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An Integrated Approach to Treating Non-Offending Parents Affected by Sexual Abuse

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Abstract

Childhood sexual abuse has been associated with a number of serious physical and psychological consequences throughout childhood and into adulthood for both child victims and their families. This paper describes the preliminary outcomes of a pilot group program to treat non-offending parents of sexually abused children. This group program is integrative in its approach combining elements of trauma-focused cognitive-behavioral and psychoeducational/supportive interventions to treat non-offending parents of sexually abused children. This study also focuses on outcomes in terms of parental post-traumatic distress and general family functioning.

A small group of non-offending parents was recruited from a local child advocacy agency. Parents attended the twelve-week group program and outcomes such as parent post-traumatic stress and family dysfunction were examined. Measures of overall satisfaction and intervention feasibility were also examined at the end of the group intervention.

Favorable outcomes included a decrease in parent self-report of post-traumatic stress and select aspects of family dysfunction. Seventy five percent of parents completed the group program. Satisfaction questionnaire responses demonstrated highly favorable perceptions of the group's content, leaders, and helpfulness.

This study served as an initial step in the development of larger family-focused interventions involving parallel parent and child groups and focused family sessions. Outcomes may begin to shed some light on the need for more parent- and family-focused interventions in families that have been affected by sexual abuse.

INTRODUCTION

The child mental health system is available to respond to youth and families impacted by childhood sexual abuse. However, few “real world” providers have evidence-based expertise in addressing youth sexual victimization and its consequences (Cohen & Mannarino, 1996; King et. al., 2003). Even more rarely, does a provider have sufficient clinical expertise to involve non-offending family members in order to rebuild parent/child relationships and protective family processes. However, over the last decade, there have been important advances in understanding the mental health issues associated with childhood traumas such as childhood sexual abuse and in the development of mental health treatments that focus on addressing the mental health consequences of childhood sexual abuse (Cohen, Deblinger, Mannarino, and Steer, 2004). There has also been evidence that including the parents in treatment increases treatment efficacy.

Early groups for parents of sexually abused children focused on psychodynamically oriented or family systems interventions (Damon & Waterman, 1986; Hildebrand & Forbes, 1987; DelPo & Koontz, 1991) and contained little or no data on outcomes. More recent studies such as those by Winton (1990) and Celano, et. al. (1996) utilized supportive and psychoeducational interventions focused on addressing issues of self-blame, guilt, betrayal, hopelessness, and traumatic sexualization. The interventions used in these studies, however, were generally theory-driven and based on anecdotal clinical impressions. Though dealing with issues that affect parents, early studies failed to directly address post-traumatic stress in the child and the family. In the past decade, however, there has been an increased awareness of post-traumatic stress in sexually abused individuals and of the need for evidence-based practices. In new studies strategies have been implemented for taking effective treatments for children and applying these to treatment for non-offending parents of sexually abused children.

The present paper describes the preliminary outcomes of a non-offending parent group for families affected by sexual abuse. The intervention examined incorporates evidence-based cognitive-behavioral interventions with supportive/psychoeducational interventions. It focuses the implementation and outcomes around the parents’ experience of the abuse and on overall family distress and functioning. Cognitive-behavioral interventions (Cohen, Deblinger, Mannarino, and Steer, 2004) have been shown to better prepare parents for a child’s treatment and to decrease parental feelings of post-traumatic distress. More importantly, these interventions may also serve to improve overall family functioning. Using these interventions in combination with psychoeducational/supportive interventions aimed at improving family functioning is an area virtually untouched in the literature on child sex abuse treatment. The authors hypothesize that the participants completing this group intervention will demonstrate a decrease in a) symptoms of post-traumatic distress and b) improvements in general family functioning following completion of the twelve-week intervention.

Prevalence of Child Sexual Abuse

The National Center for Post-traumatic Stress Disorder (NCPTSD) defines sexual abuse as a range of sexual behaviors between a child and an older person that are intended to arouse the older person without consideration for the reactions or choices of the child. The NCPTSD estimates that as many as 10% of boys and 25% of girls in this country are victims of sexual abuse. The Justice Department estimates that about 44% of sexual assault victims are under age eighteen and that one in every six victims of sexual assault is under the age of twelve. Furthermore, the National Clearinghouse on Child Abuse and Neglect Information (2004) reports that 10% of all substantiated child maltreatment cases involve sex abuse, with girls being more likely to be abused. Additionally, in the mid-1990’s, it was estimated that 75% of the substantiated child sexual abuse reports made to child protective service agencies were

perpetrated against girls. Of children in grades five through twelve, 29% percent of the girls never reported the abuse to anyone.

