The development of a structured support group for non-offending caregivers of sexually abused children

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Abstract

Child sexual abuse (CSA) affects children and their families daily in South Africa. Non-offending caregivers play an important role in their children's recovery following CSA but there are no interventions to assist caregivers to overcome their emotional reaction to CSA disclosure and to assist them to help children their children recover.

In this study, the process of developing a structured support group programme for non-offending caregivers in South Africa is discussed and its value for caregivers assessed. The programme has been developed to fit the needs of non-offending caregivers in South Africa, using an action research approach. The study utilised a mixed-method design, with a one-group pre-test, post-test design to assess the outcome of the psychoeducational support group program. The qualitative data from the psychoeducational support group sessions were used in conjunction with the pre- and post-assessment of the Hospital Anxiety and Depression scale (HADS), assessing levels of emotional distress, and the Parenting Stress index (PSI-4-SF).

The support group members were recruited for the study from Teddy Bear Clinic (TBC) and (WMACA) Kidz Clinic. Non-offending caregivers were invited to take part in the psychoeducational support group programme. Over five months, 60 non-offending caregivers were recruited for the study, 13 of whom were screened for the support group intervention and eight agreed to participate in the psychoeducational support group intervention. Two support groups met for eight sessions. Following the implementation of the program, the results from the pre- and post-intervention assessment were analysed and compared, in order to statistically determine the impact of the structured support group programme. Participants' qualitative experiences during the support group session and feedback regarding their perceived personal benefits from their involvement was analysed using thematic analysis.

The findings of the research indicate that the caregivers experienced significantly less anxiety ($p < 0.05$), and some improvements in their depression levels ($p = 0.58$) as measured by the HADS. Of the seven non-offending caregivers six expressed less anxiety and five experiences less depression symptoms after the intervention. Parenting stress did not decrease significantly for the group as a whole, although the total stress (TS) scale score indicated that five of the seven group members experienced less parenting stress after the intervention.

From the results of the study, it can be concluded that the support group had value to address the non-offending caregiver's level of anxiety and depression, as well as to relieve parental stress for some participants. The qualitative results also showed that members learned some parenting skills on how to manage their own and their children's emotional reaction to CSA. It was found that members who actively participated and attended all the sessions benefitted most. This intervention can fill the gap in treating non-offending caregivers following the disclosure of CSA. It can be implemented in Child abuse treatment centres to assist caregivers to help their children overcome the impact of CSA.

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CHAPTER 1 INTRODUCTION

In South Africa, child sexual abuse (CSA) is classified as a criminal offence and is defined across various disciplines, as an act with a child before the age of legal consent that gratifies the sexual desires of an adult and/or an older child (Criminal Law [sexual offences and related matters] Amendment Act 32 of 2007). CSA usually involves penetration of genitals into any bodily orifice, exposure of sexual anatomy; forced viewing of sexual anatomy; and showing pornography to a child or using a child in the production of pornography (Johnson, 2004; Meinck, Cluver, Boyes, & Mhlongo, 2015; World Health Organisation, 2017). Children from any economic background, race, culture, religion as well as gender can be sexually abused (Kloppen, Hauglad, Svedin, Meuhle, & Breivik, 2016).

There is a high prevalence of CSA worldwide. South Africa has the highest number of reported CSA cases in the world, although experts think that it may be under-reported (Arts, Ward, Leoschut, Kassanjee, & Burton, 2018). Experts believe that the cases reported are but a fraction of the actual child sexual abuse incidences occurring daily (Meinck, Cluver, & Boyes, 2017; Murray, Nguyan, & Colen, 2014). One reason for underreporting CSA is that the vast majority of South Africans experience difficulty accessing social and protection services. This often leaves children who have experienced CSA, non-offending caregivers and their family members uninformed about their rights and intimidated or disempowered to disclose sexual abuse because of a lack of the know-how when it comes to reporting the sexual abuse. There is a lack of services to attend to their overall well-being (The South African integrated program of action: addressing the violence against women and children, 2013-2018).

This research focuses on learning more about the experiences of non-offending caregivers of children who have been exposed to CSA and the development of an intervention to improve their psychosocial well-being. For this study, non-offending caregivers are defined as non-perpetrating caregivers of children who have been identified as being sexually abused. They do not have to be biological parents, but rather primary caretakers of the children.

This study is motivated by the high prevalence of CSA, the serious impact that CSA can have on children and non-offending caregivers and the lack of therapeutic support, especially for non-offending parents or caregivers. In this research, a supportive intervention is developed to provide non-offending caregivers with knowledge and support to access resources to provide their child with optimal support to help them overcome the impact of CSA.

1.1. Research Problem

1.1.1. CSA trends in South Africa

In South Africa, high levels of CSA are reported. Between 2013 and 2014, 51 cases of sexual violence and assault were reported daily, with a total of 18 524 cases captured in the police statistics. Due to non-specific data capturing, it was difficult to distinguish how many of the cases were rape of adults or child sexual abuse. In the recent SAPS statistics report (2019/2020, March/April) the crime-related data distinguishes between crimes against women and children, which is painting a clearer picture of issues

faced by the children of South Africa. While the numbers for sexual offences against children show a slight decline (2317) between 2018/2019 (24387) and 2019/2020 (22070), it is important to note that over five years the total number of sexual offences against children remained high between 2015/2016 (26514) to 2019/2020 (22070). This is supported by the Optimus Study, as their findings showed that about 18 000 to 20 000 cases of sexual assault are reported to the police yearly (Arts, Ward, Leoschut, Kassanjee, & Burton, 2016). In the SAPS statistic report, sexual offences refer to rape, sexual assault, attempted sexual offences and contact sexual offences. Of the total sexual offence crimes against children, rape ranked the highest with 17 118 recorded cases and contact sexual offences reported the least with 638 recorded cases.

The sexual offences crimes recorded by the police should be taken circumspectly as they may not represent an accurate measure of either the extent or trend of this crime (Kloppen et al., 2016; SAPS statistics, 2019/2020). For instance, the provincial data captured for crimes against children are reported under an umbrella category (contact crimes against children) making it difficult to locate where the cases for sexual crimes against children are reported, therefore making it difficult to locate interventions in the places where children and their families can access them.

Recent community research has provided more accurate CSA trends occurring in South Africa. The Optimus Study provided the first-ever nationally representative data in South Africa for incidence and prevalence of different forms of violence and maltreatment directed towards children (Arts et al., 2016). The Optimus study highlighted that it is important to understand the prevalence of child maltreatment in the country, to identify where intervention resources should be deployed (Artz et al., 2016; Mendelson & Letourneau, 2015).

The three-year study was undertaken by the Centre for Justice and Crime Prevention (CJCP) and the University of Cape Town. The study was designed to capture data on:

- The annual incidence and prevalence rate of CSA and maltreatment in South Africa
- CSA within the context of other forms of maltreatment and violence
- The extent and nature of other forms of child abuse and violence, including physical abuse, emotional abuse, neglect and exposure to other forms of violence, such as peer victimization, criminal violence and witnessing violence.

The study used two data sources, surveys from schools and households and in-depth interviews from agency frontline staff and workers serving the community. A sample of adolescents aged between 15 and 17 was recruited from schools (N =4, 095) and households (N =5, 635) drawn from 725 enumerator areas throughout the country for purposes of precision and coverage, with a 65% / 35% urban-rural split.

Population surveys were conducted using the Juvenile Victimization Questionnaire (JVQ) (Finkelhor, Hamby, Ormrod & Turner, 2005). The JVQ was conducted in two formats, self-administered

questionnaires (SAQ) and interview administered questionnaires (IAQs) to get an accurate picture of the nature and extent of CSA and maltreatment.

SAQs showed higher disclosure rates of abuse when compared to the IAQs conducted in schools and households. While IAQs were useful for improving participant response rates, SAQs offered the respondents the opportunity to answer the more sensitive questions in private which revealed significant results for the prevalence of CSA. As such, school SAQs results were prioritised when discussing the prevalence of CSA (Artz et al., 2016). In general, the results from the population surveys (SAQs and IAQs) indicate that one in three South African young people reported experiencing some form of sexual abuse in their lifetime.

a) School versus Household statistics.

The (SAQs) completed in schools, indicated that boys (36.8%) were more likely to report some form of sexual abuse than girls (33.9%), in both urban and rural areas. For the sample analysed geographically, females from urban areas (34.4%) are more likely to experience some forms of sexual abuse when compared to females in rural areas (27.2%). According to the study findings, in an average class size of 40 children, an estimated 12 learners would have experienced some form of sexual abuse.

In contrast to the school SAQs, household SAQs showed lower overall reported rates for child sexual abuse. In the household surveys, more girls (27.6%) reported experiencing some form of sexual abuse, compared to boys (25.2%) (Artz et al., 2016). When analysed geographically, the rates for girls reporting some form of sexual abuse experience is slightly higher in urban areas (28.4%) than is reported in rural areas (27.2%). On the other hand, males reporting some form of sexual abuse in urban (24.8%) and rural (25.7%) areas showed no significant differences.

b) The vulnerability of sexual abuse among boys and girls

According to the findings of the Optimus study, boys and girls are equally vulnerable to experiencing some form of sexual abuse throughout their lifetime (Artz et al., 2016; 2018). The rates where adults (18 years and older) were the perpetrators of children was equal for girls (15.8%) and boys (15.5%) (Artz et al., 2016). It is important to note that while both girls and boys may be vulnerable to CSA, the type of sexual abuse they are exposed to differ. For instance, girls (14.5%) are more at risk of experiencing forced penetrative sexual abuse than boys (9.1%). Boys (17.6%) reported more forced exposure to sexual abuse without physical contact, compared to girls (7.8%) (Artz et al., 2016).

c) Provincial statistics

According to the school SAQs, the prevalence for child sexual abuse among teenagers were high in Mpumalanga (36.8 %) and Gauteng (23%) while in the household questionnaires, the prevalence of child sexual abuse was higher in Limpopo (24.2%), followed by Mpumalanga (22.2%) and Gauteng (19.95%) (Artz et al., 2016).

1.2.2. Reasons for underreporting

The reasons for under-reporting of CSA are influenced by cultural and religious beliefs which influence how families resolve such matters. Threats and victimization by perpetrators (Banwari, 2011; Chabeletsane, 2015) also play a role. In addition, the lack of knowledge of available services and access to them can also be considered a plausible cause for under-reported rates of CSA. The Optimus Study (Artz et al., 2016) confirm this. From their findings, the researchers observed that the boys appear to be reporting CSA more frequently than before. They attributed this to an increase in public awareness campaigns run through social media platforms; that offer information about CSA and where to get help. As such opportunities for disclosure increase, official crime recording procedures could be improving, therefore revealing higher prevalence rates among boys than previously recorded.

From the CSA trends in South Africa, it is clear that children and families are more likely to struggle with the impact of CSA due to the lack of access to information and services. In the next section, the dynamics of CSA as it pertains to risk factors and the reaction of the non-offending caregiver and the impact that CSA has on the relationships between the non-offending caregiver and the child will be discussed.

1.2. Dynamics of CSA

1.2.1. Risk factors

Certain circumstances may predispose some children to varying forms of sexual abuse. For instance, cross-sectional studies in Africa have found that risk factors such as assault in the community, physical abuse and emotional child abuse and victimization have been associated with a greater risk for child sexual abuse of boys (McAlpine, Hossain & Zimmerman, 2016). Whereas for girls, parental neglect and orphanhood (Kidman & Palermo, 2016; Nichols et al., 2014), poverty (Banwari, 2011), and child chronic illnesses were indicated as risk factors (Kidman & Palermo, 2016; Meinck et al., 2016) were indicated as risks. These risk factors are representative of broader environmental issues inherent in communities. This may be why children in South Africa may have a greater risk of exposure to sexual abuse (Alaggia, Collin-Vezina, & Laleef, 2017; Artz et al., 2018).

Other risk factors are inherent to the home and the parent-child relationship dynamics. Family dynamics characterised by poor communication, harsh and inconsistent parenting or parental negligence, high conflict and rigid or strict traditional values are risk factors for sexual abuse of children (Artz et al., 2016; Assink et al., 2019).

Most victims are abused by people they trust and know (Alaggia et al., 2017; Reisema & Grietens, 2015; Seto, Babchishin, Pullman, & McPhail, 2015). However, there are cases where victims were abused by strangers (often adults), who took an opportunity to sexually abuse a child (Reisema & Grietens, 2015). Most CSA cases involve coercion and grooming (Winters & Jeglic, 2016; O'leary, Koh & Dare, 2017). That is, perpetrators who are closely known to the victim or the victim's family, are likely to exploit these relationships to gain access to sexually abusing the child (Al-Mahroos, Al-Amer, Al-Saddadi, & Al-Nasheet, 2011; Colton, Roberts, & Vanstone, 2011; Kenny, 2017).

The age of children exposed to these high-risk conditions also plays a significant role in their vulnerability to CSA. Children between the ages of 0 and 11 years are more likely to experience CSA than older children (Machisa et al., 2017; Child sexual abuse in South Africa, 2018; National Sexual Violence Resource Centre, 2012).

From the risk factors described above, it is clear that CSA is a systemic issue. That is to say that CSA is not borne in a vacuum where only the individual and individual's family are only affected. That would be a tunnel vision perception which contributes to the problem that we are facing today. Instead, CSA is an issue entrenched in every fibre of a community. It affects the individual to the family, the neighbourhood, the larger community context and the country as a whole. All social groupings contribute to the elimination or the promotion of CSA. While CSA may be pervasive, (partly due to the social-cultural ideal and the socio-political and economic history of South Africa); role players in government, non-profit organisations like child protection services, health professionals, educators, church and community leaders and parents are all equally responsible to ensure that young girls and boys are protected against harm. The next section will discuss how children react to CSA exposure.

1.2.2. The reaction of the child to CSA

Children differ in how they react to sexual abuse. Some children become upset by the experience and some develop serious psychological reactions that range from mild distress and confusion to clinical psychological conditions that can persist unless there is formal therapeutic intervention (Zimba, Menon, Thankian & Mwaba, 2015). There are often tell-tale signs of child sexual abuse, although these signs can also occur in the absence of child sexual abuse. They include physical indicators such as unexplained genital injury, recurrent vulvovaginitis, vaginal or penis discharge, anal complaint (fissures, pain and bleeding), bedwetting and faecal soiling beyond the usual, urinary tract infection, STI, the presence of sperm and pregnancy (Monusky 2015). Non-offending parents or caregivers usually respond to the last four signs with great concern. Behavioural indicators, on the other hand, include regression in behaviour (clinginess and irritability), regression in school performance (Phasha, 2007; Richler et al., 2014) or problems in attaining developmental milestones. Furthermore, children may experience eating and sleeping disturbances. These children may display aggressive and withdrawn behaviours as well.

Children disclose CSA in various ways, often accidentally where in the case that their parent may notice changes in their child's behaviour (physical complaints) and seeks professional help (Machisa et al., 2017; Reisema & Grietens, 2015; Tashjian, Goldfarb, Goodman, Quas, & Edelstein, 2016). In other instances, the child or someone else they have disclosed to will tell their parent about the sexual abuse (Priebe & Svedin, 2008). However, the disclosure is not always straight forward and for some parents, it may take a while to realize that their children have been sexually abused (Brattfjell, & Flåm,2019).

While CSA can be disclosed in various ways, a parent is more likely to be the first responder who has to undergo the process of reporting sexual abuse and seeking support. For the purpose of this study, parents are referred to as non-offending caregivers (NOCs). NOCs represent a biological mother, father or legal guardian that have a consistent and intimate relationship with their victimised child throughout their development.

The next section will discuss the NOC's reaction to the disclosure of CSA.

1.2.3. The reaction of the non-offending caregivers (NOCs)

The disclosure of abuse can be a difficult and traumatic experience for both the child and the NOC (Partners in social change, 2015). The Children's Act 38 of 2005 protects the interest of children at all times. Once CSA is disclosed and reported, various systems get involved to help the child or victim overcome the impact of CSA. These systems include the child protection services system, health care system and the judicial system. However, the non-offending caregiver's psychological and emotional distress tends to be overlooked (Jobe-Shields et al., 2016; van Toledo & Seymour, 2013).

NOCs carry the burden of having to deal with the effects of CSA disclosure, which they are often ill-prepared for. As a result, NOCs can experience a sense of loss of control over their lives as well as over their child's life. They struggle with their emotional reaction to CSA disclosure as well as the impact it has had on their child (Jobe-Shields et al., 2016; Smith et al., 2010; van Toledo & Seymour, 2013). NOCs often experience emotions of anger, despair, disbelief and sometimes ambivalence towards the child's disclosure story (Hernandez et al., 2009; Coohey & O'Leary, 2008; Jobe-Shields et al., 2016).

Other CSA effects on NOCs include mental health problems such as depression (Cabbigat & Kangas, 2018; Elliot & Carnes, 2001; van Toledo & Seymour, 2013). NOCs can experience guilt for not protecting their child from being abused and may question their parenting abilities while having to contend with the stress of the investigation and legal processes (Machisa et al., 2017; van Toledo & Seymour, 2013). If the perpetrator is in the family or closely known, NOCs may have to deal with the rapture of that relationship as well.

The NOCs' reaction to the disclosure of CSA may vary from person to person. However, it's important to note that their ability to respond to their child's needs is dependent on their coping capacity which can be strengthened by programmes that offer support and rehabilitation. The next section will highlight the kind of support the NOC will likely need to provide support for the child following the disclosure of CSA. This section will also provide a brief description as to how the NOC may respond to the need.

1.2.4. The importance of the non-offending caregiver's (NOC's) support following CSA disclosure

The support a child receives from their primary caregiver has consistently emerged as important for better child and parental adjustment following the disclosure of CSA (Bick, Zajac, Ralston, & Smith, 2014; Elliot, & Carnes, 2001; Lovett, 2004; Domhardt, Münzer, Fegert, & Goldbeck, 2014; Rosenthal, Feiring, & Taska, 2003). According to Godbout, Briere, Sabourn and Lussier (2014), the support rendered by the NOC has a distinct impact on the psychological symptoms the child is experiencing and interpersonal outcomes later in life (van Toledo & Seymour, 2013; Tavkar, 2010). The NOC is expected to be able to render support in direct response to the child's needs emanating from the experience of CSA (Cyr et al., 2014). Naturally, the NOC may want to offer support in the form of basic needs, safety and protection, decision-making, active parenting, instrumental support, availability, and sensitivity to the child and affirmation (Bolen et al., 2015). Yet despite the provision of these, NOCs appear to find it difficult to respond to the exact need that develops as a result of the child's experience of CSA (Cyr et al., 2014; McCarthey, 2017).

Emotional support is a critical domain of support that children need following CSA (Zajac, Ralston & Smith, 2015).

> "… the non-offending caregiver can provide their child with comfort and security during the stress and trauma of CSA, leading the child to feel that he or she is cared for by facilitating the reconstruction of a sense of self-efficacy and helping the child cope with the painful emotions of fear, anger and depressed mood which are essential in the recovery process following the experience of sexual victimization" (McCarthey, 2017, p. 6).

However, this is often difficult for the NOCs to provide this type of support as they may be finding it difficult to reconcile the events that have occurred as well as their feelings about their parenting role during the period following CSA disclosure (Cyr et al., 2017, Guetzow, Cornett, & Dougherty, 2003; Parent-Bousier & Hebert, 2015; Vazsonyi & Belliston, 2006). NOCs' emotional reaction to the disclosure of CSA is as complex as any emotions experienced and expressed following any tragic and traumatic event (Holt, Cohen, & Marinnaro, 2015; Willingham, 2007). As broad and overwhelming as their emotions are, the NOCs will prioritise their children's needs over their own needs to provide their children with optimal support. However, since the NOC is usually ill-prepared for this role, they may experience inadequacy and discomfort when their children develop problems and behaviours that challenge their parenting skills.

While children need assistance to process and recover from the impact of being sexually abused, non-offending caregivers are equally in need of assistance to equip them with the necessary resources that will help them during this challenging period. Based on the current trends of CSA and the impact thereof as discussed above, the research aims to assist non-offending caregivers.

1.3. Research rationale and aims

Previous research done in South Africa on non-offending caregivers of sexually abused children has been primarily focused on three themes:

- Empowering caregivers to report CSA (Paulsen & Wilson, 2013; Pretorius, Chauke & Morgan, 2011);
- Exploring the experiences of caregivers about the South African judicial system and reporting CSA and;
- Joint intervention for caregivers and sexually abused children (Masilo, 2011; Rust, 2011), including interventions that include playing therapy involving the larger family context (Fourie & Van der Merwe, 2014).

There seems to be a lack of accessible psychological support for non-offending caregivers of sexually abused children in the South African context (Masilo, 2011; Masilo & Davhana-Maselesele, 2016; 2017). Developing structured support groups for NOCs of sexually abused children can help alleviate the emotional and psychological impacts of CSA and empower NOCs to assist their children to cope (Mendelson & Letourneau, 2015; van Toledo & Seymour, 2013).

The aim of this research is to:

- Conduct a needs assessment with non-offending caregivers of sexually abused children
- Develop a structured support group intervention that will address the caregivers' needs
- Implement the support group at a non-profit organization for children who have been sexually abused; and
- Based on the observations and findings of the intervention, provide insight into the impact of a structured support group intervention that can inform the development of future programmes catering for the needs of non-offending caregivers.

The research will use an action research process (Kemmis, McTaggart, & Nixon, 2014) and a mixed-method (qualitative and quantitative) approach to analyse the needs and experiences of NOCs participating in the intervention. The needs of NOCs will be identified from previous needs assessment research (Hansen & Tavkar, 2011; Masilo & Davhana-Maselelsele, 2016; McCarthey, 2017; van Toledo & Seymour, 2013), and from asking current participants what their needs are. These needs will be used in the development of a structured support group intervention for NOCs. This intervention is intended to help NOCs strengthen their supportive relationships, develop adaptive coping strategies, learn

parenting skills and to gain knowledge about the impact and dynamic of sexual abuse on children. In this way the non-offending caregivers can begin their journey to healing and be better equipped at supporting their children (Tavkar & Hansen, 2011; Saloojee, 2014). The intervention will be implemented in a group of NOCs to learn from their experiences. These experiences and the outcome evaluation of the intervention will be used in further development of the intervention.

1.4. Overview of this study

In the next chapter, the literature on the emotional experiences of the NOC as it relates to emotional distress, self-esteem, parenting stress, coping and social support will be explored. This chapter will provide the reader with an understanding of the psychosocial implications of child sexual abuse from an ecological perspective, with specific reference to the NOC. This is then followed by a discussion on support groups as an intervention strategy that has been suggested to address the psychosocial needs of the non-offending caregivers.

In chapter three, the research methods will be described, specifically, the action research process used to design the programme, it will also give an overview of the structured support group programme, the methods used to assess its psychosocial impact on NOCs, the data collection process and ethical issues are taken into account.

In chapter four, the results of the study are presented, both quantitative and qualitative, as a method of triangulation has been utilised in the assessment of the outcome of the group sessions. The qualitative feedback from the participants is used to augment the quantitative data, as one cannot solely rely on statistics in person-centred research such as this.

A discussion of the results of the study follows in chapter five. The study is concluded with a summary of the findings, the implications of the research, a discussion of the limitations and recommendations for future research.

CHAPTER 2 LITERATURE REVIEW

The previous chapter discussed CSA as an issue faced by many children in South Africa on a daily basis. While the victims are minors, CSA is an issue that should be addressed by adults in various social systems. In other words, the NOC, health professionals, police, social workers, psychologists, counsellors, etc. all play an important part in helping children recover from sexual abuse. However, the NOC usually finds it difficult to interact with the various systems that have been established to ensure the safety and security of the child. This is mainly due to the lack of access to information, skills and resources. It is for this reason that the NOCs' lived experiences should be investigated and understood by social scientists in order to assist in the creation of programmes that will prepare them to integrate into the ecosystem providing support for SA victims.

In chapter one, the NOCs' reaction to the disclosure of CSA was briefly discussed. This chapter will give a detailed discussion of the important areas of functioning of the NOC that is affected as a result of CSA. Following this, the chapter will describe the common support needs as expressed by NOCs whose children have been sexually abused. The availability of interventions that offer support to NOCs was investigated, both in and outside South Africa. A discussion on support groups as an ideal treatment modality for NOCs in South African is provided, making specific reference to psycho-educational support groups that integrate some tenets of cognitive behaviour therapy such as the reconstruction of irrational thinking, education, correcting of misinformation, communication and parenting skills. The theory behind group therapy is discussed to provide the therapeutic value of group processes. The benefits and challenges that come with group treatment (psycho-educational support groups) also provide ways in which the effectiveness of group treatment can be evaluated. Lastly, the socio-ecological framework is used to illustrate how child sexual abuse is a systemic issue. The framework helps us locate the NOC within the ecological system and provides us with a map of where and how the structured psycho-educational support group program can be implemented.
The next section discusses the psychosocial impact of CSA on the NOCs following the disclosure.

2.1 Psychosocial implications of CSA on the non-offending caregiver (NOC)

CSA has an overwhelming effect on most NOCs.

2.1.1 Parenting stress and difficult child

NOCs reported experiencing stress and difficulty contending with parental demands especially when their children exhibit deviant behaviour (such as withdrawing, absconding school or aggression) during or after the sexual abuse has been disclosed (Brux, Carthwright, & Collings, 2015). McDonald, Gregoire, Poertner and Early (1997) found a causal relationship between difficult behaviour of abused children and NOCs who reported stress. Since CSA is an issue that most people do not imagine going through, it is not surprising that non-offending caregivers will be ill-prepared for such stressful experiences which can impair their parenting role (Tavkar & Hansen, 2011; Deater-Deckard, 2004). Deater-Deckard (2004) describes parental stress as "a set of processes that lead to aversive

psychological and physiological reactions arising from attempts to adapt to the demands of parenthood" (p.66). NOCs who experience significant stress post-CSA can tend to appear less available to support their children and have been found to engage in inconsistent or negative parenting behaviours (Berbardon & Pernice-Duca, 2010; Zerk, Mertin, & Proeve, 2009). The impaired parental functioning following CSA disclosure has been associated with increased or exacerbated psychological problems in sexually abused children (Doan, Fuller-Rowel, & Evans, 2012).

Most parents pride themselves in their parenting skills and their ability to provide their children with what they need and want, but when their parental role is impaired that can affect the way they feel, which can in turn affect the way they respond to their child.

2.1.2 Parent coping and parent self-efficacy post-CSA

NOCs are likely to experience distressing emotions and thoughts when they are exposed to the demands of providing support to their children in a capacity that they are ill-prepared to perform, thereby, impacting their sense of coping self-efficacy (the perceived capability for managing the internal and external post-trauma recovery demands) (Benight & Bandura, 2004; Glanz & Shwartz, 2015).
Most NOCs tend to find it difficult to respond empathically or emotionally to their children's emotional needs. This may be due in part to the avoidance coping strategy employed in response to the stress and trauma of CSA. The stress response reaction triggered by the CSA disclosure often disrupts the NOCs' ability to process their emotions or the events surrounding the sexual abuse (Brux et al., 2015; Wheaton & Montazer, 2010). For example, NOCs may employ an emotion-focused coping strategy (avoidance and withdrawal) to manage their circumstances. This is because responding empathically requires the NOC to face his or her emotions and that of their child, which can be intimidating (Brux et al., 2015). Should the NOC appraise their struggle to adapt to the news of their child's sexual abuse as negative, this can cause him or her considerable distress (primary appraisal), which may lead them to think that they have lost control over their circumstances, emotions and parental role (secondary appraisal) (Cohen & McKay, 2020).

2.1.3 Parent-child relationship functioning and family functioning

Parent-child relationships are important for healthy child development. A parent-child relationship that is characterised by compassion, unconditional regard, low conflict and non-violent parenting practices, can contribute to better school performance, higher self-esteem and reduced behavioural problems among children (Amato & Fowler, 2002; Cleveland, Gibbons, Gerrard, Pomery, & Brody, 2005; van Toledo & Seymour, 2013). On the other hand, a parent-child relationship where there are negative exchanges and harsh/punitive discipline practices in response to misbehaviour can lead to poor emotional regulation skills, low self-esteem, depressed mood and aggressive or delinquent behaviour by the child (Peterson, 2005).

Parenting relationships are directly influenced by positive social support provided by the family. That is, NOCs who are affected by CSA, cope better with their circumstances when they are provided with positive social support (emotional and practical) from their family which in turn buffers the NOC from parenting stress (Ceballo & McLoyd, 2002; Raikes & Thompson, 2005; Riina, Lippert, & Brooks-Gunn, 2016). On the other hand, NOCs who experience a disruption in their family systems due to intrafamilial CSA, usually lack the appropriate and necessary positive social support that can help buffer them from the distressing experience (Keren, Dollberg, Koster, Danino, & Feldman, 2010).

It's important to note that NOCs express pleasure and satisfaction when they can protect their children, whereas anger, anxiety, guilt and despair are expressed when they are not able to support their children after a traumatic event such as CSA (Cohen, Mayekiso, & Mbokazi, 2007; Mannarino, 2015). NOCs' emotional and psychological reaction to the disclosure of CSA is as complex as any emotion experienced and expressed following a tragic and traumatic event (Holt et al., 2015; Willingham, 2007). Often, NOCs will neglect their own needs to provide their children with the support that they need. However, this is difficult to achieve without the support of family, friends and skilled professionals. Therefore, as children need assistance to process and recover from the impact of being sexually abused, NOCs equally need supportive response.

The NOC's support needs will be discussed next.

2.2 Needs of the non-offending caregivers (NOCs)

Optimism is considered a good predictor for coping self-efficacy. (Benight & Bandura, 2004). When combined with positive social support, dispositional optimism can help to buffer non-offending caregivers from stress and increase their active coping behaviours (Glanz & Shwartz, 2015). Therefore, NOCs who are optimistic are more likely to actively seek or accept social interventions that aim to address their needs after the CSA disclosure. They are also likely to actively engage in their healing process and develop new coping strategies or strengthen their adaptive ones. Also, an optimistic non-offending caregiver is prone to the flexible use of adaptive coping strategies when faced with a stressful situation.

The following forms of social support can play an important role in helping NOCs overcome the impact of CSA. It is not arranged in any priority order.

2.2.1 Emotional and psychological support

The condition of the NOC-child relationship is compromised when the NOC uses maladaptive coping strategies to deal with the impact of disclosure (Alaggia et al., 2017; Cabbigat & Kangas, 2018). The NOC's distress experience may negatively influence how he or she responds to behavioural and emotional changes in the child (Fuller, 2016; Godbout et al., 2013; Tavkar & Hansen, 2011). External support structures become necessary especially when caregivers are isolated and ostracised by their

family members and the community at large (Cabbigat & Kangas, 2018; Hernandez et al., 2009). There is value in attending to the specific psychological and emotional needs of NOCs. The support required by a child who has experienced sexual abuse and that of a NOC may differ considerably (Fong et al., 2016; Jobe-Shields et al., 2016; Paulsen & Wilson, 2013).

2.2.2 Informational support

When NOCs understand their children's needs post-CSA disclosure, they may be in a better position to respond more appropriately (McCarthey, 2017, Tavkar & Hansen, 2011; van Toledo & Seymour, 2013). NOCs are better able to support their children when they receive information about the dynamics of abuse and disclosure, how to support their child, the process of investigation and the long-term consequences of CSA on their child and how CSA affects the wider family context (Tavkar & Hansen, 2011; van Toledo & Seymour, 2010; 2013). Parents consistently described how they felt much more capable of emotionally supporting their child after participating in their child's therapy session (McCarthey, 2017). When NOCs receive information that is comprehensive and easy to grasp, they are better equipped to respond more empathically to the needs of their children. (McCarthey, 2017; Mendelson & Letourneau, 2015; van Toledo & Seymour, 2013).

