).

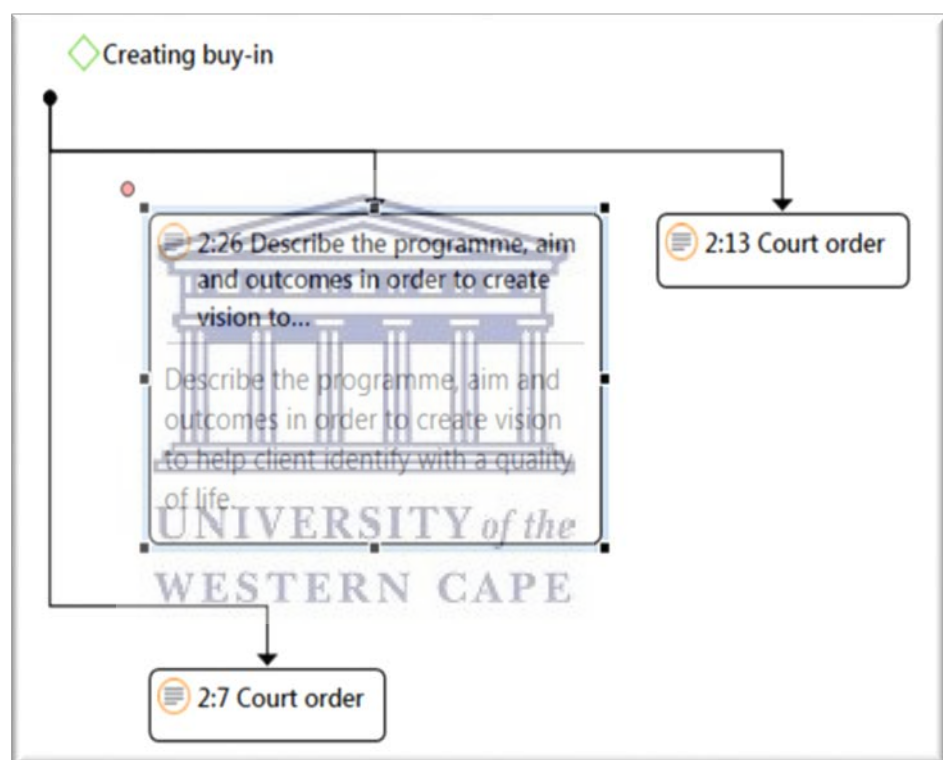


Figure 7.14: Feedback on creating participant buy-in

7.3.3.6. *Attending all sessions of the programme*

Workshop participants were asked if programme participants should attend all sessions, including those which they may not be experiencing such as elder abuse. Workshop participants felt that all sessions should be attended including the care of the elderly as they may not realise how the elderly are affected and may learn new insights nonetheless (see Figure 7.15).

7.3.3.7. Additional considerations

Workshop participants were asked if there were any additional thoughts they may have about the programme which may not have been mentioned in the activities or group discussions. Two main factors were mentioned, namely the need for collaboration as well as the topic of gender.

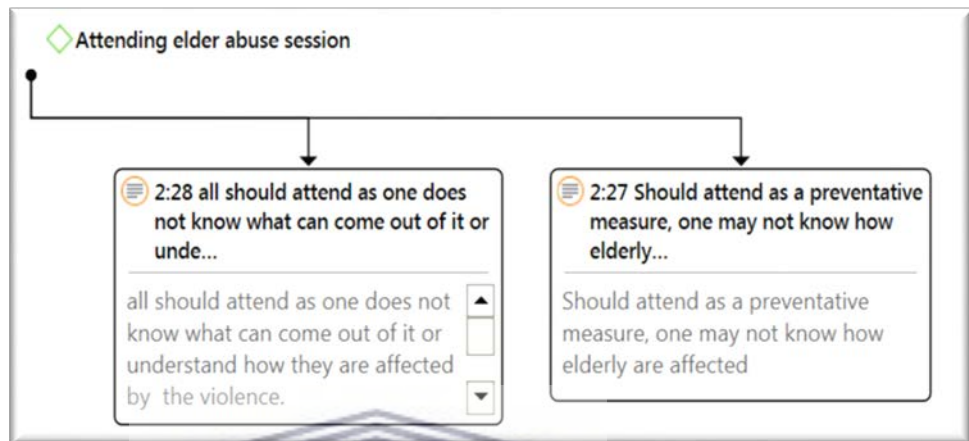


Figure 7.15: Feedback regarding elder abuse session

7.3.3.7.1. The need for collaboration

Many participants emphasised the need for collaboration amongst service providers in order to cut costs but also use resources already established in the community. These resources (NGOs or community assets) may not fit government-funding criteria, but are known to offer beneficial services in the community and can share costs and responsibilities through collaboration (see Figure 7.16).

7.3.3.7.2. Gender

Participants felt that gender cannot be overlooked when addressing family violence as gendered roles became socialised into the functioning of the family; functioning which may be further compounded if co-occurring issues are present, such as disabilities or LGBTI+ (Figure 7.17).

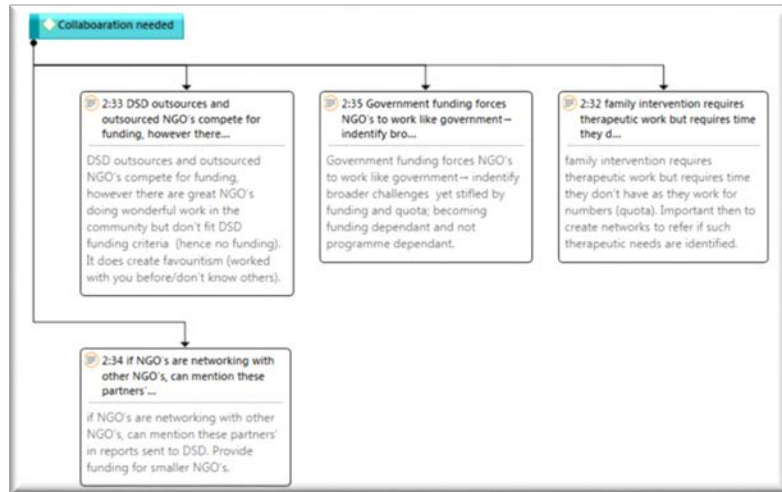


Figure 7.16: Feedback regarding collaboration

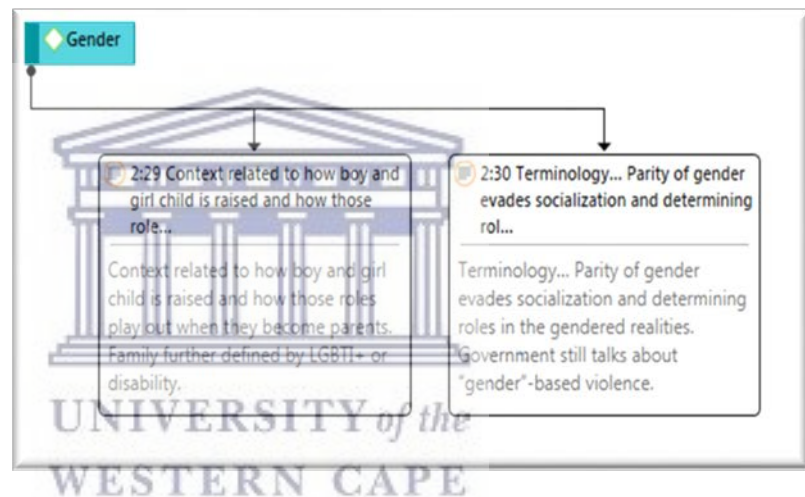


Figure 7.17: The influence of gender on family violence

7.4. Proposed intervention process and format

Drawing from all three study phases, the family violence intervention is defined as follows:

7.4.1. Screening

Referrals are open to multiple sectors [police, social development, welfare service providers, family-centred NGOs, Faith-Based organisations (FBO), etc.], which engage with families experiencing violence in the home. Families will be invited to attend the intervention programme, and on the first meeting will be screened using an assessment tool. The Delphi participants suggested using various tools

for assessment, such as “Barker’s nine stages of family assessment”, which might refer to Barker and Chang’s (2013) analysis of the Beavers Systems Model of Family Functioning, in which two dimensions are tested for, namely, family competence and family style. These dimensions define nine distinct family groupings, three of which are relatively functional, and six that are perceived as problematic and require intervention (Beavers & Hampson, 2000). Additional assessment suggestions included the use of Karpman’s drama triangle to determine family dynamics, and assist in identifying the roles within the family that may perpetuate family violence. Karpman’s drama triangle constitutes three connected roles found in family dysfunction, namely Victim, Persecutor, and Rescuer (Karpman, 1968; L’Abate, 2009).

All three roles are enacted by the self and other parties at the same time. An individual in an intimate (close, committed, interdependent, and prolonged) relationship role-plays the Victim, yet can be perceived as a Persecutor or Rescuer at the same time, depending on what is said or done (L’Abate, 2009). For instance, one partner may perceive herself as the Victim, while being perceived as a Persecutor by the other partner, who was originally seen as a Persecutor (L’Abate, 2009). If one partner perceives themselves as the Victim of their parents (Persecutors), she or he may originally perceive their partner as the Rescuer (L’Abate, 2009). In addition to the assessment tool, a history will be taken to determine the presence of substance abuse, unemployment, mental health challenges, indicators of aggression or if violence had already taken place, and if individual/s are a harm to self or others (suicide risk). High-risk families will need to be referred for further evaluation and enrolled for a more specialised intervention to address more immediate needs.

7.4.2. Initial engagement with families eligible for the programme

Families are invited to a meeting in which the programme layout, session duration and frequency (i.e. 2 hour, weekly sessions over a period of 9 weeks) will be explained of which consent and commitment to the process would be needed from the families. As Delphi respondents duly noted for at-risk families to commit to a 9-week programme may be challenging as they usually drop out of intervention

programmes (Pereira, D’Affonseca, & Williams, 2013). However, workshop participants suggest attendance can be mandated through the courts but also motivated by creating a vision of improved well-being, quality of life and inspiring future orientation.

7.4.3. Programme Intervention

Families will participate in 2 hour, weekly sessions over a period of 9 weeks. Literature as well as Delphi recipients suggest certain arrangements be made to assist family members in attendance that may need transport to and from the programme venue or child care for younger children. The programme layout is shown in Table 7.4. Techniques used within each session have dual roles in that it will function as monitoring tools to assess progress, but also act as documentation within a case-file management system for later referral.

Table 7.8: Programme layout

No.	Session theme	Session objective	Techniques used
1	Introduction	Explain what the programme aims to do, what the programme sessions will entail, to establish ground rules, and explore what participants’ expectations are in what they would like to take from the programme.	Ice breakers, discussions
2	Knowledge and perceptions of family violence	To describe and identify family violence.	Perception testing, guided discovery, cognitive restructuring (reflections).
3	Emotional affect	Becoming aware of thoughts, emotions and physical feelings and choosing the appropriate response.	Cognitive restructuring.
4	Communication skills	Identify and understand ways we communicate such as verbal and non-verbal communication.	Information sharing, guided discovery.
5	Conflict and conflict management	Understand conflict, the different ways we react to it, styles of communication, and choosing a response appropriate to a circumstance.	Information sharing, guided discovery.
6	Care of the elderly	Understanding basic care and care principals regarding the elderly and explore how context/culture can influence perceived abuse.	Information sharing, cognitive restructuring, explore the role of context/culture can influence perceived abuse.
7	Parent skills and building healthy relationships	Understanding rules, routine, consistency, responsibility, rewards, punishment, time out and how a healthy relationship can foster family management.	Information sharing, cognitive restructuring.

8	Barriers to change	Exploring barriers to change and how what was learnt so far in the programme and strengths discovered, can assist in being solution-focused.	Discussions, mapping. This session will be used as preparation for the next session.
9	Family Conference	Family action planning. This session will include a relevant professional who may assist with pressing issues needed for effective planning (access to housing, rehab, legal aid etc.).	Action planning, information sharing. Using collaborators within family violence sector and community-based assets to aid in this process.

7.5. Discussion

The aim of the study was to describe the development of a family-centred intervention programme aimed to reduce violence in the home, in collaboration with those working and contributing to the field of child and family well-being with specific focus on family violence and its effects. Participants were mostly satisfied with the programme layout, but emphasised family functioning skills, the use of assessment tools and the need for collaboration.

The skills and environmental changes needed to enhance family functioning within a family violence setting included conflict management, communication skills, appropriate affect, but also creating safe spaces within the home to air views or take a time out. The themes highlighted in this study are traditional focal areas within family violence programmes as well as family-well-being programmes, especially in considering broader contextual factors such as gender, community/institutional support, social norms. Socio-economic class, and substance abuse, all of which further shape the experience of functioning within the home (Harvey, Garcia-Moreno, & Butchart, 2007; Tsey, Whiteside, Haswell-Elkins, Bainbridge, Cadet-James, & Wilson, 2010).

The use of assessment tools was noted as key to not only determining level of risk but regarding alternative treatment pathways such appropriate intervention and referral. As noted in one systematic review, assessment tools are integral in identifying as well as in managing risk of harmful behaviour (Singh, Grann, & Fazel, 2011). Assessment tools regarding risk are used widely within clinical, psychiatric and criminal justice settings, influencing decisions regarding accessibility to inpatient and outpatient resources, civil commitment, and length of community supervision (Singh, Grann, & Fazel, 2011).

However, predictability of assessment tools vary greatly amongst studies, with findings suggesting the closer the recipients tested are to the assessment tool's original sample the more effective; Hence, assessment tools need to be used in conjunction with other forms of assessment and not as a sole basis (Singh, Grann, & Fazel, 2011; Yang, Wong, & Coid, 2010).

Collaboration was noted in both Delphi rounds, as vital to the successful implementation of the programme. Creating a collaborative environment within the family violence programme was noted within the study to, not only share responsibility of the issue among sectors, but also to widen the reach of the programme to include services which are available in the communities of families experiencing violence in the home.

This finding is reflected within international trends which show collaboration amongst all services which victims may turn to, reaches victims of violence better, become more innovative in its interventions, elicits new approaches and expands the movement of positive social change (Lehrner & Allen, 2009). Collaboration aids in seeking the best strategies in risk management, resource allocation, use of expertise, and creating innovative interventions that uplift and empower communities (Hammons, 2004; Salem & Dunford-Jackson, 2008; Lehrner & Allen, 2009). Study participants discussed collaboration also as a tool to alleviate expenses and discussed at length funding mechanisms and programme sustainability, as funding concerns makes organisations "funding-dependent and not programme-dependent".

Therefore, literature notes how programmes become co-opted into bigger systems through collaboration and begin to focus strongly on professionalization of programmes and services provided, which pathologises and even patronises services according to funder-generated requirements; in turn losing its grounding in its "movement" philosophy and failing to critique social change, thus becoming passive, uncritical members (Hammons, 2004; Lehrner & Allen, 2009).


In a South African context, which endures many challenges, such as having the highest rates of inequality in the world (Maiorano & Manor, 2017), cognizance must taken of

the factors that may impact on the feasibility of any well-being programme, and the progress of its recipients. Being mindful of the factors that are needed for the programme's success, it is important for the programme to embody its advocacy roots, and be representative of its beneficiaries, an objective the researcher attempted achieve in this current study through its consensus process, inclusive of vital stakeholders.

7.6. Conclusion

A family-centric movement around family violence would not only require political will, but collaboration in creating a multi-pronged approach engaging families experiencing violence, on most levels of support. Using a family-centred approach inclusive of collaborative multi-pronged strategy linking family, community and the public sector; we would not only begin to address family violence holistically but create an environment sensitive to family violence and the needs of families experiencing it.

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CHAPTER EIGHT

DISCUSSION, LIMITATIONS, RECOMMENDATIONS AND CONCLUSION

8.1. Discussion

When families display healthy functioning, they are observed to be cohesive, flexible and self-reflective, becoming resilient in adversity, which facilitates positive development (Benzies & Mychasiuk, 2009; Walsh, 2003; Isaacs, Roman, & Savahl, 2018). However, when family violence disrupts, or inhibits healthy family functioning, a comprehensive response is required to address the interconnectedness of the various family violence subsets, effectively, as well as access the required resources to aid the family. A holistic response requires a collaborative environment for the needs of a family that is experiencing violence; a collaboration that can only be initiated by identifying the various systemic services the family encounters, and which is available to them in their community.

This current study aimed to create a family-centred intervention, aimed at reducing violence in the home. The objectives of the study was to:

- Explore the perceptions of family violence;
- Review the current South African legislation used to address family violence;
- Conduct reviews to identify family-centred strategies used for family violence;
- Develop objectives for the design of a family intervention by using a Delphi Study.
- Design an intervention for families experiencing violence within the family

These objectives have been achieved through the studies summarised below, of which the main outcomes are highlighted and discussed. An overall discussion of the findings follows the summaries, after which the implications for practice are detailed. Subsequently, the limitations and recommendations and conclusion are presented.

8.2. Summary of chapter discussions

8.2.1. A needs assessment of families experiencing violence in a South African context: The perspectives of professionals

A family violence needs assessment had been conducted to create a depiction of perceptions, regarding family violence and the factors contributing to the violence experienced in the home. Additionally, input regarding the possible range and scope for a family-centred intervention had also been sought, aimed at reducing violence in the family. The main outcomes of the needs assessment resulted in two main themes being identified, namely, identifying the abuse, and the response to the abuse being experienced (victims as well as practitioners/law enforcement/community).

The theme of identifying family violence and the victims' response to violence emerged by asking practitioners about their ability to identify occurring violence, and whether they were able to address it, once identified. The practitioners stated that they were acute in identifying the red flags around family violence and had the necessary skills to address it. In addition, the practitioners understood that victims of family violence are not to be held responsible, when they remain in the abusive environment, as practitioners realise that victims rarely see violent acts as abuse.

However, these factors are quite important, as the practitioners' knowledge of family violence and their willingness to enquire about violence being experienced by the client, determined whether the client would not only disclose incidents of abuse, but seek assistance. The practitioner's unwillingness to enquire, or not having appropriate knowledge of the support services, has led to distrust of practitioners, as well as the under-reporting of IPV and elder abuse (Alvarez, Fedock, Grace, & Campbell, 2017; Kwiatkowski, 2015).

The longer the victim/client stays in such an abusive environment, the greater the impact on the functioning of the individual within the family setting, as this

current study revealed, with family members displaying symptoms of depression and suicidal ideation. This is not uncommon, as youth exposed to parental IPV, or experiencing a comorbidity of abuse and neglect, are at a significant risk to exposure-related psychopathology, such as depression (Menon, Cohen, Shorey, & Temple, 2018). Similarly, this is an outcome also shared by women experiencing family violence (Cody, Jones, Woodward, Simmons, & Gayle Beck, 2017). Therefore, the importance of adequately trained practitioners, and those *on the ground*, who understand family violence, and are able not only to identify family violence risk through a relatively small subset of risk factors, such as physical violence, but also able to consider other factors that may evaluate risk (Robinson, Pinchevsky, & Guthrie, 2018).

This need to extend beyond evaluating high-risk, solely based on physical violence, is highlighted in a study conducted by Robinson, Pinchevsky, and Guthrie (2018), who evaluated the police, as well as what they use to identify risk factors among victims of family violence. The police were observed to use physical violence, mostly, as an indicator of high risk; however, the police, who received training on family violence, were significantly more likely to view jealousy/controlling behaviours and spying/stalking/harassing/threatening messages as salient in evaluating the victims' future risk. These findings are important, given that these two risk factors are reflective of coercive control (Stark, 2007), considering that the criminal justice system fail to acknowledge non-violent, yet controlling behaviours linked to domestic abuse (Burke, 2007, Stark, 2007, Tuerkheimer, 2004).

Therefore, it is important that the police, or those *on the ground*, are equipped, as well as sensitive to the nature of family violence, as these form part of the referral network, which practitioners utilize, when providing efficient services to individuals and families, affected by violence. The impact of a referral system, as seen in the results, highlights the plight of those seeking aid within the judicial system, regarding family violence. In Africa, young girls, seeking assistance from law enforcement for sexual assault, are either ostracized, or dismissed, as usually neighbours or family members are implicated in the assault. The organisation of

family life, therefore, place these young girls in a dependency cycle, which render their experiences as inevitable and invisible (Aderinto, 2010). Women reporting family violence to police would have their accounts of abuse trivialized, as if no physical violence had occurred and therefore, not serious (Douglas, 2012). Women would also have to act as investigators to *prove* that family violence had occurred; locating and collating tangible evidence, presenting it to police, and demanding action, work marginalised by state employed personnel, who are supposed to investigate family violence (Douglas, 2012).

