



Interventions for caregivers of children who disclose sexual abuse: A review [☆]



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HIGHLIGHTS

- Caregiver support is an important mediating variable on outcomes for victims of CSA.
- Caregivers experience emotional and social impacts following CSA disclosure.
- Caregivers need information, support, and parenting advice following CSA disclosure.
- We review the interventions for non-offending caregivers following CSA disclosure.
- Caregiver interventions result in better outcomes for CSA victims and their family.

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ABSTRACT

The importance of interventions for non-offending caregivers following the disclosure of child sexual abuse (CSA) is increasingly recognised in the literature. These interventions are particularly important given what is currently known about the impact of CSA disclosure on non-offending caregivers and the value of caregiver support in assisting their children's recovery. This review provides summary background information on the prevalence and short-term impact of CSA on children, with a particular focus on variables that mediate outcomes including caregiver support. The impact of a child's disclosure on the non-offending caregiver is discussed considering both the emotional effects and changes in their support networks. Furthermore, we examine the associated needs of non-offending caregivers including information, emotional support, support around their own victimisation if relevant, and parenting assistance. Finally, we provide a detailed review of the specific interventions available for caregivers after such a disclosure is made. These interventions include those that just provide information, support groups, psycho-educational groups, support incorporated into the child's intervention, and individual caregiver support. We conclude that interventions for non-offending caregivers are vital in the recovery of the child and their caregiver following CSA and discuss future research considerations.

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1. Introduction

Accurate prevalence rates of child sexual abuse (CSA) are difficult to determine due to differences between studies as to how sexual abuse was defined, how the sample was obtained, and how individuals were questioned (Haugaard, 2000; Wyatt & Peters, 1986). However, recent large meta-analytic studies looking at international prevalence of CSA find that about one in five females and one in thirteen males have experienced some form of sexual abuse as children (Pereda, Guilera, Fornis, & Gomez-Benito, 2009; Stoltenborgh, Van Ijzendoorn, Euser, & Bakermans-Kranenburg, 2011). Child sexual abuse is found to occur across ethnicities (Putnam, 2003; Wyatt, 1985), socio-economic status (Alexander & Lupfer, 1987; Fergusson, Lynskey, & Horwood, 1996; Finkelhor, 1994; Putnam, 2003), parental education levels (Alexander & Lupfer, 1987), and urban/rural localities (Baker & Duncan, 1985; Mullen, Martin, Anderson, Romans, & Herbison, 1993). When children experience sexual abuse, it can have a significant impact on their wellbeing in the short-term, long-term, or both. There is also an impact on the whole family system, in particular those involved in the care of the child. Thus it is appropriate that caregivers are a target for therapy and support; both to mitigate impacts on them and other family members, and in order to assist them to help their child who is the direct victim of the abuse. This paper briefly reviews the evidence for impact of CSA on children and impact on family members. This provides the context for a more detailed consideration of interventions aimed at caregivers.

2. Impact of child sexual abuse on children

2.1. Impact of CSA on the child

The consequences of CSA on victims include short-term and long-term effects, which vary between individuals from no apparent effects to debilitating psychological and behavioural effects (Putnam, 2003). When children experience short-term effects from sexual abuse, they may require intervention and support from their caregivers. The short-term effects that children may experience include internalising features such as: anxiety, depression, and decreased self-efficacy and self-confidence; and/or externalising behaviours including sexualised behaviours, aggression, self-injurious behaviours and somatic complaints (Ligezinska et al., 1996; Swanston, Tebbutt, O'Toole, & Oates, 1997; Tyler, Johnson, & Brownridge, 2008). Sexualised behaviour is the outcome most specific to exposure to CSA compared to other forms of abuse, and can be particularly difficult for caregivers to manage

(American Psychological Association, 2001; Briere & Runtz, 1990; Putnam, 2003).

2.2. Variables that mediate the impact of CSA

For those children who experience short-term effects following CSA, there are several static and dynamic factors that may affect the degree of impact from the abuse. This in turn will affect the level of stress experienced within a family system, and the support they require from their caregivers. Static factors linked to the victim that mediate the impact of CSA include gender, age when first abused, age when abuse finished, and age at disclosure (Back & Lips, 1998; Barker-Collo & Read, 2003; Fergusson et al., 1996; Fergusson, Horwood, & Woodward, 2000).

Although the effect of the age of onset for the abuse is inconclusive, some studies indicate greater impact of abuse with earlier onset (Back & Lips, 1998; Barker-Collo & Read, 2003). Despite it being suggested that the risk of victimisation increases with age (Finkelhor, Moore, Hamby, & Straus, 1997), Mullen et al. (1993) found that 65% of CSA victims were abused before their first menses, with abuse most likely to occur between the ages of eight to 12 (highest rates at 11 years old). Girls have generally been found to be victimised earlier than boys (Baker & Duncan, 1985). A large review found that the effect of time since disclosure on individual outcomes is unclear (Kendall-Tackett, Williams, & Finkelhor, 1993).