2.2.3 Supportive environment (Empathic)

NOCs interact with child protection services, police and the judicial system, however, these systems have been described to be hostile and insensitive towards the NOC's experience (Machisa et al., 2017; Paulsen & Wilson, 2013; Simon, Barnett, Smith, Mucka, & Wilis, 2017). The lack of adequate social support may have a significant impact on the NOC's self-agency (Hill, 2001; Paulsen & Wilson, 2013; van Toledo & Seymour, 2013). Health and legal professionals are encouraged to be sensitive to the NOC's concerns relating to CSA (Fong et al., 2016; van Toledo & Seymour, 2013). It is for this reason that there is an urgent need for skilled professionals to address the needs of NOCs (Fong et al., 2016; Hernandez et al., 2009).

2.2.4 Financial Support

Similar to domestic abuse and other forms of violence against women, CSA places a huge financial burden on NOCs (KPMG, 2014). The financial cost incurred by the NOC can influence the extent to which a child and the NOC can access support. In cases where their options are limited due to their dependence on the perpetrator as a breadwinner or source of income, it may be difficult for the NOC to take advantage of opportunities to access help.

The disclosure of CSA can have a significant impact on NOCs' emotional well-being. Their ability to cope with the demands of parenthood is often compromised, which can have an impact on the parent-child relationship and the child's ability to cope with the impact of CSA (Bick et al., 2014; Cabbigat & Kangas, 2018; Jobe-Shields et al., 2016; van Toledo & Seymour, 2013). NOCs play an important role in nurturing the cognitive, social and emotional competence of children (Partners in social change, 2015;

Santrock, 2009). They will go above and beyond to provide their children with the best support possible. Therefore, prevention and treatment programmes that address the impact of CSA should be made accessible to both children and their NOCs.

The next section will discuss interventions that have been developed with the NOC in mind.

2.3. Interventions for non-offending caregivers (NOC) of children who have been sexually abused

The current literature regarding CSA has largely focused on the experiences of child victims and perpetrators and the interventions designed to rehabilitate them (Masilo, 2011; Masilo & Davhana-Maselesele, 2016; Paulsen & Wilson, 2013). The growing literature on the experiences and needs of NOCs concerning CSA is providing some promise towards treatment and prevention approaches (Masilo, 2011; Masilo & Dvahana-Maselesele, 2016; 2017; van Toledo & Seymour, 2013). However, research attention is still needed on the NOC's experiences of CSA and the interventions aimed at supporting them, especially in South Africa (Masilo & Davhana-Maselesele, 2016; van Toledo & Seymour, 2013).

The emotional and psychological treatment of NOCs, as secondary victims to child sexual abuse, is paramount as their well-being has the potential to improve children's well-being and recovery after the trauma of sexual abuse, through effective communication and parenting skills (Mandelson & Latourneau, 2015; Rudolph, Zimmer-Gembeck, Shanely, & Hawkins, 2017). As has been previously stated, the NOC's well-being after CSA disclosure has been considered an afterthought (Schmidt; 2015).

Some organisations have begun to provide psycho-educational programs which are geared towards the support of the NOCs (Wagner, Wagner& Wilson, 2018). These programs include:

2.3.1 Parent programs such as the Positive Parenting Program (Triple P)

The Positive Parenting Program aims to improve parenting skills in families with high-risk factors and families with inappropriate or abusive parenting (Sanders Kirby, Tellegen, & Day, 2014).

2.3.2 Parent-child interaction therapy (PCIT)

PCIT is a behavioural parent-training program involving live coaching of parents as they interact with their children (Chaffin et al., 2004). This therapy has shown to be effective in the reduction of physical abuse and neglect (Chaffin et al., 2004; Prinz, Sanders, Shapiro, Whitaker, & Lutzker, 2009) and can potentially be instrumental in the reduction of CSA, due to the link between the incidence of sexual abuse and other forms of child maltreatment (Mendelson & Letourneau, 2015; Rudolph et al., 2017).

2.3.3 Darkness to light

Darkness to light is an online child sexual abuse prevention program that focuses on the parent as a preventative tool for child sexual abuse. The program includes five steps:
Step 1: Educating parents to actively minimise the opportunity for child sexual abuse to occur;
Step 2: Discussing the importance of having an open conversation with children about their bodies;
Step 3: Sex and boundaries;
Step 4: Increasing parents' knowledge regarding the signs of abuse to protect children from further harm; and
Step 5: Increasing the parents' understanding on how to respond to risky behaviour and suspicions or reports of abuse (http//.www.dzl.org/education/5-steps/).

These prevention programs offer CSA education for NOCs and aid them in becoming aware of the risk and protective factors involved. For instance, the NOCs can learn the perpetrator's tactics to gain access to the child and to gain the trust of parents. These programmes can also help NOCs gain some insight into the impact that sexual abuse can have on children (Mendelson & Letaourneau, 2015; Rudolph et al., 2017). Due to their preventative designs, these programs do not provide support to NOCs post-CSA such as information regarding how NOCs can respond to and support their children's post-child sexual abuse and provide information on the legal processes involved (Rudolph et al., 2017; Tavkar & Hansen, 2011; van Toledo & Seymour, 2013).

2.3.4 Washington Coalition of Sexual Assault Programs (WCSAP)

This non-profit organisation strives to unite agencies engaged in the elimination of sexual violence. The organisation is based in Olympia, Washington, USA. WCSAP provides information, training and expertise to programs and individual members who support victims, family and friends as well as to the general public and those whose lives have been affected by sexual assault. WCSAP works to create, shape, influence and enhance policies that impact survivors of sexual assault, their families and communities. WCSAP has developed a wide variety of resources to assist sexual assault programs, allied organizations, and the public at large to increase their skills and awareness around issues of sexual violence. WCSAP also provides information, support, and consultative services to CSA advocacy programs, state and federal agencies, policymakers, allied organizations, and other interested individuals on how to best support survivors and rape crisis organizations in order to end sexual violence. They also provide training opportunities for volunteers and professionals working to end sexual violence in their communities (https://www.wcsap.org/about-us).

One of the resources they offer is the (WCSAP) Parent Support Group Guide for psycho-educational support groups for non-offending parents and NOCs of children who have been sexually abused (Micheel & Levy-Peck, 2012). The WCSAP Parent Support Group Guide is a comprehensive and user-friendly manual that provides the facilitator with a step-by-step process to develop, implement and evaluate a psycho-educational support group. In addition, the manual provides the facilitator with a

complete curriculum for sessions. The facilitator is presented with a detailed outline of how to approach each session and how to meet the goal of each session (Micheel & Levy-Pecky, 2012).

2.3.5 Project SAFE (Sexual Abuse Family Education)

Project SAFE is a support and child advocacy centre-based modular intervention located in the United States of America for families victimised by CSA. Project SAFE offers four different manualised cognitive-behavioural interventions that are offered according to the needs of the presenting family (Tavkar & Hensen, 2011). Two of the interventions focus on the NOC and the family as a whole. The Parent Support and Education Session (PSES) was developed by SAFE in 2002 and offers a single crisis session to aid parents to cope with immediate problems resulting from the child's disclosure of sexual abuse (Tavkar & Hensen, 2011). The SAFE Brief Family Intervention (BFI) is a short term, 3 to 6 session intervention, which was developed in 2003. The intervention involves individual and family counselling for sexually abused children and NOCs (Tavkar & Hensen, 2011). Their clients are referred through the advocates at the Child Advocacy Centers (CAC).

The WCSAP Parent Support Group and the Parent Support and Education Session (PSES) of Project SAFE show some promise for the treatment of NOCs whose children have been sexually abused. While these interventions are not South African based, there is an opportunity to replicate and adapt these programmes to suit communities from low-income countries.

2.3.6 TEARS Foundation

This is a women-led organisation based in South Africa which provides vulnerable women and children with access to crisis intervention, advocacy support, counselling, and prevention education services. These services are provided to those impacted by gender-based violence, including sexual assault and CSA, at no cost to the victims. The TEARS Foundation has been founded to help eliminate sexual violence through various abuse awareness campaigns. (https://www.tears.co.za/)

2.3.7 Child Advocacy Centers (CAC)

The Teddy Bear Clinic, Women and Men Against Child Abuse (WMACA) Kidz Clinic, Thuthuzela Care Centre, ChildLine South Africa, Child Welfare and Child Care South Africa, to name a few, are usually the initial sites for access to therapy, whether on-site or through referrals by community agencies (Artz et al., 2016; Tavkar & Hensen, 2011). Although the Child Advocacy Centre (CAC) model advocates a need for mental health services for non-offending family members who are victimised by CSA, it seems as though only a few of the CACs offer onsite services. It is also not clear what types of interventions are offered (Tavkar & Hensen, 2011). Project SAFE can be integrated into the CAC services so that they can provide a holistic approach to intervening with families affected by CSA.

The TEARS Foundation and the CAC services are accessible in South Africa, although they are likely to be accessed only in a crisis. This calls for more visibility, ideally through social media engagement

as information moves faster and is easily accessible through digital platforms. While the above-listed interventions are directed to the elimination of sexual violence, there is still a scarcity of parent-focused interventions to address CSA in South Africa (Masilo & Davhana-Maselesele, 2017; Mendelson & Letourneau, 2016; Rudolph, Zimmer-Gembeck, Shanley & Hawkins, 2017).

There are a few possible reasons for the lack of parent-focused interventions in South Africa. In a low to a middle-income country like this, agencies and the government are likely to be limited by the costs to train people and buy the manuals for evidence-based programmes (Gillespie-Lynch & Brezis, 2018; Radford, Allnock & Hynes, 2015). The highest-need areas in South Africa lack access to qualified health professionals that can implement the programmes in those designated areas (Meinck et al., 2016). Some of these programs require technological components such as video content, internet access and the likes, which are inaccessible and not-user-friendly in areas with poor electricity and internet facilities (Meinck et al., 2016).

Efforts have been made to address the need for parent-focused interventions in response to child abuse and maltreatment. Meinck et al. (2016) evaluated the Sinovuyo Teen Programme. It is an abuse prevention parenting programme stemming from the Parenting for Long-Life Health (PLH), a WHO and UNICEF initiative to develop and test violence-prevention for implementation in low resource contexts (Meinck et al., 2016). The researchers initiated pragmatic cluster randomised control trials with stratified randomisation of 37 settlements (rural and peri-urban) with 40 study clusters in the Eastern Cape. 600 high-risk caregiver and adolescents (10-18) dyads were involved. They were either referred by social services, their school or self-referred. The families were screened for regular arguments in the home as one of the criteria to be included in the study. The impact of the 14 session Sinovuyo Programme for Parents that was implemented in rural and peri-urban communities (schools, community halls and under trees) was compared to a control group that attended a water hygiene programme. The results showed reductions in child abuse, child delinquency, parent and child depression, parenting stress and substance abuse. It also showed improvements in parental supervision, positive parenting and social support (Meinck et al., 2016; Doubt, Loening-Voysey, Blanc, Cluver, Byrne, & Petersen, 2018).

The Sinovuyo Teen Programme is the first known trial to prevent abuse of adolescents in a low to middle-income country. This parenting programme shows promising results for the prevention of child sexual abuse among children and adolescents in low or middle-income countries (Meinck et al., 2016). However, the programme has not been designed for parents (caregivers) whose children have been sexually abused and does not address ways for them to handle the impact of CSA.

Urgent research and programme development are needed to address the lack of access to parenting programmes for non-offending caregivers of sexually abused children. Suggestions and guidelines were provided by South African researchers advocating for parenting programmes to include detailed and easy to grasp information which could ideally be provided in first response facilities such as the TEARS Foundation and CACs (Masilo & Dvhavana-Maselesele, 2017). Parent-focused prevention and

treatment programmes are an essential adjunct to the elimination of child sexual abuse occurrence (Mendelson & Letourneau, 2016). Parent training programmes such as psycho-education support groups were suggested as effective programmes (Masilo & Dvhavana-Maselesele, 2017; Mendelson & Letourneau, 2016). The WCSAP organisation offers a programme that has been designed to address the impact of child sexual abuse as it pertains to the non-offending caregivers' recovery process (Micheel & Levy-Peck, 2012).

The next section will discuss the intervention models and program delivery that have been recommended in literature advocating a clear need for mental health services for NOCs.

2.4. Suggested intervention strategies

Various research studies, as well as the existing programmes listed, have made some valuable contributions in terms of possible intervention strategies which can be implemented to reduce the risk of CSA and also assist the NOCs in their psychological and emotional adjustment post-CSA disclosure (Meinck et al., 2016; Hill, 2001; Masilo, 2011; Masilo & Davhana-Maselesele, 2017; Mendelson & Letourneau, 2015; van Toledo & Seymour, 2013). The following treatment models have been recommended for the support of NOCs.

Masilo and Davhana-Maselesele (2017) found that NOCs with PTSD, suicidal ideation, depression and maladaptive coping as a reaction to CSA disclosure, can benefit through psychotherapy and supportive counselling. Social support, a sense of belonging and companionship are factors that influence the relationship between stress and depression and maladaptive coping. Masilo and Davhana-Maselesele (2017) found that NOCs who receive positive social support from stakeholders in post-CSA disclosure are more likely to present with adaptive coping behaviours, reduced distress and increased feelings of comfort (Masilo & Davhana-Maselesele, 2017). Other studies support this as experts found that NOCs who have participated in groups have been reported to have experienced a reduction in their stress levels and increased coping capacity, self-efficacy and knowledge, enabling them to be a more effective therapeutic resource for their child (Navei, Akbari-Kamrani, Esmaelzadeh-Saeieh, Farid, & Tehranizadeh, 2018).

As such, psycho-educational support group interventions have been suggested as beneficial for addressing depressive and anxiety symptoms, suicidal ideation and maladaptive coping (Cyr et al., 2014; Hill, 2001). Furthermore, based on a literature search for existing formal and informal support systems and programs available for the parents of sexually abused children in South Africa, guidelines were given to develop support programmes for NOCs (Masilo, 2011; Masilo & Dvahana-Maselelsele (2017).

The next section will discuss psycho-educational support groups as a treatment modality. First, the background into support group treatment will be described, followed by the theory that supports group treatment. Specific reference will be made to psycho-educational support groups as it has been

suggested that they comprise necessary additions to the existing interventions that address the issues of CSA.

2.5. Support group as a parent-focused programme (prevention and remedial)

Support groups are made up of people who offer mutual support for each other regarding a shared characteristic, issue, concern or dilemma. They can be seen as a treatment of choice as they can facilitate similar and shared experiences among NOCs, build the capacity for coping with stress and help NOCs normalize their children's behaviour through support around child-rearing and parenting advice (van Toledo & Seymour, 2013). Support group treatments can yield positive outcomes as issues concerning social isolation, stigma, self-esteem and trauma processing can be discussed and explored in a safe and contained space (Babatsikos, 2010; Hernandez et al., 2009; Masilo & Davhana-Maselesele, 2016; van Toledo & Seymour, 2013). Furthermore, therapeutic outcomes can include increased optimism and hope for their members (Guthrie & Kunkel, 2015). Support groups generally aim to provide emotional, informational and social support. They also facilitate personal empowerment and increase a sense of belonging and community (Meiring, Visser, & Themistolceous, 2017). Support groups are seen to be most effective when they are non-judgemental and promote emotional expression, positive evaluation and honesty and provide an opportunity to identify and value various levels of uncertainty, information and positive appraisal (Guthrie & Kunkel, 2015).

This treatment model provides an ideal and effective environment for NOCs to address emotional issues (bouts of anger, guilt or self-blame). It also offers the NOC opportunities to learn ways to manage their child's emotional and behavioural reaction to CSA (Hansen & Tavkar, 2011; Saloojee, 2014). Mannarino et. al., (2012) noticed that by providing the necessary support (emotional and practical) to NOCs, improvements could be seen in their ability to be supportive of their children. Furthermore, the provision of positive social support can facilitate personal empowerment, a sense of self-control and overall well-being (Im, Jettner, Warsame, Isse, Khoury, & Ross, 2018). In other words, support group interventions offer a lifeline to NOCs who are in search of support and assistance.

The next section will provide the therapeutic value of group processes.

2.6. The therapeutic value of group processes

Group therapy is a dynamic and interpersonal process involving a group of people with various concerns about similar problems or situations. Group-based interventions involve a group leader or group therapist whose primary role is to provide members with an opportunity for psychological growth and the discovery of internal resources of strength (Yalom, 1992). The group treatment process allows members to develop empathy and understanding and acceptance for one another which can lead to mutual trust and a safe atmosphere where pressing concerns of group members can be explored (Yalom, 1992). An effective group leader will conduct the group process in a flexible, dynamic and creative way. The group leader's expert knowledge, education, personality and humanity are his or her

greatest tools. Thus, the group leader's ability to communicate empathy, unconditional positive regard and concrete ways of expressing emotions can influence the extent to which the group members can explore and experience themselves in a relationship.

Fixed membership groups are usually small and comprise of five to 15 people. Such group settings provide opportunities that can improve the participant's quality of life such as social support and integration, opportunities to regain autonomy and participate in meaningful activities (Whitley, 2014). Group interventions undergo different phases that lead to these outcomes. While group therapists and theorists from different schools of thought have different ways to describe the phases involved in group processes, what they seem to agree on is that all groups have a beginning phase where the group prepares to begin, a middle phase where much curative work is carried out, and a termination phase, in which the group separates and or adjusts to the loss of a member. The group prepares to end and close. In a fixed membership group, these phases recycle repeatedly as members exit the group before the intervention ends and as involvement deepens (Kieffer, 2001; Tuckman & Jensen, 1977).

For this study, Kieffer's (2001) four basic phases in the development of a therapeutic group were used to understand the phases the support group was likely to undergo.

The pre-group phase is described as a period of "parallel play". During this phase members are newly acquainted and do not relate to each other in a psychological sense. In this phase, the facilitator's primary role and responsibility are to model empathy, understanding, compassion and acceptance to help each individual to begin to experience themselves as a valued member of the group. The group lacks cohesiveness as they have not yet experienced themselves as a group but rather as individuals in a group setting.

The engagement phase is characterised by growing cohesiveness and a sense of belonging among group members. The members begin to identify with each other's experiences as they begin to display empathy, compassion, acceptance and mutual trust. In this phase, members are in a heightened state of anxiousness. The issues of trust and the safety of sharing and disclosure are tested among members of the group. Therefore, the facilitator is tasked with the responsibility of managing their anxiety to disclose and open up about issues that they either feel guilty or shameful about as well as the perception of "losing" their sense of autonomy. The facilitator can achieve this by helping the members to fulfil their desire to connect with people who mirror their needs and experiences.

The mutual and optimal responsiveness phase follows, in which a lot of group progress and curative work takes place. It is in this phase that concerns, shame and anxieties are addressed. Members are more open to being vulnerable as they experience the confines of the group as safe and trustworthy, thus lowering their defences against painful affective states. The group members would have gotten used to each other. This is when the group works more autonomously from the facilitator.

Finally, the termination phase is characterised by members who exit the group early as well as the last session of the intervention. Therefore, members who attend the full course of the intervention sessions are likely to be impacted by the loss of a valued member of the group and the facilitator may need to help the group adjust to the loss of the group member and re-establish equilibrium. At the closing of the group, the remaining members explore their feelings towards their membership in the group. This is an opportunity for the members to reflect and express what they will take from their experience.

Yalom (1995) divided the therapeutic experiences into eleven primary factors, discussed below. The relevance of these factors to this study will also be discussed.

2.6.1 Instilling hope

The instilling of hope is one of the most important therapeutic factors in therapy (Yalom, 1995). Hope is necessary for the client in therapy as it provides the client with the belief that something can be done about their reason for consulting. The simple faith of belief in therapy can be therapeutic itself. The group facilitator needs to instil belief and confidence in the group and group process. The instilling of hope is vital for NOCs as they are often consumed with anxious worry, helplessness or a feeling that they do not have control over their lives as a result of the child sexual abuse disclosure (Yalom, 1995). Yalom states that people often enter the group therapy feeling that they are alone in experiencing the "frightening or unacceptable problems, thoughts, impulses and fantasies." In joining the support group, NOCs have a chance to learn about others, who are experiencing similar problems and needs. When individuals come into contact with other individuals that mirror them ("similar others"), they often experience reduced feelings of isolation when they realize that those feelings are common among the group members. Yalom (1995) described this concept as universality, which can lead to feelings of hope and relief in knowing that they are not alone.

2.6.2 Imparting information

Yalom (1995) understood the impact of imparting information, psycho-educating or offering formal instruction to the members in group therapy. It is imperative that the group facilitator imparts information on relevant and important concerns to NOCs. These concerns include their emotional and psychological reactions following child sexual abuse. The facilitator must also correct any misconceptions about CSA and the irrational fears that the group may have. It is also important to address the NOCs' concerns with factual information and not opinion. When the NOCs understand what they are going through, receive correct information about CSA and feel that their experiences are validated, they begin to feel more self-agency and in control of their circumstances, which will lead to improved coping capacity and parental efficacy.

Members joining a support group often believe that they have very little to contribute to the group and little to offer other members as they feel that they are in need themselves. However, group settings provide members with a unique opportunity to help others with similar problems. This opportunity can

be taken advantage of when group members identify with each other and experience cohesion in the group. Yalom (1995) states that the process of helping others (altruism) is a powerful therapeutic tool that can greatly enhance a member's self-esteem and feelings of self-worth. The shame and guilt that NOCs experience due to their child being sexually abused, often impact how they view themselves as parents. Moreover, NOCs tend to battle with their parental duties which often impact their self-esteem. Despite the facilitator's expert knowledge on CSA, Yalom notes that members will readily accept observations and advice from fellow group members. The opportunity to help other NOCs in similar situations through sharing their experiences or by giving advice, can be therapeutic. This cathartic process can help to restore the NOC's sense of knowing, increase their self-efficacy and their coping ability (Yalom, 1995).

Following the disclosure of CSA, non-offending caregivers often experience ruptures with the people with whom they have meaningful and significant relationships, especially where intra-familial child sexual abuse is concerned. Social support from family has a direct impact on the parenting relationship by reducing parenting stress (Bonds, Gandoli, Sturge-Apple, & Salem, 2002; Cohen & McKay, 2020; McLoyd, 1998). The group will often represent these significant relationships, such as that of family and close friends. The facilitator (or co-facilitators) substituting an authority or professional person, often evoke feelings similar to those felt towards other professional or authority figures that the group had to deal with after the disclosure. Group members substitute significant figures of support in their lives. Yalom (1995) terms this the corrective recapitulation of the primary family group. This concept implies that people who join a therapeutic group are in some way looking for an opportunity to correct dysfunctional interpersonal relationships. In this support groups can have a powerful therapeutic impact (Kivlighan & Mullison, 1988). A support group becomes a new support system and a necessary source of positive social support for non-offending caregivers who lack the support they require (Guthrie & Kunkel, 2016).

2.6.3 Social learning

According to Yalom (1995), the development of social techniques or social learning is an inevitable aspect of all group development and he considers it an important therapeutic factor. The support group provides NOCs with a safe environment to speak openly about their concerns, experiences and needs. Also, the support group offers NOCs the opportunity to socialize with other NOCs who have experienced similar situations (Guthrie & Kunkel, 2016). This increases social interaction which can lead to improved self-esteem, improved coping strategies, parental efficacy and problem-solving skills. It can also decrease emotional distress through role-plays, sharing experiences and discussing topics surrounding CSA (Guthrie & Kunkel, 2015). The facilitator often has a powerful influence on the communication patterns of group members through live demonstrations (behavioural modelling) (Bandura, 1977). The group members gradually learn and apply active listening skills, giving non-judgmental feedback and support through imitating the facilitator (Yalom, 1995).

2.6.4 Interpersonal learning

Yalom (1995) describes interpersonal learning as a broad and complex therapeutic factor. Interpersonal learning involves the level of insight and awareness of group members. During treatment, group members experience emotions together and are bound together through one of their difficult life experiences. They render meaningful support to each other, learn from each other, and are honest with one another. For many NOCs, the support group may be the only resource to assist them with their unique emotional and psychological needs (Hill, 2001). Also, the support group may be the only place where non-offending caregivers can be open and honest. Yalom (1995) describes the development of a group as a social microcosm in which group members will interact with fellow group members in the same way that they interact in their social environment. The social microcosm developed in a support group for NOCs of sexually abused children is arguable as real, if not more, than the real world where they live in shame, worry and guilt.

2.6.5 Cohesiveness

Cohesiveness in a group is a necessary precondition for effective group interventions. The success of groups depends largely on the group cohesiveness (Yalom, 1995). When group members perceives their group as safe and supportive, group therapy can offer them an opportunity for psychological growth. Beckett and Rutan (1990) note that there are three phenomena which assist in the formation of group cohesiveness, these include:

- Members may expect the other members to know and understand important aspects of their life;
- The unspeakable (taboo) can be more readily spoken; and
- A shared life dilemma can facilitate the trust and willingness needed to reveal intimate and difficult material sooner than would normally be expected.

Support groups provide its members with opportunities for catharsis, which is an organic and powerful emotional experience where members experience a release of repressed emotions which are followed by a feeling of great relief. Thus, a group treatment model is ideal for NOCs because they tend to have intense emotions stored up which they are often unable to release or they have not had an opportunity to share them in the confines of a safe environment.

Support group members are likely to present with existential themes such as death or injury, isolation, unfairness and the indifference of the universe or God to their pain and suffering. These life realities can lead people to experience a degree of anxiety and low mood, partly because certain situations in life tend to be out of human control and is often unexplainable. The mutual trust, openness and shared experience that develops among members in the support group permit the exploration of these issues and can assist members to develop an acceptance of difficult realities. NOCs who learn of their child's sexual abuse, are often burdened with various emotions and the stigma attached to CSA, but through the exploration of these issues, within the safe confines of a support group, hope and optimism can be

re-instilled. A different perspective over their circumstances can be developed and better coping strategies can be built (Guthrie & Kunkel, 2015).

It can be concluded from this discussion that therapeutic elements of group therapy can be present in a support group. With the aid of a facilitator and the manner in which he or she directs the group, support groups have the potential to lead to positive therapeutic outcomes for NOCs.

The next section will discuss psycho-educational support groups as a treatment model for non-offending caregivers of children who have been sexually abused.

2.7. Psycho-educational support groups

Psycho-educational support groups are recommended as they can provide NOCs with the knowledge and skills that they need. They may also provide NOCs with a balance of cognitive and affective material with the same weight of importance. The general goal is to assist NOCs to develop better interpersonal skills, coping skills, problem-solving skills and more adaptive responses to predictable challenges (Friedman, 2012).

Next, the facilitation of psycho-educational support groups for NOCs is discussed.

2.7.1 Facilitation of a psycho-educational support group for non-offending caregivers of children who have been sexually abused

A goal of psycho-educational support groups is to educate. The facilitator thus needs to have expert training or experience on the issue, concern or condition of the group to effectively address the needs presented by the members (Brown, 2018). Moreover, the facilitator should have considerable self-insight and understanding of group processes and group dynamics. From the outset, he or she must discuss the inherent fears and expectations of the group members (Bor &Tilling, 1991). In the beginning stages of group development, the facilitator is the one directing and framing the group. Therefore, he or she should assist the group members to establish rules and norms which should be respected and adhered to throughout (Bor & Tilling, 1991). Group norms develop from the expectations of the members. The rules and norms need to be simple and clear such as respecting each other, keeping confidentiality, active participation, showing compassion for others and speaking one at a time. The facilitator must emphasize confidentiality throughout the group process (Bor & Tilling, 1991). Furthermore, the group facilitator may promote the use of a group contract as it often encourages commitment and accountability (Brown, 2018).

It is the facilitator's role to screen and recruit group members. Therefore, he or she should take into consideration each member's predisposing factors and presenting problems during the screening process so that appropriate and informed referrals can be made for the NOCs' additional support (Brown, 2018). Support groups are time-bound, therefore the facilitator must tailor the contents of

sessions within an eighty to ninety minute group session (Yalom, 1995). This provides sufficient time for education and group discussion but is not so long that participants begin to disengage or cannot commit to the time requirement (Brown, 2018). A setting that is safe and private and free from distraction is required. In preparation of the group, the facilitator needs to reflect and consider the nature of the group and choose a physical environment that can cater for the group size and seat members in a circle (Yalom, 1995).

Support groups can be face-to-face or internet-based, they can also be facilitated or non-facilitated. Support groups that are conducted face-to-face have the advantage of the group members being able to view non-verbal cues from others participating in the group, which is helpful when discussing emotional issues (Guthrie & Kunkel, 2016). Also, communication in face-to-face support groups allows for instantaneous responses and immediate feedback (Guthrie & Kunkel, 2016). Moreover, groups led by a facilitator have the advantage of having a person who can model empathy, understanding and unconditional positive regard (Yalom, 1995). A facilitator is also responsible for observing group processes, providing feedback and helping the group run smoothly when they get stuck (Brown, 2018).The role of a facilitator is to empower and encourage members to be as proactive as possible in their recovery and healing (Brown, 2018). The facilitator fulfils this role by assisting the members to learn from one another in establishing personal goals and encourages them to transform their insight into concrete action (Harvey , 2002). Knowledge and understanding of the needs of group members against the stages of group development will assist the group facilitator in planning and in responding to behaviours and challenges that may emerge (Kieffer, 2001). The facilitator should plan session contents in such a way that participants can apply the knowledge gained and be prepared for termination of the group when it's time.

An effective and instrumental facilitator of a psycho-educational group for NOCs of children who have been sexually abused, will take care to do some self–reflection as he or she prepares to facilitate the group (Wardale, 2013). The facilitator needs to be aware of personal boundaries on issues of self-disclosure and what topics may create discomfort (Brown, 2018). It may be of value to consider supervision or to consult a colleague with whom he or she can explore these issues. Furthermore, the facilitator needs to be aware of his/her own biases about parenting and whether his or her status as a parent or non-parent may affect how he/she interacts with the group. There's also the issue of competence. If the group facilitator is new to facilitation or a particular demographic and topic (i.e. CSA and parents), he or she may wish to partner with a trained facilitator or obtain some training (Brown, 2018). The facilitator needs to consider all the role characteristics as they will aid him or her during the group processes.

An added advantage of using psycho-educational support group programmes is that they facilitate a learning and training process which has the potential of increasing the NOC's knowledge about CSA. This may consequently affect the NOC's self-efficacy and reduce parental levels of stress (Navaei et. al. , 2018). The development of psycho-educational support groups is thus ideal for this study as they

are cost-effective in providing education and support in contexts where professional infrastructures and resources are hard to access or are limited (Becker & Duncan, 2010; Im et al., 2018; Kramer-Olen, 2014).

The next section will discuss the challenges that can be faced when developing and running a psycho-educational support group for NOCs of children who have been sexually abused.

2.7.2. Challenges of non-offending caregiver (NOC) psycho-educational support groups

NOCs need to feel safe when considering joining and coming to the support group (Delinger, Mannarino, Cohen, Runyon, & Hefin, 2015). Many NOCs find it difficult to trust and share their experience with CSA and are therefore hesitant to join support groups, despite their obvious need for social support (Dempster, Davis, Jones, Keatry, & Wildman, 2015). This is observed by Hill (2001), who explored the experiences of women attending a busy peer support group at the National Society for the Prevention of Cruelty to Children (NSPCC) in York. During the unstructured interviews, the author noted that the women did not consider group treatment as an option. Others felt that they could manage by themselves, while others were scared to join support groups and others considered a support group or group treatment as a last resort. He further adds that some women felt that they needed to overcome their fears, although they had an interest to join the group: “I just wanted someone just to listen. I was really scared going along, really terrified thinking: ‘they’re all going to know me, not know me, but they’re all going to see me, they’re all going to judge or they’re going to see what sort of person I am,’ and I was really, really scared.”