NCPTSD adds that the actual rates may be higher as abuse typically occurs in private and sexual abuse can be difficult to detect. In addition, changes in reporting strategies used by child protection agencies over the last few years may have led to a decrease in reported and documented cases of abuse (Finkelhor & Jones, 2004) suggesting that these numbers may underrepresent actual numbers.

Consequences of Child Sexual Abuse for the Child

Prior research has linked the experience of sexual abuse in childhood with poor mental health and elevated sexual risk taking behavior (Widom & Kuhns, 1996). For example, childhood sexual victimization has been associated with an increase in adolescent suicide attempts, significant increases in the risk for psychiatric hospitalization (Briere et. al, 1997), experiences of serious depression (Kendall-Tackett, 2002; Banyard et. al., 2001), diagnosis of anxiety disorder (Briere & Elliott, 1994), post-traumatic stress disorder (PTSD) symptoms (Kendall-Tackett, 2002; Briere & Elliott, 1994; Lindberg & Distad, 1985), adolescent pregnancy, HIV infection (Zierler et. al., 1991), and HIV risk behavior (Cunningham et. al., 1994). Childhood sexual abuse has also been associated with other serious physical and psychological consequences throughout adolescence and into adulthood. This form of abuse is associated with development of eating disorders in women (Wonderlick et al., 2001) and self-mutilative behavior (Zlotnick et al., 1996). Boney-McCoy and Finkelhor (1995) also found that prior victimization (sexual abuse or other) increased the risk of future sexual victimization. In addition, in a study by Siegal & Williams, a history of child sex abuse was a significant predictor of criminal offenses involving aggression and drug use in a sample of women (2003). The authors also found a relationship between sexual abuse and running away during adolescence (2003). Siegal and Williams (2003) go on to point out that both drug abuse and running away put young women at increased risk of other crimes, namely prostitution.

Consequences of Child Sex Abuse for the Family

There is a growing body of literature that suggests that the impact of childhood sexual abuse on family processes necessary to support the development of youth through adolescence is severe (Davies, 1995; Manion, McIntyre, et. al., 1996). More specifically, the intervention of child protective services and law enforcement, while serving to protect the child, rarely addresses the consequences to the youth of severing a parental relationship and the associated feelings of youth and non-offending parental self-blame (Kendall-Tackett, 2002). In other instances, discovery of youth sexual victimization serves to immobilize non-offending parents and reinforce perceptions of parenting incompetence and self-blame (Kendall-Tackett, 1993). Common non-offending parental reactions to the disclosure of sexual abuse include: guilt regarding perceived failure as a parent, ambivalent feelings toward the child, ambivalent feelings toward the offender, and concerns about the investigatory and judicial process (Regehr, 1990). Parents of sexually abused youth experience significant levels of distress of various forms that occur independently of the child's experience of problems (Davies, 1995). Mothers of sexually abused children, as compared to mothers of non-abused children, experience greater overall emotional distress, poorer family functioning, and lower satisfaction in their parenting role (Manion, McIntyre et al., 1996). Family communication about the abuse presents a significant challenge that is often blocked by upset, lack of skills, and stigma associated with childhood sexual abuse (Manion, et. al., 1998). Thus, the relationship between the child and the non-offending parent is often compromised at a time when enhanced intra-familial support is most needed.

The Interface of Child and Family Consequences

Studies have documented that the quality of the family relationships predicts mental health and the overall adjustment of children (McNeely et al., 2002; Miller et. al., 1998). In addition, family-level factors appear to offer important supports for youth, including strong family functioning, community support, and the mental health of the non-offending parents (Drake & Pandey, 1996; Paradise & Rose, 1994). Conversely, there are a number of familial risk factors that have been linked to poor child/parent reactions to sexual abuse and youth outcome. Aside from concrete factors, there are family processes that have been linked to negative outcomes. Those examined in previous studies include: poor family coping, low levels of family cohesion and adaptability, lack of maternal support, and failure to protect or believe the child at the time of the abuse (Kendall-Tackett, 1993). Other family risk factors likely to negatively impact outcomes are marital conflict, having a parent who was also sexually abused, or having a parent with limited social supports (Kendall-Tackett, 1993). Kendall-Tackett (1993) adds that a supportive family environment can assist in a child's recovery from sexual abuse. Conversely when families are emotionally strained, enmeshed, and angry in their expression of distress, children have poor recovery outcomes. Banyard et al. (2001) highlights the need for group programs for non-offending caregivers to address these issues in order to increase the likelihood of child recovery.