The effect of gender on CSA outcome is not clear. Several studies have suggested that females tend to experience more internalising symptoms, while males experience a larger range of externalising symptoms (Baker & Duncan, 1985; Fergusson et al., 2000). However, in a more recent study, Maikovitch-Fong and Jaffee (2010) found no gender differences in the development of externalising or internalising symptoms. Females tend to report higher frequency and severity of abuse, and more penetrative abuse compared to males (Fergusson et al., 2000; Maikovitch-Fong & Jaffee, 2010; Romano & De Luca, 2001; Ullman & Filipas, 2005), while men are more likely than women to be exposed to concurrent physical abuse (Baker & Duncan, 1985; Romano & De Luca, 2001). Furthermore, females are more likely than males to disclose abuse (Briggs & Hawkins, 1995; Ullman & Filipas, 2005) and have their claims substantiated (Maikovitch-Fong & Jaffee, 2010).

The effect of ethnicity on CSA prevalence and outcomes is also not clear. In a recent meta-analysis across a range of countries Stoltenborgh et al. (2011) identified some difference in CSA prevalence rates between geographical areas with the lowest prevalence rates found in Asia, highest rates for females found in Australia, and the highest rates for males in Africa. However, Stoltenborgh et al. (2011) also hypothesize

that the reasons for this difference may not be a true reflection of prevalence rates, but may instead be related to rates of disclosure affected by shame about such experiences in different cultures.

Along with individual victim characteristics such as age and gender, the relationship with the perpetrator is a significant predictor of psychological outcome in CSA victims (O'Leary, Coohy, & Easton, 2010). This may also influence the level of support available to caregivers following disclosure of CSA and the impact on caregivers themselves (Famularo, Fenton, Kinscherff, Ayoub, & Barnum, 1994; Massat & Lundy, 1998). The majority of perpetrators are male and known to the victim (Kendall-Tackett et al., 1993). Victims of intrafamilial abuse are at higher risk of experiencing negative effects following CSA which has been related to higher levels of secrecy, coercion, and distortions of relationships, which are inherent in intrafamilial abuse (Baker & Duncan, 1985; O'Leary et al., 2010). Additionally, victims of intrafamilial abuse are more likely to experience a greater number of abuse events, longer duration of CSA occurrence, a greater time before disclosure, and are generally younger at the onset of abuse (Coulburn-Faller, 1989; Fergusson et al., 1996; Fischer & McDonald, 1998; Yancey & Hansen, 2010).

2.3. Family context as a mediator of the impact of CSA

The wider family context also impacts on the effects following CSA, with greater resilience being observed in families where there is a high level of cohesion, adaptability, and low levels of conflict (Berliner & Conte, 1995; Fassler, Amodeo, Griffin, Clay, & Ellis, 2005). On the other hand, the quality of family relationships may negatively affect both the risk for CSA and responses to disclosure, with higher incidences of abuse seen in families where there is parental separation or where children are exposed to high levels of marital conflict (Baker & Duncan, 1985; Boney-McCoy & Finkelhor, 1996; Fergusson et al., 1996; Finkelhor et al., 1997). Parental substance abuse also increases the incidence and repetition of CSA, as do negative parental mental health and the presence of other concomitant abuse or neglect in the home (Barker-Collo & Read, 2003; Fergusson et al., 1996; Kellogg & Hoffman, 1997; Oates, Tebbutt, Swanston, Lynch, & O'Toole, 1998; Putnam, 2003; Stevens, Ruggiero, Kilpatrick, Resnick, & Saunders, 2005). Stepfamilies are a further risk for CSA with stepfathers being ten times more likely to be perpetrators of CSA than biological fathers (Mullen et al., 1993). The quality and nature of peer and family relationships such as attachment styles and paternal overprotection can also mediate long-term outcomes for CSA victims, with increased long-term problems for children from disorganised families (Barker-Collo & Read, 2003; Briere & Jordan, 2009; Fergusson et al., 1996; Lynsky & Fergusson, 1997).

2.4. Impact of experience of disclosure

Disclosure of CSA can have a large impact on both the individual who discloses, and those around them (Berliner & Conte, 1995; O'Leary et al., 2010; Palmer, Brown, Rae-Grant, & Loughlin, 1999). Disclosures of CSA events are usually significantly delayed, with only 33% of victims disclosing at all during childhood (London, Bruck, Ceci, & Schuman, 2005). Delays in disclosure can have a negative impact on the outcomes for children following CSA. It is following disclosure of CSA that children are most in need of support from their caregivers, which may be difficult for them because of the personal impact of disclosure (Humphreys, 1992; Lipton, 1997). The response of others to disclosure has a very important impact on the outcomes of CSA for the child (Barker-Collo & Read, 2003; Berliner & Conte, 1995; Maikovich-Fong & Jaffee, 2010; O'Leary et al., 2010). Responses to disclosure can include belief or disbelief, affective responses, and behavioural responses (ranging from removing the perpetrator from the household to allowing them continued access to the child; Alaggia, 2002). A child is more likely to experience negative outcomes when no action is taken against the

perpetrator, with better outcomes related to supportive responses such as belief, acknowledgement, and action taken against the perpetrator (O'Leary et al., 2010; Palmer et al., 1999).