Confidentiality in support groups is very important in ensuring that the members feel free and safe to express their feelings and that they are comfortable to share the circumstances that led to their child’s sexual abuse with the rest of the group. Psycho-educational support groups can help NOCs become aware of the prevalence and the “realness” of CSA and their current circumstances.

In Holm and Hansen’s study (2004), potential barriers to treatment adherence for sexually abused children and their NOCS were examined. There are barriers to initial engagement which they define as the NOCS’s ability to make a conscious decision to seek psychological intervention, to make the call for a psychological intake interview and to attend the treatment sessions that follow the initial meeting. Group facilitators running a psycho-educational support group need to be conscious of the potential obstacles they can face when trying to recruit NOCs to join a support group intervention. The facilitator may find value in screening for these potential barriers which may be structural or financial issues or issues relating to family functioning and systematic psychopathology. Issues specific to the functioning of children and parents and issues arising from the relationship between prospective group member and group facilitator, are frequently and specifically related to families who seek treatment for CSA. There are also issues specific to therapeutic service providers or agencies and clinics that have the potential to limit treatment adherence or initial engagement. Understanding the barriers of initial engagement can assist the facilitator to make a clinical assessment for commitment. In other words,

the aforementioned potential barriers can help the facilitator judge whether the potential support group members can participate in treatment sessions and practically apply the skills learned within a sessions in their everyday life. If the NOC is not able to take advantage of the access to the intervention or if a group member is unable to fully commit to attending the sessions and will drop out before the end, it can destabilize the group process.

NOCs that attend support groups are typically those who desire to gain knowledge, understanding and skills for the promotion of positive development of their child and the parent-child relationship. Therefore, NOCs who are optimistic and use problem-focused coping are more likely to actively seek psychological interventions for themselves. There is also a greater chance that they will attend the sessions and do the work outside the support group sessions. Whereas, NOCs who use emotion-focused coping are likely to find it challenging to attend a support group consistently and do the work that is required to meet their personal goals (Holm & Hansen, 2004).
With the above in mind, the next section will briefly discuss the effectiveness of psycho-educational support groups.

2.7.3. The evaluation of the effectiveness of psycho-educational support groups

In low or middle-income countries such as South Africa, group-based approaches appear to be the most feasibility because they can reach a greater number of people in a shorter period. Group-based approaches offer cost-effective treatment for providing education and support to NOCs. However, the effectiveness of such group-based interventions relies on the way they are implemented and measured. One way to measure the effectiveness of psycho-educational support groups has been through the evaluation of outcome studies, such as randomised control trials. This can be done by establishing the objectives for the support group during the recruitment and needs assessment phase. Thus, the outcomes of the support group programme will be measured against the group objectives (i.e. reducing distress, improving family functioning, educating and empowering the recipients). Most support group studies thus far have not been able to produce substantially significant results due to the small sample size and a lack of control groups (randomised trials pose ethical concerns about withholding interventions).

Im et al. (2018) developed and implemented a Trauma-Informed Psycho-education intervention (TIPE) for Somali refugee youth in urban Kenya. The study measured the outcomes of PTSD and psychosocial factors in Eastleigh, Kenya. The project formed part of the Eastleigh Youth Project supported by USAID. The project was conducted in a community-based organisation (CBO) led by Somali doctors, counsellors and community leaders (stakeholders). The TIPE included education on multifaceted impacts of trauma on the body, mind, social relationships and spirituality, followed by psychosocial competencies such as emotion-coping and problem-solving, community and support systems and conflict management skills. After the completion of the 12 session peer-led TIPE, pre-and post-tests revealed positive impacts on PTSD symptoms and psychosocial factors. Trauma-focused behaviour therapy components in a psycho-educational support group for NOCs may show similar outcomes.

Navaei et. al., (2018) undertook a study that examined the effectiveness of group counselling on parents' self-efficacy, knowledge, attitude, and communication practice in preventing sexual abuse of children aged 2-6 years. The authors used a randomized control trial with parents from three kindergartens (n = 62), using random selection (cluster sampling). They split the parents equally into an intervention and control group using block randomization. The counselling groups ran for ninety-minute sessions per week for three consecutive weeks. Using a pre-and post- outcome evaluation, the authors concluded from their results that, "group counselling is an effective tool in increasing the self-efficacy of parents on child sexual abuse. The awareness of child sexual abuse and its prevention should be raised in society through effective training programmes." (pp. 285)

It is becoming clear from the previous sections that there is scope for research studies on parent-focused programmes that offer preventative and remedial interventions with regards to CSA (Mendelson & Letourneau, 2015). Moreover, there is also an emerging need for evidence-based parent-focused interventions catering to the needs of the NOCs post-CSA (Meinck et al., 2016; Mandelson & Letourneau, 2015).

The next section will describe the ecological systems framework as the theoretical framework for this research.

2.8. Theoretical framework

The socio-ecological perspective was used as the theoretical framework of the study. This theory asserts that society interacts at different levels and that each level affects all other levels (Bronfenbrenner, 1992, 1994). The aim of using this model is to open up multiple ways of encouraging individual and community reform through changing aspects of an individual's social context interface (Visser, 2007).

CSA has shown to have rippling effects on all systems. Children, as well as NOCs, are susceptible to psychological harm resulting from sexual abuse which affects all areas of functioning (Aucamp, Steyn, & Van Rensburg, 2014). These areas of functioning exist in an interdependent and interacting system environment (Bronfenbrenner, 1992).

The next section will discuss each level of the eco-system as it relates to the impact of CSA on the NOC, the parent-child relationship and where the psycho-educational support group intervention for NOC's who have been sexually abused can be deployed.

2.8.1. Individual-level

It is important to consider the NOC's predisposition with regards to pre-existing mental health conditions, past trauma relating to sexual violence, biological factors and coping responses. These predisposing

factors are essential for planning any treatment or intervention when dealing with this problem. The next sub-section discusses the impact of the disclosure of CSA on the NOC.

2.8.2. Trauma-related factors (Disclosure)

The NOC is considered the secondary victim to the sexual abuse of their child. The NOC may learn of their child being sexually abused, either through the direct verbal disclosure by their child, witnessing the child being sexually perpetrated or seeing blood or lesions on their child's genitalia (Partners in social change, 2015). This discovery can be traumatic and can affect the NOC in a significant way (Zimba et al., 2015). Therefore the disclosure of CSA can be experienced as a psychological trauma by the NOC (Campbell, Dworkin, & Cabral, 2009). NOCs have reported shock, denial, guilt and anger to name a few stress/trauma reactions (Zimba et al., 2015). These emotions progress and become even more complex as the NOC tries to cognitively process the event, with some experiencing anxiety, depression due to attribution of self-blame and posttraumatic stress symptoms (Elliot & Carnes, 2001). This stress/trauma reaction can influence the NOC's decision-making and problem-solving abilities.

The next section will discuss how the different levels are involved.

2.8.3. Microsystem level

At this point, the NOC may need the support of their immediate family, trusted family and friends. The NOC may experience their immediate family, neighbours and trusted friends as supportive and empathic to their experiences. This will help the NOC to meet their basic social needs. However, as is evident in studies that explored the experiences and needs of NOCs, the NOCs have indicated that they often do not get the support of their immediate family, trusted neighbours and friends (Riina et al., 2016). They often experience a lack of social support from family and friends. Instead, they experience blame for the child's sexual abuse, their parenting skills being negatively criticised and they also reported feeling alone during the process (Rust, 2011). In this system, the parent-child relationship is also affected and the NOC may find it difficult to provide the necessary support to his or her child. The lack of the appropriate immediate informal social support (family ties and friendships and community leaders, church counsellors, etc.) which moderate the impact of CSA disclosure, can exacerbate the post-traumatic stress symptoms (PTSS), depressive symptoms and strengthen maladaptive coping responses.

The next section discusses how formal social support institutions or programmes can intervene.

2.8.4. Exosystem

The NOC enters the exosystem with the search of professional support, specifically from the police and wider judicial system, the child protection services and the schooling system. NOCs are usually familiar with the schooling system, however, they may find that they need to interact with these systems differently and may need the school personnel to be particularly supportive to the child's educational

functioning post the disclosure of CSA. Furthermore, the NOC is now tasked with entering new systems such as child protection services and the judicial system (Visser, 2007). NOCs are often ill-prepared to navigate these systems and may experience the process as overwhelming and daunting (Masilo, 2011; Rust, 2011). As a secondary victim of their child's sexual abuse, the NOC appears to be left outside this sub-system as there is limited access to programmes or interventions developed and focused on the emotional and psychological well-being of the NOC in South Africa (Masilo & Davhana-Maselesele, 2017).

By intervening directly in this exosystem level one can influence the adjustment of the child affected by CSA, the NOC/child relationship and the family system (Fourie & van der Merwe, 2014; Visser, 2007). This study makes use of a psycho-educational support group to intervene with NOCs of children who have been sexually abused. The structured psycho-educational support group for NOCs becomes particularly important as it can address theit needs of. These include, but are not limited to, informational emotional and psychological support provided in a supportive environment. I attempted to address the needs of the NOCs by assisting them to regain control over their circumstances, to reduce their emotional distress, to help them increase their social networks, to strengthen coping strategies and to help NOCs understand the effect of CSA on their children in order to assist their children in overcoming the trauma. This can empower them to deal effectively with the judicial system. Furthermore, the psycho-educational support group brings together each NOCs' microsystems, creating a shared experience.

This programme aligns with child protective services or stakeholders in the community that are concerned with Gender-Based Violence (GBV) and the abuse and maltreatment of children (Brown, 2018). The format, length and delivery method as described in chapter three, indicates the psycho-educational group as an ideal programme for service providers and NOCs as it is brief and provides a safe-environment. The design is user-friendly, flexible and facilitates ease of delivery and dissemination of information. It also provides for social connectedness allows space for validation and shared experience and emotional support. The programme creates opportunity to correct information and increase knowledge and understanding, develop adaptive thinking patterns and improve coping and conflict management skills (Brown, 2018; Gitterman & Knight, 2016).

Experts also argue that stakeholders in clinical or social settings should be mindful to create an ecological environment and plan support programmes that can respond to multi-sectoral needs of NOCs post-child sexual abuse disclosure (Campbell et al., 2009; Masilo & Davhana, 2017; Mendelson & Letourneau, 2015).

2.8.5. Macrosystem

CSA is not an issue that faces an individual, it is a problem that affects people from all races, creeds and backgrounds (Mendelson & Letourneau, 2016). However, due to stigma and lack of awareness about the risks factors of CSA, the dynamics involved as well as the impact on the child and NOCs, the larger societal system can appear to be ignorant and sometimes harsh to the individuals affected by CSA. Culture-specific beliefs such as those that condone violence against women and children, a silencing culture, cultural differences in responding to gender-based violence (GBV) and child maltreatment and the acceptance of rape and CSA myths, create a difficult socio-cultural context for sexual assault survivors (Cromer & Goldsmith, 2010). These dominant societal and cultural values and beliefs contribute to the NOCs' feelings of isolation, guilt and self-blame post-disclosure of CSA. NOCs have taken the blame for their child's sexual abuse due to these broader traditions and beliefs about the NOC's parenting obligations (Rust, 2011). Furthermore, the NOC may feel responsible for the perpetrator's actions, where there is interfamilial CSA (Tal, Tal, & Green, 2018; Thompson, 2017).

It is not surprising that NOCs experience a lack of support from family, friends and formal societal structures, thereby making them susceptible to guilt due to self-blame. This results in a predisposition of the NOC to depression, PTSD, maladaptive coping skills as well as dysfunction and disorganisation in the family.

2.8.6. Chronosystem

This system involves the NOC's previous experiences involving CSA, either their own or the child's previous sexual victimizations, as well as the expectations and hope for future adjustments (Bronfenbrenner, 1994). These external time-bound factors could affect the NOC's mental health and thereby influence how they cope with the disclosure of sexual abuse and contend with the impact thereof (Masilo & Davhana-Maselesele, 2017).

An ecological problem such as CSA requires an ecologically concerned intervention. Thus a structured psycho-educational support group for NOCs of children who have been sexually abused is a necessary addition to the existing interventions that address CSA (Campbell et al., 2009; Masilo & Davhana-Maselesele, 2017; Mendelson & Letarneau, 2015; www.wcasp.com).

The diagram below is a systematic representation of the impact of CSA on the NOC, the parenting relationship and the family system as a whole.

Source: Adapted from An Ecological Model of the Impact of Sexual Assault On Women's Mental Health (Masilo & Davhana – Maselesele, 2017).

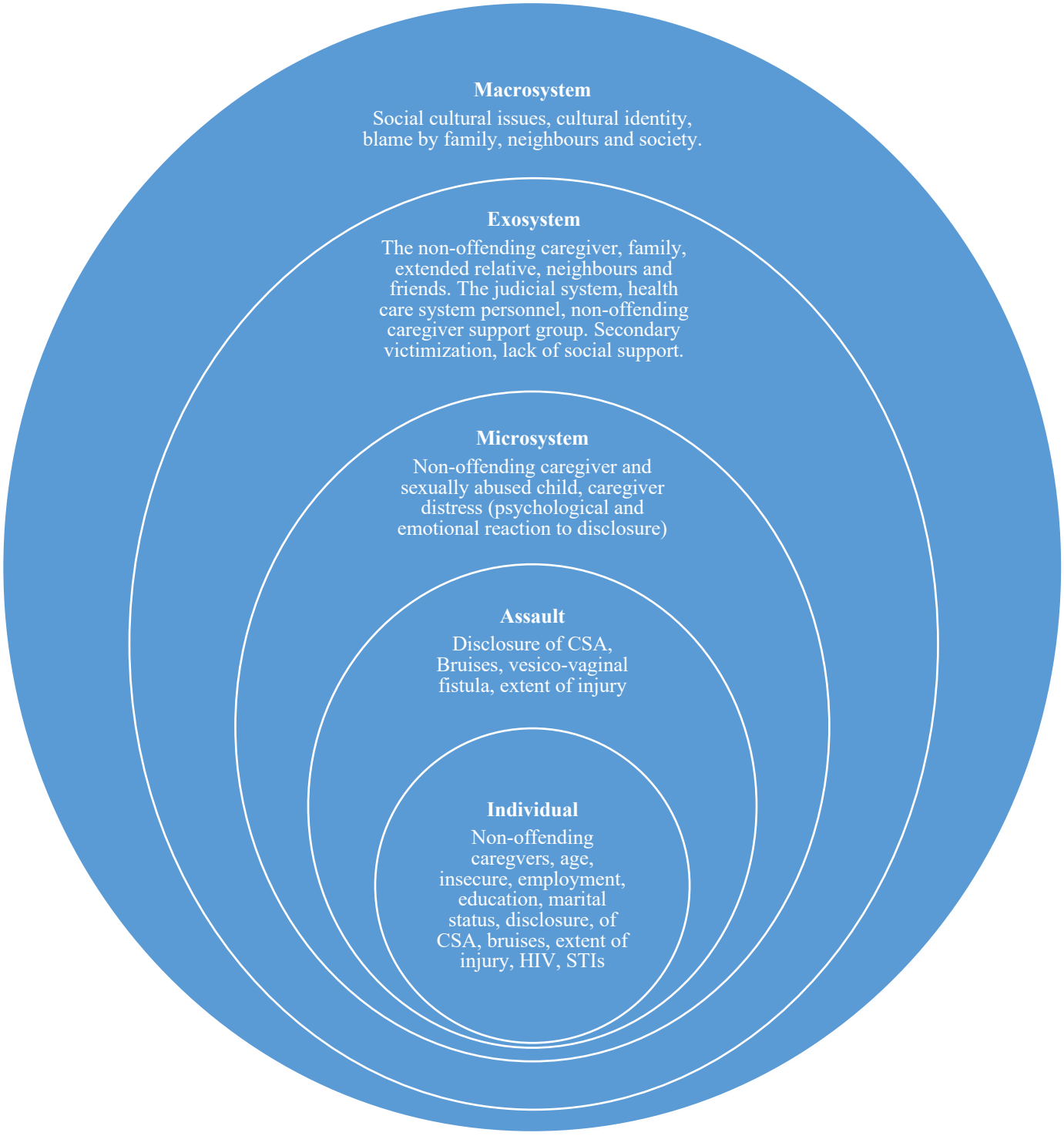

Figure 1: An ecological model of the impact of CSA on the caregiver's mental health.

In this chapter, the psychological and emotional aspects related to CSA as affecting the NOC (secondary victim of CSA) have been discussed. It is important to recognise the complex relationships taking place between the psychological and emotional well-being, coping efficacy and social support, not only of the NOC but within the parent-child relationship and the wider family context and the context of the CSA. Therefore, it is imperative that when developing an intervention for NOCs of children who have been sexually abused, that the interaction between these aspects and the social context is taken into account.

CHAPTER 3 METHODOLOGY

The purpose of this chapter is to describe the methods used to develop the structured psychoeducational support group for NOCs of children who have been sexually abused. The emphasis is on the design of the study, the implementation of the structured psychoeducational support group, and the process of data collection and analysis.

3.1 Method of research

The study used action research (Kemmis et al., 2014) in developing the structured psychoeducational programme for the support group intervention. Action research involves a process of active participation of community members in solving social issues through action and self-inquiry (Cresswell, 2009; Robertson, 2000). The assumption is that the community can support each other and develop solutions for situations they are in (Reason & Bradbury, 2008). Action researchers undergo a repeating cycle of planning, implementation and evaluation (observation and reflection) as they develop solutions (Kemmis et al., 2014). The following steps of the action research approach were implemented in the development of the intervention:

Figure 2

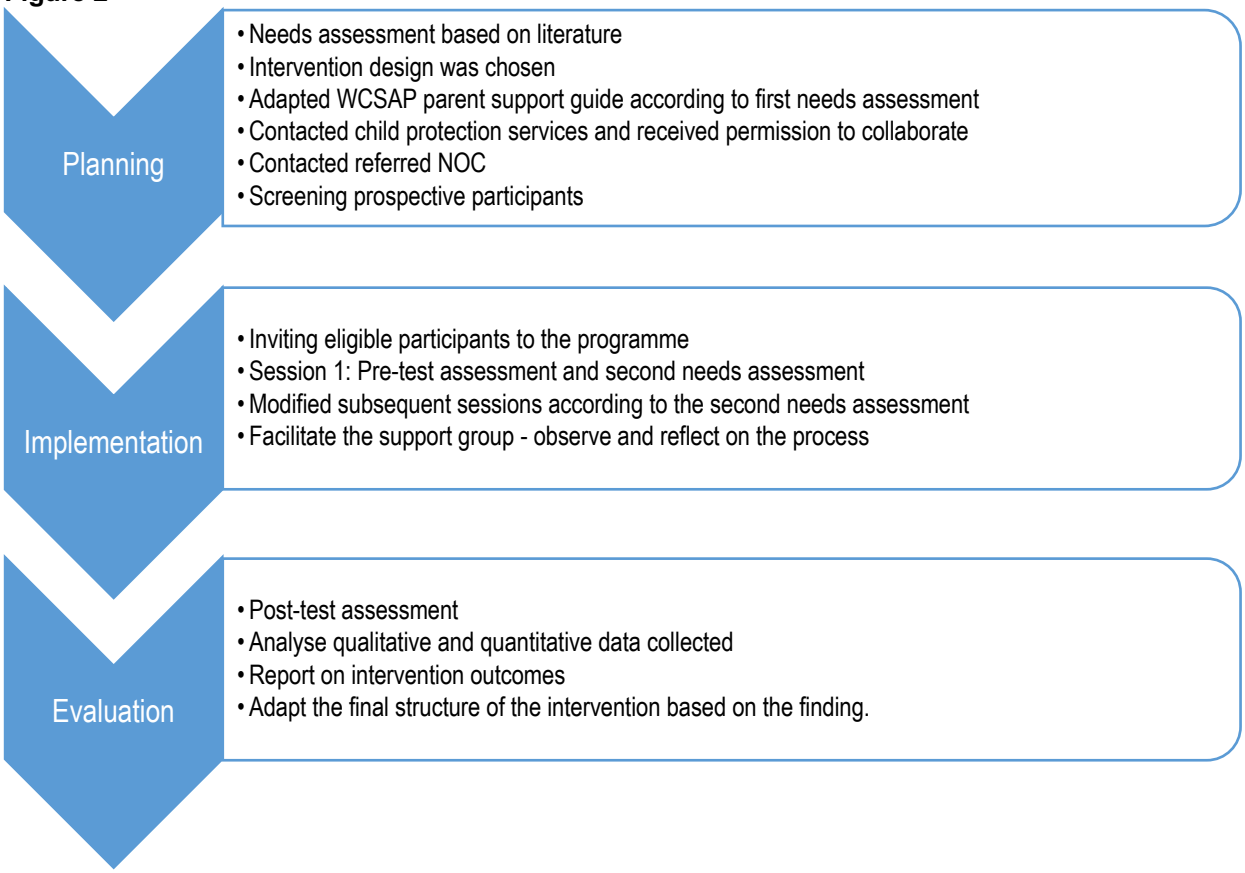

Figure 2: Steps in the development of the intervention

The action research process follows a circular pattern which allows for continuous evaluation of the study as a whole as well as of its sub-parts, which provides room for changes during the process (Kemmis et al., 2014). The diagram below describes the process sequence and changes of the research.

Figure3

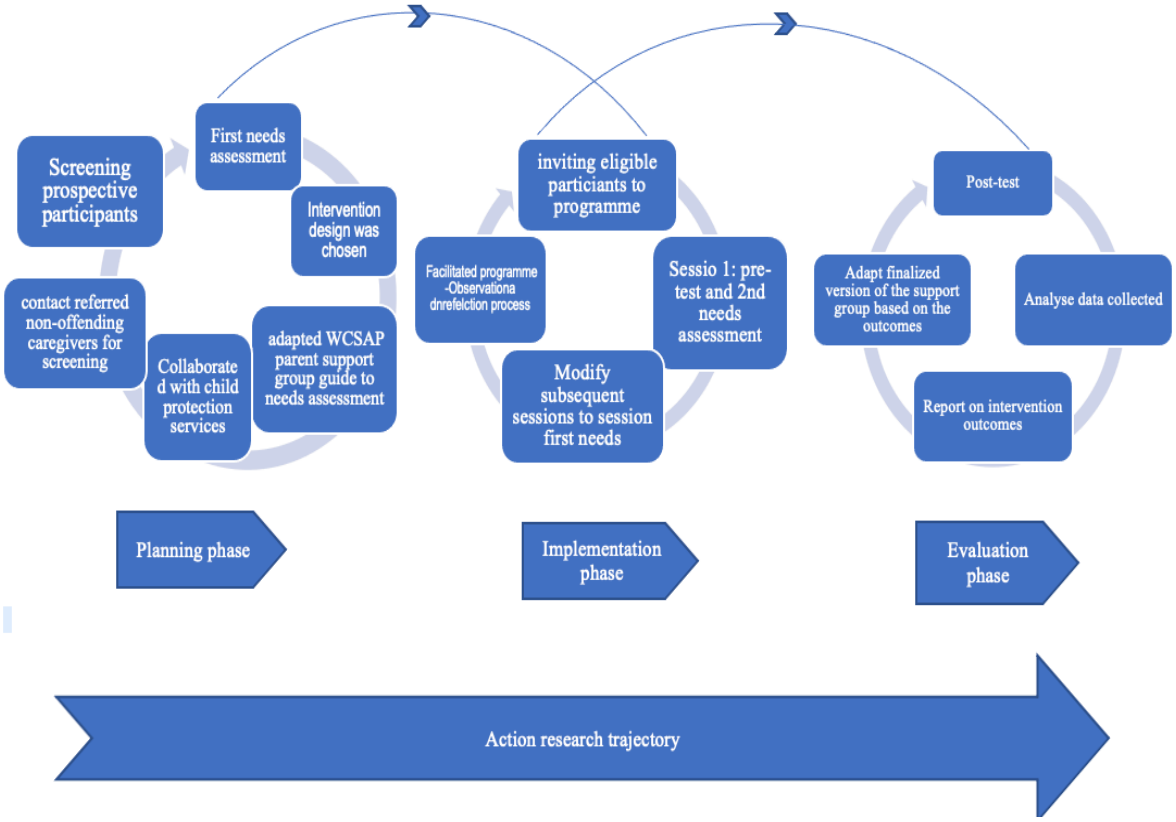

Figure 3: Action Research feedback loop

The action research process will be briefly outlined as a means to provide background as to how the current research unfolded.

3.2 A needs assessment

The needs assessment was done over two stages of the research process. The first needs assessment was done by going through existing literature that explored the needs of the NOCs of children who have been sexually abused (Mandelson & Letourneau, 2015; Masilo & Davhana, 2016; Tavkar & Hansen, 2011; Van Toledo & Seymour, 2013). Following this, the content of the Washington Coalition of Sexual Assault Programs (WCSAP) Parent Support Group Guide (Micheel & Levy-Peck, 2012) was customised to align with the needs of NOCs identified from existing literature. The second needs assessment was done during the implementation phase in the first session of the psychoeducational support group. The intention was to further tailor the programme to the specific needs represented by the NOCs recruited

for the implementation of the intervention. As part of session one of the support group, the NOCs were given index cards and asked to write down topics and questions they would like the facilitator to address during the intervention. This was an opportunity to gain insight into the nature of support the NOCs needed and allowed for the sessions to be adjusted accordingly.
The details on the development of the psychoeducational support group for NOCs of children who have been sexually abused follows in the next section.

3.3 The development of the intervention based on the expressed needs of the NOCs

The intervention aims were as follows:

- To assist NOCs to regain control over their circumstances;
- To help them increase and utilise their social networks and reduce social isolation;
- To help NOCs to understand the impact of CSA on their children;
- To help NOCs to assist their children in overcoming the sexual abuse trauma;
- To help NOCs to decrease their emotional and psychological distress levels; and
- To decrease the stress in the NOC/parent-child relationships.

Using the WCSAP Parent Support Group Guide (Michel & Peck-Levy, 2012), the eight-session support group intervention was customised based on the findings of the needs assessment during session 1 and previous research described in literature. Suggested themes to be addressed were the following:

- Emotional and psychological impact of CSA disclosure;
- Parenting skills and parent/child relationship;
- Coping strategies and social support systems; and
- Navigating the judicial system.

These themes formed a basic structure of the intervention. Feedback from each session was used to tailor the sessions that followed.

A preparation guideline and lists of materials that will be needed for each session are also included in the WCSAP Parent Support Group Guide and the Facilitator Manual. The programme sessions were semi-structured to encourage group participation (DiCicco-Bloom & Crabtree, 2006; King, Horrocks, & Brooks, 2018; Knox & Burkard, 2009). Sessions had a uniform structure; they started with an “ice-breaker exercise.” The emotional thermometer was used to check-in with the members at the beginning of each session. This exercise assisted the NOCs to become aware of their emotions and to practice emotional self-regulation. For instance, in session one, the NOCs reported emotions that they were struggling with. They rated the intensity of those emotions on a scale of 0 - 10. 0 meaning not experiencing that emotion and 10 meaning that the emotion was affecting their day to day functioning. Experiential learning took place in the form of role-play, games, story-telling, case studies and sharing of experiences. Each session involved a learning and discussion component. To conclude each session, and as a form of checking-out, the members reflected on the session’s activities and emotional

experiences. Furthermore, each session had a self-care activity for the members to do during the week. An opening and closing prayer as discussed and agreed to by the members was integrated into the programme to encourage the members' sense of belonging and group cohesiveness. (Refer to Appendices for the support group session structures.) Session outcomes from each session were used to inform the next session.

An ecological approach (Bronfenbrenner, 1997; Campbell et al., 2009) was used to customise the contents of the programme to suit the South African context. Various aspects of CSA were addressed in as much as it affected the NOC, the NOC-child relationship, the broader family context and the broader systems within which NOCs interacted. The final structure of the programme is as listed below:

- Session 1: Introduction and orientation
- Session 2: Overview of child sexual abuse
- Session 3: Coping and communication
- Session 4: How abuse affects children and adolescents
- Session 5: How abuse affects parents and siblings
- Session 6: Difficult child behaviours and parenting challenges
- Session 7: Dealing with the outside world
- Session 8: Closing session: Moving into the future

A detailed outline of the eight sessions is given below.

3.3.1 Session 1: Introduction and Orientation

Each member was presented with consent forms to participate in the group. Upon signing, the pre-assessment was conducted (HADS and PSI-4-SF, discussed in section 3.5.2.) to screen for emotional and psychological distress as well as parent-child stress levels, respectively. The members had an opportunity to share their expectations and needs, which were used to inform the sessions that followed. Group norms were discussed to create a safe and healthy environment in which they could share their concerns and also gain knowledge regarding these concerns.

3.3.2 Session 2: Overview of child sexual abuse

This session was focused on helping the NOCS share their disclosure experience and afforded them the opportunity to explore their emotions and thoughts around it. The objective of sharing stories was to create and contribute to group cohesion related to shared experiences. This was aimed at normalising the reactions and circumstances (shame, guilt and isolation) surrounding the disclosure. The session also helped to build a foundation of knowledge about child sexual abuse and provided an opportunity for questions to be asked and preconceived views about CSA to be corrected where necessary.

3.3.3 Session 3: Coping and communication

This session focused on assisting the NOCs to be able to manage their emotional reactions by developing healthy and adaptive coping strategies and healthy communication skills, which could, in turn, help their children. The members were encouraged to be aware of their emotions and to develop emotional self-regulation. This session relied heavily on the emotional thermometer exercise to help the NOCs track the intensity of the emotions that they were experiencing. For instance, the members were asked to rate their emotional reaction to the disclosure of CSA from 0 (meaning they felt nothing) to 10 (they strongly felt that emotion). Building on the emotional reactions, the session focused on emotional expression and communicating effectively with their children. This was an opportunity for members to identify unhealthy communication habits or patterns that could stifle communication between parent and child. Role-play was used to demonstrate ways of communicating effectively with their children during conflict or when offering emotional support. As a supplement to the sessions, handouts on positive communication skills were given to each member.

3.3.4 Session 4 and session 5: How abuse affects children and adolescents, parents and siblings

These two sessions addressed the reactions to CSA and how to cope with these reactions. Session four focused on how CSA affects children and adolescents, the factors that influence the impact of child sexual abuse, and the importance of healthy sexual development. As part of helping the NOCs reach their positive parenting goals, it was important to educate them and provide them with concrete ways to build resilience, ensure safety, rebuild trust, promote healthy sexuality, address sexual recovery issues, reorient the child towards normal developments, prevent re-victimization and getting help for the child.

Session five focused on how CSA affects parents and siblings. The aim was to facilitate the family's healing process by helping the NOCs understand and respond to the sibling's and partner's reaction to CSA. Due to the sensitivity of the topic, the session content was tailored and informed by each member's situation. This session was a good opportunity to highlight that the family is a system and when one family member is in trouble or pain, the entire family is affected. Also, the group discussed their concerns regarding the impact of CSA on their relationship with their partner and some of the challenges they face. This session marked an important milestone in the NOC's journey to healing. Therefore it was important to acknowledge and affirm their progress up to that point, as well as to gradually begin to acknowledge that the support group was coming to a close.

3.3.5 Session 6: Difficult child behaviours and parenting challenges

This session focused on the difficult behaviour children tend to display as a result of the CSA and the challenges parents face. The NOCs were educated in more detail regarding the behavioural reactions in sexually abused children. It is important to normalise the behavioural reactions of children by integrating knowledge about normal development to help the NOCs make the distinction between age-appropriate behaviour versus a trauma reaction. This session is an obvious extension of the previous three sessions, however with a particular interest in helping the NOCs improve their parenting skills in handling these behaviours appropriately. In the session, the aim was to encourage the NOCs to focus their attention on the behaviours they want to see more from their children and to invest time in those preferred behaviours from their child.