Existing Evidence-Based Treatments of Child Sexual Abuse with Parental Involvement

Cohen and Mannarino (1998) developed and used Trauma Focused-Cognitive Behavioral Treatment (TF-CBT) with children with various traumas, including sexual abuse, and found that children receiving this form of treatment experienced significantly greater improvement over time in depression and social competence when compared to children in the control condition. One year after treatment, these children also had significantly greater improvement in PTSD and dissociative symptoms when compared to the control group. Deblinger et al. (1996) developed and implemented a more focused trauma-focused cognitive-behavioral treatment to sexually abused children and found that children who received this form of TF-CBT had significantly greater improvement in PTSD symptoms as well. In addition, those children who received treatment with their parents experienced significantly greater improvement in child-reported depression and parent-reported behavior problems. These outcomes were maintained at 2-year follow-up.

In other studies, Cohen and Mannarino (2000) found that parental support was a strong predictor of treatment response in children. Cohen, Deblinger, Mannarino, & Steer (2004) showed in another study that interventions helping parents resolve emotional distress optimized the parent's ability to be supportive of the child, and were likely to improve the child's outcome. Parents in a TF-CBT group showed greater improvement in their own self-reported levels of depression, abuse specific distress, support of the child, and effective parenting practices when compared to parents assigned to more traditional supportive group treatment. King et al. (2000) showed that children participating in family-based CBT had lower levels of fear when compared to children in individual treatment. The above studies strongly point to the overwhelming need for sex abuse treatments to address parent distress using interventions with demonstrated effectiveness outcomes.

Few previous articles, however, have examined the potential benefits of evidence-based TF-CBT in treating symptoms of post-traumatic stress in the non-offending parents or on the quality of family functioning. The current paper describes the preliminary findings of a non-offending parent group that makes use of integrated evidence-based cognitive-behavioral interventions with more traditional supportive and psychoeducational interventions. The latter interventions, though variably used in several child protection agencies throughout the country have never been published or systematically assessed for their potential benefits to parental

distress and family functioning of those affected by sexual abuse. Furthermore, previous cognitive-behavioral approaches have involved parents in individual and/or group therapies with components of psychoeducation, behavior management, coping, modeling, and gradual exposure. All of these interventions, however, predominantly focused on the child's experience of and distress in reaction to the sexual abuse.

The intervention examined in the current study incorporates all of the above interventions, but focuses the implementation and outcomes around the parents' experience of the abuse. The use of an integrated approach that emphasized parental mental health and family-focused outcomes was derived from an assessed clinical need among parents of children attending treatment at the study site. While children routinely received individual treatment with parental involvement, parents expressed a desire to receive treatment that focused on their own emotional needs following the abuse in a supportive setting. In addition, parents expressed an interest in having a group that incorporated an educational component that covered areas such as: information about the legal system, child protective procedures, forensic examinations, and other issues specific to the needs of a non-offending parent following sexual abuse of a child. The decision to implement the intervention in a group format was guided by the existing literature showing that group psychotherapy is the treatment of choice because of its therapeutic impact on the major negative effects of sexual abuse: isolation, stigma, and self-esteem (Reeker et. al, 1997; Lomonaco et. al., 2000; McCrone et al., 2005). Furthermore, group psychotherapy has been preferred over individual treatment because of its potential to be cost-effective, less labor-intensive, and for its capacity to serve high treatment demands. In cases where family support is limited, groups offer social supports and skills training not acquired from the family (Glodich & Allen, 1998).

Parents in this intervention engaged in the process of "telling their own story" about the effects sexual abuse had on them in the presence of other parents who shared a common experience. It is believed that this process allows the parent to process their own reactions, better prepare for their child's exposure, and decrease feelings of post-traumatic distress. More importantly, it may also serve to decrease overall levels of family distress. Addressing this specific issue is an area virtually untouched in the literature on child sex abuse treatment.

DESCRIPTION OF THE GROUP INTERVENTION AND PROCEDURES

Participants for the group program were recruited from a pool of caregivers presenting to a local child advocacy center for treatment and evaluation. The child advocacy center is an agency where families seek evaluations and treatment for sexual and/or physical abuse. Agencies such as, child protective services, district attorney's offices, and other child abuse prevention and child advocacy programs were also informed of the program via mailings of flyers and presentations at agency meetings describing the treatment program.

Once a potential participant was referred, a brief telephone screen was conducted to determine eligibility for the group intervention. If deemed eligible, potential group participants were then consented and evaluated by group facilitators. Each person was assessed for factors that would rule out participation in the program such as ongoing sexual or physical abuse, active substance abuse, current suicidal ideation or attempts, current domestic violence, or severe mental illness. Those subjects meeting criterion were invited to participate in the group program. Eleven parents were successfully recruited, however, one parent declined participation based on her feeling that the intervention content was too sensitive to discuss in a group setting.