Caregiver responses to the disclosure of abuse are fluid, changing over time, with the majority of caregivers believing their child immediately, particularly in the case of extrafamilial abuse (Alaggia, 2002; Elliott & Carnes, 2001; Humphreys, 1992; Jinich & Litrownik, 1999). However, it may be difficult for some caregivers to sustain this belief, particularly if they are themselves in a relationship with the perpetrator, and in the presence of their initial reactions which may include shock, shame and/or self-blame (Bolen & Lamb, 2004; Humphreys, 1992). If a caregiver has been victimised themselves in the past this may also affect how readily they believe their child (Elliott & Carnes, 2001; Hooper, 1992).

3. Support children need from caregivers

The support children receive from their caregivers following disclosure and in following interventions is vital (Barker-Collo & Read, 2003; Cohen & Mannarino, 1996b; Cohen & Mannarino, 2000; Cohen & Mannarino, 2008; Kouyoumdjian, Perry, & Hansen, 2005; Lipton, 1997; Plummer, 2006; Saywitz, Mannarino, Berliner, & Cohen, 2000). Several studies reviewed by Elliott and Carnes (2001) have shown that the response from the non-offending caregiver can mediate the level of psychological symptoms in CSA victims as well as impacting the overall level of distress experienced by victims. Lack of caregiver care, support, nurturing and affection have been linked to increased stress and trauma symptomatology in the child (Lipton, 1997; Lynsky & Fergusson, 1997), and the higher overall level of support from caregivers is linked to better adjustment in children following CSA (Elliott & Carnes, 2001; Kendall-Tackett et al., 1993). Indeed, support from caregivers has been found to be more important than abuse-related factors in mediating the outcome for children following CSA (Tremblay, Herbert, & Piche, 1999). Caregiver support also plays an important role in assisting the child through investigation processes and treatment (Davies & Seymour, 1999a).

4. Impact of child sexual abuse on caregivers

Following the disclosure of CSA, most caregivers experience psychological and emotional distress (Elliott & Carnes, 2001), which is often overlooked by professionals (Famularo et al., 1994). Caregivers have described the disclosure of CSA as a major life crisis, with most caregivers admitting to being ill prepared to deal with the effects (Humphreys, 1995; Lipton, 1997).

4.1. Emotional impact

Caregivers have reported experiencing strong emotional reactions as a result of disclosure, such as anger, despair, disbelief, ambivalence towards their child and/or the perpetrator, guilt around their parenting role, and concerns about the investigation and legal processes (Davies, 1999; Hill, 2001; Humphreys, 1995; McCourt, Peel, & O'Carroll, 1998; Regehr, 1990). Those caregivers whose children are involved in criminal trials experience more distress related to both the trial itself and added general life stresses than those that are not involved (Burgess, Hartman, Kelley, Grant, & Gray, 1990; Regehr, 1990). Fathers generally experience more distress than mothers, and have greater intrusive and avoidant PTSD symptoms (Burgess et al., 1990). Emotional and psychological effects are stronger when the abuser is the partner of the caregiver (Hill, 2001; Humphreys, 1995). Caregivers can experience the effects of their child's victimisation for several years following disclosure, with studies showing increased rates of mental health difficulties amongst these caregivers (Elliott & Carnes, 2001; Hill, 2001; Schuetz & Eiden, 2005). It is considered important to respond to such emotional and psychological effects experienced by caregivers given that parental stress

and feelings of competence mediate the outcomes of CSA for the child (Elliott & Carnes, 2001; Schuetz & Eiden, 2005).

4.2. Availability of personal support

Caregivers are frequently cut off from social and familial support networks following CSA disclosure (Lipton, 1997; Massat & Lundy, 1998). Additionally, caregivers often experience loss of economic stability, particularly if the partner was the perpetrator of abuse (Carter, 1999; Lipton, 1997; Massat & Lundy, 1998; Plummer & Eastin, 2007). Support from within the family is particularly difficult if the perpetrator is a member of the same family, and especially where the perpetrator denies the abuse (Lipton, 1997; Plummer & Eastin, 2007). Some caregivers have also described stress arising from a lack of support from some professionals, including being accused of promoting false allegations, receiving criticism about their parenting, experiencing lack of sensitivity about their concerns, and being denied access to social services (Davies & Seymour, 1999a; Henry, 1997; Hill, 2001; Plummer & Eastin, 2007). As a result, some caregivers state that they would not have involved authorities in the disclosure process if they had been able to predict the reaction they would receive (Plummer & Eastin, 2007).

5. Needs of caregivers

The importance of caregivers in assisting children following the disclosure of CSA and the significant impact such disclosure may have on the caregivers indicates the importance of considering the needs of caregivers when working with their child. It has also been identified that the needs of the non-offending caregivers are not necessarily in parallel with the therapeutic needs of the child (McCourt et al., 1998).

5.1. Need for information

Although caregivers experience disclosure of CSA as a crisis, most are aware that they need to provide support to their child in the aftermath of disclosure (Humphreys, 1995). Nevertheless, non-offending caregivers often report being unsure of how to respond to their child after disclosure of sexual abuse, both in regards to knowing what types of new behaviours and emotions their child may display as a result of the abuse, and how to deal with these (Davies & Seymour, 1999a; Humphreys, 1995; Miller & Dwyer, 1997). Caregivers have indicated that they were better able to support their children if provided information on the dynamics of abuse and disclosure, how to be more supportive to their child, the investigation process, long-term consequences of CSA on their child, and the implications of disclosure on wider family processes (Davies & Seymour, 1999a; Forbes, Duffy, Mok, & Lemvig, 2003; Jinich & Litrownik, 1999; Miller & Dwyer, 1997). Caregivers frequently indicate that they are not given adequate information (Hooper, 1992; Humphreys, 1995), and even when they are provided with information, caregivers frequently expressed a lack of understanding of the information provided (Davies & Seymour, 1999a).