This agency in self-advocacy may be commendable but can be challenging, especially when the judicial process is predisposed to revictimization (Postmus, Severson, Berry, & Yoo, 2009). Additionally, the elderly have experienced difficulties in reporting to police, and have been known to withdraw cases of family violence, due to, not only pressure from the family, but also law enforcement not treating their cases with the same urgency as other forms of family violence, namely, child abuse or IPV (Ferreira & Lindgren, 2008).

Therefore, this current study suggests an important component for the intervention, as well as the referral networks that need to be constructed around a family-centred intervention, directed at reducing family violence. Family violence needs to be identified timeously and adequately, as well as its effects. In order to create a strengthened macrosystemic response from community-level service providers, engagement between the various mesosystems need to transpire, namely, practitioners, law enforcement and community. This engagement needs to involve information-sharing sessions, where the processes in each service sector is shared and understood, family violence frameworks are engaged, and collaborative terms of engagement negotiated between service providers, to better streamline the help-seeking activities of the families they serve. Better collaboration among different sectors to meet the needs of family violence victims, has been a sentiment shared, both internationally and within South Africa (Fanslow & Robinson, 2010; García-Moreno, Hegarty, d'Oliveira, Koziol-McLain, Colombini, & Feder, 2015; Postmus, Severson, Berry, & Yoo, 2009).

A family-centred intervention, directed at reducing family violence, needs to equip, both families and family violence support services, with knowledge on the microsystemic impact that the individual endures through the dysfunctional family-individual relationship, highlighting the urgency of adequate intervention, even when dealing with the more *subtle forms* of violence, such as spying, stalking, harassment, threats and intimidation.

8.2.2. Legislative response to family violence in South Africa: A family-centred perspective

In this chapter, the researcher reviews the various legislation intended to address family violence, and enhance family well-being in the South African context, as well as promote a family-centred approach as a feasible point of intervention. This analysis formed part of determining the perceptions of families experiencing violence in the home, and their needs for well-being and enhanced functioning, at a legislative, exosystemic level.

The main outcome was the need for collaboration, and the holistic understanding of family violence, to help facilitate collaboration and networking. The need to address legislation is that, even with a world-renowned constitution, a breakdown in implementation is experienced, due to non-integrated services to combat family violence, which are perceived as fragmented. Research regards IPV, child abuse, and elder abuse, as inextricably linked to what is occurring within the family (Tolan, Gorman-Smith, & Henry, 2006; Leoschut, 2009), with the current study advocating for legislation and policy to holistically reflect this through its findings. Through an ecological approach, family policy attempts to underlie the interplay of systemic influence and the challenges families face, such as violence in the home. However, the fragmentation in dealing with family violence, by forgetting the interrelatedness (family systems) inherent within the microsystemic dysfunction (family-individual relationship) of family violence, denotes a legislative separation from family as the focal point, leading to a fragmentation of sectors and services.

Reflective of the ecological understanding that, as families experiencing family violence are affected by systemic risk factors, so too should the various sectors assisting those families, collaborate and pool resources to create a holistic response. This assertion of collaboration and integration has been considered vital in creating an effective response towards family violence, and recognizing the heterogeneous effect it has on all family members, instead of creating disjointed interventions for parts of the same whole (Nagia-Luddy & Mathews, 2010; Parliamentary Monitoring Group, 2013).

The analysis of legislation aimed at addressing family violence, shows that South Africa does not work from a family centric perspective, as can be seen in the historical fragmentation found in delivery of services, regarding family violence. These historical fragmentations are linked to the multi-sector belief that they have different philosophies and mandates, use different professional terminology, and lastly, these sectors indicating that they have different missions (Nagia-Luddy & Mathews, 2010; Republic of South Africa [RSA], Department of Women, Children and People with Disabilities [DWCPD], 2013). However, if policy-makers, service providers, and various sectors would realise the similarities amongst the subsets of family violence (such as family perpetrators, similar frameworks used for response), a collaborative, family-centred approach would be seen as a viable option in creating a unified, integrated response which could better implement legislation, and better improve the functioning of South African families, in comparison to what the violence prevalence rates have been foreboding.

8.2.3. A review of family-centred interventions aimed at family violence

In this section of the study, the researcher aimed to map out what family-centred intervention programmes were available to address family violence. The main outcomes show interventions to be largely community-based, in both its recruitment and intervention setting, and as seen in the elder abuse review. The original research team had assisted the community-based organisation with technical assistance, regarding their intervention, a collaboration noted to have a bolstering effect on interventions, as it contributes to high attendance rates

(Spoth, Clair, Greenberg, Redmond, & Shin, 2007).

Interventions used in the family violence field have trained facilitators, either tertiary level educated, or trained specifically for the programme; a factor that, when combined (provide tertiary educated facilitators with additionally training), was noted to capacitate facilitators, not only with expertise, but also the ability to translate those experiences and knowledge to respondents, while being grounded in best practice (Lee & Nichols, 2010). Even though interventions followed varied formats of being implemented, either through sessions or themes, it was noted that, whichever way it was presented, sessions should be flexible; not exceed twice a week, to allow time to practice new behaviours and experience change, and not be time prescriptive, with, at least, one risk topic covered in a session (Eckhardt, Murphy, Whitaker, Sprunger, Dykstra, & Woodard, 2013; Katz, Blake, Milligan, Sharps, White, Rodan, Rossis, & Murray, 2008).

Additionally, themes retrieved from the reviewed programmes were commonly addressed in family violence interventions (Tolan, Gormon-Smith, & Henry, 2006). However, the reviewed interventions comprise a large portion of sessions devoted to parenting or parenting skills, which may be linked to the fact that maltreating parents, who actively participate in family-centred interventions, display lower rates of reabuse; as opposed to child-centred interventions devoid of acknowledging the complex and multiple needs of the family, such as unemployment, substance abuse, violence, to name a few (Bromfield, Sutherland, & Parker, 2012; Kemp, Marcento, Hoagwood, & Vesneski, 2009).

Only one of the reviewed studies addressed gender (Becker, Mathis, Mueller, Issari, & Atta, 2008), contrasting the body of knowledge which shows gender integral to interventions at individual/community level (Whitaker, Morrison, Lindquist, Hawkins, O'Neil, Nesius, Mathew, & Reese, 2006). This may be linked to a growing trend towards a gender-neutral framework regarding the understanding of family violence. Gender neutral family violence frameworks stem from the American context, bringing parity to the female perpetration/male victimization cases of violence (Reed, Raj, Miller, & Silverman, 2010). This may

prove challenging as women and girls are still the most likely to be killed/injured by a male intimate partner, and are more at risk, than any other class of individual (Reed, Raj, Miller, & Silverman, 2010). Disregarding gender inequality in family violence is a missed opportunity to explore deeply entrenched gender-power abuses occurring in the lives of women and girls (Reed, Raj, Miller, & Silverman, 2010).

Most of the reviewed studies showed sustained long-term positive results that resonate with outcomes associated with the family-centred approach, showing a collaborative partnership between family and professional. As stated earlier, a family-centred approach allows the challenges presented, to provide contextual explanation, rather than individual blame, where focus is given to what is happening in the family, instead of what is *wrong* with the family. Therefore, through this holistic engagement, adequate support is given (Bromfield, Sutherland, & Parker, 2012; Burns, Dunn, Brady, Starr, & Blosser, 2008).

8.2.4. A Delphi study to develop a family-centred approach to reducing violence in the home

The aim of the study was to describe the development of a family-centred intervention programme, aimed at reducing violence in the home, in collaboration with those working and contributing to the field of child and family well-being, with the specific focus on family violence and its effects. The outcome of the two round process revealed that the participants were satisfied with the programme layout, mostly, but emphasised family functioning skills, the use of assessment tools and the need for collaboration.

The skills and environmental changes needed to enhance family functioning in a family violence setting, included conflict management, communication skills, appropriate affect, as well as creating safe spaces in the home, to air views, or take time out. The themes highlighted in this current study are traditional focal areas in family violence programmes, as well as family-wellbeing programmes, especially when considering broader contextual factors, such as gender,

community/institutional support, social norms, socio-economic class, and substance abuse, all of which further shape the experience of functioning in the home (Harvey, Garcia-Moreno, & Butchart, 2007; Tsey, Whiteside, Haswell-Elkins, Bainbridge, Cadet-James, & Wilson, 2010).

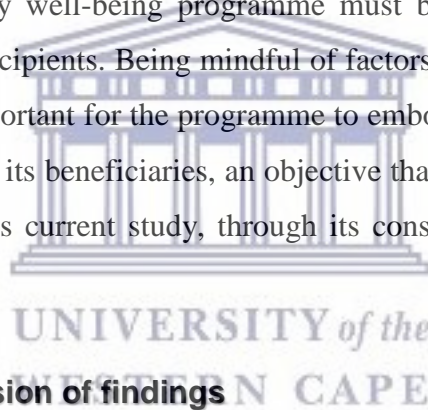
The use of assessment tools was noted as key to, not only determining level of risk, but also regarding alternative treatment pathways, such as appropriate intervention and referral. As noted in one systematic review, assessment tools are integral in identifying, as well as in managing, risk of harmful behaviour (Singh, Grann, & Fazel, 2011). Assessment tools, regarding risk, are used widely in clinical, psychiatric and criminal justice settings, influencing decisions regarding accessibility to inpatient and outpatient resources, civil commitment, and length of community supervision (Sing, Grann, & Fazel, 2011).

However, predictability of assessment tools vary greatly among studies, with findings suggesting the closer the test recipients are to the assessment tool's original sample, the more effective; therefore, assessment tools need to be used in conjunction with other forms of assessment, and not as a sole basis (Sing, Grann, & Fazel, 2011; Yang, Wong, & Coid, 2010). Collaboration was noted as vital, in both Delphi rounds, to the successful implementation of the programme. Creating a collaborative environment in the family violence programme was noted in this current study, not only to share responsibility of the issue among sectors, but also to widen the reach of the programme, to include services, which are available in the communities of families experiencing violence in the home. This finding is reflected in international trends, which reveal collaboration among all services that victims may turn to, to reach victims of violence better, become more innovative in its interventions, elicit new approaches, and expand the movement of positive social change (Lehrner & Allen, 2009).

Collaboration assists in seeking the best strategies in risk management, resource allocation, use of expertise, and creating innovative interventions that uplift and empower communities (Hammons, 2004; Salem & Dunford-Jackson, 2008; Lehrner & Allen, 2009). The study participants discussed collaboration, also, as

a tool to alleviate expenses, and discussed, at length, funding mechanisms and programme sustainability, as funding concerns make organisations *funding-dependent and not programme-dependent*.

Sentiments shared in literature, reveal how programmes become co-opted into larger systems through collaboration, and begin to focus on the professionalization of programmes and services provided. However, this pathologizes, and even patronizes services, according to funder-generated requirements, consequently, losing its grounding in its *movement* philosophy, and failing to critique social change; thereby, becoming passive, uncritical programmes (Hammons, 2004; Lehrner & Allen, 2009). In the South African context that endures many challenges, such as having the highest rates of inequality in the world (Maiorano & Manor, 2017), the factors that may affect the feasibility of any well-being programme must be considered, as well as the progress of its recipients. Being mindful of factors, needed for the programme's success, it is important for the programme to embody its advocacy roots, and be representative of its beneficiaries, an objective that the researcher has attempted to achieve in this current study, through its consensus process including vital stakeholders.



8.3. Overall discussion of findings

The findings' themes evolved into systemic levels of a family-centred intervention such as, what can be addressed at individual/family level, what can be linked to communities, and how policy plays a role in the way practitioners and other service providers intervene. These systemic understandings of intervention in family violence are not alien in its concept. Most interventions are policy determined, and family violence policies draw strongly from an ecological approach in which family, community and governmental factors are considered (Australia's National Research Organization for Women's Safety [ANROWS], 2017; Nagia-Luddy & Mathews, 2010; Tolan, Gorman-Smith, & Henry, 2006).

Therefore, a holistic approach was sought to address family violence, one that was

aware of the legislative environment in which families are meant to thrive. How violence is perceived by the families experiencing it, as well as the service providers, who are meant to assist these families, was also important. The resources and skills needed for the intervention are key factors in this approach; however, most importantly, service provider must be aware of the family itself, especially during the solution-focused action-planning phase, in which families are equipped, best, to define their needs and context.

Interventions that include the family needs are shown to be culturally sensitive as well as adaptive to the family context (Gillum, 2008; Sumter, 2006; Yasui & Dishion, 2007). Interventions are usually a fixed, manualised programme following a European American perspective of development; an etic approach examining universal/pancultural principles, where differences are found at individual level and not group (Yasui & Dishion, 2007). A move to create interventions that link cultural diversity issues to empirically supported interventions, would imply interventions that tailor towards the needs of the individual with that of the family; an emic approach that provides flexibility to cater towards diversity, while retaining the etic science (Yasui & Dishion, 2007). Families provide vital information, essential to valid assessments and appropriate intervention planning (Kemp et al., 2009).

This vital information refers to parental knowledge of children, family circumstances and cultural context (Kemp et al., 2009). Implementing a family-centred approach will create strengthened partnerships between family and caseworker/practitioner, which, in turn, will facilitate sustained positive change (Bromfield et al., 2012; Kemp et al., 2009). Furthermore, the strengthened partnership between practitioner and family can assist families to navigate their way around other needed social services, as well as aid families to comply with caseworker expectations, for positive outcomes (Bromfield et al., 2012; Kemp et al., 2009).

As partnerships between family and practitioner are indeed important, so too are the partnerships formed between the sectors themselves that aid families experiencing violence in the home. As highlighted in the chapters, yet particularly seen in the Delphi study, creating a collaborative environment allows for best strategies to be sought,

shares the responsibility, thereby alleviating expenses, and aids in allocating resources where needed. This collaboration can extend further to include the community, as illustrated in the needs assessment, as well as the review of family-centred interventions. The community is not only a family's source of support, but also act as other forms of referral (neighbours reporting incidents of violence). Most of the interventions were also run at community level.

Linking the community to the intervention (either through awareness campaigns or information sharing sessions), helps to bolster the support provided to families, experiencing violence in the home, or at-risk families, and also creates trust between the community and the service providers, as stated particularly in the needs assessment. A systemic strengthened partnership between all levels of support to the family, further ensures continuity of care once the intervention programme has been completed, and referral is needed for alternative or additional treatment pathways.

8.4. Theoretical grounding of the current programme

In support of the intervention mapping's purpose of developing evidence-based programmes, aligned with the identified needs, and theoretical approaches/strategies, through this current study, the programme formulated its theoretical grounding and expected outcomes to reduce family violence in the home, as illustrated in Table 8.1.

Table 8.2: Theoretical grounding of current programme

No.	Session theme	Session objective	Link to family systems 8 prepositions	Systemic impact	Session outcome
1	Introduction	Explain what the programme aims to do, what the programme sessions will entail, to establish ground rules, and explore what participants' expectations are in what they would like to take from the programme.	Session becomes reflective of prep.: i). Various causes of family violence viii) Self-concept created around role expectation Examination of these allows participants to voice programme expectations of changes they would like to see in the family and for themselves.	Microsystem (individual-family relationship)	In participants' reflecting on their current situation and aligning it to tangible programme expectations; this process coupled with facilitators explaining programme aim and content, will create a shared vision with the participants and create buy-in.

2	Knowledge and perceptions of family violence	To describe and identify family violence.	Quintessentially speaks to all 8 prepositions in not only identifying family violence and the dynamics of it; in relation to the theme specifically it is more definitively illustrated in preps. i-iii in which family violence and its causes are discussed and how not understanding how abuse "looks" leads to denial and underreporting.	Microsystem but also in terms of creating macrosystemic assistance (community support, programme formulation, crisis intervention). Better informs mesosystem interaction (government and civil society) in resource allocation and needs assessment through prevalence/incidence rates generated through reporting.	In identifying family violence, participants better understand the situation occurring in the home and how vital it is to take necessary action in seeking aid but also how inaction can lead to escalation and other negative outcomes.
3	Emotional affect	Becoming aware of thoughts, emotions and physical feelings and choosing the appropriate response.	vi and vii which deals with obtaining desired results through violence (reinforcement) as well as creating secondary conflict. Here the systems tenet of equifinality is utilised in exploring more than one way to reach a goal, e.g. violence not the only route in which to express feelings, thoughts or to be heard.	Microsystem (individual-family relationship)	In managing emotional affect, appropriate responses are not only given in response to upsetting situations but also in appropriately responding to the emotional needs of family members. Also using affect to show involvement in terms of showing interest in the interests of other family members. Being aware of alternative responses other than violence thereby reduces incidences of violence.
4	Communication skills	Identify and understand ways we communicate such as verbal and non-verbal communication.	i and iv, in which causes of violence as well as intergenerational transmission of stereotypes. Here patterns of poor communication is explored as both a facilitator of violent situations but also explore how this may stem from childhood exposure.	Microsystem (individual-family relationship)	The communication skills will equip participants in ways of communication not only in content but also in clarity, but also in aligning body language (non-verbal) to what is being said. These skills will limit violent alternatives as options of expression, which are seen in situations of misunderstanding and miscommunication.
5	Conflict and conflict management	Understand conflict, the different ways we react to it, styles of communication, and choosing a response appropriate to a circumstance.	i, v, vi, and vii, in which causes of family violence are explored, stereotypes affirmed through social interaction, desired results obtained through violence (positive feedback) and lastly secondary conflict	Microsystem (individual-family relationship), Macrosystem (interpreting social interaction vital if community violence present)	Understanding conflict, the manner in which to engage it (assertiveness), types of responses appropriately matched to situation (e.g. forceful approach may be useful in bargaining a price for a car but

			created. Addressing notion that current state of violent conflict produces desired effect, and that conflict is not always bad but there are ways in which to engage it, and there is a difference in whether this is done aggressively or assertively.		may not for every family matter).
6	Care of the elderly	Understanding basic care and care principals regarding the elderly and explore how context/culture can influence perceived abuse.	Mostly aligns to prep. i as looking at causes or roots of family violence as elder abuse has additional factors such as contextualised influence on how abuse is perceived.	Microsystem (individual-family relationship) Macrosystem (cross-cultural abuse)	Elaborate on broader definitions of family violence and its effects, skills on basic guidelines on caring for the elderly.
7	Parent skills and building healthy relationships	Understanding rules, routine, consistency, responsibility, rewards, punishment, time out and how a healthy relationship can foster family management.	Can relate to all 8 preps. considering intergenerational transference (roots of violence), as well as cultural beliefs and values. However, this session theme is more evident in prep. 3, denial of violence (not seeing harsh parenting as abuse); prep. 4 stereotypes are passed down through childhood exposure; lastly, violence produces desired effect (subduing child through harsh parenting).	Microsystem (individual-family relationship), Macrosystem (cultural beliefs and values around child rearing and family management) Exosystem (teacher may experience child to be withdrawn or act out due to situation at home – involve social worker) Chronosystem (time period when parents were raised, harsh parenting seen as acceptable even reflective of the times e.g. apartheid)	Establishing rules, routine, consistency, reward, punitive actions towards non-compliance, principles of care-giving, neglect and alternative behaviours, giving positive attention. Skills to enhance the parent-child relationship and family environment.
8	Barriers to change	Exploring barriers to change and how what was learnt so far in the programme and strengths discovered, can assist in being solution-focused.	All 8 prepositions (reflection of current home situation)	All systemic levels considered as inhibitive or reinforcing factors when instituting change.	Exploring barriers to address possible obstacles in instituting positive change and brainstorm possible solutions. This acts as a preparation for the family conferencing session as part of the solutions may include professionals to aid with rehab, housing, etc.

9	Family Conference	Family action planning. This session will include a relevant professional who may assist with pressing issues needed for effective planning (access to housing, rehab, legal aid etc.).	This session may directly challenge prep. viii in challenging role expectation of each member, as family members may require old roles to change or deviate in order for desired outcome to be achieved.	All systemic levels considered in order to map out solutions.	Session created in order to proactively implement programme content into action plan, within a collaborative space.
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8.5. Implications for practice

The systemic perspective, observed in this current study, marries Bronfenbrenner's (1989) concepts with family-centred approaches, to address family violence, which embody the understanding of family systems theory, as proposed by Murrey Strauss (1973). A family-centred approach, aimed at systemic engagement, allows, not only the determination of realistic change, which can occur in the family's environment to reduce violence in the home, but also cognizance of the barriers that will inhibit the family's progress to exact such change. These interplaying systems influence the family and its functioning, as these systems are not only dynamic, but also interactive, as they underpin activities, present in daily family life.

For researchers, practitioners, as well as various other beneficiaries and stakeholders of family well-being, being conscious of contextual factors that inhibit, or progress family functioning, enables the creation of effective and responsive interventions. These interventions will address, holistically, the needs of families experiencing violence in the home, or at-risk families. Additionally, through the partnership created via a family-centred approach, barriers and expectations can be discussed and engaged, ensuring compliance and positive outcomes for the family, allowing a contextual understanding to inform the practitioner.