Participants consisted of adult female caregivers with a child or children possessing a history of sexual abuse. Though the group was open to male participants, few male parents presented for treatment and of those presenting for treatment, none were successfully recruited into the

group. While both parents were invited to attend the group, all families elected to have one parent attend. In a few participating families, the father was the perpetrator and was, therefore, not allowed to have contact with the child. The type of abuse experienced by the children of the participants included: vaginal/anal/oral penetration, digital penetration, fondling, exposure to sexual acts between adults, and exposure to pornographic material. Ages of the children of the participants ranged from age 5–15. Participants were ethnically diverse reflecting Caucasian, African-American, Hispanic, and Haitian ancestries. Ages ranged from 27–52 years old. Groups met weekly for one and one half-hour sessions over twelve consecutive weeks.

Members completed pre-group and post-group questionnaires assessing post-traumatic stress and family functioning. All members also completed a personal goal-setting exercise at the start of the group intervention. Members also completed post-group satisfaction questionnaires at the end of the twelve-week curriculum.

Group Intervention and Curriculum

As mentioned earlier, the group intervention for this program integrated trauma-focused cognitive-behavioral interventions with supportive and psychoeducational interventions. The psychoeducational/supportive component of the intervention used for the current study was based on a group curriculum adapted by clinicians in the child advocacy center clinic where the study was conducted. The group's goals were to provide support, education, and to build self-esteem. The psychoeducational component exposed parents to information about sexual abuse, the child welfare/legal system, normal/maladaptive childhood sexuality, techniques of perpetrators, maintaining children's safety, managing sexualized behavior, and executing appropriate discipline. Other interventions focused on exploration of the dynamics of sexual abuse, discussions of parental family history, patterns of dysfunction in families, family communication styles, and stabilization of the family disruption following sexual abuse. Other interventions in this portion of the intervention focused on advocacy and empowerment for parents maneuvering through the child welfare and legal systems.

The second major component of the intervention used in the non-offending parent group program was based on trauma-focused cognitive-behavioral therapy (TF-CBT) (Cohen & Mannarino, 2000; Deblinger & Heflin, 1996). These interventions employed skills training commonly used in TF-CBT such as coping/relaxation, cognitive restructuring, and gradual exposure similar to that used in the TF-CBT development of trauma narratives. Each group session employed the integrative approach and was thus divided into two sections: the first section consisted of the psychoeducational/supportive portion and the second half was devoted to gradual exposure and other elements of TF-CBT as described above. For more information regarding the content of the sessions please contact the primary author.

Feasibility Assessment

After the non-offending parent group was completed a preliminary assessment of feasibility was conducted. This process allowed the authors to identify possible barriers to treatment attendance and adherence as a way to plan for future intervention development. Previous studies have shown that assessing barriers to treatment can help clinicians and researchers to effectively engage patients in treatment and improve long-term treatment adherence (McKay & Bannon, 2004). The authors coordinated a series of focused meetings with clinicians and individual interviews with group participants. Clinicians revealed site-level barriers, including: 1) space constraints 2) available time of staff and 3) need for coordination of refreshments. A problem-solving approach was used during this pilot program to address each barrier as it arose, with most of the above issues being easily resolved.

Group participants identified additional factors that facilitated or impeded attendance and implementation of the group program. A family advocate, not involved in the group process, conducted the one-on-one interviews so as to minimize biased responses. A description of the results of this feasibility assessment can be found below.

Measures

Parenting Stress Index (PSI) – Measures family stress and is used as a measure of family dysfunction (Abidin, 1995). The long form (101 items) was used which covers two main domains: Child and Parent. The PSI was normed and standardized on a diverse sample of over 2,800 males and females. Internal consistency values range from .70 – .84. Test re-test coefficients ranged from .63–.96. Sub-scale and domain development were based on factor-analytic studies. The domains measured in this questionnaire include: Child domain scales such as: Adaptability (cannot adapt to the environment), Acceptability (does not match parental expectations), Demandingness (places high demands on parent), Mood (has dysfunctional mood traits), Distractibility/Hyperactivity (possesses hyperactivity/distractibility); and Parent domain scales: Depression (depressed mood), Attachment (poor attachment to child), Role restriction (parental role restricts parental freedom), Competence (lacks childrearing skills), Isolation (isolated from peers), Spouse (lacks support from the other parent), and Health (deteriorating health). This measure also yields a Total Stress Score that measures the total amount of stress resulting from the combined child- and parent-domain scores, as well as, a Life Stress Score.