5.2. Need for emotional support

Caregivers often require personal assistance in order to increase their ability to cope and to work through feelings of denial, guilt, anger, self-pity, resentment, and fear as well as needing help to keep their child safe (Print & Dey, 1992). Furthermore, caregivers may need help in working through feelings of jealousy, betrayal, and powerlessness (Print & Dey, 1992). These needs are impacted for many by the decreases in social, and familial support discussed above. Due to the lack of the usual support systems, caregivers may be reliant on external sources of support including professionals such as counsellors, to help address their attributions for the abuse, and any impacts on relationships such as those with their partner (Humphreys, 1995).

5.3. Need for support for own victimisation

Caregivers may also have been themselves victimised in the past. Parents of children who were sexually abused are more likely than parents of non-abused children to have been themselves abused as children (Davies & Seymour, 1999a; Hooper, 1992; Oates et al., 1998). Such caregivers frequently report extreme emotional distress, requiring extra assistance to deal with their own victimisation (Davies & Seymour, 1999a; Oates et al., 1998).

5.4. Need for parenting assistance

As discussed above, there are frequently changes in children's behaviour following CSA including, but not limited to, anger, regression, sleeping disturbances, insecurity, and sexualised behaviours (see review by Kendall-Tackett et al., 1993). Caregivers may find it particularly challenging to know how to respond to these behaviours (Barth, Yeaton, & Winterfelt, 1994). When CSA has not been definitively determined, caregivers may be particularly unclear on how to parent (Plummer & Eastin, 2007).

5.5. Summary

The needs and outcomes of the non-offending caregivers are inseparable to those of their child. Davies and Seymour (1999a, 1999b) recommend that professionals involve caregivers as much as possible in the processes following disclosure, keeping them informed and assisting them in accessing support, education, and counselling as required. Additionally, personal victimisation issues are important to consider when looking at supporting caregivers. The issues that caregivers are faced with may include how to initially deal with disclosure, how to access information, how to deal with their own victimisation issues, and how to parent in this novel situation. Caregivers can be supported in meeting these needs in a variety of ways, with specific interventions needing to be tailored to the needs of the individual caregiver.

6. Interventions for caregivers

Despite limited research in this area, several studies have shown that interventions targeted at non-offending caregivers may lead to positive effects for both the caregiver and the CSA victim (Elliott & Carnes, 2001). A comprehensive literature review of interventions targeted specifically at non-offending caregivers of CSA victims was conducted using both an electronic literature search and manually searching the references of related articles. PsycINFO, PsycBOOKS, and MEDLINE were used as data sources. The search used key terms of [caregiver OR parent OR mother OR father OR Non-offending] AND [intervention OR treatment OR therapy OR support OR group] AND [child¹ sex\$ abuse OR sex\$ abuse] as well as other generic terms including [sexual], [online], and [outcomes]. Literature related to interventions for non-offending caregivers following CSA disclosure was included. Unpublished data, resources not available in English and some book chapters were not included.

Several studies were identified that have investigated a range of interventions for caregivers including the simple provision of information, providing general or psycho-educational support in a group format, providing them with individual support, or incorporating caregiver support in the children's interventions. Some of these studies included demographic information about caregivers and identified the majority of participants as Caucasian females. No information is available in these studies that allow comparison of outcomes

¹ Indicates completing search with any possible suffix.

between distinct groups, therefore it is not possible to draw conclusions about the impact of demographic features on the usefulness of different interventions. See Table 1 for a summary of interventions targeted at non-offending caregivers of CSA victims. Those interventions for CSA victims that have been developed to have parallel or adjunctive intervention for the caregiver have not been included in the table summary as they have been reviewed elsewhere (see Corcoran, 2004).

6.1. Provision of information

The mere provision of appropriate information may be beneficial for caregivers and their children in the time after CSA disclosure, either in isolation or to provide reinforcement of concepts provided during other interventions (Davies & Seymour, 1999a, 1999b; Humphreys, 1995; Jinich & Litrownik, 1999; Mara & Winton, 1990; Miller & Dwyer, 1997; Winton, 1990).

The medium the information is provided in is also an important consideration. Evidence suggests that caregivers have a preference for written and visual material over exclusively verbal information (Humphreys, 1995; Miller & Dwyer, 1997). Jinich and Litrownik (1999) demonstrated that mothers who were provided with an educational pamphlet and video retained more information and demonstrated more supportive behaviours towards their children during the evidential video interview stage of investigation than those who did not receive information. These mothers also showed more confidence in their knowledge about the investigation process, resulting in reduced stress levels and feeling better able to support their child (Jinich & Litrownik, 1999). Although there is increasingly more reliance on the Internet, with educational resources available online, no research was found related to the online provision of information for caregivers following disclosure of CSA.