This current study highlights the fact that a family-centred approach, directed at families experiencing violence in the home, prioritises collaboration between service providers, government, and community, in order to ensure that responses are aligned to the needs of families experiencing violence. In addition, this current study indicates that continuity of care must be ensured. Enforcement mechanisms must be put in place,

utilized, and upheld, to hold role players accountable to aid families affected by family violence, adequately, ensuring that services are not only aligned to, but also streamlined to the help-seeking behaviours and activities of families affected by violence in the home.

8.6. Limitations

A stark limitation, evident in this current study, is that no families were able to participate; instead practitioners and various other service providers, who work with these families on a daily basis, were approached to provide insight, regarding these families' perceptions of family violence, and the barriers that inhibit functioning. The non-participation of families was in no way linked to a lack of effort (as reflected in "*Reflections of the data collection process*" in the Methodology chapter). It was due, instead, to the gatekeepers, and most importantly, the sensitive nature of the topic, as well as family members, who were not ready to participate, because their level of discomfort with the topic and the risks involved. This included families who were in family interventions currently, or involved with safety planning.

In this study, the researcher did not focus on any particular family (special needs, disabilities, LGBTI+, specific cultural influence such as African or European, socio-economic status, substance abuse etc.), but rather aimed for a general understanding of families experiencing violence in the home, what their needs might be, and what would be needed in an intervention to help them meet those needs. In essence, the aim of this current study was to seek a *baseline reading* on the current perception of families experiencing family violence, which, to date, had been rarely discussed from a family centric standpoint, or focused on as a *family issue*. Additionally, the researcher wanted to highlight families, as a focal point for interventions, regarding issues that included them (family violence). These issues have been siloed (child abuse, IPV, elder abuse), causing fragmented efforts, and dualistic focus (victim-perpetrator relationship); however, still facing increased rates of family violence and homicide in the country.

The researcher in this current study, did not seek to explore community support structures purposely; however, the findings of this study revealed the importance of

linking family-centred interventions to macrosystemic support, such as communities and the services they provide to families.

8.7. Recommendations

The following recommendations will follow the order of addressing each point in terms of recommendations related to systemic impact, practice, and research.

- It is recommended that future family centric studies on the topic of family violence, use the findings of this study, juxtaposed to the perceptions of families, who are experiencing violence in the home, as this:
 - From a systems perspective, garners a more holistic, microsystemic perspective on the needs of families experiencing violence in the home.
 - Informs practice on highlighting specific focus areas relevant to families that may have been overlooked, or under-reported to practitioners. However, insights generated in having perspectives, from both families and practitioners, can create opportunities for better streamlined services, in line with family needs.
 - May provide research with a more in-depth insight as to what family facets needs to be further examined so as to enrich evidence-based practice.
- As mentioned under limitation, specific families were not sought; however, it will be of interest to examine, or explore the needs of families experiencing violence with co-occurring issues/contexts (substance abuse, poverty, disabilities, LGBTI+, mental health concerns etc.). The findings of families in co-occurring contexts may reveal needs totally different to what have been determined in this study:
 - A study examining families experiencing violence in co-occurring contexts may broaden macrosystemic understanding and support (community level, streamlined programmes/support services), as well as inform opportunities for mesosystem engagement.
 - Community awareness, as well as the awareness of the services providers (NGOs, welfare services, law enforcement, faith-based initiatives etc.),

may assist families, not only to recognise the abuse occurring in the home, but also inform families about where to go, knowing that they will be heard and assisted when seeking support. This further advocates the collaboration among those involved in helping at-risk families, as continuity of care is ensured by linking the intervention to the resources available to the families. Therefore, a case-file management system needs to be incorporated into the intervention, to be used as a base of referral, post-intervention.

- Compared to the intervention formulated in this current study, research around a programme aimed at multi-challenged families, or exploring family needs through more than one context, may reveal the need for additional sessions (families of low-socioeconomic status in need of a session on microfinance), or the need of an augmented version (the session on care of the elderly include carer guidelines for elderly who suffer with Alzheimer's or dementia).
- As mentioned earlier, the researcher in this study did not focus on a particular type of family, or families with co-occurring issues, and consequently, cannot conclusively assert that all the issues, which could be present in a family experiencing violence, have been unpacked thoroughly.
 - The researcher strove to initiate the conversation, and inspire the notion of placing families at the centre, when brainstorming solutions to issues that, undoubtedly, affect them, in recognising that microsystemic issues need microsystemic engagement, before identifying broader solutions. This will help to, not only streamline, but also create adequate responses from broader systemic influences, when aligned to the needs of the family.
 - Regarding practice, the intervention format proposed has been kept broad in its themes and techniques, intentionally, to allow flexibility, if used in different contexts.
 - The processes described in this current study serve as a blueprint in the methodology used to engage stakeholders and beneficiaries collaboratively in the intervention development.

8.8. Conclusion

In this study, the researcher sought to develop a family-centred intervention, aimed at reducing violence in the family. Consequently, promising results were revealed in this study, with corroborated long-term positive effects, regarding the implementation of a family-centred approach. Coupled with a collaborative network of support services, political will, and community support, it could ensure continuity of care and improved functioning for families experiencing violence in the home.

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APPENDICES

APPENDIX A: Quantitative Results for Needs Assessment

TABLE 1: DEMOGRAPHICS

		Total sample
Age	Mean age	M= 33.14 (SD=11.60)
Gender	Male	2 (22.2%)
	Female	7 (77.8%)
Race	Coloured	4 (44.4%)
	Black African	2 (22.2%)
	White	3 (33.3%)
	Indian/Asian	-
	Other	-
Language	English	1 (11.1%)
	Afrikaans	6 (66.7%)
	Xhosa	1 (11.1%)
	Other	1 (11.1%)
	Work history	Employed
Unemployed		-
Self-employed		-
Volunteer		-
Work area	Boland region	1 (11.1%)
	Cape Town	1(11.1%)
	Cederberg region	1 (11.1%)
	Lamberts Bay	5 (55.6%)
	Overberg region	1 (11.1%)
Work title	Counsellor	1 (11.1%)
	Community development worker	1 (11.1%)
	Social worker	7 (77.8%)

Socio-economic status of work area	Low income	6 (66.7%)
	Middle income	3 (33.3%)
	High income	-
Are there sufficient resources in the community to assist you in adequately addressing the needs of the families in the community?	Yes	2 (22.2%)
	No	7 (77.8%)
Are there sufficient referrals in the community which aid in assisting families experiencing violence?	Yes	2 (22.2%)
	No	7 (77.8%)
Do you receive support from the community regarding families experiencing violence?	Yes	3 (33.3%)
	No	5 (55.6%)
Do you receive support from government stakeholders in assisting families experiencing violence?	Yes	5 (55.6%)
	No	3 (33.3%)

Table 1 shows the demographics of the study sample. The mean age of the participants was 33.14 (SD=11.60) years, most of whom were female (77.8%). All of the participants were employed (100%), with most falling within the Afrikaans-speaking (66.7%), Coloured (44.4%) demographic. Majority of the participants were social workers (77.8%), working within the low income (66.7%) areas of Lamberts Bay (55.6%) in the Western Cape. Participants felt they had sufficient resources (77.8%), referrals (77.8%), as well as government stakeholder support (55.6%) to address family violence; participants however did not feel they had community support (55.6%) regarding families experiencing violence.

SECTION 2: FAMILY FUNCTIONING

The second section of the questionnaire looked at the perceived functioning of families who sought aid from the participants and their organisation.

TABLE 2: FAMILY FUNCTIONING

Family functioning regarding problem solving, communication and personal goals.	N	M	SD
1. Families experiencing violence, collaborate together to find the best way to solve their problems.	9	3.22	0.44
2. Families experiencing violence, talk freely about things which make them unhappy	9	3.22	0.67
3. Family members have less time to pursue interests and hobbies, because most of their free time is spent caring for the family.	9	2.44	0.53
4. When a family makes a decision about a problem, all family members lend a hand to carry it out.	9	3.00	0.50
5. If family members are unhappy with the behaviour of someone in the family, they tell them and suggest better ways to get along.	9	3.22	0.44
6. Despite the family problems experienced in the family, family members still find a little time for themselves.	9	2.67	0.50
7. When the family has dealt with a problem in the family, they usually discuss what they have done and whether it helped.	9	2.89	0.6
8. When family members do kind things for one another, they are thanked.	9	2.78	0.83
9. The family members feel that it is important that everyone in the family has time for themselves.	9	3.11	0.60
10. Family members feel it is helpful to share what they think about a problem as it seems that their opinion is taken into account.	9	2.89	0.93
11. Family members, who are pleased with what the other says or does, feel free to let them know openly they are pleased.	9	2.78	0.83
12. Family members succeed in doing what they promised they would do.	9	3.22	0.44
13. When the family feels they have a problem, they all meet together to	9	3.44	0.53

discuss it.			
14. When family members are angry with one another, they tend not to speak to one another.	9	2.00	0.50
15. Family members manage to do some things alone without their family member.	9	2.11	0.60
16. When the family feel they have a problem, they plan together what to do about it.	9	3.11	0.33
17. When family members do something kind for one another, they are almost never thanked as it is not thought to be necessary.	9	2.33	0.70
18. Family members feel that they have to deal with so many difficulties in the family that they have completely given up on their interests.	9	2.22	0.44
19. Family members feel they can suggest solutions to problems within the family, without the worry of being criticised.	9	3.22	0.44
20. When family members need help with something, they ask each other kindly to assist and do not make demands or orders.	9	2.89	0.93
21. Family members feel they can meet friends outside of the family.	9	2.44	0.88
22. Family members find it difficult to solve problems as they can never agree on anything.	9	2.22	0.67
23. When family members do not approve of something that one of the family members had done, they tell them politely so as not to offend them personally.	9	3.67	0.50
24. Family members can easily find interests that keep them busy.	9	3.33	0.70

RESPONSES WERE INDICATED ON A LIKERT SCALE OF 1 =ALWAYS, 2 =OFTEN, 3 =SOMETIMES, AND 4 =NEVER.

Participant's largely felt that family members experiencing family violence, have less time to pursue personal interests and hobbies, as most of their free time is spent caring for the family ($M=2.44$, $SD=0.53$). Participants suggested family members feel that they have so many family difficulties to deal with, they have given up on their interests ($M=2.22$, $SD=0.44$). However participants do note that family members manage to do some things alone without their family members ($M=2.11$, $SD=0.60$), such as being able to meet friends outside of the family ($M=2.44$, $SD=0.88$).

Communication was shown to be a standout point when addressing families experiencing violence in the home. Participants indicated that family members tend not to speak to one another when angry ($M=2.00$, $SD=0.50$), and never thank one another when family members do something kind for each another ($M=2.33$, $SD=0.70$). Furthermore, participants noted that family members never try to let each other know, politely as not to offend, if a family member had done something they did not approve of ($M=3.67$, $SD=0.50$). This breakdown in communication, can further be seen in the problem-solving habits of families affected by violence, as family members tend not agree on anything, making problem-solving difficult ($M=2.22$, $SD=0.67$).

SECTION 3: PERCEPTIONS AND ATTITUDES OF FAMILY VIOLENCE

This section of the questionnaire reflected participants' perceptions of family violence and their ability as care practitioners, to assist families affected by violence in the home.

TABLE 3: PERCEPTIONS AND ATTITUDES OF FAMILY VIOLENCE

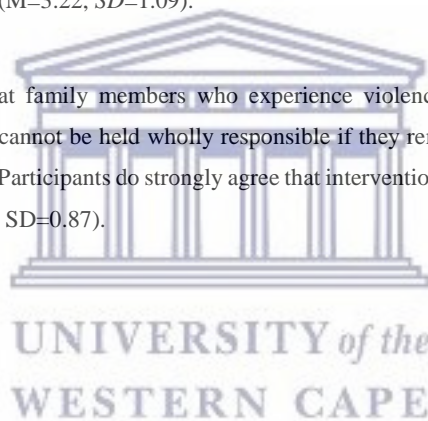
Statements about family violence	N	M	SD
1. I ask all new clients about abuse in their relationships.	9	3.00	0.87
2. I believe family violence is more prevalent these days.	9	2.89	1.17
3. I am capable of identifying family violence without asking my client about it.	9	2.89	0.60
4. I do not have sufficient training to assist individuals in addressing situations of family violence.	9	2.11	0.60
5. Clients who abuse alcohol or other drugs are likely to have a history of family violence.	9	3.22	1.30
6. If victims of abuse remain in the relationship after repeated episodes of violence, they must accept responsibility for that violence.	9	1.67	0.87
7. I am able to gather the necessary information to identify family violence as the underlying cause of client health issues (e.g., depression, migraines)	9	3.00	1.00
8. Victims of abuse could leave the relationship if they wanted to	9	2.89	0.93
9. Health care providers have a responsibility to ask all patients/clients about family violence.	9	2.67	1.00
10. Alcohol abuse is a leading cause	9	2.89	1.05

of family violence.			
11. Interventions for family violence need to be more family-centred.	9	3.44	1.01
12. Use of drugs is related to family violence victimization.	9	3.22	1.09
13. I can recognize victims of family violence by the way they behave.	9	2.56	1.01

RESPONSES WERE INDICATED ON A LIKERT SCALE OF 1=STRONGLY DISAGREE, 2=DISAGREE, 3= AGREE, AND 4= STRONGLY AGREE.

Participants feel that they do have sufficient training to assist families affected by violence ($M=2.11$, $SD=0.60$); additionally, participants also feel they have adequate information to identify family violence, either through the way clients behave ($M=2.56$, $SD=1.01$), or as an underlying cause for health issues such as depression ($M=3.00$, $SD=1.00$). Participants do feel that substance abuse has a role to play in perpetrating family violence. Family members who have a history of substance abuse were noted to most likely also have a history of family violence ($M=2.67$, $SD=1.00$), with alcohol abuse thought to be the leading cause of family violence ($M=2.89$, $SD=1.05$) and drugs related to victimization ($M=3.22$, $SD=1.09$).

However, participants felt that family members who experience violence are able to leave if they wanted to ($M=2.78$, $SD=0.83$), but also cannot be held wholly responsible if they remain in the situation of repeated family violence ($M=1.89$; $SD=1.27$). Participants do strongly agree that interventions used to address family violence, need to be family centred ($M=3.00$, $SD=0.87$).



APPENDIX B: Qualitative Analysis for Needs Assessment

QUALITATIVE FINDINGS

Semi-structured questions were directed at health practitioners on how families would experience violence in the home; how the violence in the home affected their sense of safety; if substance abuse played a role in family violence; if family violence had been marked by pathology or criminal history; if professional assistance was sought by families experiencing violence; as well as what should be important focal areas when creating a programme for family violence.

The responses elicited 6 main themes namely, 1.) Nature of abuse; 2.) Intervention in family violence; 3.) Systemic response to violence in the home; 4.) Influence of violence on the family; 5.) Substance abuse; and 6.) Programme design and goal setting.

NATURE OF ABUSE

Respondents¹¹ noted that when abuse occurred in the home, clients did not describe abusive acts as “abuse”, but either linked them to guilt, shame, or described them plainly as matter-of-fact events rather than connote them with abuse.

R1 *“I knew this one... this other case... this girl actually said that ‘my mother would throw around plates, and she will start to hit my father, but then my father will just give her any attention. Then she took it out on us...’ so then she would start beating the children hence the father didn’t give her any attention. So that is how she described violence in her perception... or ‘my mother was standing in the road and she threw me with a glass’ or something like that, but they won’t classify... as violence per say.”*

R4 *“With children it’s normally easier. Believe it or not... they will just say that ‘my mommy did this’ and ‘my daddy did that’ and this is how it normally happens, but not the grownups. With them it will normally be ‘what do we actually tell the social worker? And what do we keep to ourselves?’ But the minute you ask the child, they will normally see what happens, and for him it’s strange or not strange. But he knows now already what is happening. What he will maybe say, ‘but my mommy’... ‘my daddy stabbed my mommy with a knife’ or something like that... where the mother won’t say that the father stabbed her with the knife or something like that. They will only say that they fought. The children will say in depth what happened.”*

R7 *“...It has taken a long time uhm... for the mother to actually say what was going on. You know, she kept making excuses for what was happening. She kept making excuses for him, trying to blame it all on her own. So if you ask now with regard to the families that you have met, this one family in specific... have*

¹¹ R= Respondents; R1, R2 etc. in quotes will denote respondent 1, respondent 2 and so on.

they ever described where arguments usually start in the house...The usually... what that uhm ...the mother... the mother will tell the stories so that... that makes as if she is the cause of how the arguments began. You know she... she'll try to put all of the blame on if herself to keep it away from the father to prevent him from being upset, getting angry... which would later result in violence."

Because abuse was seen in this manner, clients found it difficult to state when arguments started, how long it lasted or when it would end. But through regular engagement with clients, respondents noted a trend that arguments usually began over 'small things' which would last for hours or days, and later brought up in a new argument, with the argument ending once someone got hurt.

R1 *"I think there was this one incident that I can refer to...Something small that agitates them you know... like making agitated in the sense that, if for example, the guy comes home 'where's my food?' and there's nothing... then the argument will start. Or where's this? Where's that Hun? Or where's the child? Why didn't you take the child to school? Things like that..."*

I remember this one lady told me that it will go on until this guy has found enough satisfaction when hitting her... its being going on for 3 years and I asked this lady but why do you allow this to happen and she's like I don't know...It's like one of the questions in the questionnaire that you asked. What is this question you asked in the questionnaire? About if you do something and the person doesn't listen is it like they a victim of their own violence. "

R2 *"it's firstly... it begins the small matter ne... and financial issues ne. Maybe the other partner...Is going to get hurt ne"*

R6 *"Usually, I'm just thinking now... very general it will be the wife nagging... But it will usually be the wives that start talking not; I think to initiate an argument but then the argument starts... They can be angry for two... for two, three days"*

R8 *"Yes, they would normally say how it started. Uhm small things or simple, simple things... The wife would normally read wrong into what the husband is saying. This would normally end up in an argument or in conflict. You see...Half hour, hour and then days because the people who argue, especially between husband and wife...The woman would normally bring it again up again the next day. Or the time when the man does something wrong again according to her, then she will bring up yesterday's argument again. She will add it to the new argument...They don't talk to each other, go to bed angry... In physical abuse is fast, you throw a plate around and it is done, or you are slapped in the face and it is done. But now... but now you don't talk. This is the one that normally lasts the longest."*

Seeing as clients would not readily see abusive acts as abuse, respondents were asked what their typical red flags were when seeing clients, and realising abuse could be occurring in the home. Red flags or warnings were noted to be physical injuries and scarring, the emotional response of client, neighbours notifying them, and referrals.

R1 *"This specific one... because this guy... he will hit this lady so bad and the last straw was when he let a pitbull attack her and uhm... he would like drag her and then the dog will like... here by her arms and everything... and you can like... also see in her face that a lot of violence is happening even when I saw*

her. I knew that something is not right with this family. Because you can see, like all over her body... is cuts and bruises and all of that."

R2 *"The neighbours ne... first I can ask from the neighbours... maybe they will be feeling afraid to tell me ...I'm not going to say so and so did tell me that er... there is something."*

R3 *"One can sense it, you can sense...The non-verbal actions and reactions towards your presence at that moment in the particular area...house... where it happens...And there... there's a type of anxiety. A type of uhm... they... they can't communicate really...Or they try to cut it very short... the conversation and they try to get rid of the elder per of the... of the social worker you know, because they are afraid of being... maybe targeted afterwards. You know... they disclose too much information or that can get them... the perpetrator in trouble... Yes, I think especially when it comes to maybe uhm... I get a lot to do with, with frail care. You know uhm frail older person's bedridden... older persons... and one can sense if the person hasn't been properly cared for and are in a... in a state of severe neglect. Physically uh also emotionally the way they act, respond. You know the physical scars, wounds due to medical conditions... And stuff like that that hasn't been cared... hasn't been treated and so it's... it's very much to do with the neglect that you can sense.*

Usually it comes up referrals. We get uh... referrals from other service providers. The...the child welfare, the RCVV, Badesa... all the NGO's."

Family violence was noted to not only come from a history of abuse but also transpired through a single stressor. The effects of this single stressor evolved into violence occurring in the home, affecting all family members.