Stress Index for Parents of Adolescence - SIPA

The SIPA is a 120-item parallel version of the PSI for use with parents of adolescents. The PSI is only valid for use with parents of children ages 12 and under. The SIPA was used for parents of children older than age 12. There is an additional domain present in the SIPA, namely the Adolescent-Parent Relationship Domain. Other domain scores are identical to the PSI. The subscales within the Parent domain are: Life Restrictions, Relationships with Spouse/Partner, Social Alienation, and Incompetence/Guilt. Within the Adolescent Domains there are: Moodiness/Emotional Lability, Social Isolation/Withdrawal, Delinquency/Antisocial, and Failure to Achieve. Reliability alpha co-efficients ranged from .80 – .90 and test re-test coefficients ranged from .87 – .92. The SIPA has also been found to correlate significantly with measures of parent personality functioning, parental coping skills, family cohesion and adaptability.

The Impact of Events Scale

(IES) this measure assesses the presence of intrusive thoughts and avoidance of trauma-related reminders in parents who have experienced a traumatic event directly or within their environment. It consists of fifteen items and two subscales measuring presence of intrusive thoughts and avoidant behaviors.

Group Participation Evaluation Questionnaire (GPEQ)

This measure was developed specifically for use with the non-offending parent group program and assessed participants' satisfaction with the group content and the group process.

Barrier Checklist

This checklist was also developed for use in the group program. It is comprised of a list of potential barriers to treatment. Barriers were clustered into three domains: personal, site, and clinician-level barriers.

The IES and the PSI/SIPA were administered in a group format immediately prior to the start of the group during an orientation session and again at the end of the group intervention. Participants were informed in advance that the final group would require additional time at the end during which questionnaires would be completed. The GPEQ was completed at the final group session as well. The Barriers Checklist was also completed post-intervention. This questionnaire was completed via one-to-one interviews in order to accommodate the group members' schedules and to obtain answers that would not be influenced by the presence of facilitators or other group participants.

DESCRIPTION OF THE THERAPEUTIC OUTCOMES

Analysis of the pilot group data were examined via different methods. Pre- and post group responses on the administered measures were compared via a range of tests. Descriptive data from the Group Participation Evaluation Questionnaire and Feasibility Checklist were also examined.

To examine preliminary group outcomes, comparison tests were conducted on the total scores for each measure, as well the sub-scales comprising each given measure. Parent reports of family functioning, as measured by the subscales of the PSI and SIPA, were analyzed independently. The individual subscales of the PSI were examined to determine if there was a significant decrease in the parents' reports of family level distress resulting from child-specific and parent-specific factors prior to and following the intervention. A significant change in scores prior and subsequent to intervention was only yielded on the Parent Relations with Spouse subscale. Parents reported improved support from spouses following the intervention. However, there were trends in parents' reports of Child and Parent domain subscales. In general, parents reported lower levels of distress among the parent-domain variables. However, in contrast with this trend, parents reported higher levels of distress subsequent to intervention on many of the Child subscales. See additional discussion on this topic below.

On average, parents obtained higher scores in the Child Domain Total following intervention. Yet, on the Parent Domain Total, parents obtained lower scores following intervention. Scores from the SIPA were also examined pre- and post-group intervention. Parents reported a decrease in stress related to adolescent-specific and parent-specific sub-tests following the intervention on most of the subscales. In addition to the above finding, on average, parents obtained lower scores across the three domains total scores.

Given that both the PSI and the SIPA have Total Stress and Life Stress Indices that are comprised of identically-derived constructs; data from both the child and adolescent samples were combined to obtain an overall Total Stress Score and Life Stress Score. As with some of the earlier score comparisons, there was a downward trend in the scores for each index with parents reporting lower levels of Total Stress and Life Stress following the group intervention.

Changes in parents' traumatic stress reactions related to the sexual trauma of their children were also examined. The Avoidance and Intrusion subscales, as well as, the Total Score were examined. A decrease in scores was again noted. Parents reported lower levels of intrusive thoughts and avoidance of trauma-related material surrounding the sexual abuse of their children.

Attendance records from the parent group were examined in order to assess compliance with the group treatment and feasibility of the intervention protocol. Attendance rates for the twelve-week program ranged from 75–80%, with the majority of group participants completing the full group intervention protocol. This rate is quite favorable when considering that national averages can be as low as 48–64% (McKay & Bannon, 2004). In addition, post-group satisfaction questionnaires allowed us to more directly assess parents' opinions about various

aspects of the group. Table 4 lists the group aspects measured in the questionnaire. It is particularly noteworthy that when rating the various aspects of the group, no participants rated the group topics to be “Somewhat Unhelpful” or “Unhelpful”. On the contrary, all participants rated the group topics as being “Helpful” or “Very Helpful”. In addition, when asked questions about the desire to recommend the group to others or about the group meeting parental needs, all parents responded “Yes”.

