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Interventions for families victimized by child sexual abuse: Clinical issues and approaches for child advocacy center-based services

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ABSTRACT

Child sexual abuse poses serious mental health risks, not only to child victims but also to non-offending family members. As the impact of child sexual abuse is heterogeneous, varied mental health interventions should be available in order to ensure that effective and individualized treatments are implemented. Treatment modalities for child victims and non-offending family members are identified and described. The benefits of providing on-site mental health services at Child Advocacy Centers to better triage and provide care are discussed through a description of an existing Child Advocacy Center-based treatment program. Recommendations for research and clinical practice are provided.

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1. Introduction

Child sexual abuse (CSA) has received increasing attention and concern in today's society as it continues to pose serious and pervasive mental health risks to child victims and their non-offending family members. There is increasing documentation that child and adolescent victims of sexual abuse and their non-offending parents and siblings are in need of mental health services (e.g., Baker, Tanis, & Rice, 2001; Heflin, Deblinger, & Fisher, 2000; Putnam, 2003; Swenson & Hanson, 1998). In the aftermath of CSA, families often face multiple challenges (e.g., loss of income, loss of a caregiver, change of residence, and limited community support) that are often accompanied by psychological distress, such as depression, guilt, embarrassment, grief symptomatology, and secondary trauma (e.g., Deblinger, Hathaway, Lippman, & Steer, 1993; Manion et al., 1996; Regehr, 1990). Given these difficulties, the need for accessible and varied interventions is paramount for not only CSA victims, but also for their non-offending family members.

Child Advocacy Centers (CACs) are increasingly being utilized as initial access sites for mental health services for sexual abuse victims, either through the provision of referrals to community agencies, or on-site care. As community-based programs designed to be child-friendly facilities, CACs approach child maltreatment as a multifaceted community problem (Jackson, 2004). Since the establishment of the first CAC in Huntsville, Alabama in 1985, there are more than 900 established and developing CACs nationwide as of 2007 (National Children's Advocacy Center, 2007). Child Advocacy Centers may be the optimal locations for immediate on-site services within a convenient, accessible, and familiar environment, as well as for prompt provision of referrals.

Given the continued prevalence of CSA in today's society and increasing utilization of CACs as the initial sites accessed by families following disclosure, the purposes of the present paper are twofold. First, various types of mental health interventions and modalities available to child victims and their families as they begin to deal with the consequences of CSA are described. The modalities of interventions that are examined include: (a) crisis interventions in the immediate aftermath of disclosure and investigation, (b) brief time-limited individual interventions, (c) group interventions, and (d) the need for longer-term interventions and referrals. The modalities of interventions, as organized in this paper, focus on attending to needs of families as they present at CACs following CSA. That is, while some families may experience marked distress in the immediate aftermath of disclosure and require prompt crisis or brief time-limited interventions, others may benefit from group interventions or referrals for longer-term services. For this reason, a variety of interventions will be discussed. Relevant literature is reviewed and a model mental health program implemented at a local CAC is described.

Second, rationale and recommendations for the dissemination of these interventions on-site at CACs will be provided. While a review of interventions currently provided at CACs is warranted, no literature presently exists. Recommendations for future directions for research and clinical practice are provided. Prior to examining treatment approaches, the heterogeneous impacts of CSA on child victims and non-offending family members will be explored to provide an understanding of the types of services needed. For the remainder of this paper, "victims" include children and adolescents, and "non-offending caregivers" include biological parents as well as any primary caregiver (i.e., step or foster parent), unless explicitly noted.

2. Varied impacts on child victims and families

In contrast to youth in general who may be referred to mental health services in response to a psychological disturbance, behavioral problems, or emotional distress, victims of CSA are initially brought to the attention of professionals because of the trauma they have endured. Thus, it is understandable that the impact of CSA on the child victim is identified as quite complex and heterogeneous, and is commonly described as short-term and/or long-term in its effects. While much research and clinical practice has focused on the varied impacts and difficulties experienced by child victims (e.g., Beitchman, Zucker, Hood, daCosta, & Akman, 1991; Beitchman et al., 1992; Finkelhor, 1990; Swanston et al., 2003; Wolfe, 2006), non-offending caregivers have been largely overlooked. In a review of past literature, Corcoran (1998) noted that non-offending mothers had generally been viewed negatively by others, specifically as being indifferent, passive, and permissive of the sexual abuse. In addition, Deblinger et al. (1993) and Heflin et al. (2000) noted that the literature on CSA has been highly critical of non-offending mothers of incest cases, and tended to view these mothers as indirectly responsible for the abuse, denying the abuse, colluding with the perpetrator, encouraging their daughters to assume a parental/spousal role, and being socially isolated.

However, few empirical studies support these negative views of non-offending caregivers. Rather, the majority of non-offending caregivers appear to suffer greatly or be traumatized upon discovery of their children's sexual abuse (Corcoran, 1998; Deblinger et al., 1993; Manion et al., 1996; Newberger, Gremy, Waternaux, & Newberger, 1993). Initial reactions by non-offending caregivers may include anger toward the perpetrator, displaced anger toward family members, guilt, self-blame, helplessness, panic, denial, shock, embarrassment, feelings of betrayal, a desire for secrecy, and fear for the child victim (e.g., Elliott & Carnes, 2001; Manion et al., 1996). In a longitudinal study of maternal adjustment, Newberger et al. (1993) found that non-offending mothers exhibited a range of symptoms, including: depression, anxiety, hostility, somatic symptoms, paranoid ideation, and psychoticism. In addition, non-offending caregivers may attempt suicide or require hospitalization following their child's disclosure (Deblinger et al., 1993), and often display symptoms of PTSD and grief symptomatology (Manion et al., 1996). Stauffer and Deblinger (1996) noted that non-offending parents often experienced elevated levels of psychosocial distress up to an average of two years following their child's disclosure of CSA.

While the literature on paternal functioning following the disclosure of extrafamilial CSA has been limited, Manion et al. (1996) reported that fathers are just as likely to experience significant levels of distress as non-offending mothers.

Non-offending caregivers may also experience considerable social, emotional, and economic consequences (e.g., stigma, increased feelings of isolation, loss of partner, loss of income, disruption of the family especially with intrafamilial CSA, change of residence, and dependence on government assistance; Elliott & Carnes, 2001), which may be more pronounced depending on whether the abuse is intrafamilial or extrafamilial. However, Manion et al. (1996) found that the majority of families in their study were able to cope fairly well despite the disclosure of extrafamilial CSA. Thus, the impact on non-offending caregivers appears to be variable, as is shown for child victims of CSA. Given the critical need for support from non-offending caregivers, particularly following disclosure, and the impact of parental distress on the child's recovery, the impact of CSA on non-offending caregivers warrants further attention (e.g., Corcoran, 1998; Stauffer & Deblinger, 1996).

Similarly, the literature on the short- and long-term effects on non-abused siblings of child victims is unfortunately sparse (Hill, 2003). Not surprisingly, siblings are not immune to the many changes that commonly take place following disclosure of CSA. Siblings may face several adverse effects, including: psychological distress of having viewed or known of the abuse; greater risk of victimization; change in family dynamics; change of residence; change of school districts; loss of friends; increased feelings of isolation, shame, and stigma; and reduced family income (e.g., Baker et al., 2001; Swenson & Hanson, 1998). The level of parental and peer support for the non-abused sibling, as well as their own psychological functioning following disclosure of CSA by the