R7 *"There was a mother and a father and three children uhm... they were accustomed to... or the father had a... good work uhm... the mother had not needed to work so the family was financially, very stable. They were well off. They were accustomed to the best things in the world. Many things had happened and the father lost his job which meant there was financial strain. Well you know uh... there were no longer many cars and there was no food every night type of thing. So with the result... with all the tension, the father started drinking and it was now leading up to intimate partner violence... you know uhm... violence against children... just over the general activities you know... violence and domestic violence, neglected children etc. It had now a ripple effect on a lot of other things as well... It was a good marriage so I would... if I were to think of... of her being dependent I would say that it was more so emotionally dependent on him because you know he was strong, he was the father figure in the house, he was like you know... he was the alpha male... protected and cared for them and then this thing happened and all of sudden it wasn't there.*

INTERVENTION IN FAMILY VIOLENCE

The most likely groups, noted by respondents, to intervene when abuse is taking place, are neighbours, at times the community members, as well as family members not in the abusive household (grandmother, extended family). However, it was stated that intervention did also occur selectively dependant if victims were married or single.

R7 *"There were neighbours that intervened but also then uhm when...when...when I was interviewing*

them, they said that the wife always... you know... went to them afterwards and said that they were okay and it was just a slight misunderstanding. It wasn't as bad as... as it sounded uhm... it was her fault... she forgot to do whatever. So they would try... but you know afterwards... and... they said they just gave up because she didn't want to be helped. She wants to be in that situation and also I've... I've... I've... I've heard of... and I've also been... done the investigations where family members would intervene. So people would intervene, but so often it was the... the victims that... that didn't want to be helped.

Their neighbours or it would be family members they would know what was going on. Say for instance like... like this one incident they... they had a family braai¹² and they knew usually that he... if he... if he... if he drank alcohol, then abuse would follow. So then family members... you see... so then family members were also kind of alert in that way so then they would phone the police, but... but the mother never. She never phoned the police and I don't think he would have beaten her to a pulp and she still would have."

R4 "In most cases where there is family violence and child abuse, the people will always say that they want to be anonymous... They don't want them... want the neighbours to know that they were the ones that reported the incident. So now we cannot reveal that person's name and in a case like this it becomes a bit difficult because now we cannot reveal the person... And the perpetrator normally accepts that it is the victim that reported the incident. It is very seldom that the victim will come and report the incident."

R2 "The community was involved... Ne like in my culture ne, we use to call the family... the two families to come together so that we can solve the matter ne... But the other family was not willing to come to... or the other... because the one is accusing the other family that the wife of our brother ne... is misusing... what they are... not staying with them... they don't know what's going on there inside that house... Then we as a community try to do... and establish a committee on that day so that when there's certain issues... like... like this arise... we as a committee will stand together."

R6 "the single girls no...no... no one will intervene... it's like the community feels you want to drug and you want to stay in that relationship, we not going to help you... Uh with the married couples I would say someone will try and intervene either from the church side or uhm neighbours...because there are children involved."

Respondents do note that self-report from the victim/s are very rare. But if professionals are approached for assistance, it is always linked to the severity of the violence in the home. Victims tend not to report the violence due to fear.

R7 "You know if they eventually do then that abuse has been going on for years and it takes people years to... from... from my experience... it takes it... usually takes years you know... that abuse has been going

¹² Barbeque or to grill meat over an open fire.

on for years and this woman just cannot anymore. You know... she's been denying and she's been lying for years and then she can't anymore... It's like really bad. It's like bad... because... because over the years you've tried to make things better and you've tried to look at your partner and find... figure out ways to know... to calm him down or whatever but then when you... when you... when they reach me then they are... you know... they are past... they don't care anymore.”

R3 *“I think they tend to not notify the police too because they fear further violence... further abuse uhm... and on the other hand they just... You know... it's like abused women. You know they... they stay in that abusive relationship. Uhm they feel that is the way... it's a mindset. You know they... they've been tortured and abused for so many years that it's very difficult for them to step out of it or to really speak out of it. Uhm and that makes it difficult to... to actually the report at the end of the day. They had to. They sometimes go through a lot... eventually reporting....I think it... it... it has to become a crisis. You know at the end... before there an invent... intervention being done on the part of the family, as well as because they keep everything silent. They don't disclose out of fear for their own lives. Threats may be made to them and all of that.”*

SYSTEMIC RESPONSE TO VIOLENCE IN THE HOME

Of the various systems in place to deal with family violence respondents noted that there are not only differences in response to the various family violence subsets by police, but they experience challenges linked to resources; enforcement mechanisms, and policy; when using these to address violence in the home.

R4 *“The one case that stands out to me the most is the one of last year... the incident of a woman who stabbed a man to death. She reported it five times and nothing came of it and this man used drugs and she also used alcohol. They were involved in an argument where he again became violent towards her. She stabbed him. A docket was opened for murder against her. Lucky for her, she was found not guilty. As a result... as they had to now... they now realized that she had an interdict. She reported the incident, but they could also see on record the interdict was followed through. So that thing stood out for me. That is the first one. What normally happens is the person that reports a crime will usually retract the statement, but this time she didn't retract it... and now that everything became too much for her and she had enough that she committed murder. They have now realized that there was attempts made to do something to the situation, but it wasn't correctly followed through from her side.*

... The woman had a inter...had a interdict against the perpetrator, but then she never used it. You see... or they use it... but they use it... like we would say for a 'special weekend'. They go the Friday to make a case so the person can be imprisoned for the weekend. But when it's Monday and they have to take the matter further ... then they go and say no, they are dropping the case. This is what happens in most cases.”

R6 *“I would say when there are children involved...I get the idea that there is a quicker response because you've also got this unit that we have... well they... I don't work with the children now but they would come out and they would investigate... especially when children are involved especially when its sexual abuse uhm they have their unit in this sector that does just that. When it comes to the intimate partner violence or basically*

partner abuse uhm... I think the police are a bit hesitant because of all the paper work and then on Monday morning... then the cases are withdrawn... And we usually tell these women this... That you are responsible for this slow response from the police because you do this all the time... How many times have you gone on a Friday and opened a case? and by Monday you go and you withdraw the case or pay the bail? To tell you the truth, you know, with the elder abuse I got a bit more co-operation from the police... Definitely... I think there... I got quite quick response. I think the uhm... people are just more open for... for the older persons and the children.”

As mentioned, respondents also noted that there was a lack of resources. These include satellite offices to conduct sessions safely (for practitioner and client), inadequate training on trauma rooms to conduct proper debriefing sessions, nor availability of shelters.

R1 *“I actually saw the whole family, but not the perpetrator... The guy... cause I was so scared of him. Because this guy... I don’t know if it’s... if he has an anger management problem... what it is... but he has like this... you know people with schizophrenia right?... They feel like people are constantly watching them... and then when I did the whole visit... the guy was like ...but ‘who’s this?’ ...and then the lady told him...but ...I’m her friend... And to that extent she put my life in danger because what if this guy knows that I’m a social worker? And the stuff that he does... like he doesn’t care about interdicts or all of that... and he will still go to your house and give you a beating.”*

R3 *“Where people get so frustrated... so... one so angry especially... when the victim and the uhm... and the perpetrator are... are aware of each other or become aware of each other because of the living space. And everything one tries to do deal with it uhm...as confidential as possible, but it’s not always easy. So there might be times that they listen into discussions and stuff, especially with us having no uhm... satellite offices...our own offices in the regions where we operate... So I’ve... I end up sometimes also uhm uh talking to child... Uh to do clients... getting the... into the car... you know that that... we don’t have to sit in... in the house where everybody listens into the... into the discussion.”*

R6 *“Okay we’ve got the trauma room at the police station... very nice room, fully equipped but not functional... we’ve had a few people that go there and they sit there and no one... you know... it’s there but no one will come and help them... or even just give them a cup a tea or anything like that. Those are for the rape victims and uh so on. So it’s not fully functioning... it is there! But if they are uhm... too scared to go home, they can go there. But that’s only for 24 hours ... So we haven’t got like a safe house where they can stay for two weeks or three weeks while we try and sort the situation out... so they either have to go back to mommy’s house and then a few days later go back to their own house or otherwise they’ve got nowhere to go.”*

Respondents were reflective of how policy influenced how they handled families experiencing violence in the home. Services were noted to be family-centred at one point yet this soon changed with the advent of individuated mandates and their quotas, which determined access to budgets.

R6 *“Like there worked a few years ago... where you had this whole basket of service, you know, if the father was uhm... abusing alcohol or drugs then you could get him into that program...if the mother was the victim of violence from the father... so the father would be in the substance abuse program, he would be in the parenting program, he would be in the, the perpetrator program. The mother would be in whatever we have... family programs, individual programs... so you must tackle the whole family and not only individual therapy... we also had the children violence ...children in a separate group, to also develop their skills... and we had family days and couple’s enrichment. So you worked on all levels and they were all involved. So that worked nice... and then all of a sudden we got three different programs and now we all just working on our little bits... You know, we work fragmented like this because this is the way the government is funding us. And that’s what’s so sad... You just work to get your target because they don’t want to know... did you refer this woman for uhm... to the victim empowerment program? They want to know did you... like... in my program, did you do your early intervention bit with this addict? Otherwise they not worried what happens further.*

With the subsidies they set targets and they want stats... when you do after care or treatment, then you... you focus more on the family... but what we doing now in this early intervention, they just want to know how many people did you put through this program? Not what did you do with the families and that, that to me is frustrating.”

R1 *“I only know... for this one lady I explained the cycle of violence and how it happens and she was like oh ok I’ll do it next time and all of that you know. But I don’t... Because we only focus on child protection, that is the main thing, keeping that child safe. There’s no time for you to actually do intervention with the parents you know... if there’s violence happening.”*

INFLUENCE OF VIOLENCE ON THE FAMILY

Respondents shared many examples of how violence would influence the family, such as transferring onto other family members, intergenerationally, the role family dysfunction would have on mental well-being; also how violence experienced would allocate specific roles to family members to maintain peace in the home, and not to aggravate the perpetrating family member.

R7 *“The mother eventually she... she became so dead. I don't know if she's desperate or that... she actually... she started harming the kids... that how we like... when all this was going on with the father... and the father was... the father never abused the kids. He abused the mother. You know verbally, emotionally probably financially. I don't know... I don't know about sexually but he was abusing the mother but he wasn't abusing the kids, and so what happened was that she started harming the kids. You know... like not even giving them a hiding... can't even call it a hiding like beatings. You know... and there was this one incident where the mother actually... they... remember the old stoves had those spirals ... that plates that... the boy was naughty and she took his hand, and you know, she like switched it on and she put his hand on... on the stove and the marks... You know that thing burnt into his... into his hand uhm and, and when asked about it, the school reported this incident because they could see the child's hand was swollen... and they could see immediately... they could see what it was and what happened. It was placed on there for punishment because he was naughty but uhm when asked about it... she... she could you know... she had such regret about what she had done but she said that as she had blacked out.*

She does not know what the lead to her getting as upset because obviously she didn't have any place to go with this anger... so whenever they did anything... this anger would obviously be channelled to them. So she lost control... I mean like... that thing got infected because nobody cleaned it, the state his hand was in it was just uhm... besides for the physical harm... but the emotional scars the child had afterwards, it was horrible to see."

R1 *"I spoke to her and she was like no but, this is the last time that this is the last it will happen. So I explained to her the cycle of violence and... and how that um... is prevalent in her case... and she was like okay when he does it again I'll go to the police. And on her birthday on Christmas day, he had this pitbull bite her... hit her in her face, and the daughter was screaming hysterically... but then she ran away and left her daughter with this guy just to go get help...eventually the police go and locked him up... I also went down to the police station to give my account of this case. It was a sexual abuse case...sexually assaulted his daughter, 2½ years old...so...and that is where everything came about...and I think a lot of people fear this guy... even burnt down his mother's house..."*

...Not the mother of this child, but her mother actually said that she fears for her daughter's life and her own life because this guy he would just come onto your property and beat you or does whatever he wants... because they live just around the corner ... so when her daughter runs to her house, then the guy would also come there and then there would be violence. So then that family... like where the mother is staying... he will start beating the father and he will just beating, beating, beating ... so there is just violence...the great granny told me that he come to their house the one Saturday and he just started um beating the brother or someone... and then he also had a fight with the grandfather and great grandfather. And the next day the guy died of a heart attack... that is how I would say evil... but violent this guy is."

Respondents would also acknowledge that there is an intergenerational aspect to the family experiencing violence.

R4 *"What I've realized that it's not a dispute that people cannot change. It's a dispute of us pulling the strings tighter... as to what the consequences can be. Look, certain mother's don't realize the impact that family violence has on the children. Uhm sometimes it comes from the perpetrator's side and it is now that he was influenced. In his mind... of the child, this is acceptable because look in their family where he was raised. There was never an impact. So we need to change his mindset and say that, what he knew and what he was exposed to was not right. This is not normal. The perpetrator of the family violence also needs psychological assistance."*

R6 *"I remember when I did uhm my masters, we did a whole course on... on violence... sexual violence against children uhm... and then this one uhm... lecturer we had, she actually just worked with perpetrators, and I said to her, 'I never want to do your job' uhm... but then she says you must always remember, something happened to him and if you see now, as an adult... and as a violent person... but remember sometime he was also a small child and something happened. So you have to work on both sides you can't just work on the victim."*

Also respondents noted that family dysfunction could not only alter family functioning roles but affect mental well-

being.

R6 *“Because the children already know uhm... when they... they know the body language of the father when he comes in, ‘Now I must just go and sit in my room’... Uhm... I remember this one family I had uhm ...this little girl said when the father comes in the house, then she already knows must she go and fetch his... his uhm kommetjie¹³ with warm water for his feet. So she would run... and she was about seven, eight years old... for him and then she has to wash his feet, because that relaxes him. You know... so she had her position in the house.”*

R1 *“This other family that I had intervention with... the grandmother... she told me... but well she’s seeing someone... and then her grandchild actually tried to commit suicide er... because she couldn’t take it anymore with her family... being so dysfunctional. So I think she’s twelve... ja twelve or thirteen years old. Took some of her granny’s tablets and then she fainted... and then they didn’t even take her to the doctor to pump her stomach...”*

R6 *“I’m thinking of the couples now... the wives are all on... on anti-depressant. What do they call them? They don’t say trepiline, they say ‘trepiline’. They all go for ‘trepiline’ at the...at the clinic... like a anti-anxiety... depression cover up... I don’t know.”*

SUBSTANCE ABUSE

Substance abuse was noted to appear in most of the respondents cases, however most did not attribute it a focal point but more of an ‘add on’, a way to mask much deeper issues contributing to the occurrence of family violence. Furthermore, respondents associated substance abuse at times more strongly with victim than perpetrator, with some mentioning co-dependence of victim and perp. on substance abuse as a precipitating factor which starts most family violence arguments. Also types of substance abuse were associated to particular age groups.

R1 *“I actually asked this mother of this child that was sexually abused, but does he use anything she’s like no he just smokes cigarettes and drink alcohol..And it’s like it’s not even an addition, he’s not even addicted to it. It’s just that he does it... and with the other one as well... because that mother she just drinks for days.”*

R5 *“Substance abuse is the main cause for it... and uh... if they... if they don’t have the... the funds or the means to get the substances.. they do substances other than their drug of choice, it normally methamphetamine and when they drink, they hurt each other pretty bad... It’s normally the elder people who... who will abuse alcohol and the younger will use methamphetamine or mandrax...”*

R6 *“But with the elderly it would be the perpetrators in... in intimate partner violence it most commonly the*

¹³ A small basin

husband...well the male. But with the... with the substance abuse from both sides you know, it's usually an argument about drugs... who used whose drugs? And who didn't pay for his or her share? Uhm... and no matter how much they love each other, the fight will be about the drugs. What stands out to me with the... with the substance abuse I would say... it's this uhm... co... what do the relationship... co- reliant... They rely on each other; you know... one would always see that the drug would be available. So it's... it's like this uhm... poisonous relationship.”

R7 “Substance abuse? Absolutely... absolutely... because you know it changes... it changes people. You know it makes them do things they wouldn't normally do when they are... when they are... you know... under the influence of the goods. They don't necessarily, like, tik¹⁴ you know...you don't have to be drugged to have the weirdest behaviour. You know... it's like the process... the process you know... your everyday doings. It changes people... you know completely... so substance abuse is the leading abuse of family violence in my opinion.

They don't... they don't handle emotions. Emotions is something that is being dealt with through substance abuse. People... you know... what I've encountered, people rarely talk about it. They don't have the ability. I don't know why it... or where it comes from... but people I've seen struggle to say that... to acknowledge what they are feeling, 'I'm sad today because this happened', 'I'm feeling hurt'... you know 'I'm feeling neglected'.”

R4 “In some families they cannot communicate with one another...uhm some people is in the position where they must be under the influence of substances in order for them to communicate.”

R8 “Is not just the alcohol...is not just the tik. If a person speaks to them, then you'll hear there's something else that's not right. So there must be other issues and there must be one trauma which they have...Is very seldom that it is only substance abuse. You use just because you want to use and now you are addicted to substance abuse. Some of the abuse is consistent, but it isn't the issue or challenges. It's an add on and make makes it more difficult. They will get addicted to substance and that family violence will occur. I would not say it's a big issue. People go back to their issues as they don't have someone to solve their problems. They use because they cannot solve their issues. I will say the people are devastated, as they cannot resolve them”.

PROGRAMME DESIGN AND GOAL SETTING

Respondents noted that clients are clear in setting goals and can be specific in regards to substance abuse or grants. However, in describing their 'perfect world' scenario as to what they would wish for in their family life, clients often used vague terms such as happiness or peace but would never link these to action. Thus would later end up back in session due to another incident of family violence.

¹⁴ Methamphetamine

R6 *"You know I think they all dream of what they see is the perfect house that is what is so sad this is one that I said she's always in...She's got in a... she... she reads all the romance books and things you know. So she's got in her head this idea of what the perfect husband would be and the perfect home and she would sit here and cry and say this is all I want, someone to love me, someone to care for me and someone to respect me uhm and that's not too much to ask you know. So I think most of them have got an idea even with the with their, with the single girls uhm when they come from rehab they would say uhm now I feel I... I need a new partner... I can't go back to this guy you know I need someone cause they their self-image is built up at the rehab...So they want someone better now. Uhm and as soon as they relapse then they back to the old guy. You know they feel that is what I'm worth. I think it's got a lot to do with, with self- image you know what I think I'm worth. They have an idea definitely...They dream.*

I work a lot with them on change you know if you want to change uhm what do you have to change. I've always got the saying to their, with all of them, the substance abuse, the couple, then I say everyone wants to change but not everyone is willing to change. You know why because if you willing to change you have to sacrifice somethings...Okay so if you willing to change what has to change and then we would set and say okay I can't have this boyfriend anymore, I can't go this, to the tavern or to the bar anymore, I have to change my lifestyle, I have to change my attitudes. All those and what do we have to change and then I think It's just becomes too much. You know it's easier to stay that way... than to...to change all these things. It's safer the thing that you know... even though it's not nice but its hard work to change...Especially if you've been into substance abuse for 14 years, It's so a ritual and now you must change. Uhm make new friends, have new hobbies. It's tiring, it's hard work and if you've been married for 19 years and now you say okay we going to change this relationship now, this way of communicating. It's very hard work and not everyone is committed to working on it."

R8 *"Everyone just want to be happy. No one wants to work on it. So if they say what they will do differently, then they say that they just want to be happy. Not anything specific. So you need to actually gain their trust first before you receive that specific... specific information. They just want to be happy. They just want to see change...Immediately... If you come in today, then you should solve my problem today."*

R1 *"Most people will say that the alcohol abuse or drug abuse needs to stop. But you know once people get a trigger they relapse immediately so most... I think most of the problems come from substance abuse within the family... but if this family discord... something happening like that... it's not necessarily drug abuse but that is mainly the issue within families. And I think that the fact that they not clear goals of what needs to be in the family that also confuse them because if you look at the task centred approach... if I can take the example of this family that is so dysfunctional... everyone had a task. It just worked for 2 weeks you know... and the mothers request was that the children should be home on time and they should leave her children alone and not put so much stress on them. So we worked around that... but like I said after 2 weeks it was back to square one."*

Respondents had all agreed that a family-centred approach is needed and that focusing on communication and conflict management was vital, especially if linked to other areas highlighted such as problem-solving and dealing with emotions. Also places of safety need to be linked to the programmes especially for the elderly.

