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The Secondary Survivors of Trauma:
A Research Portfolio on the Experiences of Non-Offending
Caregivers Whose Children Have Disclosed Sexual Abuse

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May 2019

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Research Portfolio Abstract

Background: Non-offending caregivers (NOCs) of children who have disclosed sexual abuse have a vital role in supporting their child post-disclosure. Nevertheless, research indicates that NOCs experience clinically elevated levels of distress, which may impact their ability to support their child. Despite this, services have been found to often overlook the support needs of NOCs and there are gaps in the literature around NOCs' own experiences and distress post-disclosure. This research portfolio aimed to address these research gaps in two parts: 1) a systematic review investigating what key factors have been found to be associated with NOCs' psychological distress; and 2) a mixed-methods empirical paper exploring NOCs' post-disclosure experiences, with secondary aims to investigate their help-seeking experiences and the psychological construct 'mentalization' in this population.

Method: A systematic search of quantitative literature was conducted to identify papers exploring the association of key factors, such as psychosocial, environmental, personal, familial and abuse-related characteristics, with NOCs' psychological distress. An appraisal tool was used to assess the quality of the studies. The empirical paper adopted a predominantly qualitative mixed-methods design which primarily involved an in-depth exploration of the post-disclosure and help-seeking experiences of NOCs via interviews, with mentalization being measured via a questionnaire. Grounded theory was used to integrate these findings into a model illustrating the themes derived from the data.

Results: The systematic review indicated that psychological factors, such as cognitive processes, as well as social and environmental factors, such as social support, had the most evidence for being associated with distress. The evidence was weaker and the findings were more contradictory for the associations between other factors and psychological distress, including NOCs' abuse history, abuse-related factors, and child and parent characteristics. The empirical study's grounded theory model centred around core categories of NOCs' perceptions

of feeling out of control and isolated. These linked to other themes around the parental role, including parental self-efficacy, as well as the importance of feeling listened to and supported by the wider system, including services. Quantitative mentalization scores were linked with emotional expressiveness in interviews. Qualitative themes related to mentalization were indicated to be linked to NOCs' distress in the more immediate disclosure aftermath.

Conclusions: While tentative inferences can be made from the systematic review about the most important factors associated with NOCs' distress, methodological issues in the studies made it difficult to draw firm conclusions. For example, the predominantly cross-sectional nature of studies and their exploration of factors in isolation meant that a more in-depth understanding of interactional processes over time was not possible. The grounded theory model suggests that NOCs have complex multifaceted experiences post-disclosure, characterised by interacting processes linking to their distress. These are not fully accounted for in existing theories of secondary traumatization. Clinical and future research implications are discussed.

Research Portfolio Lay Summary

Background: Child sexual abuse (CSA) has been found to be associated with an increased likelihood of mental health difficulties in children. Parents or caregivers who did not perpetrate their child's abuse are often the main sources of support for their child after a disclosure. However, these caregivers have also been found to experience high levels of distress. There are gaps in our understanding of caregivers' real-life experience following a child's disclosure of CSA. A greater understanding of this could help to inform services about how best to support caregivers at this traumatic time.

This research: This thesis aimed to address some of these research gaps in two ways:

- 1) A systematic review of the existing literature exploring what factors are associated with psychological distress in caregivers of children who have disclosed CSA. Factors considered in the review included psychological, social and environmental factors, personal characteristics of the caregiver and child, as well as abuse-related characteristics.
- 2) A project investigating the lived-experiences of caregivers following their child's disclosure. Ten caregivers whose children were accessing child services for support with CSA participated in the study. They took part in an interview about their own experience after their child's disclosure, which included their experiences of services. They also completed a questionnaire measuring the psychological construct 'mentalization'. Mentalization is the capacity to recognize one's own mental states, as well as the mental states of others, including thoughts, feelings and intentions.

Main Findings: The systematic review found that psychological factors, such as negative thinking patterns, and social and environmental factors, such as poor social support, appeared to be the factors most associated with psychological distress. There was less consistent evidence for psychological distress being associated with factors such as demographic

characteristics of a parent or their child, abuse-related characteristics (e.g. abuse severity), or whether the caregiver had their own abuse history. However, the quality of studies in the review varied, which limited the reliability of conclusions.

The research project resulted in a detailed model to illustrate the many themes which came up from the interviews. The main aspects highlighted were feelings of isolation and lack of control. These experiences stemmed from and were made worse by factors such as self-blame and feeling inadequate in fulfilling the parenting role. The importance of feeling supported, listened to and understood by others, including professionals, was particularly emphasized. Caregiver mentalization scores may be linked to their current expression of emotions, with qualitative accounts of mentalization indicating that this factor may play a role in caregiver distress in the more immediate disclosure aftermath.

Conclusions: The systematic review findings have an underlying hopeful message, as the factors highlighted as having the most evidence for a relationship with psychological distress, such as social support, can be identified and changed through support and intervention. The findings can therefore help services to be aware of the areas to look out for and focus on when supporting caregivers. However, the review highlighted that higher quality research studies into the significance of different factors in predicting psychological distress are needed in the future.

The research project provides a model indicating the complexity of caregivers' experiences. It shows how different factors interact and contribute to their distress. This can be used by professionals to understand the multi-layered post-disclosure experiences of caregivers. It also indicates areas to target in interventions, such as empowering individuals in their role as a parent or building a caregiver's support network. Further research exploring these factors is recommended in the future in order to continue to develop and evaluate service delivery for these caregivers.

Journal Article 1: Systematic Review**Factors Associated with the Psychological Wellbeing of Non-Offending Caregivers
Whose Children Have Disclosed Sexual Abuse: A Systematic Review**

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The journal's guidance for authors can be found in Appendix A.

Abstract

Background: Non-offending caregivers (NOCs) of sexually abused children have been found to experience clinically significant distress. However, as distress levels vary across this population, this review explored what key factors are associated with NOCs' psychological wellbeing.

Methods: A systematic review of quantitative literature was conducted using online databases. Reference lists were also searched for relevant papers. A quality assessment tool was used to assess the relative strengths and weaknesses of the studies.

Results: Psychological factors, such as rumination, as well as social and environmental factors, such as social support, appeared to have the most evidence for being associated with psychological distress. The evidence was weaker and the findings were more contradictory for the associations between other factors and psychological distress, including NOCs' abuse history, abuse-related factors, as well as child and parent characteristics.

Discussion: Studies were significantly limited by methodological issues, such as population heterogeneity, sampling bias and reliance on cross-sectional methods. These are likely to have contributed to the variability in findings and limit the possibility of drawing firm conclusions as to the most important factors. Tentative inferences can be made around factors which may be relevant in clinical contexts. These implications and recommendations for future research are discussed.

Keywords: *child sexual abuse; non-offending caregiver; parent mental health; parent wellbeing.*

Factors Associated with the Psychological Wellbeing of Non-Offending Caregivers Whose Children Have Disclosed Sexual Abuse: A Systematic Review

Child sexual abuse (CSA) is being increasingly recognised as a prominent public health concern, with the World Health Organisation (WHO; 2016) documenting that 1 in 5 women and 1 in 13 men report having been sexually abused as a child. Furthermore, Barth et al's, (2013) detailed systematic review and meta-analysis identifies the rate of CSA as ranging between 8-31% for girls and 3-17% for boys. CSA is broadly defined as any sexual activity perpetrated against a child, including (but not exclusively): inappropriate touching, inviting a child to touch the perpetrator sexually, rape, exhibitionism, and involving a child in pornography or prostitution (Collin-Vézina, Daigneault, & Hébert, 2013). The negative impact of CSA on the survivor has been widely investigated, demonstrating that these experiences can be associated with a range of significant short and long term mental health difficulties and risk behaviours (Maniglio, 2009). Examples of this include Post Traumatic Stress Disorder (PTSD), depression, anxiety, dissociation, self-esteem and self-concept impairment, self-harm, suicidality, substance misuse and interpersonal problems.

Non-offending Caregivers

Research has also started to explore the impact of a child's disclosure of CSA on their non-offending caregivers (NOCs). In the context of this paper, NOCs are defined as caregivers who did not perpetrate the sexual abuse of their child. A NOC can be any individual who had a key caring role for the child, and thus can include biological parents, step-parents, grandparents, adoptive parents, kinship carers, and foster carers. Previous reviews in this area have focused predominantly on how NOCs respond to their child's disclosure (for example, whether they believe their child or have an ambivalent response), what contextual factors play a role in their response and support to their child, how parental support links to the child's outcomes (Bolen & Gergely, 2014; Elliott & Carnes, 2001; Knott & Fabre, 2014), as well as outcomes for

treatment interventions involving NOCs (Van Toledo & Seymour, 2013). However, there has been less focus on understanding the broader experiences of NOCs following their child's disclosure, beyond their response or support towards their child and how this may link with the child's outcomes.

Research has shown NOCs to have a range of complex and challenging experiences post-disclosure. For example, in addition to finding out about their child's CSA, they can experience subsequent and ongoing stressors, such as a breakdown in economic stability and family relationships (Van Toledo & Seymour, 2013), as well as being involved in court proceedings (Dyb, Holen, Steinberg, Rodriguez, & Pynoos, 2003) and the child's medical examinations (Rheingold, Davidson, Resnick, Self-Brown, & Danielson, 2013). As NOCs are often expected to be the main support for their child following disclosure, it is pertinent to strive to more fully understand NOCs' own experiences and support needs during this challenging time.

Psychological Distress in Non-offending Caregivers

Over the past three decades, research has attempted to broaden our understanding of NOCs' psychological wellbeing and distress, with substantial evidence that NOCs have clinically elevated levels of psychological distress compared to the general population. Elliott & Carnes' (2001) review highlights that NOCs experienced clinically heightened levels of PTSD symptoms, depression, anxiety and general psychological distress. Subsequent papers further support this by also highlighting elevated symptoms of depression (Santa-Sosa, Steer, Deblinger, & Runyon, 2013), anxiety (Kim, Noll, Putnam, & Trickett, 2007) and PTSD, particularly intrusive thoughts (Dyb, Holen, Steinberg, Rodriguez, & Pynoos, 2003). Due to the cross-sectional nature of many of the studies, and a lack of an assessment of pre-disclosure functioning, it is not possible to decipher whether the increased distress is a direct result of the child's disclosure. Nevertheless, the evidence is clear that this population is significantly more psychologically distressed than the normal population, and thus require effective support

alongside their child. Despite this, qualitative investigations into the impact of CSA disclosure on NOCs indicate that interventions from services often focus solely on child survivors and legal procedures regarding the judgement of the perpetrator, rather than the needs of carers (Kilroy, Egan, Maliszewska, & Sarma, 2014).

Studies have also found great heterogeneity in the NOC population with regard to their distress levels following a child's disclosure. For example, Kim, Noll, Putnam, & Trickett's (2007) found a range of depression symptom severity. Furthermore, not all caregivers have been found to experience clinical levels of distress (Wagner, 1991). It is thus pertinent to explore what risk or protective factors are associated with NOCs level of distress, in order to have a more comprehensive understanding of the intricacies of their experiences post-disclosure. This would assist professionals in being able to identify more at-risk NOCs in order to provide appropriate support. Having an understanding of NOCs' psychological distress and what factors may be associated with this is additionally important as there is evidence that different types of psychological distress, such as elevated depression symptoms, are associated with more inconsistent parenting behaviour and poorer monitoring/supervision of their child (Santa-Sosa et al., 2013). It is therefore beneficial for both parent and child outcomes to investigate the psychological wellbeing of NOCs.

The Present Study

Despite the importance of understanding the factors which may be associated with psychological wellbeing in NOCs, to our knowledge, there have not been any published attempts to systematically review and provide a narrative synthesis of risk or protective factors associated with psychological distress in this population. This paper therefore aimed to systematically review the quantitative literature to answer the research question: *What factors are associated with the psychological wellbeing of non-offending caregivers of child survivors of sexual abuse?* This was specifically focusing on psychosocial, environmental, personal,

familial, and abuse-related factors. This range of factors is based on similar reviews looking at the association between various factors and mental health presentations in other populations (Evans, Hawton, & Rodham, 2004). It is also informed by the common approach in reviews of factors associated with PTSD symptoms, where factors are conceptualised as pre-, peri- and post-trauma factors (National Collaborating Centre for Mental Health, 2005). The review therefore attempts to cover a similar range of factors, whilst ensuring that these are appropriate for the NOC population. The psychological wellbeing variable aimed to focus on measures related to any facets of psychological wellbeing, distress or mental health difficulties. Specific examples include assessments of symptoms of general distress, depression, anxiety or PTSD.

The purpose of the review was to provide a more comprehensive understanding of the variety of factors potentially associated with NOCs' psychological wellbeing and distress, about which there is currently a gap in the literature. This would be with the aim of contributing to the clinical assessment of NOCs when attending for services with their children, as well as informing interventions which may wish to target specific risk or protective factors.

Methods

Literature Search Strategy

The approach to the systematic literature search was informed by the Centre for Reviews and Dissemination (CRD; 2009) guidelines. An initial scoping search was conducted to ensure no existing systematic review had been already undertaken on the topic. In line with best practice, a protocol was submitted to PROSPERO for transparency and to reduce the chance of replication of the review (see Appendix B).

The search was conducted with relevant online databases in January 2019. The databases searched in this review were: OVID (*EMBASE, PsychINFO, MEDLINE, and MEDLINE: daily update*) and ASSIA (*Applied Social Sciences Index and Abstracts*). The search terms were

utilised across databases relating to the parents included (non-offend* OR nonoffend* OR “non offend*” OR non-perpetrat* OR nonperpetrat* OR “non perpetrat*” OR non-abus* OR nonabuse* OR “non abuse”) with (parent* OR carer* OR caregiver* OR mother* OR father* OR maternal OR paternal). These were combined with search time relating to the child’s experience of CSA which included (child* OR adolescent* OR infant*) with (sex*) and (trauma* OR abuse* OR ptsd OR “post traumatic stress*” OR. “post-traumatic stress*”). The truncation [*] was applied, along with the range of terms for NOCs seen in the literature, to maximise sensitivity of the search. The search terms were kept broad to reduce the likelihood of relevant papers being missed (CRD, 2009).

Due to the unfeasibility of translation, only publications in English were included. There were no limits set around the date of publication. Following the removal of duplicates, inclusion and exclusion criteria were initially applied to titles and abstracts, and then to the identified full texts for final selection. Reference lists of the full-text articles were additionally reviewed for further relevant articles. Data was systematically extracted from papers and a quality appraisal tool was applied. Meta-analysis of the findings was not feasible due to the heterogeneity of studies, particularly in terms of the variability in outcome measures. Thus, evaluation of findings was conducted through a narrative synthesis (Petticrew & Roberts, 2006).

Inclusion and Exclusion Criteria

The inclusion criteria for the review were that the article: a) had a sample of NOCs whose children were aged <18 years and were survivors of CSA; b) included a formalised assessment of psychosocial, environmental, personal, familial, and abuse-related factors as an independent variable (either a standardized measure or via questionnaire or interview where appropriate, for example, for demographic information); c) included a standardized assessment of concepts related psychological distress or wellbeing as a dependant variable; d)

had data presented and extractable on the association between relevant factors and psychological distress measurement; e) was an epidemiological population-based study with cross-sectional, prospective or longitudinal designs; f) used quantitative methodology with statistical analysis including regression, mediation, moderation, group comparison, and statistical modelling analysis. Exclusion criteria were: a) previous review papers; b) case studies; c) treatment studies; d) book chapters; e) grey material; f) papers only using correlation analysis; g) qualitative methodology.

The exclusion criteria of studies which solely used simple correlation analysis was applied with the aim to enhance the robustness of the review's results with regards to which factors were associated with and predictive of distress levels. This allowed the focus to be on exploring predictors and risk factors, moving away from simple correlates, which are not able to be used to draw firm conclusions around predictors (Murray, Farrington, & Eisner, 2009). The review also only included quantitative methodology due to there being a recent review of qualitative and mixed-method studies within this field (Serin, 2018). It was viewed that an investigation into the quantitative literature would thus address a gap with regards to systematic reviews in the research area, as well as allow a more robust exploration of empirically measured levels of distress and statistically analysed associations with different factors.

Data Extraction

The process of extracting data from the selected papers was undertaken using a form designed for this study, informed by CRD's (2009) and PRISMA (Moher et al., 2009) guidelines. This involved the following variables being extracted: a) study design; b) study aims/objectives; c) inclusion and exclusion criteria; d) sample size; e) participants' key demographic variables; f) key demographic variables pertaining to the children of the participants; g) abuse-related characteristics, including type and perpetrator; h) data analysis

procedure; i) relevant factor measure/assessment; j) measure of psychological distress/wellbeing; k) main findings.

Quality Appraisal

An assessment of the quality of the studies was conducted with an adapted version of the AXIS quality appraisal tool for cross-sectional studies (Downes, Brennan, Williams, & Dean, 2016). The bespoke checklist was informed by the Agency for Healthcare Research Quality (AHRQ)'s guidance on quality appraisal, with additional relevant items added from the AHRQ methodology checklist and irrelevant items removed from the AXIS scale, to ensure a comprehensive tool was applied (West et al., 2002). Both the AXIS and AHRQ items focus on methodological quality of papers. This resulted in application of a bespoke 13-item quality appraisal tool (see Table 1). The National Institute for Health and Care Excellence (NICE, 2012) scoring scale for quality informed the scoring of this checklist, with each domain being rated as 2 (yes), 1 (partial), 0 (no), or NA (not applicable). A second rater was given a randomised sample of 5 papers to co-rate using the quality appraisal tool to assist with increasing reliability and reducing bias in the quality rating process. These ratings were concurrent in 90.2% of cases and any incongruencies were discussed and decided upon.

Table 1

Bespoke quality assessment tool.

1	Were the aims/objectives of the study clear?
2	Was the study design appropriate for the stated aim(s)?
3	Was the sample size justified?
4	Was the target/reference population clearly defined? (Is it clear who the research was about?)
5	Were inclusion and exclusion criteria for being in the study appropriate, prespecified and applied uniformly to all participants?
6	Was the sample adequately described?
7	Was the selection process likely to select subjects/participants that were representative of the target/reference population under investigation?
8	Were the factor variables measured correctly using formalised instruments/measurements where appropriate?
9	Were the psychological wellbeing outcome variables measured correctly using valid and reliable instruments/measurements?
10	Were analysis methods appropriate?
11	Were the data adequately described?
12	Are potential non-response / drop out bias identified and taken into account?
13	Were the results internally valid? (i.e. are any potential bias/confounding variables taken into account?)

Results

Selection of Studies

As detailed in Figure 1, database searches identified 2153 potentially relevant studies to the review, with 1521 papers remaining after duplicates were removed. A further 1479 records were excluded following the above inclusion and exclusion criteria being applied to the titles and abstracts, leaving 42 full-texts to be reviewed for eligibility. A further 6 papers were identified through reviews of the reference lists. At this stage, 27 studies were excluded, to leave 21 relevant papers to be included in the final review.

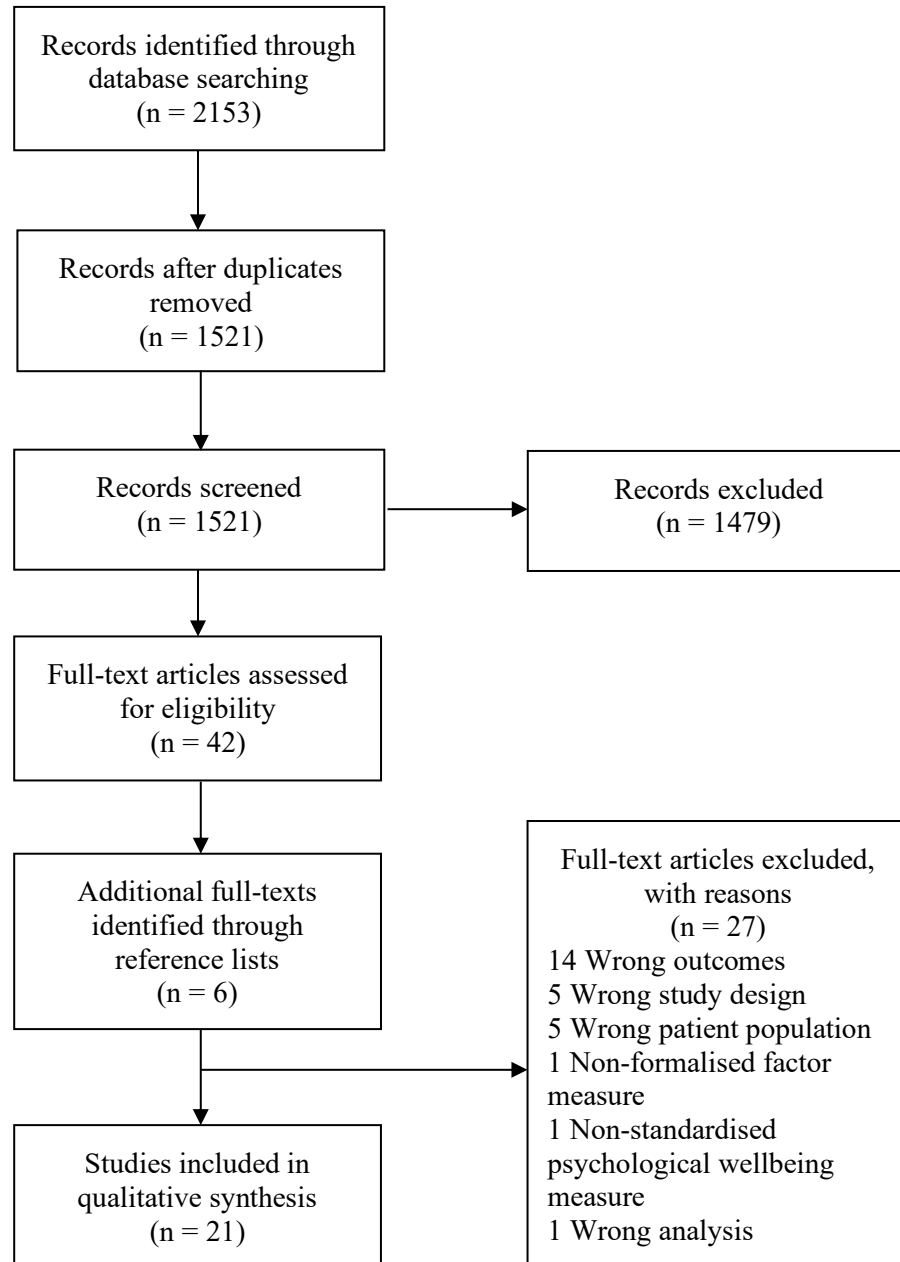


Figure 1. PRISMA Flow chart of study selection (Moher et al., 2009).

Characteristics of Studies

Studies were predominantly conducted in the United States, with six based in Canada (Cyr et al., 2016; Cyr et al., 2018; Manion et al., 1998; Manion et al., 1996; Hébert, Daigneault, Collin-Vézina, & Cyr, 2007; Hiebert-Murphy, 1998), one in Australia (Mcgillivray et al., 2018), and one in The Netherlands (van Delft, 2016). The majority of the studies employed a

cross-sectional design, aside from three taking a more longitudinal approach (Cyr et al., 2018; Manion et al., 1998; Newberger, et al., 1993). The 21 studies incorporated data from 17 different cohorts of NOCs. Kim, Noll, Putnam, & Trickett (2007) and Kim, Trickett, & Putnam, (2011) both analysed data taken from the cohort from Putnam & Trickett's (1987) long-term study, and Deblinger et al. (1993) and Deblinger et al. (1994) also shared a sample. Due to being longitudinal follow-up studies, Cyr et al. (2016) and Cyr et al. (2018) additionally used the same cohort, as did Manion et al. (1996) and Manion et al. (1998). To the best of our knowledge, all other studies used independent cohorts in their analysis. A full summary of study characteristics can be found in the Systematic Review Appendix.

Sample Population

The total number of NOCs across all studies was 1544, with sample sizes ranging from 28 to 183 participants. The ages of the NOCs ranged from 18 to 60 years, based on the studies which reported these details. All studies had a majority Caucasian sample, with some studies having a smaller demographic of black, Hispanic and other ethnic minority groups. Samples were recruited from a range of healthcare, social care, and third sector organisations, the majority of which specialised in CSA. These included community services, outpatient clinics, children's hospitals, child protection agencies, child advocacy services, school-base clinics, emergency departments, and treatment centres. Seven studies used mixed gender samples, with the remainder focusing solely on mothers. Some studies included a wide range of caregivers including step-parents, grandparents or adoptive parents (Cyr et al., 2016, Cyr et al., 2018; Lewin & Bergin, 2001; Newberger, et al., 1993), while other papers restricted selection criteria to just biological parents, such as Deblinger, Stauffer, & Landsberg, (1994). The age of the NOCs' children who had experienced CSA in the studies varied, with an overall age range of 6 months to 17 years. Based on the studies which reported these demographics, eight studies included children across childhood and adolescence, four studies only went up to early

adolescence (<13 years) and one study focused on infants (<48 months). Type of CSA also varied across studies, with some including only contact sexual abuse, whereas others encompassed a wider range of CSA, such as non-contact (Runyon, Spandorfer, & Schroeder, 2014) and threats (Baril, Tourigny, Paille, & Pauze, 2016; Plummer, 2008).

Measures of Psychological Wellbeing

A range of constructs associated with psychological wellbeing and distress were measured across the studies. The majority of tools used were self-report questionnaires, with a minority of cases using clinical interviews or reports from clinicians. As can be seen in the Study Characteristics Table (see Systematic Review Appendix), the outcome of self-reported general or global psychological distress was one of the most common across studies. The most prevalent scales used to measure this were the Symptom Checklist-90 (SCL-90), its shortened version (Brief Symptom Inventory; BSI) and its General Severity Index (GSI) subscale. Other measures of distress included the General Health Questionnaire (GHQ), Depression, Anxiety and Stress Scale (DASS-21), as well as two similar French measures (Baril et al., 2016; Hébert, Daigneault, Collin-Vézina, & Cyr, 2007). PTSD or Post-Traumatic Stress (PTS) Symptoms were also prevalent outcomes, measured predominantly via the Impact of Events Scale (IES), but also through the Modified PTS Symptom Scale Self-Report (MPSS-SR), the Diagnostic and Statistical Manual of Mental Disorders (DSM) clinical interview, SCL-90 PTSD subtest, and the Purdue Post-Traumatic Stress Disorder-Revised (PPTD-R). Some studies focused specifically on outcomes of anxiety (using the State-Trait Anxiety Inventory; STAI) or depression, measured via the Beck Depression Inventory (BDI) or the Positive and Negative Affect Schedule's (PANAS) negative affect subscale. One study focused specifically on the outcome of dissociation via the Dissociation Experiences Scale (DES; Kim et al., 2007), while another measured externalised anger using the Response Styles Questionnaire (Plummer, 2008).

Factors Associated with Psychological Wellbeing

The review highlighted six main categories of factors focused on in the 21 studies: 1) psychological factors; 2) social and environmental factors; 3) caregiver abuse history; 4) abuse-related factors; 5) caregiver characteristics; and 6) child characteristics.

Psychological factors. Nine of the studies focused on a range of NOC psychological factors which were associated with their measures of wellbeing. Psychological factors which yielded a significant association were resilience, self-compassion, positive reappraisal, rumination, empowerment, avoidant coping, parenting satisfaction, abuse-specific cognitions, locus of control, disgust sensitivity and attachment.

Mcgillivray, Pidgeon, Ronken, & Credland-Ballantyne (2018) found small to medium effect sizes for resilience and self-compassion as negative predictors, and, unexpectedly, positive reappraisal as a positive predictor, of psychological distress in mothers. They found significantly more psychological distress in groups of low-resilience mothers compared to high resilience, however also revealed self-compassion and positive appraisal as significant mediators of the relationship between resilience and psychological distress, with small effect sizes.

Plummer (2008) found increased rumination to be the only significant contributor to explained variance of distress scores, over abuse severity and mother's CSA history, in predicting both externalizing anger and negative affect. Lower empowerment was also found to significantly predict higher psychological distress in Hébert et al.'s (2007) study. Increased use of avoidant coping strategies (Hébert et al., 2007; Hiebert-Murphy, 1998) and decreased satisfaction in the parenting role (Manion et al., 1998; Manion et al., 1996) were furthermore found to be significantly associated with maternal distress. Poor parenting satisfaction was indicated to be predictive of distress when assessed at 3 months following disclosure but not at the 12-month follow-up time point (Manion et al., 1998).

Runyon, Spandorfer, & Schroeder's (2014) study indicated that abuse-specific cognitions (for example, feeling that their child's life is ruined by the abuse), were significant predictors of depression but not PTS symptoms, even after controlling for general attributional style within a hierarchical multiple regression model. Other psychological factors have in contrast been found to significantly predict PTS symptoms, such as Dyb et al. (2003) suggesting that external locus of control was a significant predictor (small-medium effect size) of intrusion and avoidance symptoms. Additionally, higher sexual disgust sensitivity was positively associated with PTS symptoms, whereas moral and pathogen disgust sensitivity were not related to outcomes (van Delft et al., 2016). However, this relationship was only present when the perpetrator was unrelated to the child.

Kim et al.'s (2011) study explored attachment style (secure, avoidant and anxious), as well as attachment representations of parents and peers, in a sample of NOCs and comparison mothers (i.e. whose child had not experienced CSA). Attachment representations of parents and peers were measured using the Inventory of Parent and Peer Attachment (IPPA), which obtains information about a mother, father and past close peer relationship in terms of mutual trust, communication and alienation. A small-medium effect size was found in the hierarchical regressions showing attachment security and peer attachment representations predicting trait anxiety scores. There was a significant interaction relationship between child CSA and peer attachment representations, with parents of children with CSA only having significantly higher anxiety than parents whose children were not abused, when they had low attachment representations of peers. Parent attachment representations as measured on the IPPA, however, were not found to be a significant predictor when considered in a hierarchical multiple regression analysis.

The range of psychological factors explored, with many studies focusing on only a few variables, makes it difficult to draw firm conclusions about which psychological factors may

be most significant in NOCs' distress. Furthermore, the variety of dependant variable measures employed across studies does not facilitate direct comparisons between studies, thus limiting conclusions about what aspects of wellbeing are associated with which independent variables.

Social and environmental factors. In five studies the role of social support in caregivers' outcomes was explored. The majority of studies investigating this variable found a small effect size in its contribution to the prediction of maternal psychological distress (Hiebert-Murphy, 1998; Manion et al., 1998; Manion et al., 1996; McGillivray, Pidgeon, Ronken, & Credland-Ballantyne, 2018). In contrast, Dyb et al.'s (2003) study failed to find an association between perceived social support and PTS symptoms. Half the studies used standardised measures of self-report (Hiebert-Murphy, 1998; McGillivray, et al, 2018; Dyb et al. 2003) while the remaining papers gathered this information through the authors' own interviews and coding for this construct. Related variables included perceived aloneness in facing a crisis, which was ascertained through a structured interview developed for the study, and was found to have a small effect size in predicting maternal distress (Deblinger, Hathaway, Lippmann, & Steer, 1993). However, family functioning as measured by the Family Adaptability and Cohesion Evaluation Scales (FACES-III) standardized assessment was not found to be associated with maternal distress (Manion et al., 1998; Manion et al., 1996)

Five studies also investigated the impact of life stressors or secondary stressful events related to the abuse. Life stressors in the past year were found to predict psychological distress (Cyr et al., 2016), with Cyr et al. (2018) finding that intensity of overall distress increased according to the level of stress from life events. Plummer, (2008) also found life stressors correlated with externalizing anger and negative affect, however this relationship was mediated by rumination. These three studies measured life stressors using standardized questionnaires. Dyb et al. (2003) found that secondary life changes as a result of disclosure, such as change of residence, contributed significantly to the prediction of avoidance and intrusion PTS

symptoms, with a small-medium effect size. The authors further investigated the impact of stressful events specifically related to the abuse. Of these, police interviews and media exposure were not related to PTS symptoms. Having a child testifying in court was significantly correlated with symptoms, although multiple regression analysis did not show a predictive relationship. This was incongruent with Burgess, Hartman, Kelley, Grant, & Gray's (1990) earlier finding that global distress and PTS symptoms were higher in mothers whose child testified in court, compared to those whose children did not testify. Both Dyb et al (2003) and Burgess et al (1990) elicited these variables from interviews and questionnaires developed for their studies.

Caregiver's abuse history. Abuse history of caregivers was one of the most frequently investigated factors, with 12 studies reporting on its impact on NOC psychological distress. This variable also produced the most mixed findings across studies: half these papers found an association between caregiver abuse history and NOC wellbeing, but the other six studies failed to find a relationship. Three studies found that non-offending mothers with CSA histories demonstrated significantly higher levels of global distress than non-offending mothers without an abuse history (Deblinger, Stauffer, & Landsberg, 1994; Hiebert-Murphy, 1998; Timmons-Mitchell, Chandler-Holtz, & Semple, 1998), with Timmons-Mitchell et al. (1998) also finding a difference in PTS symptoms. Hiebert-Murphy's (1998) multiple regression analysis found that maternal sexual abuse as a child and adolescent significantly contributed to the prediction of emotional distress, in a sample of 102 mothers of whom 74% had experienced this form of sexual abuse. In contrast, Deblinger, Hathaway, Lippmann, & Steer (1993) indicated no correlations for maternal CSA. However, they found a small effect size when investigating whether NOCs experiencing sexual assault as an adult predicted general distress, in a sample (n=99) where 22.2% of NOCs reported to have experienced sexual assault as an adult. This factor was found to contribute significantly to the variance of distress scores in a stepwise

multiple regression model. Other studies also found additional abuse experiences to be predictive of outcomes. For example, Hébert et al. (2007) found both history of CSA and victimisation from a partner to be predictive of psychological distress. Furthermore, Cyr et al. (2018) indicated that intensity of distress increased depending on the extent to which a NOC had experienced historical sexual, physical, emotional abuse and neglect.

Conversely, Deblinger et al. (1993) did not find correlations between NOCs' general distress and physical abuse as a child or domestic violence. Other studies failed to find a significant difference between groups of mothers with and without a history of sexual, physical and emotional abuse in terms of depression and dissociation (Kim, et al, 2007), as well as anxiety (Kim, et al, 2007; Kim et al., 2011). Lewin & Bergin, (2001) additionally found no difference for anxiety and depression scores between groups of mothers with and without abuse histories. Parental CSA was further found not to be predictive of PTS symptoms (van Delft et al., 2016) and maternal sexual, physical and emotional abuse and neglect were not predictive of either PTS symptoms or general distress (Cyr et al., 2016; Deblinger et al., 1993). The association between maternal CSA and negative affect or externalising anger was also not found to be significant following application of a regression model (Plummer, 2008).

There may be a number of explanations for these mixed findings. Firstly, there are indications that other factors may be interacting with NOC abuse history and distress. For instance, when other factors were added into statistical models, NOC abuse history was rendered non-significant in predicting distress, such as rumination remaining significant in Plummer's (2008) regression model when NOC history of abuse did not. A number of methodological issues in these papers looking at NOC history of abuse also need to be considered when interpreting their results, as there was significant variation in how NOCs' abuse history was characterised and measured. The papers varied in what constituted abuse, with some focusing on CSA, others broadening out to other experience of childhood

maltreatment, such as physical or emotional abuse. Some also considered maltreatment in adulthood (Hébert et al., 2007). A further issue was the lack of standardisation across studies in the way NOCs' own history of abuse was measured. It is therefore challenging to reliably derive which types of maltreatment may be associated with the authors definition of abuse, which may explain why some studies found an association with wellbeing and others did not.

Abuse-related factors. Twelve studies in the review focused on the role of the child's abuse-related factors in NOCs' distress. Some papers explored the effect of whether the abuse was extra- or intra-familial, which again produced inconclusive findings. The perpetrator's identity and relationship with the NOC was found to predict psychological distress, with increased distress occurring in intra-familial abuse in Hébert et al.'s (2007) study. However, Van Delft et al. (2016) revealed that the relationship between disgust sensitivity and PTS symptoms was only present when the abuse was extrafamilial. Other studies failed to find any relationship, with Deblinger et al. (1993) finding no difference in distress between groups of mothers classified according to perpetrator identity. Furthermore, perpetrator identity was not found to be significantly associated with negative affect and externalizing anger (Plummer, 2008) or PTS symptoms and psychological distress (Cyr et al., 2016; Cyr et al., 2018; Manion et al., 1998; Manion et al., 1996).