In preparation for session seven, the NOCs were asked to write down questions they had regarding the judicial system, child protective services and the school system. This allowed the social workers, invited to session seven, to prepare to address the NOCs' general questions.

3.3.6 Session 7: Dealing with the outside world

This session focused on exploring the various sources of stress and support in NOCs' lives and to provide information to help them navigate the judicial system, particularly that they become involved in following the CSA disclosure. NOCs often have to contend with new responsibilities, new people, new systems and changing relationships and it was, therefore, important to discuss how one should prepare and respond to these changes. Discussions were aimed at helping NOCs to carefully think about what they have learned through their interaction with the criminal justice system, child protection services, schools, family and friends following CSA in terms of coping and support. The NOCs had the opportunity to ask questions and learn from social workers who work at the child protection services, as well as from those who specifically interact with the judicial system, to prepare children for testifying in court.

In anticipation of the closing session, it was important to prepare the NOCs about the session activities and expectations regarding the duration of the session and how they were expected to engage. This allowed the NOC time to reflect on the support group as well on the post-test and end-of-group evaluations.

3.3.7 Session 8: Closing session: Moving into the future

This was the closing session. The aim was to provide closure for the group and to instil confidence and hope for the future of their families. The post-test assessment also took place during this session. Work commitments of NOCs limited the time spent in the sessions and the activities that were covered. Qualitative feedback regarding the intervention as a whole was provided.

The next section will describe the implementation of the intervention.

3.4 Implementation of the intervention in a structured psychoeducational support group

Over five months (18/04/2018-28/09/2018), two psychoeducational support groups were implemented for this study. This section will describe the type of sampling that was used, the criteria used to get the sample as well as how each group member was recruited. Furthermore, the section will provide an account of how the psychoeducational support group was formed, giving detail as to what location was used, who was involved and for how long the psychoeducation support group programme was implemented.

Recruitment of group members

Purposive sampling was used in this study. This involved the selection of members who were NOCs of children who have disclosed child sexual abuse (Etikon, Musa, & Alkassin, 2016; TerreBlanche et al., 2006). Non-profit organisations that provide services for CSA victims in and around Gauteng Province were approached per email to request their participation in the development of a structured psychoeducational support group for NOCs. Teddy Bear Clinic (TBC) in Parktown, Johannesburg, and Women and Men against Child Abuse (WMACA) Kidz Clinic in Boksburg, agreed to take part in the study. These organisations provide services that aim to minimize secondary harm to children and their families when they enter the child protection service. TBC and WMACA Kidz Clinic achieve this through therapeutic counselling and support for the child as well as for the NOC. When I received permission letters confirming a professional collaboration with the TBC and WMACA Kidz Clinic, I provided the social work staff of the organisations with the following inclusion and exclusion criteria to consider when identifying possible participants for the groups.

Inclusion Criteria

- The age range was limited to 18 years and 60 years of age;
- Male and female NOCs of children who have disclosed CSA;
- They may or may not have received any type of emotional and psychological support after the disclosure of CSA;
- The NOCs must be functioning reasonably well;
- NOCs should understand either English, Zulu, Xhosa or Sotho; and
- NOCs should be willing to participate in the programme at the designated child protection service.

The social workers provided me with a list of contact details of NOCs they believed would benefit from participating in the programme.

Contacting NOCs

I contacted 60 non-offending caregivers from TBC and five NOCs from Kids Clinic telephonically, inviting them to the screening interview for the possible engagement in the psychoeducational support group. During the telephonic call, the prospective group members were informed about the psychoeducational support group and the research process. NOCs showed interest in the support

group. Due to the sensitive nature of the topic many were scared to join a group. They were hesitant to talk about their experiences in front of others. Others had work-related and transport problems that made it difficult for them to join the support group.

Screening Interview

The screening interview process was conducted for over three months (2/05/2018-19/07/2018). An account of this period is provided in the section discussing the recruitment challenges.

I met with 13 prospective group members individually to determine whether they were fit to join the group. This served as an opportunity to build rapport and trust. During each interview, the NOCs were given information about the psychoeducational support group programme and their possible participation. Once I was confident that the prospective group members had all the necessary information, I gave each of them an informed consent form (see appendix) to sign if he or she was willing to participate in the study. Once the prospective group members had officially agreed to join the support group programme, the interview commenced. The screening interview served to assess commitment to the group and addressed requirements such as regular attendance and willingness of the NOC to join the group. The interview also screened for a minimum of grade 10 level literacy and the ability to listen and answer simple questions.

Recruitment challenges

Transport limitations and work commitments were challenges that NOCs had to contend with, not only to attend the screening interviews but to attend the structured psychoeducational support group programme on a regular basis. Many non-offending caregivers could, subsequently, not participate in the programme as they could not attend the sessions on a regular basis.

In addition to the above-mentioned challenges, TBC and Kidz Clinic are non-profit organisations (NPOs), which means that their resources are limited for the services they currently offer and often offices are designated for the permanent working staff at the respective NPOs. Thus, there was difficulty in finding space and time to accommodate support group sessions. Both organisations operate only on weekdays during general working hours which had a direct impact on the pool of prospective group members.

Inviting eligible group members to the programme

Following the screening interview, the NOCs who fitted the criteria were invited to join the psychoeducational support group and each NOC was notified via SMS of the venue, date and time of the first session. Eight non-offending caregivers were selected from TBC and two NOCs were selected from Kidz Clinic. Of these ten selected, eight NOCs agreed to join the psychoeducational support group which constituted the sample of the study. The sample was ideal, because it was small enough to carry out an intervention (Etikan et al., 2016; TerreBlanche et al., 2006).

The demographics of the group were as follows: One White and seven Black NOCs of which two were fathers and six mothers of sexually abused children. We were glad to include fathers as paternal support has been found to be significant for the child who has been sexually abused (Cyr et al., 2014). The unique and distinct impact that significant paternal figures have on their child often play an important role in the recovery of the child victim and their preparation to deal with the outside world (Cyr et al., 2014). It was found that the level of paternal support and involvement of the paternal figure directly influenced the level of psychological distress that sexually abused children experience in their adulthood (Cyr et al., 2014; Malloy & Lyon, 2006). Together NOCs can overcome the turmoil that follows CSA as they learn from each other's experiences (Cyr et al., 2014).

The group members' ages spanned between 28 and 59 years. In terms of relationship status, three NOCs were single, four of them were married and one NOC was divorced. Regarding formal education, one NOC completed Grade 8, two completed Grade 10, one completed Grade 11, two caregivers completed Grade 12 and two had tertiary qualifications. Two NOCs were unemployed, one was self-employed and five were formally employed. One NOC was English speaking, one IsiPedi speaking, four isiZulu speaking, two IsiXhosa speaking and all comprehended English. All group members were their child's biological parent. Two NOCs did not know the perpetrator and six NOCs knew the perpetrator. Of the eight parents, six children are girls and two children, were boys. The child victims' ages at the time of the abuse were between 4 years and 16 years at the time of disclosure. Four parents dropped out before the post-test session (they were Black, three women and one man). Telephonic contact was made with each of the group members and attempts were made to encourage them to re-join the group. Reasons for not attending offered by the parents included work commitments.

The next section will describe the implementation of the psychoeducational support group programme.

3.4.1. Implementation of the group sessions

Venue

Since group members were recruited from two different child protection services, and potential members had work commitments and travel costs, it was convenient to conduct the psychoeducational support group sessions at the non-profit organisations that they were recruited from. Thus each week, two psychoeducational group sessions were held on separate days.

Session attendance

The ability for NOCs to attend sessions was a significant concern in assessing the impact of the intervention. As this study seeks to measure the impact of a structured support group, group members who attended a limited number of sessions could have had a considerable influence on the overall outcome of the programme. The table below provides a statistical account of the number of participants attending the sessions.

Table 1

The number of participants attending sessions								
Child Protection Service (Non-Profit Organisations)	**Starting Date**	**End date**	**Total number of participants screened**	**Total number of participants eligible for this study**	**Total number of participants who joined the program**	**Number of sessions completed**	**Total number of participants in the first session**	**Total number of participants in the last session**
Teddy Bear Clinic Parktown, Johannesburg	26/07/2018	27/10/2018	10	8	6	8	6	2
WMACA-Kidz Clinic, Boksburg	20/07/2018	28/10/2018	3	3	2	8	2	2
Total:			13	11	8	16	8	4

Table 1: The number of participants attending sessions

The goal of the psychoeducational support group was to create an intimate space for NOCs to share their experiences and learn how to cope with their own and their child's emotions. The psychoeducational support group was designed as a closed group to ensure that the group atmosphere was safe, contained and consistent. Confidentiality was emphasized in the group. The support group was facilitated by the researcher. My role as the group facilitator was to guide discussions amongst group members using the relevant topics and to contain the emotions that were carried in the group and to allow the group to support one another. I achieved this by paying attention to personal and interpersonal dynamics at work within the group.

I was the researcher and facilitator during the study. On the one hand this entailed being able to build a trusting relationship with the NOCs; a relationship held together by honest and open conversations around CSA and where empathic responses were appropriate. I also had to encourage interaction among the members to facilitate learning while at the same time protecting privacy and dignity and maintaining respect for the autonomy of the participants (Toy-Cronin, 2018). On the other hand, I had to report on the findings accurately. The advantage of being a facilitator-researcher simultaneously is that I could gain richer data from gaining access to the experiences of the NOCs, while also being able to study the subject at hand. Moving between the two roles throughout the action research process required me to be mindful of my own actions and emotions (Herbet, 2010). Failing to do so, would have resulted in compromising the quality of the data collected and the analysis thereof (Toy-Cronin, 2018).

Cultural considerations

The group sessions were conducted in English, although each group member was free to speak in the language they felt most comfortable speaking. I disclosed that I was proficient in English, isiZulu and IsiXhosa and that I had an understanding of Sesotho. Being proficient in other South African official languages came as an advantage as I was able to understand each member of the group and I was able to translate in English where other group members could not understand. Fortunately, the group members were proficient in the same languages, except for one English speaking member. This added to the homogeneous nature of the group and contributed to the group cohesiveness.

Economic Considerations

The socio-economic context within which this study took place, played an important role in the design of the study. Of the 13 screened group members, four were unable to afford transportation to and from the child protection services to attend the support group sessions once a week for eight weeks. This influenced the selection of eligible participants as well as attendance. In view of the socio-economic context, prospective group members were informed during the screening interview that there were no financial benefits in joining the support group. Those who were eligible and agreed to join the support group were, however, informed that refreshments would be provided during the support group sessions.

Confidentiality

Confidentiality is central in developing a trusting and productive relationship when working with an individual or in group-based work such as psychoeducational support groups (Corey, 2013). This ethical concept ensures that the facilitator does not disclose any group member's information without their consent (American Psychological Association, 2002, 2010; Corey, 2013). Furthermore, it was important for me as the facilitator, to discuss the nature and purpose of confidentiality with the group and to inform them that certain information regarding the sessions would be discussed with my research supervisor (American Psychological Association, 2002, 2010; Collins et al., 2018; Corey, 2013; Mikesell, Bromley, & Khodyakov, 2013). The importance of confidentiality was emphasised throughout the implementation of the psychoeducational support group. During the recruitment process, confidentiality was mentioned over the telephonic invitation and then discussed in detail during the screening interview. The NOCs were assured that identifying information such as names, would not be used in the research and the writing up of the data (Orb, Eseinhauer, & Nynaden, 2001). Furthermore, they were informed that their information would be locked and secured in a filing cabinet at all times. Confidentiality was also addressed in the first session of the psychoeducational support group. The participants in the group were informed about confidentiality and how it contributes to the participants experiencing the psychoeducational support group as a place where they would be able to feel comfortable in speaking freely, and not have to worry about being judged or stigmatised (Collins et al., 2018; Mikesell et al., 2013; Orb et al., 2001). The participants agreed that confidentiality was an important norm in the group. All participants signed informed consent forms during the screening interview and those who were selected to join the intervention, signed informed consent forms during the first session.

3.5 The Evaluation of the psychoeducational support group

3.5.1 The design of the study

A mixed-methods design (TerreBlanche et al., 2006) was employed to evaluate the effect of the intervention. A one-group pre-test, post-test design was used to assess the outcome of the psychoeducational support group programme. With the stigma and secrecy surrounding CSA, it was difficult to recruit enough NOCs to establish a group. It was not considered ethical to contact NOCs to be in a comparison group that did not receive any assistance but only shared in the assessments. Only one group was used and comparisons of pre- and post- assessments were done before and after the intervention.

The advantages of a mixed-methods design are that words and narratives can be used to add meaning to numbers while numbers can add some rigour to narratives (Johnson & Onwuegbuzie, 2004). In this research, the qualitative data from the psychoeducational support group sessions were used in conjunction with the quantitative data from two scales of pre-and post-intervention. The post-modernistic school of thought emphasises the importance of multiple understandings of reality (Creswell, 2009). Thus, the mixed methods design was ideal for this study as it allowed me to get a perspective of multiple understandings of reality regarding the data (Creswell, 2009; Seedat, Duncan & Lazarus, 2001). Also, this strategy improves the validity and reliability of the research findings. The mixed-methods design can increase the generalizability of results (Johnson & Onwuegbuzie, 2004; TerreBlanche et al., 2006). This research method is characterised by facilitation of support group sessions, complementary and triangulation of different sources of data (Creswell, 2009; Creswell & Creswell, 2017; Seedat, Duncan, & Lazarus, 2001).

3.5.2 Data collection strategies/procedures

3.5.2.1. Qualitative Assessment: The experience of participation in the psychoeducational support group

Qualitative data were used in this study to supplement the quantitative data.

Tape recordings and process notes

The recorded sessions were transcribed after the sessions to obtain an accurate report of participants' opinions and experiences during the intervention. The sessions were tape-recorded as a backup to refer to session conversations and to be able to complete process notes. Much of the data of this study came from the session recordings as recordings offer the opportunity to re-listen and re-experience the session to get richer data. I also took process notes at each session. The process notes included observations regarding the way the group was interacting throughout sessions and throughout the intervention. I took note of learning outcomes from discussions and questions that could be valuable to follow-up on in other sessions. I used the process notes to reflect on my personal and professional experiences. Additionally, the process notes were used in the formative evaluation of the programme to identify elements of the programme that enhance participation, personal and professional growth as well as problems in the implementation process.

Verbal feedback of participants

After each session, the NOCs gave feedback on what they have gained from the sessions. The feedback was used to adapt aspects of the intervention for future use. The group members were asked to provide feedback on their experience of the structured psychoeducational support group intervention in order to attain a comprehensive understanding of the impact of the intervention. The questions focused on their expectations and whether they were met; their experiences of the group interaction; the facilitation; and the content discussed in the programme. The questions also enquired as to which parts of the programme the group members learnt from most and which parts they felt were not valuable.

3.5.2.2. Quantitative Measures

I was interested in assessing anxiety and depression symptoms because they would provide me with insight regarding the level of emotional distress and parenting stress that the NOCs were experiencing. NOCs completed two pre-and post-assessment questionnaires, namely the Hospital Anxiety and Depression Scale (HADS) and the Parenting Stress Index (PSI-4-SF). The assessments formed part of the activities of session one and session eight. It was explained to the members that the pre-and post-tests were not about measuring the progress of participants but focussed on measuring the level of the impact the programme had on the group.

The assessments, namely the Hospital Anxiety and Depression Scale (HADS) and Parenting Stress Index (PSI-4-SF) were used to quantitatively measure the impact the support group had on the NOCs. The assessments respectively, measure anxiety and depressive symptoms as well as the level of parental stress experienced by the NOC.

The Hospital Anxiety and Depression Scale (HADS)

The HADS is a standardised questionnaire developed by Zigmond and Snaith (1983). The questionnaire consists of 14 questions where respondents have to indicate how often they experienced specific symptoms of anxiety and depression in the preceding month. The anxiety and depression subscales consist of 7 items each. Answers are given on a 4-point Likert scale ranging from “not at all” to “most of the time.” Both subscales have a score range of 0 – 21. High scores point to high levels of distress (Spinhoven et al., 1997). According to Zigmond and Snaith (1983), scores of 11 or more on either subscale are indicative of depression and anxiety, whereas scores of 8 to10 represent “borderline” cases and 0 to 7 acceptable mental wellness. A study conducted by Stordal, Kruger, Kruger, Mykletun and Dahl (2001) confirmed that both the anxiety and depression subscales were found to be internally consistent, with a Cronbach coefficient of 0.80 for anxiety and 0.76 for depression.

The HADS was designed to screen clinically significant anxiety and depression among patients in non-psychiatric settings, as well as to measure the severity of these mood disorders. It is especially useful because it provides a dimensional representation of mood. This instrument has been utilised in various South African studies as a measure of depression and anxiety (Hatzipapas, Visser, & van Rensburg, 2017; Stein, Ahokas, & de Bodinat, 2008; Wouters et al., 2012).

Parenting Stress Index (PSI)

The PSI is a 101-item inventory plus life stress scale designed to evaluate the magnitude of stress in the parent-child system. The PSI identifies dysfunctional parenting and can predict the potential for parental behaviour and child adjustment difficulties within the family system (Abidin, 1990). The PSI-4-SF (short version of the PSI) was used in this study to evaluate the magnitude of stress in the parent-child system as perceived by the non-offending caregivers of children who have disclosed CSA. PSI-4-SF is the fourth edition abbreviated version of the full PSI-4. The PSI-4-SF consists of 36 Items. The PSI-4-SF has preserved the three-factor structure and length of the original PSI-SF, which was originally developed through a series of replicated factor analyses (Abidin, 1995) using data from mothers

completing the full-length PSI. The three-factor structure of the PSI-4-SF is considered relatively stable and thus adequately describes the instrument (Abidin, 2012). Responses are given on a five-point Likert scale which ranges from strongly agree to strongly disagree with higher scores indicating parenting stress. The PSI-4-SF assesses three domains, Parental Distress (PD), Parent-Child Dysfunctional Interaction (P-CDI), and Difficult Child (DC), which combine to form a Total Stress scale (Abidin, 2012). The sub-scales of the PSI-4-SF correlated high the original PSI, which confirm the consistency of the short form (Abidin, 2012). The original PSI has been normed on more than 2,500 parents and is useful in programmes aimed at early identification and prevention of family problems. The scale has been validated among Chinese mothers in Hong Kong and it was found to have a reliability coefficient of .93 (Tam, Chan, & Wong, 1994). In a South African study parenting stress was assessed using two subscales of the PSI, namely Parenting Distress and Parent-Child Dysfunction. Both subscales had a Cronbach alpha of 0.82 (Boeving-Allen et al., 2013).

When I understood the participants' experiences I was in a better position to tailor the support group sessions in such a way that it addressed the needs of the NOCs sensitively. The measuring instruments helped me to assess whether NOCs' needs included emotional distress and parenting stress following the disclosure of CSA.

3.5.3 Data analyses

The process notes and the tape recordings of the sessions were transcribed and translated into English where necessary. The qualitative data from the needs assessment, the eight sessions and the post-evaluation interviews were analysed using thematic analysis (Braun & Clarke, 2006) to identify the NOCs' experiences of CSA as well as their experiences of the intervention that could be used in the evaluation and refinement of the intervention as part of the action research process. This was done to identify major themes from the subjective experiences of the participants. The process of analysis involved reading and re-reading the text to extrapolate themes which were clustered according to higher-order themes. Paraphrased extracts were used to capture the participant's views (Cooper & Schindler, 2006). I tried my best to maintain reflexivity throughout the process of analysis by recording my encounters in a journal (Robertson, 2000). This ensured self-monitoring to increase objectivity and eliminate biases. The analysis was done by the researcher and a co-researcher to enhance the trustworthiness of the interpretation (Johnson & Onwuegbuzie, 2004).

The NOCs' responses were scored for the two measures relating to emotional distress and parental stress. These were cross-checked by two co-researchers and were then entered for analysis using the Statistical Package for the Social Sciences (SPSS version 23.0) (Wagner, 2016). The Wilcoxon Signed-Rank Test was used to compare pre- and post-results of the scale scores for each participant (Wagner, 2016). It is a nonparametric test that is used to analyse differences in paired scores (Wagner, 2016).

The data from the qualitative and quantitative analysis were triangulated to understand the reactions of participants (Wagner, 2016). Triangulation was used as a means of ensuring the trustworthiness of the

data analysed. The qualitative and quantitative data were compared, contrasted and integrated to ensure the accuracy of the participants' experience during the intervention (Driscoll, Appiah-Yeboah, Salib, & Rupert,2007). The results from the measuring instruments allowed me to assess the credibility and inter-reliability of the pre-assessment and post-assessment as it provided some insight into the level of change that took place during the intervention.

The role of the researcher: Knowledge broker and change agent

In this research I took on two roles, the developer and facilitator of the intervention and the researcher. The choice of research topic was motivated by my involvement at Teddy Bear Clinic as part of my BPsych degree requirements. During my work preparing children to testify in court, I noticed that the parents would be sitting and sharing their experiences with other parents who were in a similar situation. I often wondered about their experiences concerning their children's sexual abuse, especially in the process of testifying. This motivated me to do this research.

As the facilitator of the psychoeducational support group programme, I took on the role of the outsider. This meant that although I came with expert knowledge (knowledge broker) regarding CSA, I was not aware of the NOC's lived experiences. Thus, as an outsider, I facilitated the group discussions and observed the changes taking place in the participants through group interaction. In addition to gaining insight into the group's inter-subjective experiences (Kemmis et al., 2014; Stringer, 2007), facilitating the group discussions from an outsider perspective offered an empowering experience to the participants as each enlightened me about their experiences (Berger, 2014; Kerstetter, 2012; Schwandt, 2000). This insight allowed me to observe and understand the commonalities and differences existing between the participants (Kemmis et al., 2014; Stringer, 2007). Being unfamiliar with the specific experiences studied, allowed me to ask questions that could lead the participants to new ways of thinking and provide the group with a fresh and different viewpoint of the researcher (Berger, 2013; Robertson, 2000).

Another important role that I, as a researcher, played during this study was to develop a programme that aimed to offer a sustainable and tangible, or real change, in the lives of the participants who joined (change agent). Together we were affected by the impact of CSA. Also, I hoped to offer a solution to the problem. This meant that the participants worked collaboratively with me as a researcher to bring about sustainable change. I developed a programme with the anticipation that it would address the specific needs of the participants and the participants again informed my study and helped me to continuously improve the programme. During the facilitation process, I imparted some expert knowledge on the CSA topic to the participants, who in turn provided information on their lived experiences. This information equipped me with a deeper understanding of the impact of CSA to assist in addressing their emotional, social and psychoeducational needs in a more effective way.

As the researcher, it was important for me to be conscious of how I interacted with the participants right from the recruitment process to the last session of the programme. I recognised that the participants were autonomous people who had chosen to participate. The disclosure of intimate details of their lives was entirely up to them. It was my responsibility to encourage disclosure during the storytelling part of the intervention and to build trust between participants and myself, while at all times being mindful of potential ethical issues such as protecting privacy, confidentiality and minimising harm (Mikesell et al., 2013). Being aware of the interaction between myself and the participants was crucial in the data collection process, as it allowed me to be clear about my role as a researcher in fulfilling the research objective. It also provided me with clarity as to my role as a facilitator in addressing the needs of the NOCs, which aligns with the action research method as continuous evaluation (reflection and observation) of process can yield insight into my participation (Kemmis et al., 2014; King et al., 2018; Knox & Burkard, 2009; Stringer, 2007).

My dual role could have influenced the group members' reactions in the intervention which could be both a strength and limitation of the study (Berger, 2004; Kerstetter, 2012). I developed a trusting relationship with the participants which helped the participants to share personal information with me as the researcher – this led to richer data. On the other hand, it is possible that group members censored their responses or only gave responses they perceived would fit into the researcher's perspective (Knox & Burkad, 2009). My involvement in the group could have influenced my perspective and analysis of the data (Berger, 2013; Robertson, 2000). Thus, to add to the trustworthiness of the interpretation, a co-researcher who had not been involved in the sessions also interpreted the data independently and compared the analysis with that of the researcher (Cresswell, 2009; Knox & Burkard, 2009). Including another coder, helped to group categories of themes with the corresponding quotes. This helped to increase the trustworthiness of the data analysis process (Cresswell, 2009; Knox & Burkard, 2009)

3.6. Ethical Considerations

The study received ethical clearance from the Ethics Committee of the Faculty of Humanities, University of Pretoria. The two organisations where participants were recruited, TBC and Kidz Clinic, gave their permission to work with their clients. Participants were referred by the social work staff from the respective child protection services. Considering that I recruited the NOCs from two child protection services within the Gauteng Province, I was not faced with the ethical responsibility of reporting any issues involving child abuse. However, when I was faced with an ethical issue involving a participant's concern about a child, I was able to access the social worker at the designated child protection services who advised me on what to do based on the Children's Act (2007).

The participants were informed about the intentions of the research and informed of their rights as participants. The participants consented to complete a pre- and post-assessment questionnaire as well as to taking part in the support group. It was important for me to seek ongoing consent (Sin, 2005), as this emphasized that the participants were capable and autonomous people throughout the research process (Collins, et al, 2018; King et al., 2018; Kvale, 1996; Orb et al., 2001). Confidentiality was

emphasized throughout the research process and reinforced during the first session when the group of participants were asked to commit to confidentiality as a norm so that members could feel comfortable to share personal information (Corey, 2015). Participants were made aware of their right to refuse contribution to the group and the right to withdraw at any time without being penalized. Furthermore, in the case where participants experienced any adverse effects as a result of the study, they were made aware of the psychological services offered by the Teddy Bear Clinic and the WMACA Kidz Clinic. The qualifications of the professionals offering support to the NOC would be the intern psychology students and intern social work students completing their hours at these organisations. All group members were notified about these services. These services come at no cost to the NOC as their from the organisation.

3.7. Conclusion

This chapter outlined the action research process and methods used to develop, implement and evaluate the impact of the structured psychoeducational support group. The study was done from a post-modernistic research perspective, using a one group pre- and post-assessment design. The intervention was adapted to the needs and expectations of the NOCs who joined the structured psychoeducational support group. This intervention was developed from an ecological theory viewpoint, addressing all levels of the systems with a particular focus on the exosystem level. In the following chapter, the results obtained from this study will be presented.

CHAPTER 4 RESULTS

In this chapter, the results from the data are analysed. The qualitative data on the experiences of the intervention group are presented first. Then the needs of the NOCs are described, followed by findings from the support group sessions. Thematic analysis was used to describe the themes that emerged in each session. Themes and sub-themes are presented in order to give context and meaning to the quoted texts. Following the qualitative data, the results from the quantitative data are described through tables and figures for the scales used to measure the impact of the intervention.

In this section, the study will present the qualitative results through thematic themes and sub-themes.

4.1. Needs assessement

The support group members were asked what they were expecting from the programme prior to their involvement. From the thematic analysis, eight themes were identified.

The table below describes the overarching themes from the qualitative results of the needs assessment. Following that, descriptions of the themes and quotes from NOCs are provided to give context and background to the events that occurred in the support group sessions.

THEMES

1. The need to gain information and support concerning CSA	2. The need to have a safe space and support
3. Knowledge and Skills to support their children	4. Information on the impact of CSA on the family system
5. The opportunity to develop healthy coping strategies	6. Information on the judicial system and how to navigate the system
7. Information on how to prevent potential future victimization	8. Knowledge on how to support other parents in a similar situation

The NOCs expressed a lack of information to understand CSA, ways to support their kids and to cope. This is expressed in the following quotes:

> “I came expectant and curious. I wanna know. Just feed me, give me, help me.”

> “I wanna do this. I wanna be here. I know it has to be done. I need, I need this.”

The NOCs were seeking a safe space to talk and to have a shared experience with others in a similar situation experience.

> "I was expecting. I wanted to come here because, you know what? I felt like if I, the more I talk about this, hearing from other people. I'll . . . fine let me not lose this opportunity. It'll be easy for me to hear that it's not me alone."

> "When I'm done with this group, I'm expecting to forget about what was happening to my child."

NOCs noticed differences in the way their children behaved after CSA. They presented the need to learn about the ways in which CSA has affected their children's cognitive, behavioural, and emotional well-being.

> "I want to know more about it. This sexual abuse can disract him when he is old."

NOCs expressed a need to learn how CSA affects the family as a whole, with a particular interest on siblings and partners as illustrated in the following quote:

> "Understand the impact of CSA on siblings and partners."

NOCs needed to learn ways in which they could regulate their emotions in order to cope and overcome the trauma, thereby being able to support their children.

> "To learn how to support my child."

> "Child to be happy, child to go to school, to be proudly with herself."

> "To handle truamatised children and parents."

The NOCs needed information on how the judicial system worked and how they could navigate their way through it.

> **"**I'm very angry with the law because . . . there are all these signs and all things about child's rights and child protection but when your child goes through it you are stuck in a system where I don't feel there's help or anything for your kids . . . so they're very quick to put the stuff in place but when it happens it's . . . not dealt with very well in our country.**"**

NOCs expressed a concern about the safety and security of people (females) that they closely relate to, such as family members. They wanted more information about risk factors, prevalence, myths of CSA and how to identify a perpetrator to prevent the potential for future victimization of people they know. They were shocked by the current situation and wanted to prevent others from going through the same experience.

> "Security of our country to prevent abuse of women and kids. What is the future of kids in this world in 20 years to come. How do we create a safe environment for our kids and women?. . . killing of our innocent kids."

NOCs wanted to learn ways in which they could offer support to parents in a similar situation.

> "Be able to offer support to other parents facing the same issue."

From the themes provided above, it appears that the NOCs' overarching need was to overcome their present circumstances relating to CSA, through obtaining knowledge and information in order to understand the nature of CSA. They wanted to learn new ways to overcome the impact of CSA. Lastly, they wanted to find ways to navigate their response through the judicial system. These themes informed the content for support group session activities described below.

4.2. Description of themes identified from the sessions

The sessions of the intervention were transcribed and analysed to learn from the NOCs' reactions to CSA and to understand the value of the intervention for NOCs. The goals and discussion themes of each session are outlined as well as themes on NOCs' reaction to CSA and how they benefitted from the intervention.

Session 1 Introduction and Orientation	Pre-intervention test (HADS & PSI-4-SF) - Their children's general well-being is a priority - Quality time spent with their children is valued
Session 2 Overview of child sexual abuse	Emotional reaction to CSA disclosure - Anger/frustration, shock/disbelief, Helpless and in need of support, worry/fear, feeling betrayed, psychosomatic reaction, lack of The parent's knowledge and understanding of CSA Cathartic experiences - Relief, opening up to repressed emotions, hope and gaining new information about CSA
Session 3 Coping and communication	Coping with the impact of CSA

	- Maladaptive coping strategies (Initial coping strategies, Coping resources that turned into stressors) - Developing healthy and adaptive coping strategies Communication skills - Barriers and blind spots - Confrontational versus avoidant conflict resolution - Assumptions about how children articulate traumatic experiences - Self-forgiveness - Improving communication between parent and child Further psycho-emotional support Session outcome - Shared experience among the parents - Recognising support group as a coping resources
Session 4, 5 and 6 How abuse affects children and teens; parents and siblings	Parents' observations of CSA impact on the child victim - Emotional disturbances - Scholastic difficulties - Behavioural changes CSA impact on the family - Reprimanding versus nurturing - Parenting fatigue Impact of CSA on the siblings
Session 7 Dealing with the outside world	Identifying supportive resources in various systems - family and friends - school system - Child protection services - Judiciary
Session 8 Closing session: Moving into the future	Post-assessment test

4.2.1. Session 1 - Introduction and Orientation

- Goal of the session

The goal of the session was to begin the creation of a safe and healthy group environment in which participants could gain knowledge and share concerns.