Other open-ended questions were asked at the end of the questionnaire where participants could list additional comments of their own choice in blank spaces. Responses for the open-ended questions were generally favorable. Parents listed aspects or benefits of the group that contributed to its overall effectiveness. The comments listed included social support received from other group parents, the opportunity to share feelings about the abuse with others, increased communication with their children, and increased understanding of themselves and of how sexual abuse occurs. When barriers to treatment were assessed among parents that completed the group and those that did not complete the group various reasons were offered. Interestingly, many of the critiques from parents reflected situations that were unrelated to the content of the group interventions. One non-completer parent offered the current desire to avoid discussing her child’s sexual abuse as a reason for leaving the group after the first session. This avoidance distinctly distinguished this parent from other completer parents in the group, all of whom emphatically supported the process of discussing the abuse and its effect on themselves and the family. Some of the critiques offered by both completers and non-completers included limited opportunities to contact group members outside of group, members leaving group early due to family obligations, and the absence of groups of longer duration.

As mentioned previously, our evaluation of therapeutic outcomes also included an assessment of feasibility to explore barriers to treatment. The majority of group members indicated that personal, site, and clinician-level barriers did not prevent them from attending group treatment (See Table 5.). Of those respondents who reported barriers, personal-level barriers presented the greatest obstacle. No group participants indicated that clinician-level barriers prohibited them from obtaining treatment. In cases where barriers to treatment existed, these issues often did not result in a parent discontinuing participation in the group.

DISCUSSION

Prior literature in the field of sexual abuse of children linked sexual abuse with a number of mental health consequences (Briere et. al, 1997; Widom & Kuhns, 1996; Kendall-Tackett, 2002). Other literature suggests that sexual abuse has enduring consequences for the non-offending parents in such families (Regher, 1990; Davies, 1995). Furthermore, there has been substantial documentation of the relationship between poor family functioning and child mental health outcomes when a child has experienced sexual abuse.

This pilot non-offending parent group program is unique in its combined use of evidenced-based trauma-focused cognitive-behavioral techniques and psychoeducational/supportive interventions specifically developed for non-offending parents. The interventions used herein also differ from other interventions in that outcomes are centered around the non-offending parents’ post-traumatic experience of the abuse and the potential effects on family distress and functioning. Previous treatments have centered interventions around the child’s experience of the abuse, often leaving important parental and family issues unresolved. The present program is part of a preliminary treatment development project aimed at specifically designing interventions to address parent and child mental health issues, as well as improving family functioning in a number of areas. Future interventions for this project will include parallel child and parent groups to address sexual abuse as it more directly affects the family.

The outcome questionnaire scores, post-group satisfaction questionnaires, and attendance records from the current pilot were all examined. Examination of pre and post- group responses on measures of family-related stress and post-traumatic reactions demonstrated a decrease in scores in several areas. In the child-related areas of stress, parents reported lower levels of child hyperactivity and acceptability. In the adolescent domain, parents reports demonstrated lower levels of stress related to their child's mood, isolation, and delinquency-related behaviors. In the areas specific to parent-related stress, there were lower scores in the areas of: incompetence, attachment, health, role restriction, spousal relationships, and adolescent-parent relationships. Scores reflecting overall levels of family-related stress, such as Total Stress and Life Stress, also changed post treatment.

A curious finding that emerged from the data was the presence of an increase in a number of the stress-related scores. Most of these were found in the child domain total score and subscale scores. These increases were found in the areas of stress related to child adaptability, child demandingness, and child mood. In the parent domain subscale scores, parental depression showed a slight increase as well.

When examining post-traumatic stress reactions prior to and following the group intervention, a decrease was again noted. Parents reported less severe symptoms of intrusive thinking related to the abuse and less avoidance of abuse-related material, including conversations about the abuse. This finding, however, is particularly noteworthy given its direct potential relationship to child treatment outcomes. This issue will be addressed in more detail below.

As mentioned previously, results should be interpreted with caution, as the group size was small. While decreases may be attributable to improvements resulting from the intervention, it is still puzzling that some scores actually increased post-treatment. There may be various reasons for the increase in scores. For example, parent-related depression increased. It is not uncommon for parents or victims of abuse to experience more negative feelings as awareness of the circumstances of the abuse and their reactions in response to the abuse increase. The particular intervention used in this program did not address all symptoms of depression directly, but focused on post-traumatic symptoms regarding the sexual abuse. In addition, though parents and victims may experience more intense emotions during treatment it is also common for families to report an increase in the ability to cope with feelings, which in turn, can reduce impairment in functioning. The increases in child-related stressors may have been due to a number of factors. It is important to note that there was a large amount of variation in the treatment status of most of the children whose parents participated in the pilot group. Many of the children were not in treatment consistently and others were in treatment outside of the clinic where the parent group occurred. Those children in treatment at the clinic were in various forms of treatment and at different stages of treatment. It is possible that the abuse-related symptoms/ issues that originally led to treatment in many of these children had not yet been resolved. This hypothesis is particularly noteworthy, as it would support the notion of the need for children and parents to have parallel treatments. When appropriate, parallel parent and child treatment allows the family the opportunity to potentially progress and resolve issues uniformly over the course of treatment. This parallel process may lead to further improvement in individual and family outcomes as well.