Specific characteristics of the child's abuse were also explored. Kelley (1990) found parents of ritualistically ("cult worship"-related) abused children to have higher levels of psychological distress than those of non-ritualistically abused. Additionally, one paper found severity of abuse to significantly predict intrusion PTS symptoms, but not avoidance symptoms (Dyb et al., 2003). The use of force and severity of abuse was found to be correlated to NOC distress in Newberger et al.'s (1993) study, however the association was not explored further through more sophisticated analysis. The majority of other studies, in contrast, did not find type of abuse to be significantly predictive of outcomes. For example, abuse severity was not

associated with negative affect and externalizing anger (Plummer, 2008), just general distress (Hébert et al., 2007), or both distress and PTSD symptoms (Cyr et al., 2016; Cyr et al., 2018; Manion et al., 1998; Manion et al., 1996). Duration (Hébert et al.'s, 2007) and frequency (Cyr et al., 2016; Cyr et al., 2018) of abuse were also not found to be related to outcomes.

Another abuse-related factor investigated was time since disclosure. Multiple time-point longitudinal studies revealed a decrease in NOCs' distress over time. Cyr et al., (2018) found that mothers', but not fathers', general distress was found to significantly reduced between 12- and 18-months post-disclosure. However, 34.4% of mothers and 28.1% fathers still had clinical levels of distress at follow-up. The authors also found a significant reduction in PTS symptoms for both mothers and fathers between these time points, yet 10.2% of mothers still reached the clinical threshold for symptoms at 18-months.

In further support, Newberger, Gremy, Wateraux, & Newberger's (1993) study indicated a significant improvement in mothers' general distress between the initial research meeting and 12-month follow-up. However, the authors still found that the anxiety subscale was significantly higher than normal at follow-up, as well as one third of mothers still having clinically significant symptoms. The mothers' overall decline in distress scores was associated with the time their child spent in therapy but not the number of weeks of contacts they received for therapy themselves. However, these were simple correlational findings and were not explored using more sophisticated statistical methods. Similarly, Manion et al. (1998) found a significant decrease in mothers' general distress and PTSD symptoms between 3- and 12-month post-disclosure time-points and with global distress scores at the 3-month time-point being found to predict the level of global distress at 12-months. Again, there was still a proportion of mothers experiencing significant distress at follow-up, with 38% having global emotional functioning scores that fell within the clinical range. In contrast to the majority of

findings, Hiebert-Murphy's (1998) cross-sectional study found no correlation between NOC distress and time since disclosure.

Caregiver characteristics. Six studies of three cohorts looked specifically at the role of caregiver gender on wellbeing. Mothers were generally found to have significantly higher levels of psychological distress and PTS symptoms when compared to fathers (Cyr et al., 2016; Cyr et al., 2018; Manion et al., 1998; Manion et al., 1996), with gender being predictive of PTS symptoms (Cyr et al., 2016). The exception to this was Kelley's (1990) study revealing fathers to have significantly higher distress than mothers. The significance of NOCs' gender was not supported in all cases however, with Dyb et al., (2003) not finding any difference in distress or PTS symptoms between mothers and fathers.

As well as exploring gender, studies found that higher family income significantly predicted higher PTS symptoms in Cyr et al.'s (2016) study but not in Cyr et al.'s (2018) follow-up. Furthermore, socioeconomic status (Newberger et al., 1993) was correlated with psychological distress, however the analysis needed to understand these associations in more depth, such as applying regression models, was not undertaken. In other studies, income and education (Plummer, 2008; Deblinger et al., 1993), as well as employment status (Runyon et al., 2014; Deblinger et al., 1993) were not associated with mental health measures. Ethnicity has also not been found to be associated with negative affect and externalized anger (Plummer, 2008), global distress (Newberger et al., 1993), depression and PTS symptoms (Runyon et al., 2014), or general distress (Deblinger et al., 1993). Finally, age was not associated with distress (Newberger, et al., 1993), depression or PTS (Runyon et al., 2014).

Child characteristics. This final category of factors was the least prevalent across studies, with minimal associations found between the characteristics of child and NOC's distress. For example, the parent-reported behaviour of the child (Manion et al., 1996), as well as the child's gender (Cyr et al., 2016; Cyr et al., 2018), were not found to be predictive of maternal general

distress or PTS symptoms. In contrast, Manion et al., (1998) found that parent-reported internalizing behaviour of their child was predictive of parental emotional functioning at 12-month follow-up but not the initial 3-month time-point. Correlation analysis in other studies indicated that the child's symptomology and gender (Newberger et al., 1993) were associated with distress, however this relationship was not explored with any further sophisticated statistical analysis, as had been applied in other papers.

Study Quality

The quality appraisal tool ratings are detailed in Table 2, highlighting the relative weaknesses and strengths of the 21 studies. Overall, the aims of the studies were clearly outlined and the chosen designs seemed appropriate for their aims. In general, the data were adequately described and analysis procedures were also appropriate. In some cases, however, statistical tests were limited and did not take account of potential bias such as multiple comparisons (Kelley, 1990; Timmons-Mitchell et al., 1998). Papers also did not always sufficiently report test statistics of their analysis outcomes, such as regression steps (Dyb et al., 2003), non-significant results (Cyr, Frappier, Hébert, et al., 2018), or effect sizes.

The most prominent methodological issue across studies was the justification of sample size as none of the papers in the review provided power calculations. The generally small sample sizes across studies indicate that this may not have been fully considered by authors. This means that it is not possible to assess whether samples were sufficiently powered to detect a result, which could have impacted the reliability of their findings, potentially limiting the credibility of claims made in the studies. This is of particular importance in studies which explore multiple comparisons (Vanvoorhis & Morgan, 2007). For example, Dyb's (2003) study exploring multiple demographic, psychosocial and abuse related-factors with a sample size of 39 did not include a power calculation evidencing that this sample is sufficient to account for the multiple variables. In this respect the study did not appear to adhere to

conventions around sample size and power for multiple regression analyses (Vanvoorhis & Morgan, 2007), which may have meant that there was insufficient power to detect a result, or that reportedly significant results may have been due to type 1 error.

Another issue generally pervasive across the papers was a failure to fully and explicitly define the target population in the study. Although studies described their focus on NOCs, they did not go on to define what specific population of NOCs their research was aiming to represent, for example, whether it was the entirety of the NOC population, those whose child had experienced intra- or extra-familial abuse, or just those accessing services. Linked to this, studies varied in amount of detail regarding inclusion and exclusion criteria for the study. The participant selection process was also a notable problem across all papers. Although the majority of studies used standardised procedures, they all employed non-randomised and opportunity sampling, with the exception of Baril et al. (2016), which was the only study to apply randomised sampling methods. Over half of the studies adequately described their sample, including parent, child, and abuse-related characteristics. However, the remainder failed to report some important sample variables such as child age or gender (Deblinger et al., 1994; Hiebert-Murphy, 1998; McGillivray et al., 2018; Timmons-Mitchell et al., 1998) or parent ethnicity, which was not reported in ten studies. Many studies also did not specify details of the child's abuse (Deblinger et al., 1994; Timmons-Mitchell et al., 1998), such as the type of abuse, the perpetrator, or whether they had experienced any other abuse or maltreatment. All these issues mean that generalisation to the overall NOC population is limited. They may also explain why there were such contradictory findings with regards to some factors, since these variables were not always considered in the analysis of results.

The measures used to collect the psychological distress levels in NOCs were a strength across the studies reviewed, as reliable and validated measures for this population were used in all the studies. The methods used to gather details on different factors were more variable,

albeit generally of good quality. Psychological factors were all measured using validated and reliable questionnaires producing continuous scores. Caregiver and child characteristics were appropriately gathered via demographic interviews or questionnaires. Collecting details on NOC's own history of maltreatment and abuse was varied. The majority of studies did not employ available standardised measures for this. Instead they used dichotomous codes to record whether a caregiver had experienced a form of abuse, taking the information from data collected via their own developed questionnaires or through adapting existing interviews. In many studies it was also not specified what parameters the authors were using to define the abuse experienced by NOCs. Only three studies employed standardised measures: Cyr et al., (2016) and Cyr et al. (2018) used the Early Trauma Inventory, and van Delft et al., (2016) the Adverse Childhood Experience Questionnaire. Similarly, the characteristics of the child's CSA were gathered via the researcher's own questionnaires and interviews with the parents, or from professionals or medical records. Although this form of data collection is considered appropriate for such information, the variability of abuse definitions meant there were inconsistencies between studies with the ways in which certain characteristics were coded for use in the analysis, for example, the manner of rating severity of abuse.

Further, there were some inconsistencies in studies around the extent to which they measured and took into account other potential biases. In terms of non-responder bias, only two studies analysed whether non-responders differed significantly on any variables (Manion et al., 1998; Manion et al., 1996). Others acknowledged the amount of non-responders but did not incorporate this into their analysis (Burgess et al., 1990; Dyb et al., 2003; Kelley, 1990), while the remainder of papers did not report on non-responders. Internal validity was also assessed in studies, to see whether bias caused by potential confounding variables was accounted for. The majority of the studies measured possible confounding variables across the three main groups of potential covariates (caregiver, child, and abuse-related characteristics).

Ten of the papers encompassed at least two of these three most common groups of confounding variables and subsequently combined these into their analysis. Two studies failed to acknowledge possible confounders and the potential for this to impact on results (Mcgillivray et al., 2018; Burgess et al., 1990), with the remainder of studies taking into account only a limited number of potential co-variables. Whether the study took into account confounding variables may provide a possible explanation for why there were mixed findings around the association of abuse-related stressors, such as whether NOCs child testified in court, and NOCs' distress. Burgess (1990) found a significantly higher levels of PTS related avoidance and intrusion symptoms in NOCs' of testifying compared to non-testifying children but they did not take confounding variables into account. Dyb (2003) by contrast, who did account for confounders, found higher intrusion but not avoidance scores. It is therefore possible that there is less of an association between this factor and psychological symptoms when other variables are considered.

Table 2

Bespoke quality appraisal tool ratings

Quality Item	Paper Codes																				
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
1	++	++	++	++	++	++	++	++	++	++	++	++	++	++	+	++	++	++	++	++	++
2	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++
3	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
4	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
5	-	++	++	+	+	+	++	++	+	++	++	+	++	++	-	+	+	++	++	+	+
6	+	++	++	+	++	++	++	++	++	++	++	+	+	+	++	+	++	++	+	+	++
7	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	++	+	+	+	+	+
8	++	+	+	++	++	++	++	+	+	++	+	+	++	++	+	+	+	+	+	+	++
9	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++
10	++	++	++	++	++	++	++	++	++	++	++	++	++	++	+	++	++	++	++	++	+
11	++	+	++	++	+	+	+	++	+	++	+	+	++	++	+	+	+	++	+	+	+
12	-	-	+	-	-	+	+	-	-	-	-	+	++	++	+	-	-	-	-	-	+
13	-	+	+	++	++	++	+	+	++	+	++	++	++	+	-	++	++	++	+	+	+

Scoring (informed by NICE guidelines): ++ (yes; has been addressed); + (partial; unclear or not all aspects been addressed); - (no; significant sources of bias persist); NA (not applicable). See Table 1 for full Quality Appraisal tool items. Details on paper codes can be found in the Study Characteristics Table (Systematic Review Appendix).

Discussion

This review systematically evaluated the quantitative evidence for the association of specific factors with NOCs' psychological wellbeing. The 21 studies focused on six key groups of factors: psychological; social and environmental; caregiver abuse history; abuse-related characteristics; caregiver characteristics; and child characteristics.

Main Findings

Psychological factors. Psychological factors appeared to attract the most evidence for an association with NOC psychological wellbeing. The psychological constructs explored can be understood in the context of existing models of psychological distress and these findings contribute to the relevance of these theories in understanding the experiences of this particular population. For example, McGillivray et al.'s (2018) findings around self-compassion support the compassion-focused model (Gilbert, 2010) and are corroborated by evidence from other populations where low self-compassion has been linked to parental distress (Zeller, Yuval, Nitzan-Assayag, & Bernstein, 2015). The link of distress with an external locus of control and empowerment could be conceptualised from the view of the power-threat meaning model, which hypothesises that psychological distress stems from the negative operation of external power upon an individual (Johnstone & Boyle, 2018).

Although the construct of attachment, in terms of security and representations of peers, was only focused on in one study, Kim et al.'s (2011) findings of its association with NOCs' psychological wellbeing seem of particular relevance within attachment theory (Bowlby, 1973) and in the wider NOC literature. For example, there is evidence that mothers of female survivors of CSA have poorer childhood attachment relationships compared to mothers of girls without an abuse history (Leifer, Kilbane, & Kalick, 2004). This indicates that attachment or related constructs may be key in understanding the unique experiences of NOCs. Furthermore, cognitive processes such as rumination and abuse-specific cognitions, as well as coping

mechanisms such as avoidant coping, may also be key in understanding levels of NOCs' distress. These findings can be understood in the context of cognitive-behavioural models (Beck, 2011), where these cognitive and coping mechanisms have been found not only to be associated with, but also to maintain, mental health issues, such as depression and anxiety.

Social and environmental factors. There was also reasonable evidence for the effect of wider social and environmental factors. This is in keeping with interpersonal psychotherapy models indicating the importance of social support networks in the role of depression (Markowitz & Weissman, 2004). It is further supportive of empirical research into stressful life event models, indicating the impact of a build-up of stressful events on family units (Malia, 2006), and linking this to psychological distress and the protective role of social support (Cohen & Wills, 1985).

Caregiver abuse history. In terms of NOCs' history of abuse, theoretically it may have been hypothesised that there would be an overall trend of NOCs with a history of abuse or maltreatment to have overall higher levels of distress than NOCs who did not have their own history. This hypothesis is based on the PTSD and impact of trauma literature indicating numerous negative mental health reactions to traumatic experiences (Courtois, 2004), with the assumption that NOCs with a trauma-history would therefore be more likely to already be experiencing higher levels of mental health symptoms. However, as this review shows that only half the studies investigating this factor indicated a significant association with distress in NOCs, there is initial promising evidence that a NOC's history of abuse is likely not to be deterministic of experiencing increased mental health difficulties. This factor in particular needs further robust investigation going forward to provide more conclusive answers, since these mixed findings may be due to other factors mediating the effect between NOCs' own history of CSA and psychological wellbeing. This was indicated in some studies exploring the role of psychological factors, such as rumination (Plummer, 2008), but was not explored in all

papers. Furthermore, with evidence demonstrating the difficulty that individuals experience around disclosing past trauma (Ullman, Foyne, & Tang, 2010), it is possible that participants may not have wanted to share these experiences with the researchers, particularly if this is something that they had not previously disclosed. This may have confounded any analysis which assumed group affiliation of NOCs with and without a history of abuse that was based on self-report.

Abuse-related factors. Exploration of abuse-related factors also produced limited evidence for the perpetrator identity, abuse type, or abuse severity having a significant association with psychological wellbeing measures, which is a potentially unexpected finding. One important factor however appeared to be time since disclosure, since all three longitudinal studies indicated a reduction in NOCs' distress over time, which is in keeping with literature around typical emotional responses to a crisis (Roberts, 2005). Nevertheless, approximately one third of NOCs' still experienced clinically significant levels of distress in the 12 to 18-month follow-ups. The studies seemed to initially attempt to explain this, illustrating that different factors, such as parent satisfaction and child's internalizing behaviour, were associated with distress at different time points. However, more in-depth understanding of what factors predict changes in distress overtime is needed going forward.

Child and parent factors. The final two factors, parent and child characteristics, were the least prevalent in the studies and also attracted minimal and contradictory support for their associations with NOCs' psychological wellbeing. For example, there was a trend of evidence supporting the finding that female caregivers had higher levels of psychological distress than males, which is in line with well-established findings around women being more likely to be treated for a mental health difficulty (Singleton & Lewis, 2003). However, this could also be representative of males being less likely to report and seek help for psychological distress, potentially due to the social context of masculine gender-roles focusing around toughness and

not relying on others (Addis & Mahalik, 2003). These issues may reduce the likelihood of male NOCs reporting psychological distress, and thus these findings may not be truly representative of their experiences. Furthermore, with one study finding male NOCs to be experiencing more distress and others finding no role of gender, it is clear that this is not a robust finding and more investigation is required.

Key Limitations of Studies

Although the papers in the review indicate a range of factors which are likely to have important implications in understanding the experiences of NOCs, it is clear from the summary of the review's findings and quality critique of the studies that there was significant variability across studies and a high likelihood of bias due to methodological issues. Thus, even though this is a well-established literature spanning almost thirty years, there are fundamental and pervasive methodological and theoretical issues across these studies, which affects the reliability of conclusions that can be made about the factors associated with NOCs' psychological wellbeing.

Population heterogeneity. A key issue was the heterogeneity of the NOC populations included in the studies and the variability between the studies in their inclusion and exclusion criteria in defining which NOCs can participate. Some studies focused solely on biological parents, whereas others included a variety of caregivers, such as step-parents and grandparents. The lack of male NOCs participating across all studies is a further issue. Some authors specified this in their inclusion criteria, while others simply found that in general more mothers participated in the studies. Additionally, some studies focused specifically on extra- or intra-familial abuse, while others only looked at specific types of CSA, such as contact or non-contact. This variation in research participants across studies may not only underlie the mixed findings in some areas, but also significantly limit the generalisability of the findings to the broader NOC population.

Sampling methods. There were further issues across all studies related to sampling. Most predominantly, samples were generally small and there were no power calculations or justifications of sample size. There were further potential biases in the process of sample selection. For example, NOCs were often recruited from outpatient settings or child protection units, meaning that only those NOCs who were accessing services were recruited. Most studies are therefore only representative of NOCs who are accessing services and the findings could not be generalised to those more under-represented NOCs, such as those not attending services. Additionally, the predominantly Western Caucasian sample across all studies means that these findings would also be limited when generalising to other ethnicities or cross-culturally.

Finally, as only one study used a randomised approach to sampling, there was likely to be notable bias in the selection of the sample. For example, recruitment often relied on clinician recommendation, meaning that the sample may be biased towards NOCs whose clinicians felt were 'resilient' enough to take part in the research. This is particularly of note as it indicates that the entirety of this evidence-base is likely to be derived from essentially skewed samples, only representing a small and probably higher-functioning cross-section of this population.

In addition to issues with generalisation it is possible, due to this bias, that some factors may not have been found to be associated with distress due to NOCs' having received specific support for their distress from services. For example, the finding that parent-reported child behaviour does not predict distress in Manion et al.'s (1996) study may be due to the fact that parents were recruited from services in which their child was being supported. This support may have reduced externalising behaviours, if they were receiving recommended interventions such as Trauma-Focused Cognitive Behavioural Therapy (TF-CBT), which targets such difficulties (Kliethermes, Wamser Nanney, Mannarino, & Cohen, 2015). This finding therefore may not necessarily be valid of NOCs who are not accessing services and whose children have not received support for their externalising difficulties.

Study design. Another significant issue across the majority of studies in this area is the use of primarily cross-sectional design: only 3 out of the 21 studies used a longitudinal approach. These cross-sectional designs significantly limit the conclusions that can be drawn about the overall experience of NOCs, as they solely capture NOCs' distress and the factors related to this as a static variable, representative only of the day they participated in the research. However, the level and type of distress is likely to vary over time, as indicated in research illustrating NOCs' experience of ongoing stressors in the aftermath of disclosure (van Toledo & Seymour, 2016). The cross-sectional design also limits the exploration of any bi-directional relationships or causality between factors.

The longitudinal studies explored in this review highlight the importance of going beyond a cross-sectional investigation, by demonstrating the significance of time since disclosure in reducing distress, as well as how different factors are associated with distress at different time points. As cross-sectional studies are only representative of one point in time, they may not capture the significant factors associated with distress throughout the NOCs' recovery period post-disclosure. This may further account for the differences in findings between studies. Nevertheless, even in the longitudinal studies there was minimal exploration around what factors predicted the reduction in distress over time, meaning again that only tentative conclusions can be drawn. This is particularly important as the longitudinal studies generally found that despite there being an overall significant reduction in distress over time, a proportion of the sample remained clinically distressed at follow-up.

Exploration of isolated factors. The fact that many of the studies each only explored a small number of variables is also a significant limitation. It is particularly an issue as with regard to the psychological factors, since the majority of studies have each explored different factors in isolation. This means that firm conclusions cannot be made more generally about what degree of variance of NOCs' distress may be accounted for by different psychological

variables, as well as any interactional effects between these factors. Consequently, it is difficult to identify, from this body of research, the most important factors to focus on when working clinically with this population. The broad and disconnected number of variables explored across studies highlights a key issue within this field, namely that there does not seem to be an integrated theoretical framework within which to understand NOCs' distress and the factors which may contribute to this. As a result, a variety of factors are being explored in isolation with minimal attempts to investigate how they interlink and interact with one another. This means that our understanding of NOCs' experiences is likely to be oversimplified and disjointed, not necessarily representative of the complex reality which NOCs' experience.

Heterogeneity of wellbeing measures. There also appears to be huge inconsistency across studies as regards the tools used to measure psychological wellbeing and distress. This indicates possible theoretical conflicts around what constructs are viewed as most appropriate in the NOC populations. The predominant use of general distress measures means that NOCs' experiences may be oversimplified, especially since other studies indicate there are very specific trauma related variables, such as avoidance and intrusion symptoms of PTSD, which are associated with some factors and not others. Furthermore, the heterogeneity of measures, even for the same constructs, inhibits possible comparisons and meta-analysis across studies. This makes it difficult to draw more robust conclusions from the existing evidence-base.

Limitations of the Review

The review was constrained by time and resources and therefore a review of grey literature was not feasible. The inclusion of only studies available in the English language may also have meant other relevant papers were missed, and also potentially limits cross-cultural generalisation. The studies did span North America, Australia and Europe, and therefore there was some global generalisability, however as these were predominantly Western cultures, broader cross-cultural application may be limited. The limitations of the studies themselves

affected the reliability of the conclusions which the review was able to produce. Both psychological wellbeing and associated factors were predominantly measured by self-report questionnaires, introducing a potential reporting bias. Furthermore, there was a high heterogeneity of measures used, which may contribute to limitations in the review making comparisons between studies and drawing general conclusions. The extent to which the review could make firm conclusions was further hampered by the small and possibly underpowered samples in the studies. Finally, with the majority of studies using a cross-sectional design, it is not possible for the review's conclusions to go beyond associations to a causal link (Sedgwick, 2014).

Implications for Clinical Practice

Despite the limitations, this review offers several important findings which can begin to inform clinical practice. Having an awareness of factors that may be impacting NOCs' distress allows clinicians to have a more in depth and empirically-based assessment, which in turn means NOCs who are more at risk for high psychological distress can be identified and supported quickly and effectively.

A number of factors which are likely to already be incorporated into clinical assessment, such as abuse and perpetrator characteristics, as well as NOCs' own history of abuse, produced mixed findings in relation to their association with distress. It is therefore important that services take into account that previous assumptions, for example about higher distress in NOCs who are themselves survivors of trauma, may not always be well-founded. Although these factors are still important to consider in an assessment when supporting NOCs, they are not necessarily the sole or most significant risk factor for psychological distress. This review indicates that other psychosocial factors need also to be focused on. Based on the findings from this review, clinicians may also want to incorporate specific questions around factors such as

social support and wider life stressors, attachment-related factors, or to assess particular cognitive processes (e.g. abuse related cognitions or rumination) in their initial assessment.

Furthermore, the factors identified also indicate a potential focus for treatment which may help improve parent distress or mental health symptoms. For example, they indicate the potential benefit of drawing on existing interventions which focus on developing self-compassion, such as Compassion-Focused Therapy (Gilbert, 2010), as well as other cognitive behavioural interventions (Beck et al., 2011) targeting cognitive patterns, such as rumination or abuse related cognitions. Additionally, services supporting NOCs may benefit from helping them to build up their social networks. This could be done through community links, or undertaking therapies which target building interpersonal networks, such as Interpersonal Psychotherapy (Markowitz & Weissman, 2004).

Recommendations for Future Research

The conclusions of this review should be applied to clinical practice with some caution, since further research is needed to increase our understanding of what are the most important factors in predicting NOC psychological wellbeing. Particularly in areas where there are contradictory findings across studies, such as the role of NOCs' own history of abuse, more robust quantitative studies are needed to investigate the role of these factors more reliably by addressing the methodological limitations of the studies reviewed here. With regards to methodological improvement in future research, the issues around measures need to be addressed, by using validated scales to be used where necessary, such as when measuring NOC's history of abuse. The field would benefit from establishing a consensus on which validated measures are most appropriate for studies assessing psychological distress and associated factors in NOCs. This will increase the ability to make comparisons between studies and reduce potential bias that non-validated measures produce as a result of the subjectivity of

defining ‘abuse’. Furthermore, larger higher-powered studies clearly detailing power calculations would help going forward in terms of decreasing the likelihood of bias.

Use of more stringent randomised sampling methods are also required to reduce potential bias, as well as a need to broaden research out to incorporate a wider range of NOCs. With the family set-up changing in the wider social context and moving away from the traditional ‘nuclear family’ (Finch, 2007), it will be important to involve caregivers aside from just biological parents going forward. Additionally, attempts should be made to include NOCs in harder to reach populations, such as those not attending services, male caregivers, and NOCs from ethnic minority groups, to ensure that research is more representative of the whole NOC population.

There is also scope for exploring those potential factors which have not yet been researched in relation to parent wellbeing, but nevertheless have some theoretical grounding. For example, increased research into attachment styles and representations, or psychological concepts related to this may be of benefit, such as parental mentalization or reflective functioning, as this construct has been found to be linked to child outcomes (Ensink, Bégin, Normandin, & Fonagy, 2017). Furthermore, mindfulness is a related construct to self-compassion, and has also been found to be related to wellbeing in other parent populations (Cachia, Anderson, & Moore, 2015), and therefore may be beneficial to explore. Qualitative papers exploring support needs of NOCs have also indicated the significance of guilt and shame (Serin, 2018), suggesting that these also may be important factors to explore quantitatively.

Another key indication in this review is that the factors identified are likely to be interlinked and impacting on each other. However, since much of the evidence summarised here is derived from exploration of only a few factors per paper, particularly in the case of psychological factors, it would be beneficial to undertake a more in depth look into how these relate to one another. Future research should take into account the presence of multiple interacting variables,

using mediation analysis and sophisticated models, to explore which factors are most significant in understanding caregivers' distress. This would facilitate a deeper understanding of the complexities of NOCs' experience, particularly for factors where there were mixed findings.

In line with this, there is a need for proposed theoretical frameworks for this population to specifically conceptualise the interaction of factors which may be contributing to NOCs' distress, in an attempt to integrate some of the findings in the review and provide a framework for future studies to test hypothesised associations. This would allow the field to move away from researching concepts in isolation, towards a more integrated understanding of NOCs' experiences. Therefore, designs which allow exploration of more interactional and bi-directional processes over time are also needed. Qualitative or mixed-methods studies can provide initial in-depth detail around these processes on a smaller scale, leading to hypothesised models of individuals' lived experiences which can then be tested further in larger quantitative studies. Additionally, more prospective longitudinal studies are also required to help eliminate limitations of cross-sectional studies and aid with determining cause and effect on a larger scale. These would also allow identification of what factors may predict a change in distress overtime, as well as contributing further to our understanding of what factors are significant at different time points in NOCs' distress. This would give clinicians a better understanding of risk factors of distress, as well as contributing to a more cohesive model of theoretical NOCs' experiences.

Conclusion

The needs of NOCs of child sexual abuse survivors have often been overlooked in health, social care, and legal settings. There is also a paucity of research into understanding caregivers' own experiences, with studies mainly focusing on child outcomes and parenting behaviour.

Nevertheless, it is clear from existing research that NOCs suffer from heightened mental health difficulties when compared to the normal population. To our knowledge, this review is the first of its kind to systematically assess potential factors which are associated with psychological wellbeing in NOCs. Overall, there are significant and fundamental weaknesses in this field. In light of the methodological limitations of the studies highlighted in the review, only tentative conclusions can be made about the associations between these factors and levels of psychological distress. Nevertheless, this paper indicates that based on the reviewed studies, there is more support for the association between psychological wellbeing and the NOCs' psychological and social factors, rather than demographic or abuse-related characteristics. More research is needed to address the methodological issues highlighted in the review to ensure higher quality studies in this field, particularly in relation to the role of NOCs own abuse history, which produced mixed results. This will help to draw more firm conclusions and to provide more specific recommendations for clinical practice. However, these findings have an underlying hopeful message, as the factors highlighted as having the most evidence for an association with psychological distress, such as negative cognitions or poor social support, have the potential to be identified and changed through support and intervention.

References

- Addis, M. E., & Mahalik, J. R. (2003). Men, Masculinity, and the Contexts of Help Seeking, 58(1), 5–14. <https://doi.org/10.1037/0003-066X.58.1.5>
- Baril, K., Tourigny, M., Paille, P., & Pauze, R. (2016). Characteristics of Sexually Abused Children and Their Nonoffending Mothers Followed by Child Welfare Services: The Role of a Maternal History of Child Sexual Abuse. *Journal of Child Sexual Abuse*, 25(5), 504–523. <https://doi.org/10.1080/10538712.2016.1176096>
- Beck, J. S. (2011). *Cognitive Behavior Therapy: Basics and Beyond*. The Guilford Press. <https://doi.org/10.1017/CBO9781107415324.004>
- Bolen, R. M., & Gergely, K. B. (2014). A Meta-Analytic Review of the Relationship Between Nonoffending Caregiver Support and Postdisclosure Functioning in Sexually Abused Children. *Trauma, Violence, & Abuse*. <https://doi.org/10.1177/1524838014526307>
- Bowlby, J. (1973). *Attachment and Loss: Volume II, Separation Anxiety and Anger*. London: The Hogarth Press and the Institute of Psycho-Analysis.
- Burgess, A. W., Hartman, C. R., Kelley, S. J., Grant, C. A., & Gray, E. B. (1990). Parental response to child sexual abuse trials involving day care settings. *Journal of Traumatic Stress*, 3(3), 395–405. <https://doi.org/10.1007/BF00974779>
- Cachia, R., Anderson, A., & Moore, D. W. (2015). Mindfulness, Stress and Well-Being in Parents of Children with Autism Spectrum Disorder: A Systematic Review. *Article in Journal of Child and Family Studies*. <https://doi.org/10.1007/s10826-015-0193-8>
- Centre for Reviews and Dissemination: University of York. (2009). *Systematic Reviews: CRD's guidance for undertaking reviews in health care*. (Vol. 91). York: York Publishing Services.
- Cohen, S. & Wills, T.A. (1985). Stress, social support, and the buffering hypothesis.

- Psychological Bulletin*, 98(2), 310–357. <https://doi.org/10.1037/0033-2909.98.2.310>
- Collin-Vézina, D., Daigneault, I., & Hébert, M. (2013). Lessons learned from child sexual abuse research: prevalence, outcomes, and preventive strategies. *Child and Adolescent Psychiatry and Mental Health*, 7, 1. <https://doi.org/10.1186/1753-2000-7-22>
- Courtois, C. A. (2004). Complex trauma, complex reactions: Assessment and treatment. *Psychotherapy*, 41(4), 412–425. <https://doi.org/10.1037/0033-3204.41.4.412>
- Cyr, M., Frappier, J.-Y., Hébert, M., Tourigny, M., McDuff, P., & Turcotte, M.È. (2016). Psychological and Physical Health of Nonoffending Parents After Disclosure. *Journal of Child Sexual Abuse ISSN:*, 25(7), 757–776.
- Cyr, M., Frappier, J. Y., Hébert, M., Tourigny, M., McDuff, P., & Turcotte, M. E. (2018). Impact of child sexual abuse disclosure on the health of nonoffending parents: A longitudinal perspective. *Journal of Child Custody*. <https://doi.org/10.1080/15379418.2018.1460649>
- Deblinger, E., Hathaway, C. R., Lippmann, J., & Steer, R. (1993). Psychosocial Characteristics and Correlates of Symptom Distress in Nonoffending Mothers of Sexually Abused Children. *Journal of Interpersonal Violence*, 8(2), 155–168. <https://doi.org/10.1177/088626093008002001>
- Deblinger, E., Stauffer, L., & Landsberg, C. (1994). The impact of a history of child sexual abuse on maternal response to allegations of sexual abuse concerning her child. *Journal of Child Sexual Abuse: Research, Treatment, & Program Innovations for Victims, Survivors, & Offenders*, 3(3), 67–75. https://doi.org/10.1300/J070v03n03_05
- Division of Clinical Psychology. (2018). The Power Threat Meaning Framework: Overview.
- Downes, M. J., Brennan, M. L., Williams, H. C., & Dean, R. S. (2016). Development of a critical appraisal tool to assess the quality of cross-sectional studies (AXIS). *BMJ Open*, 6(12), 1–7. <https://doi.org/10.1136/bmjopen-2016-011458>

- Dyb, G., Holen, A., Steinberg, A. M., Rodriguez, N., & Pynoos, R. S. (2003). Alleged sexual abuse at a day care center: Impact on parents. *Child Abuse and Neglect*, 27(8), 939–950. [https://doi.org/10.1016/S0145-2134\(03\)00141-8](https://doi.org/10.1016/S0145-2134(03)00141-8)
- Elliott, A. N., & Carnes, C. N. (2001). Reactions of nonoffending parents to the sexual abuse of their child: a review of the literature. *Child Maltreatment*, 6(4), 314–31. <https://doi.org/10.1177/1077559501006004005>
- Ensink, K., Bégin, M., Normandin, L., & Fonagy, P. (2017). Parental reflective functioning as a moderator of child internalizing difficulties in the context of child sexual abuse. *Psychiatry Research*, 257, 361–366. <https://doi.org/10.1016/j.psychres.2017.07.051>
- Evans, E., Hawton, K., & Rodham, K. (2004). Factors associated with suicidal phenomena in adolescents: A systematic review of population-based studies. *Clinical Psychology Review*, 24(8), 957–979. <https://doi.org/10.1016/j.cpr.2004.04.005>
- Finch, J. (2007). Displaying Families. *Sociology*, 41(1), 65-81. <https://doi.org/10.1177/0038038507072284>
- Gilbert, P. (2010). *The Compassionate Mind: a new approach to life's challenges*. Constable.
- Hébert, M., Daigneault, I., Collin-Vézina, D., & Cyr, M. (2007). Factors linked to distress in mothers of children disclosing sexual abuse. *Journal of Nervous and Mental Disease*, 195(10), 805–811. <https://doi.org/10.1097/NMD.0b013e3181568149>
- Hiebert-Murphy, D. (1998). Emotional distress among mothers whose children have been sexually abused: the role of a history of child sexual abuse, social support, and coping. *Child Abuse & Neglect*, 22(5), 423–435. [https://doi.org/10.1016/S0145-2134\(98\)00006-4](https://doi.org/10.1016/S0145-2134(98)00006-4)
- Kelley, S. J. (1990). Parental Stress Response to Sexual Abuse and Ritualistic Abuse Of Children in Day-Care Centers. *Nursing Research*. <https://doi.org/10.1097/00006199-199001000-00006>
- Kilroy, S. J., Egan, J., Maliszewska, A., & Sarma, K. M. (2014). “Systemic trauma”: The

- impact on parents whose children have experienced sexual abuse. *Journal of Child Sexual Abuse*, 23(5), 481–503. <https://doi.org/10.1080/10538712.2014.920458>
- Kim, K., Noll, J. G., Putnam, F. W., & Trickett, P. K. (2007). Psychosocial characteristics of nonoffending mothers of sexually abused girls: Findings from a prospective, multigenerational study. *Child Maltreatment*, 12(4), 338–351. <https://doi.org/10.1177/1077559507305997>
- Kim, K., Trickett, P. K., & Putnam, F. W. (2011). Attachment representations and anxiety: Differential relationships among mothers of sexually abused and comparison girls. *Journal of Interpersonal Violence*. <https://doi.org/10.1177/0886260510363416>
- Kliethermes, M., Wamser Nanney, R., Mannarino, A., & Cohen, J. (2015). Trauma-Focused Cognitive-Behavioral Therapy. In *Treating Complex Traumatic Stress Disorders in Children and Adolescents: Scientific Foundations and Therapeutic Models* (pp. 184–202).
- Knott, T., & Fabre, A. (2014). Maternal Response to the Disclosure of Child Sexual Abuse: Systematic Review and Critical Analysis of the Literature. *Issues in Child Abuse Accusations*, 20.
- Leifer, M., Kilbane, T., Kalick, S., & Kalick, S. (2004). Vulnerability or Resilience to Intergenerational Sexual Abuse: The Role of Maternal Factors. *Child Maltreatment*, 9(1), 78–91. <https://doi.org/10.1177/1077559503261181>
- Lewin, L., & Bergin, C. (2001). Attachment Behaviors, Depression, and Anxiety in Nonoffending Mothers of Child Sexual Abuse Victims. *Child Maltreatment*, 6(4), 365–375.
- Malia, J. A. (2006). Basic concepts and models of family stress. *Stress, trauma, and crisis*, 9(3-4), 141-160. <https://doi.org/10.1080/15434610600853717>
- Maniglio, R. (2009). The impact of child sexual abuse on health: A systematic review of

reviews. *Clinical Psychology Review*, 29(7), 647–657.