The session began with welcoming the NOCs to the support group. They gave consent and filled out the pre-test Hospital Anxiety and Depression Scale (HADS) and Parenting Stress Index – Short Form (PSI-SF) forms. Following that the structure of sessions was described. NOCs also had an opportunity to express additional concerns and expectations as it pertained to the support group. Lastly, the NOCs were provided the opportunity to express how they would want the sessions to begin and end as well as the norms they wanted the support group to be guided by.

Despite their worries and concerns, however, the NOCs also experessed hope for the future. They indicated that their connectedness to their family and children was important. They prioritised their children's needs and wants over their own. For instance, during the exercise where the NOCs where asked how they would spend a R1000.00 if they were given such an amount. They stated the following ways to which they would put the money to use:

I. Their children's well-being is a priority

"We prioritise our kids more than anything else. You know what? . . . I used to say, the reason I breathe. The reason I work hard like this, it's for only her. Since I had this child. You know what? Like my husband like will give . . . will say this is for you, go and spend for yourself. When I enter into a shop… but, I can't, she's part of me." (Caregiver A)

"Well I just feel it's only right that when you become a parent, you live for your kids. You live to bring them up, that when they move on they learn to stand on their two feet . . . I have friends that like that, they went to the spa for the day or . . . that does nothing for me. I can't, I . . . it really, honestly, it does nothing for me." (Caregiver B)

II. Quality time spent with their children is valued

The NOCs each expressed that they would use the money towards activities that will make them spend as much time with their children as possible.

"What I'd love to do if I get it. I would just take R500 and book a ticket and we'll go to Gold Reef. " (Caregiver D)

" I and my kids, most of the time if I'm with them we used to getting this, this and this. Okay, let's break it down and make it equivalent to us." (Caregiver C)

" It would be great. He likes going out. We'll go out and eat, take pictures, do anything fun, social and have a good time." (Caregiver G)

- Session outcome

The NOCs entered the session expecting a solution to their probems. Despite not knowing each other personally and intimately, the NOCs were open and willing to share intimate details of their lives such as their concerns and worries. They were engaged and actively participated in all the session activities.

- Facilitator's experience during the session

I was eager to facilitate the support group, despite my nervousness. I understood how important it was that I facilitated the group in such a way that the NOCs felt that the support group was a safe space to express their experiences. But more importantly, that they believed that they could gain resources that would help them to gain understanding of the issues that they were facing, be it emotional or practical.

I allowed myself to be part of the group by staying in the present. I believe that my genuine curiosity and will to facilitate and guide the NOCs on their journey to healing, helped ease my anxiety. At the end of a session I was filled with optimism and excitement for our journey.

4.2.2. Session 2 - Overview of child sexual abuse

- Goal of the session

The goal of the session was to establish a foundation of knowledge about child sexual abuse that could be built upon in the sessions to follow. A further goal was to dispel misunderstandings and myths about sexual abuse that may be contributing to the group members' emotional experiences such as, but not limited to shame, guilt and isolation.

The NOCs were asked to share their experience, feelings and thoughts when they first learned about their child's sexual abuse and the impact it had on their lives. The themes provided below are meant to describe the emotions, thoughts and experiences of the NOCs.

- Emotional reaction to CSA disclosure

The NOCs shared feeling and thoughts that they experienced when they first heard of their children's abuse. They also shared their current feelings and thoughts about the impacts of CSA that they have observed. While the circumstances of each disclosure was different, what seems to be evident in each disclosure is the trauma reaction characterised by intense emotions. The NOCs expressed that, since finding out about their children's sexual abuse, they have been intensely frustrated, angry, helpless, fearful and anxious (worried).

- Shock

Some of the NOCs were shocked at the news of CSA. Their children's abuse was something they couldn't conceive because it was almost unheard of.

> "I actually thought I was going to have a heart attack. This physically, emotionally, mentally, spiritually finished me. I just didn't know and I'm not someone who goes to the doctor, I'm tough. I'm just like, get on with it. And I had to go to a doctor, I actually ended up being put on medication 'cause I wasn't coping. I said to my husband I actually felt like I was going to have a heart attack and I have been with my faith. I have been praying and crying to God for the last two to three years and at the beginning of this year I actually said Lord, I can't do another year, I will not cope and everything that's happening was now starting affect our whole family. My other kids feeling it and it was just, it was very bad." (Caregiver B)

> "It's like you're panicking, but have a way to structure all the damage so that it's controlled." (Caregiver C)

> "As a person who has a family, this has never happened in our family, never! You see. Family, the Dlamini family, this has never happened. It's shocking . . . I was shocked to hear that, you understand? But, I didn't show people that I'm shocked." (Caregiver F)

- Worry and Fear

Worry and fear response was different for each of the NOCs. For some, the disclosure triggered feelings of uncertainty about the safety of their children where potential future victimization was concerned. However, the anxious worry was expressed as a generalised concern for all children.

> "I'm not emotional a lot but I get worried a lot about the future of our kids in 20 years coming or 10 years coming. Because this thing . . . it's not like an incident which will end tomorrow . . . these things I tried to create a page for that, I see a very big mess which is worrying me a lot." (Caregiver C)

For some, the uncertainty of children potentially being victimized by the same perpetrators created the worry.

> "I also feel worried because it happened when she was at a party enjoying herself. I feel worried a lot because my daughter said she saw them. They weren't arrested and she said that she saw them recently, they are still around, the two boys. So, I get worried because what's next after that? Because she sees them and maybe they see her too. What could they be thinking? Because they know what they did, you see. So that's why I feel worried." (Caregiver E)

Others perceived a threat to life that left them fearing for their lives and that of their children.

> "I live in fear because they gave the perpetrator bail. I don't know where he is. My child needs to go to school and when I knock off I must go straight home. I don't know if he stands there or if he'll come in and kill us. No matter what, I've given it to God. Everything is in His hands and my life included. No one has my life. So that's why some of it does not go away so easy." (Caregiver D).

> "Everything is at a scale of 10. Even when I go out, I feel like he isn't far from me. When I'm asleep, I feel like he will come in through the door. When I'm out, no matter where, my child is not safe when on her way to school. She leaves, whether she's there or not. Everything I do now I must call when school is out and ensure that she's home and instruct her not to go out. You know these kids; you'll find her playing outside . . . so, for me it's really hard." (Caregiver D)

- Psychosomatic reaction

One NOC reported experiencing physical ailments as a result of news of her child's sexual abuse. Her ailments resolved as soon as she received support from the child protection service counsellor

> "The whole week I was sick. My body was exhausted. Being in pain like, you know it's like that thing that you were holding like, you were…carrying, didn't take it out. You'll, once you spoken it out…That's when you get sick because you are sick but you say you can't talk about this thing. I couldn't tell…I didn't tell anyone…no one knows except the teachers, you understand. But the thing was eating me. After I spoken to the counsellor, that when you see, ukuthi, you know there's something that I did today." (Caregiver A)

- Feeling betrayed by people they trust

Most of the NOCs felt betrayed by people they thought they could trust, such as their neighbours, church members and even family members.

"His mother came to me saying that she wants to kick him out, he is a dog. I will chase this dog away, he is useless. I calmed my sister and persuaded her against that, you can't chase the child away. But my sister saw something in her child. If my sister was alive today, what would she be feeling? Her own son, her only son. Doing this. What is that? What is that?" (Caregiver F)

- Anger/frustration

The NOCs' anger response seemed to be driven by the sense of betrayal as the valued members of their community turned their backs on them when they needed them most. Secondly, their frustration was fuelled by the process of the cases they have opened but where the perpetrator had not been convicted.

"It just makes me angry to hear it . . . We realise how it's still inside us. We still have anger; we still have frustration. So . . . I'm a very angry person at the moment . . . but it's where we're at and I'm very grateful that this is taking place because I haven't found any help out there." (Caregiver B)

- Helpless and in need of support

The NOCs' responses indicated that they lacked vital resources (internal and external) such as adaptive coping strategies and knowledge and people that they could turn to for support outside of their immediate family, as well as skills to handle the news of the CSA and to manage the impact.

> "And you see, sometimes it's good when a child has a mother and father. It's very good. But a child that doesn't have a mother, sometimes she doesn't have a defence. I think that's why that happened to my child because a person who grows up without a mother that's the problem . . . It's better when there are two parents in the household. But if you're a single parent, you're in trouble." (Caregiver G)

> "I literally was on my knees and God answered my prayer but not with an answer that I wanted to hear but it was an answer and it was a very difficult answer, but I'm a lot better now . . . I can feel I'm not going to have a heart attack, you know. I know what the answer is, I've got to deal with it. It's not a nice answer, it's not what you want to hear what your child has been through." (Caregiver B)

- Lack of parental self-efficacy

NOCs expressed feeling helpless and unequipped to support their children. This experience seems to have been contributed by the parents thinking that they had failed to protect their children from rape and danger. The disclosure of the CSA created an insecurity in the NOCs' experience of their parenthood.

> "I cannot stand for my child, because already, I see myself as someone who can't, who's not bold enough, you understand?" (Caregiver A)

> "I'm in the same boat because my son was being abused for two years and I never saw it. And I'm like, you know? So that same thing, why didn't I see it and because you're a parent you want to look after your child. I mean I had to say to my son, I'm sorry, I feel like I failed him. I feel like I didn't protect him from this person and now I wanna show him that I will do whatever it takes to get this man behind bars. I want my son to know that I will do whatever it takes to help my son not just by taking this man to court and all." (Caregiver B)

- The parent's knowledge and understanding of CSA

The NOC's knowledge and understanding of CSA was explored. It's important to highlight that the NOCs made really good observations from their own experiences, which enabled them to engage in a discussion of the dynamics of CSA. For some NOCs, there were gaps in their knowledge of CSA. For instance, some NOCs were not aware that young boys can be perpetrated and that adult women can be perpetrators. Below are the themes that arose from the discussion about CSA.

- CSA as defined by non-offending caregivers

The NOCs had a good idea of what CSA involved. Such as an older person (adult) who takes advantage of a minor by exposing them to sexual content that they are unable to understand and consent to. Their description was broader than their respective disclosure stories. This understanding was influenced by the parenting classes they attended at Teddy Bear Clinic which were largely informational.

- Who the CSA perpetrator is and how they're likely to behave?

To a large extent, the NOCs were able to identify and articulate the characteristics and habits that describe a CSA perpetrator, e.g. typically known by the family and can be described as manipulative and opportunistic.

> "I identified a perpetrator as they hype and create a false relationship with the family and also, he can use you the power as . . . a child molester is very difficult to identify, very difficult. Especially if he is in the family, very difficult." (Caregiver F)

- CSA risk factors

NOCs discussed the type of circumstances that make children vulnerable to CSA. They reflected on parenting habits that make children vulnerable to abuse. This included, exposing children to sexuall inappropriate content on television, not educating children about appropriate interaction between self and strangers or applying a laissez-faire parenting style.

> "Growing up we never slept in the same bed as our parents. But now a child sleeps in the same bed as her father, where he can disrespect the child. Then the child will want to repeat the same behaviour, with someone else not knowing that they are doing something wrong. The child just assumes what a parent does is right. A child can't tell that this is wrong. So, I blame us parents. We're in the wrong. We don't respect our children." (Caregiver D)

> This NOC was aware that not everything that is broadcasted on TV is good for kids and so it's important to expose children to age-appropriate TV channels and shows.

> "The things we show children on TV shows as well." (Caregiver F)

The NOCs had some understanding of the dynamics involved in child sexual abuse. They were able to define some conditions where CSA could occur and they could describe the ways in which a perpetrator could gain access to children. Some still held misconceptions when it came to the risk factors. These aspects of CSA were explored and discussed with the aim of correcting myths and misconceptions surrounding CSA and providing new information.

- Judicial system

The NOCs believed that CSA is not an issue that just affects and concerns the victim and their family. Instead, they believe that CSA issues concerns the victim, family unit, communities, schools, judiciary and government systems.

"The Judicial system does not take care of the child" (Caregiver C)

From the beginning the NOCs had strong and emotionally charged opinions when it came to the efficiency, fairness and effectiveness of the judicial system. These opinions were all negative and based on the NOCs' experiences with reporting the CSA, the court/trial processes and the conviction of the perpetrators.

"I'm very angry with the law because . . . there are all these signs and all things about child's rights and child protection, but when your child goes through it, you are stuck in a system where I don't feel there's help or anything for your kids . . . so they're very quick to put the stuff in place, but when it happens, it's . . . not dealt with very well in our country." (Caregiver B)

"Children's rights aren't implemented well and perpetrators get away with it." (Caregivers C)

The NOCs expressed mixed emotions throughout the session as a result of child sexual abuse. They expressed feelings of dissapointment, emotional pain and anger. The NOCs expressed worries and concerns as it related to their children's safety and security, scholastic functioning post CSA, concern with parenting capacity post CSA, their childen's happiness, future development and general well-being.

- Session experiences and outcome

Each disclosure impacted the group members differently. Some showed a level of understanding and displayed empathy and compassion. Some were curious about certain events of the disclosures. Questions were allowed, given that it would lead to a deeper understanding. However, the NOCs had the choice to answer or decline to answer questions. The caregivers experienced the session as therapeutic because they could express their feelings. They mostly gained knowledge, felt relief and experienced new hope.

- Cathartic experiences

- Opened up emotional experiences

Listening to others opened up NOCs' emotional experiences.

"You definitely opened up something. I'm holding back tears. No, I think what triggered it was the first thing, that woman with the suicide. It brings back a memory, I suppose. That for me was very life changing because I'm the one that saw my son hanging from the tree. No one can take that

moment away . . . I don't know, I just think talking something just opened. Obviously, something I've been holding. Very emotional. I was fine when I walked in. It's just as we're talking." (Caregiver B)

- Relief through a shared experience

Sharing the experiences allowed NOCs the chance to share their difficult experiences. Listening to others helped them to know that they were not alone and others shared their pain. This created a sense of shared experiences which helped to create cohesion and healing in the group.

"For me. I just feel like, it's getting better for me . . . feel a little bit of relief . . . sad when I hear other stories. Some are going through . . . You know what? Before I couldn't speak about this thing. Now at least I can talk and tell you this what happened." (Caregiver A)

"Although all our stories are slightly diffferent . . . we are going through the same confusion and pain and everything and it's kind of like, what's your story. You want to know. I want to know." (Caregiver B)

"Such stories is like a relief because if you have something on your chest you cough it out. Yes, it's painful but at the end of the day you have relieved yourself of some, certain items. It's a very good dialogue." (Caregiver C)

"So, when I spoke here with others and each person sharing their experiences, I felt relieved . . . My worry was at a 10 but now it's at 5. I can see that this support group will be helpful as I keep attending. You see this is my first session." (Caregiver E)

- Hope

Partaking in the support group and sharing their experiences with others in a similar situation has provided the NOCs with a sense of normalcy and validation of their feelings and thoughts. This seems to have created a sense of hope for a postive outcome in their individual lives. Their ability to acknowledge positive change and outcomes since joining the support group was proof of this hope being present, despite the group being small and progress gradual process of healing.

- Gaining new information and knowledge

The NOCs learn more about CSA.They realised there are more people in a simiar situation as them. The NOCs learned more about typical emotioal reactions to traumatic situations such as the disclosure of CSA.

"It's life. I've learned. I've learned something. I've learned that . . . I'm not well, its like I have flu but right now, my flu is better, it's better. I'm not coughing anymore, you understand. The way I have talked and what I heard." (Caregiver F)

- Facilitator's experience during the session

This session involved the experiences of NOCs' disclosure of CSA and the impact on their lives. For many, this session was the first time that caregiveres spoke about their emotions. The facilitator therefore had to moderate the session closely and carefully.

There was a lot to process emotionally with regards to each disclosure experience. While I was part of the group, I was fully aware that I had little insight when it came to the NOCs' lived experience of CSA. In a sense, I was like one of the group members who was actively participating (in my own capacity) and listening to each disclosure. While in another sense, I was an outsider observing and listening. This was a unique experience for me personally and professionally.

I was really glad to see each NOC trusting the process, myself as a facilitator and each other enough to be open and honest about their experiences. Hearing the group members share their experiences was incredible. They displayed courage and vulnerability. By the end of the session, I was tense. This experience brought feelings of sadness, accompanied by the thought of how life can deal a person an unfair hand. However, the outcome of the session brought me a sense of hope for the NOC's journey towards healing. This was a unique experience - an eye-opening and therapeutic experience.

4.2.3. Session 3 - Coping and communication

- Goal of the session

The goal of the session was to help NOCs develop coping strategies and communication skills in order to be able to handle their own emotional reactions.

In this session, we addressed two aspects of the healing process, which are coping strategies used to overcome the impact of CSA in their own lives and the barriers that prevent or impede healing. We discussed their current coping strategies first as they would help drive the conversation towards barriers to healing.

It's important to highlight that while some coping strategies are great to use in some instances, they fail to serve their purpose in other situations. The text and themes provided below show that for some NOCs their Christian beliefs and understanding became an added stressor to their experience, which impeded their healing process. While for others, whose CSA experience occurred outside the confines of the church, their ability to lean on their faith as a source of support remained intact.

- Coping with the impact of CSA

- Initial coping strategies (Maladaptive coping strategies)

The NOCs seemed to rely on their religious beliefs to cope with the situation. Some NOCs leaned on the Christian scriptures in order to make sense of their circumstances and inform their coping strategies.

> "I just trust that God is her shepherd because I cannot be her shepherd." (Caregiver D)

> "God is here, so anything is possible. He will protect her because she goes to play outside and she comes back late instead of coming in at the right time." (Caregiver E)

One NOC compared his situation with that of Job who did not give up believing in God.

> "I personally believe that there was Job, he was in a very bad situation. His wife ended up losing hope. Even told Job why can't you insult your God, but Job never gave up. He prefers to curse his day of birth instead. He then said to his wife: 'you foolish woman. Why do you only expect good?" In this situation, it's obvious that God is the answer, is the key. The judiciary is working on its hands, we won't challenge it." (Caregiver C)

- Coping resources that turned into stressors (Maladaptive coping strategies)

One of the NOCs expressed that she experienced conflict with how their church responded to the disclosure of the abuse of her son. The perpetrator was a church counsellor, a trusted member of the church. Instead of supporting her and upholding the principles and values of the church, her church did the opposite. This has resulted in a conflict in the way she and her family attempt to reconcile CSA, the lack of support and justice from her church and what is expected of her as a Christian.

> "Very angry at the church, very angry at the pastor who has turned their backs. I know that the counsellor is the nephew and they've taken it personally instead of allowing their faith, you know. So, I have a big battle. I have a Christian battle as well as a family battle and place. I have anger, bitterness and hatred. I know the Holy Spirit can't even dwell in me with the ugliness that's in my heart right now." (Caregiver B)

> For this NOC, the church where the abuse occurred, stopped being a source of support and resource for coping. The anger and feeling of betrayal influenced her healing process. A barrier to healing appeared to be the difficulty to separate the church members from religion but also, in understanding that while the perpetrator and church members are followers of the Christian faith, they're fallible beings capable of contributing to CSA.

- Developing healthy and adaptive coping strategies

As the session progressed, the NOCs began to realise that it's important that they prioritise their own healing as a necessary part of supporting their children's healing process. They indicated different ways

that they thought could contribute to their healing process. The discussion included getting psycho-emotional support as parents, learning ways to reconcile with the circumstances under which the CSA occurred, getting professional help for their children, supporting them with their educational needs and being able to be transparent with their children about important issues. The following themes show this.

- Communication skills

- Communication - barriers and blind spots

In the discussion NOCs highlighted a few barriers in communication that did not help them or their children to cope with the emotional consequences of CSA.

- The assumption that children articulate their emotional reaction to trauma

Due to the limited knowledge that non-offending caregivers have in terms of CSA and its impact on children, some NOCs expected that their children would be forthcoming and able to articulate themselves when it came to expressing their internal and external struggles. For instance, two children (one in primary school and the other in high school) were finding it hard to concentrate at school and found it difficult to regulate their emotions whenever they felt frustrated at school or at home. This also frustrated the parents as they felt helpless as their children were experiencing scholastic difficulties.

- Confrontational versus avoidant conflict resolution

In general, the NOCs struggled to adapt their parenting habits where discipline and parental compassion was involved. However, caregiver B seemed to express greater difficulty than the others in her parenting role with her son who struggles with mood disorder symptoms. As a result, she oscillated between taking a confrontational approach to disciplining her son and avoiding to reprimand her son as a means of keeping the peace.

"I can see my son has a lot of anger because we're not coping. If there's an issue, we got to sort something out. It's just, he retaliates with anger, you know . . . when you don't want to bring . . . like I'm tip-toeing at times 'cause you don't want to deal with that anger. He's very angry. So, it's just that juggling every day on." (Caregiver B)

- Improving communication between parent and child

The NOCs indicated that the best way they thought they could improve and open up opportunities for communication between them and their children was through transparency. They explained that by talking about the circumstances they were in and how it has affected them as parents, could help their children to open up to them about their internal conflicts and struggles.

> "I know growing up I don't recall my parents ever telling my sister and I about their issues. We were kids. My husband and I are different, we believe in, we're a family and we're all in the same boat. If we're going through something you need to know about it . . . but to a degree, so." (Caregiver B)

- Getting psycho-emotional support

The NOCs observed that since the CSA disclosure they have struggled to cope which in turn reflected in their parental difficulties. They expressed that when they were not coping, the family unit also struggled to cope. The NOCs found value in getting their own support in order to deal with the impact of CSA on them as parents, as this was helping their children as well.

> "I've found the sessions, it's like we were being dealt with. We need to get to a place where we're strong enough and be able to help our kids. Because you can't help your child, and I see, when I'm wobbling, the family wobble. If I'm strong, the family is strong. Seem so weird. I see it in my son, when I'm not coping, he falls apart. But if I'm coping, it's like he's fine. So, I think I have found, and yes it has been about him and all these sessions . . . it's dealing with me, me as a wife, as a mother, me. I do want to get to a place to help my son. Because I can see, you know, he's battling." (Caregiver B)

- Forgiving (self, perpetrator and others) as a part of the healing process

NOCs needed to forgive in order to move along their healing journey. They agreed that by forgiving themselves for not being able to prevent the abuse, they would be able to overcome the feeling that they have failed to protect their children, which has affected their parenting confidence.

> "What I've learned now is forgiveness. If I can forgive myself because I kept on blaming myself it makes it seem like we're not there for our children . . . we're . . . if we fail them. You understand? If I forgive myself first then I'll be able to deal with the whole situation. It won't be right for me to help someone if I'm not forgiven myself. I know. I couldn't help her; I didn't see what happened but it just happened. Let me start with myself." (Caregiver A)

NOCs explored different ways in which they could improve their communication skills. They started by identifying possible barriers to effective communication with their children and suggested ways to change their communication with their children.

- Session outcome

The NOCs expressed a strong reliance on a higher power to cope with their present circumstances. It appeared as though they had come to realise that they had little control over their situation and that they themselves had limited resources available outside their religion to overcome the impact of CSA. However, their spiritual beliefs and faith practices seemed to instil the NOC with a sense of hope for the future. More importantly, the NOCs recognised concrete sources for support such as their peers in the group in sharing a similar experience, gaining new knowledge and skills to overcome their difficulties.

- Shared experience and understanding with other non-offending caregivers

In the session, the NOCs were open and honest about their experiences (emotional and cognitive). They were also open to exploring alternative ways of coping and behaving. In this session, NOCs' participation showed ownership, trust and compassion.

- Recognising the support group as a coping resource

The support group itself was also seen as a source of support. The NOCs acknowledged that the discussions were helping them to think differently about their realities, build insight into their current habits and envision alternative outcomes. They were starting to take lessons from the session and apply them in their day-to-day life, including sharing it with their family.

> "That's why I'm saying, I think these sessions have definitely been getting my mind thinking, we talking. You saying stuff, you saying stuff, going off-on. You know, the notes and I'll mention stuff to my husband, we bounce it off each other. So, things are happening and I can feel working through and going through whatever, I go through . . . but I don't want it to be about me, you know. I can just see my teenage boy just going through stuff, so yeah." (Caregiver B)

- Facilitator's experience during the session

My experience in this session was positive in that I was confident and comfortable. I was settling in with the NOCs. Tracking and guiding conversations were slightly difficult as the NOCs were tested in terms of their blind spots. They were still willing to reflect deeply and share their experiences. I believe trust was the driving force in this session.

Their honesty and transparency was something I marveled over as it revealed the impact of the support group as providing a safe space for sharing and reflecting on one's own experience.

The NOCs' faith and spiritual belief was highly instrumental in this session. I saw it beneficial to use this coping resource therapeutically. It was necessary for me to highlight or drive insight into the value of their faith as a coping resource. In addition, I was pleased to see that the NOCs showed compassion and empathy to the extent that they were validating each others' experiences with their faith, it's precepts and their traumatic experience as it related to CSA.

The next few sessions will be discussed under one section as the themes are similar and interconnected.

4.2.4. Session 4, 5 and 6 - How abuse affects children and teens; parents and siblings

- Goal of the session

The goal of the session was to help NOCs understand the impact of abuse on their children in the context of normal developmental stages and issues. Additionally, to facilitate the family unit's healing

process by helping NOCs understand and respond to the impact of CSA on their non-abused children and their partners.

The NOCs reflected on the impact of CSA on their children's functioning (emotional regulation, behaviour, scholastic and social functioning). It is safe to assume that the sessions that preceded helped the NOCs gain insight into the needs of their children. The discussions also lead to the secondary impact of CSA on the family with regards to changes in family dynamics and parenting challenges.

- NOCs' observations of CSA impact on the child victim

The disclosure stories showed that each child reacted differently to being sexually abused. However, the common theme that came up in this session was that sexually abused children need various forms of support (psychological support, peer support and educational support) simultaneously or as the need arises. The areas of functioning that the NOCs identified as impaired in their children are listed below.

- Emotional disturbances

The CSA victims can develop psycho-emotional problems as a result of being exposed to such a traumatic experience. At times, the emotional trauma can lead to mood disorders. One of the victimised children developed clinical depression as he was struggling to cope with the sexual abuse he endured for over two years before it was disclosed.

"When my son was 13/14/15 years he was failing school . . . he was very angry, he wasn't eating, he wasn't talking, he was losing weight, he was covered in boils (abscesses), wasn't bathing, he was smelly, he hit depression and we were trying to help him . . . my son tried to commit suicide and in that we tried a neurologist as well. They've got him on depression tablets and tablets to stabilize his emotions 'cause we just didn't know, you know." (Caregiver B)

- Scholastic difficulties

The children experienced noticeable difficulties at school. NOCs observed that their children were finding it difficult to cope with their academic demands. Common complaints included fleeting attention or the inability to concentrate on their school work and losing interest in school work.

> "I don't understand you my daughter, when it comes to school work, you don't say anything, we even fight. You can do a homework that is supposed to take only 30 minutes, it can take even an hour, 30 minutes doing one thing. I don't know why this thing is disturbing because before, you know what? I wouldn't ask her, when she comes, she's say: 'mommy I've got homework, mommy there's a project, mommy there is this and that, this is a letter from school.' You know what? This time, you suppose to push. Why it disturbs school work?" (Caregiver A)

"…I've had so many meetings with the school and then they put us onto an educational psychologist . . . So, he's battling and they say that he loses concentration. He'll start and then he's playing and his mind, you know. We've got to try and get him back to routine, do you know, and then it becomes a fight sometimes." (Caregiver B)

- Behavioural changes

There were noticeable changes in behaviour as a result of the impact of CSA. NOCs observed that children were challenging rules more than usual. They also exhibited some changes in their personality. For example, how they interacted with people around them (being more reserved than usual).

"She doesn't listen. She can come back from school, throw her books on the floor and go play and come back late. Then I ask myself, why is this child like this?" (Caregiver F)

"You know your child; you can see in their behaviour that there's something that's not quite right. They would be lost in their mind and when you say: 'hey!' They get startled. You get complaints from the school about them not taking their work seriously, not listening. When you ask them what's wrong, they just say: 'nothing mom." (Caregiver D)

As the discussions deepened, the NOCs observed changes in the family dynamics since the disclosure of the abuse. Themes discussed included parenting practices and experiences and CSA impact on siblings.

- CSA impact on the family

A family is a system set in its own way, based on various interactions by its members. In the event of CSA, which is traumatic in nature, the abused child's experiences can be observed by the rest of the family members. This can have an impact on the family system such as changing how the family members interact with the abused child and how the abused child interacts with the rest of the family.

"Everything that's happening was now starting to affect our whole family. My other kids feeling it and it was just very bad. My husband, our marriage everything, our family was falling apart...Our whole family is falling apart, or feels like it's falling apart and we're going through such trauma and watching our kid what he's going through and we as a family is trying to deal and they'll carry on." (Caregiver B)

- Reprimanding versus nurturing

NOCs experienced challenges when it came to exercising their parental role. They found that disciplining their children was becoming a difficult task. One challenge described by the NOCs was the inability to differentiate between behavioural changes caused by a reaction to sexual abuse and typical behaviours expected from children at that age group. Another challenge involved was striking a balance

between reprimanding their children for ill-behaviour, while showing compassion and understanding towards their adjustment challenges.

> **"**But we like tried everything. We tried ignoring him and then tried helping him . . . So, I'm trying to understand a teenage boy that's been abused for two years of his life. Whose head I know is stuffed up by this person." (Caregiver B)

- Parenting fatigue

Since the disclosure of CSA, NOCs have experienced their role as parents to be overwhelming. They have had to spend a lot more time and energy supporting their abused children while tending to the family's needs as a whole. Due to their spouses falling ill or attending to work commitments, this amount of parental responsibility has left the NOCs feeling frustrated and more tired than usual.

> "He was sick and he was…What is it that I can do? I can't do anything, so you have to do everything by yourself. School, concert, school meeting, everything." (Caregiver A)

> ". . . I'm not the victim, okay. I'm just the mom. But I'm like at this stage now, can we just try a bit harder . . . I've got two other children as well. It's not just him, I've got two other children 13 and 7. So, they are all demanding, you know . . . I know they haven't been through what he's been through but they get up, they do what they got to do. Everyone is part of the house, everyone, whereas he isn't." (Caregiver B)

- Impact of CSA on siblings

It appears that the abused victims' siblings can experience the impact of CSA I vicariously, in that they also witness the intense emotions and change in behaviour from the abused child. This can be traumatic to witness and impact how other sibling react to the circumstances.

> "The child abuse, my middle child had to be brought into it. Because he needed to know: 'why is my brother falling? Why is my mom falling? Why this? . . . what happened there started a lot of fights between the two boys because they are only two and half years apart. They've got frustration and anger. When my eldest son loses it and then my middle child . . . when he was younger he never fought back but now he's older, he fights back, then it becomes really bad." (Caregiver B)

- Session experiences and outcome

This session highlighted the effect of CSA on the family unit from the perspective of the NOC. There are numerous processes that influence how the NOCs cope. While the NOC tries to support the victim, there are other siblings who need attention as well.

The NOC admitted to being impatient with the rate at which their children were healing and as result, they pushed harder because they were frustrated, but this has caused them to overlook their children's need to develop a sense of autonomy and to self-direct, which can be empowering for their children.

The NOCs sounded quite burdened and overwhelmed as they seemed to be the main source of support for the family unit. One NOC expressed that her child needs to take more responsibility, but also felt guilty for feeling frustrated about the pace at which her child was healing. However, the NOCs highlighted areas where they saw progress and were delighted by this. They described that spending time with their children was building the family unit.

The NOCs supported one another to build each other's confidence by offering suggestions and tips on parenting practices that have worked for them, such as setting healthy boundaries for their children.