Attendance records during the group showed that the vast majority of participating parents remained in the group treatment for the duration. Group satisfaction questionnaires allowed parents to rate the group along a number of different variables. Parent ratings were overwhelmingly favorable, with parents providing few critiques. The intervention parents rated most helpful was that in which each parent "told his/her story" about the abuse from their own perspective. This form of gradual exposure is entirely focused on the parents' experience of the abuse rather than focused on the child's experience. It is believed that this process enhances

the parents' treatment outcomes much in the way that a TF-CBT trauma narrative enables the child to become desensitized to traumatic reactions to their own abuse. Furthermore, it is believed to enhance a parents' involvement in their child's treatment by preparing them for joint sessions with their children, as well as, facilitating coping of their own reactions and communication with their child about sexual abuse and its consequences. The potential benefits of this type of treatment on family communication and overall family functioning has yet to be subject to systematic scientific evaluation. The current program may begin to answer some of these questions.

Future directions in treatment development may examine the way these treatments impact on family communication styles, particularly around sexual abuse and its potential consequences. A benefit in this area may improve parent and child mental health, but may also serve to improve another problem area commonly present among sexual abuse victims, sexual risk taking and risk of HIV infection.

Exploration of these factors is a potential strength of the current program and something that makes it unique in comparison to past studies in the field of sexual abuse among children. Another strength is the emphasis on assessing treatment outcomes for parental post-traumatic stress reactions and family-level distress. Furthermore, as mentioned above, this pilot group intervention combines the use of evidence-based treatments and supportive non-offending parent group interventions. Unlike others, this group treatment focuses all trauma-specific interventions on the parents' post-traumatic experience of the abuse so as to facilitate child treatment and promote overall family mental health.

Unlike most other treatment outcome studies, the current project incorporated the use of a feasibility assessment to determine the presence of barriers to treatment adherence. This process allowed the research team to evaluate existing barriers and plan for future studies. Though some barriers were identified, these did not significantly impact participation. In fact, the vast majority of parents in the pilot evidenced high rates of attendance. The authors believe this outcome was the result of procedures meant to enhance involvement and reduce obstacles to treatment. For example, trained and supervised volunteers provided child-care, food was served during and after group, and funds were provided for transportation.

Despite the unique integrative approach of the current pilot, it has some limitations as well. The most obvious limitation of the study is the small group size and the resulting limited generalizability. Another obvious limitation is the absence of a control group or randomization procedures, which limit the ability to exclusively attribute any post-treatment changes to the intervention. This study was intended to serve as a pilot and the preliminary work for a larger treatment development project. Future projects will make use of larger numbers of participants and involve implementation of a parallel group for the children affected by sexual abuse. Both parent and child treatments will run concurrently and culminate in a series of joint sessions for both parents and children centered around the sexual abuse narrative and parent-child communication.

Another weakness of this pilot is the limited assessment of variables such as parental general mental health. As a pilot project with few participants, the authors were limited in their ability to assess many important variables. Due to limited resources, only self-report measures were used. Future projects will include both clinician and self-report measures of issues such as: child mental health variables, parent mental health variables, family functioning, family communication, and sexual risk-taking behavior.

CONCLUSION

For social workers treating children and families presenting with histories of sexual abuse and trauma, the outcomes and future directions of this pilot intervention present an opportunity to begin developing a comprehensive evidence-based treatment model. Although many clinicians generally encourage parental involvement when working with abused children, there have been few studies that actually attempt to systematically involve parents in treatment specifically geared towards improving family outcomes. Addressing and processing the range of emotions that often plague non-offending parents, from guilt to shame to inadequacy and more, allows parents to move past the silence that typically surrounds a child's abuse. This adjustment can lay the foundation for improved coping skills for the parent and an increase in willingness and motivation to aid their child's treatment and recovery.