6.2. Support groups

Several exploratory studies have indicated that peer support is important for caregivers coping with the disclosure of CSA (Alaggia, 2002; Hewitt & Barnard, 1986; Hill, 2001; Humphreys, 1995). As noted earlier, caregivers report decreases in social support after their child's disclosure of sexual abuse, particularly in relation to intrafamilial abuse (Carter, 1999; Hewitt & Barnard, 1986; Hill, 2001). Support groups have been suggested as a useful way to increase the support networks of non-offending caregivers, though individual work with caregivers may also assist them to increase social networks in the community in discussing how they can talk to others (Carter, 1999; Humphreys, 1995). In developing support groups for caregivers, cultural considerations must be taken into account due to limited access to services and increased stigmatisation in some communities, which would make such groups difficult (Abney & Priest, 1995; Bernard, 1999; Comas-Diaz, 1995). In addition to helping re-build vital social networks, support groups may provide relief from finding others with similar experiences, aid individuals in coping with their own stresses, provide support around child rearing, help to normalise their child's behaviour, and may even reduce depression in mothers of CSA victims (Hernandez et al., 2009; Hewitt & Barnard, 1986; Hill, 2001; Print & Dey, 1992; Winton, 1990).

In small short-term and long-term support groups common themes around loneliness, loss, anger, sexuality, economic problems, relationships with children, trying to understand incest, and issues around dealing with agencies were identified (Hewitt & Barnard, 1986). Caregivers reported that they benefited vicariously through other caregivers' disclosures and appreciated the non-judgemental environment of these groups, which enabled them to express their own emotions safely (Hewitt & Barnard, 1986; Hill, 2001). In general, caregivers reported satisfaction with support groups, feeling able to give and receive support irrespective of how soon they joined the

group after disclosure with mutual help sometimes extending beyond the sessions themselves (Barth et al., 1994; Hernandez et al., 2009; Hewitt & Barnard, 1986; Print & Dey, 1992). Caregivers in small support groups reported increases in self-esteem and improved trauma processing as a result of group participation during interviews, while the groups also appeared to indirectly help their children's recovery by making the caregivers more confident in discussing difficult topics and dealing with the challenging behaviours their children presented with (Hewitt & Barnard, 1986; Hill, 2001).

Although such support groups have been found to be beneficial, several studies have indicated that support groups would be best carried out in conjunction with wider family interventions (Miller & Dwyer, 1997; Print & Dey, 1992). Hernandez et al. (2009) suggest that such support groups may be a good way to prepare caregivers in being involved in the child's individual therapy.

6.3. Psychoeducational groups

Psychoeducational groups combine group support with the provision of information. Most of the research in this area has been restricted to mothers (Barth et al., 1994), although some studies also include small numbers of fathers (Ostis, 2002; Winton, 1990). Such interventions include information for caregivers about victim's responses to abuse as well as practical advice on how to deal with these behaviours and emotions (Barth et al., 1994; Deblinger, Stauffer, & Steer, 2001; Hernandez et al., 2009; Hewitt & Barnard, 1986; Hill, 2001; Ostis, 2002; Winton, 1990). Psychoeducational groups therefore typically include efforts to increase caregiver confidence and self-efficacy, improve dysfunctional behaviours of their children, provide a place for parents to understand and deal with their own emotions, and provide the caregivers with a wider support network (Barth et al., 1994; Winton, 1990). These aspects of caregiver interventions may be tackled explicitly (Barth et al., 1994; Deblinger et al., 2001) or may come up spontaneously during group discussions (Hewitt & Barnard, 1986; Hill, 2001; Ostis, 2002; Winton, 1990).

Participants usually reported that the content of psychoeducational groups was relevant, while the supportive group structure and setting was enjoyable and provided opportunities for empowerment, practical help, and increased understandings (Barth et al., 1994; Winton, 1990). In some small studies, caregivers suggested that they would like professionals such as social workers, police, and lawyers to be present to help them understand their role as the caregiver in the investigation process (Mara & Winton, 1990).

In several studies caregivers reported increased wellbeing, confidence and understanding about child behaviour management, and feeling better able to care for the child in their care as a result of participating in psychoeducational groups (Barth et al., 1994; Winton, 1990). Additionally, caregivers reported improved coping and stress management and greater ability to deal with professionals as a result of the interventions, though Winton (1990) found that actual stress levels as reported on psychometrics did not change. There are some conflicting reports about the usefulness of psychoeducational groups in decreasing problem behaviours in children, with some reporting a decline in problem behaviours (Winton, 1990) and others failing to find any change (Barth et al., 1994).

Group cohesion, both in supportive and psychoeducational groups, was generally found to be formed quickly, which was usually attributed to the shared experience of its members (Barth et al., 1994; Hewitt & Barnard, 1986; Hill, 2001; Print & Dey, 1992). In general, caregivers appreciated not being pressured to speak in the groups because this helped them to feel in control. Nevertheless, some participants felt it was important that everyone contributed to the group process (Hill, 2001; Winton, 1990). Both types of groups were more useful to caregivers if they were in place long-term, though some studies suggest that the attendance of such extended support groups

Table 1
Description of intervention studies for caregivers.