<https://doi.org/10.1016/j.cpr.2009.08.003>

Manion, I., Firestone, P., Cloutier, P., Ligezinska, M., McIntyre, J., & Ensom, R. (1998).

Child extrafamilial sexual abuse: Predicting parent and child functioning. *Child Abuse and Neglect*, 22(12), 1285–1304. [https://doi.org/10.1016/S0145-2134\(98\)00103-3](https://doi.org/10.1016/S0145-2134(98)00103-3)

Manion, I. G., McIntyre, J. E., Firestone, P., Ligezinska, M., Ensom, R., & Wells, G. (1996).

Secondary traumatization in parents following child disclosures of extrafamilial sexual abuse. *Child Abuse and Neglect*, 55(11), 1095–1109.

Markowitz, J. C., & Weissman, M. M. (2004). Interpersonal psychotherapy: principles and applications. *World Psychiatry: Official Journal of the World Psychiatric Association (WPA)*, 3(3), 136–9.

McGillivray, C. J., Pidgeon, A. M., Ronken, C., & Credland-Ballantyne, C. A. (2018).

Resilience in Non-Offending Mothers of Children Who Have Reported Experiencing Sexual Abuse. *Journal of Child Sexual Abuse*.

<https://doi.org/10.1080/10538712.2018.1477221>

Moher, D., Liberati, A., Tetzlaff, J., Altman, D. G., Altman, D., Antes, G., Tugwell, P.

(2009). Preferred reporting items for systematic reviews and meta-analyses: The PRISMA statement (Chinese edition). *Journal of Chinese Integrative Medicine*, 7(9), 889–896. <https://doi.org/10.3736/jcim20090918>

Murray, J., Farrington, D. P., & Eisner, M. P. (2009). Drawing conclusions about causes from systematic reviews of risk factors: The Cambridge Quality Checklists. *Journal of Experimental Criminology*, 5(1), 1-23.

National Collaborating Centre for Mental Health (2005). Predictors of PTSD and screening for the disorder. In *Post-Traumatic Stress Disorder: The Management of PTSD in Adults and Children in Primary and Secondary Care*. Gaskell.

- National Institute for Health and Care Excellence. (2012). *Methods for the development of NICE public health guidance (third edition)*.
- Newberger, C. M., Gremy, I. M., Waternaux, C. M., & Newberger, E. H. (1993). Mothers of sexually abused children: Trauma and repair in longitudinal perspective. *American Journal of Orthopsychiatry*, 63(1), 92–102. <https://doi.org/10.1037/h0079398>
- Petticrew, M., & Roberts, H. (2006). *Systematic reviews in the social sciences: A practical guide*. Blackwell.
- Plummer, C. A. (2008). Non-Abusive Mothers of Sexually Abused Children: The Role of Rumination in Maternal Outcomes. *Journal of Child Sexual Abuse*, 15(2), 103–122. https://doi.org/10.1300/J070v15n02_07
- Putnam, F. W., & Trickett, P. K. (1987). Psychobiological effects of sexual abuse. A longitudinal study. *Annals of the New York Academy of Sciences*, 821, 150–9.
- Rheingold, A. A., Davidson, T. M., Resnick, H., Self-Brown, S., & Danielson, C. K. (2013). The relationship between knowledge and child and caregiver distress during the medical examination for child sexual abuse. *Journal of Child Sexual Abuse*, 22(5), 552–571. <https://doi.org/10.1080/10538712.2013.800937>
- Roberts, A. R. (2005). *Crisis intervention handbook : assessment, treatment, and research*. Oxford University Press.
- Runyon, M. K., Spandorfer, E. D., & Schroeder, C. M. (2014). Cognitions and distress in caregivers after their child's sexual abuse disclosure. *Journal of Child Sexual Abuse*, 23(2), 146–59. <https://doi.org/10.1080/10538712.2014.869291>
- <https://doi.org/10.1080/10538712.2014.869291>[org/10.1080/10538712.2014.869291](https://doi.org/10.1080/10538712.2014.869291)
- Santa-Sosa, E. J., Steer, R. A., Deblinger, E., & Runyon, M. K. (2013). Depression and Parenting by Nonoffending Mothers of Children Who Experienced Sexual Abuse. *Journal of Child Sexual Abuse*, 22(8), 915–930.

- <https://doi.org/10.1080/10538712.2013.841309>
- Sedgwick, P. (2014). Cross sectional studies: Advantages and disadvantages. *BMJ (Online)*, 348. <https://doi.org/10.1136/bmj.g2276>
- Serin, H. (2018). Non-abusing mothers' support needs after child sexual abuse disclosure: A narrative review. *Child and Family Social Work*, 23(3), 539–548.
<https://doi.org/10.1111/cfs.12455>
- Singleton, N., & Lewis, G. (2003). Better or worse: a longitudinal study of the mental health of adults living in private households in Great Britain. *National Statistics*, 170.
- Timmons-Mitchell, J., Chandler-Holtz, D., & Semple, W. E. (1998). Post-Traumatic Stress Disorder Symptoms in Child Sexual Abuse Victims and Their Mothers. *Journal of Child Sexual Abuse ISSN:*, 6(4), 1–14. <https://doi.org/10.1300/J070v06n04>
- Ullman, S. E., Foynes, M. M., & Tang, S. S. S. (2010). Benefits and barriers to disclosing sexual trauma: A contextual approach. *Journal of Trauma and Dissociation*, 11(2), 127–133. <https://doi.org/10.1080/15299730903502904>
- van Delft, I., Finkenauer, C., Tybur, J. M., & Lamers-Winkelmann, F. (2016). “Disgusted by sexual abuse: Exploring the association between disgust sensitivity and posttraumatic stress symptoms among mothers of sexually abused children”: Erratum. *Journal of Traumatic Stress*, 29(6), 581–582. <https://doi.org/http://dx.doi.org/10.1002/jts.22118>
- van Toledo, A., & Seymour, F. (2016). Caregiver Needs Following Disclosure of Child Sexual Abuse. *Journal of Child Sexual Abuse*, 25(4), 403–414.
<https://doi.org/10.1080/10538712.2016.1156206>
- van Toledo, A., & Seymour, F. (2013). Interventions for caregivers of children who disclose sexual abuse: A review. *Clinical Psychology Review*, 33, 772–781.
<https://doi.org/10.1016/j.cpr.2013.05.006>
- van Voorhis, C. W., & Morgan, B. L. (2007). Understanding power and rules of thumb for

- determining sample sizes. *Tutorials in quantitative methods for psychology*, 3(2), 43-50.
- Wagner, W. G. (1991). Depression in mothers of sexually abused vs. mothers of nonabused children. *Child Abuse & Neglect* 15(1), 99-104.
- West, S., King, V., Carey, T. S., Lohr, K. N., McKoy, N., Sutton, S. F., & Lux, L. (2002). Systems to rate the strength of scientific evidence. *AHRQ Publication No. 02-E016*, (47), 1–11.
- Zeller, M., Yuval, K., Nitzan-Assayag, Y., & Bernstein, A. (2015). Self-Compassion in Recovery Following Potentially Traumatic Stress: Longitudinal Study of At-Risk Youth. *Journal of Abnormal Child Psychology*, 43(4), 645–653. <https://doi.org/10.1007/s10802-014-9937>

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Systematic Review Appendix: Table of Study Characteristics

Codes	First Author (Year) Country	N Participants/ Population/	Sample characteristics: Mean baseline age (SD); age range; ethnicity	Child characteristics: Age mean (SD) & range; Gender.	Abuse characteristics: Perpetrator, nature.	Relevant study aims	Study design; analysis	Relevant Factor measures	Psychological Wellbeing measure	Relevant Findings
1	McGillivray 2018 Nr. (Authors based in Australia)	68 mothers Specialist child sexual abuse organisation.	43.22 (8.12) 28-67 Nr	Nr	77.9% intrafamilial; 25% extrafamilial. Nr	Relationships between resilience positive reappraisal, social support, self-compassion, and psychological distress.	Cross-sectional. Multi-mediation analysis. MANOVA.	<i>Resilience</i> : CD-RISC. <i>Positive reappraisal</i> : CERQ (4-item CERQ Positive Reappraisal subscale). <i>Self-Compassion</i> : SCS. <i>Social support</i> : SPS.	<i>Psychological Distress</i> : DASS-21.	High resilience group significantly lower psychological distress than low resilience group ($F(1,66)=11.10, p=.001$); ($\eta^2=.14$). Resilience ($b=-.45$; $p<.001$), self-compassion ($b=-.62$; $p<.001$) and social support ($b=-.25$; $p<.05$) significant negative predictors of psychological distress. Positive reappraisal positive predictor of psychological distress ($b=.39$; $p<.001$). Self-compassion ($b_{ab}=-.38$), social support ($b_{ab}=-.15$), and positive reappraisal ($b_{ab}=.23$) significantly mediated relationship between resilience and psychological distress. Self-compassion was strongest predictor.
2	Kim 2007 USA	72 mothers (with own CSA: $n=31$; without own CSA: $n=38$; remainder did not report) [+43 control mothers]. Putnam and Trickett's (1987) Cohort. Protective Service Agencies.	35.4 (5.5) 24-49. 52.8% white and remainder ethnic minorities (55 African American, 1 Hispanic, 1 Asian American)	Nr Inc. crit.: age 6-16. Female.	Intrafamilial. Contact CSA.	Impact of mothers CSA history on depression, dissociation and anxiety.	Cross sectional (one time-point of larger longitudinal study). GLM. Post-hoc Bonferroni correction. Covariates: Ethnic minority and SES as covariates.	<i>Maternal childhood sexual, physical and emotional abuse</i> : MDHQ (Structured interview protocol developed for current study, using binary codes for parent experience of abuse: 0=no abuse; 1=abuse)	<i>Depression</i> : BDI. <i>Dissociation</i> : DES <i>Anxiety</i> : STAI.	No difference between mother's CSA groups on depression, dissociation and trait anxiety.
3	Kim 2011 USA	72 mothers (with own CSA: $n=31$; without own CSA: $n=38$; remainder did not report) [+43 control mothers]. Putnam and Trickett's (1987) Cohort. Protective Service Agencies.	35.4 (5.5) 24-49. 52.8% white and remainder ethnic minorities (55 African American, 1 Hispanic, 1 Asian American)	Nr Inc. crit.: age 6-16 Female	Intrafamilial. Contact CSA.	Role of maternal and child CSA, attachment style, and parent and peer attachment representations in maternal trait anxiety.	Cross sectional (one time-point of larger longitudinal study). Hierarchical multiple regression model.	<i>Maternal childhood sexual, physical and emotional abuse</i> : MDHQ (Structured interview protocol developed for current study, using binary codes for parent experience of abuse: 0=no abuse; 1=abuse) <i>Attachment style</i> : AAQS <i>Attachment representations</i> : IPPA.	<i>Trait Anxiety</i> : STAI.	In IPPA parent model, only AAQS significantly predicted trait anxiety (mother: $b=-.35, p<.01$; father: $b=-.41, p<.001$), with mothers reporting a secure attachment style showed a lower level of trait anxiety symptoms regardless of daughter's CSA. In IPPA peer model, both AAQS ($b=-.22, p<.05$) and IPPA peer ($b=-.32, p<.01$) were significant. (Regression model: $R^2=.27$). Significant interaction relationship between child's CSA and IPPA peer ($b=-.24, p<.05$), with trait anxiety being significantly low IPPA peer but not high IPPA peer representations in mothers of CSA survivors. No differences on outcomes based on maternal abuse.

4	Hiebert-Murphy 1998 Canada	102 mothers Childrens hospital's sexual assault clinic and community-based service for families affected by 3 rd party abuse.	33.67 (5.73) Nr 74% Caucasian; 24% Aboriginal, 2% other ethnic backgrounds	Nr	Third party abuse. Occurred in past 12 months. Non-contact (e.g. exposure) and contact	Maternal sexual abuse in childhood or adolescence, lack of social support, and use of avoidant coping as predictors of emotional distress.	Cross sectional. Hierarchical regression analyses. T-tests.	<i>Maternal CSA:</i> Finkelhor's sexual victimisation survey (1979) – modified version. Structured interview scored based on presence/absence of history of CSA. <i>Social Support:</i> PSR. <i>Coping strategies:</i> CRI (Part II: Subscales of avoidance and approach coping. Scored for relative avoidance coping.) <i>Demographic variables:</i> demographics questionnaire.	<i>Emotional distress:</i> (GSI) subscale of BSI.	Maternal CSA (adj. $r^2=.083$), relative avoidance coping strategies (adj. $r^2=.111$), and social support (adj. $r^2=.132$) significantly contributed to the prediction of emotional distress. These variables contributed independently to the variance (hierarchical regression: $r^2=.281$). Comparison of groups revealed significantly more distress in mothers with history of CSA compared to those without ($t(100)=3.30, p<.01$). Distress not associated with referral source, race, marital status, education, employment status, participant age, or abuse characteristics (time since disclosure or abuse, length of abuse, gender of offender or child, age of offender, or abuse severity).
5	Cyr 2016 Canada (French)	109 mothers (4 step mothers). 43 fathers (7 step fathers). 4 sites: Child protection agencies (2); child advocacy centre (1); non-profit organization (1).	Female: 37.4 (6.3) Nr Male: 41.7 (7.8) Nr Majority French Canadian. 15.6% other ethnic group	9.4 (2.0) 6-13 72.3% female	Parent/step-parent (22%); sibling/step-sibling (23%); member of the family 21%. Contact (nr if also non-contact).	Gender differences in psychological health. Can variables including abuse factors, child characteristics, socio-economic characteristics, parents' maltreatment history, life/disclosure event stressors, predict psychological distress.	Cross-sectional. Correlations and GEE.	<i>Caregivers' abuse:</i> ETI-SR SF <i>Life Stressors:</i> Life Event Sources of Stress Questionnaire (Stress from events following disclosure – assessed through 8 items using same scale) <i>Other variables:</i> Demographic Questionnaire	<i>Psychological Distress:</i> PSI. <i>PTS Symptoms related to past trauma and child's disclosure:</i> MPSS-SR. <i>Past month episodes of PTSD and Depression disorders:</i> SCID	Mothers had significantly higher symptoms of depression (Wald $\chi^2=5.76$), PTSD (Wald $\chi^2=5.29$), and psychological distress (Wald $\chi^2=6.66$) at $p<.05$. No difference between gender in past trauma PTSD. Life stressors in past year played role in psychological distress (b=0.55, $p=.01$). Post-disclosure stress (b=0.53, $p=.03$) and higher family income (b=1.09, $p=.001$) relate to PTSD (MPSS-SR). Gender (b=2.36, $p=.03$) and post-disclosure stress (b=0.74, $p=.01$) in part explained PTSD (SCID), being higher for mothers and those with elevated post-disclosure stress. Childhood maltreatment, CSA variables (e.g. perpetrator, abuse severity), and interval between disclosure and evaluation, were not related to parents' psychological distress.
6	Cyr 2018 Canada (French)	92 mothers (2 step mothers) 32 fathers (3 stepfathers) 4 sites: Child protection agencies (2); child advocacy centre (1); non-profit organization (1).	Female: 37.9 (6.5) Nr Males: 41.2 (7.2) Nr 84.3% French Canadian. 15.7% other ethnic groups	9.3 (1.9) 6-13 75% female	99.2% known by the child. 21.2% biological or step parents. Time since disclosure at Time 1: 1-47 months. Contact (nr if also non-contact).	Parents' distress over first 18-months. Whether variables (e.g. abuse factors, child characteristics, socio-economic characteristics, parents' maltreatment history, life/disclosure event stressors) are related to psychological distress over time. Gender differences.	Longitudinal. Mixed models for continuous outcomes and generalized mixed models for categorical outcomes.	<i>Time since disclosure:</i> measured over 3 time points (initial meeting; 12 months; 18 months). <i>Caregivers' abuse:</i> ETI-SR SF <i>Life Stressors:</i> Life Event Sources of Stress Questionnaire (Stress from events following disclosure – assessed through 8 items using same scale) <i>CSA characteristics:</i> gathered from professional working with family <i>Other variables:</i> Demographic questionnaire.	<i>Psychological distress:</i> PSI. <i>PTS Symptoms:</i> French-Canadian MPSS-SR.	Mothers had significantly higher psychological distress ($F=11.0, p<.001$) and PTSD ($F=28.2, p<.001$) compared to fathers. Mother's psychological distress significantly reduced between 12 and 18 months. Intensity of distress increased according to intensity of stress from life events and the number of types of past maltreatment suffered by parent. Significant decrease of PTSD symptoms for all parents between 12 and 18 months ($F=28.2, p<.001$). Intensity of PTSD could be explained by past levels of PTSD or time between disclosure and evaluation. The perpetrator identity, and family income were not associated with parent's psychological distress. Severity and duration of abuse, as well as child gender, were not correlated with distress and not included in the model.

7	Newberger 1993 USA	46 female (44 mothers; 1 grandmother; 1 stepmother) N=42 at 12 months. Children's hospital emergency department.	33 (Nr) 76% white; 17% black; 7% Hispanic	8.5 (Nr) Nr 72% female; 28% male.	Perpetrator was biological father or father figure in 28% of cases. 61% abused multiple times. Contact (Nr if also non-contact).	Mother's psychological distress over the year following disclosure.	Prospective longitudinal. T-tests. Ordinary least-squares linear regression re change over time.	<i>Time since disclosure:</i> Measured over 3 time points (initial; 6 months; 12 months)	<i>Psychological distress:</i> BSI; GSI index.	Mother's psychological distress significantly decreased between initial time-point and 12 months ($t=-3.896$, $p<.001$). Separate symptom scores were significant.
8	Runyon 2014 Nr. (Authors based in USA)	68 mothers (94.1% biological) Medical school-based outpatient clinic specialising in child abuse.	23-58 33.5 (7.00) 61.8% Caucasian 19.1% African American Hispanic (13.2%) Biracial (5.9%)	9.2(4.1) 3-17 76.6% female	Nr Contact and/or non-contact abuse.	Relationship between mothers' attributions and abuse-specific cognitions with depression and PTSD symptoms.	Cross-sectional. Hierarchical regression analysis.	<i>Attributions:</i> ASQ. <i>Abuse Specific cognitions:</i> Measure developed by authors. 5-point Likert scale on how frequently experience common abuse-specific beliefs.	<i>Depression:</i> BDI-II. <i>PTS Symptoms:</i> IES-R.	Abuse-specific cognitions was a significant predictor of depression symptoms ($b=0.41$, $p<.001$) even after controlling traumatic symptom score and negative general attribution style. Abuse specific cognitions were not significant predictor of PTSD symptoms after controlling for depression and negative attributional style,
9	Hébert 2007 Canada (French)	149 mothers Hospital-based Child Protection Clinic.	20-49 33.42 (7.13) Nr	Nr 4-12 Female.	71.6% intrafamilial (50.7% immediate family member; 20.5% extended family, 25.3% known but unrelated, 3.4% stranger.) Contact (nr if also non-contact).	Associations between variables (abuse related factors, maternal abuse history, mother's coping and feelings of empowerment) and psychological distress.	Cross-Sectional. Logistical regression analysis.	<i>Coping styles:</i> Brief 21-item version of WCCQ. <i>Empowerment:</i> Family dimension on FES. <i>Partner victimisation:</i> Brief 12-item version of CTS. <i>Maternal CSA:</i> Answered question on past CSA. <i>Abuse-related factors:</i> coded from medical records (severity, duration, and perpetrator).	French version of Psychological Distress Scale of the Quebec Health Survey'. (Translation of the PSI).	Partner victimisation ($b=1.17$, $P=.04$), history of CSA ($b=1.09$, $P=.02$), use of avoidant coping strategies ($b=0.18$, $P=.007$) and scoring low on empowerment ($b=-0.13$, $P=.008$) all predict increased psychological distress. Identity of perpetrator was the only abuse characteristic to predict psychological distress ($b=1.01$, $p=.05$). Severity or frequency did not reach significance.
10	Van Delft 2016 Netherlands	72 mothers Cohort from larger study (Van Delft 2015). Outpatient treatment centres specialising in childhood trauma.	Nr	9.76 (3.9) 4-16 Nr	61.1% perpetrators were biologically unrelated. Contact and non-contact.	Association of disgust sensitivity, maternal CSA, relatedness to perpetrator with PTSD symptoms.	Cross sectional. Hierarchical regression analysis.	<i>Disgust sensitivity:</i> TDDS. <i>Perpetrator identity:</i> dichotomous code (0 -non-biological); 1 - biological). <i>Abuse frequency:</i> dichotomous code (1 -single abuse; 0 - chronic). <i>CSA severity:</i> from case files, and coded using the MMCS. Assigned dichotomous code re penetration (1 - yes; 0 - no). <i>Maternal abuse:</i> ACEQ. <i>Rumination:</i> RSR Short Form. <i>Abuse severity:</i> Questions asking about abuse and perpetrator details. Composite score developed, comprising summation of z scores. <i>Mother's CSA:</i> Questions on abuse experience, assigning score of 0 (no) 1 (yes) or 0.5 (uncertainty). <i>Life Stressors:</i> PDHS-R; LES.	<i>PTS symptoms:</i> IES-R.	Higher sexual disgust sensitivity positively associated with PTS symptoms ($r=.39$; $p=.001$; $b=.39$). This relationship was moderated by the perpetrator relation to the child, with relationship only present when the perpetrator was unrelated ($b=.35$; $p<.001$). Maternal CSA, being biologically related perpetrator, and moral/pathogen disgust sensitivity were not associated with PTSD.
11	Plummer 2008 USA	125 mothers >86% biological. Clinical Settings.	20-62 36.05 66% Caucasian; 22.4% African American	Age: 20% <6 43.2% 7-11 27.2% 12-15 9.6% 16< Nr 68% female	82% 1 perpetrator; 10% 2 perpetrators. 65% intrafamilial, 35% extrafamilial Contact (nr if also non-contact).	Rumination and maternal outcomes. Role of rumination in relation to other variables.	Cross Sectional. Correlation and mediation analysis.	<i>Life Stressors:</i> PDHS-R; LES.	<i>Negative Affect:</i> PANAS; Negative Affect Schedule. <i>Externalizing Anger:</i> Taken from RSQ.	Past child abuse ($p<.05$), and rumination ($p<.01$) were significantly correlated with negative affect. Life stressors were also associated with externalised anger ($p<.01$). Only rumination remained significant contributor to explained variance of externalizing anger ($b=.574$; $p<.01$) and negative affect ($b=.572$; $p<.01$) after regression. Rumination mediated effect of life stressors on externalizing anger (4.7; $p<.001$) and negative affect ($p<.001$), and the effect of child abuse on externalizing anger (2.85; $p<.005$) and negative affect (2.84; $p<.005$). Severity of abuse (type or perpetrator), ethnicity or education level were not associated with outcomes.

12	Dyb 2003 Norway	39 parents (24 mothers; 15 fathers) Parents whose children alleged sexual abuse at a specific day care centre and later took part in the offered treatment programme.	39.2 (6.4) Nr	6-12 8.8 24 girls; 8 boys. 14 children were siblings.	Extrafamilial by day care staff. Contact.	Parent distress 4 years following disclosure of abuse. Predictors of distress.	Cross Sectional. Mann-Whitney test, Spearman's product moment correlation, and Multiple Stepwise regression.	<i>Locus of Control (LOC):</i> LOCB. Semi-structured interview assessing: <i>Demographics. Secondary life changes. Perceived social support. Severity of CSA:</i> coded into 3 categories (1: no CSA; 2: intrusive CSA; 3: Highly intrusive CSA). <i>Stressful events:</i> Dichotomous coding (had experience or not) of giving formal police statements, giving court testimony, or in the media. Rated 0-5 on how stressful these experiences were.	<i>PTS Symptoms:</i> IES. <i>General Distress:</i> GHQ-30.	Abuse severity ($r_s=.30$), LOC ($r_s=.35$) and secondary life changes ($r_s=.30$) were significantly correlated with IES intrusion scores at $p<.05$. LOC ($r_s=.51$, $p<.01$), life changes ($r_s=.39$; $p<.05$) and testifying in court ($r_s=.32$; $p<.05$) were significantly correlated with IES Avoidance. Police interviews, media exposure, and perceived social support did not significantly correlate with IES avoidance or intrusion scores. Testifying in court was not associated with IES intrusion scores. Multiple regression revealed external LOC ($b=.53$) and secondary life changes ($b=.46$) contributed significantly to the level avoidance ($p=.01$). LOC ($b=.40$; $p=.01$) and secondary life changes ($b=.33$; $p=0.5$) contributed significantly to the level Intrusion. No significant caregiver gender difference, marital status, or number at day centre.
13	Manion 1996 Canada	93 parents from 63 families with 56 children (63 mothers and 30 fathers). 136 matched pairs comparison parents (74 mothers, 62 fathers) from 75 families with 75 children. Child protection team of Children's Hospital.	Nr Nr	10.26 (3.1) 5.5-15.8 Nr	Extrafamilial. Contact CSA. Disclosure reported to authorities within 3 months. CSA <1 year prior to disclosure. CSA before age 16. Contact.	Association between objective aspects of abuse and subjective experience of abuse of parent with parents' initial distress. Parent gender comparison.	Cross sectional. Standard and hierarchical multiple regressions. Group comparison.	<i>Abuse characteristics and perceptions:</i> Structured Interview specific to CSA about context of disclosure, relationship with perpetrator, family involvement in court. Perceptions on aftermath of sexual abuse. Scoring co-rated with good inter-rater reliability. <i>Parental self-esteem:</i> PSCS. <i>Family functioning:</i> FACES III. <i>Parent's beliefs/attributions of blame around abuse:</i> Parent's perception of events (scale from the larger PIQ). <i>Child Behaviour:</i> CBC-PF.	<i>Global Distress:</i> BSI <i>PTS Symptoms:</i> IES	Maternal parent satisfaction ($sr^2=.16$) and perceived environmental support ($sr^2=.19$) were significant predictors of maternal emotional functioning. Perceived child behaviour and family functioning, as well as objective abuse characteristics, did not contribute to predictions. Mothers experienced more intrusive ($F(1,80)=13.30$, $p=.001$) and avoidance ($F(1,80)=4.19$, $p<.05$) PTSD symptoms, as well as global distress ($F(1,49)=4.43$, $p<.05$). than fathers. No association between covariates and dependant variables.
14	Manion 1998 Canada	93 parents from 63 families with 56 children (63 mothers and 30 fathers). 136 matched pairs comparison parents (74 mothers, 62 fathers) from 75 families with 75 children. Child protection team of Children's Hospital. Manion's 1996 cohort.	Nr Nr	10.26 (3.1) 5.5-15.8 Nr	Extra-familial. Contact CSA. Disclosure reported to authorities within 3 months. CSA <1 year prior to disclosure. CSA before age of 16. Contact.	Factors affecting parents' emotional adjustment up to one year following child's disclosure.	Prospective longitudinal. MANCOVA and Standard multiple regressions.	<i>Time points:</i> data collected at two time points (3 month and 1-year post-disclosure) <i>Abuse characteristics and perceptions:</i> Structured Interview specific to CSA about context of disclosure, relationship with perpetrator, family involvement in court. Perceptions on aftermath of sexual abuse. Scoring co-rated with good inter-rater reliability. <i>Parental self-esteem:</i> PSCS. <i>Family functioning:</i> FACES III. <i>Parent's beliefs/attributions of blame around abuse:</i> Parent's perception of events (scale from the larger PIQ). <i>Child Behaviour:</i> CBC-PF	<i>Global Distress:</i> BSI. <i>PTS Symptoms:</i> IES.	Global distress ($F(4,53)=3.39$, $p=.015$), Intrusion ($F(1,56)=26.68$, $p=.000$) and avoidance ($F(1,56)=9.53$, $p=.003$) significantly improved between time points. Mothers had overall higher levels of avoidant ($F(1,56)=9.24$, $p=.004$) and intrusive ($F(1,56)=11.85$, $p=.001$) symptoms than fathers. Maternal parent satisfaction ($sr^2=.20$), intrusive symptoms ($sr^2=.09$), and perceived environmental support ($sr^2=.12$) were significant predictors of maternal emotional functioning. Avoidance symptoms ($sr^2=.05$), perceptions of child's internalizing behaviour ($sr^2=.05$), and mother's 3-month emotional functioning ($sr^2=.13$), were significant predictors of emotional functioning at 12 months. Abuse related variables did not contribute to emotional functioning

15	Burgess 1990 USA	111 parents (65 mothers and 46 fathers of 67 children). Child care settings.	Mothers: 34.05-26-43 Fathers: 36.5-30-45 Nr	Nr. Age of children at time of abuse 1-7 (2.8) Mean age of testifying was 6.8. 55% female	Extrafamilial. Contact CSA. Day care setting. Mean abuse duration: 14.95 months. Time between disclosure and data collection: 6-47 months.	Comparing parent's distress to CSA whether child testified in court or not.	Cross sectional. Group comparison. T-tests.	<i>Testifying in court:</i> Allocated into testifying (n=17) and non-testifying (n=50) groups. Questionnaire to gather details on: <i>Parent and/or child received therapy after abuse disclosure; Parent CSA; Marital status; Family income; Stressful life events since disclosure; and reactions to court involvement.</i>	<i>Global distress:</i> GSI of SCL-90-R. <i>PTS Symptoms:</i> IES	GSI (t=2.17; p=0.02), avoidance (p=0.01), and intrusion (t=1.96, p=0.03) significantly higher for mothers of children who testified compared to those who didn't for. GSI (t=2.93; p=0.003), avoidance (t=3.92; p=0.000), and intrusion (p=0.000) significantly higher for mothers of children who testified compared to those who didn't for.
16	Baril 2016 Canada (French)	87 Mother Child dyads (children aged 3-18) (51% with own history of CSA) From larger study cohort of children and their families in Quebec.	Nr	11.6 Nr 71% female	Perpetrator 36.9% family member, someone they trusted 60.7%, someone unknown 10.7%. Contact (nr if also non-contact).	Role of maternal CSA in mother's psychological distress.	Cross-sectional. Group comparison. T-test, Chi Square and Logistical regressions.	<i>Maternal CSA:</i> Asked by trained interviewer if had experienced CSA. Dichotomously coded yes/no. <i>Mather's abuse history:</i> Childhood Trauma Questionnaire (excluding sexual items).	<i>Lifetime mental health:</i> CIDIS (diagnosing using DSM-III criteria). <i>Psychological distress:</i> IDP. (Subtests of distress, anxiety, depression, irritability, cognitive problems) <i>PTS:</i> IES	Mothers with history of CSA reported significantly higher irritability in past two weeks (t(85)=-2.41, p=.018), but no difference on depression, anxiety, cognitive problems, or PTS symptoms. Mothers with CSA more likely to report a history of lifetime mental health problems, including alcohol abuse or dependence disorder (x ² (1)=7.09, p=.008), panic disorder (x ² (1)=4.92, p=.027), or dysthymia (x ² (1)=6.14, p=.012).
17	Lewin 2001 USA	38 Mothers (biological/adoptive) 23 with personal history of abuse; 15 did not. (27 of sample compared to 27 matched pairs sample of mothers of children who had not experienced CSA.) Ambulatory clinics of a medical college.	Abuse history: 21.7 (3.6) No abuse history: 23.1 (6.1) Abuse history: Caucasian 100% No abuse history: Caucasian 86.6%	Nr Inc. crit.; 6-48 months. Nr	44.7% father/stepfather/paramour; 21% other family member; 13.1% friend of mother; 21% Unsure.	Role of maternal history of CSA in maternal depression, anxiety. (Data set 1 aims relevant for this review).	Cross-sectional MANCOVA (child age and maternal education as co-variables).	<i>Maternal abuse:</i> Demographic questionnaire designed for study asking about mother's history of abuse. Used to allocate mothers into groups.	<i>Depression:</i> BDI. <i>Anxiety:</i> STAI.	No significant differences between depression or anxiety scores between mothers with and without history of abuse. No significant differences on covariates.
18	Deblinger 1993 USA	99 mothers Centre for Children's support at a University of Medicine and Dentistry, used for evaluation and treatment of CSA survivors.	30.85 (6.66) 19-52 76.8% White; 15.2% Black; 5.1% Hispanic; 3% other ethnic groups	1-14 7.17 (3.63) 79.8 % female	Perpetrators: Group 1: fathers (36.4%); Group 2: Other relatives (30.3%); Group 3: nonrelatives (30.3%). Contact sexual abuse (non-contact was excluded).	Comparing three groups of non-offending mothers (based on perpetrator identity) on distress. Determining correlates of maternal symptom distress.	Cross sectional. ANOVA. Multiple regression.	The structured interview (modified version of the Parent Interview) to gather details of: <i>Abuser identity; Age of child victim; Frequency, duration, and nature of abuse; Maternal sexual assault as an adult and child; Maternal physical assault as a child and domestic violence; Maternal experiences of social support.</i>	<i>General distress:</i> SCL-90-R (GSI).	No significant difference on symptom distress between groups. Perceived aloneness in facing crisis (partial r ² =.12; p<.001) and history of sexual assault as an adult (partial r ² =.08; p<.01) positively predicted current symptom distress. Ethnicity, income, employment and education not correlated to distress.
19	Deblinger 1994 USA	183 mothers (Fathers and other cares excluded). Centre for Children's support at a University of Medicine and Dentistry. (Deblinger 1993 Cohort)	30.5 (6.9) 18-52 72.7% white; 20.2% black; 5.5% Hispanic; 1.6% other.	Nr	Nr	Compared mothers with (n=83) and without (n=100) history of CSA on psychosocial functioning.	Cross sectional group comparison.	Structured Clinical Interview to ascertain details on: <i>Demographic information; Life experiences (e.g. maternal CSA); Adult functioning; Nature of and responses to child CSA allegations.</i>	<i>Global distress:</i> SCL-90-R (GSI).	Mothers with history of CSA reported a higher level of distress compared to mothers who have not experienced CSA (F(1,181)=11.95, p<.05).

20	Timmons-Mitchell 1996	28 Mother/Child dyads	33.6 34.0 Nr	Nr	Nr	Exploring whether PTSD symptoms differ in mothers with (n=14) and without (n=14) history of CSA.	Cross Sectional. Between groups. T-Tests.	Maternal CSA: family history questionnaire and have face to face interview.	PTSD symptoms: PPTD-R; Crime Related PTSD scale from SCL-90-R. Global distress: SCL-90-R.	Mother's who'd experienced CSA scored higher on crime-related PTSD subscale (t=2.37; p<.05) and SCL-90-R subscales: positive symptom index (t=2.61; p<.01), GSI (t=2.71; p<.01), paranoia (t=2.67; p<.01), anxiety (t=2.38; p<.05), depression (t=2.41; p<.05), interpersonal sensitivity (t=2.75; p<.01), obsessive-compulsive (t=2.86; p<.01), somatization (t=2.28; p<.05).
21	Kelley 1990 Nr. (Author based in USA)	111 parents of children who were sexually abused in day care settings. Not for profit organisation for parents of sexually and ritually abused children; a district attorney's office; and a mental health centre. (67 control parents with non-abused children.)	Group 1 (non-ritualistic): Mothers: 33.5; 26-42. Fathers: 30-45; M=36. Group 2 (ritualistic): mothers: 34.6; 28-43. Fathers: 37 (26-55). Nr.	Nr. Age of abuse: Group 1- 1-4 (2.38) Group 2- 1-7 (3.2)	Extra-familial (Day-care). Non-ritualistic and ritualistic abuse. Average of 2.2 years post-disclosure. Contact (nr if also non-contact).	Impact of child's CSA being ritualistic (n=54) or not (n=57) on caregiver distress.	Cross sectional group comparison. T-Tests and ANOVA.	Types of abuse (ritualistic vs non-ritualistic): based on statements made to their parents or therapists and by questionnaire.	Global distress: SCL-90 including GSI. PTS Symptoms: IES	Parents of ritually abused children scored higher on GSI than non-ritualistically abused (mothers: t=1.79, p<.05; fathers: t=2.08, p<.05). No significant difference in IES scores. Fathers scored significantly higher on GSI (t=-2.52, p<.05). Depression only subscale which was significantly higher (t=3.15, p<.05). Mothers scored significantly higher on intrusion symptoms (t=2.36, p<.05), but no difference in avoidance subscale.