- Facilitator's experience during the session

In this session, I was outside looking in once more, as I am not a parent and have little insight into parenting stress in the absence of sexual abuse. I used my experiences as a child and the type of relationship I had with my parents. This helped me to imagine the dynamics that would be involved if I were to be in their shoes as parents and in the shoes of their children. While imagining this it did not really give me a complete picture, but it allowed me to step a little closer into the world that these parents were experiencing when it came to parenting distress.

4.2.5. Session 7 - Dealing with the outside world

- Goal of the session

The goal of the session was to explore the various sources of stress and support in parents' lives and to provide the NOCs with information they needed to navigate the systems that they were involved with, following CSA disclosure.

The session discussions were centred on exploring sources of stress they were exposed to and helping the NOCs to identify various sources of support in each system (family, school, child protection services and judicial system).

- Family and friends

In the previous session, the NOCs were tasked with organising a family activity. They had to choose who would attend. These were supposed to be people in their lives they value and trust. When asked to reflect on the outcome of the activity, the NOCs identified people in their lives who were supportive (directly and indirectly). These people were family members and neighbours.

"My Mom, sister, my sister-in-law all of them were supportive." (Caregiver C)

- School system

The NOCs experienced the school staff as supportive. They appreciated that the school provided a counsellor that their children could consult. They also appreciated that the school staff kept the learners' CSA confidential.

> "They're very support even today and the thing I was happy about at the school is that they don't have the right to say things like 'yea you were sexually abused' or 'you're behaving like this because of such and such.' The teachers keep it as a secret. It's my daughter who might talk to her friends but at school they keep to the rules. It's not the kind of school where it would let its learners know what's happening with another child. At the school they have a counsellor. My child also had a counsellor." (Caregiver D)

- Child protection services

The NOCs found that child protection services helped their children to overcome the impact of CSA.

> "No, the engagement with . . . CPS was so, it was very good. The approach, when they assess the child, when they asked me what happened and all the courses which are the child . . . they were so good, I never had a problem . . . I was very happy about it. I didn't know that there is a unit or an organisation which . . . deals with . . . children if they have trauma." (Caregiver C)

> "I don't see a problem because the problem that I had had when my child started, it was tough, but there were people who help me through. The social workers here, they did their work and they even pushed for it because now she's finished. With Teddy Bear I can see the proof of their work. It isn't the same as in the beginning, indeed. I am grateful that there were people that knew how to help people who are going through such problems. With a child they're able to teach them." (Caregiver D)

- Judiciary

The judiciary system was experienced as a stressful system to interact with. Mostly because the NOCs had little knowledge on how to navigate it. They have identified child protection services such as Teddy Bear Clinic and Kidz Clinic as resources that they could use as they were helpful in the process of preparing their children to testify in court.

The session discussions highlighted that when parents learn that their children have been sexually abused, they're likely to develop tunnel vision, making it difficult for them to identify sources of support that are around them.

- Session outcome

The NOCs were reflective during the session discussions. They identified people that they could lean on for support, such as family members, neighbours and colleagues.

They also identified resources that have played an instrumental role in helping them get information and services that have helped them on their healing journey. These included collaborating with the school to help with their children's educational needs. The child protection services offer trauma counselling and court preparation classes for children and parents, which can help them navigate the judiciary system that they seem to contend with.

- Facilitator's experience during the session

This session was mostly solution focused. Encouraging the NOCs to identify positive outcomes from a traumatic and uncomfortable experience, like learning that your child was sexually abused, was an easier task than anticipated. The NOCs' ability to identify resources in their community that they could reach out to, meant that they were equipped to face the outside world with more confidence. This hints to the impact of the sessions up to this point. Each session was geared towards helping to reframe the NOCs' thoughts around coping capacity, parental efficacy and their resourcefulness. I felt confident that the NOCs gained what they needed from the support group.

4.2.6. Session 8 - Closing session: Moving into the future

- Goal of the session

The goal of the session was to commend the group members on their efforts and growth during the seven sessions and to instill confidence and hope in the NOCs for the future.

Due to various comittments, the NOCs were unable to attend the full duration of the session. The NOCs filled out the PSI-4-SF and the HADS as part of the post-assessment tests for parenting stress, mood and anxiety levels.

The NOC also filled out the post-assessment tests and the feedback form. They were thankful for the opportunity to join a safe space where they could talk openly about their lived experiences.

- Facilitator's experience during the session

I was really humbled. I actually had to take a moment to reflect on the journey and process I underwent with the NOCs. The session felt surreal, because I, alongside the NOCs, went through various emotions which included the anxiety of meeting with strangers and talking about a sensitive topic that one rarely discusses in social settings. Taking the leap of faith in the process in order to achieve the best outcomes possible and having to say goodbye and separate with a group of people that were brought together by a common problem and together found a way to heal, was not easy for me.

4.3. Quantitative outcome of research

Surveys were conducted with NOCs before and after the intervention to assess what changes took place in the NOCs' emotional well-being and their parental functioning.

The sample is described, followed by the presentation of the results from the pre- and post-intervention analysis. The changes that took place in the members before the intervention and the end of the intervention were compared in terms of the outcome variables, so as to measure changes that took place during the intervention.The implications of these results will be discussed in the following chapter.

4.3.1. Sample Demographics

More females 75 % (n = 6) joined the support group than males 25 % (n = 2) (table 1)

Table 2. Gender

Gender	Frequency	Percentage
Male	2	25%
Female	6	75%
Total	8	100%

Table 3. Age range

Age range	Frequencey	Percentage
18 to 29	2	25%
30 to 39	1	12,5%
40 to 59	5	62,5%
Total	Mean age = 42	100%

Most NOCs were aged between 40 and 59 (n = 5) and only two were between the ages of 18 and 29.

Table 4. Race

Race	Frequency	Percentage
Black	7	87.5 %
White	1	12.5 %
Total	8	100 %

Of the 8 NOCs who joined the support group, 7 (87.5 %) were black and 1 was white (12.5 %).

Table 5. Language

Language	Frequency	Percentage
isiPedi	1	12.5 %
isiZulu	3	37.5 %
isiXhosa	2	25 %
English	1	12.5 %
Total	8	100 %

In terms of the the members' preferred language of instruction, the majority of the NOCs spoke isiZulu (37.5 %, n = 3), folllowed by isiXhosa (25 %, n = 2). The members, however, all understood and could speak English.

Table 6. Education

Education	Frequency	Percentage
Did not completed matric	3	37, 5%
Has passed matric	3	37,5%
Post matric education	2	25%
Total	8	100 %

Three members did not complete matric, while three others completed matric and two had post matric qualifications. However, all NOCs had at least a Grade 10 level of reading and writing.

Table 7. Marital Status

Marital status	Frequency	Percentage
Single	3	37.5%
Married	4	50%
Divorced	1	12.5%
Total	8	100%

More NOCs were married 50 % (n = 4), 37.5 % (n = 3) were single and 12.5 % (n = 1) was divorced.

4.3.2. Comparison between pre- and post-intervention

Differences between pre- and post-intervention scores of the members were examined to assess changes that took place within the NOC with regards to emotional distress and parenting stress scores. This was done to enrich the qualitative data presented above. The data from the qualitative and quantitative analysis was then triangulated to understand the reactions of participants.

In this section, the Wilcoxon Signed Rank Test statistical results are presented to show the changes that took place in the NOCs for depression and anxiety symptoms and parenting stress scores. Following that, the NOC's results were looked at individually in order to get a deeper picture into the changes that took place for each member.

4.3.3. Intervention group outcome variables

Based on the small sample size and members who dropped out of the study before the support group was concluded, the Wilcoxon Signed-Rank Test was used to compare pre- and post-results of the scale scores. The Wilcoxon Signed-Rank Test shows that there were insignificant differences in parenting scores for the group as a whole (p-value > 0.05), failing to reject the null hypothesis (Table 8). However, there were significant differences in caregivers' anxiety scores (p-value < 0.05).

Table 8.

Wilcoxon Signed Rank Test						
	w+ (sum of positive ranks)	w- (sum of negative ranks)	W (Test Statistic)	Standard Error	Standardized Test Statistic	Asympt. Sig (2 tailed)
PSI-4-SF						
Parent Distress (**PD**)	1	6	5.000	5.916	-1.521	.128
Parent-Child Dysfunctional Interaction (**P-CDI**)	3	4	9.000	5.916	-.845	.398
Dysfunctional Child (**DC**)	3	4	9.500	5.916	-.763	.445
Total Stress	2	5	8.000	5.916	-1.014	.310
HADS						
Anxiety	1	6	2.000	5.863	-2.047	.041
Depression	1	5	1.500	4.743	1.897	.058
Total N = 7						
Null Hypothesis = 0, p-value 0.05						

Table 8: Analysis of differences in paired scores using the Wilcoxon Signed Rank Test

While the post-test results do not show significant differences in parenting stress for the group as a whole, there were differences in the scores of individuals. The Total Stress sub-scale for PSI-4-SF, showed significant differences for some participants. Five of the members experienced less parental stress after the intervention, while two members experienced more parental stress (Figure 4.1).

Figure 4.1

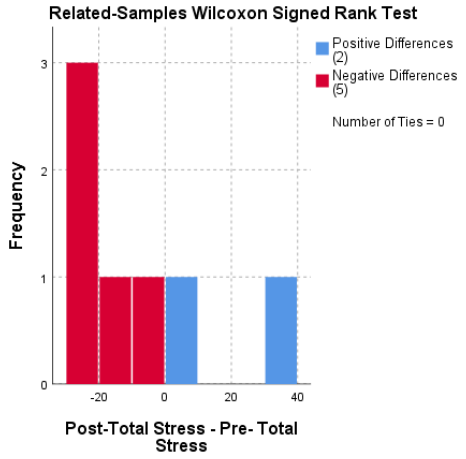

Figure 4.1: Post-Total Stress- Pre-Total Stress

On the other hand, the HADS post- test results for anxiety were statistically significant (p-value < 0.05), which suggests that the group as a whole experienced less anxiety after the intervention. While the differences in depression symptoms showed a slight reduction. These results indicate that the intervention had a positive impact on the NOCs' level of emotional distress. Six of the members showed less anxiety after the intervention, while one showed an increase in anxiety (Figure 4.2). Similarly, five members experienced less depression after the intervention while two experienced more depression (Figure 4.3).

Figure 4.2

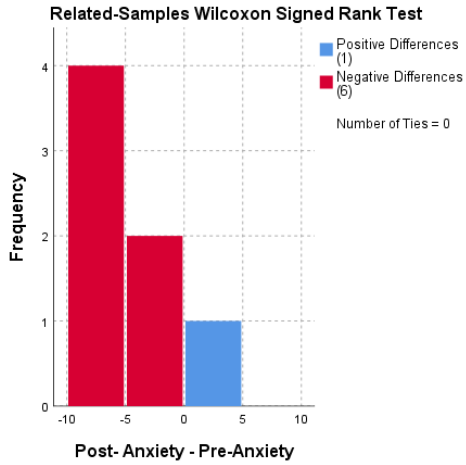

Figure 4.2: Post-Anxiety-Pre-Anxiety

Figure 4.3

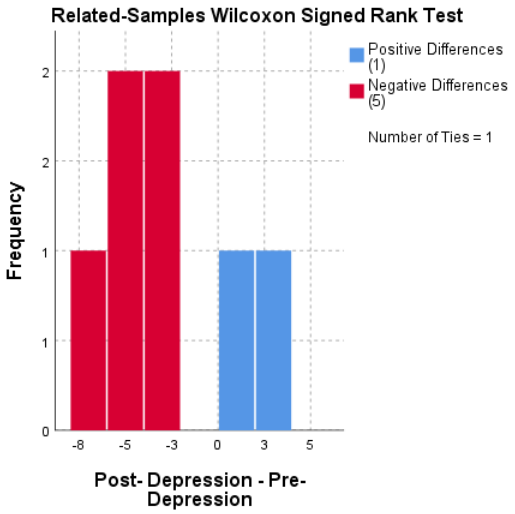

Figure 4.3: Post-Depression-Pre-Depression

To explore which of the NOCs showed improvements in their emotional distress (anxiety and depression symptoms) and parenting stress, each NOC's pre- and post-intervetion scores were compared. The graphs below represent each NOC's total scores for the PSI-4-SF and HADS results. Subscales were compared before and after the support group intervention. This manner of analysis can offer a deeper understanding of the changes that took place during the support group intervention for each of the NOC and provide richer data for the triangulation of the quantitative and qualitative analysis.

The following factors were considered when analysing the results presented in the graphs below: the presenting problem, attendence, drop out and participation in the support group.

Attending sessions

Attendance was an important factor in assessing the changes in the NOCs' presenting symptoms (anxiety, depression and parenting stress). Each session offered different information and resources that were interlinked. The sessions focused on the NOC's experiences and needs (emotional and practical). Therefore, attending all eight sessions was necessary in order to benefit most from the support group.

Dropout

Out of the eight NOCs who joined the support group, four NOCs (A,B,C,D) completed the full course of the support group, while four (E, F, G, H) dropped out along the way due to work commitments. NOC H's data is not provided as she only attended session one (Introduction and Orientation). She could not be reached to get information about dropping out.

Participation during sessions

The participation of the NOCs during sessions was an important factor considered in trying to understand the pre- and post-results. The NOCs were required to actively participate during sessions and share their experiences with other NOCs, asking questions and offering support to others during sessions. Active participation was a way for the NOCs to engage with the content. This way, they could identify resources that they required to meet their needs.

NOCs A, B, C, D, and F showed active participation in all the sessions. They asked questions, shared their own expriences and offered advice to fellow group members. For the sessions that NOCs E and G attended, they showed some participation. However they were mostly passive during sessions (they observed and spoke only when spoken to directly). This does not mean that they were not engaging with the content, it simply means that their participation style should be considered when interpreting their results.

It's also important to highlight that these sessions required NOCs to develop rapport with strangers who were in a similar situation. The session activities engaged the NOCs with content that addressed various issues surrounding CSA. This process required the NOCs to be honest and open on issues that elicit strong emotions. This kind of vulnerability can be intimidating, especially when one does not identify with or feel safe to share one's experiences with other NOCs. This should be considered when looking at the data.

The HADS results are presented first, followed by the PSI-4-SF results. The improvement in anxiety and depression scores (Figure 4) can be attributed to NOCs actively engaging with the content presented in the sessions.

Figure 4.4

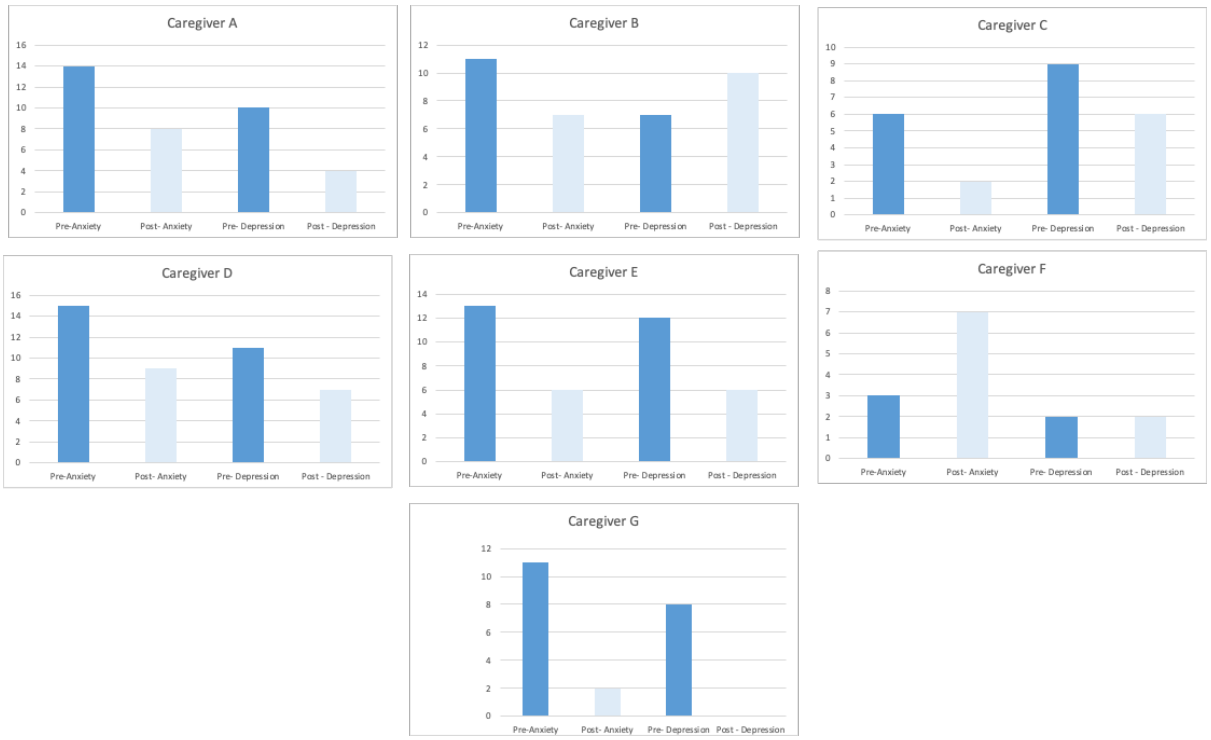

Figure 4.4: Pre- and post-HADS results

Non-offending caregiver A

Her pre-anxiety and depression scores indicated abnormal and borderline symptoms respectively. Her post-test scores show borderline abnormal symptoms for anxiety and a normal level of depression symptoms.

Non-offending caregiver C

Pre- and post-assessment scores for anxiety symptoms fell in the normal range, however there was a decline in the post-assessment symptoms. His depression symptoms went from borderline abnormal to normal.

Non-offending caregiver D

Her anxiety and depression symptoms improved from abnormal to normal.

Non-offending caregiver E

Her anxiety and depression symptoms improved from abnormal to normal. These results show a significant decline of scores in the post-assessment results.

Non-offending caregiver G

Significant differences in scores are seen in her scores as her symptoms improved from abnormal to normal for anxiety and from borderline abnormal to asymptomatic. Under reporting of emotional distress with regards to depression symptoms are suspected.

Non-offending caregivers B and F's post-test results differed from the rest of the group.

Non-offending caregiver B's anxiety symptoms showed improvement (abnormal to borderline abnormal), while her depression symptoms seemed to worsen (normal to borderline abnormal symptoms). Caregiver B, seemed to think and feel that she had little control over her current situation. She needed access to emotional support and information on the topics discussed in the support group. Improvement in her anxiety symptoms can be attributed to gaining access to resources that provided her with the information she needed, while also meeting her emotional needs for control over her current experiences. The high depression symptoms can be attributed to her feeling helpless when it came to supporting and helping her child.

Non-offending caregiver F's anxiety symptoms slightly worsened but symptoms remained within the normal range. His depression symtoms showed no change, with sccores in the normal range. Non-offending caregiver F's anxiety symptoms and total stress subscale results showed a spike when tested after the support group ended. This suggests that he was exposed to information he previously did not have, or that myths and misconceptions held were corrected. During the sessions he attended, he showed an external locus of control. He attributed his inability to cope with the impact of CSA to being the only surviving parent. On the other hand, he had support from his sister, but he seemed to be ostracised by his family for reporting the abuse. Passive engagement and the externalised locus of control could be the reasons why the non-offending caregiver's anxiety and total stress results worsened instead of improving.

Non-offending caregivers E and G's scores improved as well. It's difficult to tell what contributed to the decrease in anxiety and depression symptoms as they left the group early. They attended the first three sessions which offered information that corrected misconceptions held about CSA, offered the opportunity to share personal experiences and develop a shared experience by showing support to fellow group members. Having a shared experience may have made these NOCs feel less alone in the situation and could have normalised the experience for them as well.

Next, the differences in scores for the PSI-4-SF results will be analysed individually for each non-offending caregiver (Figure 5).

Figure 5.5

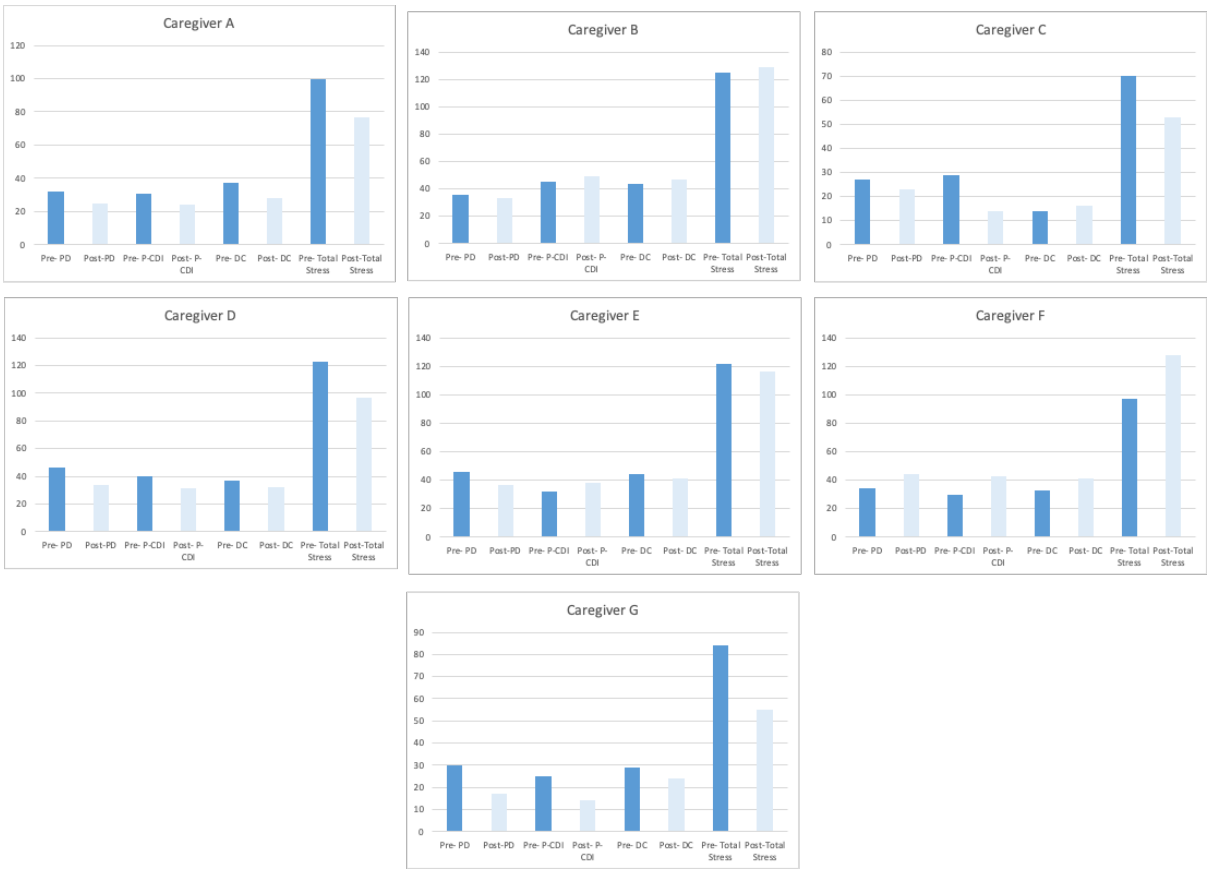

Figure 4.5: Pre- and post- PSI-4-SF results

Non-offending caregiver A

Her subscale scores for parenting stress remained in the normal range for pre- and post- assessment. However, a slight decline in the level of parenting stress is seen in the post-assessment scores. Improvements in these scores are consistent with improvements in her HADS scores.

Non-offending caregiver B

The PD subscale fell in the normal range, while P-CDI, DC and Total Stress were clinically elevated for pre- and post-assessment results, with a slight increase in Total Stress when tested after the intervention. These scores are consistent with her HADS scores which were elevated. The judicial issue regarding her son's case has made it difficult for her to provide professional psychotherapy for her son who needs it. This made her parenting experience very stressful.

Non-offending caregiver C

For pre-assessment scores, PD, P-CDI and Total Stress fell in the normal range, while DC fell below the normal range. For post-assessment scores, P-CDI and Total Stress fell below the normal range.

Under- reporting of parenting experiences is suspected. During sessions, it appeared as if the non-offending caregiver wanted to show himself as a competent parent and that everything is in his control. It also seemed as if he wanted that to show in how his child adjusted after the abuse. This is seen in his overgeneralised concern for women and young girls in the world versus the situation in his own home. He seemed distant from his own experiences.

Non-offending caregiver D

Pre-assessment scores PD, P-CDI and Total Stress were clinically elevated, while DC scores fell in the normal range. For post-assessment scores, all the parenting stress subscales scores showed a reduction and fell in the normal range. This indicated an improvement in the non-offending caregiver's parenting self-efficacy in reducing parenting stress. Her scores are consitent with the improvements seen in her HADS scores.

Non-offending caregiver E

Her pre-assessment scores were clinically elevated, except for P-CDI which fell in the normal range. However, in the post-assessment scores only the PD subscale score reduced to the normal range, while other scores were clinically elevated. Non-offending caregiver E only attended three sessions. She received new information about CSA and other related topic, but she missed the sessions that could have provided her with knowledge and skills concerning healthy coping strategies and improving her parenting role.

Non-offending caregiver F

His parent stress subscale scores fell in the normal range in the pre-assessment and was clinically elevated when assessed at the end of the intervention. These results are consistent with his HADS scores which showed elevated emotional and parenting stress. The sessions did not help caregiver F to cope better emotionally and as a parent.

Non-offending caregiver G

Her pre-assessment scores for parent stress subscales fell in the nomal range. When assessed after intervention, there was a significant decline in scores for parent stress with PD and P-CDI falling below the clincially depressed scores, and the Total Stress scores falling just above them. This non-offending caregiver's scores suggest that she benefitted from the intervention or that she was under-reporting her parenting experience in the post-assessment.

4.4. Conclusion

In this chapter, the results of the study were presented in terms of qualitative themes and sub-themes of the events that occurred during support group sessions. These were triangulated with the quantitative results that were presented in terms of pre- and post-intervention analysis for emotional distress and parenting stress using the HADS and PSI-4-SF scales.

From the outcome of the quantitative assessment of the intervention, participants in the support group showed significant improvements in emotional distress, specifically for anxiety symptoms, whereas there were no significant differences related to parenting. To understand NOCs' responses in the scales, each members' scores on the HADS and PSI-4SF were presented and their pre- and post-scores were interpreted based on their experiences during the intervention.

In terms of the HADS results, most of the NOCs showed improvements in their anxiety and depression results. Whereas differences in scores for the PSI-4-SF subscales varied for each NOC with some subscales showing clinical elevation for post-intervention scores. Variations in scores for parenting stress subscales included PD and P-DCI and Total Stress, which were reported by most non-offending caregivers at clinically elevated or depressed levels. Early dropout from the intervention and participation style could have influenced some results. There was a clear link between the quantitative results and the experiences of members during the sessions, such as their attendance and participation style. These provided additional data to explain the quantitative results.

Following this chapter, the results that have been presented will be discussed, with a special focus on the programme assessment, implications of the results and their relation to past research.

CHAPTER 5 DISCUSSION

This final chapter gives an overview of the research process, summarizes the results of the study and discusses the programme evaluation in terms of the significance and the implications of the results. In conclusion, the limitations of this study are discussed and recommendations for future research are provided.

5.1. Overview of the research

CSA is an issue that faces many children in South Africa daily. Previous research has mainly been conducted to understand the experiences of victimised children and perpetrators of CSA. Interventions have been developed and institutionalised to rehabilitate victims and perpetrators (Masilo, 2011; Masilo & Davhana-Maselesele, 2016; Paulsen & Wilson, 2013). The same attention is not given to the NOCs, especially in South Africa (Masilo & Davhana-Maselesele, 2016; Schmidt; 2015; van Toledo & Seymour, 2013). NOCs and their families are secondary victims of CSA by virtue of disclosure (Holt et al., 2015; Willingham, 2007). NOCs tend to struggle with the impact of CSA because they have limited access to interventions that assist them to overcome their emotional reactions to CSA and how to support their victimised children (Meinck et al., 2016). Most families in low resourced countries are not empowered to report sexual abuse as they lack adequate knowledge on how to navigate the judicial system and how to respond to the needs of a sexually abused child (Meinck et al., 2016).

The reality is that NOCs play an important role in helping their children overcome sexual abuse. They can do this effectively when they receive emotional and practical support that addresses their needs following CSA disclosure (Masilo, 2011; Masilo & Davhana-Maselesele, 2017; Mendelson & Letourneau, 2015; Rudolph et al., 2017; van Toledo & Seymour, 2013). In response to the gap in service provision in South-Africa, this study developed a psycho-educational support group for NOCs of sexually abused children. The ecological systems framework was used to open up multiple ways in which CSA advocates and professionals can develop solutions to CSA problems facing individuals, families, communities and the country at large (Aucamp, Steyn, & Van Rensburg, 2014; Visser, 2007). By studying the various independent and interacting systems that NOCs interact with following CSA disclosure, the exosystem was identified as the ideal system to develop a structured psycho-educational support group for NOCs. This way, different microsystems (NOCs) can gather together to create a shared experience and journey towards healing.

The next section will discuss the study according to the aims outlined in chapter two literature review.

5.2. Two need assessments were conducted

The first needs assessment was done by going through the literature and the research done to explore the needs of NOCs following CSA. The findings indicated that emotional support, informational support, financial support and a supportive environment were the common needs expressed by NOCs following CSA. Using these findings and the Washington-Coalition of Sexual Assault Programme (WCSAP) guide, the general outline of the psychoeducational support group was developed.

The second assessment was done during the first session of the programme in order to tailor content according the needs of the of the group members. The following needs were identified:

5.2.1. Informational support.

The NOCs stated that to overcome their circumstances, they needed access to knowledge and information to understand the nature of CSA. This information helped the NOCs understand why their children were vulnerable to sexual abuse. The NOCs also wanted to understand their children's psycho-emotional reaction to CSA and how to respond. It was also important for NOCs to find ways to respond to the judicial system.

5.2.2. A safe and supportive environment.

NOCs expressed the need to be in a caring environment where they felt understood and not alone while going through this experience.

The findings show that the needs of NOCs can differ per individual and per group of NOCs at a given time. While NOCs needed information surrounding CSA and to learn how to navigate the judicial system, it was also important to help the NOCs not to base their ability to overcome their circumstances on the outcome of court cases. Therefore, it was not enough to rely on literature but it was important to investigate the needs of the NOCs so that the support group could meet those needs.

5.3. The structured support group programme was developed based on the need assessments conducted

5.3.1. Psycho-educational support group content

The needs expressed during the screening interview and the first session of the programme were integrated in the Washington Coalition of Sexual Assault Programmes' (WCSAP) Parent Support Group Guide (Micheel & Peck-Levy, 2012) so that the support group content addresses the needs of the

parents. The content of the sessions presented, addressed most of the needs of NOCs who joined the support group. Some recommendations can be made for future implementation:

5.3.2. Needs that were addressed

- Safe environment and supportive environment

Providing a consistent and predictable environment to meet with other NOCs helpful in creating a safe environment. The Child Protection Centres that the NOCs were recruited from were ideal because they were familiar with the organisation's services and the working staff. A supportive environment was created through transparency about the supportive group aims and the motive thereof. I made sure that I was empathic throughout the process and ensured that I continually asked for consent. Establishing group norms with an emphasis of on confidentiality and empathy added to the safe group environment.