R8 *“The entire family should be there. Yes. It’s like you’ve seen at the rehabilitation center. The family must be involved. Because if that person should come back then the family know what to do. He’s no longer the same person. He’s a different person. If you treat him differently you need to speak to him this is the most important for the family involved.”*

R1 *“if you can maybe look at integrating it from all the different levels like group of community work and individual case work I think that that can also be helpful because then you work a process with that people in the sense that ok this is a individual child that’s being abused and then the mother and father beat the child. Right so they slot in group work and then you can have the violent sessions where you can make people aware of the correct parenting style or alternative measures of disciplining your child. In the sense that you look at how can we stop the violence happening in the family and then from that you create a community development program or look at violent or awareness or something like to that effect.”*

R7 *“Like emotions you know learning how to deal with your emotions learning how to verbalize it to acknowledge it that it’s there and to deal with it. You know uhm problem solving skills like I have this problem do I just focus on this problem what am I gonna do actually what are the steps that I’m gonna take place or what are the steps. I’m gonna put in place to solve this problem of mine you know people need to just to, to acknowledge that they have flaws and it’s here you know also to like yourself never mind love, people don’t even like themselves and also to communicate with each other you know in a proper manner because people don’t know how to communicate you know they that’s why there’s all this shouting and screaming and hitting because for some people that’s the only way they know how to express themselves. You know so life skills. Hand out information. Uhm guidance. You know like, like maybe the focus areas could maybe be you know some just you know this big brother this mentoring programs mentoring programs like the father thing that Andries in place has even that would work wonders. You can teach the fathers how to be father’s actually and teaching the mother’s how to be mother’s. you know teaching them that kind of programs would really, would really, would really it would help families but then at the other hand uhm it will, stuff will need to happen in the community as well you know to help, help, help families to function more.”*

R6 *“To teach them communication skills and conflict management so I... I would say work on the whole family uhm with parenting skills and fatherhood and everything that we did up till now and then things broke down a bit. Uhm but concentrate on the children with interventions. Uhm to, to, to break the cycles so that you know the next generation won’t come out of uhm homes that don’t know how to handle this.”*

R3 *“You compare working with older persons in terms of their acts on a older persons comparing to the children’s act. There needs to be much more homes.. you know... places of safety to safeguard older persons...that finds themselves in terms... find themselves being neglected, abused, uhm... to have a place of safety shelter where there could be a more multi-disciplinary uh service rendered to them.”*

APPENDIX C: Questionnaire Used for Quantitative Needs Assessment

SECTION A: BIOGRAPHICAL INFORMATION

Gender		Male		Female	
Age					
Race	Coloured	Black African	White	Indian / Asian	Other
Language	English	Afrikaans	Xhosa	Other	
Work history	Employed	Unemployed	Self-employed	Volunteer	
Work area					
Work title					
Socio-economic status of work area	Low income	Middle income	High income		
Are there sufficient resources in the community to assist you in adequately addressing the needs of the families in the community?	Yes			No	
Are there sufficient referrals in the community which aid in assisting families experiencing violence?	Yes			No	
Do you receive support from the community regarding families experiencing violence?	Yes			No	
Do you receive support from government stakeholders in assisting families experiencing violence?	Yes			No	

SECTION B: FAMILY FUNCTIONING

Statement	Always	Often	Sometimes	Never
3. Families experiencing violence, collaborate together to find the best way to solve their problems.	1 (Always)	2 (Often)	3 (Sometimes)	4 (Never)
4. Families experiencing violence, talk freely about things which make them unhappy	1 (Always)	2 (Often)	3 (Sometimes)	4 (Never)
5. Family members have less time to pursue interests and hobbies, because most of their free time is spent caring for the family.	1 (Always)	2 (Often)	3 (Sometimes)	4 (Never)
6. When a family makes a decision about a problem, all family members lend a hand to carry it out.	1 (Always)	2 (Often)	3 (Sometimes)	4 (Never)
7. If family members are unhappy with the behaviour of someone in the family, they tell them and suggest better ways to get along.	1 (Always)	2 (Often)	3 (Sometimes)	4 (Never)
8. Despite the family problems experienced in the family, family members still find a little time for themselves.	1 (Always)	2 (Often)	3 (Sometimes)	4 (Never)
9. When the family has dealt with a problem in the family, they usually discuss what they have done and whether it helped.	1 (Always)	2 (Often)	3 (Sometimes)	4 (Never)
10. When family members do kind things for one another, they are thanked.	1 (Always)	2 (Often)	3 (Sometimes)	4 (Never)
11. The family members feel that it is important that everyone in the family has time for themselves.	1 (Always)	2 (Often)	3 (Sometimes)	4 (Never)
12. Family members feel it is helpful to share what they think about a problem as it seems that their opinion is taken into account.	1 (Always)	2 (Often)	3 (Sometimes)	4 (Never)
13. Family members, who are pleased with what the other says or does, feel free to let	1 (Always)	2 (Often)	3 (Sometimes)	4 (Never)

them know openly they are pleased.				
14. Family members succeed in doing what they promised they would do.	1 (Always)	2 (Often)	3 (Sometimes)	4 (Never)
15. When the family feels they have a problem, they all meet together to discuss it.	1 (Always)	2 (Often)	3 (Sometimes)	4 (Never)
16. When family members are angry with one another, they tend not to speak to one another.	1 (Always)	2 (Often)	3 (Sometimes)	4 (Never)
17. Family members manage to do some things alone without their family member.	1 (Always)	2 (Often)	3 (Sometimes)	4 (Never)
18. When the family feel they have a problem, they plan together what to do about it.	1 (Always)	2 (Often)	3 (Sometimes)	4 (Never)
19. When family members do something kind for one another, they are almost never thanked as it is not thought to be necessary.	1 (Always)	2 (Often)	3 (Sometimes)	4 (Never)
20. Family members feel that they have to deal with so many difficulties in the family that they have completely given up on their interests.	1 (Always)	2 (Often)	3 (Sometimes)	4 (Never)
21. Family members feel they can suggest solutions to problems within the family, without the worry of being criticised.	1 (Always)	2 (Often)	3 (Sometimes)	4 (Never)
22. When family members need help with something, they ask each other kindly to assist and do not make demands or orders.	1 (Always)	2 (Often)	3 (Sometimes)	4 (Never)
23. Family members feel they can meet friends outside of the family.	1 (Always)	2 (Often)	3 (Sometimes)	4 (Never)
24. Family members find it difficult to solve problems as they can never agree on anything.	1 (Always)	2 (Often)	3 (Sometimes)	4 (Never)

25. When family members do not approve of something that one of the family members had done, they tell them politely so as not to offend them personally.	1 (Always)	2 (Often)	3 (Sometimes)	4 (Never)
26. Family members can easily find interests that keep them busy.	1 (Always)	2 (Often)	3 (Sometimes)	4 (Never)

SECTION C: PERCEPTIONS AND ATTITUDES OF FAMILY VIOLENCE

Statement	Strongly disagree	Disagree	Agree	Strongly Agree
1. I ask all new clients about abuse in their relationships.	1 (Strongly disagree)	2 (Disagree)	3 (Agree)	4 (Strongly agree)
2. I believe family violence is more prevalent these days.	1 (Strongly disagree)	2 (Disagree)	3 (Agree)	4 (Strongly agree)
3. I am capable of identifying family violence without asking my client about it.	1 (Strongly disagree)	2 (Disagree)	3 (Agree)	4 (Strongly agree)
4. I do not have sufficient training to assist individuals in addressing situations of family violence.	1 (Strongly disagree)	2 (Disagree)	3 (Agree)	4 (Strongly agree)
5. Clients who abuse alcohol or other drugs are likely to have a history of family violence.	1 (Strongly disagree)	2 (Disagree)	3 (Agree)	4 (Strongly agree)
6. If victims of abuse remain in the relationship after repeated episodes of violence, they must accept responsibility for that violence.	1 (Strongly disagree)	2 (Disagree)	3 (Agree)	4 (Strongly agree)
7. I am able to gather the necessary information to identify family violence as the underlying cause of client health issues (e.g., depression, migraines)	1 (Strongly disagree)	2 (Disagree)	3 (Agree)	4 (Strongly agree)
8. Victims of abuse could leave the relationship if they wanted to	1 (Strongly disagree)	2 (Disagree)	3 (Agree)	4 (Strongly agree)

9. Health care providers have a responsibility to ask all patients/clients about family violence.	1 (Strongly disagree)	2 (Disagree)	3 (Agree)	4 (Strongly agree)
10. Alcohol abuse is a leading cause of family violence.	1 (Strongly disagree)	2 (Disagree)	3 (Agree)	4 (Strongly agree)
11. Interventions for family violence need to be more family-centred.	1 (Strongly disagree)	2 (Disagree)	3 (Agree)	4 (Strongly agree)
12. Use of drugs is related to family violence victimization.	1 (Strongly disagree)	2 (Disagree)	3 (Agree)	4 (Strongly agree)
13. I can recognize victims of family violence by the way they behave.	1 (Strongly disagree)	2 (Disagree)	3 (Agree)	4 (Strongly agree)



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APPENDIX D: Interview Schedule for Qualitative Needs Assessment

INTERVIEW SCHEDULE

1. In relation to the families you have encountered experiencing family violence, have they ever described how arguments usually started within the house?

[Prompt: If so, could you describe the incident?

What usually happens during these arguments?]

2. How long would these arguments last?
3. How would these arguments end?
4. What usually happens when the argument is over?
5. Of all the incidents you heard of relating to family violence, which one stands out for you and why?
6. During these incidents of family violence, have you ever heard of the neighbours, friends, children, or any of the family members intervene when an argument or confrontation occurred?
7. Have any of the family members affected by family violence ever told you explicitly they were afraid for their safety?
8. How has a family member described what had been happening in the home?
9. Have any of the family members ever called the police in regards to the violence occurring in the home? If so, why?
10. Do you know if any of the family members were using alcohol or drugs?
11. Has any of the family members ever revealed if anyone in the family had been treated for depression or past suicidal thoughts/attempts? *[Prompt: When, where, why?]*
12. Have any of the family members stated if they have received assistance from a social worker or any other professional in regards to what was happening at home?
13. Have any of the family members admitted if any of their family members have been arrested, imprisoned or involved with illegal activity?
14. Have the family members ever mentioned to you what in particular they would want changed in their families?

[Prompt: What would you as a practitioner like to see implemented? /would a family violence intervention including all the family members be helpful?]

APPENDIX E: Family-Centred Interventions for Intimate Partner Violence: A Systematic Review

Abstract

The effect of Intimate Partner Violence (IPV) is noted as having a spillover effect on all family members. The aim of this paper was to systematically review interventions which had been family-centred in addressing IPV. Intervention studies were systematically collected from data bases such as PubMed, BioMed Central, SABINET, SocIndex, PsycArticles, and Academic Search Complete for the time period 2005-2015. These studies were methodologically appraised, and results presented according to the RE-AIM framework. Family centred interventions focused towards IPV yielded positive results in improving parent-child interaction.

Keywords: Domestic violence, Evaluation studies (family intervention), Evidence based practice, Family Re-Unification.

Introduction

The effect of domestic violence on family members is documented in studies on intimate partner violence (IPV), child abuse, and elder abuse (Tolan-Gorman, Smith & Henry, 2006). Yet most studies fail to coalesce commonalities amongst family violence subsets, especially its effects on the family, an understanding needed for an integrated, effective response (Gracia, Rodriguez, Martín-Fernández, & Lila, 2017; Ryan & Roman, 2017). Often, when IPV occurs, family members present. These family members include parents, in-laws, siblings and children (Bassadien & Hochfeld, 2005; Rasool, Vermaak, Pharoah, Louw, & Stavrou 2002). Youth witnessing family members intentionally hurt one another, were thrice as likely to carry weapons, twice as likely to be in a fight and four times more likely to have threatened/injured someone with a weapon; than youths who had not been exposed to violence in the home (Holborn & Eddy, 2011). Women exposed to IPV in childhood, are at risk for adult revictimization of IPV (Gass, Stein, Williams, & Seedat, 2011; Ryan, Rich & Roman, 2015); with another study stating that 27% of IPV would not have occurred if boys had not been exposed to IPV (Abrahams & Jewkes, 2005). These findings hold the possibility that young people are learning violent strategies to cope with current and future domestic life. IPV needs more holistic approaches than what has been done for individualized batterer, victim or child programs addressing IPV and provide services more effectively (Sartin, Hansen & Huss, 2006; Stover, Meadows & Kantman, 2009; Tolan, Gorman-Smith & Henry, 2006; Whitaker, Morrison, Lindquist, Hawkins, O'Neil, Nesius, Mathew & Reese, 2006). Family members are noted to be present during the IPV incidents and are affected, a reality which needs to be acknowledged in interventions. A family-centred approach, which is all family members included in an intervention (Lock & Le Grange, 2013), is noted in being the best suggested method when trying to create an intervention for family violence (Tolan, Gorman-Smith & Henry, 2006). Family-centred interventions show long term success in comparison to victim or batter programs (Gillum, 2008; Stover, Meadows, & Kaufman, 2009; Sumter, 2006). This is attributed to the entire family seen as the change agent and is paramount in creating a strengthened family, equipped with family centric skills to respond healthily to various stressors.

Previous systematic reviews focusing on IPV had examined this phenomenon in relation to child and women health outcomes (Bair-Merritt, Blackstone, & Feudtner 2006; Beydoun, Beydoun, Kaufman, Lo, & Zonderman, 2012; Coker, 2007); IPV and its risk factors (Capaldi, Knoble, Shortt & Kim, 2012; Gil-González, Vives-Cases, Ruiz, Carvasco-Portiño, & Álvarez-Dardet, 2008); and IPV screening tools and programs (Rabin, Jennings, Campbell, & Bair-Merritt, 2009; O'Reilly, Beale, & Gillies, 2010; O'Campo, Kirst, Tsamis, Chambers, & Achmad, 2011). Regarding family interventions aimed at IPV, a scoping review studying family therapy and systemic interventions by Carr (2009) had largely addressed IPV in terms of community engagement. A study conducted by Rizo, Macy, Ermentrout, & John, (2011), reviewed family interventions addressing IPV over a 20 year period, but from a child-focused perspective. A family-centred intervention extends its focus beyond a particular family member, which is ideal for IPV which affects all members. A family-based intervention reduces violence in the family and enhances family functioning (Chaudhury, et.al, 2016). However few studies are noted to explore family-based interventions in relation to IPV (Chaudhury, et al., 2016).

Therefore the aim of this paper was to systematically review family-centred interventions aimed at reducing IPV. The objective was to methodologically appraise these interventions to elicit the most robust evidence-based interventions aimed at IPV reduction through a family-centred approach.

Method

The search protocol was discussed with the fellow reviewer (NR). The full search, examined titles and abstracts matching the selection criteria; were done by the first reviewer (JR) and the second reviewer (NR).

Due to limited family-centred interventions addressing IPV, broad search terms were used. Data bases utilized were PubMed, BioMed Central, SABINET, SocIndex, PsycArticles and Academic Search Complete. Limiters were adapted where necessary (certain data bases needed specificity, e.g. ‘Humans only’ studies). Search terms included family-centred, family-based, interventions, strategies, programs, intimate partner violence, gender-based violence, partner violence, domestic violence and community-based.

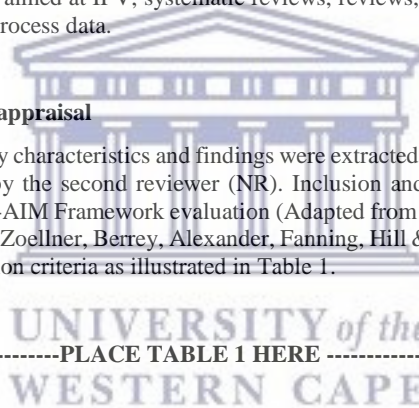
All publications which implemented interventions which were family centred and aimed at IPV, were included. Articles were searched for within a 10 year span to date of the study being done (2005-2015) and in English. A 10 year span was decided upon in order to elicit latest trends and interventions used at family level for IPV. The search protocol was developed using the PICOS framework for systematic reviews, specifically: i) Population- Family members affected by IPV; ii) Intervention: interventions aimed at reducing IPV and its effects, yet inclusive of family members; iii) Context: interventions that were community-based, offered via NGO’s, primary health care; iv) Outcomes: based on the RE-AIM framework (Reach, Effectiveness, Adoption, Implementation or Maintenance) of the intervention; v) Study Design: This was not defined to a specific study design but the studies however had to report on an intervention including process data.

The RE-AIM framework assists to facilitate development, delivery and evaluation of health interventions according to five elements, namely i.) Reach – which refers to which target population will the intervention reach and was the intervention used on the intended target population, ii.) Effectiveness – refers to the intervention achieving its objectives/outcomes, iii.) Adoption – refers to target staff or organisation adopting the intervention, iv.) Implementation – refers to consistency and adaption of intervention protocol to practice, v.) Maintenance – refers to intervention effects on participants over time (Matthews, Kirk, MacMillan & Mutrie, 2014).

Exclusion criteria included protocols, interventions focused only on one individual hence not inclusive of the family, case studies, interventions not aimed at IPV, systematic reviews, reviews, and also studies which had not reported on interventions inclusive of process data.

Data extraction and quality appraisal

Data relating to study characteristics and findings were extracted and tabulated and was performed by one reviewer (JR) and reviewed by the second reviewer (NR). Inclusion and exclusion criteria were used to clarify difference of opinion. The RE-AIM Framework evaluation (Adapted from Glasgow 1999; Glasgow, McKay, Piette & Reynolds, 2001; Blackman, Zoellner, Berrey, Alexander, Fanning, Hill & Estabrooks, 2013) was used to evaluate the interventions fitting selection criteria as illustrated in Table 1.



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Results

The results as shown in Figure 1, show a total of 18 038 potential articles were found via the electronic databases through the various search terms. After duplicates were removed and article titles were screened, 25 abstracts were retrieved. A further 18 articles were removed due to studies not fitting selection criteria as they were either reviews, case studies or only directed the intervention at one member of the family. Six articles had met the desired score of 67%-100% as per methodological quality as seen in Table 2. The data extraction of the six articles is shown in Table 3.

-----PLACE FIGURE 1 HERE-----

-----PLACE TABLE 2 HERE-----

Reach

Of the interventions, 5 were conducted in the USA (Becker, Mathis, Mueller, Issari & Atta, 2008, Ermentrout, Rizo & Macy, 2014; Graham-Bermann, Lynch, Banyard, DeVoe & Halabu, 2007; Graham-Bermann & Miller-Graff, 2015; Kan & Feinberg, 2015), and 1 in Sweden (Grip, Almqvist & Broberg, 2012). Interventions sought a diverse group of participants who either volunteered (Graham-Bermann, Lynch, Banyard, DeVoe & Halabu, 2007; Graham-Bermann & Miller-Graff, 2015; Grip, Almqvist & Broberg, 2012, Kan & Feinberg, 2015) or court mandated to participate (Becker, Mathis, Mueller, Issari & Atta, 2008; Ermentrout, Rizo & Macy, 2014). Four out of the six interventions assessed parent-child dyads (Ermentrout, Rizo & Macy, 2014; Graham-Bermann, Lynch, Banyard, DeVoe & Halabu, 2007; Graham-Bermann & Miller-Graff, 2015; Grip, Almqvist & Broberg, 2012), one study sought pre-natal couples (Kan & Feinberg, 2015), and one study incorporated two parents and child/ren (Becker, Mathis, Mueller, Issari & Atta, 2008). Majority of participants completed most of the intervention session (e.g. 7

out of 8 or 10 out 12). Most of the interventions had participants within the low-socio economic range. The interventions were conducted largely with a White racial group, with only two interventions having either an African American majority (Ermentrout, Rizo & Macy, 2014) or participants of multi-ethnic descent (Becker, Mathis, Mueller, Issari & Atta, 2008).

Effectiveness

The interventions aimed to assist families to reduce violence and minimize IPV effects; such as depression in parents and behavioral conduct in children. Intervention themes include conflict resolution and communication skills, with 4 out of the 6 studies including knowledge and awareness about family violence (Becker, Mathis, Mueller, Issari & Atta, 2008; Graham-Bermann, Lynch, Banyard, DeVoe & Halabu, 2007; Graham-Bermann & Miller-Graff, 2015; Grip, Almqvist & Broberg, 2012). Safety planning had been included in 3 of the 6 studies (Ermentrout, Rizo, and Macy, 2014; Grip, Almqvist & Broberg, 2012; Graham-Bermann & Miller-Graff, 2015). All interventions stated their aims were achieved, even though one intervention only got through 95% of their program content due to time constraints (Kan & Feinberg, 2015). Limitations noted were issues specific to the IPV population, which included custody battles which greatly affected child participant attrition (Ermentrout, Rizo & Macy, 2014; Graham-Bermann, Lynch, Banyard, DeVoe & Halabu, 2007; Graham-Bermann & Miller-Graff, 2015;), loss of housing/moving (Graham-Bermann, Lynch, Banyard, DeVoe & Halabu, 2007; Graham-Bermann & Miller-Graff, 2015); inconsistent contact information (Becker, Mathis, Mueller, Issari & Atta, 2008; Graham-Bermann, Lynch, Banyard, DeVoe & Halabu, 2007; Graham-Bermann & Miller-Graff, 2015), all of which created challenges in sample attrition, session planning and rapport building.