Table abbreviations: Nr (Not Reported); MANOVA (multivariate analysis of variance); CD-RISC (Connor-Davidson Resilience Scale); CERQ (The Cognitive Emotional Regulation Questionnaire); SCS (Self-Compassion Scale); SPS (Social Provisions Scale); DASS-21 (Depression Anxiety Scales-21); CSA (Child Sexual Abuse); MDHQ (Mother's Developmental History Questionnaire); IPPA (Inventory of parent and peer attachment); AAQS (The Adult Attachment Style Questionnaire); STAI (State-Trait Anxiety Inventory); PSR (Provision of Social Relations Scale); CRI (The Coping Responses Inventory); GSI (General Severity Index); BSI (Brief Symptom Inventory); GEE (Generalised Estimated Equations); ETI-SR SF (Early Trauma Inventory Self-Report: short form); PSI (Psychiatric Symptom Index); PTS (Post-traumatic Stress); MPSS-SR (Modified PTS Symptom Scale-Self Report); PTSD (Post-Traumatic Stress Disorder); DSM (Diagnostic and Statistical Manual); SCID (Structured Clinical Interview for DSM-IV); ASQ (Attributional Style Questionnaire); Beck Depression Inventory (BDI); IES/IES-R (Impact of Events Scale/-Revised); WCQ (Ways of Coping Questionnaire); FES (Family Empowerment Scale); CTS (Conflict Tactics Scale); TDDS (Three Domain Distress Scale); MMCS (Modified Maltreatment Classification System); ACEQ (Adverse Childhood Experiences Questionnaire); RSR (Rumination Responses Scale); PDHS-R (Parenting Daily Hassles Scale-Revised); LES (Life Events Scale); PANAS (Positive and Negative Affect Schedule); RSQ (Response Styles Questionnaire); LOCB (Locus of Control Behaviour); GHQ-30 (General Health Questionnaire-30); PSCS (Parent Sense of Competence Scale); FACES-III (Family Adaptability and Cohesion Evaluation Scales); PIQ (Parent Impact Questionnaire); CBC-PF (Child Behaviour Checklist – Parent Form); MANCOVA (multivariate analysis of covariance); SCL-90-R (Symptom Checklist-90-Revised); CIDIS (Composite Diagnostic Interview Simplified); IDP (Indice de Detresse Psychologique); (PPTD-R Purdue Post-Traumatic Stress Disorder-Revised); ANOVA (Analysis of Variance).

Journal Article 2: Empirical Paper**The Secondary Survivors of Trauma: A Grounded Theory of Caregiver Experiences Following a Child's Disclosure of Sexual Abuse**

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Abstract

Non-offending caregivers (NOCs) of children who have disclosed sexual abuse can experience significant distress post-disclosure. This study aimed to develop a model conceptualising NOCs' post-disclosure experiences, incorporating the role of help-seeking and parental mentalization. A primarily qualitative mixed-methods design was employed, using grounded theory methodology. NOCs were recruited from child services and took part in qualitative interviews and a parental mentalization questionnaire. The resulting grounded theory model centred around two core qualitative categories: feeling isolated and out of control. These connected to other qualitative themes such as parental self-efficacy, self-blame, and perceived coping resources, such as support from services. Mentalization scores were linked with emotional expressiveness in interviews. The model suggests NOCs have complex multifaceted experiences related to distress post-disclosure, with thoughts and feelings such as perceived failure as a parent, which are not fully accounted for in existing theories of secondary traumatization. Implications for clinical practice and future research are discussed.

Keywords: child sexual abuse; non-offending caregiver; secondary trauma; parent wellbeing, help-seeking; mentalization; reflective function.

The Secondary Survivors of Trauma: A Grounded Theory of Caregivers' Experiences Following a Child's Disclosure of Sexual Abuse

The global prevalence of child sexual abuse (CSA) has been documented as 11.8%, with evidence of occurrences ranging between 8-31% for girls and 3-17% for boys in meta-analytic studies (Stoltenborgh, van IJzendoorn, Euser, & Bakermans-Kranenburg, 2011; Barth, Bermetz, Heim, Trelle, & Tonia, 2013). These experiences have been associated with a range of short and long-term difficulties, with evidence that approximately two thirds of child survivors of CSA experience symptoms related to psychopathology, both in populations receiving support from trauma-specialist services as well as individuals who have not been referred to services for psychiatric input (Carr, 2016; Putnam, 2003). These difficulties can encompass depression, anxiety, post-traumatic stress disorder (PTSD), dissociation, self-esteem and self-concept impairment interpersonal problems, as well as high-risk suicidal or self-injurious behaviours (Maniglio, 2009).

Impact of Disclosure on Non-offending Caregivers

Non-offending caregivers (NOCs) are defined as key caregivers who did not perpetrate the sexual abuse of their child. NOCs have been found to experience a variety of secondary stressors following the disclosure of their child's CSA, including concern about legal proceedings, as well as a breakdown in social, financial and professional support (Van Toledo & Seymour, 2013). Serin's (2018) narrative literature review of NOCs post-disclosure support needs identified themes across 12 papers, including NOCs feeling angry, experiencing shame and guilt, the importance of coping strategies, as well as needing more social network supports. However, a key limitation of the studies reviewed is that the majority focus on intrafamilial abuse and biological mothers, limiting generalisability to the wider NOC population. Additional methodological limitations were small samples, for instance, three participants in a grounded theory qualitative study (McCallum, 2001).

Having an accurate understanding of NOCs' post-disclosure experience and of the factors that may be associated with this is important for both the parent and child. For example, there is evidence that NOCs' experience of distress post-disclosure, such as elevated depression symptoms, is linked with more inconsistent parenting behaviour and poorer monitoring/supervision (Santa-Sosa et al., 2013). This is pertinent to consider as there is often an expectation from professionals that NOCs will be the key source of ongoing support for their child (Cyr, Frappier, Hebert, et al., 2018). Furthermore, research indicates that the parents and caregivers can act as protective factors with regards to children's response to traumatic events and can contribute to their recovery (Elliott & Carnes, 2001).

Psychological distress of non-offending caregivers. Quantitative evidence indicates that NOCs have been found to experience high psychological distress, as in the study by Lewin and Bergin (2001) which indicated that mothers of child survivors of sexual abuse experience clinically heightened levels of depression and anxiety. There is further evidence of NOCs experiencing PTSD symptoms, such as intrusive thoughts (Dyb, Holen, Steinberg, Rodriguez, & Pynoos, 2003), and feelings of self-blame (Serin, 2018). To explain these findings, researchers have attempted to apply the theories of 'vicarious' or 'secondary' traumatization to NOCs of CSA survivors (Banyard, Rozelle, & Englund, 2001; Bux, Cartwright, & Collings, 2016a; Fuller, 2016). These two concepts have been used predominantly for describing the parallel trauma responses experienced in professionals working with survivors of trauma. The main symptoms of vicarious or secondary trauma mirror those experienced by primary trauma survivors and include disturbances in the following: affect; beliefs about the self, identity and the world; interpersonal relationships; and internal imagery (Dunkley & Whelan, 2006; Pearlman & Saakvitne, 1995). Studies have thus subsequently proposed that NOCs may experience a similar 'vicarious' or 'secondary' trauma response, with these concepts being

viewed in the field as a helpful lens for understanding the impact of CSA on a NOC's psychological state (Bux et al., 2016).

However, there appears to be some confusion of these two concepts in the literature with the two terms often being used interchangeably (Dunkley & Whelan, 2006), which can also be found in research into NOCs. These are in fact distinct concepts. Vicarious trauma was conceptualised specifically with regards to psychotherapy contexts and is described as a negative transformation of the therapist's cognitions and inner experience as a result of empathic engagement with a client's trauma (Deville, Wright, & Varker, 2009), through processes such as countertransference (Dunkley & Whelan, 2006; Pearlman & Saakvitne, 1995). Secondary traumatization on the other hand is conceptualised more generally as the paralleled post-traumatic stress symptoms experienced by any individual who is in a close caring role in relation to the trauma survivor. The individual can be a family member or friend, as well as a professional (Deville, Wright, & Varker, 2009; Dunkley & Whelan, 2006; Figley & Kleber, 1995).

Thus, a limitation of the studies which suggest using these concepts in the context of NOC populations, is that they apply the existing 'vicarious trauma' theory, which was originally developed to apply to professionals, to the experiences of NOCs. As vicarious trauma involves processes specific to the context of a therapeutic relationship, it is likely that NOCs are in fact experiencing different psychological processes to professionals when finding out about their child's trauma. Particularly, as for them, the trauma is occurring in the context of an existing caregiver-child attachment relationship (Bakel & Hall, 2018). There have therefore been criticisms of this approach. Kilroy (2015) postulates that the impact of CSA disclosure on NOCs does not seem to be fully accounted for by a typical 'vicarious trauma' reaction as currently described in the literature, due to the complexities and intricacies of parents' experiences. The concept of secondary trauma, which is theoretically appropriate not

just for professional relationships, may thus be a more appropriate framework to understand NOCs' distress. However, how secondary trauma relates and presents specifically in NOC populations has not yet been fully conceptualised. For example, secondary traumatization was initially described in the context of spouses and children of war veterans (Figley & Kleber, 1995). Furthermore, existing literature on NOCs often focuses solely on suggestions of a descriptive set of symptoms or experiences of secondary traumatization, rather than presenting a more interactional model of NOCs' distress and factors influencing and maintaining this.

A more specific model of secondary trauma in NOCs is required in order to develop a better understanding of the processes contributing to NOCs' distress, particularly in light of research indicating there are varying levels of distress found to be experienced across the NOC population (Kim, Noll, Putnam, & Trickett, 2007; Wagner, 1991). As detailed in the author's systematic review, there are a number of factors highlighted which may impact on the level of psychological distress experienced by NOCs, such as self-compassion (McGillivray et al, 2018), attachment, or history of abuse (Kim et al., 2011). Nevertheless, the claims made by these studies are significantly limited by methodological issues, such as their predominantly cross-sectional designs and exploration of individual factors in isolation. Furthermore, there are various psychosocial factors which were not considered in the reviewed studies, which may contribute towards a better conceptual understanding of NOCs' specific experiences of secondary traumatization.

Therefore, designs which are able to explore the more dynamic and interactional nature of NOCs' secondary trauma experiences post-disclosure and the role of a variety of factors is needed. Qualitative methodology provides scope for this form of exploration. However, existing studies of this nature have been limited by predominantly employing variations of thematic analysis which focus primarily on description of common themes. There is consequently a distinct lack of research that integrates these themes into existing theory or that

proposes a theoretical model to explain NOCs' experiences following their child's disclosure. Theoretical model development in qualitative research is often done via grounded theory methodology and is beneficial for conceptualising individuals' experiences to help inform clinical work, as well as guiding future research in the area. Unfortunately, only a small number of papers have employed grounded theory in this area and these have not fully pursued this later stage of theory development. For example, Kilroy's (2015) qualitative paper proposes the idea of 'systemic trauma' as a lens to view NOCs experiences, providing a helpful viewpoint to consider the role of wider systems in how a NOC responds following their child's disclosure. However, this is limited by a lack of a subsequent theoretically grounded model as recommended in the grounded theory literature (Charmaz, 2014).

Help-seeking in non-offending caregivers. There is an emerging evidence-base for interventions for CSA survivors which include NOCs. These interventions predominantly focus on psychoeducation or parental-skill building, although some have a more cognitive focus or advocate seeing the caregiver separately (Van Toledo and Seymour, 2013). National guidelines for trauma-informed working additionally stipulate the importance of services facilitating support which meets the needs of caregivers (NHS Education for Scotland, 2017).

However, despite initial interventions being developed and the established evidence indicating that NOCs are negatively impacted by a child's CSA disclosure, studies exploring the support needs of NOCs post-disclosure imply that NOCs are not receiving adequate support. NOCs have reported qualitatively that they frequently felt governmental services were insensitive to and misunderstood their own experiences post-disclosure. For example, they felt services often focused more on the child's difficulties and the legal proceedings associated with the perpetrator than the needs of the NOCs (Kilroy et al., 2014; Serin, 2018). Fuller (2016) suggests that a greater understanding of the specific help-seeking processes of NOCs would illuminate why they may be feeling their needs are not being met by services and how this links

with their distress. For example, investigating the nature of support services they do or do not engage with, and how they engage with them if they do, would help identify areas in which NOCs have positive experience of service support, as well as the barriers to help-seeking that they may encounter.

Mentalization and Attachment Theory

Mentalization (also referred to as ‘reflective functioning’) is the capacity of an individual to recognize their own mental states, as well as the mental states of others, including thoughts, feelings and intentions. Attributing mental states to others can make behaviours meaningful and predictable, enabling social interactions and relationships (Fonagy et al., 2016; Fonagy & Target, 1997). ‘Parental mentalization’ is specifically the ability of a parent to mentalize their child. This understanding of a child’s thoughts, feelings and motivations is necessary in order to respond in an attuned manner (Camoirano, 2017). Development of mentalization is believed to stem from early childhood experiences of caregiving (Fonagy & Target, 1997) and higher levels of parental mentalization have been associated with attachment security in children (Fonagy, et al, 1991), better parent-child relationships (Rostad & Whitaker, 2016) and positive parenting behaviours (Camoirano, 2017). Although a parent’s mentalizing capacity is thought to originate from their own early childhood experiences, parental mentalization and parenting behaviours have been found to improve following interventions that directly target mentalizing capacities (Sadler et al., 2013; Kalland, Fagerlund, von Koskull, & Pajulo, 2016).

Mentalization and attachment in non-offending caregivers. Mentalization is conceptualised as the ability to fully grasp the reality of another. Thus, it can be hypothesised that parents’ mentalizing capacity following a child’s disclosure of CSA may be crucial in order to understand their child’s subjective experience and respond to their needs (Ensink et al., 2017). However, limited research has been undertaken to explore this hypothesis. Two initial studies have indicated a link between a child’s experience of sexual abuse, poorer

maternal mentalization, and worse child outcomes. These results indicate that maternal mentalization is an independent predictor of child externalizing difficulties (Ensink et al., 2016), and when CSA and parental mentalization were considered together, only parental mentalization was associated with child internalizing and externalizing behaviour (Ensink, et al. 2017). Although providing promising results, these studies do not include male caregivers and focus solely on children under 12 years, which limits the generalisability of findings. Furthermore, there are other factors associated with a child's CSA disclosure in which mentalization may play a role which have yet to be explored, such as parenting behaviour towards the child following disclosure, as well as parental stress and coping.

Mentalization is one component of the broader child-caregiver attachment relationship. Within attachment theory (Bowlby, 1973), both the child's attachment style and the parent's internal representation of the child-caregiver relationship is vital for attachment security (Bakel & Hall, 2018). Parent representations have, as a set goal, to protect the child. These representations include evaluations of themselves as a caregiver, including the effectiveness of caregiving strategies and the ability to read and understand signals from their child (George & Solomon, 1996). These can be related to the parent's ability to mentalize. In times of distress, particularly related to the child, attachment systems are activated and the parent's representations of the relationship and their ability to protect the child can be challenged, often causing increased stress (George & Solomon, 1996). In this context, mentalization as a process may play an important role in understanding NOCs' distress following a child's disclosure as it has been linked with emotional regulation in times of stress (Allen, 2006). An individual's capacity to mentalize is believed to interlink closely with the biological stress response (Fonagy, 2006). This view is supported by neuro-imaging studies in which the pre-frontal cortex has been found to be connected with mentalizing (Gallagher et al., 2000). A traumatic stressor can temporarily inhibit the pre-frontal and frontal areas of the brain, following which

the more autonomic and motor systems come online to manage the threat (Fonagy, 2006). Thus, if the pre-frontal functioning goes offline, mentalizing ability is likely to be compromised at times of stress which are related to challenged attachment representations, such as caused by a child's disclosure of CSA and the subsequent stressors associated with disclosure. Parents may then find it more challenging at these times to know how best to respond to and support their child.

Mentalization can also help NOCs make sense of their own thoughts and feelings, as well as the minds of others in their support system. This may be relevant to their help-seeking experiences, as Stein (2006) hypothesises that mentalization plays an important role in promoting recognition of requests for, or acceptance of, support from others. Understanding the role of mentalization in NOCs' experiences post-disclosure, such as distress and help-seeking, is vital to help develop the best interventions for this population. Particularly, since mentalization-based therapies have been shown to be effective for parents in other contexts, they could be a beneficial intervention for parents of CSA survivors if adapted appropriately.

The Present Study

The primary aim of the present study was to explore the experiences of NOCs following their child's disclosure of CSA. Within this primary aim, there are two secondary objectives of the study. The first is to specifically explore NOCs' post-disclosure help-seeking experiences in order to help fill the gap in the literature about how services can effectively support this population. The other secondary objective is to contribute to the emerging but limited existing literature on mentalization in parents of CSA survivors. Although initial links have been made between maternal mentalization and children's distress, a more in-depth understanding of the specific dynamic and interactional role of mentalization on the wider experience of parents after their child's disclosure is needed. This study will also build on previous literature by addressing some of the methodological issues discussed. For example, a broader population of

NOCs will be recruited, including non-biological caregivers, as well as those whose children had experienced extrafamilial or intrafamilial abuse.

The primary and secondary research questions are therefore as follows:

1. *What are the experiences of NOCs following their child's disclosure of CSA?*
2. *a) What are NOCs post-disclosure help-seeking experiences with the various kinds of support and services available to them? b) What is the role of mentalization in NOCs' experiences following their child's disclosure?*

The overall goal of the study is to subsequently develop a model of NOCs post-disclosure experiences which is theoretically grounded and empirically based, to inform clinical practice, existing theory and to guide research going forward.

Method

Design

To address the research aims, the present study adopted a mixed-methods design with the primary focus given to the qualitative component. This exploratory qualitative component addressed the primary aim and first secondary objective. A formalised measure of mentalization was used to address the final objective.

Rationale for mixed-methods methodology. A mixed-method design of 'QUAL+quant' is employed. The primary approach stems from an inductive qualitative method, in which a quantitative component is embedded within the qualitative framework and data are collected simultaneously (Creswell, 2015; Johnson, Onwuegbuzie, & Turner, 2007). This approach is applied in contexts where application of quantitative methods can elucidate qualitative findings (Barker, Pistrang, & Elliot, 2002). It allows development of a hypothesised model of NOCs experiences following their child's disclosure from the in-depth qualitative data collection, as

well as exploration of a key variable (mentalization) using a validated measure, and the subsequent integration of both these qualitative and quantitative components. A key concept of this method is methodological ‘triangulation’, in which each method can substantiate findings, providing a richer understanding of the phenomenon (Johnson et al., 2007). Driven by an ‘everyday pragmatism’ approach, this design was chosen as it was best fit for the research aims (Biesta, 2015; Johnson & Onwuegbuzie, 2004). Furthermore, the methods and constructs of this approach have been shown to be helpful when applied to investigations of other populations reported in the literature (Braehler & Schwannauer, 2012).

Grounded Theory. Social constructivist grounded theory was employed as the qualitative methodology (Charmaz, 2014). Other qualitative methods were considered, such as Interpretative Phenomenological Analysis, which provides themes from detailed explorations of individual lived experiences (Barker et al., 2002). However, grounded theory was deemed to be most suitable for the research objectives as it enables exploration beyond a description of experience and would facilitate generation of a theory grounded in the data (Charmaz, 2014), which had been lacking in previous research of the experience of NOCs. Grounded theory has also been acknowledged as appropriate for mixed-methods approaches (Willig & Stainton Rogers, 2008) and can be employed to “elaborate and extend existing theory” (Strauss & Corbin 1998), which in this case would be focusing on parental mentalization in parents and further applying these concepts to the new population of NOCs.

Quality control. Yardley’s (2015) quality framework of four core competencies for ensuring validity and reliability in qualitative research were adopted in this study. These competencies are: 1) sensitivity to context; 2) commitment and rigour; 3) coherence and transparency; 4) impact and importance. Specific applications of these principles are highlighted throughout the paper.

Participants

Inclusion and exclusion criteria. The target population was NOCs of child survivors of sexual abuse who were accessing National Health Service (NHS) outpatient Child and Adolescent Mental Health Services (CAMHS) for support with CSA. This research did not aim to represent the entire population of NOCs. The focus of the qualitatively driven methods was on rich in-depth exploration of experiences.

Within the service, whilst acknowledging practical and ethical constraints, the aim was to keep inclusion criteria for study participation as broad as possible in order to encapsulate the NOC population in CAMHS. Participants were included in the study if they were a non-offending caregiver of a child (aged <18 years) who had disclosed sexual abuse. They also were required to have had a key caregiving role at the time of their child's disclosure until present. This included biological parents, step-parents, grandparents, foster parents, adoptive parents, kinship carers or other caregivers. Due to the focus on interviews and in-depth intricate communication in the study, individuals who were non-English speaking or had a known diagnosis of a learning disability were not included. Families who were currently undergoing court or legal proceedings or where the disclosure had occurred less than 6 months ago were also excluded, as were caregivers who were currently declining interventions offered from the service. This was to ensure that there was on going service engagement for participants to access appropriate support if any distress arose from taking part in the research. Finally, caregivers who were assessed by their treating clinicians as currently being in crisis or deemed as being too high risk to meet on a one-to-one basis were not invited to take part in the study.

Sample characteristics. Fifteen NOCs who met the inclusion criteria were asked by their child's clinicians to take part in the study. Of these, ten individuals agreed to take part, giving a response rate of 66.6%. Due to ethical constraints, it was not possible to gather personal information on study refusers. It was thus not possible to analyse differences between those

who did and did not participate in the study. Demographic characteristics for the ten participating NOCs are presented in Table 1. In the interest of protecting confidentiality, these are described for the sample as a whole.

Table 1

Sample characteristics

Demographic Information	Participant information
Gender	Female (n=8); male (n=2).
Age	31-58 years.
Ethnicity	White British (n=10).
Relationship to child	Mother (n=8) father (n=1); stepfather (n=1)
Child Gender	Female (n=7); male (n=3).
Child age at interview	10-17 years.
Time since child's disclosure	1 year 8 months – 6 years
Type of abuse	Intrafamilial (n=3); Extrafamilial (n=6); not specified (n=1)
Service	CAMHS trauma service (n=9); CAMHS general outpatient (n=1)
Time in CAMHS service	1-22 months

Sampling in Grounded Theory. The process of theoretical sampling in grounded theory involves allowing the data to drive the number of participants required for the study (Birks & Mills, 2015). Data collection and analysis were undertaken as parallel processes, with recruitment continuing until rich enough data had been collected and the theoretical categories were viewed to have reached 'theoretical saturation' (Charmaz, 2014). The sample size is also in line with Smith's (2003) guidance that between 6 and 15 interviews is usually undertaken for this form of study.

Procedure

Recruitment. Participants were recruited via convenience sampling across both specialist trauma CAMHS and general CAMHS, where clinicians identified potential participants from their caseloads who met inclusion criteria. Clinicians provided individuals with the participant information sheet (Appendix C). The potential participant would then be given at least 24 hours to review the information. If the individual expressed interest in taking part, the clinician passed

on the participant's contact details to the researcher to organise a convenient location and time to meet.

Data Collection. Following recruitment into the study, participants met with the researcher in person. The majority of participants were seen in the specialist trauma CAMHS base (n=6), with the remainder being seen in general CAMHS settings (n=2) and GP surgeries (n=2). The researcher verbally reiterated information from the participant information sheet concerning the participant's right to withdraw, data protection and management processes, as well as confidentiality and the limits of this around risk management. Consent to participate in the study was obtained at the start of the meeting via the participant consent form (Appendix D). Participants were also offered travel reimbursement for attending the research meeting. Clinicians were asked to fill in a Background Information Sheet for a client who took part, which included demographic information, as well as information about past and current service engagement (Appendix E). The consent form asked for participants' consent for this form to be passed on to the researcher.

Quantitative data collection. Participants were then asked to fill in Parental Reflective Functioning Questionnaire-A (PRFQ-A; Luyten, Mayes, Nijssens, & Fonagy, 2017a), for the standardised mentalization measure (Appendix F). The original PRFQ is an 18-item questionnaire designed as a brief and easy to administer tool to measure parental mentalization in the context of research (Camoirano, 2017; Patrick Luyten, Mayes, Nijssens, & Fonagy, 2017b). Each item receives a score on a 7-point Likert Scale from 1 (strongly disagree) to 7 (strongly agree). It measures three factors associated with parental reflective functioning: 1) pre-mentalizing, or a 'non-mentalizing' stance; 2) certainty of mental states, which can range from hypermentalizing (being overly certain of mental states) to hypomentalizing (being very uncertain of mental states); and 3) interest and curiosity in mental states. This 3-factor structure has been supported by exploratory and confirmatory factor analysis, with good internal

consistency (Luyten et al., 2017b). Despite its recent development, the scale has already been applied in a range of published research (Rostad & Whitaker, 2016; Rutherford, Goldberg, Luyten, Bridgett, & Mayes, 2013). Although the PRFQ was originally developed for parents with children aged 0-5 years, it has recently been adapted with minor wording changes for application with older young people, in the form of the PRFQ-A. The scoring system and the three-factor structure, as well as the validity and reliability, remain unchanged (Luyten, Mayes, Nijssens, & Fonagy, 2017a). Other measures of mentalization are more in-depth interviews lasting 1-2 hours, which are then scored by trained coders, such as the Adult Attachment Interview (George, Kaplan, & Main, 1996). Although regarded as a highly valid measure, it was appraised ethically as too burdensome for the participant both time-wise and emotionally, for example, it includes questions about childhood maltreatment. The questionnaire was therefore deemed as the most appropriate measure for the present study.

Qualitative data collection. An ‘intensive interviewing’ approach was used, as is typically adopted in grounded theory methodology (Charmaz, 2014). This is characterised as an in-depth exploration of a participant’s experience, with the aim to understand an individual’s own perspective, meanings and experiences with respect to the study phenomena. There is a particular focus on following-up on implicit views, hints, accounts of actions, and unanticipated areas of inquiry (Charmaz, 2014). According to Birk and Mills (2015), ideally the interviewer should refrain from imposing structure onto the interviews. However, the interviewer should also not take a passive approach, as their role is to actively engage in a discourse with the interviewee with the aim of developing the emerging theory (Corbin & Strauss, 2008). In keeping with Yardley’s (2015) quality control recommendations around commitment and rigour, steps were taken to ensure fidelity to the process of in-depth grounded theory interviews. For example, the researcher was provided with feedback from supervisors

experienced in grounded theory methodology on both a lay person pilot interview (Birk and Mills, 2015) and three initial participant interviews.

Interviews were audio recorded and ranged from 37 to 96 minutes (median = 66 minutes). The interview was set up by explaining that the researcher was interested in hearing about the NOC's own personal experience following their child's disclosure of sexual abuse. Due to the interview being driven by the information provided by the respondent, a set interview schedule was not used (Charmaz, 2014). Instead, similar initial rapport building questions were asked, such as enquiries around the participant's family and what they like to do together. This was followed by enquiring how long ago the child made their disclosure. Participants were then asked similar broad open questions which invited them to share their experiences following their child's disclosure. The interviewer had a guide for follow-up areas or questions depending on the direction of the interview (Charmaz, 2014). The interview questions were based on guidance in the literature around interviewing in the context of grounded theory. An example of the interview guide, along with typically asked questions, can be found in Appendix G. In line with the grounded theory methodology, early interviews were broader and more exploratory, while later interviews incorporate more focus around investigating emerging themes (Charmaz, 2014).

Analysis. In grounded theory, data collection and analysis are parallel processes. Analysis of qualitative data was guided by Charmaz's (2014) grounded theory methodological model of open, focused and theoretical coding. 'Memo-writing' was used throughout data-collection and analysis. This involves the researcher writing analytic notes regarding emerging codes and theory, as well as engaging in reflexivity around the research process, in line with quality guidelines around sensitivity and context, as well as coherence and transparency (Yardley, 2015). Interview recordings were transcribed verbatim by the researcher with the aim of becoming immersed in the data, which is often regarded as the initial analysis stage (Ranney

et al., 2015). All identifiable information was removed from transcripts in the interest of confidentiality and data-protection.

Subsequently, 'open' or 'line by line' coding was employed for all interview transcripts. This is a micro-analysis of data, applying a label (or 'code') of what has been identified as important, to each line or section of the interview transcript. In-Vivo codes were used where appropriate, meaning that the wording of codes is taken straight from the original transcript. The second intermediate stage of analytic coding is 'focused coding', where initial codes are sorted and synthesised, with the most frequent or significant open codes being elevated to focused codes. Focused codes are more conceptual and start to indicate tentative emerging low-level categories. An example of how interview transcripts were coded can be found in Appendix H.

The third advanced level of coding applied was 'theoretical coding', in which codes and existing literature are used to further conceptualize the emerging categories and how they inter-relate. This moves the analysis in a theoretical direction towards the grounded theory. The process of 'constant comparison' and re-evaluation of categories and concepts, including examination of links between them with reference to memos, allowed emergence of the higher level categories (Charmaz, 2014). The final stage of analysis was generation of the core categories. These are characterised as one or two categories around which all other categories are centred, with the organisation and structuring of these becoming the final grounded theory. A theoretical framework is also employed following the development of core categories to facilitate theoretical coding. These frameworks are not 'forced upon' the grounded theory model but are used to further explain and strengthen the strategies and proposed relationships between these concepts (Birk & Mills, 2015). Quantitative scores from the PRFQ-A were also considered as part of the final stage of analysis process. These provided an additional layer of analysis and informed a constant comparison process that enabled exploration of whether

certain qualitative categories were associated with those scoring a higher or lower mentalizing ability. The analysis in grounded theory is viewed as a non-linear process, with the different steps being revisited where appropriate to facilitate interpretation, emergence of categories, and to remain grounded in the data (Charmaz, 2014).

The software package 'NVivo 11' was used to assist the coding, integration of qualitative and quantitative data, as well as the memo-keeping process. This helped to ensure quality control in relation to coherence and transparency (Yardley, 2015) as an audit trail linking each step of the study to final interpretations and write-up was kept. Furthermore, each stage of the coding process was checked by supervisors on an ongoing basis to ensure quality control and validity of analysis.

Participant follow-up. An additional avenue for advancing analysis which can be employed in qualitative studies is for researchers to meet with some participants again to discuss the study's findings. This is with the purpose of asking for their feedback on the analysis process and grounded theory model to ensure that their views are represented accurately. This is sometimes referred to as member checking (Fossey, Harvey, Mcdermott, & Davidson, 2002) and is in line with maintaining quality and validity, in accordance with Yardley's (2015) commitment and rigour recommendations. One follow-up meeting with a participant was possible within the time scale of the study presented here and was undertaken as part of an ongoing follow-up process.

Research context and researcher's position. In line with the social constructivist perspective (Charmaz, 2014) and Yardley's (2015) quality guidance on sensitivity to context, the researcher was sensitive to the potential influences of the participants perceptions of the project and researcher, the context of the research process, as well as the possible personal influence of the researcher on data collection and analysis. Thus, there was recognition and

reflexivity about the current context of the research and how the researcher is positioned within the project (Birk & Mills 2015).

The researcher/interviewer was working clinically within a specialist sexual trauma service for children and families at the time of the research, as part of their work placement for clinical psychology training. This enabled immersion in contexts related to the population under exploration, helping to develop shared language and background knowledge of aspects such as services and procedures that NOCs may encounter, as advised by Charmaz (2014). This additionally allowed development of rapport building skills with this population. Nevertheless, in being connected to the health service, the interviewer was aware of the potential for bias in interviews, such as discussing positives and negatives of the service, with a possibility of being drawn towards more positive discussions around the services related to those in which interviewer worked in. Additionally, the interviewer was reflective about the potential influence that their dual role may have on participants who may be aware that they had a post within the health service, specifically, in terms of how much participants would feel able to share their true experiences of services following disclosure. Another area of reflection was the influence of the interview setting, as this was where participants usually had clinical appointments. The interviewer therefore took steps to address any potential influence or bias relating to this, by distinguishing their role as a researcher and clinician and by attempting to reduce any 'clinical' presence in the research meetings, for instance not wearing service-related identification badges. The researcher also did not interview anyone who they were currently seeing for therapeutic work.

The researcher's background in clinical psychology and undertaking training in this area at the time entailed further reflexivity around how this may impact the researcher's interview approach and interpretation of results. For example, possibly being drawn to imposing psychological theories in interview questioning or applying these theories too early

in the analysis instead of keeping these steps explorative and grounded in the participant's data. Particular focus was given to this due to the mixed-methods nature of the study. As the researcher had already established a theoretical position in terms of using a mentalization questionnaire alongside the qualitative data collection and analysis, there was potential for bias in terms of the researcher's approach to data collection or analysis. For example, giving labels of open codes which were in line with mentalization theory instead of staying close to the data. Additionally, this could have increased the likelihood of the researcher prematurely grouping participants into low or high mentalization abilities, which may influence how they interpret interview data and coding. The researcher therefore ensured that they were conscious of this and engaged in regular supervision to reflect on the interviews and analysis with supervisors. Additionally, the researcher was blind to mentalization questionnaire scores until qualitative data had been analysed, and these were integrated in the last stage of analysis.

Ethical Approval. NHS and university ethics guidelines were followed to ensure the study met appropriate ethical standards. The study was reviewed and supported by the South East Scotland Regional Ethics Committee (REC) 03 by NHS Research Ethics Committee. Ethical approval was subsequently given by management and the health board's NHS Research and Development Office (see Appendix I). The project was additionally registered with the University of Edinburgh School of Health in Social Science's Ethics Department, as per best practice guidelines.

Results

Organisation of Qualitative Categories

Table 2 provides an overview of the main categories which emerged from the qualitative analysis. Two overarching themes (core categories) were identified: 1) *Losing and regaining control* and 2) *Isolation and connection*. These were elevated to core concepts as they seemed

to epitomise NOCs' experiences and permeated through the other higher-level categories: *Child's disclosure and trauma response; Parental self-efficacy and identity; Perceived coping resources; Actions in response to lack of control and isolation; Outlook for the future*. These concepts encompass a range of lower-level sub-categories. As space does not permit detailed description of these lower-level categories in this paper, they are outlined in Appendix J in the interest of coherence and transparency (Yardley, 2015). These categories aim to provide the background for the proposed grounded theory model, which is the key focus of the study's findings. Through the process of identifying links between key categories, lower level categories emerged to illustrate processes which are hypothesised to link the higher-level categories: *Shame/blame/guilt; Parents' 'mentalizing' capacity of child and others; and Feeling understood ('mentalized') by services*. These were then raised to higher-level categories due to significance in the model (Charmaz, 2014). These latter two qualitative categories relating to mentalization emerged independently to the PRFQ-A scores, by drawing on mentalization theory in the theoretical coding process. Therefore, both quantitative scores of mentalization and qualitative categories capturing this construct are considered in the results.