Authors	Country	Intervention					Programme type	Source of client group	
		Description	Aim						
Barth et al. (1994)	USA	Psycho-educational (for foster parents)	Education (behaviour)			Group	Child Protection Team		
Deblinger et al. (2001)	USA	Support vs. CBT	Support; CBT (Coping, education, behaviour management)			Group	Regional Child Abuse Diagnostic and Treatment Centre		
Forbes et al. (2003)	UK	Not specified	Education (investigation, parenting, behavioural management)			Not specified	Child and Family Mental Health Service		
Hernandez et al. (2009)	USA	TF-CBT, support, psychoeducation	Support, education, build self-esteem			Group	Child Advocacy Centre		
Hewitt and Barnard (1986)	Australia	Support	Support (married to perpetrator)			Group	Sexual Assault Clinic		
Hewitt and Barnard (1986)	Australia	Support	Support (married to perpetrator)			Group	Sexual Assault Clinic		
Hill (2001)	UK	Support	Support			Group	Community sample		
Jinich and Litrownik (1999)	USA	Informational (video and pamphlet)	Teaching (supportive parenting)			Individual	Centre for Child Protection		
Ostis (2002)	USA	Psycho-educational and support	Support, self-mastery and support to child			Group	Sexual Abuse Treatment Program (SATP)		
Winton (1990)	USA	Psycho-educational and support	Education and emotional processing			Group	Hospital-based child abuse unit		
van Toledo (2010)	New Zealand	Psycho-educational and support	Education, behavioural management, and coping			Individual	Sensitive Claims treatment provider		
Authors	Logistics						Outcomes		
	Facilitators	Sample size	Duration	Session length	Frequency	Timeliness	Measures	Control	Findings
Barth et al. (1994)	Two clinicians	15 (all females)	11 sessions	Not specified	Not specified	Not specified	Quantitative and Qualitative	Not specified	Increased understanding/care; no decrease in problem behaviour
Deblinger et al. (2001)	Therapists	44 (21 CBT; all females)	11 sessions	105 min	Weekly	Not specified	Quantitative	Support Group	CBT: reduction of intrusive thoughts and emotional distress
Forbes et al. (2003)	Not specified	39 (mix male/female)	Not specified	Not specified	Not specified	Not specified	Quantitative	None	Decreased parental distress and psychopathology
Hernandez et al. (2009)	Not specified	10 (all female)	12 sessions	90 min	Weekly	Not specified	Quantitative	None	Decreased parental stress and symptoms, better child behaviour
Hewitt and Barnard (1986)	Two social workers	3 (all females)	10 sessions	90 min	Weekly	Post-disclosure to post-court	Qualitative	None	Changed child behaviour; increased support outside group
Hewitt and Barnard (1986)	Two social workers	9 (all females)	Open-ended	90 min	Fortnightly	Post-disclosure to post-court	Qualitative	None	Increased confidence; emotional and practical support
Hill (2001)	Mothers	11 (all females)	Open-ended	Not specified	Fortnightly	Anytime	Qualitative	None	Trauma processing
Jinich and Litrownik (1999)	Researcher	64 (all females)	1 session	22 min	Once	Children during evidentiary video	Quantitative	Control videotape	More supportive to child
Ostis (2002)	Two therapists	31 (mix male/female)	16 Sessions	90 min	Weekly	Not specified	Quantitative	None	Increased mastery; better support for children
Winton (1990)	Male/female co-therapists	27 (mix male/female)	13 sessions	120 min	Weekly	Not specified	Quantitative	None	Decreases child's dysfunctional behaviour; learned coping skills
van Toledo (2010)	Therapist	37 (mix male/female)	5 sessions	60 min	Not specified	Not specified	Quantitative and Qualitative	None	Increased understanding/coping; improved child behaviour

is not easy to maintain (Barth et al., 1994; Hewitt & Barnard, 1986; Hill, 2001).

6.4. Caregiver intervention incorporated in child's intervention

Several interventions for children have been developed to also include some parallel or adjunctive intervention for the caregiver (see review by Corcoran, 2004). Most of these interventions are based on cognitive behavioural therapy (CBT; Corcoran, 2004), though there are some based on filial therapy (Costas & Landreth, 1999; West, 2010), and again other studies that incorporate some parenting support or family therapy in the treatment package offered to the child, though these are usually not well defined which makes it difficult to draw conclusions on their efficacy (Friedrich, Luecke, Beilke, & Place, 1992; Grosz, Kempe, & Kelly, 2000). A recent meta-analysis of interventions incorporating caregivers has shown that there is benefit of involving caregivers in treatment, with better long-term outcomes for children (Corcoran & Pillai, 2008).

There are also indications that having caregiver involvement in treatment improves the acceptability and successful completion of interventions by children, which can be facilitated through multi-agency centres such as the Children's Advocacy Centres (CAC) in the United States where caregivers and their children are able to access services in one place (Cummings, Berkowitz, & Scribano, 2012; McPherson, Scribano, & Stevens, 2012; National Children's Advocacy Centre, 2013).