Adoption

The intervention settings were described as community-based with only 2 interventions stating specifically which community (Graham-Bermann, Lynch, Banyard, DeVoe & Halabu, 2007; Graham-Bermann & Miller-Graff, 2015). Recruitment occurred through the courts or health care settings (hospitals and clinics). The interventions were well-received as improvements were seen in the parent-child interaction, co-parenting; psychological distress in adults, and conduct in children (diminished aggression and delinquency) (Graham-Bermann, Lynch, Banyard, DeVoe & Halabu, 2007; Grip, Almqvist & Broberg, 2012). Interventions were facilitated by clinicians with family violence training; recruited specifically for the program. Five of the six interventions were already adopted as community-based interventions (Becker, Mathis, Mueller, Issari & Atta, 2008; Ermentrout, Rizo & Macy, 2014; Graham-Bermann, Lynch, Banyard, DeVoe & Halabu, 2007; Graham-Bermann & Miller-Graff, 2015; Grip, Almqvist & Broberg, 2012) .

Implementation

The duration of the program session ranged from 8 to 12 sessions, with sessions being 2½ hours for adults and children (Ermentrout, Rizo, & Macy, 2014). The other studies did not mention session time for child participation. Organisation members had been active in the training of facilitators and in conducting post assessment. Most of the interventions held parent and child groups separately with similar themes; except parent groups which included parenting skills/parenthood. One study addressed parenthood transition, as the target sample was pre-natal couples (Kan & Feinberg, 2015). The interventions focused on family violence education, beliefs and attitudes of family violence; emotional affect, communication; conflict management, decision-making, and focus on the self. Only one study addressed gender stereotypes (Becker, Mathis, Mueller, Issari, & Atta, 2008).

Maintenance

Only 4 out of the 6 interventions clearly indicate post-intervention follow-up (Graham-Bermann, Lynch, Banyard, DeVoe, & Halabu, 2007; Graham-Bermann & Miller-Graff, 2015; Grip, Almqvist, & Broberg, 2012; Kan & Feinberg, 2015). The remaining 2 studies either indicated that a follow-up was done, but did not state when exactly it occurred (Ermentrout, Rizo, & Macy, 2014); or only occurred on the last day of the intervention , not stating long term follow-up (Becker, Mathis, Mueller, Issari & Atta, 2008). Follow-up ranged from 6 months to a year post-intervention (Graham-Bermann, Lynch, Banyard, DeVoe & Halabu, 2007; Graham-Bermann & Miller-Graff, 2015; Grip, Almqvist & Broberg, 2012; Kan & Feinberg, 2015).

Indicators used for follow-up assessment included positive parenting (improvement in communication/parent-child relationship) and child conduct. For parents, 3 of the 6 interventions used interviews regarding program efficacy and recorded observations (Ermentrout, Rizo & Macy, 2014; Grip, Almqvist & Broberg, 2012; Kan & Feinberg, 2015). Questionnaire assessments were used in 4 of the 6 interventions namely, Beck's Depression Inventory; The Anxiety and Parental Child Rearing Styles Scales, and rating checklists (Graham-Bermann, Lynch, Banyard, DeVoe & Halabu, 2007; Graham-Bermann & Miller-Graff, 2015; Grip, Almqvist & Broberg, 2012; Becker, Mathis,

Mueller, Issari & Atta, 2008). Children's outcomes were assessed through interviews with children (Ermentrout, Rizo & Macy, 2014), interviews with parents (Grip, Almqvist & Broberg, 2012; Kan & Feinberg, 2015), and using questionnaire assessments specifically the Child Behavior Checklist (Graham-Bermann, Lynch, Banyard, DeVoe & Halabu, 2007; Graham-Bermann & Miller-Graff, 2015; Becker, Mathis, Mueller, Issari & Atta, 2008).

Five interventions had sustained outcomes at follow-up (Ermentrout, Rizo & Macy, 2014; Graham-Bermann, Lynch, Banyard, DeVoe & Halabu, 2007; Graham-Bermann & Miller-Graff, 2015; Grip, Almqvist & Broberg, 2012; Kan & Feinberg, 2015). Three of the six studies sustained positive outcomes from 8 months to 1 year post-intervention, namely reduced IPV; reduced trauma symptoms of mothers, reduced problem child behaviors, and increased child pro-social activities (Graham-Bermann, Lynch, Banyard, DeVoe & Halabu, 2007; Graham-Bermann & Miller-Graff, 2015; Kan & Feinberg, 2015). Only 1 of 6 interventions showed outcomes not sustained at 1 year post-intervention follow-up, which was attributed to screening not being done at baseline for pre-existing disorders, which may have needed an intense, individualized therapeutic process (Grip, Almqvist & Broberg, 2012).

----- PLACE TABLE 3 HERE-----

Discussion

Most of the interventions targeted mother-child dyads. Parent-child dyads and parents are sought after when looking at positive or negative experiences within the family. The parents' relationship as well as the parent-child relationship is considered connected due to the spillover hypothesis. The hypothesis indicates that if one part of the family system (e.g. parents) experiences discord/conflict, it may affect the other parts of the family system (parent-child relationship) (Levendosky, Leahy, Bogat, Davidson, & Von Eye, 2006). Mother-child dyads notably display a parent-child relationship indicative of positive or negative child outcomes (Renner & Boel-Studt, 2013).

Participants completed most of the intervention sessions, which is encouraging as high risk families often show low retention rates in intervention programs (Pereira, D'Affonseca & Williams, 2013). Furthermore 4 out of the 6 interventions had a majority White sample which may be problematic in providing an inclusive picture. Literature notes Black specifically African Americans as being most at risk for IPV (Capaldi, Knoble, Shortt, & Kim, 2012; Cho, 2012; Langhinrichsen-Rohling, Selwyn, & Rohling, 2012). Interventions which were essentially individualistic (only focusing on victim or perpetrator) had not only shown short term success, but inadvertently excluded ethnicities such as Hispanics, African Americans and Asians (Gillum, 2008; Sumter, 2006). These ethnicities are noted as being group-centred and would turn to their community (e.g. church) or family when in need (Gillum, 2008; Sumter, 2006). Family-centred interventions thus holds prospect in dealing with IPV effectively especially in reaching previously excluded demographics.

Many of the reviewed interventions were run at community level. Recruitment was mainly done from health care facilities such as clinics or hospitals, which is a common form of recruitment within IPV research (El-Khorazaty, Johnson, Kiely, El-Mohandes, Subramanian, Laryea, Murray, Thornberry & Joseph, 2007). Only two studies stated a recruitment criteria (Ermentrout, Rizo, & Macy, 2014; Graham-Bermann, Lynch, Banyard, DeVoe & Halabu, 2007).

The reviewed interventions showed themes commonly addressed within family violence (Tolan, Gormon-Smith, & Henry, 2006). Only one study reviewed addressed gender (Becker, Mathis, Mueller, Issari, & Atta, 2008), contrasting the body of knowledge which shows gender integral to interventions at individual/community level (Whitaker, Morrison, Lindquist, Hawkins, O'Neil, Nesius, Mathew, & Reese, 2006). This may be linked to a growing trend towards a gender neutral framework when understanding IPV. Gender neutral IPV frameworks stem from the American context bringing parity to the female perpetration/male victimization cases of IPV (Reed, Raj, Miller, & Silverman, 2010). This may prove challenging as women and girls are still the most likely to be killed/injured by a male intimate partner, the most at risk more than any other class of individual (Reed, Raj, Miller, & Silverman, 2010). Disregarding gender inequality within IPV is a missed opportunity to explore deeply entrenched gender-power abuses occurring in the lives of women and girls (Reed, Raj, Miller, & Silverman, 2010).

Program sessions would range from 8 to 12 sessions, being $2\frac{1}{2}$ hours for adults and children (Ermentrout, Rizo & Macy, 2014). Generally there is no prescribed time duration for interventions, due to flexible implementation regarding IPV (Eckhardt, Murphy, Whitaker, Sprunger, Dykstra & Woodard, 2013). Though not time prescriptive, facilitators would necessitate that at least one risk topic is covered in a session (Katz, Blake, Milligan, Sharps, White, Rodan, Rossis, & Murray, 2008).

Interventions indicating long term follow-up such as 8 months (Graham-Bermann, Lynch, Banyard, DeVoe & Halabu, 2007; Graham-Bermann & Miller-Graff, 2015) to 1 year (Kan & Feinberg, 2015), sustained long-term positive outcomes. These positive outcomes included reduced IPV, reduced trauma symptoms of mothers, reduced problem child behaviors and increased child pro-social activities (Graham-Bermann, Lynch, Banyard, DeVoe & Halabu, 2007; Graham-Bermann & Miller-Graff, 2015; Kan & Feinberg, 2015). A finding affirmed by literature, which states family-centred approaches do facilitate long term success especially in comparison to batterer programs (Gillum, 2008; Stover, Meadows, & Kaufman, 2009; Sumter, 2006). The similarities of these interventions were that these interventions used a randomized control trial (RCT) study design, used broad reaching recruitment techniques, and focused their co-leader facilitators to act as role models in addition to facilitating the sessions and providing educational material.

Strengths and limitations

The study may be the first systematic review focusing on the family to address IPV. Additionally, the study also aimed to investigate the efficacy of a family-centred approach in reducing IPV and its affects. The study utilized a rigorous process to ascertain the strongest methodological studies, used more than one reviewer to facilitate the process; also using broad terms in the search. This robust process was done to be inclusive of diverse families, nationalities and context. However, limitations include interventions reporting largely on developed countries and consisting of a majority White racial demographic; limiting generalizability of findings. Furthermore, these limitations may also highlight a potential lack in reporting intervention process information of developing countries or a lack of family-centred interventions taking place in developing countries regarding IPV.

Recommendations

Future considerations should include intervention process information be clearly stipulated. Clear strategies need to be formulated in order to produce adequate follow-up data. These considerations may provide future interventions with a blue print in creating context and needs sensitive interventions.

None of interventions followed a clear format in reporting and presenting intervention information and results, making it challenging in consistent comparison. It is hoped this systematic review would present the RE-AIM framework not only as a tool but a structure to report intervention information in such a way as to allow easy translation of evidence.

Conclusion

Family-centred interventions focused towards IPV yielded positive results not only on an individual level but also at a family systemic level in improving parent-child interaction. This merits the possibility that family-centred interventions addressing IPV can maintain long term positive outcomes and can be adopted and sustained in diverse communities.

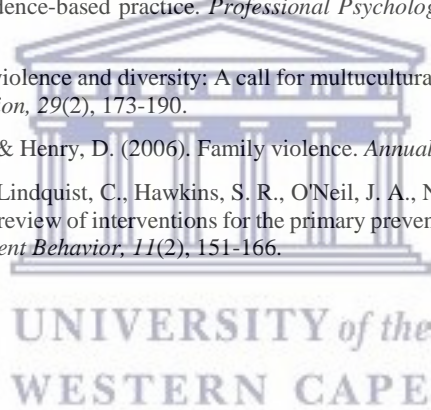
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APPENDIX F: Family-Centred Interventions Addressing Child Abuse: A Scoping Review

ABSTRACT

Child abuse affects close to 300 million children as young as age 3-4. Child abuse not only inhibits child development but has consequences which extend well into adulthood. There are interventions used within child welfare services to address child abuse/ maltreatment, however majority of interventions are in the best interest of the children (child-centred) instead of balancing the needs of the family with that of the child, by working with the family (Family-centred). This study sought to identify family-centred interventions directed at child abuse/maltreatment through a scoping review, and highlight the key components of these interventions. For the purpose of the scoping review, data was systematically collected from databases which included Health Source: Consumer Edition and PUBMED as well as peer-reviewed journals. A total of 10654 prospective articles had been found. After 320 duplicates were removed, 29 titles were screened as eligible, of which 5 abstracts were deemed relevant to the study. The RE-AIM framework had been used to disseminate results, to allow for cross-comparison of core components within the relevant interventions. Family-centred interventions aimed at child abuse and neglect yielded positive, long term results not only for parent-child interaction as well as improving sibling relations.

BACKGROUND

Child abuse or maltreatment is defined as all forms of physical/emotional ill-treatment, sexual abuse, neglect or negligent treatment, commercial or other forms of exploitation; resulting in the actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power (Radford, Corral, Bradley, Fisher, Bassett, Howat, & Collishaw, 2011; WHO, 2002). Child abuse has extensive and far-reaching consequences which not only inhibits development but extends into adulthood. Consequences of child abuse include disruption in brain and nervous/immune system development, which has been linked to extreme stress; physical injury; school failure, conduct disorder, depression and suicide; increased risk in engaging with high risk behaviors, such as substance abuse and high risk sexual behavior; sexually transmitted diseases, HIV or unintended pregnancies; other health risks such as heart disease or obesity (Scott, 2009; WHO, 2016).

Child abuse is stated to affect close to 300 million children aged 3-4 (UNICEF, 2017). Many children are also indirectly affected by violence in the home, as around 176 million children under the age of 5, live with a mother who is a recent victim of intimate partner violence (IPV) (WHO, 2017). Child exposure to IPV increases the risk of intergenerational transmission of domestic violence, especially in the form revictimization (Renner & Slack, 2006; Ryan, Rich, & Roman, 2015). Exposure to IPV often co-occurs with child abuse and maltreatment, resulting in greater aggression and delinquency, difficulty in regulating emotions as well as managing social interactions (Haselschwerdt, Savasuk-Luxton, & Hlavaty, 2017). The co-occurrence of IPV and child abuse potentially affects the child's attitude and belief about violence regarding its place in relationships and as a form of conflict resolution (Grogan-Kaylor, Stein, Clark, Galano, & Graham-Bermann, 2017; Haselschwerdt, Savasuk-Luxton, & Hlavaty, 2017). Furthermore, UNICEF notes acceptance of violence against children as problematic, with 1.1 billion caregivers (1 in 4) admitting to physical punishment as an acceptable form of discipline (UNICEF, 2017). However corporal punishment goes unchecked, as only 60 countries have signed legislation prohibiting the use of corporal punishment in the home, leaving almost 600 million children under the age of 5, without full legal protection (UNICEF, 2017).

There are interventions used within child welfare services to address child abuse/ maltreatment or prevent out-of-home placement, however majority of interventions are in the best interest of the children (child-centred) instead of balancing the needs of the family with that of the child, by working with the family (Family-centred) (Dubowitz, 2013). The difference between child focused and family centred, is the child focused approach entails the professional providing the family with a plan of care, being prescribed by the professional to the parent in the form of one way communication ; with all differences seen in parents determined as in conflict with the child's best interest (Burns, Dunn, Brady, Starr & Blosser, 2008). This is in contrast to a family-centred approach which creates a collaborative relationship where family needs are balanced with the best interest of the child; parental input on plan of care is encouraged, with each family treated as unique instead of prescriptive to a specific group (Burns, Dunn, Brady, Starr & Blosser, 2008). In cases of extreme high risk situations, immediate action is expected, yet for long term results a family-centered approach is best suited as opposed to a child focused approach which is seen as a short term reprieve (Burns, Dunn, Brady, Starr & Blosser, 2008). This study sought to identify family-centred interventions directed at child abuse/maltreatment through a scoping review, and highlight the key components of these interventions. Implementation research evaluating both procedural and theoretical adherence to the family-centred practice principles is noted as much needed, especially within child welfare services (Lietz, 2011).

METHOD

Data was systematically collected from databases namely, Health Source: Consumer Edition; PUBMED, PsychArticles; SocIndex, and Academic Search Complete. Additionally, child relevant; peer-reviewed journals were also searched; such as African Safety Promotion: A Journal of Injury and Violence Prevention, South African Journal of Psychology; as well as Child Abuse and Neglect (Elsevier). Searches were done for the period 2007-2017, which was within the 10 year period of relevant literature to the date of study.

Search terms included child maltreatment, child abuse; child neglect, family intervention/s; parent-child centred, family wellness; family approach, and community-based. The titles and abstracts of the literature identified for this study were screened by two researchers independently using the inclusion criteria as stated below. The full text articles that were potentially relevant to the systematic study were retrieved and screened by one researcher (JR) with secondary screening done by another researcher (NR) using the same inclusion criteria in order to determine eligibility of the studies for this study.

Inclusion criteria were i) English, intervention studies, ii) full text articles, iii) from 2007-2017, iv) intervention studies about humans only and v) studies must speak to addressing child abuse specifically from a family-centred approach. Exclusion criteria included consensus studies, studies using secondary data, studies which did not show a programmatic layout beyond just screening, protocols, interventions focused only on one individual hence not inclusive of the family, case studies, interventions not aimed at child abuse, systematic reviews, and reviews. Initial search was conducted by one researcher, yielding a total of 10654 prospective articles, which had the search terms in their titles, keywords and abstracts. Titles and abstracts were screened by the same researcher. After 320 duplicates were removed in searches, 29 titles were screened as eligible of which 5 abstracts were deemed relevant to the study. The search process, titles, and abstracts underwent secondary screening by another researcher who acted as first reader.

Interventions use varied methods, as well as varied assessments in delivery and evaluation. The RE-AIM framework had been used to disseminate results to allow for cross-comparison of core components inherent in health promotion interventions.

The RE-AIM framework assists to facilitate development, delivery and evaluation of health interventions according to five elements, namely i.) Reach – which refers to which target population will the intervention reach and was the intervention used on the intended target population, ii.) Effectiveness – refers to the intervention achieving its objectives/outcomes, iii.) Adoption – refers to target staff or organisation adopting the intervention, iv.) Implementation – refers to consistency and adaption of intervention protocol to practice, v.) Maintenance – refers to intervention effects on participants over time (Matthews, Kirk, MacMillan & Mutrie, 2013). Data extraction according to these elements is shown in Table 1.

----- PLEASE INSERT TABLE 1 HERE-----

RESULTS

Reach

The interventions sought families (Jouriles, McDonald, Rosenfield, Norwood, Spiller, Stephens, Corbitt-Schindler, & Ehrensaft, 2010; Travis, Heyman, & Smith, 2015), parent-child dyads (Linares, Jimenez, Nesci, Pearson, Beller, Edwards, & Levin-Rector, 2015; Schneider-Muñoz, Renteria, Gelwicks, & Fasano, 2015); with one intervention aimed specifically at heterosexual couples expecting their first child (Kan & Feinberg, 2014). The average age of participating parents were about 28 years for mothers (Jouriles et al, 2010; Kan & Feinberg, 2014), and 29-30 years for fathers (Kan & Feinberg, 2014). Of the reviewed studies which provided child age groups, the average age was indicated to be between 7.2 years and 9.7 years of age (Linares et al, 2015). One study states, of 35 participating families, 23 were single-mother families (Jouriles et al, 2010). Children were either mostly male (Kan & Feinberg, 2014) or 26% male and 37% female as well as mixed sibling pairs respectively (Linares et al, 2015). Where racial demographics were identified, the reviewed studies showed majority of participants to be African American (Jouriles et al, 2010; Linares et al, 2015); only one study noted 90-91% of participants being 'non-Hispanic White' (Kan & Feinberg, 2014). Participants were referred by child protection/welfare agencies as well as foster care agencies (Jouriles et al, 2010; Linares et al, 2015; Schneider-Muñoz et al, 2015). One study which looked at military personnel, did not specifically state who had referred the cases, only that upon allegations of maltreatment, the family would be mandated for an intake interview (Travis, Heyman, & Smith, 2015). Reasons for intervention referral were linked to neglect and maltreatment (Linares et al, 2015; Travis, Heyman, & Smith, 2015) or specifically physical abuse (Jouriles et al, 2010).

Effectiveness

The reviewed studies showed families completed most of the program sessions. According to Jouriles et al (2010), 11 out of 17 families completed 11 out of the 12 parenting skills facilitated through the program. The remaining families only completed half of the parenting skills (6/12 parenting skills) (Jouriles et al, 2010). Of the programs presenting 8 sessions, on average 5-6 sessions were completed (Kan & Feinberg, 2014; Linares et al, 2015); with 85% children and 62% parents regularly attending sessions and an overall program attendance of 73% (Linares et al, 2015). Dropout rates show 2 couples before the intervention and 37 couples at follow-up (Kan & Feinberg, 2014). Of the reviewed studies, program outcomes include reductions in 1.) mothers' perceived inability to manage children's behaviour, and, 2.) harsh, ineffective parenting (Jouriles et al, 2010). Additionally, post-natal parenting showed 'inoculation' from pre-birth intimate partner violence and its effects (Kan & Feinberg, 2014). In another study, a strengthened ability of foster parents to nurture positive sibling relationships was seen (Linares et al, 2015). Improvement in children attending these programs, include reduced sibling conflict and enhanced sibling interactions (Linares et al, 2015). Overall families had shown a marked improvement, in comparison to families invited to participate in the family-centred program, but refused (Schneider-Muñoz et al, 2015). Limitations noted by the reviewed studies were small samples sizes; bias related to participants, staff, and sample selection; and the use of home-visitation which may not be feasible for resource-strapped agencies (Jouriles et al, 2010; Kan & Feinberg, 2014; Linares et al, 2015; Schneider-Muñoz et al, 2015).