Table 2

Core categories and other main categories

Core Categories	Losing and Regaining Control
	Isolation and Connection
Other Main Categories	Child's disclosure and trauma response
	Parental self-efficacy and identity
	Perceived coping resources
	Feeling shame/blame/guilt
	Parents' mentalization of child and others
	Feeling understood ('mentalized') by services
	Actions in response to loss of control and isolation
	Outlook for the future

Quantitative Results

The scores of the PRFQ-A are presented in Table 3. There appeared to be some patterns linking parental mentalization scores more to the narrative interview style of participants, as documented in memos. Overall, there was a pattern of lower scores on the ‘pre-mentalizing modes’, with many scores lying around population mean for the original PRFQ which can be used as a guide (Luyten et al., 2017b). However, there seemed to be a cluster of elevated scores of participants 1, 2, 3 and 6, indicating that these individuals were perhaps more likely to adopt a non-mentalizing stance or malevolent attributions. Participants 1, 2 and 6 also scored lower on ‘interest and curiosity in mental states’, compared to others who fell around the means in the normal population found for the original PRFQ. This indicates that this cluster of participants may struggle more with mentalizing than the others. This cluster of participants also had narratives characterised by a dearth of emotional expression, even following prompts exploring this. They therefore contributed less frequently to sub-categories of *Parents’ emotional response to trauma* and *Feeling shame/blame/guilt*. Following exploration of their emotional experience, they touched on feelings such as anxiety and anger, however did not provide as detailed or spontaneous accounts as other participants did.

The qualitative category conceptualized as *Parental mentalization of child and others* through theoretical coding did not map on exactly to the clusters of participants indicated by the PRFQ-A scores. For example, there was not a clear-cut pattern of only the individuals with lower mentalizing scores contributing to this qualitative category. However, participant 1 and 3 did contribute most to this qualitative category’s sub-category of *Difficulty mentalizing child*, as well as participant 3 and 6 contributing least to its other sub-category of *Mentalizing child’s thoughts/feelings/behaviour*, indicating that there may be some overlap between scores, particularly pre-mentalizing modes, and the qualitative mentalization category.

Table 3

PRFQ-A subscale scores

Participant	Pre-mentalizing modes	Certainty about Mental States	Interest and Curiosity in Mental States
1	2.2	4.7	4.7
2	2.5	4.7	5
3	2.8	4.7	6.2
4	1.3	5.7	7
5	1	4.8	6.7
6	2.8	3.1	4.2
7	1.7	5.7	5.7
8	1.3	3.2	5.2
9	1.7	4.3	5.8
10	1.7	4.5	5.8

Proposed Grounded Theory Model

The model presented in Figure 1 illustrates the proposed grounded theory of NOCs' experiences following their child's disclosure. In line with Yardley's (2015) sensitivity and rigour quality recommendations, categories and links are outlined in more detail and anonymised verbatim extracts of interview sections are provided in support of the analysis and interpretations where appropriate. In the interest of protecting confidentiality of participants, all identifiable information has been removed from quotes, such as names, family characteristics and abuse-related details.

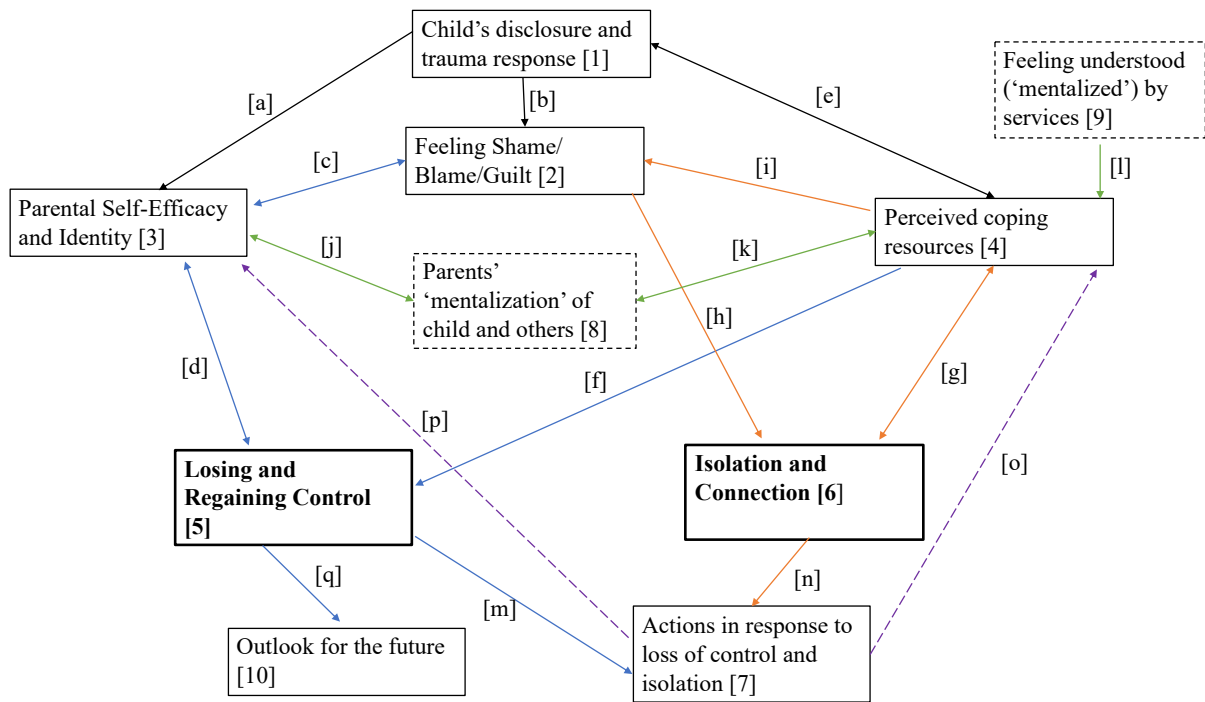


Figure 1. Grounded Theory Model: main categories and interconnections

Theoretical framework. The proposed grounded theory model can be understood in the context of three broad established theoretical frameworks:

1) ABC-X model of family stress (Rosino, 2016). This hypothesises that a stressor causes crisis for a family depending on their available resources to manage and their perception of the event. This model has also been used in descriptions of secondary traumatic stress (Figley & Kleber, 1995);

2) Power-Threat Meaning Framework (Johnstone & Boyle, 2018), which is informed by Attachment (Bowlby, 1973) and Self-Compassion theories (Gilbert, 2010). This model dictates that psychological distress stems from individuals' attempts of coping with a 'core threat', which originates from a negative operation of power, and how this is then appraised (i.e. the 'meaning' it is given);

3) Mentalization constructs, informed by Attachment Theory (Fonagy & Target, 1997).

In addition to these frameworks, wider relevant literature is also used to further explain the proposed model.

Description of the Grounded Theory Model. In line with the research questions, the interviews were anchored by a concrete time point of the NOC's child disclosing sexual abuse. The category of *Child's disclosure and trauma response [1]* encompasses both the NOCs learning of the occurrence of abuse, as well as their child presenting with increased internalising and externalising difficulties. These difficulties experienced by their children can be understood in the context of well documented models of response to traumatic events, including profound effects on the mental health and wellbeing of survivors (Courtois, 2004; Felitti et al., 1998). This is illustrated in Participant 4's account of her child:

You know when she was so angry towards them... so the support I've had to give [child] is erm... [child]'s been diagnosed with anxiety, depression... PTSD... So she self-harms... she cuts... erm... she doesn't feel like she's worthy for anything... she's not been- she's a non-attender at school.

The disclosure of abuse, as well as the subsequent internalising and externalising difficulties experienced by the child, can therefore both be conceptualised as stressors within the ABC-X model. A 'stressor' can turn into a crisis and cause dysfunction within a family if it disrupts the equilibrium of having sufficient material and emotional resources to manage (Rosino, 2016). The Power-Threat Meaning Framework (PTMF) revolves around 'core threats' to safety, survival and wellbeing. Thus, the stressor of their child's abuse disclosure can also be conceptualised as a 'core threat' to the NOC, in terms of the threatened safety of their child.

First core category: Losing and Regaining control. The significance of the NOCs' perception of feeling in control was paramount throughout all interviews, with participant 1 stating: "...and that's when things started to, do you know what I mean, spiral out of control...". This grounded theory highlights a number of pathways contributing to NOCs' feelings of being out of control. Initially, the category of *Child's disclosure and trauma*

response [1] contributes to the concept *Parental self-efficacy and identity [3]*. NOCs described a strong sense of not knowing how to support their child, feeling incompetent, and doubting their ability to parent their child following disclosure. “[I] wished there was something more practical, or I could think of the right thing to say... or something that was useful to say to help her...” [Participant 3 speaking about her child].

There was also an indirect pathway between these categories (via links b and c), with the child’s disclosure bringing intense experiences of *Feeling shame/blame/guilt [2]* for many participants. This is with regards to viewing the abuse as their fault due to a failure to protect their child: “I blamed myself” [Participant 4] and “[I was] just feeling guilty that I’d had a child that this had happened to” [Participant 7]. This then connects to *Parental self-efficacy and identity [3]* as many NOCs identified that they felt unable to adequately fulfil the ‘parenting role’ as they had failed in this by not protecting their child from abuse. The notion of a perceived ideal ‘parenting role’ can be understood with reference to models of ‘good-enough parenting’, which focus primarily on prevention of harm and adversity, and promotion of positive things that may help the child (Hoghughi & Long, 2004). Within attachment theory, an individual’s balanced representations of the child-caregiver relationship focus on perceptions of themselves as a caregiver, centring around their ability to protect their child and include evaluations of their effectiveness of delivering caregiving strategies (George & Solomon, 1996). Thus, parents seem to be perceiving the event of their child’s abuse, as well as being unable to support their child’s needs following this, as a fundamental failure to fulfil this parenting attachment role:

But as a mother, it’s my only job I’ve got in the world... Because I can’t work anymore, so the only job I’ve got is a mother, is to protect her and I failed in that..... And I’ll never not feel that... I’ll never not feel that guilt and failure feeling. [Participant 8]

This poor parental self-efficacy and feelings of shame and guilt can be viewed within the PTMF as a core threat to self-concept and identity, with a new shameful identity being adopted (e.g.

a ‘bad parent’, exemplified by Participant 4: “I’m an absolutely rubbish mother, how did I not see this...”). Within the PTMF, one assigns a ‘meaning’ to a ‘core threat’, and thus it could be posited that NOCs make sense of this experience by conceptualising it as meaning that they are ‘guilty, blameworthy, responsible’ as well as a ‘shamed, humiliated’ (Johnstone & Boyle, 2018). Similarly, within the ABC-X model, these can be understood as the parents’ negative ‘perceptions’ of the stressor, which contribute to a disruption of the family equilibrium, causing stressors to become overwhelming and perceived as crises. This all in-turn leads to NOCs feeling out of control in terms of their own perceived ability to support their child (via link d).

The initial concept of *Child’s disclosure and trauma response [1]* also links to the category *Perceived coping resources [4]* via link (e). This stems from the disclosure and child’s subsequent difficulties increasing the demands on parents to manage amplified stress and responsibilities, including practical repercussions such as reporting to legal professionals, as well as managing the child’s trauma response. This can be understood in the context of the ABC-X model of family stress, as in addition to having negative perceptions, it could be hypothesised that a child’s disclosure also disrupts the family’s equilibrium when NOCs perceive their external and internal coping resources to be insufficient, resulting in the stressor becoming a crisis.

The perceived coping resources identified in this study were, firstly, external resources such as the support from services and social support networks. Many participants described a dearth of services available to support them: “I was offered no services, I was offered no supports at all, whatsoever”; “like nothing or nobody was supporting us... there was nothing there” [Participant 4]. Where participants were engaged in services, a particular issue highlighted by participants was the lack of communication both from and between different services. This meant participants often received mixed messages or incorrect information, as well as putting more pressure on NOCs to liaise with multiple services, adding to their on-going levels of

stress. This is highlighted by Participant 9: “it probably would have been quite good if CAMHS could have maybe talked more to school... about er... supporting a child who has been through a trauma”. Participant 9 further highlights how they felt responsible and the focal point of organising different services: “You’re the one that co-ordinates it rather than somebody [professional] being in control of it and they become the focal point”.

Belsky's (1984) determinants model of parenting and Bronfenbrenner's social ecological systems theory of parenting (Bronfenbrenner & Morris, 1998; Hoghughi & Long, 2004) both indicate that having the support of wider systems contributes to a parent's ability to fulfil a ‘good enough’ parenting role. Thus, without the presence of these, a parent's ability to meet the expectations of parenting in the traumatic situation are compromised. Through the PTMF, the lack of support and services which NOCs report experiencing could be considered to be the negative operation of systemic power. This could relate to: services holding the power with regards to deciding who receives support; there being insufficient access or funding for services which NOCs need to help them fulfil a ‘good enough’ parent role; as well as NOCs feeling threatened by the potential power that services hold. For example, Participant 5 reflected on her experience of decisions being made by services: “And it's basically... ‘this is what's happening’... there's no other option... it's been agreed by housing kind of... all the way through we've never been listened to...”. Participant 6 also shared fears about contact with services if she shared her distress: “And then you're afraid you'll get your kids taken off you...”.

Secondly, the category *Perceived coping resources [4]* in this study also incorporated the NOC's own personal coping ability. Participants reported being compromised by their own emotional response to the trauma, as well as the impact of their past experiences and current additional life stressors. Participant 7 stated in relation to her own history of CSA:

For me it's... been a lot more personal as well... and that was difficult for me... because I had kind of blocked it all out... and...I had just kind of hid from it... when [child] was going through it, I was going through it... cos...I was, I never ever went to court or anything like that... but when [child] was going to court it was like... it made me feel things about the justice that I should have had.

Perceived coping resources [4] in turn also feeds into the core category of *Losing and reconciling control [5]* (path e), with NOCs feeling that due to the insufficiency of coping resources, such as feeling unsupported by services or that their internal ability to cope emotionally is overwhelmed, the situation is beyond their control, causing feelings of helplessness. This is illustrated by Participant 3: “Ah just really... you just feel so helpless... you know... cos there's nothing you can do to make it better... you just want to sort of fix things but it's really difficult”, Participant 7: “Erm... sometimes I felt like I... I couldn't really cope with that... just because it was... things that were kind of outwith your control”, and Participant 4: “A lot of it's like you've got a blindfold on and you just don't know... you know that feeling... where you're going, you're unsure”.

Second core category: Isolation and Connection. *Perceived coping resources [4]* also contributes to the other core category of *Isolation and Connection [6]* (link g), with many NOCs feeling unsupported by services and experiencing a lack of support from their wider network of family and friends. This contributes to NOCs feeling ‘alone’ in dealing with this new situation, with Participant 3 reflecting: “it was quite a... lonely time” and Participant 2 recounting a conversation with their partner about a lack of service support: “So then after a week, we went to have a chat, cos then it was just down to us cos social services didn't think it was that serious.” This feeling of isolation was also compounded by the feelings of *Feeling shame/blame/guilt [2]* (link g). In this context this stemmed from NOCs reporting to feel judged by others in their system, both from friends as well as professionals (link i). Participant 9 illustrates this with her feelings of being judged by others as a parent, viewing that others do not understand what she was going through:

Just maybe perhaps that I could have done more, that I didn't protect her enough... and sometimes other people can be very judgmental... And they don't really know what it's like to have a child who's ill... and they think that... 'oh just, just get her out of bed and send her to school' and i-i-it's like... ok I've tried that and she can't do it... it's like... you're failing as a parent because you can't get her to go to school.

Participant 9 went on to describe experiencing direct judgment from friends when visiting them: "And it turned into an intervention... and the two of them ganged up on me saying... I wasn't disciplining my children enough".

Finkelhor & Browne's (1985) model of the impact of child sexual abuse on survivors could be generalised to NOCs in order to conceptualise this experience. Their model depicts four factors associated with a survivor's negative responses to trauma, one of which is 'Stigmatization'. This refers to the negative connotations around trauma experiences, which can stem from attitudes of the system or society and be internalised into ones self-image, such as sexual abuse being 'shameful' (Finkelhor & Browne, 1985). Stigmatization is believed to contribute to individuals withdrawing from others and becoming isolated. Within the PTMF, this stigma can be conceptualized as another 'meaning' given to the 'core threat' of the abuse, in terms of a social discourse around discussing CSA and judgment of parents whose children have been abused. It seems therefore that within these models, due to this perceived stigmatization, NOCs can withdraw from potential support networks, which appears to increase the perception of a lack of external systemic coping resources [4], diminishing the individuals' perceived internal capacity to cope (bi-directional link g).

This was also found to be true in the reverse, when at the times NOCs perceived that their needs were being met by external coping resources, such as services, there was a sense of an increased feeling of being in control and less isolated. This is illustrated by Participant 10 describing how being able to contact her child's therapist in moments of stress was beneficial:

I was just getting so frustrated and immediately I thought... I can't do this I'm failing with him again... [child's] going to drop out of [school]... and that was really when my back-up was [CAMHS therapist]... and instead of thinking here I can't cope with

this... he's going to drop out of [school], it's all going to go back flip again... I just sent her a text and then she got back to me and called me today and was just like 'phew'... it was a huge relief.

Participant 10 also particularly highlighted the importance of having a professional there for her as a parent: "just knowing that she was there and she was going to call me".

When caregivers received specific guidance on parenting support from professionals, this also appeared to help regain their feeling of being in control [5] and subsequently increased positive feelings related to *Parenting self-efficacy and identity* [3] (via bi-directional link d). For example, Participant 8 reflects on the impact of learning parenting techniques from CAMHS: "it's like 'we've got this'... and I can be like... right ok... I know what this means...we're going to try this" and "it's that thinking, oh yeah, we're doing something right... you know she's not falling apart so... we must be doing something right". Furthermore, Participant 10 highlights the importance of feeling empowered and not blamed by clinicians:

I've never ever ever felt... in the whole time that I've come that [CAMHS therapist] thought I was a failure as a mother... even though I might think it, I've never ever thought that... and I'm just realising that... and that again is huge... that I've never ever thought that she thought I was failing [child].

Role of Mentalization. In addition to quantitative exploration of this concept through the PRFQ-A, *Parents' mentalization of the child and others* [8] also arose as a key qualitative category in the process of theoretical coding, with NOCs reporting on their abilities in their own minds in relation to understanding what was going on in the minds of their children and others. Within mentalization theory, it is suggested that an individual's mentalizing capacity can be compromised at times of increased stress or threat (Fonagy, 2006). As described in the context of the PTMF, NOCs are experiencing numerous 'core-threats' and the negative 'meaning' attributed to these. This may explain the qualitative findings of parents struggling to consider what is in their child's mind in a space of increased pressure and perceived lack of coping resources [4]. There is evidence for this from some participants in terms the difficulty

in parental mentalization category [8] in turn perpetuating feelings of poor parental self-efficacy [3] (link j), subsequently leading to NOCs feeling more out of control. This is illustrated in Participant 9's experience of her difficulties as a parent in understanding what is in her child's mind at times of increased stress and the impact of this on day-to-day life:

But sometimes [child] doesn't talk and sometimes it's actions... So you'll say to her are you going to get ready to go to [after school activity] ... and then she just wouldn't put the uniform on and like she's telling me that she doesn't want to go but she's not saying it... And sometimes that is how she communicates and I miss the point... Because it's not what I want to hear... it's like... I want you to go and that's what I want you to do... but I don't hear the other non-verbal cues... because maybe I'm too busy or I have other things to do.

Participant 9 further also reflected on how she felt she missed or didn't understand what was in her child's mind at these times due to her own ways of coping or lack of knowledge: "I probably missed quite a lot of it... because my way of coping with trauma is just to stick to a routine and just to keep going"; "And it's maybe for me the lack of understanding... or maybe not realising how ill she actually is." Attachment theory lends an integrated lens to understand these processes, with the parental internal representations of the attachment relationship being based on their perception of being able to understand and respond to a child's cues. Thus, when this representation is challenged, it is likely to affect how the parent perceives their ability to fulfil the attachment relationship.

In addition, non-parental mentalization, such as being able to consider the minds of others in the social network, is implicated as important within the category of *Parents' mentalization of the child and others* [8], through its sub-category of *difficulty mentalizing others*. This is illustrated through Participant 8's reflections around not considering her partner's feelings during her experiences of distress post-disclosure:

Participant 8:

My temper was just a bit shorter...but [husband] did get, he did get the brunt of it.

Interviewer:

Uh huh... ok... and what was that like for you guys?

Participant 8:

Not nice... yeah it's not nice... it isn't nice for him... you forget that he... he's been through the whole thing with [child] as well.

This exemplifies the hypothesised link (k) between *Parents' mentalization of the child and others [8]* and *'Perceived coping resources [4]*, as a compromised ability to consider the minds of others can cause rifts between potential support networks, lessening the potential coping resources, and increasing feelings of isolation (link g).

Mentalization also seemed to be important in terms of the services' ability to understand the needs and experiences of NOCs. The lower-level key categories of *not feeling listened to/understood/validated by professionals* and *valuing professionals listening and validating* were conceptualised through theoretical coding as the importance of *Feeling understood ('mentalized') by services [9]* which contributed to NOCs' *Perceived coping resources [4]* (path m). For example, Participant 5 shares an experience of their concerns being invalidated by a professional: "we were basically told that there were more needy people out there". Participant 6 also describes attending her child's medical examination, where she felt that she was not respected or understood by professionals, and that they were not sensitive to her specific circumstances:

Thing with that appointment is she came out wearing a police badge... It was horrible... how is... how is that... a police officer coming to shout your name in the waiting room..... Because we were in a waiting room of people, ordinary people in the [children's hospital] who were waiting for ordinary appointments..... It wasn't private at all, no.

The reverse was then also true with NOCs valuing being listened to and validated by professionals, associating this with positive service experience and changes. Participant 10

illustrates this in describing how she felt the way in which the clinician responded to her validated her worries and felt her concerns were taken seriously:

‘Cos she immediately got back to me, she just said is everything ok, is anything up... almost immediately and it was out of hours when I text her... and I said yeah it’s fine I just need to speak to you about [school] and stuff and then she did call me but it was just like... she cares about my child.

She further linked this validating response explicitly to feeling calmer: “She cares about us... and immediately that calmed me down and things are going to be ok you know”.

Actions in response to loss of control and isolation. In response to the core experiences of isolation and feeling out of control, NOCs attempted a number of ways to cope the best they can in the circumstances. This is encompassed in the category *Actions responding to loss of control and isolation* [7]. These actions can be conceptualised with the PTMF as ‘threat responses’, which have functions such as ‘maintaining a sense of control’ and ‘seeking attachments’ (Johnstone & Boyle, 2018). There were a number of sub-categories within this concept illustrating actions, with some actions producing these intended outcomes of increasing a sense of control and connection. For example, *seeking help from services and social networks* led to an increase in perceived coping resources (link p). This is illustrated by Participant 3:

I thought she might be having a breakdown. She was in quite a bad way. And I phoned... I was trying to remember if we did have a CAMHS, we had had a referral to CAMHS and I did have the name of someone, and I phoned and spoke to him and he was really good, phoned back and gave me advice.

Other actions can be conceptualised within the PTMF as best attempts at coping, which produce unintended negative consequences in the long-term, often perpetuating feelings of isolation and being out of control. For example, due to feeling out of control, a number of parents contributed to the sub-category of being *hypervigilant to negative events* in order to ensure that things did not ‘spiral out of control’ again by being on hyperalert and engaging in avoidance behaviours of situations over-appraised as ‘dangerous’. Participant 1 describes this

as “you’re sitting there on a knife edge.” This can have negative impacts on day-to-day life, with Participant 6 reflecting on her avoidance due to difficulty trusting others to look after her children:

Participant 6:

They don’t stay with anybody..... they don’t stay anywhere...overnight... They will, well they sometimes stay at my [family member]’s... but I don’t like it... it makes me really panicky.

Interviewer:

And when you’re saying you’re panicky, what’s going through your mind? What, what is that panic about do you think?

Participant 6:

In case somebody hurts them a-... them again.

Additionally, in response to feeling out of control and isolated due to lack of supports and perceived judgment, NOCs often seem to take on the role of being the ‘*centre of support for the child and family*’, which was identified as a sub-category. They take on increased responsibilities of emotionally supporting others, as well as being the central contact of legal, social and health professionals.

Participant 6:

I was having to deal with Police and everything by myself... without anybody else to defend me... like I was having to phone in to make the appointments... and they were phoning me... directly me, not to a social worker... it was like... and when I was home I was holding my phone all day because of it.

Interviewer:

And what was that like... having to be that person... talking to everyone?

Participant 6:

Oh, it was mad

Interviewer:

Yeah... how did you feel at that time?

Participant 6:

I don’t know... I think I was just... I wasn’t thinking anything or feeling anything... I was just focused on helping [child] and that was it.

Although this seems an attempt to regain some control in the chaotic situation, this in turn leads to further feelings of being overwhelmed. It also links to the sub-category of many parents stating they have to *be strong for the family*, by masking their own stress and emotions, as well

as maintaining a 'normal life' for the rest of the family. This seemed to be intrinsically linked to the importance of protecting their child and maintaining the 'good enough parent' role:

I just didn't want any of my kids... but especially [child] when this was going on... to feel like I wasn't strong because I think that they're so dependent on you... that if they think that you're not coping and you're not strong... then how are they ever going to get through it. [Participant 7]

It's the whole swan thing. You know, it's nice and calm on top and trying not to let the kids, trying not to let [child] see that it was upsetting me. You know, how upset and anxious and guilty I felt. Just so that she didn't feel those things. [Participant 8].

However, in striving to 'be strong' and be the 'centre of support', in the context of perceived lack of appropriate resources to help, NOCs can bottle up their feelings with no outlet. This can have negative consequences in terms of having to take time off work. The stress may present in other situations too, such as shouting more at family members or having heightened mental health difficulties themselves. Participant 9 reflected on the impact on her own mental health: "I've got my own issues to deal with as well and I do find it quite overwhelming as I'm trying to be well myself and I'm trying to help two children who are not well.", and Participant 8 recognised the effect on the wider family: "I mean the kids did get, the kids did get, they probably did get shouted at a bit more...but for, not getting ready for school... or... my temper was just a bit shorter". These unintended consequences of actions thus result in vicious cycles, worsening the NOCs' situation and distress. For example, this further depletes parental self-efficacy [3] (link i) feeding back into feeling out of control [5] (link c).

Outlook for the future. The final key category that emerged was the NOCs' perception of what the future held for them and their child. A common experience across participants was the continuation of difficulties presented by their child, as well as their own stress, as Participant 4 describes:

I go through stages where I'm really angry still... and then I go through days... they're fewer... but when I don't want to get up in the morning... and I'm just like 'ugh'... my

brain's tired... you know what I mean. I've been going through this and my brain's tired and I need to get up and I need to clean the house again, I need to do it.

There were however differences found within and between participants narratives in terms of their views of the future. There was a sub-category of '*viewing the future as negative and hopeless*', as exemplified by Participant 1:

Participant 1:

It may even been recently... putting herself in a vulnerable position drinking with somebody in a local park. So, she still has the wee, 'keeping yourself safe'...

Interviewer:

What did that bring up for you?

Participant 1:

It's, nah, just a warning that all is not totally well yet, and there's a long way to go.

This seemed to stem from ongoing feelings of being outside their control or powerlessness over their situation going forward (link r). Participant 9 describes feeling at a loss and not knowing what to do to improve the situation, linking with feeling that things are not going to get better in the near future:

I don't know what to do about that... erm I maybe need to change my life and you know... big things... like I said to you about do you move... do I give up my work... Do I... I don't know... erm... but I can see that it's not going to fix anytime soon.

There was also a sub-category of *noticing improvements and having a positive outlook*, in which individuals communicated a more optimistic view of the future and recovery from the abuse for both them and their children. Participant 6 reflects on her more positive management of her own emotional responses with support from professionals: "Cos before when I had a panic attack in the street I would phone an ambulance or something... and now I just phone [support worker]". Participant 2 further comments on the changes that they observed in their child at present: "I think [child]'s a lot happier now, he's told us that, that he is a lot happier, that he goes to school and he doesn't have those worries, he just comes home now." Linked to this, another lower-level category was *post-traumatic growth* which was conceptualised through theoretical coding in the context of resilience literature as developing positive skills or

relationships as a result of the traumatic experience (Tedeschi & Calhoun, 2004). This described how some participants felt that either they or their child became stronger or saw positive changes from getting through their traumatic experience. For example, Participant 1 discusses their change in outlook in thinking about their child's self-harming, due to their own increase in understanding about their child's difficulties: "It's just if I see my daughter's [body part with self-harm marks]..... I sometimes... I know this sounds bizarre, but eh, you can take positives out of it... because she's standing there not hiding it". These more positive outlooks seemed to be linked to having a more internal locus of control, indicating that NOCs may feel they have regained some agency and sense of control these situations (link m) linking to feeling stronger and more able to cope going forward: "... whereas now I feel so much stronger... if something comes along... I feel that I can cope with it... I can do the things that I need to do to get us through it". [Participant 7].

Participant Follow-up

The additional follow-up meeting allowed the researcher to ascertain participant feedback on the categories and grounded theory model from one participant. This participant viewed the main categories and overall model to be an accurate representation of their experiences following their child's disclosure. They further provided specific comments on which sub-categories were most relevant to their experiences. As this was the first participant in the planned ongoing follow-up phase, the feedback from this participant will be considered in the context of subsequent participant follow-up sessions, as this phase is planned to be an ongoing process for the present study.

Discussion

Main Findings

This study aimed to develop a grounded theory model to address the primary research question of exploring the experiences of NOCs following their child's disclosure of CSA. Additionally, the model incorporated exploration of the secondary research aims which focused on NOCs' experiences of help-seeking, as well as their parental mentalization abilities post-disclosure. The proposed grounded theory model highlighted central themes around NOCs' perception of the degree to which they felt isolated and not in control. Contributing to and interacting with these main categories were other themes around how NOCs perceived their own ability to parent their child and fulfil the parenting role, as well as feelings associated with self-blame. Perceived coping resources, including NOCs perception of their own internal ability to cope as well as the availability of external resources, such as services and support from their wider system, also contributed to the degree NOCs felt out of control and isolated.

The model postulates answers to the secondary research question regarding NOCs experiences of help-seeking. Many NOCs described a perceived lack of services available to support them as well as their child. This fits in with other findings highlighting the dearth of services available for NOCs (Serin, 2015). However, the present study revealed that NOCs can experience barriers to engaging in services which are actually available. Such barriers include finding the perceived power that services hold to be threatening or judgmental, such as a fear that social services might remove children from the home if the parent is perceived as struggling to cope. Furthermore, NOCs reported feeling that professionals often did not seem to listen to, understand, or empathise with their own experiences and needs. Within the model, such experiences were conceptualized within Mentalization theory, i.e. how 'mentalized' NOCs feel by professionals (Fonagy & Target, 1997). These negative help-seeking experiences can then lead to NOCs avoiding engagement with services. The perceived judgment and

stigmatization of NOCs were also experienced in relation to others in their wider system, such as from friends, which subsequently led to some NOCs withdrawing from social supports and subsequently be less likely to seek help from these networks in the future. These experiences overall perpetuated their feelings of isolation and powerlessness.

Regarding the final secondary question, quantitative measures of parental mentalization did not produce clear-cut groups of individuals in terms of high and low mentalization scores which could be then related specifically to particular main qualitative categories of NOCs post-disclosure. However, there was a cluster of participants with lower mentalization scores who had less emotionally expressive and reflective interview narratives than others in the group.

One explanation for this may be that NOCs with higher mentalization ability may actually experience higher levels of distress, with individuals perhaps having a heightened attunement to the impact of the trauma on themselves and their child. Similar findings have emerged in psychosis populations where a better mentalizing capacity (or related constructs) have been associated with poorer quality of life (Macbeth, Gumley, Schwannauer, & Fisher, 2011) and depression symptoms (Lysaker et al., 2005). An alternative explanation is that NOCs with poorer mentalizing ability may struggle more with recognising and discussing their own and their child's emotional experience. This suggests that even years after the disclosure, NOCs with poorer mentalizing capacity may present differently to services in terms of how forthcoming they are around discussing their own emotional experiences. This could subsequently be another barrier for some NOCs in terms of their help-seeking and service engagement. Further exploration of the intricacies of these factors are therefore required in order to understand the needs of this population.

Qualitative data independently indicated a theme around NOCs' ability to conceptualise their child's mind, and the minds of others, in the more immediate aftermath of disclosure. This was subsequently coded within qualitative theoretical coding as NOCs' mentalization of child

and others. The model indicated that this qualitative category pertaining to a difficulty in mentalizing may play a role in NOCs' parental self-efficacy, feelings of being out of control, and depleted coping resources at the time. Attachment theory can provide an overall frame to understand the significance of this interactional relationship between mentalization, distress, parenting self-efficacy, and control. Within this theory, a parent's positive representation of the caregiver-child attachment relationship depends on their evaluation of their ability to use effective parenting strategies and being able to understand and respond to their child's signals. When the attachment system is activated and these representations are challenged, as is likely to be occurring in the context of a CSA disclosure, this can cause feelings of distress and helplessness as a parent (George & Solomon, 1996). As increased stress has been found to impact mentalization and the brain areas associated with this concept (Fonagy, 2006), it means that there is likely to be a constant interaction and perpetuating cycle between mentalization, parental self-efficacy, feeling out of control, and levels of distress.

The quantitative scores of mentalization appeared somewhat related to this qualitative category, as some of the participants who had the lower mentalization scores were the highest contributors to this category. However, this was not a clear-cut association given that a number of participants with a range of PRFQ-A scores also contributed to the qualitative category related to difficulty in mentalizing. This difference between the quantitative scores and qualitative findings might be explained by the nature of the questionnaire, with it being a cross-sectional measure capturing the NOCs' mentalizing ability at a specific time-point which was at least 20 months after the child's initial disclosure in this sample. NOCs' mentalizing capacity may be dynamic and have been more hindered closer to the time of disclosure as indicated in the interviews, with parents reporting this to be the most distressing period. This interpretation is only tentative as the qualitative category of mentalization in the immediate disclosure aftermath was not measured empirically. This is an important consideration, as commenting

on one's mentalizing ability may take a degree of reflection on one's own mind, so those with lower mentalization may not have been able to accurately report on their abilities in this domain in the context of an exploratory interview. Therefore, further research is needed to reliably track the process of mentalization over time following disclosure.

The results of this study support the application of the theory of secondary traumatization to the NOC population, with some qualitative categories mirroring an individual's first-hand response to trauma. Examples include the parent's emotional response to trauma within the internal coping resources category, their experience of hypervigilance, feelings of shame and self-blame, as well as fundamentally feeling out of control, powerless and isolated. However, the findings also contribute important insights into how secondary traumatization may be conceptualised in the NOC population.

Previous studies have been limited by generating a more general descriptive set of symptoms of secondary traumatization in NOCs (Fuller, 2016), or suggesting the application of the vicarious trauma concept which was originally developed for professionals (Bux, Cartwright, & Collings, 2016). This study's findings however contribute a proposed model for understanding the generation and maintaining processes of these experiences related to secondary trauma specifically in NOCs. It hypothesises the importance of the interacting role of other relationships, such as with services and the wider systems, in helping or hindering NOCs' adaptation following their child's disclosure. This supports Kilroy's (2015) notion of 'systemic trauma'. Additionally, the model suggests that the pathways to NOCs' sense of lack of control and isolation are specifically related to NOCs' perceptions of themselves as a parent and their resources for fulfilling the parenting role successfully. The study highlights that bi-directional processes are likely to be occurring, such as the reciprocal relationship between thoughts and feelings such as self-blame and parental self-efficacy. These kinds of interactional relationships have been difficult to capture in the cross-sectional research looking at

associations between psychosocial factors and NOCs distress, as highlighted in the author's systematic review.

Although there may be similarities in terms of presentation, the processes which are hypothesised to lead to distress in NOCs are therefore fundamentally different from those associated with those within the theory of vicarious trauma, which was originally developed for professionals. This can be conceptualised as being due to vicarious trauma occurring with the context of a therapeutic relationship, including empathic therapeutic engagement, counter-transference and multiple exposures to traumatic material from clients (Pearlman & Saakvitne, 1995). This is in contrast to NOCs' experience where their secondary traumatization is within an established caregiver-child attachment relationship. This grounded theory model suggests that an important process is that parents feel they feel are partly responsible for the abuse, as they have failed to protect their child. Additionally, that they often find it challenging to know how to effectively support their child after disclosure. This leads to feeling that they are not fulfilling their parenting role within the attachment relationship, resulting in feelings of helplessness. Furthermore, attachment related processes such as parental mentalization may also be playing a role in these secondary trauma experiences. This is markedly different to professionals who are somewhat removed from the circumstances of the trauma and do not have the same experiences of feeling responsible for the abuse. Thus, rather than the concept of 'vicarious trauma', the application of a specific model of secondary traumatization in the context of the NOC population, such as the one presented in this study, is advocated for this field.