Despite the limitations of this pilot, this group program raises complex questions and concerns for clinicians and researchers in the field of child sexual abuse. Previous publications have emphasized the need for therapists to attend to the need of non-offending parents of sexually abused children. However, there is still a question as to whether or not present treatments sufficiently meet the needs of non-offending parents. Do existing treatments need to go beyond providing parents with tools to help their children cope with sexual abuse? Do some families need a more parent-specific and/or family-specific focus to promote overall family mental health, consequently, enabling families to cope with some of the long-term consequences of child sexual abuse? As social work practice has largely focused on strengthening family systems, it almost seems imperative that future treatment models for abused children and their parents implement an integrative treatment paradigm, allowing for parallel treatment of children and parents. The present pilot project takes the first step in addressing some of these questions and concerns, and in developing treatments with a more family-focused approach to recovery.

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Table 1
Paired Samples T-Test Results for PSI and SIPA Subscales at Pre- and Post-Assessment (N = 10)

Subscales	Preassessment		Postassessment		Significance	
	M	SD	M	SD	t Value	p Value
Distractibility/Hyperactivity	25.00	7.31	24.80	6.91	.22	.84
Adaptability	25.00	7.45	27.40	9.37	-.95	.40
Reinforces Parent	12.40	4.62	11.20	6.57	.66	.55
Demandingness	21.40	5.03	23.40	7.47	-1.80	.15
Mood	10.60	3.05	11.40	4.39	-.57	.60
Acceptability	17.20	7.60	16.60	8.62	.74	.50
Competence	27.20	8.23	29.60	7.50	-.66	.55
Isolation	12.40	2.88	12.40	3.97	.00	1.00
Attachment	15.20	5.12	14.60	4.93	.61	.57
Health	14.20	3.70	13.60	6.02	.36	.74
Role Restriction	16.20	5.89	15.20	4.76	1.12	.33
Depression	19.40	7.99	20.20	9.88	-.52	.63
Spouse	18.40	4.04	15.80	5.36	2.98	.04*
Moodiness/Emotional Lability	33.80	8.67	29.60	13.39	1.31	.26
Social Isolation/Withdrawal	25.40	8.29	23.00	9.38	2.06	.11
Delinquency/Antisocial	22.20	13.12	20.00	11.36	1.58	.19
Failure to Achieve or Persevere	27.20	11.32	27.40	12.90	-.12	.91
Life Restrictions	29.80	13.55	29.40	15.84	.19	.86
Relationship with Spouse/Partner	17.00	7.00	18.00	12.59	-.33	.76
Social Alienation	17.60	3.65	17.20	2.28	.26	.81
Incompetence/Guilt	23.40	7.77	20.40	3.78	.99	.38
Adolescent-Parent Relationship	46.20	14.55	39.40	14.71	1.56	.19

* NOTE: Results are significant at the $p < .05$ level.

Table 2

Means and Standard Deviations for Combined PSI and SIPA Domain and Total Stress Scores Pre- and Post-Assessment

<i>Subscales</i>	Preassessment		Postassessment	
	M	SD	M	SD
Child Domain	111.6	32.2	114.8	40.2
Parent Domain	123.0	28.0	121.4	33.8
Adolescent Domain	107.6	37.3	100.0	45.6
Parent Domain	87.8	17.0	66.0	30.4
Adolescent-Parent Relationship Domain	46.2	14.5	39.4	14.7
Total Stress	238.1	56.4	230.1	76.4
Life Stress	6.3	7.3	4.5	6.7

Table 3

Paired Samples T-Test Results for IES at Pre- and Post-Assessment (N = 10)

Subscales	Preassessment		Postassessment		Significance	
	M	SD	M	SD	t Value	p Value
Intrusion	18.40	9.38	16.10	6.19	.69	.51
Avoidance	18.60	11.36	17.00	9.76	.50	.63
Total Score	37.00	13.52	33.10	14.66	.68	.52

Table 4

Participant Group Satisfaction Ratings

Aspect of Group	Response Choices	Percentage of Participants' Response Choices
Group Size	Just Right	100%
Length of sessions	Just Right	40%
	Too Short	60%
Length of group	Just Right	30%
	Too Short	60%
	Too Big	10%
Sharing your Story	Very Helpful	90%
	Helpful	10%
Group Discussion	Very Helpful	100%
Co-leaders	Very Helpful	90%
	Helpful	10%
Group should continue	Yes	100%
Obtained needed information	Yes	90%
	No	10%
Recommend group to others	Yes	100%

Table 5

Endorsed Obstacles to Treatment

<i>Barrier</i>	Percent Endorsing Barrier
Childcare	14.3
Transportation	0.0
Health of Self/Child	14.3
Competing Priorities	14.3
Time Constraints	14.3
Sensitivity of Material	14.3
Other	0.0
Total Personal Level	10.2
Center Environment	0.0
Reception at the Center	0.0
Treatment from other Staff	0.0
Time of the Group	14.3
Location of the Center	28.6
Group Room	0.0
Other	0.0
Total Site Level	6.1