Adoption

The intervention setting is not clear in 3 of the reviewed studies (Kan & Feinberg, 2014; Schneider-Muñoz et al, 2015; Travis, Heyman, & Smith, 2015). However 2 of the reviewed studies stated the intervention setting was home-based (Jouriles et al, 2010) or within New York City where the recruitment took place (Linares et al, 2015). Most of the interventions made use of trained facilitators who were either masters-level practitioners (Jouriles et al, 2010; Linares) or trained specifically for the program (Kan & Feinberg, 2014; Schneider-Muñoz et al, 2015). Outsourcing of family services were utilised in one study, if services could not be provided by the program itself (Travis, Heyman, & Smith, 2015). Whether the programs in the reviewed studies had been adopted by other organisations, at state/community level or by the participants, had not been explicitly stated.

Implementation

The intervention layouts varied across studies. Two studies described their programs as consisting of 8 sessions (Kan & Feinberg, 2014; Linares et al, 2015), one study of which described them as 90 min, weekly sessions (Linares et al, 2015). A further 2 studies did not have a specific amount of sessions planned, but were theme or needs focused. These themes comprised of sessions completing 12 parenting skills (which included attentive/non-directive play; listening to and comforting the child; contingent praise and positive attention; appropriate instructions/commands; contingent negative consequences for noncompliance/aggressive behaviour) over an eight month period (Jouriles et al, 2010); or worked on specific family needs within a family conferencing format (Schneider-Muñoz et al, 2015). Overall themes covered by the reviewed interventions included co-operation; problem-solving; self-regulation; and addressing barriers/challenges in the home (Jouriles et al, 2010; Linares et al, 2015; Schneider-Muñoz et al, 2015). Techniques incorporated to carry out themes were role plays; written materials; coaching; and positive feedback (Jouriles et al, 2010; Kan & Feinberg, 2014; Schneider-Muñoz et al, 2015). One of the studies stated 52% of the program time had been dedicated to the parenting component of the intervention, which focused exclusively on decision-making and problem-solving (Jouriles et al, 2010). Only one study did not provide information about program treatment, as incidents were dealt with on a case-by-case basis (Travis, Heyman, &

Smith, 2015).

Maintenance

Follow up ranged from 4 to 16 months post intervention (Jouriles et al, 2010; Kan & Feinberg, 2014; Schneider-Muñoz et al, 2015). Indicators used were observational data as well as interview and questionnaire assessments. Observational data was obtained through home-based interviews as well as video-taped interactive sessions between parent and child (Jouriles et al, 2010; Kan & Feinberg, 2014; Linares et al, 2015). Observational data sessions were noted to be 45 minutes (Jouriles et al, 2010). Questionnaire assessments included subscales from the Parental Locus of Control Scale and the Revised Conflict Tactic Scale (Jouriles et al, 2010); as well as the Sibling Indication Quality Scale, Conflict Checklist, and Sibling Aggression Scale (Linares et al, 2015). One study used their referral source to see if any new cases of maltreatment had been reported (Schneider-Muñoz et al, 2015). Overall 4 out of the 5 reviewed studies showed sustained positive long term effects of the interventions (Jouriles et al, 2010; Kan & Feinberg, 2014; Linares et al, 2015; Schneider-Muñoz et al, 2015), of which 1 showed no statistical significance (Jouriles et al, 2010). Only 1 of the 5 reviewed studies did not explicitly state follow up results; cases are either closed once recommendations are carried out, or cases are listed as unresolved if offenders are non-compliant (Travis, Heyman, & Smith, 2015).

DISCUSSION

The focus of the review was to identify family-centred interventions directed at child abuse/maltreatment and highlight the key components of these interventions. Though families were sought for the interventions, mainly mother-child dyads were noted. Mother-child dyads are shown to be the most telling in terms of parent-child relationships which outline negative or positive outcomes for children; as the maternal relationship determines types of attachment the child forms, as well as has a stronger intergeneration transference link in terms of child maltreatment and IPV (Jonason, Lyons, & Bethell, 2014; Renner & Boel-Studt, 2013). The demographic of these interventions were given, showed majority African American participation in comparison to only one study showing a majority White participant base. An African American majority in participants is an appropriate representation in accordance to literature. Child maltreatment is noted to be prevalent amongst African American families, especially when linked to harsh parenting (Dubowitz, Kim, Black, Weisbart, Semiatin, & Magder, 2011; Gershoff, Lansford, Sexton, Davis-Kean, & Sameroff, 2012). The interventions were well attended, with families completing most of the sessions. Parent participation in child interventions is regarded as the hallmark of a gold standard (Kemp, Marcento, Hoagwood, & Vesneki, 2009). For one intervention, most of the sessions addressed parenting (Jouriles et al, 2010), which may be linked to maltreating parents who actively participate in family-centred interventions show lower rates of reabuse; as opposed to child-centred interventions devoid of acknowledging the complex and multiple needs of the family (unemployment, substance abuse, violence etc.) (Bromfield, Sutherland, & Parker, 2012; Kemp, Marcento, Hoagwood, & Vesneki, 2009). However, parental engagement in child services are noted as low and infrequent and a clear challenge, with parent and child services usually held separately, creating missed opportunities for parent-child interaction (Kemp et al., 2009; Lochman & Van Den Steenhoven, 2002). The reviewed studies showed consistent attendance which bodes well, as high risk families show low retention rates in interventions (Pereira, D'Affronessa, & Williams, 2013). Parents and children in attendance showed marked improvement. Parents were noted in improving parenting ability and children were shown to display improved behaviour and interactions with siblings, outcomes consistent with interventions which used a family-centred approach (Lochman & Van Den Steenhoven, 2002; Spoth, Clair, Greenberg, Redmond, & Shin, 2007). In two studies, interventions were noted as home-based, with the remaining studies not clearly stating the intervention setting. Home-based interventions regarding child abuse had been documented since the 80's (O'Reilly, Wilkes, Luck, & Jackson, 2010) however its feasibility especially with resource-strapped NGO's is problematic (Azzi-Lessing, 2011). Facilitators used were either tertiary level educated or trained specifically for the program. However to provide tertiary educated facilitators with additionally training, will capacitate them not only with expertise, but the ability to translate those experiences and knowledge to respondents, while being grounded in best practice (Lee & Nichols, 2010). Furthermore, when facilitators are provided with supervision, they are more prepared to deal with expected and unexpected challenges concerning program delivery (Lochman & Van Den Steenhoven, 2002). Though two of the interventions had specific amount of sessions, two other interventions were mainly theme or needs focused, which spanned over 8 months. The sessions noted by the interventions, which had structured them according to a specific amount, were not different to trends followed by short term family interventions; which ranged from 6-10 sessions, averaging $1\frac{1}{2}$ to 2hrs in length (Rockville, 1999). These sessions were not conducted more than twice a week, to allow time to practice new behaviors and experience change (Rockville, 1999), equating to what we see in the findings. Themes noted in the interventions were normally addressed in family violence interventions (Tolan, Gorman-Smith, & Henry, 2006). Most of the reviewed studies showed sustained long term positive results which resonate with outcomes associated to the family centred approach; showing a collaborative partnership between family and professional. A family centred approach allows challenges presented to provide contextual explanation rather than individual blame; focus is given to what is happening in the family rather than what is "wrong" with the family, hence through this holistic engagement, adequate support is given (Bromfield, Sutherland, & Parker, 2012; Burns, Dunn, Brady, Starr & Blosser, 2008).

Implications for practice

Interventions which are inclusive of the family needs are shown to be culturally sensitive as well as adaptive to the family context (Gillum, 2008; Sumter, 2006; Yasui & Dishion, 2007). Interventions are usually a fixed, maualized programme following a European American perspective of child development; an etic approach examining universal/pancultural principles, where differences are found at individual level and not group (Yasui & Dishion, 2007). A move to create interventions which link cultural diversity issues to empirically supported interventions would mean interventions which tailor towards the needs of the individual child with that of the family; an emic approach which provides flexibility to cater towards diversity, whilst retaining the etic science (Yasui & Dishion, 2007). Families provide vital information essential to valid assessments and appropriate intervention planning (Kemp, Marcenko, Hoagwood, & Vesneski, 2009). This vital information refers to parental knowledge of children, family circumstances and cultural context (Kemp, Marcenko, Hoagwood, & Vesneski, 2009). Implementing a family-centred approach will create strengthened partnerships between family and caseworker/practitioner, which in turn will better facilitate sustained positive change (Bromfield, Sutherland, & Parker, 2012; Kemp, Marcenko, Hoagwood, & Vesneski, 2009). In addition, the strengthened partnership between practitioner and family can better assist families to navigate their way around other needed social services; but also aids in families complying with caseworker expectations for positive outcomes, as parents feel they can manage parenting responsibilities and better understand their children's development needs (Bromfield, Sutherland, & Parker, 2012; Kemp, Marcenko, Hoagwood, & Vesneski, 2009).

CONCLUSION

Family-centred interventions aimed at child abuse and neglect yielded positive, long term results not only for parent-child interaction as well as improving sibling relations. This posits the possibility that family-centred interventions addressing child abuse and maltreatment can maintain long term positive outcomes, improve family functioning, and can be adopted and sustained amongst diverse families and context.

DECLARATION OF CONFLICT OF INTEREST

None to declare

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APPENDIX G: Family-Centred Interventions for Elder Abuse: A Narrative Review

Elder abuse has been difficult to define, let alone holistically understand (Ferreira & Lindgren, 2008). However, elder abuse is commonly understood to be a single/repeated act, or lack of appropriate action, occurring within any relationship which embodies an expectation of trust, which causes harm or distress to elderly individual (WHO, 2002; Tolan, Gorman-Smith, & Henry, 2006).

In elder abuse, the relationship of trust usually entails the family, as it family members who are noted to be the most likely perpetrators of elder abuse (Berkman, 2006; Soares, Barros, Torres-Gonzales, Ioannidi-Kapolou, Lamura, Lindert, De Dios Luna, Macassa, Melchiorre & Stankūna, 2010). Research has identified that there is an interconnected relationship between the elderly and their family, with the family not only being a source of care but also abuse (Bookman, & Kimbrel, 2011; Berkman, 2006; Soares, Barros, Torres-Gonzales, Ioannidi-Kapolou, Lamura, Lindert, De Dios Luna, Macassa, Melchiorre & Stankūna, 2010). About 4-6% of seniors experience abuse in the home, and over a third of family carers reporting perpetrating abuse (Cooper, Selwood & Livingston, 2008; Sethi, Wood, Mitis, Bellis, Penhale, Marmolejo, Lowenstein, Manthorpe, & Kärki, 2011). Cases of family carers perpetrating abuse have been attributed to carer stress and therefore the majority of family interventions are aimed at reducing the stress of carers (Cooper, Selwood, Livingston, 2008; Tam & Neysmith, 2006). In a systematic review focusing on interventions for elder abuse, only one fourth of the results showed interventions aimed towards family caregivers, with most studies showing an intervention aim towards professionals (Ploeg, Fear, Hutchinson, MacMillan, & Bolan, 2009).

In understanding that elder abuse occurs mostly within the family, it seems misaligned that majority of elder abuse interventions focus on bolstering social services, service delivery and knowledge of elder abuse (Daly, Merchant, & Jogerst, 2011; Jagielska, Piłkuła, Łukasik, 2015, Pillemer, Mueller-Johnson, Moch, Suitoer & Lachs, 2007). Furthermore, service delivery or public services are notably individual-orientated than family or community focused (Parra-Cardona, Meyer, Schiamberg & Post, 2007). Thus, in order to reduce elder abuse, the focus should be a family-centred approach bolstering family functioning and well-being.

A family-centred approach means the family is not only included in the intervention, but partakes in the formation of the intervention, allowing the program to be needs sensitive to the specific family. Hence, a family-centred approach creates a collaborative relationship between families and professional whereby family input is encouraged and each family is treated as unique, instead of prescriptive to a specific group (Burns, Dunn, Brady, Starr & Blosser, 2008). This view of family as a collaborator and unique in structure and functioning, denotes an efficient way to address elder abuse; as elder abuse is grounded in cultural and social contexts (Gair, 2015), which has lead abuse and neglect to always be interpreted differently across cultures and context. A family-centred approach is an adequate and holistic response which acknowledges the role of family in elder abuse and its subsequent solution. It is for this reason we needed to determine what family-centred interventions addressing elder abuse were available and how this could map out possible solutions for future interventions. The aim of the paper was thus to identify family-centred interventions used to address elder abuse.

METHODS

Databases searched included Google Scholar, Academic Search Complete, PubMed, SocIndex, MEDLINE, PsychARTICLES and Research Gate. Search terms included elder abuse and neglect, community-based, family, family interventions, family-centred and family-based interventions. The interventions sought were in English as well as searched from within an 11-year time frame from date of study (2006-2017) to elicit latest trends. Articles seen to relate to the search terms, were assessed via titles, abstracts as well as article content. Articles sought for this review had to be family-centred interventions with a primary aim to address elder abuse. The interventions had to have included the elderly and at least the family caregiver. Furthermore, the intervention was to go beyond screening but also include a program referral plus a description of the program layout, with the program potentially to be implemented at community level. Furthermore, a systematic review of citations for elder abuse (Erlingsson, 2007) had been referred to in order to identify specific journals which would yield results in offering more articles in terms of family-based interventions.

RESULTS

In total 34 929 hits were found via the databases. This total excludes Research gate results, as Research gate does not provide an exact number of hits. Only 3 articles were identified via title with 1 identified through Research

Gate. Of the 4, 1 was later excluded due to the intervention not aimed primarily at elder abuse. In total only 3 articles were identified as family-centred interventions aimed at primarily addressing elder abuse. The family-centred interventions were conducted in Israel, Iran and in the United States with the Native American community.

The results had been analyzed according to the RE-AIM framework. The RE-AIM framework assists to facilitate development, delivery and evaluation of health interventions according to five elements, namely, 1.) Reach – which refers to which target population will the intervention reach and was the intervention used on the intended target population, 2.) Effectiveness – refers to the intervention achieving its objectives/outcomes, 3.) Adoption – refers to target staff or organisation adopting the intervention, 4.) Implementation – refers to consistency and adaption of intervention protocol to practice, 5.) Maintenance – refers to intervention effects on participants over time (Matthews, Kirk, MacMillan & Mutrie, 2014). These RE-AIM elements will not only highlight vital aspects of the intervention but allow for comparison. These interventions will be looked at individually and later coalesced to deduce trends within family-centred interventions directed at elder abuse.

Israel

A multi systemic approach had been used with services provided to victim, perpetrator, and family as well as community awareness as described by Lowenstein & Naim (2015).

Reach

The initiative is aimed at the elderly and their families (these include victim, perpetrator and their families), with the participants choice to include community members as well. No specific age criteria had been given but abuse would have had to have been identified by the interdisciplinary violence committees established in hospitals. These cases are then linked to support in the clients respective communities for continuity of care.

Effectiveness

Efficacy of the intervention is not explored as the article only described the intervention and had not carried it out with a specific group. Therefore, limitations, attrition and specific outcomes had not been reported.

Adoption

The intervention was inspired by a national initiative instituted by the Israeli ministry of health for professionals within the health system to identify, report, and provide recommendations for elder abuse of which continuity of care needs to be established with relative community services. The intervention which is a multi-systemic model had been created by the Unit for Services for the Elderly within the Ministry of Welfare, the National Insurance Institute and the Association for Planning and Development of Services for Aged in Israel. The setting in which the model is described is in the cities of Afula, Nazareth and Yezreel Valley, which contain municipalities which have Violence Prevention Units which implement the model. Those that facilitate the program as well as create each program include social workers, legal advisors, geriatrists and psychiatrists.

Implementation

The process begins with an elder abuse intake team which consists of an internal consultation team of the community and welfare unit in the regional council and not only acted as the diagnostic tool but helped build a program for the various cases. The procedure in which this was to be conducted was dependant on the various regional councils. Yet the format would usually consist of the case being discussed with the multidisciplinary team in the presence of the family. The multidisciplinary team is an expanded team consisting of a legal advisor and geriatrist/psychiatrist. A choice is given to the family if they would like community members involved in the intervention or prefer anonymity by working solely with a social worker. The communities also had their support and resources bolstered through training courses offered on elder safety and welfare as well as have loneliness, violence and other age related issues reduced by means of 'settlement support programs'.

Maintenance

Follow-up had not been given as the article described the intervention model and not carried it out.

Iran

The intervention unpacked by Khanlary, Maarfrand, Biglarian & Heravi-Karimooi (2016) is the family-based cognitive behavioral social work intervention.

Reach

The intervention targeted the elderly aged ≥ 60 years, who have experienced at least one form of abuse as measured according to the Domestic Elder Abuse Questionnaire (DEAQ) as well as their families. All potential participants should not have participated in any family or individual based intervention and both elders and family members would have to be willing to participate. Overall 30 participants and their families were enrolled with 3 families later excluded due to reasons undisclosed yet which contributed for participants not participating in more than two-thirds of the sessions. Of the participants, 85.2% were male, with 59.2% living with their families in households of 3-4 individuals. All participants reported at least one type of abuse with 77.8% reporting their children to be the main abusers.

Effectiveness

The aim of the study was to test how effective family-based cognitive behavioral social work would be in reducing elder abuse. The intervention had been reported to reduce all forms of elder abuse except for physical abuse. Limitations noted were a small sample size and lack of long-term follow-up (3-6 months).

Adoption

Recruitment was noted to take place in a social security retirement association within Karaj, Iran with an announcement distributed in the Social Security Pensioners Club in Karaj. However, it is not clear if these associations provided the setting for the intervention to be conducted. It is not explicitly stated if the intervention is widely used already by organisations or state or who delivered or facilitated the program.

Implementation

The intervention was noted as a 5 session program. The program covered themes such as neglect and alternative behaviors, principles of elderly care giving, and principles and techniques of conflict resolution. Techniques used was ice-breakers (first sessions), cognitive restructuring, modeling and role playing, guided discovery and brainstorming. Homework assignments were given at the end of each session, with these assignments reviewed at the start of the next session. Facilitators for the program had not been stated.

Maintenance

A 30 day follow up was done where 5 participants were evaluated on the DEAQ which used variables highlighting the different forms of elder abuse such as emotional neglect, care neglect, financial neglect, curtailment of personal autonomy, psychological abuse, physical abuse and financial abuse. No long term follow up had been conducted (3, 6 or 12 months post-intervention). The intervention reduced all forms of abuse except for physical abuse which showed no significant difference before and after the intervention.

United States

The Family Conference Care (FCC) as accounted by Holkup, Salois, Trip-Reiner & Neinert (2007), is an elder-focused, family-centred, community-based intervention which involves family members, family-nominated supportive community members, spiritual leaders if desired, and the relative social service provider.

Reach

The Family Care Conference (FCC) was aimed at Native American families living on the reservations experiencing elder mistreatment. It targets the elders who have been mistreated, their family, but also includes family-nominated supportive community members, spiritual leader if desired as well as related health and service providers. Initially 26 families were referred for the intervention, with 3 families excluded due to high risk, 12 families deferred or

resolved their issues another way. Ultimately 10 families participated.

Effectiveness

Whether the 10 families who participated reached resolution is not directly unpacked but is described in having followed through with the meetings. Only 1 family is noted pending outcome. Limitations are not addressed.

Adoption

The FCC used in this study is an adapted version initially created by the Maori people in New Zealand to address child welfare in a way that would not undermine families and traditional values. The FCC had been an elder well-being and safety 5-year community-based participatory research project started by The Caring for Native American Elders Project. The FCC has now been adopted by the Community Health Representative Program, a program which has an established relationship with the reservation community, who will run it as a community-based project with the research team providing technical assistance. The FCC had hired and trained 3 tribal women from the reservation to serve as facilitators. The facilitators had a long history as tribe members, and not only understood the communities norms, family variations of assimilation and traditionalism but the facilitators were also respected by the communities on the reservation.