Limitations

The conclusions of the present study need to be considered in the context of its limitations. Firstly, qualitative methods are unable to infer causality between categories. This grounded theory model should therefore be viewed as a collection of hypothesised processes and

relationships between key categories, which can be used to help inform professionals about the experiences of NOCs, while these relationships are explored further in future research. With regard to the quantitative part of the study, a limitation is that questionnaire used depends on self-report and is therefore subject to bias, such as demand characteristics.

Limitations of the mixed-methods design also needs to be considered, in terms of integrating a quantitative method into a grounded theory design. In theory, a researcher undertaking grounded theory traditionally is expected to enter their research with an open mind and be naïve to the theory or previous research within a field to minimise pre-existing hypotheses influencing data-collection and analysis (Birk and Mills 2015). More recent grounded theory approaches acknowledge the unfeasibility of the full adherence to this approach, as often researchers are already working in and have knowledge of the research area before-hand (Charmaz, 2014). Nevertheless, using a mentalization questionnaire within the mixed-methods framework could be viewed to increase the chance of bias from the researcher, as a specific theoretical viewpoint had been established in part of the project from the beginning. It was thus particularly pertinent for the researcher to engage in reflexivity around this and steps to be put in place to reduce the potential risk of bias, as detailed in the methods section. From a social-constructivist perspective, the data presented in a grounded theory model is constructed through the experiences and interactions of the interviewer and interviewee. Therefore, within this approach, the data is never viewed as being completely void of influence from the researcher, which should therefore be considered when interpreting the findings of the present study. However, appropriate steps were taken in this case to minimise the risk of bias and maintain quality as permitted by the nature of the study, as well as within the constraints of time and other resources.

The focus of this research was to understand the experiences of NOCs whose children were accessing CAMHS services for support with CSA. This means that the model presented in this

paper may not be representative of other groups of NOCs, such as those who are not accessing services, those whose children are not presenting with mental health difficulties, or those seeking other supports such as through the third sector. Additionally, the generalisability of findings is constrained by the convenience and clinician-selection of participants. There is therefore potential for self-selection bias in the sample population, for example, it may be that only NOCs who were in a more stable emotional and contextual place volunteered for the study or were selected by their clinicians.

This may also explain why there were no clear clusters of mentalization scores: the fact that the NOCs were already engaging in services may have resulted in them having a more developed mentalizing capacity overall. Alternatively, the clinician selection of participants may have been skewed towards those who had a higher mentalizing capacity, as these clients may have been viewed as more likely to reflect on their experience in an interview. Additionally, as clinicians may have selected clients who were in a less distressed place, this may have meant generally their mentalization capacity was higher as a group. In line with this, research participants who were currently less distressed and therefore perhaps have a better mentalizing capacity may have been more inclined to agree to take part in the study. All these factors may have limited variability of mentalization scores in the sample.

The study aimed to account for methodological limitations of previous studies by having a more inclusive and representative NOC population rather than focusing just on the biological mother of the child survivor, as well as survivors of both intra- and extra-familial abuse. Nevertheless, despite the broader inclusion criteria, the majority of participants were biological caregivers and all participants were of Caucasian ethnicity. These restrict the generalisability of the model to all NOCs, which remains an important consideration for future research. Furthermore, the sample consisted predominantly of female caregivers, with only two out of the ten participants being male. The analysis did not indicate that there were significantly

different themes and experiences associated with specifically male or female participants, suggesting that both groups may have similar post-disclosure experiences. However, this may be due to the small number of male participants not allowing in-depth exploration of emerging themes for this group. As detailed in the author's systematic review, there is evidence in the quantitative literature that there is a gender difference with regards to the levels of caregiver distress post-disclosure, however these findings are inconsistent. Therefore, further studies focusing on exploring the specific post-disclosure experiences of male caregivers are important in future research, as the mostly female sample in this study limits generalisability to male caregiver populations.

Clinical Implications

In line with Yardley's (2015) quality criteria around impact and application of research to inform practice, the findings of the study make an original contribution to the understanding of the provision, process and content of support needed for NOCs. In terms of service provision, it is vital to address the finding that NOCs perceive there to be a significant dearth of services and a need for improvement in the availability of supports and services for caregivers and families following a child's disclosure, as expressed by Participant 4:

I just think... someone... they need to fix this so that parents have got support... because... apart from losing a child... not protecting your child through something horrendous like that... is probably... that is the worst feelings ever I've had to experience.

The move towards a 'Trauma-informed work-force' in Scotland, as part of the Transforming Psychological Trauma Framework (NHS Education for Scotland, 2017), highlights a government and societal recognition of the importance of services meeting the needs of trauma survivors. The findings of the present study are congruent with the recommendations within this framework, which stipulate that in order to be 'trauma-informed',

existing services and professionals need to strive to provide sufficient supports to meet the needs of the traumatised system around the child, and not only of the individual child survivor.

Therefore, in addition to indicating the need for a general increase in service availability for NOCs, the grounded theory model in this study can be used to as a guide on how existing services can meet the needs of NOCs. For example, it acknowledges the difficulties NOCs experience when they perceive professionals and services to not listen to them or understand their needs, which may put up barriers for NOCs engaging in services going forward. Therefore, the manner in which professionals interact with NOCs is a vital consideration. With a greater knowledge of the potential internal and external experiences of NOCs post-disclosure, it is hoped that this model may help services to adopt more of a mentalizing stance towards NOCs by listening to and validating their own experiences as well as their child's. Particularly, in terms of being aware of how NOCs' feelings associated with their secondary trauma experiences, such as powerlessness, isolation and self-blame, specifically link to their role as a parent. Therefore, this model provides some insights into working with NOCs for a broad range of legal, health and social care professionals who may come into contact with this population.

This study's findings also have important implications for the content of interventions. Empirical evidence for psychosocial supports available which involve NOCs as well as the child is still in its infancy. Van Toledo and Seymour's (2013) review of interventions for caregivers demonstrate that interventions for NOCs can be beneficial for both their own difficulties and their child's outcomes. However, the review highlighted there are few available descriptions of therapy interventions, with many proposed approaches having different therapeutic goals. For example, many interventions focus specifically on providing information, psycho-education or parenting skills sessions, which can often be with the goal of improving child rather than parent outcomes. The present grounded theory model supports why these approaches may be found to be beneficial, as an increased knowledge of the impact of

trauma and development of skills to support their child are likely to improve parental self-efficacy, which in turn leads to parents regaining some sense of control over the situation. However, these interventions are not tapping into the multifaceted experience facing NOCs as illustrated in the model, for instance by focusing on NOCs' negative cognitions around being a parent and core feelings of self-blame and isolation.

Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) provides a more multifaceted approach, since the parent learns about the cognitive-behavioural model and is involved in talking through or 'processing' the trauma with the therapist (Kliethermes, et al, 2015). However, this approach is still primarily working with the child and does not explicitly provide scope for working with the parent on their difficult shame and blame emotions, or their negative cognitions about parenting. TF-CBT is also regarded as primarily child-focused and is often critiqued as lacking a wider perspective with regards to systemic working (Coulter, 2013). This is also important as the grounded theory model indicates that isolation is a key issue experienced by caregivers and so it is important to have a broader scope of intervention to help tackle these difficulties.

This paper's grounded theory model supports the idea of more recent systemic approaches to complex trauma. For example, Trauma Systems Therapy (Navalta, Brown, Nisewaner, Ellis, & Saxe, 2015) illustrates the importance of focusing both on supporting the child and on helping the system to move from 'distressed' to 'stable' in order to provide support for the child in the long-term. This similarly echoes principles of innovative integrative approaches to treating complex trauma such as Briere & Lanktree's (2015) Integrative Therapy of Complex Trauma. This intervention advocates not only the importance of incorporating caregivers into the child's treatment and engaging in family therapy, but also providing caregivers with their own individual support and therapy where necessary, either on an individual level or via group intervention. These truly systemic interventions provide a framework for intervening with a

wide range of complex trauma experiences and thus suggestions for interventions with caregivers are kept broad. This grounded theory model makes important contributions to these existing general frameworks of trauma interventions by shedding light on the unique experiences of caregivers of children who have experienced sexual abuse. It provides specific guidance on what is likely to be a helpful focus of interventions with caregivers, such as parental self-efficacy, self-blame, and powerlessness.

The grounded theory model also supports the use of support groups and group interventions for NOCs as a means of targeting the core category of 'isolation'. Groups have been found to facilitate normalisation and validation from others in similar situations, reducing the stigmatization and judgment from others (Van Toledo & Seymour, 2013). Furthermore, with the grounded theory model highlighting the significance of NOCs feeling isolated and alone, an intervention goal for NOCs might be to potentially link in with other community supports to broaden their social network, which is often diminished following a disclosure. This could also be specifically linked into individual therapeutic work, for example, by using approaches such as Interpersonal Psychotherapy which focuses explicitly on building interpersonal relationships and improving mood (Markowitz & Weissman, 2004).

Finally, the study's results highlight considerations for the wider structure of services. In particular, participants reported that they often feel that they are the centre for support for the family, as well as the lead for communication with all the different legal, social and health services. They also highlighted negative experiences of poor communication both from within services and between the different sectors, which resulted in them having to undertake additional responsibilities with regards to contacting services and exacerbated their stress in their already distressing circumstances. Effective communication between services and with clients is thus crucial to clients' outcome and wellbeing. It therefore seems pertinent for services working with traumatized families to ensure that they provide a cohesive system of

support with clear communication with families and each other. One participant suggested that families may benefit from a ‘liaison worker’ who can be the centre for communication with services, with families then only having to speak to one professional for the majority of the time. This is in line with the Nordic Barnahus model for supporting survivors of child abuse, which advocates a ‘one door’ policy where families have a single contact rather than being moved round different services (Johansson, Stefansen, Bakketeig, & Kaldal, 2017). This is therefore a key consideration when planning broader service provision and developments.

Recommendations for Future Research

It would be beneficial in future research to test the hypothesised links between key categories in the proposed grounded theory, for example, between a child’s disclosure, NOCs’ feelings of shame, and parental self-efficacy. The finding that NOCs’ mentalization of their children and others may have an important role in their experiences closer to the time of disclosure indicates that further exploration measuring mentalization at this time may be beneficial, particularly if measures can be repeated across time points to track any changes in mentalization. This research could include quantitative exploration of both parental and non-parental mentalization and the associations with factors implicated in the model, such as parental psychological distress, service engagement, and self-efficacy. Undertaking more thorough measures of mentalization, for example via the more in-depth interview-based assessments, may also be beneficial if in keeping with ethical guidelines, in order to address some of the limitations associated with self-report questionnaires. This would be able to provide further evidence as to whether mentalization would be a beneficial target for intervention for NOCs, as indicated by the presented model.

There is also limited research available around professionals’ lived experiences working with NOCs. This is necessary not only to provide further insights into the process of NOCs’ help-seeking and to help to identify any areas of difficulty services may have in terms of

engaging this population, but also to plan training for staff working in this area. The suggestion that NOCs experience professionals as not always demonstrating an attuned mentalizing response indicates avenues for more quantitative explorations of the role of staff mentalization in parent distress or service engagement and a focus for staff development.

In terms of treatment research, consideration of targeting within interventions some of the areas highlighted in the model and empirically evaluating these would also be a recommendation going forward. It is also important to examine what outcomes are being measured in intervention studies. For example, many intervention outcomes focus on child outcomes but there is inconsistency in collecting parent outcomes across studies (Corcoran & Pillai, 2008). This model indicates that other factors are important and should perhaps be considered in outcome measures, for example, NOCs' feelings of shame or parental-self-efficacy.

Conclusion

This study aimed to develop a theoretical model to explain the unique experiences of NOCs following their child's disclosure of sexual abuse, incorporating an exploration of their help-seeking and parental mentalization. The proposed grounded theory model illustrates the intricacies of NOCs' experiences, which centre around concepts of control and isolation, specifically in relation to their perception of themselves as a parent. Additional key themes that arose were the experience of feeling unsupported by services and the importance of feeling listened to and validated by professionals. This was particularly with regards to professionals recognising the specific experiences of NOCs, for example, the disclosure's impact on their parental role and self-efficacy. While quantitative measures of parental mentalization suggested that this construct may influence NOCs' ability to express their own emotional experience, they did not show a clear-cut pattern with regards to its role in NOCs' overall post-

disclosure experience. Nevertheless, the qualitative findings suggested that a parent's mentalizing capacity, in relation to their child as well as other people, may be important in the immediate disclosure aftermath, and thus requires further investigation. Despite its limitations, the present study provides valuable contributions to the current theoretical understanding of secondary traumatization in NOCs and important implications of this for clinical work and future research in this area.

References

- Allen, J. G. (2006). Mentalizing in Practice. In *Handbook of Mentalization-Based Treatment* (pp. 1–30). Wiley & Sons. <https://doi.org/10.1002/9780470712986.ch1>
- Banyard, V. L., Rozelle, D., & Englund, D. W. (2001). Parenting the traumatized child: Attending to the needs of nonoffending caregivers of traumatized children. *Psychotherapy: Theory, Research, Practice, Training*, 38(1), 74–87. <https://doi.org/10.1037/0033-3204.38.1.74>
- Barker, C., Pistrang, N., & Elliot, R. (2002). *Research Methods in Clinical Psychology: An Introduction for Students and Practitioners*. *Materials Research Bulletin*, 31. [https://doi.org/10.1016/0025-5408\(96\)80018-3](https://doi.org/10.1016/0025-5408(96)80018-3)
- Barth, J., Bermetz, L., Heim, E., Trelle, S., & Tonia, T. (2013). The current prevalence of child sexual abuse worldwide: A systematic review and meta-analysis. *International Journal of Public Health*, 58(3), 469–483. <https://doi.org/10.1007/s00038-012-0426-1>
- Belsky, J. (1984). The Determinants of Parenting: A Process Model. *Child Development*, 55(1), 83. <https://doi.org/10.2307/1129836>
- Biesta, G. (2015). Pragmatism and the Philosophical Foundations of Mixed Methods Research1. In *SAGE Handbook of Mixed Methods in Social & Behavioral Research* (95–118). United States: SAGE Publications. <https://doi.org/10.4135/9781506335193.n4>
- Birks, M., & Mills, J. (2015). *Grounded Theory a practical guide*. Sage Publications (Vol. 18). https://doi.org/10.1007/978-3-8349-9258-1_12
- Bowlby, J. (1973). *Attachment and Loss: Volume II, Separation Anxiety and Anger*. London: The Hogarth Press and the Institute of Psycho-Analysis.
- Braehler, C., & Schwannauer, M. (2012). Recovering an emerging self: Exploring reflective function in recovery from adolescent-onset psychosis. *Psychology and Psychotherapy: Theory, Research and Practice*, 85(1), 48–67. <https://doi.org/10.1111/j.2044->

8341.2011.02018.x

Briere, J., & Lanktree, C. (2015). Integrative Treatment of Complex Trauma. In *Treating*

Complex Traumatic Stress Disorders in Children and Adolescents: Scientific

Foundations and Therapeutic Models. Guilford Press. (pp. 143–161).

Bronfenbrenner, U., & Morris, P. (1998). The ecology of developmental processes. Wiley.

Burke Johnson, R., & Onwuegbuzie, A. J. (2004). *Mixed Methods Research: A Research*

Paradigm Whose Time Has Come. *Source: Educational Researcher*, 33.

Bux, W., Cartwright, D. J., & Collings, S. J. (2016b). The experience of non-offending

caregivers following the disclosure of child sexual abuse: Understanding the aftermath.

South African Journal of Psychology, 46(1), 88–100.

<https://doi.org/http://dx.doi.org/10.1177/0081246315595038>

Camoirano, A. (2017). Mentalizing Makes Parenting Work: A Review about Parental

Reflective Functioning and Clinical Interventions to Improve It. *Frontiers in*

Psychology, 8, 14. <https://doi.org/10.3389/fpsyg.2017.00014>

Carr, A. (2016). *The handbook of child and adolescent clinical psychology. A contextual*

approach. Routledge.

Charmaz, K. (2014). *Constructing grounded theory*. Sage.

Corbin, J., & Strauss, A. (2008). *Basics of Qualitative Research (3rd ed.): Techniques and*

Procedures for Developing Grounded Theory. United States : SAGE Publications.

<https://doi.org/10.4135/9781452230153>

Corcoran, J., & Pillai, V. (2008). A Meta-Analysis of Parent-Involved Treatment for Child

Sexual Abuse. *Research on Social Work Practice*, 18(5), 453-464.

<https://doi.org/10.1177/1049731507313980>

Coulter, S. (2013). Systemic psychotherapy as an intervention for post-traumatic stress

responses: An introduction, theoretical rationale and overview of developments in an

- emerging field of interest. *Journal of Family Therapy*, 35(4), 381–406.
<https://doi.org/10.1111/j.1467-6427.2011.00570.x>
- Courtois, C. A. (2004). Complex trauma, complex reactions: Assessment and treatment. *Psychotherapy*, 41(4), 412–425. <https://doi.org/10.1037/0033-3204.41.4.412>
- Creswell, J. W. (2015). Mapping the Developing Landscape of Mixed Methods Research. In *SAGE Handbook of Mixed Methods in Social & Behavioral Research* (pp. 45–68). United States: SAGE Publications. <https://doi.org/10.4135/9781506335193.n2>
- Cyr, M., Frappier, J.-Y., Hebert, M., Tourigny, M., McDuff, P., & Turcotte Mireille. (2018). Impact of child sexual abuse disclosure on the health of nonoffending parents: A longitudinal perspective. *Journal of Child Custody: Research, Issues, and Practices*, <https://doi.org/http://dx.doi.org/10.1080/15379418.2018.1460649>
- Devilley, G. J., Wright, R., & Varker, T. (2009). Vicarious Trauma, Secondary Traumatic Stress or Simply Burnout? Effect of Trauma Therapy on Mental Health Professionals. *Australian & New Zealand Journal of Psychiatry*, 43(4), 373–385.
<https://doi.org/10.1080/00048670902721079>
- Division of Clinical Psychology. (2018). *The Power Threat Meaning Framework: Overview*.
- Dunkley, J., & Whelan, T. A. (2006). Vicarious traumatisation: Current status and future directions. *British Journal of Guidance and Counselling*, 34(1), 107–116.
<https://doi.org/10.1080/03069880500483166>
- Dyb, G., Holen, A., Steinberg, A. M., Rodriguez, N., & Pynoos, R. S. (2003). Alleged sexual abuse at a day care center: Impact on parents. *Child Abuse and Neglect*, 27(8), 939–950.
[https://doi.org/10.1016/S0145-2134\(03\)00141-8](https://doi.org/10.1016/S0145-2134(03)00141-8)
- Elliott, A. N., & Carnes, C. N. (2001). Reactions of nonoffending parents to the sexual abuse of their child: a review of the literature. *Child Maltreatment*, 6(4), 314–31.
<https://doi.org/10.1177/1077559501006004005>

- Ensink, K., Bégin, M., Normandin, L., & Fonagy, P. (2017). Parental reflective functioning as a moderator of child internalizing difficulties in the context of child sexual abuse. *Psychiatry Research*, 257, 361–366. <https://doi.org/10.1016/j.psychres.2017.07.051>
- Ensink, K., Bégin, M., Normandin, L., Fonagy, P., & Bé Gin, M. L. (2016). Maternal and child reflective functioning in the context of child sexual abuse: pathways to depression and externalising difficulties. *European Journal of Psychotraumatology*, 7(1). <https://doi.org/10.3402/ejpt.v7.30611>
- Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Perma-Nente, K. (1998). *Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults The Adverse Childhood Experiences (ACE) Study*. *Am J Prev Med* (Vol. 14).
- Figley, C. R., & Kleber, R. J. (1995). Beyond the “victim”: Secondary traumatic stress. *Beyond Trauma: Cultural and Societal Dynamics*. https://doi.org/http://dx.doi.org/10.1007/978-1-4757-9421-2_5
- Finkelhor, D., & Browne, A. (1985). The Traumatic Impact of Child Sexual Abuse: A Conceptualization. *American Journal of Orthopsychiatry*, 55(4). <https://doi.org/10.1111/j.1939-0025.1985.tb02703.x>
- Fonagy, P. (2006). The mentalization-focused approach to social development. In *Mentalization: Theoretical Considerations, Research Findings, and Clinical Implications* (pp. 3–56). <https://doi.org/10.4324/9780203927250>
- Fonagy, P., Luyten, P., Moulton-Perkins, A., Lee, Y.-W., Warren, F., Howard, S., Lowyck, B. (2016). Development and Validation of a Self-Report Measure of Mentalizing: The Reflective Functioning Questionnaire. *PloS One*, 11(7), e0158678. <https://doi.org/10.1371/journal.pone.0158678>
- Fonagy, P., Steele, M., Steele, H., Moran, G. S., & Higgit, A. C. (1991). The capacity for

- understanding mental states: The reflective self in parent and child and its significance for attachment. *Infant Mental Health Journal*. <https://doi.org/10.1002/1097-0355>
- Fonagy, P., & Target, M. (1997). Attachment and reflective function: Their role in self-organization. *Development and Psychopathology*, *9*, 679–700.
- Fossey, E., Harvey, C., Mcdermott, F., & Davidson, L. (2002). Understanding and evaluating qualitative research, 8–10. [https://doi.org/10.1111/\(ISSN\)1440-1614](https://doi.org/10.1111/(ISSN)1440-1614)
- Fuller, G. (2016). Non-offending parents as secondary victims of child sexual assault. *Trends and Issues in Crime and Criminal Justice*, (500), 1–7.
- Gallagher, H. L., Happeâ, F., Brunswick, N., Fletcher, P. C., Frith, U., & Frith, C. D. (2000). Reading the mind in cartoons and stories: an fMRI study of theory of theory of mind' in verbal and nonverbal tasks. *Neuropsychologia*, *38*, 11–21.
- George, C., Kaplan, N., & Main, M. (1996). Adult Attachment Interview.
- George, C., & Solomon, J. (1996). Representational Models of Relationships: Links between Caregiving and Attachment. *Infant Mental Health Journal*, *17*(3), 198–216. [https://doi.org/10.1002/\(SICI\)1097-0355\(199623\)17:3](https://doi.org/10.1002/(SICI)1097-0355(199623)17:3)
- Gilbert, P. (2010). *The compassionate mind : a new approach to life's challenges*. Constable.
- Hoghughi, M., & Long, N. (2004). *Handbook of parenting : theory and research for practice*. Sage Publications.
- Johansson, S., Stefansen, K., Bakketeig, E., & Kaldal, A. (2017). Implementing the nordic barnahus model: Characteristics and local adaptations. *Collaborating Against Child Abuse: Exploring the Nordic Barnahus Model*, 1–31. https://doi.org/10.1007/978-3-319-58388-4_1
- Johnson, R. B., Onwuegbuzie, A. J., & Turner, L. A. (2007). Toward a Definition of Mixed Methods Research. <https://doi.org/10.1177/1558689806298224>
- Kalland, M., Fagerlund, Å., von Koskull, M., & Pajulo, M. (2016). Families First: the

- development of a new mentalization-based group intervention for first-time parents to promote child development and family health. *Primary Health Care Research & Development*, 17(01), 3–17. <https://doi.org/10.1017/S146342361500016X>
- Kilroy, S. J., Egan, J., Maliszewska, A., & Sarma, K. M. (2014). “Systemic trauma”: The impact on parents whose children have experienced sexual abuse. *Journal of Child Sexual Abuse*, 23(5), 481–503. <https://doi.org/10.1080/10538712.2014.920458>
- Kim, K., Noll, J. G., Putnam, F. W., & Trickett, P. K. (2007). Psychosocial characteristics of nonoffending mothers of sexually abused girls: Findings from a prospective, multigenerational study. *Child Maltreatment*.
<https://doi.org/10.1177/1077559507305997>
- Kim, K., Trickett, P. K., & Putnam, F. W. (2011). Attachment representations and anxiety: Differential relationships among mothers of sexually abused and comparison girls. *Journal of Interpersonal Violence*. <https://doi.org/10.1177/0886260510363416>
- Kliethermes, M., Wamser Nanney, R., Mannarino, A., & Cohen, J. (2015). Trauma-Focused Cognitive-Behavioral Therapy. In *Treating Complex Traumatic Stress Disorders in Children and Adolescents: Scientific Foundations and Therapeutic Models* (pp. 184–202).
- Luyten, P., Mayes, L. C., Nijssens, L., & Fonagy, P. (2017a). *The Parental Reflective Functioning Questionnaire - Adolescent version*. Belgium.
- Luyten, P., Mayes, L. C., Nijssens, L., & Fonagy, P. (2017b). The parental reflective functioning questionnaire: Development and preliminary validation. *PLoS ONE*, 12(5). <https://doi.org/10.1371/journal.pone.0176218>
- Lysaker, P. H., Carcione, A., Dimaggio, G., Johannesen, J. K., Nicolo, G., Procacci, M., & Semerari, A. (2005). Metacognition amidst narratives of self and illness in schizophrenia: associations with neurocognition, symptoms, insight and quality of life.

Acta Psychiatrica Scandinavica, 112(1), 64–71. <https://doi.org/10.1111/j.1600-0447.2005.00514.x>

Macbeth, A., Gumley, A., Schwannauer, M., & Fisher, R. (2011). Attachment states of mind, mentalization, and their correlates in a first-episode psychosis sample. *Psychology and Psychotherapy: Theory, Research and Practice*, 84, 42–57.

<https://doi.org/10.1348/147608310X530246>

Maniglio, R. (2009). The impact of child sexual abuse on health: A systematic review of reviews. *Clinical Psychology Review*, 29(7), 647–657.

<https://doi.org/10.1016/j.cpr.2009.08.003>

Markowitz, J. C., & Weissman, M. M. (2004). Interpersonal psychotherapy: principles and applications. *World Psychiatry : Official Journal of the World Psychiatric Association (WPA)*, 3(3), 136–9.

McCallum, S. (2001). Nonoffending mothers: An exploratory study of mothers whose partners sexually assaulted their children. *Violence Against Women*, 7(3), 315–334.

<https://doi.org/http://dx.doi.org/10.1177/10778010122182460>

Navalta, C. P., Brown, A. D., Nisewaner, A., Ellis, B. H., & Saxe, G. N. (2015). Trauma systems therapy. In *Treating Complex Traumatic Stress Disorders in Children and Adolescents: Scientific Foundations and Therapeutic Models* (pp. 329–347). Guilford Press.

NHS Scotland. (2017). *Transforming Psychological Trauma*.

Pearlman, L. A., & Saakvitne, K. W. (1995). *Trauma and the therapist : countertransference and vicarious traumatization in psychotherapy with incest survivors*. Norton.

Putnam, F. W. (2003). Ten-Year Research Update Review: Child Sexual Abuse. *J. Am. Acad. Child Adolesc. Psychiatry*, 42(3), 269–278.

<https://doi.org/10.1097/01.CHI.0000037029.04952.72>

- Ranney, M. L., Meisel, Z. F., Choo, E. K., Garro, A. C., Sasson, C., & Guthrie, K. M. (2015). Interview-based Qualitative Research in Emergency Care Part II: Data Collection, Analysis and Results Reporting. *Academic Emergency Medicine*, 22, 1103–1112. <https://doi.org/10.1111/acem.12735>
- Rosino, M. (2016). ABC-X Model of Family Stress and Coping. *Encyclopedia of Family Studies*, (October), 1–6. <https://doi.org/10.1002/9781119085621.wbef313>
- Rostad, W. L., & Whitaker, D. J. (2016). The Association Between Reflective Functioning and Parent–Child Relationship Quality. *Journal of Child and Family Studies*, 25(7), 2164–2177. <https://doi.org/10.1007/s10826-016-0388-7>
- Rutherford, H. J. V., Goldberg, B., Luyten, P., Bridgett, D. J., & Mayes, L. C. (2013). Parental reflective functioning is associated with tolerance of infant distress but not general distress: Evidence for a specific relationship using a simulated baby paradigm. *Infant Behavior and Development*, 36(4), 635–641. <https://doi.org/10.1016/j.infbeh.2013.06.008>
- Sadler, L. S., Slade, A., Close, N., Webb, D. L., Simpson, T., Fennie, K., & Mayes, L. C. (2013). Minding the baby: Enhancing reflectiveness to improve early health and relationship outcomes in an interdisciplinary home-visiting program. *Infant Mental Health Journal*, 34(5), 391–405. <https://doi.org/10.1002/imhj.21406>
- Santa-Sosa, E. J., Steer, R. A., Deblinger, E., & Runyon, M. K. (2013). Depression and Parenting by Nonoffending Mothers of Children Who Experienced Sexual Abuse. *Journal of Child Sexual Abuse*, 22(8), 915–930. <https://doi.org/10.1080/10538712.2013.841309>
- Serin, H. (2018). Non-abusing mothers' support needs after child sexual abuse disclosure: A narrative review. *Child and Family Social Work*, 23(3), 539–548. <https://doi.org/10.1111/cfs.12455>

- Stein, H. (2006). Does Mentalizing Promote Resilience? In *Handbook of Mentalization-Based Treatment* (pp. 307–326). <https://doi.org/10.1002/9780470712986.ch16>
- Stoltenborgh, M., van IJzendoorn, M. H., Euser, E. M., & Bakermans-Kranenburg, M. J. (2011). A global perspective on child sexual abuse: Meta-analysis of prevalence around the world. *Child Maltreatment, 16*(2), 79–101.
<https://doi.org/10.1177/1077559511403920>
- Tedeschi, R. G., & Calhoun, L. G. (2004). *Posttraumatic Growth: Conceptual Foundations and Empirical Evidence*. Lawrence Erlbaum Associates. Inc. Psychological Inquiry (Vol. 15).
- Van Bakel, H. J., & Hall, R. A. (2018). Parent–Child Relationships and Attachment. In *Handbook of parenting and child development across the lifespan* (pp. 47-66). Springer, Cham. <https://doi.org/10.1007/978-3-319-94598-9>
- Van Toledo, A., & Seymour, F. (2013). Interventions for caregivers of children who disclose sexual abuse: A review. *Clinical Psychology Review, 33*, 772–781.
<https://doi.org/10.1016/j.cpr.2013.05.006>
- Wagner, W. G. (1991). Depression in mothers of sexually abused vs. mothers of nonabused children. *Child Abuse & Neglect 15*(1), 99-104.

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Research Portfolio References

- Addis, M. E., & Mahalik, J. R. (2003). Men, Masculinity, and the Contexts of Help Seeking, 58(1), 5–14. <https://doi.org/10.1037/0003-066X.58.1.5>
- Allen, J. G. (2006). Mentalizing in Practice. In *Handbook of Mentalization-Based Treatment* (pp. 1–30). <https://doi.org/10.1002/9780470712986.ch1>
- Bakel, H. J. A. Van, & Hall, R. A. S. (2018). Handbook of Parenting and Child Development Across the Lifespan. *Handbook of Parenting and Child Development Across the Lifespan*. <https://doi.org/10.1007/978-3-319-94598-9>
- Banyard, V. L., Rozelle, D., & Englund, D. W. (2001). Parenting the traumatized child: Attending to the needs of nonoffending caregivers of traumatized children. *Psychotherapy: Theory, Research, Practice, Training*, 38(1), 74–87. <https://doi.org/10.1037/0033-3204.38.1.74>
- Baril, K., Tourigny, M., Paille, P., & Pauze, R. (2016). Characteristics of Sexually Abused Children and Their Nonoffending Mothers Followed by Child Welfare Services: The Role of a Maternal History of Child Sexual Abuse. *Journal of Child Sexual Abuse*, 25(5), 504–523. <https://doi.org/10.1080/10538712.2016.1176096>
- Barker, C., Pistrang, N., & Elliot, R. (2002). *Research Methods in Clinical Psychology: An Introduction for Students and Practitioners*. *Materials Research Bulletin* (Vol. 31). [https://doi.org/10.1016/0025-5408\(96\)80018-3](https://doi.org/10.1016/0025-5408(96)80018-3)
- Barth, J., Bermetz, L., Heim, E., Trelle, S., & Tonia, T. (2013). The current prevalence of child sexual abuse worldwide: A systematic review and meta-analysis. *International Journal of Public Health*, 58(3), 469–483. <https://doi.org/10.1007/s00038-012-0426-1>
- Beck, J. S. (2011). *Cognitive Behavior Therapy: Basics and Beyond*. The Guilford Press. <https://doi.org/10.1017/CBO9781107415324.004>

- Belsky, J. (1984). The Determinants of Parenting: A Process Model. *Child Development*, 55(1), 83. <https://doi.org/10.2307/1129836>
- Biesta, G. (2015). Pragmatism and the Philosophical Foundations of Mixed Methods Research1. In *SAGE Handbook of Mixed Methods in Social & Behavioral Research* (pp. 95–118). 2455 Teller Road, Thousand Oaks California 91320 United States: SAGE Publications, Inc. <https://doi.org/10.4135/9781506335193.n4>
- Birks, M., & Mills, J. (2015). *Grounded Theory a practical guide*. Sage Publications (Vol. 18). https://doi.org/10.1007/978-3-8349-9258-1_12
- Bolen, R. M., & Gergely, K. B. (2014). A Meta-Analytic Review of the Relationship Between Nonoffending Caregiver Support and Postdisclosure Functioning in Sexually Abused Children. *Trauma, Violence, & Abuse*, 1524838014526307. <https://doi.org/10.1177/1524838014526307>
- Bowlby, J. (1973). *Attachment and Loss: Volume II, Separation Anxiety and Anger*. London: The Hogarth Press and the Institute of Psycho-Analysis.
- Braehler, C., & Schwannauer, M. (2012). Recovering an emerging self: Exploring reflective function in recovery from adolescent-onset psychosis. *Psychology and Psychotherapy: Theory, Research and Practice*, 85(1), 48–67. <https://doi.org/10.1111/j.2044-8341.2011.02018.x>
- Briere, J., & Lanktree, C. (2015). Integrative Treatment of Complex Trauma. In: *Treating Complex Traumatic Stress Disorders in Children and Adolescents: Scientific Foundations and Therapeutic Models*. Guilford Press. (pp. 143–161).
- Bronfenbrenner, U., & Morris, P. (1998). The ecology of developmental processes. Wiley.
- Burgess, A. W., Hartman, C. R., Kelley, S. J., Grant, C. A., & Gray, E. B. (1990). Parental response to child sexual abuse trials involving day care settings. *Journal of Traumatic Stress*, 3(3), 395–405. <https://doi.org/10.1007/BF00974779>

- Burke Johnson, R., & Onwuegbuzie, A. J. (2004). *Mixed Methods Research: A Research Paradigm Whose Time Has Come*. Source: *Educational Researcher* (Vol. 33).
- Bux, W., Cartwright, D. J., & Collings, S. J. (2016). The experience of non-offending caregivers following the disclosure of child sexual abuse: Understanding the aftermath. *South African Journal of Psychology*, 46(1), 88–100.
<https://doi.org/http://dx.doi.org/10.1177/0081246315595038>
- Cachia, R., Anderson, A., & Moore, D. W. (2015). Mindfulness, Stress and Well-Being in Parents of Children with Autism Spectrum Disorder: A Systematic Review. *Article in Journal of Child and Family Studies*. <https://doi.org/10.1007/s10826-015-0193-8>
- Camoirano, A. (2017). Mentalizing Makes Parenting Work: A Review about Parental Reflective Functioning and Clinical Interventions to Improve It. *Frontiers in Psychology*, 8, 14. <https://doi.org/10.3389/fpsyg.2017.00014>
- Carr, A. (2016). *The handbook of child and adolescent clinical psychology. A contextual approach*. Routledge.
- Centre for Reviews and Dissemination: University of York. (2009). *Systematic Reviews: CRD's guidance for undertaking reviews in health care*. (Vol. 91). York: York Publishing Services.
- Charmaz, K. (2014). *Constructing grounded theory*. Sage.
- Cohen, S. & Wills, T.A. (1985). Stress, social support, and the buffering hypothesis. *Psychological Bulletin*, 98(2), 310–357. <https://doi.org/10.1037/0033-2909.98.2.310>.
- Collin-Vézina, D., Daigneault, I., & Hébert, M. (2013). Lessons learned from child sexual abuse research: prevalence, outcomes, and preventive strategies. *Child and Adolescent Psychiatry and Mental Health*, 7, 1. <https://doi.org/10.1186/1753-2000-7-22>
- Corbin, J., & Strauss, A. (2008). *Basics of Qualitative Research (3rd ed.): Techniques and Procedures for Developing Grounded Theory*. United States: SAGE Publications.