Four NOCs dropped out and while they explained that they exited the group due to work commitments. It's also likely that the NOCs did not identify with the group norms despite contributing to establishing them. The NOC might have been uncomfortable to with the emotions that the discussions evoked. The NOCs could have found the group context intimidating and unsafe, especially because three of the four NOCs drop out within the first three sessions which were centred around creating a safe and supportive environment, sharing knowledge around CSA and NOCs sharing their disclosure experiences

- Autonomy

Literature suggests that the parents of sexually abused children experience sense of self-efficacy is affected following the disclosure of CSA. NOCs often feel helpless and the parents in the support group expressed that they felt like they did not protect their children from the abuse. It was important to help the NOCs to begin to regain control over their circumstances by involving them in the decision-making aspects of the support group such as time and date, as well as continually asking for consent throughout the support group. The decision to join support group, the decision to participate and the decision to exit the group was entirely up to the parents. While the study did not measure self-efficacy and the NOCs did not overtly express this concept as a need, this aspect of their experience was acknowledged as a need that had to be addressed as part of the intervention's aims. This will be further discussed under the value of the intervention.

- Communication and parenting skills

The content around parenting and difficult child behaviour could have been covered over two sessions as there were many questions and interest around that topic. More time was needed to help the NOCs to tell the difference between normal childhood behaviour and a reaction to CSA. The NOCs needed more time to reflect on and develop healthier ways to communicate appropriate boundaries and how to show compassion. This could have improved the results on parenting stress and self-efficacy.

5.3.3. Needs that were not met

- Knowledge on navigating the Judicial system

The NOCs needed more information about the judicial system. The knowledge shared by the psycho-legal team helped the NOCs gain perspective about the judicial system when it came to the bureaucratic limitation and conviction rates. However, it would have been valuable to have discussed the how the NOCs would cope with their circumstances the event that the perpetrator is not convicted of sexual abused against their child or receives a lighter sentence to that one the NOCs expected.

The needs of the NOCs were informational in nature. However, it was also important to present some topics as activities that parents can take part in. The NOCs learned through action (experience) and they were able to take what they learn in the sessions into their everyday lives.

5.4. The implementation of the psycho-educational support group

The psycho-educational support group was implemented at two non-profit organizations. The following processes contributed to the successful implementation of the intervention:

5.4.1 Building a collaborative relationship with organisations

The implementation of the programme was successful because the Teddy Bear Clinic and Kidz Clinic were supportive of the support group programme. We worked collaboratively during the recruitment of NOCs and they offered a safe and accommodative space to host the support group.

5.4.2 Structure and preparation

The programme was structured, meaning that there was a detailed account of the number of sessions, the content that would be covered and who would be facilitating the sessions. This could have assisted in creating a sense of consistency and predictability for the NOCs. We negotiated the day and time of sessions. This collaborative decision could also have helped the parents attend the sessions and take ownership of the process.

5.4.3 Support group processes

The support group provided the NOCs with a safe space to talk freely and openly about their CSA experiences. The NOCs had the opportunity to set the tone of the sessions by collaboratively agreeing to norms that they valued. This helped the NOCs take ownership of the process. They actively participated in their healing journey by reflecting on their experiences and the new information gained from the sessions. They used their insights to change their habits from one session to the other. The group members developed mutual trust in each other which helped them to open up about conflicts they were experiencing in their parenting roles and religious beliefs. The mutual trust, openness and shared experiences led to altruistic experiences among the support group members which allowed them

to offer each other compassion and supportive advice on parenting as well as encouragement to cope with their current difficulties. The cathartic experiences among the group members may have enhanced group cohesion.

5.4.4 Facilitator's contribution

My contribution to the support group was to facilitate healing through developing cohesion among group members who were facing a similar experience. This was done by offering a safe and contained space in which one could talk about uncomfortable and painful experiences. I offered expert knowledge on the dynamics of CSA and helped them develop insight into emotional and psychological experiences through activities. At the same time I was monitoring the group process which allowed for the NOC to actively engage with content and fellow group members with the anticipation of creating a shared experience, mutual trust, altruistic behaviours and coping capacity. My previous experience of running psycho-educational support groups was instrumental in managing the group processes. My experience in preparing sexually abused children for court provided me with background information concerning the impact of CSA on children. This helped me empathise with the NOCs' experiences and helped me to explain the children's perspective to the NOCs.

As a facilitator I was as much a part of the group as the NOCs - despite my role. I shared group experiences along with the NOCs and gained a deeper understanding of the impact of CSA. After the intervention, I was still engaged with the group processes, but as a researcher, I was listening to the tape recordings and transcribing, reliving each session to interpret the results. This helped help me to notice things I may have missed in the session such as pauses in a statement, compassionate responses by fellow group members, learning outcomes and even frustrations of the group. I did not have a co-facilitator, which meant that I needed to be very reflective in and out of group sessions and practice self-care so that I would be able to separate myself from the intervention to have a fresh perspective with each session. Having had to interpret the research results by myself, meant that it was part of the research process, as the action research method is the study of one's own actions and reflections towards a solution (Kemmis et al., 2014).

5.5. Value of the structured psycho-educational support group

Observations and findings of the intervention provided insight into the value of a structured psycho-educational support group intervention.

The intervention aimed to:

- Assist NOCs to regain control over their circumstances;
- Help NOCs increase their social networks and reduce social isolation;
- Help NOCs to understand the impact of CSA on their children;
- Help NOCs to assist their children in overcoming the sexual abuse trauma;
- Help NOCs decrease their emotional and psychological distress levels; and

- Decrease the stress in the NOC/parent-child relationship.

In this study, the value of the eight-session structured psycho-educational support group for NOCs of children who have been sexually abused was assessed using a mixed-method research approach, with a pre-and post-test design. Quantitatively, specific attention was paid to the programme's effect on NOC's emotional distress and parenting stress. Qualitative data from observations of the programme sessions were utilised to understand the NOCs' experiences of CSA and how the group sessions affected their emotional distress and parenting stress.

5.5.1. Quantitative outcomes

5.5.1.1. Emotional distress levels

The structured psycho-educational support group had an impact on the the NOCs' emotional distress levels. The intervention had a showed a positive effect on the group's overall anxiety levels ($p < 0.05$) and there were slight improvements in their depression levels ($p = 0.58$) as measured by the HADS. Six members showed less anxiety and five showed less depression after the intervention.

At the beginning of the intervention, NOCs expressed that they were feeling an array of emotions as a result of the impact of CSA. Shock, anger, frustration, worry, fear and helplessness were the most commonly expressed emotional reactions. This is confirmed in the HADS scale scores pre-intervention where most of the NOC's anxiety and depression symptoms ranged from borderline to abnormal. Only one NOC's scores were in the normal range for both anxiety and depression symptoms.

From the second session right through to the end of the intervention, NOCs reported a positive change in their emotional experiences. Relief was commonly reported, mainly due to seeing others in a similar situation and receiving information that contextualised their experiences. In each session, NOC were asked to monitor how intensely they experienced their emotions and most caregivers noted a reduction in intensity. The reduction in emotional distress is confirmed in the HADS post-intervention results as five of the NOCs' anxiety and depressions scores were in the normal range. These results suggest that the sharing of emotions with other NOCs who experienced a similar situation, is therapeutic. In addition, when NOCs monitor and reflect on their emotional experiences, they build the capacity for emotional self-regulation. Two NOCs experienced increased levels of emotional distress after the intervention. They had other confounding factors such as pending court cases which seemed to add considerable stress to the NOCs. Their increased emotional distress could be attributed to their emotion-focused coping strategies (avoidance and withdrawal). The sessions may have forced them to face difficult emotions and realities about their circumstances which conflicted with their avoidance coping strategy. This could be the cause of the increased levels of emotional distress after the intervention.

Research has shown that NOCs tend to find it difficult to process intense emotions (anger, despair, disbelief and ambivalence) following CSA disclosure. Their reaction to the disclosure may be likened to

the stress reaction exhibited in traumatic events (Holt et al., 2015; Willingham, 2007). Since people respond to stressful situations differently, their coping strategies can affect how quickly they process the trauma and whether or not they will be able to emotionally support their children (Brux et al., 2015; Cabbigat & Kangas, 2018; Elliot & Carnes, 2001; Toledo & Seymour, 2013).

5.5.1.2. Parental stress levels

The PSI-4-SF outcome did not show significant changes in the group's parenting stress scores. The small sample size (n = 7) could have contributed to the lack of significant results. The analysis of the total stress subscale (TS) indicated that five of the group members experienced less parenting stress after the intervention, while two group members experienced more parenting stress.

The members' individual scores were investigated to get a better picture of the NOC's experiences during the intervention. The intervention seemed to have lowered the parent distress scores (PD) of six NOCs, the parent-child dysfunction (P-DCI) scores of four NOCs and the dysfunctional child (DC) score of four NOCs. Similar to results of the HADS there were two or three NOCs who experienced an increase in parental stress through the intervention. There was an observable link between the HADS anxiety subscale and the PSI-4-SF total stress subscale, suggesting that the intervention had the most impact on emotional distress. The results suggest that the NOC's anxiety symptoms depended on the levels of stress experienced in their parenting role.

5.5.1.3. Pre-intervention scores

When screened for parenting stress before the intervention, NOCs showed elevated levels of parenting stress on all the subscales, while two NOCs' scores were clinically elevated and one's DC score was on the clinically depressed level. These scores are supported by qualitative reports during sessions. The NOCs experienced their parenting role as burdensome. For most of them, parenting stress appeared to be overwhelming, as most of them were the main source of emotional support for their children. Most of the NOCs' children were in their pre-adolescent to late adolescent years. This developmental period is difficult for most parents to deal with, as most children are in a process of defining who they are and exercising their autonomy (Monusky, 2015). However, the picture is likely to look different when that child is also dealing with the trauma of being sexually abused. NOCs were finding their parenting role cumbersome mainly due to their impatience with their children's recovery process.

Research shows that the impact of CSA places great demands on the NOCs' parenting abilities, especially with difficult child behaviours (Brux et al., 2015). As such, NOCs can experience significant stress, making it difficult for them to respond to their children's emotional needs (Benight & Bandura, 2004; Cabbigat & Kangas, 2018; Glanz & Shwartz, 2015; Zerk et al., 2009). The parent-child relationship is also likely to suffer due to harsh parenting practices.

5.5.1.4. Post-intervention scores

Further analysis showed that it was mainly the parents that entered the intervention with clinically elevated scores that did not improve during the intervention. One NOC experienced ongoing stressors concerning judicial processes, difficult child behaviours as well as family-related stressors. The other NOC's DC and Total Stress remained at clinically elevated levels, suggesting that despite access to the resources provided in the support group, the stress levels remained high. The child's substance use problem and abscondence from school maintained this level of stress. These findings align with the causal relationship found between difficult behaviour of abused children and NOCs who reported stress (Cabbigat & Kangas, 2018). These NOCs, reported that their adolescent children demonstrated difficult behaviour with regards to testing boundaries and coping with the psycho-emotional reaction to being abused. This was attributed to the fact that their children had not received support that addressed their emotional needs.

Two NOCs' PD scores fell on clinically extreme (elevated and depressed) levels post-intervention. Both NOCs dropped out of the support group. Both these NOCs' pre-assessment PD scores were in the normal range and although they reported that their needs were met, their scores suggest otherwise, as clinically depressed scores indicate underreporting. This is confirmed by the defensive reporting scale. When the score is 10 or less it indicates that the NOCs "approached the questionnaire with a strong bias to present the most favourable impression of themselves or to minimise indications of problems or stress in the parent-child relationship" (Abidin, 2012, p. 59). One NOC attended two sessions and dropped out before the session discussing parenting stress, difficult child behaviour and the parent-child relationship. The other NOC attended six sessions. The clinically elevated scores suggest that this NOC's knowledge and understanding around CSA increased, while all their PSI-4-SF scores were elevated suggesting that the newly gained information could have been intimidating in shifting their perspective about their circumstances.

5.5.2. Qualitative outcome

The NOCs entered the support group with heightened emotional distress and parenting stress. They felt insecure as parents because they believed that they failed to protect their children from the abuse. They felt unequipped to manage the demands of their parenting role following CSA as they felt that they had lost control over their circumstances, emotions and parental role (Smit, 2016). Gaining access to the support group could have given the NOCs the hope that something could be done about their circumstances. It is important to note that the non-offending caregivers (N = 4) who attended the full course of the structured psycho-educational support group had already undergone efforts to seek help for their children. That is, they reported their children's sexual abuse to the police and worked together

with the CACs to assist their children to overcome the impact of the abuse. Despite their emotional distress, the NOCs could identify opportunities to overcome their circumstances and use them to their advantage.

The NOCs needed knowledge and understanding of how to overcome the impact of CSA and a safe environment in which they could talk about their experiences. They were expectant and ready for positive outcomes. From the beginning of the intervention, the NOCs who attended the full course of the intervention showed active engagement through the intervention and set the tone of the group climate by contributing the values that would guide the group. The sharing of stories helped NOCs learn that they are not alone, which helped to normalise CSA related experiences. Being able to identify and learn from others' experiences with CSA, could have helped the NOCs envisage a different and positive outcome to their circumstances. They asked specific questions regarding the dynamics of CSA, coping with difficult child behaviours and ways to navigate and interact with their children's school and judicial systems following CSA. They completed homework tasks and provided feedback during the sessions. This attitude could have helped them to take ownership of their healing process. The NOCs took note of important lessons and applied them in their lives - which was a positive sign that they were getting valuable resources that they could use to solve their problems. NOCs that actively participated in the intervention benefitted most.

The NOCs dropped out of the intervention due to work commitments but they may have had other reasons that they did not want to disclose. For instance, confronting their emotions and having to reflect on their experiences with other NOCs for which they weren't ready. Another reason could be that they could not imagine positive outcomes to their situations as these NOCs had no record of previous efforts to seek support.

Past research shows that optimistic people are likely to perceive themselves as capable to manage the demands of traumatic experiences and thereby actively seek ways to overcome them. This includes getting help and taking every opportunity to use the resources offered to them (Glanz & Shwartz, 2015). Therefore, the NOCs whose scores showed improvement in their emotional distress and parenting stress could be using optimism to cope. They perceived themselves as being able to overcome the demands of their circumstances with the aid of the support group, thus they actively participated in their healing process.

The next section will discuss the therapeutic elements of group processes that contributed to positive quantitative and qualitative outcomes of the intervention.

5.5.2.1. Hope and dispositional optimism (Instillation of hope)

Yalom (1995) stressed that it is the facilitator's responsibility to instil hope in group-based interventions. He asserted that hope is an important therapeutic factor for group members as it can help them believe

that they can do something about their situation, which can help reduce levels of emotional distress such as anxiety and helplessness (Brown, 2018). From the recruitment phase right through to the termination of the intervention, it was important to help NOCs gain confidence in the proposed intervention as a resource to regain control over their lives. Through the process of active engagement, NOCs began to see themselves as capable of overcoming their difficult experiences. The NOCs expressed that they used their religious beliefs to cope. Their belief seemed sufficient enough to promote hope for healing and so it was important to use this resource therapeutically.

5.5.2.2. Positive social support (Social Learning)

The NOCs appreciated being among other NOCs who shared similar emotions and thoughts when it came to the impact of CSA. They opened up to each other about their insecurities and concerns with parenting demands and they shared their frustrations about navigating the judicial system. Non-offending caregivers showed empathy and compassion towards each other, offering support and guided advice (Guthrie & Kunkel, 2015).

Research has shown that access to positive social support helps NOCs to buffer against parenting stress. Support from family and close friends, and access to parenting programmes such as psycho-educational support groups, offer NOC the opportunity to process their emotions, find adaptive coping mechanisms and learn ways to support their children (Cabbigat & Kangas, 2018; Cyr et. al., 2014; Hill, 2001; Hernandez et al., 2009; Masilo & Davhana-Maselesele, 2017; Meiring et al., 2017; van Toledo & Seymour, 2013).

5.5.2.3. Coping self-efficacy (Interpersonal learning)

Right from the recruitment phase, NOCs expressed that they were not coping well, especially in their parenting role. Through engaging in the intervention activities and sharing stories, painful emotions and experiences in their parenting role, the NOCs may have developed a gradual tolerance for distressing emotions confronting them during sessions. This may have made it easier for them to strengthen adaptive coping strategies and develop new ways to process emotions through engaging with the sessions' content.

The support group seemed to provide a contained space for the NOCs, especially those that stayed the full course of sessions. They felt that they could talk freely about their parenting difficulties. It was important for the NOCs that they felt in control of their emotions and their parenting responsibility (Guthrie & Kunkel, 2016). Through the intervention, the caregivers learned that their emotional healing was directly linked to their children's ability to cope with their experiences as well. The NOCs learned to identify unhealthy parenting practices such as harsh discipline and difficult conversations, and how to replace them with appropriate parenting practices.

5.6. Implications of the study

The results from this research have some important implications for research and the development of psychosocial interventions for NOCs of sexually abused children in the South African context.

This study provides a socio-ecological perspective of CSA, with specific reference to the interconnectedness of independent and interacting systems that NOCs have to navigate following the disclosure of CSA. The study therefore also has valuable relevance for CSA in general, as it calls professionals to focus their intervention strategies to NOCs because they are the very people who have to support their children to overcome the impact of CSA.

While there are few African studies that have attempted to explore the actual experiences of NOCs (Masilo & Dvhana-Maselesele, 2017), this study provides valuable insight into the experiences and needs of the NOCs and how they benefitted from their involvement in the psycho-educational support group.

Similarly, the process of overcoming the impact of CSA as a NOC has been understudied and underappreciated (Masilo, 2011; Rust, 2011). This research provides valuable information on the impact of CSA on the NOCs' emotional adjustment and parenting capacity following the disclosure and how to recover.

While Meinck et al. (2016) described the first child abuse prevention parenting programme, this research developed the first remedial psycho-educational support group for NOCs after the sexual abuse of children for use in the South African context. In this study the specific needs of the NOCs were assessed and utilised in the development of the structured psycho-educational support group, aimed at assisting NOCs to help their children in overcoming the trauma of sexual abuse (Tavkar & Hansen, 2011; Hill, 2001; Elliot & Carnes, 2001). The content of the Parent Support Group Guide of the Washington Coalition of Sexual Assault Programme (WCSAP) to guide psycho-educational support groups for non-offending caregivers of children who have been sexually abused (Micheel & Levy-Peck, 2012), was adjusted and customised for the appropriate use in the South African context.

A mixed-methods research design was used in the evaluation of the intervention. The findings of the study indicated that the support group had some value in addressing the NOC's level of anxiety and depression, as well as to relieve parental stress for some participants. The results from the qualitative evaluation agreed with findings from the psychometric instruments (HADS and PSI-4-SF). The qualitative results also showed that members learned some parenting skills on how to manage their own and their children's emotional reaction to CSA. It was found that members who actively participated and attended all the sessions benefitted most.

5.7. Acknowledgment of the limitations

While this study is the first of its kind to be implemented in South Africa and formally documented, it is important to acknowledge the limitations of the results and the research.

Due to prospective members who were not ready to meet with other NOCs in a similar situation, a small number joined the intervention. Unfortunately two NOCs dropped out of the intervention, making a small sample, even smaller. A group size of 5 to 15 members is considered appropriate for small group interventions (Whitley, 2014). The small group size made it easier to facilitate the group and offer in-depth qualitative results. However, it has negative implications for the quantitative assessment of the value of the intervention. With only seven NOCs having completed the post- assessment, it could result in not producing significant results thus decreasing the generalisability of the results. In reaction to this, the quantitative results were interpreted in a qualitative way to understand the reactions of members individually.

The intervention was held at two different CACs to accommodate the NOCs who were willing to join the intervention, which meant that the intervention was run twice-weekly for eight sessions. TBC had six NOCs and Kidz Clinic had two NOCs. A group of six members can function well to create a supportive environment and learn from others. On the other hand, the two NOCs who were hosted at Kidz Clinic, missed out on dynamic group interaction and the experience of not being alone in their situation.

My dual role as a researcher and a facilitator could influence the data interpretation. I was very involved in the group intervention. My role as a researcher can be described as an insider. This has many advantages as I experienced the reactions of caregivers first hand. It also has some disadvantages that I may be too close to the data to give an objective interpretation. With this in mind, I kept a reflexive journal as a method of self-monitoring throughout the process of analysis (Robertson, 2000) to increase objectivity and eliminate some biases. A co-researcher was used to enhance the trustworthiness of the interpretation (Johnson & Onwuegbuzie, 2004).

5.8. Study recommendations

The following recommendations can be made for future research. More research is needed to investigate the experiences of NOCs of sexually abused children following the disclosure of CSA. This can be done in collaboration with CACs by providing NOCs with a questionnaire during intake sessions.

Psycho-educational support groups are cost-effective because the needs of more than one NOC can be addressed and the programme content can be tailored to the needs of each group of NOCs. As such, support groups are appropriate for low resourced communities in South Africa (Brown, 2018; Gitterman & Knight, 2016; Im et al., 2017). Support groups can be institutionalised as standard practice in CACs, clinics and hospitals. This will provide more evaluation opportunities to further develop the

intervention. More evaluations of the effectiveness of psycho-educational support groups are needed to measure the impact and value of the intervention for different groups of NOCs. The more evidence-based interventions for NOCs are provided, the more it can be customised to their needs. NOC programmes can serve as a good adjunct for the support and rehabilitation of children following CSA trauma.

Lastly, the development of future interventions focussing on non-offending caregivers of sexually abused children should be implemented where non-offending caregivers can easily access them such as CACs, health clinics or hospitals. Community health workers can be trained to implement such interventions in low-resourced areas to assist in the great need for interventions.

5.9. Conclusion of the study

Until now there has been limited research done about the experiences of non-offending caregivers following CSA in South Africa. Existing interventions with NOCs are mostly preventative and not treatment-based. Interventions for NOCs are mostly done in well-resourced countries. South Africa has the highest number of reported cases for CSA in the world. Interventions to rehabilitate NOCs are thus desperately needed.

This study has made use of the lessons learned in developed countries to mitigate the impact of CSA both for children and their NOCs. A socio-ecological perspective was considered in taking into account the socio-cultural aspects of the South African context. An intervention aimed at assisting NOCs of sexually abused children towards their psychosocial adjustment following CSA was developed around their needs. The intervention was implemented in a small group of NOCs and found to effective in contributing to decreased anxiety, depression and parental stress for some. The group climate helped caregivers to process their emotions and to learn skills to enable them to understand their children's reactions and to help their children to overcome the trauma of CSA.

From the results of this research, it seems evident that there is a need for interventions to assist NOCs to adjust to the psychosocial impact of CSA on them and their children. It's also evident that CSA affects more than just the child, it has a rippling effect within a much larger system. The outcomes of this study are interwoven and interconnected within a broader system of systems concerned with CSA ranging from the police, to health care workers, social workers and the judiciary. The results also highlight the urgent need for social professionals to get involved and play their part in mitigating the impact of CSA on the whole family system as it seems that psychosocial interventions can assist NOCs in their healing journey.

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16 March 2018

Dear Ms Makamba

Project:	**The development of a structured support group for non-offending caregivers of sexually abused children**
Researcher:	**NU Makamba**
Supervisor:	**Prof M Visser**
Department:	**Psychology**
Reference number:	**15053203 (GW20180234HS)**

Thank you for your response to the Committee's letter of 11 March 2018.

I have pleasure in informing you that the Research Ethics Committee formally **approved** the above study at an *ad hoc* meeting held on 16 March 2018. Data collection may therefore commence.

Please note that this approval is based on the assumption that the research will be carried out along the lines laid out in the proposal. Should your actual research depart significantly from the proposed research, it will be necessary to apply for a new research approval and ethical clearance.

We wish you success with the project.

Sincerely

Prof Maxi Schoeman
Deputy Dean: Postgraduate and Research Ethics
Faculty of Humanities
UNIVERSITY OF PRETORIA
e-mail: tracey.andrew@up.ac.za

cc: Prof M Visser (Supervisor)
Prof C Wagner (HoD)

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DEPARTMENT OF STATISTICS

Letter of Co-Authorship Acknowledgement

Thank you for applying for statistical support from the Internal Statistical Consultation Services. As per our guidelines, the nature and extent of the research should be such that it is publishable as an article in a journal. It is expected that the contribution of the statistical consultant/s is acknowledged by granting co-authorship. This entails at least editing the statistical section of the article by the statistical consultant/s. For record-keeping purposes we require that an electronic copy of the final article be send to us on completion of the project.

Please complete the following form, and return it to the ISCS (Internal Statistical Consultation Services) in order for an appointment to be set up to discuss the project.

Which journals are you planning to submit the article to?

___Journal of child and adolescent mental health or Child abuse

What is the planned date of submission?

___March 2019

I hereby confirm that co-authorship will be granted to the statistical consultant/s.

Student Name: N.U. MAKAMBA Student Number: U15053203

Student signature Date: 20 NOV 2018

Supervisor Name: ___MJ Visser____

_____MJ Visser_____ __14 Nov 2018____

Supervisor Signature Date

Co-Supervisor Name: _____

Co-Supervisor Signature Date

Head of Department Name: Thasina Gunz

Head of Department Signature Date: 13.11.18

*Required for the application to be processed

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15 August 2018

To Whom It May Concern:

RE: PERMISSION TO CONDUCT RESEARCH AT WOMEN AND MEN AGAINST CHILD ABUSE (WMACA), KIDS CLINIC BOKSBURG – NONHLANLA MAKAMBA

Herewith confirmation that the above mentioned person has been granted permission to conduct research at Women and Men Against Child Abuse (WMACA), Kids Clinic Boksburg.

Please feel free to contact the writer with any queries in this regard.

Yours Faithfull

Kind Regards,

Nonhlanhla Biyase
Social Work Supervisor
Email: nonhlanhla@wmaca.org
Tel: 011-892-0404
Fax: 011-892-0406

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THE TEDDY BEAR CLINIC T/A TEDDY BEAR FOUNDATION.

23 May 2017

To Whom It May Concern:

RE: PERMISSION TO CONDUCT RESEARCH AT TEDDY BEAR FOUNDATION – NONHLANLA MAKAMBA

Herewith confirmation that the above mentioned person has been granted permission to conduct research at Teddy Bear Foundation.

Please fee l free to contact the writer with any queries in this regard.

Yours Faithfully

Dr. Shaheda Omar
CLINICAL DIRECTOR

Dear Participant,

My name is Nonhlanhla Makamba, a Masters (counselling psychology) student at the University of Pretoria. My research interest involves:

Title of the study: The development of a structured support group for non-offending caregivers of sexually abused children.

Purpose of the study: The research aims to help the non-offending caregivers understand the effects of child sexual abuse on their children and to help the non-offending caregivers assist their children in overcoming the traumatic experience of child sexual abuse. By so doing, the researcher hopes to increase a sense of social support networks and an increased sense of autonomy over their circumstances.

Procedure: This is a screening interview where you will be engaged in conversation regarding the nature of the study, your availability and readiness to join a support group that addresses the needs of non-offending caregivers of children who have been sexually abused. The screening interview will be conducted by two facilitators who will also be conducting the support group. The co-facilitator is female and she is competent to co-manage the process of the support group. The co-facilitator will be bound by the same ethical principles as the researcher.

Risk: Little or no risk of harm will be experienced by you. Should you experience emotional or psychological distress, the Teddy Bear Clinic's counselling services will be available to you.

Benefits: There are no financial gains in participating in the research study. However, you will help in the development of a support group intervention for the prospective non-offending caregiver

Rights of participants: Participation in this research is completely voluntary. You may withdraw from participating at any time without any negative consequences.

Confidentiality: All information will be treated confidentially. Your identity will be kept anonymous in all reports emerging from the study. Furthermore, as a participant in the needs assessment, you will be expected to undertake to keep information discussed in the group as confidential. Should you wish to withdraw participation in the research study, data relating to you will be destroyed. The researcher and

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her supervisor named below will have unrestricted access to the research data.

Storage of research data: Data obtained during the research process will be kept safe at the University of Pretoria after the study has been completed. No personal information will accompany the usage data. The data will be stored securely for 15 years from the completion of this project at the University of Pretoria's department of psychology.

Publication: The findings of this study may be published in an academic journal

---

If you have any questions or concerns regarding this study and would like to talk to someone other than a member of the research team, contact

Research Supervisor: Prof Maretha Visser E-mail: maretha.visser@up.ac.za

Researcher: Nonhlanhla Makamba E-mail: Nonhlanhla.ursh.makamba@gmail.com

By signing here below, I_____ agree to the terms and understand their implications and conditions stated above and will give my full participation during the interview session.

_____ _____

SIGNATURE (participant) DATE

SCREENING INTERVIEW SCHEDULE

1. Biographical Information

Gender: _____

Age: _____

Marital Status: _____

Education: _____

Employment: _____

Relation to child: _____

Immediate family composition:

_____

_____

Home Language: _____

Preferred language of instruction: _____

SCREENING INTERVIEW SCHEDULE

2. Interview Questions

- Under which circumstance did you learn that your child was sexually abused?

_____

_____

- After hearing that your child has been sexually abused, describe how you were feeling. For how long did you experience these emotions? How did you manage with them, if at all?

_____

_____

- Describe the type of help you received. What did you appreciate about it?

_____

_____

- What was the most difficult part to deal with as a caregiver having to cope with his/her child being sexually abused?

_____

_____

3. Availability and commitment

- Are you interested to join the support group?

_____

_____

- If yes, are you able to attend group sessions on Saturdays for 8 weeks?

_____

_____

- If yes, what factors could make it difficult for you to attend the group sessions?

_____

_____

Dear Participant,

My name is Nonhlanhla Makamba, a Masters (counselling psychology) student at the University of Pretoria. My research interest involves:

Title of the study: The development of a structured support group for non-offending caregivers of sexually abused children.

Purpose of the study: The research aims to help non-offending caregivers understand the effects of child sexual abuse on their children and to help the non-offending caregivers assist their children in overcoming the traumatic experience of child sexual abuse. By so doing, the researcher hopes to increase a sense of social support networks and an increased sense of autonomy over their circumstances.

Procedure: You will be involved in an eight-session support group intervention. Each session will be 60 minutes long. The sessions will involve different kinds of activities. You will complete two questions before the support group begins as well as after the eight-sessions have been completed. The sessions will be conducted by two facilitators (the researcher and a co-facilitator). The co-facilitator is competent in conducting support groups and will be involved throughout the process. The co-facilitator will be and will be bound by the same ethical principles as the researcher.

Risk: Little or no risk of harm will be experienced by you. Should you experience emotional or psychological distress, the Teddy Bear Clinic's counselling services will be available to you.

Benefits: There are no financial gains in participating in the research study. However, you will have the opportunity to deal with the emotional issues related to CSA. In addition, your participation in this research study will help to inform future research.

Rights of participants: Participation in this research is completely voluntary. You may withdraw permission to participate at any time. Furthermore, you have missed two consecutive sessions you will be considered as no longer a part of the support group.

Confidentiality: All information will be treated confidentially. Your identity will be kept anonymous in all reports emerging from the study. Furthermore, as a participant in the support group program, you will be expected to undertake to keep information discussed in the group as confidential as per the group rules, which will be discussed. Should you wish to withdraw participation in the research study, data relating to you will be destroyed. The researcher and her supervisor named below will have unrestricted access to the research data.

Storage of research data: Data obtained during the research process will be kept safe at the University of Pretoria after the study has been completed. No personal information will accompany the usage data. The data will be stored securely for 15 years from the completion of this project at the University of Pretoria's department of psychology. Data from the study may be useful in future research studies. By signing this consent form you give are giving permission for data to be re-used in future research studies which will also comply with all ethical procedures.

Publication: The findings of this study may be published in an academic journal.

If you have any questions or concerns regarding this study and would like to talk to someone other than a member of the research team, contact

Research supervisor

Prof Maretha Visser E-mail: maretha.visser@up.ac.za

Researcher

Nonhlanhla Makamba nonhlanhla.ursh.makamba@gmail.com

By signing here below, I_____ agree to the terms and understand their implications and conditions stated above and will give my full participation during the interview session.