Implementation

The FCC consists of 6 stages. Stage one are the referrals obtained from elder protection programs, community health representative programs, the housing authority, domestic violence programs, tribal court, child protection as well as from the community and concerned family members. The second stage is the screening of the families with families with a high potential of violence excluded and immediately referred to the Elder Protection program for further evaluation and assessment. The third stage relates to engaging with the family. This entails establishing a primary contact in order to invite the family. Once the family is together, the opportunity is taken to engage as to why some family members were not asked to attend which may make present members reconsider those who attend the conference. During this stage the facilitator notifies those in attendance the purpose of the gathering is address the concern of elder-well-being and safety but also address concerns the family members may have. This in turn requires communications skills which are non-judgmental and therapeutic in nature as a multitude of feelings such as resentment, grief, stress, shame and anger may have to be discussed in order for family members to commit to the family conference. This is preferably done face to face but distant relatives can be allowed to engage via conference phone call. Stage four deals with the logistical preparation for the family conference. Once all the nominated family and community members as well as service providers have been contacted, an agreeable meeting time is arranged. The facilitator sends out a letter to the prospective participants summarizing the purpose of the meeting and stipulating the date, time and venue. The day prior to the meeting, the facilitator called all family members who could be reached by phone. The venue chosen needed to be carefully considered as some might prefer their homes and others a more neutral place such as a conference room. Gracious hospitality was a strong community norm so the facilitator prepared snacks in line with dietary requirements and allowing participants to take whatever was left home. The participants also need to be told to consider participation barriers such as arranging child care, transportation as well as joining via conference call. These are all important to consider as the length of conference may be 2-5 hours long.

The fifth stage is the family meeting. The beginning of the meeting starts with a welcome to all attending and as the facilitator, to point out that it is an honor to participate in this process which is a sensitive as well as intimate issue. The spiritual adviser who may have been invited could open with prayer. The facilitator then engages the group to establish ground rules or group norms everyone will follow during session. These points are written on a flipchart and placed in a position for all to see. Following this is the information sharing section of the session. Here concerns are identified and letters of those family members who could not attend are read aloud. Points made within this session are written on a flipchart. The facilitator draws from these points and highlights strengths of the family identified through this process of engagement. Following this the family engages in developing a plan. During this time the family has the option to ask all non-family members to leave the room in order to develop a plan. The family is reminded to nominate a scribe during this process to write down everything discussed. The facilitator checks on the family periodically to clarify any questions they may have. Once the plan has been developed, the facilitator and service providers return to the room to assist in logistics needed to implement the plan of action such as assist in i) Identifying resources, ii) establishing timelines and iii) designating respective responsibilities to family members.

The plan is recorded and sent in a letter to family members the following week. The family also indicates when

they would like the follow up meeting to occur. The closing of the family meeting allows the participants to evaluate what they liked about the process and what could have been done differently. This also allows for debriefing to take place.

The sixth stage of this process is the follow up meeting. This allows for the family to meet with service providers (maybe housing is needed for the elderly member while the caregiver or identified family member requires rehab). Also the family may discuss how the plan is working, maybe certain requests need to be modified or they decide to hold a second family conference for issues which may have deliberately been kept closed but now needs to be addressed.

Maintenance

Not clearly reported.

Coalesced results and noted trends

Each study was evaluated according to the RE-AIM framework with results broken down into these elements for a holistic comparison. This framework structure allows us to collate the findings in a holistic manner to obtain process data and programmatic content.

Reach

All elderly participants had experienced at least one form of abuse or mistreatment as identified by the Domestic Elder Abuse Questionnaire (DEAQ) (Khanlary, Maarefvand, Biglarian, & Heravi-Karimooi, 2016) or have mistreatment identified and reported by mental health or medical practitioners (Lowenstein & Naim, 2015; Holkup, Salois, Tripp-Reimer & Weinert, 2007). Inclusion criteria were that the elderly and their family members are willing to participate in the process as stated in all the studies reviewed, yet only one study stated an exclusion criterion whereby the elderly and their families should not have previously been in any other elder abuse interventions (Khanlary, Maarefvand, Biglarian, & Heravi-Karimooi, 2016). Only one of the reviewed studies provided participant demographics which stated the age of elderly participants to be ≥ 60 years, most of the participants were male, and who stayed with their families in households of 3-4 people (Khanlary, Maarefvand, Biglarian, & Heravi-Karimooi, 2016). Of the participants, 77.8% reported their children to be the main abusers (Khanlary, Maarefvand, Biglarian, & Heravi-Karimooi, 2016). In two of the three reviewed studies, community members who are close to the family or who play a family-like role to the participant families, were also invited to participate (Holkup, Salois, Tripp-Reimer & Weinert, 2007; Lowenstein & Naim, 2015) as well as a spiritual advisor could be invited to the process if desired (Holkup, Salois, Tripp-Reimer & Weinert, 2007).

Efficacy

Only one of the reviewed studies provided specific outcomes, which showed a reduction in all forms of abuse except physical abuse (Khanlary, Maarefvand, Biglarian, & Heravi-Karimooi, 2016). The remaining two interventions reviewed, had not specified specific outcomes as the articles had only described the multi-systemic model of intervention for elder abuse (Lowenstein & Naim, 2015) and the other which only reported the number of families which had participated and followed through with the intervention (Holkup, Salois, Tripp-Reimer & Weinert, 2007).

Adoption

In terms of participant recruitment, community-based organisations (Khanlary, Maarefvand, Biglarian, & Heravi-Karimooi, 2016, Holkup, Salois, Tripp-Reimer & Weinert, 2007) as well health care facilities (Lowenstein & Naim, 2015) acted as referrals to the various programs. One of the two reviewed studies described the intervention as being part of a national mandate to identify, report, and provide recommendations for elder abuse of which continuity of care needed to be established with relative community services which referred participants to community-based facilities, which had used social workers, legal advisors, geriatrists and psychiatrists as program developers and case facilitators (Lowenstein & Naim, 2015). The other study stated the intervention was part of a 5 year community-based participatory research project by the Caring for the Native American Elders Project (Holkup, Salois, Tripp-Reimer & Weinert, 2007). The intervention was then adopted by the Health Representative Program, an organisation which had an established relationship with the participant community, with the original project team providing technical assistance (Holkup, Salois, Tripp-Reimer & Weinert, 2007). Facilitators for the sessions, were three well respected tribal women known to the community and who were familiar with the community norms and traditions (Holkup, Salois, Tripp-Reimer & Weinert, 2007).

Implementation

Two of the reviewed interventions described their programs consisting of 5 -6 stages although frequency of sessions were not reported within the article (such as sessions per week) (Holkup, Salois, Tripp-Reimer & Weinert, 2007; Khanlary, Maarefvand, Biglarian, & Heravi-Karimooi, 2016). The third intervention only stated they had implemented a multi-systemic model created by the Unit for Services for the Elderly which was formed through various national agencies, with family interventions created on a case by case basis (Lowenstein & Naim, 2015). The implementation process had been stipulated in only one study which included referrals, screenings, and family engagements to commit to the process, logistical preparation, the family conference and a follow-up session, with the family conference session described as being 2-5 hours in duration (Holkup, Salois, Tripp-Reimer & Weinert, 2007). Themes of the elder abuse intervention were only described in one study, and ranged from neglect and alternative behavior, principles of elderly care giving, as well as principles and techniques of conflict resolution (Khanlary, Maarefvand, Biglarian, & Heravi-Karimooi, 2016). Techniques used were ice breakers, cognitive restructuring, modeling and role playing, guided discovery and brainstorming (Khanlary, Maarefvand, Biglarian, & Heravi-Karimooi, 2016). Homework assignments had also been included (Khanlary, Maarefvand, Biglarian, & Heravi-Karimooi, 2016). Only two of the three interventions state who delivers the intervention which are either facilitators recruited from within the community and trained for the intervention (Holkup, Salois, Tripp-Reimer & Weinert, 2007) or using service providers from within the health and welfare system to formulate and carry out the intervention programs (Lowenstein & Naim, 2015).

Maintenance

Only one of the reviewed interventions implemented a follow-up of 30 days post intervention of which the dimensions of the Domestic Elder Abuse Questionnaire (DEAQ) was used to assess progress (Khanlary, Maarefvand, Biglarian, & Heravi-Karimooi, 2016).



DISCUSSION

This review provides insight into how elder abuse had been addressed through family-centred approaches in order to create a comprehensive response. The RE-AIM framework allowed for not only a core comparison of the interventions to occur, but ease in collating the interventions core components. This comparison elicited trends within these interventions which brought forth key factors. These factors are namely the role of community and culture and how this may shape how we define elder abuse and effectively respond to it.

Two of the three interventions had brought through strong community ties as well as cultural undertones (Holkup, Salois, Tripp-Reimer & Weinert, 2007; Lowenstein & Naim, 2015), which is very important. Community and culture are factors which fall within a spectrum of understudied groups within family violence (Barrett, Miller-Perrin & Perrin, 2011). Community and culture needs to be explored to create an adequate response through cultural competence within family violence practice and research (Barrett, Miller-Perrin & Perrin, 2011). This ties in adequately in addressing elder abuse, as the elderly are noted in valuing social connections and family ties (Grundy, 2006; Lowenstein, Katz, & Gur-Yaish, 2007). With culture at times dictating these social connections and family ties, as seen with Chinese and Latino elders (Tam & Neysmith, 2006; Parra-Cardona, Meyer, Schamberg & Post, 2007).

Most of the interventions reviewed were community-based and in the case of the Family Care Conference (FCC) intervention, was later adopted by another community-based organisation who received technical assistance from the original research team (Holkup, Salois, Tripp-Reimer & Weinert, 2007). Community-based teams as seen in the Holkup, Salois, Tripp-Reimer, & Weinert (2007) study, receiving technical assistance from the original research/project team is noted to have a bolstering effect on interventions as it contributes to high attendance rates (Spoth, Clair, Greenberg, Redmond & Shin, 2007).

The interventions reviewed in this study were largely based in the Middle East and the Native American community in the US and do not ascribe to western thinking around dealing with family violence, as explicitly pointed out in the study using the FCC (Holkup, Salois, Tripp-Reimer & Weinert, 2007). The interventions in these reviewed studies were community orientated with families being the cornerstone of community norms and traditions. For this reason elder abuse cannot be decontextualized, as traditional values and norms played an important role, as seen in 2 of the 3 interventions reviewed (Holkup, Salois, Tripp-Reimer & Weinert, 2007; Lowenstein & Naim, 2015). These traditions and norms may impact on the way abuse is defined, the context within which it exists and how elder abuse is addressed. This is seen the case of Chinese and Mexican immigrants.

A study focused on elder abuse amongst Chinese immigrants settled in Canada (Tam & Neysmith, 2006) showed that the very perception of abuse differs from western norms. This phenomenon was also seen amongst Latino

immigrants settled in the United States (Parra-Cardona, Meyer, Schamberg & Post, 2007). The perceptions of abuse amongst the Chinese were shown to have a strong basis in violating cultural norms and values. These forms of abuse identified by Tam and Neysmith (2006) included violating i) care respect - which would be seeing to the needs of the elderly but not being emotionally present, ii) virtual respect - which means having specially requested food and drink (maybe due to health related dietary requirements) but having it denied, iii) linguistic respect - such as name-calling and rudeness, and lastly, iv) special respect - which refers to providing adequate living quarters yet restricting the elderly and their movements. These acts may not seem overtly abusive within western society but are seen as blatant for example amongst the Chinese (Tam & Neysmith, 2006). Elderly immigrants and elders caught up in cross cultural abuse are additionally reluctant to report abuse as stated earlier; their first instinct is to protect the family, which also includes their recognition of institutionalized racism, which is reflected through them and their ethnicity, by being marginalized within the labor market (Tam & Neysmith, 2006). This adds to the fear of being a burden on their family, a fear found cross-culturally (Tam & Neysmith, 2006; Barnett, Miller-Perrin, & Perrin, 2011). This is important to note as the themes covered in the interventions reviewed related to conflict management and principles in taking care of the elderly. Furthermore we need to be sensitive as to what constitutes or denotes care giving and what is seen as abuse in order for any intervention not only to be needs sensitive but culturally competent.

By its very nature a family focused intervention is proven to be culturally inclusive and to show long term-results around ethnicities noted to be group-centred, as they would usually turn to family or community when in need (Gillum, 2008; Spoth, Clair, Greenberg, Redmond & Shin, 2007; Sumter 2006). This group-centred characteristic was noted in all 3 interventions yet was explicitly catered for in 2 of the 3 interventions which invited community participation (Holkup, Salois, Tripp-Reimer & Weinert, 2007; Lowenstein & Naim, 2015).

The content of the family centred interventions show a blend of what is traditionally done within elder abuse but also introduces the collaborative element of a family centred intervention, of using family caregivers as part of the solution in an attempt to sensitize them to the principles of elder well-being. These differences can be seen whereby all the programs presented in the paper did awareness raising, knowledge sharing and action planning with all concerned family members, which is in contrast to what has been done in European and Western interventions.

European and Western reactions, which are directed towards the elderly victim primarily, focus on knowledge and rights awareness in terms of prosecution, to bolster assertiveness, to create public awareness, extensively bolster and support social services and health care, and to provide support to caregivers (Zych, 2015; Jagielska, Pikuła, & Łukasik, 2015; Daly, Merchant, & Jogerst, 2011).

These foci may be helpful in extreme cases of elder abuse or in terms prevention, but when treating elder abuse, it may aggravate the fears of the elderly. Fears such as forced removal and institutionalization resulting in secondary trauma (Parra-Carolona, Meyer, Schamberg & Post, 2007; Ploeg, Fear, Hutchinson, MacMillan, & Bolan, 2007), fear of revenge, blame or potentially breaking up the family if they report elder abuse (Prokop, 2015). These fears are not far from reality as reported by Gair (2015) who found that the legal system was used against the elderly, in the form of protection orders and denied/disrupted visitation of their grandchildren, due to their reporting of family violence and neglect. The elderly were even viewed by certain authorities as 'meddlesome' or interfering when reporting child abuse and neglect of their grandchildren (Gair, 2015).

The limitations of the current study can evidently be seen in the fact that the studies presented took place in communities that had strong ties and influence on the family. Thus it would not be sufficient to say if family centred interventions would have the same effect within European or Western societies as the dominant response is individualized and largely institutionalized when it comes to treating elder abuse. Additionally maintenance had not been reported for most of the interventions except one intervention, which had a 30 day follow-up but noted a long-term follow up was needed (Khanlary, Maarefvand, Biglarian, & Heravi-Karimooi, 2016). This is important as long-term follow-up is needed in order to establish long-term sustainability of behavior change and to assess which approaches offer the best chance of success (Jones, Sinn, Campbell, Hesketh, Denney-Wilson, Morgan, Lubans & Magarey, 2011). Also, only 3 studies were found to be family-centred in addressing elder abuse which makes generalizing the results and creating conclusive inferences challenging. Further recommendations for future research would be to explore family-centred interventions within developed countries, which may improve the prevalence of elder abuse, if used as an alternative to what is currently being done.

Conclusion

Family-centred interventions have been shown to decrease elder abuse due to its multisystemic approach in treating elder abuse in a holistic manner and incorporating factors which largely affect elder abuse. The aim of this paper was to offer family centred interventions to address elder abuse, by recognizing the elderly as important members not only within our communities, but families. Furthermore it is hoped that through this family centred approach, we can negate fear in speaking up about elder abuse and promote elder well-being within the family and community.

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APPENDIX H: Information Sheet



UNIVERSITY OF THE WESTERN CAPE

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e-mail: jillryan23@gmail.com

INFORMATION SHEET

Project title: The design of an intervention to reduce violence in the family: A family-centred approach

What is this study about?

This is a research project being conducted by Jill Ryan at the University of the Western Cape. We are inviting you to voluntarily participate in this research project. We are seeking participation from practitioners, NGO community workers and volunteers who work with families regarding their experiences with families who experience violence in the home and have sought help from organisations to assist them in this regard. Participants will assist in the formation of an intervention programme aimed at assisting families experiencing violence in the home.

What will I be asked to do if I agree to participate?

You will be asked to fill in a questionnaire divided into three sections. The first section will ask about demographical information such as age, gender, race, employment, followed by YES/NO questions about support in addressing the needs of the families experiencing violence. The second section will be questions pertaining to family functioning as witnessed or experienced by the practitioners when dealing with families who experience violence. The third section pertains to the perceptions and attitudes of family violence. In addition to this, those who participate in the questionnaire completion will be asked if they would like to participate in interviews which would explore strategies in making this intervention family-focused and what to consider when addressing family violence in this regard.

Would my participation in this study be kept confidential?

The utmost will be done to keep your personal information confidential. In aiding the protection of your identity, the information provided will be private; no names or any other descriptors will be used to ensure that you will not

be able to be identified when participating in this study. In this way you will remain anonymous and confidentiality will be maintained. This would entail that:

- Your name will not be included in the report.
- A pseudonym will be used in the report.

If an article or report is written about this research study, your identity will remain anonymous as best is possible. The reports will be kept in a locked compartment with only the researcher and research supervisor having access to the information. The research findings will not include any of your personal details.

What are the risks of this research?

There are potential risks in participating in this study as discussing a sensitive topic such as this may illicit feelings of distress or discomfort. If however, this causes some difficulty, a resource list will be made available to participants to contact if the need arises.

What are the benefits of this research?

There is no one programme currently developed to address all forms of abuse at home. The information gathered through this study will create a programme first of its kind which will be a benefit to all organisations and departments who deal with family violence. It will provide them with a framework to deal with and assist families experiencing violence in a more holistic manner aimed at optimal family functioning.

Do I have to be in this research and may I stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits to which you otherwise qualify.

Is any assistance available if I am negatively affected by participating in this study?

Every effort has been taken to protect you from any harm in this study. If however, you may feel affected you can be referred to your nearest community resource for assistance. This has been described earlier in risks relating to this study.

What if I have questions?

If you are unsure about anything relating to this study please make use of the initial contact or via email 2839413@myuwc.ac.za. If you have any questions about the research study itself, please contact Prof. N. Roman (Supervisor) at: Department of Social Work, tel. 021 959 2277/2970, email: nroman@uwc.ac.za.

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Professor Jose Frantz – Dean of the Faculty of Community and Health Sciences

Tel No: 021 959 2631/2746

Email address: jfrantz@uwc.ac.za

This research has been approved by the University of the Western Cape's Senate Research Committee and Ethics Committee.



APPENDIX I: Consent Form (Questionnaire)



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DEPARTMENT OF SOCIAL WORK

CONSENT FORM (questionnaire)

Title: The design of an intervention to reduce violence in the family

The letter serves to grant my consent to complete and participate in the study. It is a self-reported questionnaire regarding my experiences in dealing with families experiencing family violence. The objective of the study is to create an intervention for family violence with the information I will provide. I am aware that I may withdraw from the study at any time should I not feel comfortable discussing the topic. I understand that the information is private and will be managed by the interviewer, confidentially and anonymously.

I understand that I give consent that the information gathered during the interviews will be typed and anonymously presented in research reports and publication articles.

Participant's name	
Participant's signature	
Witness	
Date	

Should you have any questions regarding this study or wish to report any problems you have experienced related to the study, please contact the study coordinator:

Study Coordinator's Name: Prof. N Roman

University of the Western Cape

Private Bag X17, Belville 7535

Telephone: 021 959 2277/2970

Email: nroman@uwc.ac.za



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APPENDIX J: Consent Form (Qualitative)



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DEPARTMENT OF SOCIAL WORK

CONSENT FORM (interview)

Title: The design of an intervention to reduce violence in the family

The letter serves to grant my consent to complete and participate in an individual interview with the interviewer. It is an interview with questions relating to my experiences in dealing with families experiencing family violence. The objective of the study is to create an intervention for family violence with the information I will provide. I am aware that I may withdraw from the study at any time should I not feel comfortable discussing the topic. I understand that the information is private and will be managed by the interviewer, confidentially and anonymously.

I understand that I give consent that the information gathered during the interviews will be typed and anonymously presented in research reports and publication articles.

Participant's name	
Participant's signature	
Witness	
Date	

Should you have any questions regarding this study or wish to report any problems you have experienced related to the study, please contact the study coordinator:

Study Coordinator's Name: Prof. N Roman

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APPENDIX K: Editorial Certificate

08 August 2019

To whom it may concern

Dear Sir/Madam

RE: Editorial certificate

This letter serves to prove that the thesis listed below was language edited for proper English, grammar, punctuation, spelling, as well as overall layout and style by myself, publisher/proprietor of Aquarian Publications, a native English speaking editor.

Thesis title

THE DESIGN OF AN INTERVENTION TO REDUCE VIOLENCE
IN THE FAMILY: A FAMILY-CENTRED APPROACH

Author

Jill Ryan

The research content, or the author's intentions, were not altered in any way during the editing process, and the author has the authority to accept, or reject my suggestions and changes.

Should you have any questions or concerns about this edited document, I can be contacted at the listed telephone and fax numbers or e-mail addresses.

Yours truly



E H Londt
Publisher/Proprietor



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