<https://doi.org/10.4135/9781452230153>

- Corcoran, J., & Pillai, V. (2008). A Meta-Analysis of Parent-Involved Treatment for Child Sexual Abuse. <https://doi.org/10.1177/1049731507313980>
- Coulter, S. (2013). Systemic psychotherapy as an intervention for post-traumatic stress responses: An introduction, theoretical rationale and overview of developments in an emerging field of interest. *Journal of Family Therapy*, 35(4), 381–406.
<https://doi.org/10.1111/j.1467-6427.2011.00570.x>
- Courtois, C. A. (2004). Complex trauma, complex reactions: Assessment and treatment. *Psychotherapy*, 41(4), 412–425. <https://doi.org/10.1037/0033-3204.41.4.412>
- Creswell, J. W. (2015). Mapping the Developing Landscape of Mixed Methods Research. In *SAGE Handbook of Mixed Methods in Social & Behavioral Research* (pp. 45–68). United States: SAGE Publications. <https://doi.org/10.4135/9781506335193.n2>
- Cyr, M., Frappier, J.-Y., Hébert, M., Tourigny, M., McDuff, P., & Turcotte (2018). Impact of child sexual abuse disclosure on the health of nonoffending parents: A longitudinal perspective. *Journal of Child Custody: Research, Issues, and Practices*.
<https://doi.org/http://dx.doi.org/10.1080/15379418.2018.1460649>
- Cyr, M., Frappier, J.-Y., Hébert, M., Tourigny, M., McDuff, P., & Turcotte, M.-È. (2016). Psychological and Physical Health of Nonoffending Parents After Disclosure. *Journal of Child Sexual Abuse ISSN:*, 25(7), 757–776.
- Deblinger, E., Hathaway, C. R., Lippmann, J., & Steer, R. (1993). Psychosocial Characteristics and Correlates of Symptom Distress in Nonoffending Mothers of Sexually Abused Children. *Journal of Interpersonal Violence*, 8(2), 155–168.
<https://doi.org/10.1177/088626093008002001>
- Deblinger, E., Stauffer, L., & Landsberg, C. (1994). The impact of a history of child sexual abuse on maternal response to allegations of sexual abuse concerning her child. *Journal*

of Child Sexual Abuse: Research, Treatment, & Program Innovations for Victims, Survivors, & Offenders, 3(3), 67–75. https://doi.org/10.1300/J070v03n03_05

Devilly, G. J., Wright, R., & Varker, T. (2009). Vicarious Trauma, Secondary Traumatic Stress or Simply Burnout? Effect of Trauma Therapy on Mental Health Professionals. *Australian & New Zealand Journal of Psychiatry*, 43(4), 373–385.

<https://doi.org/10.1080/00048670902721079>

Division of Clinical Psychology. (2018). The Power Threat Meaning Framework: Overview. Retrieved from www.bps.org.uk

Downes, M. J., Brennan, M. L., Williams, H. C., & Dean, R. S. (2016). Development of a critical appraisal tool to assess the quality of cross-sectional studies (AXIS). *BMJ Open*, 6(12), 1–7. <https://doi.org/10.1136/bmjopen-2016-011458>

Dunkley, J., & Whelan, T. A. (2006). Vicarious traumatization: Current status and future directions. *British Journal of Guidance and Counselling*, 34(1), 107–116.

<https://doi.org/10.1080/03069880500483166>

Dyb, G., Holen, A., Steinberg, A. M., Rodriguez, N., & Pynoos, R. S. (2003). Alleged sexual abuse at a day care center: Impact on parents. *Child Abuse and Neglect*, 27(8), 939–950.

[https://doi.org/10.1016/S0145-2134\(03\)00141-8](https://doi.org/10.1016/S0145-2134(03)00141-8)

Elliott, A. N., & Carnes, C. N. (2001). Reactions of nonoffending parents to the sexual abuse of their child: a review of the literature. *Child Maltreatment*, 6(4), 314–31.

<https://doi.org/10.1177/1077559501006004005>

Elliott, A. N., & Carnes, C. N. (2001). Reactions of nonoffending parents to the sexual abuse of their child: A review of the literature. *Child Maltreatment*, 6(4), 314–331.

<https://doi.org/10.1177/1077559501006004005>

Ensink, K., Bégin, M., Normandin, L., & Fonagy, P. (2017). Parental reflective functioning as a moderator of child internalizing difficulties in the context of child sexual abuse.

- Psychiatry Research*, 257, 361–366. <https://doi.org/10.1016/j.psychres.2017.07.051>
- Ensink, K., Bégin, M., Normandin, L., Fonagy, P., & Bégin, M. L. (2016). Maternal and child reflective functioning in the context of child sexual abuse: pathways to depression and externalising difficulties. *European Journal of Psychotraumatology (ISSNOnline) Journal, homepage*, 2000–8198. <https://doi.org/10.3402/ejpt.v7.30611>
- Evans, E., Hawton, K., & Rodham, K. (2004). Factors associated with suicidal phenomena in adolescents: A systematic review of population-based studies. *Clinical Psychology Review*, 24(8), 957–979. <https://doi.org/10.1016/j.cpr.2004.04.005>
- Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., ... Perma-Nente, K. (1998). *Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults The Adverse Childhood Experiences (ACE) Study*. *Am J Prev Med* (Vol. 14). Retrieved from www.elsevier.com.
- Figley, C. R., & Kleber, R. J. (1995). Beyond the “victim”: Secondary traumatic stress. *Beyond Trauma: Cultural and Societal Dynamics*. https://doi.org/http://dx.doi.org/10.1007/978-1-4757-9421-2_5
- Finch, J. (2007). *Displaying Families*. <https://doi.org/10.1177/0038038507072284>
- Finkelhor, D., & Browne, A. (1985). The Traumatic Impact of Child Sexual Abuse: A Conceptualization. *American Journal of Orthopsychiatry*, 55(4).
- Fonagy, P. (2006). The mentalization-focused approach to social development. In *Mentalization: Theoretical Considerations, Research Findings, and Clinical Implications* (pp. 3–56). <https://doi.org/10.4324/9780203927250>
- Fonagy, P., Luyten, P., Moulton-Perkins, A., Lee, Y.-W., Warren, F., Howard, S., ... Lowyck, B. (2016). Development and Validation of a Self-Report Measure of Mentalizing: The Reflective Functioning Questionnaire. *PloS One*, 11(7), e0158678. <https://doi.org/10.1371/journal.pone.0158678>

- Fonagy, P., Steele, M., Steele, H., Moran, G. S., & Higgitt, A. C. (1991). The capacity for understanding mental states: The reflective self in parent and child and its significance for attachment. *Infant Mental Health Journal*. [https://doi.org/10.1002/1097-0355\(199123\)12:3](https://doi.org/10.1002/1097-0355(199123)12:3)
- Fonagy, P., & Target, M. (1997). Attachment and reflective function: Their role in self-organization. *Development and Psychopathology*, *9*, 679–700.
- qualitative research, 8–10. [https://doi.org/10.1111/\(ISSN\)1440-1614](https://doi.org/10.1111/(ISSN)1440-1614)
- Fuller, G. (2016). Non-offending parents as secondary victims of child sexual assault. *Trends and Issues in Crime and Criminal Justice*, (500), 1–7.
- Gallagher, H. L., Happeâ, F., Brunswick, N., Fletcher, P. C., Frith, U., & Frith, C. D. (2000). Reading the mind in cartoons and stories: an fMRI study of 'theory of mind' in verbal and nonverbal tasks. *Neuropsychologia*, *38*, 11–21.
- George, C., Kaplan, N., & Main, M. (1996). Adult Attachment Interview. Retrieved from <http://library.allanschore.com/docs/AAIProtocol.pdf>
- George, C., & Solomon, J. (1996). Representational Models of Relationships: Links between Caregiving and Attachment. *Infant Mental Health Journal*, *17*(3), 198–216. [https://doi.org/10.1002/\(SICI\)1097-0355\(199623\)17:3<198::AID-IMHJ2>3.0.CO;2-L](https://doi.org/10.1002/(SICI)1097-0355(199623)17:3<198::AID-IMHJ2>3.0.CO;2-L)
- Gilbert, P. (2010). *The compassionate mind : a new approach to life's challenges*. Constable.
- Hébert, M., Daigneault, I., Collin-Vézina, D., & Cyr, M. (2007). Factors linked to distress in mothers of children disclosing sexual abuse. *Journal of Nervous and Mental Disease*, *195*(10), 805–811. <https://doi.org/10.1097/NMD.0b013e3181568149>
- Hiebert-Murphy, D. (1998). Emotional distress among mothers whose children have been sexually abused: the role of a history of child sexual abuse, social support, and coping. *Child Abuse & Neglect*, *22*(5), 423–435. [https://doi.org/http://dx.doi.org/10.1016/S0145-2134\(98\)00006-4](https://doi.org/http://dx.doi.org/10.1016/S0145-2134(98)00006-4)

- Hoghughi, M., & Long, N. (2004a). *Handbook of parenting : theory and research for practice*. Sage Publications.
- Hoghughi, M., & Long, N. (2004b). *Handbook of parenting : theory and research for practice*. Sage Publications.
- Johansson, S., Stefansen, K., Bakketeig, E., & Kaldal, A. (2017). Implementing the nordic barnahus model: Characteristics and local adaptations. *Collaborating Against Child Abuse: Exploring the Nordic Barnahus Model*, 1–31. https://doi.org/10.1007/978-3-319-58388-4_1
- Johnson, R. B., Onwuegbuzie, A. J., & Turner, L. A. (2007). Toward a Definition of Mixed Methods Research. <https://doi.org/10.1177/1558689806298224>
- Kalland, M., Fagerlund, Å., von Koskull, M., & Pajulo, M. (2016). Families First: the development of a new mentalization-based group intervention for first-time parents to promote child development and family health. *Primary Health Care Research & Development*, 17(01), 3–17. <https://doi.org/10.1017/S146342361500016X>
- Kelley, S. J. (1990). Parental Stress Response to Sexual Abuse and Ritualistic Abuse Of Children in Day-Care Centers. *Nursing Research*. <https://doi.org/10.1097/00006199-199001000-00006>
- Kilroy, S. J., Egan, J., Maliszewska, A., & Sarma, K. M. (2014). “Systemic trauma”: The impact on parents whose children have experienced sexual abuse. *Journal of Child Sexual Abuse*, 23(5), 481–503. <https://doi.org/10.1080/10538712.2014.920458>
- Kim, K., Noll, J. G., Putnam, F. W., & Trickett, P. K. (2007). Psychosocial characteristics of nonoffending mothers of sexually abused girls: Findings from a prospective, multigenerational study. *Child Maltreatment*, 12(4), 338–351. <https://doi.org/10.1177/1077559507305997>
- Kim, K., Trickett, P. K., & Putnam, F. W. (2011). Attachment representations and anxiety:

- Differential relationships among mothers of sexually abused and comparison girls. *Journal of Interpersonal Violence*. <https://doi.org/10.1177/0886260510363416>
- Kliethermes, M., Wamser Nanney, R., Mannarino, A., & Cohen, J. (2015). Trauma-Focused Cognitive-Behavioral Therapy. In *Treating Complex Traumatic Stress Disorders in Children and Adolescents: Scientific Foundations and Therapeutic Models* (pp. 184–202).
- Knott, T., & Fabre, A. (2014). Maternal Response to the Disclosure of Child Sexual Abuse: Systematic Review and Critical Analysis of the Literature. *Issues in Child Abuse Accusations*, 20.
- Leifer, M., Kilbane, T., Kalick, S., & Kalick, S. (2004). Vulnerability or Resilience to Intergenerational Sexual Abuse: The Role of Maternal Factors. *Child Maltreatment*, 9(1), 78–91. <https://doi.org/10.1177/1077559503261181>
- Lewin, L., & Bergin, C. (2001). Attachment Behaviors, Depression, and Anxiety in Nonoffending Mothers of Child Sexual Abuse Victims. *Child Maltreatment*, 6(4), 365–375.
- Luyten, P., Mayes, L. C., Nijssens, L., & Fonagy, P. (2017a). *The Parental Reflective Functioning Questionnaire - Adolescent version*. Belgium.
- Luyten, P., Mayes, L. C., Nijssens, L., & Fonagy, P. (2017b). The parental reflective functioning questionnaire: Development and preliminary validation. *PLoS ONE*, 12(5). <https://doi.org/10.1371/journal.pone.0176218>
- Lysaker, P. H., Carcione, A., Dimaggio, G., Johannesen, J. K., Nicolo, G., Procacci, M., & Semerari, A. (2005). Metacognition amidst narratives of self and illness in schizophrenia: associations with neurocognition, symptoms, insight and quality of life. *Acta Psychiatrica Scandinavica*, 112(1), 64–71. <https://doi.org/10.1111/j.1600-0447.2005.00514.x>

- Macbeth, A., Gumley, A., Schwannauer, M., & Fisher, R. (2011). Attachment states of mind, mentalization, and their correlates in a first-episode psychosis sample. *Psychology and Psychotherapy: Theory, Research and Practice*, *84*, 42–57.
<https://doi.org/10.1348/147608310X530246>
- Malia, J. A. (2006). Basic concepts and models of family stress. *Stress, trauma, and crisis*, *9*(3-4), 141-160. <https://doi.org/10.1080/15434610600853717>
- Maniglio, R. (2009). The impact of child sexual abuse on health: A systematic review of reviews. *Clinical Psychology Review*, *29*(7), 647–657.
<https://doi.org/10.1016/j.cpr.2009.08.003>
- Manion, I., Firestone, P., Cloutier, P., Ligezinska, M., McIntyre, J., & Ensom, R. (1998). Child extrafamilial sexual abuse: Predicting parent and child functioning. *Child Abuse and Neglect*, *22*(12), 1285–1304. [https://doi.org/10.1016/S0145-2134\(98\)00103-3](https://doi.org/10.1016/S0145-2134(98)00103-3)
- Manion, I. G., McIntyre, J. E., Firestone, P., Ligezinska, M., Ensom, R., & Wells, G. (1996). Secondary traumatization in parents following child disclosures of extrafamilial sexual abuse. *Child Abuse and Neglect*, *55*(11), 1095–1109.
- Markowitz, J. C., & Weissman, M. M. (2004). Interpersonal psychotherapy: principles and applications. *World Psychiatry : Official Journal of the World Psychiatric Association (WPA)*, *3*(3), 136–9.
- McCallum, S. (2001). Nonoffending mothers: An exploratory study of mothers whose partners sexually assaulted their children. *Violence Against Women*, *7*(3), 315–334.
<https://doi.org/10.1177/10778010122182460>
- McGillivray, C. J., Pidgeon, A. M., Ronken, C., & Credland-Ballantyne, C. A. (2018). Resilience in Non-Offending Mothers of Children Who Have Reported Experiencing Sexual Abuse. *Journal of Child Sexual Abuse*.
<https://doi.org/10.1080/10538712.2018.1477221>

- Moher, D., Liberati, A., Tetzlaff, J., Altman, D. G., Altman, D., Antes, G., Tugwell, P. (2009). Preferred reporting items for systematic reviews and meta-analyses: The PRISMA statement (Chinese edition). *Journal of Chinese Integrative Medicine*, 7(9), 889–896. <https://doi.org/10.3736/jcim20090918>
- Murray, J., Farrington, D. P., & Eisner, M. P. (2009). Drawing conclusions about causes from systematic reviews of risk factors: The Cambridge Quality Checklists. *Journal of Experimental Criminology*, 5(1), 1-23.
- National Collaborating Centre for Mental Health (2005). Predictors of PTSD and screening for the disorder. In *Post-Traumatic Stress Disorder: The Management of PTSD in Adults and Children in Primary and Secondary Care*. Gaskell.
- National Institute for Health and Care Excellence. (2012). *Methods for the development of NICE public health guidance (third edition)*.
- Navalta, C. P., Brown, A. D., Nisewaner, A., Ellis, B. H., & Saxe, G. N. (2015). Trauma systems therapy. In *Treating Complex Traumatic Stress Disorders in Children and Adolescents: Scientific Foundations and Therapeutic Models* (pp. 329–347).
- Newberger, C. M., Gremy, I. M., Waternaux, C. M., & Newberger, E. H. (1993). Mothers of sexually abused children: Trauma and repair in longitudinal perspective. *American Journal of Orthopsychiatry*, 63(1), 92–102. <https://doi.org/10.1037/h0079398>
- NHS Scotland. (2017). *Transforming Psychological Trauma*.
- Pearlman, L. A., & Saakvitne, K. W. (1995). *Trauma and the therapist : countertransference and vicarious traumatization in psychotherapy with incest survivors*. Norton.
- Petticrew, M., & Roberts, H. (2006). *Systematic reviews in the social sciences : a practical guide*. Blackwell Pub.
- Plummer, C. A. (2008). Non-Abusive Mothers of Sexually Abused Children: The Role of Rumination in Maternal Outcomes. *Journal of Child Sexual Abuse*, 15(2), 103–122.

https://doi.org/10.1300/J070v15n02_07

Putnam, F. W. (2003). Ten-Year Research Update Review: Child Sexual Abuse. *J. Am. Acad. Child Adolesc. Psychiatry*, 42(3), 269–278.

<https://doi.org/10.1097/01.CHI.0000037029.04952.72>

Putnam, F. W., & Trickett, P. K. (1987). Psychobiological effects of sexual abuse. A longitudinal study. *Annals of the New York Academy of Sciences*, 821, 150–9.

Ranney, M. L., Meisel, Z. F., Choo, E. K., Garro, A. C., Sasson, C., & Guthrie, K. M. (2015). Interview-based Qualitative Research in Emergency Care Part II: Data Collection, Analysis and Results Reporting. *Academic Emergency Medicine*, 22, 1103–1112.

<https://doi.org/10.1111/acem.12735>

Rheingold, A. A., Davidson, T. M., Resnick, H., Self-Brown, S., & Danielson, C. K. (2013). The relationship between knowledge and child and caregiver distress during the medical examination for child sexual abuse. *Journal of Child Sexual Abuse*, 22(5), 552–571.

<https://doi.org/10.1080/10538712.2013.800937>

Roberts, A. R. (2005). *Crisis intervention handbook : assessment, treatment, and research*. Oxford University Press.

Rosino, M. (2016). ABC-X Model of Family Stress and Coping. *Encyclopedia of Family Studies*, (October), 1–6. <https://doi.org/10.1002/9781119085621.wbefs313>

Rostad, W. L., & Whitaker, D. J. (2016). The Association Between Reflective Functioning and Parent–Child Relationship Quality. *Journal of Child and Family Studies*, 25(7), 2164–2177. <https://doi.org/10.1007/s10826-016-0388-7>

Runyon, M. K., Spandorfer, E. D., & Schroeder, C. M. (2014). Cognitions and distress in caregivers after their child’s sexual abuse disclosure. *Journal of Child Sexual Abuse*, 23(2), 146–59. <https://doi.org/10.1080/10538712.2014.869291>

Rutherford, H. J. V., Goldberg, B., Luyten, P., Bridgett, D. J., & Mayes, L. C. (2013).

- Parental reflective functioning is associated with tolerance of infant distress but not general distress: Evidence for a specific relationship using a simulated baby paradigm. *Infant Behavior and Development*, 36(4), 635–641.
<https://doi.org/10.1016/j.infbeh.2013.06.008>
- Sadler, L. S., Slade, A., Close, N., Webb, D. L., Simpson, T., Fennie, K., & Mayes, L. C. (2013). Minding the baby: Enhancing reflectiveness to improve early health and relationship outcomes in an interdisciplinary home-visiting program. *Infant Mental Health Journal*, 34(5), 391–405. <https://doi.org/10.1002/imhj.21406>
- Santa-Sosa, E. J., Steer, R. A., Deblinger, E., & Runyon, M. K. (2013). Depression and Parenting by Nonoffending Mothers of Children Who Experienced Sexual Abuse. *Journal of Child Sexual Abuse*, 22(8), 915–930.
<https://doi.org/10.1080/10538712.2013.841309>
- Sedgwick, P. (2014). Cross sectional studies: Advantages and disadvantages. *BMJ (Online)*, 348. <https://doi.org/10.1136/bmj.g2276>
- Serin, H. (2018). Non-abusing mothers' support needs after child sexual abuse disclosure: A narrative review. *Child and Family Social Work*, 23(3), 539–548.
<https://doi.org/10.1111/cfs.12455>
- Singleton, N., & Lewis, G. (2003). Better or worse: a longitudinal study of the mental health of adults living in private households in Great Britain. *National Statistics*, 170.
- Stein, H. (2006). Does Mentalizing Promote Resilience? In *Handbook of Mentalization-Based Treatment* (pp. 307–326). <https://doi.org/10.1002/9780470712986.ch16>
- Stoltenborgh, M., van IJzendoorn, M. H., Euser, E. M., & Bakermans-Kranenburg, M. J. (2011). A global perspective on child sexual abuse: Meta-analysis of prevalence around the world. *Child Maltreatment*, 16(2), 79–101.
<https://doi.org/10.1177/1077559511403920>

- Tedeschi, R. G., & Calhoun, L. G. (2004). *Posttraumatic Growth: Conceptual Foundations and Empirical Evidence*. Lawrence Erlbaum Associates, Inc. *Psychological Inquiry* (Vol. 15).
- Timmons-Mitchell, J., Chandler-Holtz, D., & Semple, W. E. (1998). Post-Traumatic Stress Disorder Symptoms in Child Sexual Abuse Victims and Their Mothers. *Journal of Child Sexual Abuse* ISSN:, 6(4), 1–14. <https://doi.org/10.1300/J070v06n04>
- Ullman, S. E., Foynes, M. M., & Tang, S. S. S. (2010). Benefits and barriers to disclosing sexual trauma: A contextual approach. *Journal of Trauma and Dissociation*, 11(2), 127–133. <https://doi.org/10.1080/15299730903502904>
- van Delft, I., Finkenauer, C., Tybur, J. M., & Lamers-Winkelmann, F. (2016). “Disgusted by sexual abuse: Exploring the association between disgust sensitivity and posttraumatic stress symptoms among mothers of sexually abused children”: Erratum. *Journal of Traumatic Stress*, 29(6), 581–582. <https://doi.org/http://dx.doi.org/10.1002/jts.22118>
- van Toledo, A., & Seymour, F. (2016). Caregiver Needs Following Disclosure of Child Sexual Abuse. *Journal of Child Sexual Abuse*, 25(4), 403–414. <https://doi.org/10.1080/10538712.2016.1156206>
- Van Toledo, A., & Seymour, F. (2013). Interventions for caregivers of children who disclose sexual abuse: A review. *Clinical Psychology Review*, 33, 772–781. <https://doi.org/10.1016/j.cpr.2013.05.006>
- Wagner, W. G. (1991). Depression in mothers of sexually abused vs. mothers of nonabused children. *Child Abuse & Neglect* 15(1), 99-104.
- West, S., King, V., Carey, T. S., Lohr, K. N., McKoy, N., Sutton, S. F., & Lux, L. (2002). Systems to rate the strength of scientific evidence. *AHRQ Publication No. 02-E016*, (47), 1–11.
- Wilson Vanvoorhis, C. R., & Morgan, B. L. (2007). *Understanding Power and Rules of*

Thumb for Determining Sample Sizes. Tutorials in Quantitative Methods for Psychology
(Vol. 3).

World Health Organisation. (2016). Child maltreatment.

Zeller, M., Yuval, K., Nitzan-Assayag, Y., & Bernstein, A. (2015). Self-Compassion in Recovery Following Potentially Traumatic Stress: Longitudinal Study of At-Risk Youth. *Journal of Abnormal Child Psychology*, 43(4), 645–653. <https://doi.org/10.1007/s10802-014-9937>

Research Portfolio Appendices

Appendix A: Journals' Guidance for Authors

Clinical Psychology Review



CLINICAL PSYCHOLOGY REVIEW

AUTHOR INFORMATION PACK

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DESCRIPTION

Clinical Psychology Review publishes substantive reviews of topics germane to **clinical psychology**. Papers cover diverse issues including: psychopathology, psychotherapy, behavior therapy, cognition and cognitive therapies, behavioral medicine, community mental health, assessment, and child development. Papers should be cutting edge and advance the science and/or practice of clinical psychology.

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Immediately after the abstract, provide a maximum of 6 keywords, using American spelling and avoiding general and plural terms and multiple concepts (avoid, for example, 'and', 'of'). Be sparing with abbreviations: only abbreviations firmly established in the field may be eligible. These keywords will be used for indexing purposes.

Abbreviations

Define abbreviations that are not standard in this field in a footnote to be placed on the first page of the article. Such abbreviations that are unavoidable in the abstract must be defined at their first mention there, as well as in the footnote. Ensure consistency of abbreviations throughout the article.

Acknowledgements

Collate acknowledgements in a separate section at the end of the article before the references and do not, therefore, include them on the title page, as a footnote to the title or otherwise. List here those individuals who provided help during the research (e.g., providing language help, writing assistance or proof reading the article, etc.).

Formatting of funding sources

List funding sources in this standard way to facilitate compliance to funder's requirements:

Funding: This work was supported by the National Institutes of Health [grant numbers xxxx, yyyy]; the Bill & Melinda Gates Foundation, Seattle, WA [grant number zzzz]; and the United States Institutes of Peace [grant number aaaa].

It is not necessary to include detailed descriptions on the program or type of grants and awards. When funding is from a block grant or other resources available to a university, college, or other research institution, submit the name of the institute or organization that provided the funding.

If no funding has been provided for the research, please include the following sentence:

This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

Footnotes

Footnotes should be used sparingly. Number them consecutively throughout the article. Many word processors can build footnotes into the text, and this feature may be used. Otherwise, please indicate the position of footnotes in the text and list the footnotes themselves separately at the end of the article. Do not include footnotes in the Reference list.

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TIFF (or JPEG): Combinations bitmapped line/half-tone (color or grayscale), keep to a minimum of 500 dpi.

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Please submit tables as editable text and not as images. Tables can be placed either next to the relevant text in the article, or on separate page(s) at the end. Number tables consecutively in accordance with their appearance in the text and place any table notes below the table body. Be sparing in the use of tables and ensure that the data presented in them do not duplicate results described elsewhere in the article. Please avoid using vertical rules and shading in table cells.

References

Citations in the text should follow the referencing style used by the American Psychological Association. You are referred to the Publication Manual of the American Psychological Association, Sixth Edition, ISBN 1-4338-0559-6, copies of which may be ordered from <http://books.apa.org/books.cfm?id=4200067> or APA Order Dept., P.O.B. 2710, Hyattsville, MD 20784, USA or APA, 3 Henrietta Street, London, WC3E 8LU, UK. Details concerning this referencing style can also be found at <http://humanities.byu.edu/linguistics/Henrichsen/APA/APA01.html>

Citation in text

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As a minimum, the full URL should be given and the date when the reference was last accessed. Any further information, if known (DOI, author names, dates, reference to a source publication, etc.), should also be given. Web references can be listed separately (e.g., after the reference list) under a different heading if desired, or can be included in the reference list.

Data references

This journal encourages you to cite underlying or relevant datasets in your manuscript by citing them in your text and including a data reference in your Reference List. Data references should include the following elements: author name(s), dataset title, data repository, version (where available), year, and global persistent identifier. Add [dataset] immediately before the reference so we can properly identify it as a data reference. The [dataset] identifier will not appear in your published article.

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Reference style

References should be arranged first alphabetically and then further sorted chronologically if necessary. More than one reference from the same author(s) in the same year must be identified by the letters "a", "b", "c", etc., placed after the year of publication. **References should be formatted with a hanging indent (i.e., the first line of each reference is flush left while the subsequent lines are indented).**

Examples: Reference to a journal publication: Van der Geer, J., Hanraads, J. A. J., & Lupton R. A. (2000). The art of writing a scientific article. *Journal of Scientific Communications*, 163, 51-59.

Qualitative Research in Psychology

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About the Journal

Qualitative Research in Psychology is an international, peer-reviewed journal publishing high-quality, original research. Please see the journal's [Aims & Scope](#) for information about its focus and peer-review policy.

Please note that this journal only publishes manuscripts in English.

Qualitative Research in Psychology accepts the following types of article:

- Articles, Book Reviews

Qualitative Research in Psychology aims to become the primary forum for qualitative researchers in all areas of psychology—cognitive, social, developmental, educational, clinical, health, and forensic—as well as for those conducting psychologically relevant qualitative research in other disciplines.

Qualitative Research in Psychology is dedicated to exploring and expanding the territory of qualitative psychological research, strengthening its identity within the international research community and defining its place within the undergraduate and graduate curriculum. The journal will be broad in scope, presenting the full range of qualitative approaches to psychological research. The journal aims to firmly establish qualitative inquiry as an integral part of the discipline of psychology; to stimulate discussion of the relative merits of different qualitative methods in psychology; to provide a showcase for exemplary and innovative qualitative research projects in psychology; to establish appropriately high standards for the conduct and reporting of qualitative research; to establish a bridge between psychology and the other social and human sciences where qualitative inquiry has a proven track record; and to place qualitative psychological inquiry appropriately within the scientific, paradigmatic, and philosophical issues that it raises.

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Preparing Your Paper

Articles, Book Reviews

- Should be written with the following elements in the following order: title page; abstract; keywords; main text introduction, materials and methods, results, discussion; acknowledgments; declaration of interest statement; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figures; figure captions (as a list)
- Should contain an unstructured abstract of 150 words.
- Should contain between 5 and 10 **keywords**. Read [making your article more discoverable](#), including information on choosing a title and search engine optimization.
- Types of Manuscripts. Qualitative Research in Psychology will publish the following types of paper:
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 - 2) Empirical papers that report psychological research using qualitative methods and techniques, those that illustrate qualitative methodology in an exemplary manner, or that use a qualitative approach in unusual or innovative ways
 - 3) Debates
 - 4) Book reviews

Submissions for special issues will normally be announced via an advertisement in the journal, although suggestions for topics are always welcome. Book reviews will normally be suggested by the Reviews Editor, although unsolicited reviews will be considered. The journal will also review other relevant media as well as qualitative research software.

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References

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2. You can opt to include a **video abstract** with your article. [Find out how these can help your work reach a wider audience, and what to think about when filming](#).
3. **Funding details.** Please supply all details required by your funding and grant-awarding bodies as follows:

<i>For</i>	<i>single</i>	<i>agency</i>	<i>grants</i>
This work was supported by the [Funding Agency] under Grant [number xxxx].			
<i>For</i>	<i>multiple</i>	<i>agency</i>	<i>grants</i>
This work was supported by the [Funding Agency #1] under Grant [number xxxx]; [Funding Agency #2] under Grant [number xxxx]; and [Funding Agency #3] under Grant [number xxxx].			
4. **Disclosure statement.** This is to acknowledge any financial interest or benefit that has arisen from the direct applications of your research. [Further guidance on what is a conflict of interest and how to disclose it](#).

5. **Data availability statement.** If there is a data set associated with the paper, please provide information about where the data supporting the results or analyses presented in the paper can be found. Where applicable, this should include the hyperlink, DOI or other persistent identifier associated with the data set(s). [Templates](#) are also available to support authors.
6. **Data deposition.** If you choose to share or make the data underlying the study open, please deposit your data in a [recognized data repository](#) prior to or at the time of submission. You will be asked to provide the DOI, pre-reserved DOI, or other persistent identifier for the data set.
7. **Supplemental online material.** Supplemental material can be a video, dataset, fileset, sound file or anything which supports (and is pertinent to) your paper. We publish supplemental material online via Figshare. Find out more about [supplemental material and how to submit it with your article](#).
8. **Figures.** Figures should be high quality (1200 dpi for line art, 600 dpi for grayscale and 300 dpi for color, at the correct size). Figures should be supplied in one of our preferred file formats: EPS, PDF, PS, JPEG, TIFF, or Microsoft Word (DOC or DOCX) files are acceptable for figures that have been drawn in Word. For information relating to other file types, please consult our [Submission of electronic artwork](#) document.
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10. **Equations.** If you are submitting your manuscript as a Word document, please ensure that equations are editable. More information about [mathematical symbols and equations](#).
11. **Units.** Please use [SI units](#) (non-italicized).

Appendix B: PROSPERO protocol

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NHS
National Institute for
Health Research

UNIVERSITY of York
Centre for Reviews and Dissemination

Systematic review

1. * Review title.

Give the working title of the review, for example the one used for obtaining funding. Ideally the title should state succinctly the interventions or exposures being reviewed and the associated health or social problems. Where appropriate, the title should use the PI(E)COS structure to contain information on the Participants, Intervention (or Exposure) and Comparison groups, the Outcomes to be measured and Study designs to be included.

Factors associated with the psychological wellbeing of non-offending caregivers of child sexual abuse survivors: a systematic review

2. Original language title.

For reviews in languages other than English, this field should be used to enter the title in the language of the review. This will be displayed together with the English language title.

3. * Anticipated or actual start date.

Give the date when the systematic review commenced, or is expected to commence.

01/01/2019

4. * Anticipated completion date.

Give the date by which the review is expected to be completed.

26/09/2019

5. * Stage of review at time of this submission.

Indicate the stage of progress of the review by ticking the relevant Started and Completed boxes. Additional information may be added in the free text box provided.

Please note: Reviews that have progressed beyond the point of completing data extraction at the time of initial registration are not eligible for inclusion in PROSPERO. Should evidence of incorrect status and/or completion date being supplied at the time of submission come to light, the content of the PROSPERO record will be removed leaving only the title and named contact details and a statement that inaccuracies in the stage of the review date had been identified.

This field should be updated when any amendments are made to a published record and on completion and publication of the review. If this field was pre-populated from the initial screening questions then you are not able to edit it until the record is published.

The review has not yet started: No

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Review stage	Started	Completed
Preliminary searches	Yes	No
Piloting of the study selection process	Yes	No
Formal screening of search results against eligibility criteria	Yes	No
Data extraction	No	No
Risk of bias (quality) assessment	No	No
Data analysis	No	No
Provide any other relevant information about the stage of the review here (e.g. Funded proposal, protocol not yet finalised).		

6. * Named contact.

The named contact acts as the guarantor for the accuracy of the information presented in the register record.

Laura Wells

Email salutation (e.g. "Dr Smith" or "Joanne") for correspondence:

Laura

7. * Named contact email.

Give the electronic mail address of the named contact.

s1688005@sms.ed.ac.uk

8. Named contact address

Give the full postal address for the named contact.

School of Health in Social Science, University of Edinburgh, Old Medical Building, Teviot Place, Edinburgh, EH8 9AG

9. Named contact phone number.

Give the telephone number for the named contact, including international dialling code.

10. * Organisational affiliation of the review.

Full title of the organisational affiliations for this review and website address if available. This field may be completed as 'None' if the review is not affiliated to any organisation.

University of Edinburgh

Organisation web address:

11. * Review team members and their organisational affiliations.

Give the title, first name, last name and the organisational affiliations of each member of the review team.

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Affiliation refers to groups or organisations to which review team members belong.

Miss Laura Wells. University of Edinburgh
Professor Matthias Schwannauer. University of Edinburgh

12. * Funding sources/sponsors.

Give details of the individuals, organizations, groups or other legal entities who take responsibility for initiating, managing, sponsoring and/or financing the review. Include any unique identification numbers assigned to the review by the individuals or bodies listed.

Review is being undertaken as part of Laura Wells' Doctorate in Clinical Psychology at the University of Edinburgh.

13. * Conflicts of interest.

List any conditions that could lead to actual or perceived undue influence on judgements concerning the main topic investigated in the review.

None

14. Collaborators.

Give the name and affiliation of any individuals or organisations who are working on the review but who are not listed as review team members.

15. * Review question.

State the question(s) to be addressed by the review, clearly and precisely. Review questions may be specific or broad. It may be appropriate to break very broad questions down into a series of related more specific questions. Questions may be framed or refined using PI(E)COS where relevant.