6.4.1. Interventions based on cognitive behavioural therapy

There are several interventions based on CBT that focus on the child, with involvement of the non-offending caregiver either in conjunction with the child's intervention, or as a separate component (Cohen, Deblinger, Mannarino, & Steer, 2004; Cohen & Mannarino, 1996a, 1997, 1998a, 1998b, 2000; Cohen, Mannarino, & Knudsen, 2005; Deblinger, Lippmann, & Steer, 1996; Deblinger, Mannarino, Cohen, & Steer, 2006; Deblinger, McLeer, & Henry, 1990; Deblinger, Steer, & Lippmann, 1999; Deblinger et al., 2001; King et al., 2000; Smith & Kelly, 2008; Stauffer & Deblinger, 1996). These studies show benefit for the child in accessing CBT-based interventions, with additional benefit of having caregiver involvement irrespective of whether this is individual support for caregivers or in a group format.

In several of these studies caregivers were provided with their own individual Sexual Abuse Specific Cognitive Behavioural Therapy (SAS-CBT) or Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) to decrease parental emotional distress, enhance parental support for their child, and manage child behavioural difficulties related to the abuse (Cohen & Mannarino, 1996a, 1997, 1998a, 1998b, 2000; Cohen et al., 2004; Deblinger et al., 2006). These studies reinforced the importance of parental support to improve children's outcomes following CSA, also over longer term, though the research was limited as they could not control for the children's individual therapy occurring concomitantly.

In other studies, caregivers accessed cognitive behavioural therapy (CBT) in a group format with other caregivers (Deblinger et al., 1990; Deblinger et al., 1996; Deblinger et al., 1999; Deblinger et al., 2001; Stauffer & Deblinger, 1996). As a result of participating in the CBT groups, caregivers reported reductions in intrusive thoughts and negative emotional reactions when compared to a supportive group (Deblinger et al., 2001). Additionally, they also noted decreases in parental distress and decreases in the levels of their children's sexualised behaviours (Stauffer & Deblinger, 1996). However, overall, mothers who received individual CBT interventions showed greater improvements in negative emotions and intrusive thoughts than those in support groups (Deblinger et al., 2001).

6.4.2. Child-centred play therapy

Several small studies have also investigated the impact of using filial therapy training (e.g., Child Parent Relationship Therapy; CPRT) for

children and their non-offending caregivers following abuse disclosure (Costas & Landreth, 1999; West, 2010). This type of intervention trains caregivers to show acceptance and empathy to their children with the aim of improving the parent-child relationship. Despite these studies being of small size, there is evidence that there is benefit to the parent-child relationship, increased acceptance of child, greater empathy, positive behavioural changes, and some improvement in the child's psychological well-being (Costas & Landreth, 1999; West, 2010). However, in their study, Deblinger et al. (2006) demonstrated that CBT based interventions were more efficacious than child-centred therapies both in the short-term and long-term.

6.4.3. Summary

Therefore, irrespective of whether the caregiver's adjunctive intervention occurs individually or in a group setting, caregivers reported benefits for themselves and their children as a result of getting their own intervention, irrespective of treatment modality.

6.5. Individual support for caregivers

Non-offending caregivers may require counselling separate from their children in order to help with their own healing processes (Carter, 1999). Therapeutic interventions have been advised for caregivers who experience difficulties with their child's behaviour, have unrealistic expectations for their child, lack involvement in their child's therapy, or are themselves in need of more intense treatment or support (Mara & Winton, 1990). Thus, it has been suggested that individual interventions with caregivers should include components that foster recognition of their role in child protection, enable them to acknowledge and deal with a range of emotions, understand normal behavioural development in children, as well as assisting to support their child through continued trauma processing (Mara & Winton, 1990). Individual therapy to address the caregiver's own healing processes may be particularly important if the caregiver has their own victimisation issues (Davies & Seymour, 1999a, 1999b; Manion et al., 1996). One study investigated the impact of up to five individual counselling sessions for non-offending caregivers and their children (van Toledo, 2010). The focus of these sessions was to provide caregivers with parental self-management and coping strategies, education about sexual abuse and its effects, and strategies to manage their children's behaviours. In general, caregivers reported improvements in their own coping, understanding, and management of their children, while they also noted improvements in their child. These changes were sustained at 12-month follow-up. Typically studies investigating individual therapies for caregivers are small and extraneous variables (such as individual support children may be receiving) are difficult to control for.

6.6. Aspects of interventions requested by caregivers and clinicians

Caregivers and clinicians alike have indicated the importance of including educational, supportive and therapeutic components in interventions, with some suggesting the usefulness of home visits to assist learning of behavioural management techniques (Barth et al., 1994; Ostis, 2002; van Toledo, 2010). Educational components may be particularly pertinent in preventing recurrence of intrafamilial abuse (Ostis, 2002). The need to involve paternal non-offending caregivers has also been highlighted (Humphreys, 1995; van Toledo, 2010).

Caregivers and intervention providers both indicate that cost may be a barrier to access, therefore the provision of childcare, reimbursement of travelling costs, and other incentives for participation (such as receiving educational credit for attendance) would increase consistent attendance at intervention sessions (Barth et al., 1994; van Toledo, 2010). Some parents expressed the desire for interventions to be provided earlier than they had experienced. Additionally, the importance of making

interventions available to non-offending fathers and couples has also been raised.