_____ _____

SIGNATURE (participant) Date

PSI-4 SHORT FORM

Record/Profile Form

Richard R. Abidin, EdD

nstructions:

On the inside of this form, write your name, gender, date of birth, ethnic group, and marital status; oday's date; and your child's name, gender, and date of birth. This questionnaire contains 36 statements.

Read each statement carefully. For each statement, please focus on the child you are most concerned about nd circle the response that best represents your opinion. **Answer all questions about the same child.**

Circle SA if you strongly agree with the statement.
Circle A if you agree with the statement.
Circle NS if you are not sure.
Circle D if you disagree with the statement.
Circle SD if you strongly disagree with the statement.

For example, if you sometimes enjoy going to the movies, you would circle A in response to the following :atement:

I enjoy going to the movies. SA (A) NS D SD

While you may not find a response that exactly states your feelings, please circle the response that comes losest to describing how you feel. **Your first reaction to each question should be your answer.**

Circle only one response for each statement, and respond to all statements. **Do not erase!** If you need to nange an answer, mark an "X" through the incorrect answer and circle the correct response. For example:

I enjoy going to the movies. SA A NS (X) (SD)

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PSI-4 SHORT FORM Answer Sheet

Name _____ Gender _____ Date of birth ___/___/___

Ethnic group _____ Marital status _____ Today's date ___/___/___

Child's name _____ Child's gender _____ Child's date of birth ___/___/___

SA = Strongly Agree **A = Agree** **NS = Not Sure** **D = Disagree** **SD = Strongly Disagree**

1.	I often have the feeling that I cannot handle things very well.	SA	A	NS	D	S
2.	I find myself giving up more of my life to meet my children's needs than I ever expected.	SA	A	NS	D	S
3.	I feel trapped by my responsibilities as a parent.	SA	A	NS	D	S
4.	Since having this child, I have been unable to do new and different things.	SA	A	NS	D	S
5.	Since having a child, I feel that I am almost never able to do things that I like to do.	SA	A	NS	D	S
6.	I am unhappy with the last purchase of clothing I made for myself.	SA	A	NS	D	S
7.	There are quite a few things that bother me about my life.	SA	A	NS	D	S
8.	Having a child has caused more problems than I expected in my relationship with my spouse/parenting partner.	SA	A	NS	D	S
9.	I feel alone and without friends.	SA	A	NS	D	S
10.	When I go to a party, I usually expect not to enjoy myself.	SA	A	NS	D	S
11.	I am not as interested in people as I used to be.	SA	A	NS	D	S
12.	I don't enjoy things as I used to.	SA	A	NS	D	S
13.	My child rarely does things for me that make me feel good.	SA	A	NS	D	S
14.	When I do things for my child, I get the feeling that my efforts are not appreciated very much.	SA	A	NS	D	S
15.	My child smiles at me much less than I expected.	SA	A	NS	D	S
16.	Sometimes I feel my child doesn't like me and doesn't want to be close to me.	SA	A	NS	D	S
17.	My child is very emotional and gets upset easily.	SA	A	NS	D	S
18.	My child doesn't seem to learn as quickly as most children.	SA	A	NS	D	S
19.	My child doesn't seem to smile as much as most children.	SA	A	NS	D	S
20.	My child is not able to do as much as I expected.	SA	A	NS	D	S
21.	It takes a long time and it is very hard for my child to get used to new things.	SA	A	NS	D	S
22.	I feel that I am: (Choose a response from the choices below.)	1	2	3	4	
23.	I expected to have closer and warmer feelings for my child than I do, and this bothers me.	SA	A	NS	D	S
24.	Sometimes my child does things that bother me just to be mean.	SA	A	NS	D	S

1. a very good parent.
2. a better-than-average parent.
3. an average parent.
4. a person who has some trouble being a parent.
5. not very good at being a parent.

SA = Strongly Agree **A** = Agree **NS** = Not Sure **D** = Disagree **SD** = Strongly Disagree

25. My child seems to cry or fuss more often than most children. ..... SA A NS D SD
26. My child generally wakes up in a bad mood. ..... SA A NS D SD
27. I feel that my child is very moody and easily upset. ..... SA A NS D SD
28. Compared to the average child, my child has a great deal of difficulty in getting used to changes in schedules or changes around the house. ..... SA A NS D SD
29. My child reacts very strongly when something happens that my child doesn't like. .. SA A NS D SD
30. When playing, my child doesn't often giggle or laugh. ..... SA A NS D SD
31. My child's sleeping or eating schedule was much harder to establish than I expected. SA A NS D SD
32. I have found that getting my child to do something or stop doing something is: (Choose a response from the choices below.) 1 2 3 4 5

    1. much harder than I expected.
    2. somewhat harder than I expected.
    3. about as hard as I expected.
    4. somewhat easier than I expected.
    5. much easier than I expected.

33. Think carefully and count the number of things which your child does that bothers you. For example, dawdles, refuses to listen, overactive, cries, interrupts, fights, whines, etc. (Choose a response from the choices below.) 1 2 3 4 5

    1. 1-3
    2. 4-5
    3. 6-7
    4. 8-9
    5. 10+

34. There are some things my child does that really bother me a lot. ..... SA A NS D SD
35. My child's behavior is more of a problem than I expected. ..... SA A NS D SD
36. My child makes more demands on me than most children. ..... SA A NS D SD

Please do not write in this area.

PSI-4 SHORT FORM Scoring Sheet

Name _____ Gender _____ Date of birth ____/____/____

Ethnic group _____ Marital status _____ Today's date ____/____/____

Child's name _____ Child's gender _____ Child's date of birth ____/____/____

Defensive Responding (sum of shaded responses; significant if score is 10 or less) ☐

1.	5	4	3	2	1
2.	5	4	3	2	1
3.	5	4	3	2	1
4.	5	4	3	2	1
5.	5	4	3	2	1
6.	5	4	3	2	1
7.	5	4	3	2	1
8.	5	4	3	2	1
9.	5	4	3	2	1
10.	5	4	3	2	1
11.	5	4	3	2	1
12.	5	4	3	2	1
13.	5	4	3	2	1
14.	5	4	3	2	1
15.	5	4	3	2	1
16.	5	4	3	2	1
17.	5	4	3	2	1
18.	5	4	3	2	1
19.	5	4	3	2	1
20.	5	4	3	2	1
21.	5	4	3	2	1
22.	1	2	3	4	5

PD ☐

23.	5	4	3	2	1
24.	5	4	3	2	1

P-CDI ☐

Percentile Profile

%ile	Raw score				%ile
≥99	47-60	44-60	48-60	128-180	≥99
98	45-46	42-43	45-47	125-127	98
96	43-44	40-41	43-44	120-124	96
94	42	38-39	42	118-119	94
92	41	37	41	116-117	92
90	40	36	40	114-115	90
88	39		39	113	88
86	38	34-35	38	110-112	86
84				108-109	84
82	37	32-33	37	106-107	82
80	36	31	36	104-105	80
78	35	30	35	102-103	78
76	34	29	34	98-101	76
74				93-97	74
72	33	28	33	90-92	72
70	32	27	32	89	70
68	31		31	87-88	68
66	30	26	30	85-86	66
64	29			83-84	64
62	28	25	29	82	62
60				80-81	60
58	27	24	28	78-79	58
56			27	76-77	56
54	26	23		75	54
52			26	74	52
50	25	22		73	50
48		21			48
46	24		25	71-72	46
44				70	44
42		20		69	42
40			24	68	40
38	23			67	38
36	22	19		66	36
34			23	65	34
32	21	18		64	32
30			22	63	30
28		17		61-62	28
26	20		21	60	26
24		16		59	24
22	19		20	58	22
20	18			57	20
18		15	19	56	18
16				54-55	16
14	17	14	18	53	14
12				51-52	12
10	16	13	17	50	10
8	15		16	48-49	8
6	14		15	45-47	6
4	13	12	14	42-44	4
2	12		13	40-41	2
≤1			12	36-39	≤1

PD		P-CDI		DC		Total Stress	
_____	+	_____	+	_____	=	☐	Raw score
_____		_____		_____		_____	%ile

See Appendix C of the PSI-4 Professional Manual for a detailed normative conversion table.

25.	5	4	3	2	1
26.	5	4	3	2	1
27.	5	4	3	2	1
28.	5	4	3	2	1
29.	5	4	3	2	1
30.	5	4	3	2	1
31.	5	4	3	2	1
32.	5	4	3	2	1
33.	1	2	3	4	5
34.	5	4	3	2	1
35.	5	4	3	2	1
36.	5	4	3	2	1

DC ☐

Hospital Anxiety and Depression Scale (HADS)

Tick the box beside the reply that is closest to how you have been feeling in the past week. Don't take too long over your replies: your immediate response is best.

D	A		D	A	
		I feel tense or 'wound up':			**I feel as if I am slowed down:**
	3	Most of the time	3		Nearly all the time
	2	A lot of the time	2		Very often
	1	From time to time, occasionally	1		Sometimes
	0	Not at all	0		Not at all
		I still enjoy the things I used to enjoy:			**I get a sort of frightened feeling like 'butterflies' in the stomach:**
0		Definitely as much		0	Not at all
1		Not quite so much		1	Occasionally
2		Only a little		2	Quite Often
3		Hardly at all		3	Very Often
		I get a sort of frightened feeling as if something awful is about to happen:			**I have lost interest in my appearance:**
	3	Very definitely and quite badly	3		Definitely
	2	Yes, but not too badly	2		I don't take as much care as I should
	1	A little, but it doesn't worry me	1		I may not take quite as much care
	0	Not at all	0		I take just as much care as ever
		I can laugh and see the funny side of things:			**I feel restless as I have to be on the move:**
0		As much as I always could		3	Very much indeed
1		Not quite so much now		2	Quite a lot
2		Definitely not so much now		1	Not very much
3		Not at all		0	Not at all
		Worrying thoughts go through my mind:			**I look forward with enjoyment to things:**
	3	A great deal of the time	0		As much as I ever did
	2	A lot of the time	1		Rather less than I used to
	1	From time to time, but not too often	2		Definitely less than I used to
	0	Only occasionally	3		Hardly at all
		I feel cheerful:			**I get sudden feelings of panic:**
3		Not at all		3	Very often indeed
2		Not often		2	Quite often
1		Sometimes		1	Not very often
0		Most of the time		0	Not at all
		I can sit at ease and feel relaxed:			**I can enjoy a good book or radio or TV program:**
	0	Definitely	0		Often
	1	Usually	1		Sometimes
	2	Not Often	2		Not often
	3	Not at all	3		Very seldom

Please check you have answered all the questions

Scoring:

Total score: Depression (D) _____ Anxiety (A) _____

0-7 = Normal

8-10 = Borderline abnormal (borderline case)

11-21 = Abnormal (case)

Feelings Following a Sexual Abuse Disclosure

Anxious	0	1	2	3	4	5	6	7	8	9	10
Angry	0	1	2	3	4	5	6	7	8	9	10
Betrayed	0	1	2	3	4	5	6	7	8	9	10
Confused	0	1	2	3	4	5	6	7	8	9	10
Disappointed	0	1	2	3	4	5	6	7	8	9	10
Disbelieving	0	1	2	3	4	5	6	7	8	9	10
Exhausted	0	1	2	3	4	5	6	7	8	9	10
Frustrated	0	1	2	3	4	5	6	7	8	9	10
Frightened	0	1	2	3	4	5	6	7	8	9	10
Guilty	0	1	2	3	4	5	6	7	8	9	10
Hurt	0	1	2	3	4	5	6	7	8	9	10
Lonely	0	1	2	3	4	5	6	7	8	9	10
Miserable	0	1	2	3	4	5	6	7	8	9	10
Overwhelmed	0	1	2	3	4	5	6	7	8	9	10
Regretful	0	1	2	3	4	5	6	7	8	9	10
Sad	0	1	2	3	4	5	6	7	8	9	10
Worried	0	1	2	3	4	5	6	7	8	9	10
Withdrawn	0	1	2	3	4	5	6	7	8	9	10
Others											
	0	1	2	3	4	5	6	7	8	9	10
	0	1	2	3	4	5	6	7	8	9	10
	0	1	2	3	4	5	6	7	8	9	10

Group rules and norms

Confidentiality

This means to keep the discussions of the group within the group **ONLY**.

Active participation

Every member of the group is expected to take part in **ALL** group activities

Empathy

We show empathy to a fellow group member by **listening attentively**, not showing judgment and without rushing to give advice.

Trust

We show that we are trust worthy to fellow group members when we keep group discussions confidential, when we show empathy and when we share our stories with other members.

Support members

We can show support to other members by sharing encouraging words and being patient with one another.

Punctuality

Every Member is expected to attend sessions **ON TIME**.

Attendance

If you miss more than **TWO** sessions in a row and **FOUR** sessions in total, you will be asked to exit the program.

I agree to and understand the above stated norms. I_____ promise to adhere to them.

Date	Topic	Duration	Facilitators
	Screening Interview		Nonhlanhla Makamba
	Session one – *Beginning our journey together* **Goal of session**: To begin the creation of a safe and healthy group environment in which participants can gain knowledge and share concerns.		Nonhlanhla Makamba
	Session two – *Overview of child sexual abuse* **Goal of session**: To establish a foundation of knowledge about child sexual abuse that can be built upon in following sessions. Dispel misunderstandings and myths about sexual abuse that may be contributing to participants' feelings of shame, guilt and isolation.		Nonhlanhla Makamba
	Session three – *Coping and communication* **Goal of session**: To help parents develop some coping strategies and communication skills to be able to handle their own emotional reactions and to help their children.		Nonhlanhla Makamba
	Session four – *How abuse affects children and teens* **Goal of session**: To help parents understand the effects of abuse on children and teens in the context of normal developmental stages and issues.		Nonhlanhla Makamba
	Session five – *How abuse affects parents and sibling* **Goal of session**: To facilitate the family's healing process by helping parents understand and respond to the impact of abuse on siblings and partners.		Nonhlanhla Makamba
	Session six – *Difficult child behaviours and parenting challenges* **Goal of session**: To identify common behavioural responses to sexual abuse, and to increase parents' skills in handling these behaviours appropriately.		Nonhlanhla Makamba

	Session seven – *Dealing with the outside world* **Goal of session**: To explore the various sources of stress and support in parents' lives and provide information to help parents navigate the systems that become involved following a disclosure.		Nonhlanhla Makamba
	Session eight – *Moving into the future* **Goal of session**: To provide closure for group participants and instill confidence and hope for the future of their families.		Nonhlanhla Makamba

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YUNIBESITHI YA PRETORIA

2020

A GUIDE TO PSYCHO-EDUCATIONAL SUPPORT GROUP for non-offending caregivers of children who have been sexually abused adapted from the WCSAP Parent support group guide (Micheel, Peck-Levy, 2012)

NON-OFFENDING CAREGIVER SUPPORT GROUP MANUAL GUIDE

SUPPORT GROUP STRUCTURE: OVERVIEW OF SESSIONS

Each session outline contains a structure for the sessions. This structure is intended to customise the group members and create a sense of familiarity.

1. GOAL OF SESSION

The goals are designed to follow or complement and aligned with the stages of group development.

2. CHECK-IN

The group facilitators ask each participant, in turn, to respond briefly to a prompt. This provides the facilitator with an opportunity to acknowledge each person and to set the framework and tone for the season.

3. HANDOUTS

4. LEARNING AND DEVELOPMENT

Provides the group members with the opportunity to integrate their experiences with a wider knowledge of the topic

5. ACTIVITIES

The activities serve to build group cohesiveness, to engage group members in active learning and to make the session more interesting and enjoyable.

6. SELF-CARE ACTIVITY

These are brief activities and are designed to help caregivers cope and care for themselves so they can care for their children.

7. CHECK-OUT

Each participant has a chance to make a brief comment in turn. This closing activity teaches realistic goal-setting and assisting in managing the emotions that may be stirred up by the group.

STRUCTURED SUPPORT GROUP SESSION OUTLINE.

Session one-*Beginning the Healing Journey*

GOALS OF SESSION

To create a safe and healthy group environment in which the members can gain knowledge and share concerns.

Introduction to group

- The facilitator welcomes the group members and acknowledges that it may have been difficult showing up for the first meeting.

Introduction of members

- Members will be asked to share their first names and whether they have related to or partnered with another group member

Development of ground rules

- Each group member is asked to come up with ground rules. These rules are written on a flip chart so that it is visible for everyone to see.
- The facilitator should add if the following was not mentioned:

Confidentiality

Members are reminded that the information given to them during the screening process about the mandated exceptions to confidentiality.

Discussion of safety issues

Attendance policies

Respecting and non-judgemental responses, especially about parenting issues

Format of each meeting

- Letting the members know what to expect with regards to the structure and flow of sessions.

EVALUATION

- Members will be asked to complete two pre-self-report assessments that are aimed at measuring the level of distress that they enter the group with.
- This information will allow the facilitator to tailor the activities more sensitively.

CHECK-IN *Getting to know each other*

If you had an afternoon all to yourself and R1000.00 you could spend on something fun, what would you choose to do

ACTIVITY 1 *All of our children*

Aim: the facilitator explains that using the silhouettes gives participants a glimpse of each other's family situations without getting too personal and keep the importance of children at the forefront of the group.

Resources:

- Cut-out silhouettes of children of all types, from babies to teens
- Blank paper
- Black markers, scissors and tape

Participants are asked to choose the silhouettes that remind them the most of their children. The members will have to paste the silhouettes to the wall around the room. When they are finished, members will be asked to look around the room and comment on what they notice. Group members will then be asked what they learned from this exercise. Members will learn that child sexual abuse can face any kind of family.

LEARNING AND DEVELOPMENT

Preview of topics to be discussed in subsequent sessions

- Members will each be given a hand-out with the dates and topics of group sessions
- Members will be provided with index cards and will be asked to write down (anonymously) any questions or topics they would like the facilitator to cover during the eight weeks of the group. Group members will then slip the cards in one large envelope.

Familiarising the members to the concepts of the healing process

The facilitator will address the following:

- Sexual abuse affects every member of the family
- Each individual and each family is at different points in their healing
- Be patient with yourself and each other
- No parent is prepared for his/her child to be sexually abused and no one is born an expert at dealing with all the consequences of abuse
- Advice giving is generally not helpful. Members are allowed to share your thoughts and experiences but you are not allowed to tell others what to do or feel
- Members will be encouraged to brainstorm about what to do if someone becomes upset during a session or in the days between group sessions

SELF-CARE ACTIVITY *Talking about true and positive things*

Aim: To help the members to remember the true and positive things during difficult times.

Members will pair-up/group-up depending on the number of members.

- Members tell each other about any one of their kids if you have more than one. ONLY TRUE AND POSITIVE THINGS
- Each person has a turn to share

CHECK-OUT

What I most hope to achieve in this group.

Session two- *Overview of Child Sexual Abuse*

GOALS OF SESSION

To establish a foundation of knowledge about child sexual abuse that can be built upon in the following sessions. Dispel misunderstandings and myths about sexual abuse that may be contributing to participants' feelings of shame, guilt and isolation.

CHECK-IN

Participants are asked about how they feel about being back for this session. They describe the emotion they feel and they each rate themselves on an emotional thermometer.

LEARNING AND DISCUSSION

The rules established by the members at the previous meeting are re-visited and asked if there are any questions or additional thoughts. A typed copy of the group rules will be handed out.

SELF-CARE ACTIVITY *-Being fully present*

Resources: A box is placed just inside the door to the meeting room. Members are provided three slips of paper.

- Members are asked to write down the top three worries they are bringing into the room today, one per slip of paper. This information will not be shared.
- Members then deposit the paper slips into the box after writing

The facilitator explains that sometimes it is hard to concentrate when they have so many things on their minds. Just for this meeting time, they can lay those worries aside so they can be fully present in the group.

ACTIVITY1 *Childhood Stories Video Documentary*

This documentary features four adult survivors of child sexual abuse and sheds light on how they coped with and thought about the abuse as children. This video is intended to help caregivers to understand why their child did not tell and what tactics offenders use to gain access to and groom children. The survivors also talk about the impacts that the abuse has had on their lives.

HANDOUTS

Each member will be handed a *Child Sexual Abuse Sheet for Parents, Teachers and Information about Sexual Offenders*

LEARNING AND DISCUSSION

What is child sexual abuse?

- The range of contact behaviours will be discussed (sexual touching, penetration, and non-contact behaviours (taking nude photos, peeping, exposure, that constitute child sexual abuse.
- Validate caregivers by explaining that the legal response does not define the experience of their children.

Why does it happen?

- Members will be asked why they think child sexual abuse happens. The underlying issues that contribute to child sexual abuse will be addressed and the grooming tactics used by the abusers.

Who perpetrates child sexual abuse?

- The focus of this section will be on dispelling common myths about abusers and providing general statistics.

ACTIVITY 2 *Telling and Recanting*

Aim: To help caregivers start processing their emotions (anger, hurt guilt, etc.) and normalise the fact that many children do not disclose for understandable reasons.

Sharing Our Stories

This will serve as an opportunity for the members to tell what happened to their child and to share a portion of their story.

- The experience of telling/listening to a detailed account of a child sexual abuse can be overwhelming
- Session one: group members have not had an opportunity to build trust with each other and may still be tentative about trusting the facilitators
- Limiting the time sets the tone for respecting group boundaries and giving each parent a voice
- Those who choose not to participate, they will be expected to participate through listening.
- As a rule, during sharing members are to listen only. No comments, advice-giving or judgement will be allowed.

Members are asked to brainstorm reasons why a child may not disclose sexual abuse and why a child may disclose and then say it didn't happen.

The facilitators share that it is quite common for children to wait for months or even years to disclose abuse.

CHECKOUT

What is the one thing you learned in the session today that was most helpful to you?

Session three *Coping and Communication*

GOAL OF SESSION

To help caregivers develop some coping strategies and communication skills to be able to handle their emotional reactions and to help their children.

CHECK-IN

When you are upset, what is one thing you do that helps you to calm down

HANDOUTS

- Feelings following a Sexual Abuse Disclosure
- Dialectic Behaviour Therapy Validation Strategies for Parents by Christy Matta
- The Optimistic Child: Raise Your Children to be Optimists by Elizabeth Scott

ACTIVITY 1 *Feelings following a Sexual Abuse Disclosure*

Resources: Copies of the hand-out "Feelings following a Sexual abuse Disclosure". Each member will be given pencils.

- Members are given the hand-outs and expected to read through the list of emotions. The members are given instructions on how to rate themselves.
- After each person has filled out the form, members will be asked to share aspects of the questionnaire that surprised them.

LEARNING AND DISCUSSION

The facilitator normalises the common experiences, responses and emotions of the caregiver when sexual abuse is disclosed. The facilitator also reinforces the concepts of the healing journey that were addressed in session one.

ACTIVITY 2 – *Obstacles to Communication*

Resources: Chairs will be used to serve as a physical "obstacle." Signs will be made that contain statements that caregivers/parents often make.

Aim-To highlight to the caregivers that these statements can create obstacles to communication. To help caregivers understand how these statements may stifle communication between them and their children.

LEARNING AND DISCUSSION

The facilitator will teach the caregivers how to communicate effectively with their child and how to also listen to their child. The facilitator will use the hand-out Dialectic Behaviour Therapy Validation Strategies for Parents by Christy Matta, to discuss positive communication skills.

SELF-CARE ACTIVITY – *Relaxation Exercises*

AIM- To help caregivers teach their children how to relax in stressful situations and provide the caregiver with the opportunity to lead their children by example.

- The facilitator will teach the caregivers a simple relaxation exercise
- After the caregivers have been taught, the facilitator will ask them to thinks about how they can integrate brief relaxation exercises into their day

CHECK-OUT

What's one thing you can do this week to open up communication with your child?

Session Four -*How abuse affects children and teens*

GOAL OF SESSION

To help parents understand the effects of abuse on children and teens in the context of normal development stages and issues.

CHECK-IN

What is one change you have seen in your child since discovering that he or she was sexually abused?

ACTIVITY 1- *Images of Hope*

Resources: Paper, Crayons, Markers and coloured pencils. Magazines, Scissors and glue sticks.

Participants will be each is given a piece of paper and drawing materials. They will be asked to draw a picture that represents their hopes for their child. If they are uncomfortable withdrawing, they can write words or use magazine pictures. Allow time to share.

AIM – To help the caregivers increase their hope for their children in a tangible way.

LEARNING AND DISCUSSION

- General information on how sexual abuse affects children and teens
- Factors that influence the impact of child sexual abuse
- Why does development matter
- Ensuring safety
- Rebuilding trust
- Building a healthy sexuality
- Addressing sexual recovery issues
- Reorienting the child towards normal developmental tasks and activities
- Preventing Re-victimisation
- Getting help for the child

ACTIVITY 2 *One stepper goal*

Resources- Flip charts, markers and index cards

Aim- to help caregivers set parenting goals and plan how they intend to meet them. Furthermore, this will help caregivers learn from each other's ideas.

- Participants will be asked to go around the room and write one thing they can do this week to further each of these goals.
- Discuss and brainstorm as a group so participants can learn from each other's ideas.
- Have each participant choose ONE step toward one goal and write it on an index card.
- Let participants know that they will continue to gain skills and knowledge in future sessions that will help them to reach these parenting goals.

SELF-CARE ACTIVITY- *Focusing on your strengths*

- In groups, the member will be asked to describe a difficult situation that they handled really well when they were growing up.
- Members will be asked to identify personal characteristics and support systems that helped them to deal with it successfully.

CHECK-OUT

AIM- To encourage the caregivers to take a parenting goal that they had written down on the index cards and put in efforts to meet those goals.

Share the one thing you chose to do this week to support your child's recovery and healthy development.

Session Five- *How abuse affects parents and siblings*

GOAL OF SESSION

To facilitate the family's healing process by helping parents understand and respond to the impact of abuse on siblings and partners.

CHECK-IN

Aside from the abused child, which family member do you worry about the most in terms of his or her reaction to what has happened

ACTIVITY 1- *Brother and Sisters*

AIM – To help caregivers understand and empathise with sibling's experience.

Resources: Poster Board with pictures of a variety of children and the heading "Brothers and Sister." Bring sticky notes and pens.

HAND-OUT- Parenting siblings

LEARNING AND DISCUSSION

The facilitator asks members to reflect on the activity. The facilitator will explain the entire family system is connected and that when one family member is in trouble or pain, the entire family is affected. The facilitator will further explain that family members can be a great source of support but they may also contribute to the stress that parent is feeling.

SELF-CARE ACTIVITY *Grown-up's day out*

Each member will be encouraged to take a few minutes to plan some pleasant time with another adult (couple/friend). The members will be instructed that the time should be designated as a "relaxation zone", with no discussion of the abuse allowed. Examples will include: watching television together, taking a walk together, having tea with a friend.

CHECK-OUT

What activity with your partner or friend have you decided on for this week?

Session Six -*Difficult child behaviours and parenting challenges*

GOAL OF SESSION

To identify common behavioural responses to sexual abuse, and to increase parents' skills in handling these behaviours appropriately.

CHECK-IN

How did your "Grown-ups' day out" last week go

ACTIVITY 1 *More or less*

AIM- To help caregivers identify the behaviours of their children that they would like to see more and less of. The facilitator will encourage the caregiver to be more specific when naming the behaviour. The examples that they provide will be used later in the session when we discuss how to encourage good behaviour.

Resources- two pieces of flip chart paper. One is labelled "more" and the other one "less." Marking pens.

LEARNING AND DISCUSSION

Impact of abuse on children:

- Fear-related behaviours
- Sleep Disturbances
- Moodiness, depression or irritability
- Sexual behaviour problem

The facilitator will describe the common behavioural reactions of children (tailoring the information to the age level of the children I am discussing. The facilitator will take care to let the caregivers know that some children show no behavioural changes. It will be further explained to the caregivers that some children deal with their feeling internally, or their coping skills may be effective in alleviating behavioural changes. Every child will handle the aftermath of abuse differently.

SELF-CARE ACTIVITY *Quality time with the family*

Resources-Paper and pencils

- Members are tasked with planning a fun family activity. The family activity can involve just the parent and the child who has been abused, other family members or the entire family.
- Members will then have to answer questions that will help them plan the family activity

CHECK-OUT

Members will be asked to share their plans for a fun family activity with the rest of the group.

Session seven -*Dealing with the outside world*

GOAL OF SESSION

To explore the various sources of stress and support in parents' lives and provide information to help parents navigate the systems that become involved following a disclosure.

CHECK-IN

What has been most challenging for you dealing with the "outside world?"

ACTIVITY 1 *Navigating systems*

AIM- To help caregivers prepare for and respond to the new changes and encourage the caregivers to think about ways in which they can empower their child by providing information and opportunities for input.

Resources

- Signs that say (school, child protective services and criminal justice system. The signs are taped around the room.
- Large envelope
- Index cards
- Pens

LEARNING AND DISCUSSION

The facilitator will discuss the questions generated from the activity regarding the different systems that the caregiver have had to interact and engage with, since disclosure of sexual abuse.

- Criminal Justice System
- Child Protective Services
- School
- Family and Friends

SELF-CARE ACTIVITY- *Life Savers*

Resources- A swimming ring

- Caregivers will be asked to write names of all of the people in their lives that they can turn to for help on their lifesavers
- If it is safe for the caregivers to take the lifesavers home, they will be encouraged to pull them out during times that they are feeling alone or need support.

ACTIVITY 2

AIM- to help caregivers synthesize all of the skills and information they have gained while also connecting with their children.

- Each caregiver will be asked to write a letter to his or her child.
- This is an opportunity to express the thoughts and feelings that they may have been unable or unprepared to express before
- The letter might include an apology, words of encouragement or hopes for the future.
- For the low literacy caregivers, the facilitator may suggest the option of recording a letter on their mobile phones.
- It is the caregiver's choice whether to give the letter to his or her child or share it with the group in the last session.

CHECK-OUT

Who has been the biggest source of support to you in recent weeks?

Session Eight- *Moving into the future*

GOAL OF SESSION

To provide closure for group participants and instil confidence and hope for the future of their families.

CHECK-IN

What are your feelings about this being our last session together?

LEARNING AND DISCUSSION

- Debrief with the group about the last session's homework. Members will be given time to share their letters with the group if they wish
- Discuss the difficult balance between caregivers' desire to protect their children and the need to let children have appropriate freedom and make mistakes
- Discuss the prevention of re-victimization on the context of resilience
- Discussion with caregivers about establishing healthy boundaries and how this is related to the prevention of re-victimization.
- Reviews any concerns caregivers may have about their ability to recognize potential abusers and protect their children

ACTIVITY 1 *Wall of wisdom*

Resources- Flip chart

AIM-Provide the caregivers an opportunity to use their experiences and knowledge to help other caregivers whose children have been abused.

The facilitator will encourage the members to think about words of encouragement or insights and information that they would like to pass on to other parents who were beginning their healing journey.

ACTIVITY 2- *Graduation*

Resources- Certificates

AIM- To commemorate the start of a new chapter. To help the members to recognise and honour their progress while being realistic that the work is on-going.

ACTIVITY 3 *Post-test and end-of-group evaluation*

Post-test:

- The same questionnaires that the group participants completed at the beginning of the group will be completed in this session so that the facilitator can show any change in response as a result of the group.
- The facilitator will explain to the group that the pre and post-tests are not about measuring the progress of participants; rather, they are measuring the helpfulness of the group.

End of Group Evaluation:

- If allows, the facilitator will wish to discuss participant's feedback in addition to giving them the written questionnaire

CHECK-OUT

What gives you hope for the future

EVALUATION

- Members will be asked to complete two post- self-report assessments, these are the same as the pre- self-report assessments that were completed in session one
- Member will also be asked to fill out an evaluation form regarding their experience of the group