In summary, there is evidence that providing interventions for caregivers has a positive effect on the functioning of the child in their care, indicating the importance of providing targeted assistance for caregivers.

7. Research considerations

Although interventions for caregivers of children who disclose sexual abuse are available, adequate research in this area is minimal as indicated in the previous section. Most studies have small sample sizes, cultural homogeneity, lack control groups, and suffer from selection bias (Deblinger et al., 2001; Forbes et al., 2003; Ostis, 2002; Winton, 1990). The lack of control groups is a problem, as children may spontaneously recover from the negative impacts of CSA without the need for caregiver interventions (Hetzel-Riggin, Brausch, & Montgomery, 2007; Winton, 1990). Without a control group the effects of the intervention cannot be separated from maturation processes or spontaneous recovery. Additionally, much of the research fails to control for the fact that children often receive separate interventions alongside the caregiver intervention that is being evaluated (Forbes et al., 2003; Winton, 1990). While the need for randomised controlled trials is thus apparent (Forbes et al., 2003), this is difficult due to ethical concerns about withholding interventions and the sensitive nature of research in this area (Winton, 1990).

Furthermore, there is limited information about the effectiveness of different types of interventions for different characteristics of child and caregiver demographics including age, gender, and ethnicity. Although some studies identify these characteristics, the studies to date have generally had small sample sizes, used qualitative methods, and the majority of participants have been Caucasian mothers when identified. As a result the influence these characteristics may have on intervention effectiveness is unknown. In further research, it would seem important to not only gather information on characteristics and child and caregiver demographics, but also to ensure there is adequate sample size to allow for comparison between these groups.

Another issue with research into caregiver interventions is that the duration of interventions required to provide benefits both to the caregivers and their children has not been investigated (Ostis, 2002; Winton, 1990). Additionally, assessing the long-term effects by lengthened follow-up periods would provide further support of intervention effectiveness (Deblinger et al., 2001; Jinich & Litrownik, 1999; Ostis, 2002; Winton, 1990). In the research described above, only a few indicated the timeliness of intervention (Jinich & Litrownik, 1999; van Toledo, 2010), some merely stated that the time post-disclosure ranged from soon after disclosure until much later (Hewitt & Barnard, 1986; Hill, 2001), while the rest of the studies did not provide any information on this. This could have implications for deciding which treatment aspects would be useful at different times post-disclosure (Ostis, 2002).

Another area for future research is to investigate the effectiveness of educational resources available online, given the ever increasing reliance on the Internet. As has been pointed out in relation to parenting programmes with behaviour problem children, only a minority of parents access face to face programmes, and online resources have the potential for far greater population reach (Metzler, Sanders, Rusby, & Crowley, 2012). Self-directed and web-based support have been shown to be effective in enhancing parents' ability to manage the oppositional behaviour in their children (Sanders, Calam, Durand, Liversidge, & Carmont, 2008). A similar impact may be expected for parents of children who have been sexually abused: Jinich and Litrownik (1999) demonstrated that the mere provision of information is helpful to caregivers following disclosure of CSA, therefore it is likely that accessing online resources would also be beneficial. Future research could investigate the availability and effectiveness of online resources, whether used independently or in conjunction with face to face caregiver support.

Establishing a firm evidence base for interventions with caregivers of sexually abused children demands further research, with larger sample sizes, and control groups included. Further investigation of a range of delivery modalities is required in order to establish what interventions are most helpful, and for whom, according to different child and caregiver characteristics. Discovering how to improve population outreach with effective support will maximise the benefits for the victims of CSA and their caregivers.

8. Conclusion

There are strong indications for the need to provide interventions for non-offending caregivers of sexually abused children, particularly given what is presently known about the impact of CSA disclosure on caregivers and the value of caregiver support in assisting the caregiver and their children's recovery from such events.

The use of evidence-based practice is being increasingly acknowledged as a way of ensuring clients receive the most effective and efficient interventions available to them (Mudford, McNeill, Walton, & Phillips, 2012). Although to date there are only relatively small outcome studies in this area, the research evidence supports the need for caregiver interventions following the disclosure of CSA in clinical work. The appropriate targets for such caregiver interventions include provision of information, support, assistance in the care and management of their children, and responses to caregivers' own reaction to the disclosure of CSA by their child. Interventions may be provided in a group setting or individually, with the aims of increasing knowledge about the impact of CSA on the child and family, the needs of the child, and the investigation process; providing practical support for the care and management of the child; and providing caregivers with a space to process their own reactions to the disclosure of CSA in the family, which may be particularly salient if they themselves have a history of victimisation. The literature indicates that by more adequately addressing the needs of the caregiver after their child discloses CSA, the outcomes for the child may be improved.

There is no available information about how frequently and extensively such interventions are available to non-offending caregivers after CSA disclosure. However, in a sample of over 100 mothers interviewed by Davies (1999) in New Zealand, only a few had received services specifically targeted for parents. There are also very few available descriptions of intervention programmes provided for caregivers, which is surprising given the clear need for such interventions indicated in this review. The programmes that have been described and evaluated are generally small-scale descriptive studies employing qualitative methods without control groups. Additionally, different intervention goals are often mixed in studies, making an evaluation of effectiveness difficult. Future research is needed to address these deficiencies.

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