What factors are associated with psychological wellbeing of nonoffending caregivers of child survivors of sexual abuse?

16. * Searches.

Give details of the sources to be searched, search dates (from and to), and any restrictions (e.g. language or publication period). The full search strategy is not required, but may be supplied as a link or attachment.

Search databases: OVID (EMBASE, PsycINFO, MEDLINE, and MEDLINE: daily update) and ASSIA

(Applied Social Sciences Citation Index and Abstracts).

Date restrictions: No.

Search dates: January 4th-18th 2019.

Example of search strategy on PsycINFO:

(non-offend* OR nonoffend* OR "non offend*" OR non-perpetrat* OR nonperpetrat* OR "non perpetrat*" OR non-abus* OR nonabuse* OR "non-abuse") AND (parent* OR carer* OR caregiver* OR mother* OR father* OR maternal* OR paternal) AND (child* OR adolescent* OR infant*) AND (sex*) AND (trauma* OR abuse* OR ptsd OR "post traumatic stress" OR "post-traumatic stress")

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17. URL to search strategy.

Give a link to a published pdf/word document detailing either the search strategy or an example of a search strategy for a specific database if available (including the keywords that will be used in the search strategies), or upload your search strategy. Do NOT provide links to your search results.

Alternatively, upload your search strategy to CRD in pdf format. Please note that by doing so you are consenting to the file being made publicly accessible.

Do not make this file publicly available until the review is complete

18. * Condition or domain being studied.

Give a short description of the disease, condition or healthcare domain being studied. This could include health and wellbeing outcomes.

The domain being studied in this review is the psychological wellbeing of non-offending parents of children who have experienced sexual abuse. Psychological functioning outcomes incorporates levels of Anxiety, Depression, Post Traumatic Stress, and Psychological Distress, and by psychological factors, environmental factors, familial factors, child factors, health factors and abuse-related factors.

19. * Participants/population.

Give summary criteria for the participants or populations being studied by the review. The preferred format includes details of both inclusion and exclusion criteria.

The participants in the review are nonoffending caregivers of children who have experienced sexual abuse.

Nonoffending caregivers are defined as caregivers who did not perpetrate the sexual abuse of their child.

NOCs can be any individual who had a key caring role for the child, and thus can include biological parents, step-parents, grandparents, adoptive parents, kinship carers, and foster carers.

20. * Intervention(s), exposure(s).

Give full and clear descriptions or definitions of the nature of the interventions or the exposures to be reviewed.

N/A

21. * Comparator(s)/control.

Where relevant, give details of the alternatives against which the main subject/topic of the review will be compared (e.g. another intervention or a non-exposed control group). The preferred format includes details of both inclusion and exclusion criteria.

N/A

22. * Types of study to be included.

Give details of the types of study (study designs) eligible for inclusion in the review. If there are no restrictions on the types of study design eligible for inclusion, or certain study types are excluded, this should be stated. The preferred format includes details of both inclusion and exclusion criteria.

Epidemiological population-based studies with cross-sectional, prospective or longitudinal designs.

23. Context.

Give summary details of the setting and other relevant characteristics which help define the inclusion or

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exclusion criteria.

The inclusion criteria for the review were articles that a) had a sample of nonoffending caregivers whose children were survivors of CSA and were aged 18 years; b) included a standardised assessment of psychological distress or wellbeing as an outcome; c) included a formalised assessment (either standardised or via questionnaire or interview where appropriate e.g. for demographic information) of psychosocial, environmental, personal, familial, and abuse-related factors as predictors; d) has data which is presented and extractable on the association between relevant factors and psychological distress outcome; e) use quantitative methodology with statistical analysis. Exclusion criteria were: a) previous review papers; b) case studies; c) treatment studies; d) book chapters; e) qualitative methodology; f) papers only using correlation analysis; g) grey material.

24. * Main outcome(s).

Give the pre-specified main (most important) outcomes of the review, including details of how the outcome is defined and measured and when these measurement are made, if these are part of the review inclusion criteria.

Mental health related measures, e.g. anxiety, depression, post-traumatic stress symptoms, general psychological distress and psychological wellbeing.

Timing and effect measures

25. * Additional outcome(s).

List the pre-specified additional outcomes of the review, with a similar level of detail to that required for main outcomes. Where there are no additional outcomes please state 'None' or 'Not applicable' as appropriate to the review

None.

Timing and effect measures

26. * Data extraction (selection and coding).

Give the procedure for selecting studies for the review and extracting data, including the number of researchers involved and how discrepancies will be resolved. List the data to be extracted.

Studies retrieved from the database searches will firstly be deduplicated. Subsequently, initial screening of titles and abstracts will be undertaken by the main author to determine whether they meet the inclusion criteria. Following this, full texts will be reviewed by the main author for the remaining studies, with inclusion and exclusion criteria being applied for final selection. Reference lists of full texts will also be reviewed for relevant studies.

Data will be extracted from the final selection of papers by the main author using a standardised electronic form. This will involve the following variables being extracted:

- a) Study design;
- b) Study aim/objectives;

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- c) inclusion and exclusion criteria;
- d) sample size;
- e) participant's key demographic variables;
- f) participant's child's key demographic variables;
- g) abuse characteristics (e.g. including type and perpetrator);
- h) data analysis procedure;
- i) relevant factor measure/assessment;
- j) outcome measure of psychological distress/wellbeing;
- k) main findings.

Study quality will be assessed by two independent reviewers using the bespoke quality assessment tool. Any discrepancies will be discussed, recorded, and an additional opinion of a third reviewer will be sought if required.

27. * Risk of bias (quality) assessment.

State whether and how risk of bias will be assessed (including the number of researchers involved and how discrepancies will be resolved), how the quality of individual studies will be assessed, and whether and how this will influence the planned synthesis.

Risk of bias will be assessed using a bespoke quality assessment will be used using an adapted version of the AXIS quality appraisal tool (Downes, Brennan, Williams, & Dean, 2016), informed by Agency for Healthcare Research Quality (AHRQ)'s and NICE guidance on quality appraisal. A second rater will additionally conduct the quality assessment on a sample of papers to ensure reliability, and the opinion of a third rater will be sought if necessary. The assessment of study quality will be used in the narrative synthesis.

28. * Strategy for data synthesis.

Give the planned general approach to synthesis, e.g. whether aggregate or individual participant data will be used and whether a quantitative or narrative (descriptive) synthesis is planned. It is acceptable to state that a quantitative synthesis will be used if the included studies are sufficiently homogenous.

We plan to present a narrative synthesis of study findings. This will include summary tables of extracted data, as well as a descriptive narrative of findings structured around the type of factors measured (for example, psychosocial factors, environmental factors etc). Meta-analysis is not anticipated to be suitable for the present review due to the expected heterogeneity of measures.

29. * Analysis of subgroups or subsets.

Give details of any plans for the separate presentation, exploration or analysis of different types of participants (e.g. by age, disease status, ethnicity, socioeconomic status, presence or absence or co-morbidities); different types of intervention (e.g. drug dose, presence or absence of particular components of intervention); different settings (e.g. country, acute or primary care sector, professional or family care); or different types of study (e.g. randomised or non-randomised).

None.

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30. * Type and method of review.

Select the type of review and the review method from the lists below. Select the health area(s) of interest for your review.

Type of review

Cost effectiveness
No

Diagnostic
No

Epidemiologic
Yes

Individual patient data (IPD) meta-analysis
No

Intervention
No

Meta-analysis
No

Methodology
No

Narrative synthesis
Yes

Network meta-analysis
No

Pre-clinical
No

Prevention
No

Prognostic
No

Prospective meta-analysis (PMA)
No

Review of reviews
No

Service delivery
No

Synthesis of qualitative studies
No

Systematic review
Yes

Other
No

Health area of the review

Alcohol/substance misuse/abuse
No

Blood and immune system
No

Cancer
No

Cardiovascular

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No
Care of the elderly
No
Child health
No
Complementary therapies
No
Crime and justice
No
Dental
No
Digestive system
No
Ear, nose and throat
No
Education
No
Endocrine and metabolic disorders
No
Eye disorders
No
General interest
No
Genetics
No
Health inequalities/health equity
No
Infections and infestations
No
International development
No
Mental health and behavioural conditions
Yes
Musculoskeletal
No
Neurological
No
Nursing
No
Obstetrics and gynaecology
No
Oral health
No
Palliative care
No
Perioperative care
No
Physiotherapy
No
Pregnancy and childbirth
No

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Public health (including social determinants of health)
 No

Rehabilitation
 No

Respiratory disorders
 No

Service delivery
 No

Skin disorders
 No

Social care
 No

Surgery
 No

Tropical Medicine
 No

Urological
 No

Wounds, injuries and accidents
 No

Violence and abuse
 Yes

31. Language.

Select each language individually to add it to the list below, use the bin icon to remove any added in error.
 English

There is an English language summary.

32. Country.

Select the country in which the review is being carried out from the drop down list. For multi-national collaborations select all the countries involved.

Scotland

33. Other registration details.

Give the name of any organisation where the systematic review title or protocol is registered (such as with The Campbell Collaboration, or The Joanna Briggs Institute) together with any unique identification number assigned. (N.B. Registration details for Cochrane protocols will be automatically entered). If extracted data will be stored and made available through a repository such as the Systematic Review Data Repository (SRDR), details and a link should be included here. If none, leave blank.

34. Reference and/or URL for published protocol.

Give the citation and link for the published protocol, if there is one

Give the link to the published protocol.

Alternatively, upload your published protocol to CRD in pdf format. Please note that by doing so you are consenting to the file being made publicly accessible.

No I do not make this file publicly available until the review is complete

Please note that the information required in the PROSPERO registration form must be completed in full even

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if access to a protocol is given.

35. Dissemination plans.

Give brief details of plans for communicating essential messages from the review to the appropriate audiences.

This review will initially be reported as a doctoral thesis, which will be available for the general public via open access archives of the University of Edinburgh. The review also plans to be submitted as an article to a relevant and reputable academic journal.

Do you intend to publish the review on completion?

Yes

36. Keywords.

Give words or phrases that best describe the review. Separate keywords with a semicolon or new line. Keywords will help users find the review in the Register (the words do not appear in the public record but are included in searches). Be as specific and precise as possible. Avoid acronyms and abbreviations unless these are in wide use.

37. Details of any existing review of the same topic by the same authors.

Give details of earlier versions of the systematic review if an update of an existing review is being registered, including full bibliographic reference if possible.

38. * Current review status.

Review status should be updated when the review is completed and when it is published. For newregistrations the review must be Ongoing.
Please provide anticipated publication date

Review_Ongoing

39. Any additional information.

Provide any other information the review team feel is relevant to the registration of the review.

40. Details of final report/publication(s).

This field should be left empty until details of the completed review are available.

Give the link to the published review.

Appendix C: Participant Information Sheet



Participant Information Sheet



Research study: *Parents of child trauma survivors accessing services: exploring parents experiences*

You are invited to take part in a research study. Before you decide if you would like to participate, it is important that you understand why the research is being done and what it would involve for you. Please take the time to read the following information carefully and discuss it with others if you wish. This will explain what the research is about and what it involves. Please ask questions if anything you read is not clear or if you would like more information.

What is the purpose of this study?

The study aims to develop our understanding of parents' experiences following a child's disclosure of sexual abuse. We know that a disclosure can have a huge impact on the family. We also know that parents play a vital role in their child's recovery and supporting them through this difficult time. Therefore, it is hoped that a greater understanding of parents' experiences will help us to develop services and interventions to better meet the needs of parents and their children. This research is being conducted as part of a Doctoral training in Clinical Psychology.

Why have I been invited to take part?

You have been invited to take part because your child has experienced sexual trauma, and is currently accessing CAMHS or social work services.

Do I have to take part?

No. Participation in this study is entirely voluntary. Participation or non-participation in this study will in no way affect the treatment that you or your child receives. If you decide to take part, you are still free to withdraw at any time and you do not have to give a reason.

What would I have to do?

You will be invited for a meeting with a researcher. This will involve: 1) filling in a short questionnaire, and 2) taking part in an interview about your experiences of supports and services, your thoughts and feelings, and things you have found helpful or unhelpful since your child's disclosure. These interviews will be recorded on a secure NHS audio recording device.

If you choose to take part, your clinician will pass on your details to the research team so we can get in contact with you to organise a convenient meeting time and location for you. This will most likely be in the service in which you and your child are accessing. We will allow approximately 90 minutes for the meeting, however this can last a shorter time. In addition, your clinician will fill in a 'background information form' with you around some basic personal information (e.g. age and gender) and practical information about your involvement in services (e.g. how long you have attended CAMHS or social work). We will give you an information sheet about the study for your child and you can choose if you would like to share this with them. We would also like to offer the reimbursement of your travel expenses for participation in the study.

You will be given the option to come to a follow-up meeting with a researcher later in the project to provide comments and feedback on the findings from interviews, to help with the analysis of the interview information. This helps to ensure that we have recorded and understood information from the interviews accurately. This meeting would last approximately 45 minutes.

How do I participate in the study?

Enclosed with this information sheet, you will see a consent form. You will have at least 24 hours to review this information sheet and consent form before you decide whether you want to take part. Your child's clinician will then speak about whether or not you are interested in being in the study. If you are interested, the clinician will ask your permission to pass on your contact details to the researcher so they can get in touch to organise a time to meet. You will have the opportunity to speak to your clinician or contact the researcher to ask any questions. If you decide to take part, you will be asked to sign this consent form at the beginning of the meeting with the

researcher. In this form, we will ask for the 'background information form' (described above) to be shared with the researcher. The consent form will also provide the option for you to consent for the researcher to inform your GP about your study participation. You can still take part in the study if you opt for your GP not to be contacted. The consent form also includes space for you to opt in to be contacted later in the study to take part in the second meeting to provide feedback and views on the information gathered in the study. In the unlikely event that you lose capacity to consent during the study, the research team would retain the data collected until that point, and continue to use it confidentially in connection with the purposes for which you originally provided consent for, but no further information would be collected.

What are the possible disadvantages of taking part?

It is possible that some aspects of the interview may bring difficult thoughts or memories to the front of your mind. This could bring about feelings of discomfort or distress. You will be encouraged to let the researcher know if you have these feelings. If you require any extra support after taking part in the research, we will ask you to speak to your child's clinician, and they will be able to suggest any helpful supports that may be of benefit. You can also withdraw from the study at any time, without giving a reason.

What are the possible benefits of taking part?

It is not anticipated that there will be any direct advantages to taking part in the study. It is hoped that the results of this study will increase our understanding of the experiences of caregivers of child trauma survivors. This will help develop services and supports to best address the needs of families going forward.

What will happen to the information I give?

The information you give will be treated confidentially. The audio recordings will be uploaded to secure password protected NHS Lothian computers and deleted from the recording device as soon as possible. The recordings will then be written up word for word. All identifiable information (e.g. names) will be removed written interview scripts.

Your consent forms and background information sheets will be given an individual code which will be linked to the non-identifiable interview scripts. These will all be stored separately. Identifiable information will be kept in a locked filing cabinet on NHS Lothian premises and the only people who will have access to this will be the research team (named below), who are all clinicians in NHS Lothian. Non-identifiable information will be analysed at the university, and non-identifiable quotes from interviews may be used in publication of the research.

If during the study you inform the researcher of anything that indicates that there may be a risk to you or to someone else, (e.g. child protection issues or disclosures of criminal activity) they will have to share this with the clinicians involved in your care. They will follow the service's standard procedures of sharing this information with the relevant services to ensure safety.

What will happen to the results of this study and will I be informed of the results?

The non-identifiable results of this research study will be written up and submitted as a Doctoral thesis in Clinical Psychology at the University of Edinburgh. It may also be published in a scientific journal so that other professionals can read about the results. Individuals who participate in the study will never be identified in any way in any publication arising from this research. The results of the study will be shared with CAMHS and Social Work services, and you will be asked at the end of the study if you would like to be sent a summary of the results.

Who has reviewed this study?

The >insert appropriate REC committee<, which has responsibility for scrutinising proposals for medical research on humans, has examined the proposal and has raised no objections from the point of view of medical ethics. NHS management approval has also been obtained.

Who can I contact about this study?

You are welcome to contact us to ask questions about the research and share any considerations. Please get in touch with Laura Wells (Researcher and Trainee Clinical Psychologist) on: 0131 451 7400 or email: laura.wells@nhslothian.scot.nhs.uk (based at The Meadows, NHS Lothian, 1st Floor, Fountainbridge Library Building, 137 Dundee Street, Edinburgh, EH11 1BG).

Alternatively, you can contact any of the research supervisors:

Clinical Supervisor:

Dr Tara Pennington-Twist
 Clinical Psychologist
 The Meadows, NHS Lothian
 1st Floor, Fountainbridge Library Building
 137 Dundee Street
 Edinburgh, EH11 1BG
 0131 451 7400

Clinical supervisor:

Dr Gillian Radford
 Clinical Psychologist
 The Meadows, NHS Lothian
 1st Floor, Fountainbridge Library
 Building
 137 Dundee Street
 Edinburgh, EH11 1BG
 0131 451 7400

Academic supervisor:

Prof. Matthias Schwannauer
 Consultant Clinical
 Psychologist/Programme Director
 School of Health in Social
 Sciences, The University of
 Edinburgh, Medical School Teviot
 Place, Edinburgh EH8 9AG. 0131
 6513972
m.schwannauer@ed.ac.uk

If you would like to discuss this study with someone independent of the study team please contact:

Dr Angus Macbeth

*School of Health in Social Science, Clinical Psychology, Room 1M.2, Doorway 6, Medical Quad
 Teviot Place, Edinburgh, EH8 9AG
 Tel: +44 (0)131 650 3893
 Email: angus.macbeth@ed.ac.uk*

If you wish to make a complaint about the study please contact NHS Lothian:

*Patient Experience Team, NHS Lothian, 2nd Floor, Waverley Gate, 2-4 Waterloo Place, Edinburgh
 EH1 3EG
 Tel: 0131 536 3370
 Email: feedback@nhslothian.scot.nhs.uk*

If you are feeling distressed or would like some support, we encourage you to speak to your child's clinician. You may also find the following services helpful:

*Samaritans: telephone - 116 123, website - <https://www.samaritans.org/>
 SANE: telephone - 0300 304 7000, website - <http://www.sane.org.uk/support>*

Thank you very much for reading this information sheet

Appendix D: Consent Form



CONSENT FORM



Title of Project: *Parents of child trauma survivors accessing services: exploring parents' experiences*

Name of Researcher: Laura Wells, Trainee Clinical Psychologist.

Please initial box

1. I confirm that I have read the information sheet dated 22/06/2018 (version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without mine or my child's medical care or legal rights being affected.
3. I agree to my interview being recorded on an encrypted NHS audio recorder.
4. I agree to the researcher having access to the 'background information sheet' which my clinician will fill in. This includes information on: mine and my child's age and gender; my ethnicity; how long my family have engaged in the service; and other services we have accessed since my child's disclosure.
5. I understand that I have the option to share the 'Child's Information Sheet' with my child.
6. I understand that relevant sections of data collected during the study may be looked at by individuals from the regulatory authorities and from the Sponsor(s) (NHS Lothian and the University of Edinburgh) or from the/other NHS Board(s) where it is relevant to my taking part in this research. I give permission for those individuals to have access to my records.
7. I agree for my anonymised data to be used in future ethically approved research.
8. I agree to take part in the above study.

Do you give permission for the researchers to inform your GP about your involvement in the study?
This can be done at a later time if preferred. Please speak to the researcher regarding this.

Please circle: Yes / No

If yes, please complete GP contact details section below.

In this project, we would like to invite some participants back to provide feedback and comments on some of the study's findings. Would you be happy for us to contact you in the future? By saying yes,

you will NOT be obliged to take part in further research. We are simply asking for your permission to contact you again. **Please circle: Yes / No**

If your answer is yes, please tick how you would like your clinician to contact you:

Post

Telephone

_____	_____	_____
Name of Participant	Date	Signature

_____	_____	_____
Name of Person taking consent	Date	Signature

Original (x1) to be retained in site file. Copy (x1) to be retained by the participant

GP Contact details:

Name:

.....
.....

Surgery:

.....
.....

Address:

.....
.....
.....
.....

IRAS ID:

Centre Number:

Study Number:

Participant Identification Number for this trial

Appendix E: Background Information Form



Background Information Form



This form is to be filled out for clients who have expressed interest in participating in the following study:

Parents of child trauma survivors accessing services: exploring parents' experiences

This form is to be filled out by clinicians. This can be done with information case films or with the client in session.

Participant code:.....

1. What is their age?
2. What is their gender?
3. What is their ethnicity/country of origin?
4. What is their child's age?
5. What is their child's gender?
6. When was their child's disclosure?
7. When were they referred to *>insert service<?*
8. When did they/their family first start attending *>insert service<?*
9. How long have they been attending *>insert service<?*
10. What has been the family's help-seeking pathway from disclosure until now? (e.g. previous CAMHS involvement, third sector services, Social Work).

Consent for the researcher to have access to this form will be sought from the participant at the first research interview. Only after consent is sought will the researcher have access to the above information.

Appendix F: PRFQ-A

Parental Reflective Functioning Questionnaire - A

Listed below are a number of statements concerning you and your child. Please read each item carefully and decide whether you agree or disagree and to what extent.

Use the following rating scale, with 7 if you strongly agree, and 1 if you strongly disagree; the midpoint, if you are neutral or undecided, is 4.

1	2	3	4	5	6	7
Strongly Disagree						Strongly Agree

1. ___ The only time I'm certain my child loves me is when he or she is smiling at me.
2. ___ I always know what my child wants.
3. ___ I like to think about the reasons behind the way my child behaves and feels.
4. ___ My child cries or acts up/is difficult around strangers to embarrass me.
5. ___ I can completely read my child's mind.
6. ___ I wonder a lot about what my child is thinking and feeling.
7. ___ I find it hard to actively participate in make believe play or imaginary activities with my child.
8. ___ I can always predict what my child will do.
9. ___ I am often curious to find out how my child feels.
10. ___ My child sometimes gets ill to keep me from doing what I want to do.
11. ___ I can sometimes misunderstand the reactions of my child.
12. ___ I try to see situations through the eyes of my child.
13. ___ When my child is being difficult he or she does that just to annoy me.
14. ___ I always know why I do what I do to my child.
15. ___ I try to understand the reasons why my child misbehaves.
16. ___ Often, my child's behavior is too confusing to bother figuring out.
17. ___ I always know why my child acts the way he or she does.
18. ___ I believe there is no point in trying to guess what my child feels.

Appendix G: Example of Guide for Interview Questions

Based on Charmaz's (2014) guidance for intensive interviewing in Grounded Theory.

Initial introductory questions:

- To help me get a picture of you and your family, what do you like to do together?
- Can you tell me how long ago was your child's disclosure?

Initial open-ended questions

- Could you tell me about your own experience of what happened following your child's disclosure?
- Could you tell me about your own experience of services/organizations/supports following your child's disclosure?

Intermediate/guiding Questions:

- Could you tell me about your thoughts and feelings at this time?
- Can you tell me about how the disclosure impacted your life? (How was x time different from y time?)

Ending questions

- Could you tell me about anything which was helpful/supportive (unhelpful/unsupportive) to you during this time?
- Is there something else you think I should know to understand your experience better?

Prompt examples

- *How did that make you feel?*
- *What was going through your mind at that time?*
- *What did you make of that?*
- *What do you think your child was thinking/feeling at that time?*
- *Can you tell me about a specific time when this happened/you felt like that?*
- *Could you tell me how you would define [x] in your own words?*
- *What sense did you make of that? / What do you understand as to why that happened?*

Appendix H: Interview Transcript and Coding

Interview Transcript Excerpt to illustrate coding process.
Interview dialogue between Interviewer (I) and Participant 7 (P7).

Interview transcript	Open codes	Focused codes
<p>I: And I guess... because people kind of can ‘not cope’ in different ways... I just wondered what that was like for you when you felt like you weren’t coping?</p> <p>P7: Erm... just really doubting myself... just feeling guilty that I’d had a child that this had happened to... *pause*.... I don’t know... a lot of different emotions...</p> <p>I: Yeah-</p> <p>P7: Sometimes I felt really strong, sometimes I felt like it made me and [child] stronger together as a mother and daughter, so sometimes things like that were...quite sort of warming, to think that we were getting through this together</p> <p>I: Yeah, yeah</p> <p>P7: But then other times... it did just feel hard to accept, that this is something that had happened that we could never ever change.. and I just hoped that it wasn’t going to impact on relationships that she had in the future with men</p> <p>I: yeah</p> <p>P7: Obviously her school work was suffering... I mean for [child] that wasn’t really a reality at that time for her...</p> <p>I: mhmm</p> <p>P7: But for me I knew that at some point we were going to be where we are now, that she’s doing exams, that she’s going to really struggle... but I couldn’t put that on her because at that point in time, it wasn’t even possible... she just had so much, the anxiety was really bad at that time...</p> <p>I: Mhmm</p> <p>P7: And like she just... she couldn’t concentrate, she couldn’t focus on anything... like there was no way I could try and encourage her to be doing school work or be at school</p> <p>I: Ok</p>	<p>Doubting self; feeling guilty; blaming self; experiencing range of emotions</p> <p>Feeling strong; “stronger together as a mother and daughter” (<i>In Vivo code</i>); getting through together</p> <p>Being unable to process abuse; contrasting feeling strong and struggling to accept; being unable to change situation; worrying about impact on child’s future relationships;</p> <p>Believing child is struggling at school</p> <p>Observing child’s anxiety;</p> <p>Focusing on mental health over school work;</p>	<p>Doubting Ability as a parent</p> <p>Feeling guilt/self-blame and shame</p> <p>Post-traumatic growth</p> <p>Worrying about the future</p> <p>Viewing future as negative/hopeless</p> <p>Child’s negative response to trauma</p> <p>Negative impact on day-to-day life</p>

<p>P7: Or things like that... it was more about focusing on her mental health at that point... whereas now that I feel like she's been to CAMHS for quite a while... she does know... I mean sometimes I think she will maybe play on it slightly... but they're not really the right words I'm looking to use but I can't really think how else to, to describe it because she's not like that at all... [child]'s not that kind of child</p> <p>I: Mhmm</p> <p>P7: But I think naturally she does shy away and use things like that as an excuse because she's struggling erm... and I think she herself feels useless at times because she knows that it's affected her</p> <p>I: -Ok, yeah-</p> <p>P7: And possibly even that she feels angry with herself too because... it's changed how our life is going to be... and it was outwith our control really... and I think that is a really difficult thing to try and cope with, to come to terms with</p> <p>I: And you've mentioned that a few times, that kind of not feeling in control of things-</p> <p>P7: Yeah</p> <p>I: and it's interesting cos that's what a lot of other parents have said that, that it kind of feels that these situations are quite out of control</p> <p>P7: Yeah</p> <p>I: And I just wondered how that, you know, how that was for you as a parent when those things felt kind of out of control?</p> <p>P7: I mean you feel that... you're the one that should be in control of your child</p> <p>I: Right ok</p> <p>P7: Like it's really down to you how they turn out because you're the one that's bringing them up... you're, every single bit of input that you put into them from the moment they're born is going to determine how they are going to turn out as adults. But when something like that comes along... it just goes against everything... all the good that you've tried to put into them... all the hard work that you've done</p>	<p>Engaging with CAMHS;</p> <p>Child using difficulties as excuse to avoid things;</p> <p>Contemplating child's thoughts and feelings; child feeling useless;</p> <p>Child feeling angry; Life not as wanted it to be; being out of control;</p> <p>Parent should be in control;</p> <p>Parenting determines child's outcome; importance of fulfilling parent role; abuse undoing 'good parenting'</p>	<p>Engaging with services</p> <p>Child's negative response to trauma</p> <p>Feeling helpless/out of control; Life not as wanted it to be</p> <p>Not fulfilling parent role; Feeling helpless/out of control</p>
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Appendix I: NHS Ethical Approvals (IRAS and R&D)

Lothian NHS Board

South East Scotland Research
Ethics Committee 02



Waverley Gate
2-4 Waterloo Place
Edinburgh
EH1 3EG
Telephone 0131 536 9000

www.nhsllothian.scot.nhs.uk

Date 27 June 2018
Your Ref
Our Ref **18/SS/0066 ID 246480**

Enquiries to : Joyce Clearie
Extension: 35674
Direct Line: 0131 465 5674
Email: Joyce.Clearie@nhsllothian.scot.nhs.uk

27 June 2018

Prof Matthias Schwannauer
Department of Clinical Psychology
School of Health in Social Sciences
Medical School, Teviot Place, EDIN
EH8 9AG

Dear Prof Schwannauer

Study title: Parents of child trauma survivors accessing services:
exploring parents' experiences
REC reference: 18/SS/0066
Protocol number: CAHSS1805/01
IRAS project ID: 246480

Thank you for your letter of 22nd June 2018, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair and Vice-Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to make a request to postpone publication, please contact hra.studyregistration@nhs.net outlining the reasons for your request.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.



Headquarters
Waverley Gate
2-4 Waterloo Place
Edinburgh EH1 3EG

Chair Brian G. Houston
Chief Executive Tim Davison

Lothian NHS Board is the common
name of Lothian Health Board



Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for HRA and HCRW Approval (England and Wales)/ NHS permission for research is available in the Integrated Research Application System, at www.hra.nhs.uk or at <http://www.rdforum.nhs.uk>.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact hra.studyregistration@nhs.net. The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from the HRA. Guidance on where to register is provided on the HRA website.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:



<i>Document</i>	<i>Version</i>	<i>Date</i>
Copies of advertisement materials for research participants [Poster]	2	22 June 2018
Covering letter on headed paper [Cover letter]	1	04 May 2018
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Clinical Trial Liability Insurance]	1	27 July 2017
GP/consultant information sheets or letters [GP letter]	2	22 June 2018
Interview schedules or topic guides for participants [Interview Protocol]	1	04 May 2018
IRAS Application Form [IRAS_Form_09052018]		09 May 2018
IRAS Application Form XML file [IRAS_Form_09052018]		09 May 2018
Letters of invitation to participant [Participant invitation from Clinician]	1	04 May 2018
Other [Employers Liability Insurance]	1	01 August 2017
Other [Public Liability Confirmation]	1	26 July 2017
Other [Professional Indemnity Insurance]	1	04 August 2017
Other [Background Information Form]	1	04 May 2018
Other [Participant follow-up invitation letter]	1	04 May 2018
Other [REC letter]	1	29 March 2018
Other [Cover Letter Response to REC regarding provisional opinion]	1	22 June 2018
Other [Child Information Sheet]	1	22 June 2018
Participant consent form [Consent Form]	2	22 June 2018
Participant information sheet (PIS) [Participant Information Sheet]	2	22 June 2018
Research protocol or project proposal [Research Protocol]	1	04 May 2018
Summary CV for Chief Investigator (CI) [Chief Investigator CV]	1	04 May 2018
Summary CV for student [CV for student]	1	04 May 2018
Validated questionnaire [PRFQ-A]	1	04 May 2018

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document “*After ethical review – guidance for researchers*” gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

**User Feedback**

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: <http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/>

HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at <http://www.hra.nhs.uk/hra-training/>

18/SS/0066	Please quote this number on all correspondence
-------------------	---

With the Committee's best wishes for the success of this project.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Lindsay Murray', written in a cursive style.

Mr Lindsay Murray
Chair

Email: joyce.clearie@nhslothian.scot.nhs.uk

Enclosures: "After ethical review – guidance for researchers"

Copy to: *Charlotte Smith, University of Edinburgh*
Miss Melissa Taylor, NHS Lothian

University Hospitals Division



Queen's Medical Research Institute
47 Little France Crescent, Edinburgh, EH16 4TJ

FM/FM/approval

10 July 2018

Laura Wells
1st Floor, Fountainbridge Library Building
137 Dundee Street
Edinburgh
EH11 1BG

Research & Development
Room E1.16
Tel: 0131 242 3330

Email:
accord@nhslothian.scot.nhs.uk

Director: Professor Tim Walsh

Dear Laura Wells

Lothian R&D Project No: 2018/0194

REC No: 18/SS/0066

Title of Research: Parents of child trauma survivors accessing services: exploring parents' experiences

Participant Information Sheet: Participant
Information Sheet - Version 2 – 22 June 2018

Consent Form: Consent Form - Version 2 – 22 June
2018

Child Information Sheet - Version 1 – 22 June 2018

Protocol: Version 1, 04 May 2018

I am pleased to inform you this letter provides Site Specific approval for NHS Lothian for the above study and you may proceed with your research, subject to the conditions below. Please note that the NHS Lothian R&D Office must be informed of any changes to the study such as amendments to the protocol, funding, recruitment, personnel or resource input required of NHS Lothian.

Substantial amendments to the protocol will require approval from the ethics committee which approved your study and the MHRA where applicable.

Please keep this office informed of the following study information, **which is a condition of NHS Lothian R&D Management Approval:**

1. Date you are ready to begin recruitment, date of the recruitment of the first participant and the monthly recruitment figures thereafter.
2. Date the final participant is recruited and the final recruitment figures.
3. Date your study / trial is completed within NHS Lothian.

I wish you every success with your study.

Yours sincerely

Ms Fiona McArdle
Deputy R&D Director

CC -Tim Montgomery, Director of Operations, Royal Edinburgh Hospital
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Appendix J: Table of Qualitative Categories

	<u>Higher Level Categories</u>	<u>Lower Level Sub-categories ('Focused coding')</u>	<u>Examples of open codes</u>	
<u>Core Categories</u>	Losing and Regaining control	Feeling helpless and out of control.	<i>There's nothing you can do. (In Vivo)</i>	
			<i>Feeling disempowered.</i>	
	Isolation and Connection	Feeling alone.	<i>Dealing with own difficulties alone.</i>	
			<i>Being a lonely time.</i>	
<u>Other Main Categories</u>	Child's disclosure and trauma response	Finding out about abuse	<i>Reading messages from perpetrator.</i>	
		Child's negative response to trauma	<i>Child being withdrawn.</i>	
	Parental Self-Efficacy and Identity	Importance of fulfilling parent role	<i>Identifying ongoing protection as parent's role.</i>	
		Not knowing, feeling incompetent and lost.	<i>Feeling unequipped to support family,</i>	
		Doubting ability as a parent	<i>Feeling a failure in job as a mother.</i>	
	Perceived coping resources	<u>Services:</u>		
		Feeling unsupported by services.		<i>Feeling family need more support.</i>
		Feeling reassured others are sharing responsibility of support.		<i>Reassuring not all on parent to listen.</i>
		Positive changes attributed to therapeutic input		<i>Linking CAMHS input to feeling more competent</i>
		<u>Personal internal coping:</u>		
		Being influenced by past experiences		<i>Child's disclosure triggering own CSA memories</i>
		Parent's emotional trauma response		<i>Feeling panicky.</i>
		Additional wider life stressors		<i>Finding sibling's behavior difficult.</i>
<u>Social Support:</u>				
Positive support network and leisure activities			<i>Opening up to others about problems</i>	
Feeling judged by others				

	Negative impact on wider system and life	<i>Having negative impact on work</i>
Feeling Shame/ Blame/Guilt		<i>Feeling guilty.</i>
		<i>I blamed myself. (in vivo)</i>
Parents' Mentalization of child and others	Difficulty Mentalizing child	<i>Viewing child's behavior as trying to 'test' parents.</i>
	Mentalizing child's thoughts/feelings/behaviours	<i>Associating child's panic attacks with feeling frightened</i>
	Difficulty mentalizing others	<i>Forgetting partner is going through same thing.</i>
Feeling understood ('mentalized') by services	Feeling invalidated by professionals	<i>Being told needs weren't severe enough.</i>
	Not feeling listened to by Professionals.	<i>Receiving no help when asked for it.</i>
	Not feeling understood by services.	<i>Feeling misrepresented in meetings.</i>
	Valuing professional's listening and validating.	<i>Valuing services taking concerns seriously.</i>
Coping actions in response to loss of control and isolation	Being 'center' of support for family	<i>I was therapist for rest of my kids (In Vivo).</i>
	Having to 'be strong' for family	<i>Masking emotions.</i>
	Hypervigilance and overestimating negative events	<i>Being hype-alert unnecessarily.</i>
	Seeking help from services	<i>Seeking support from school.</i>
	Seeking help from support network	<i>Seeking support and advice from friend.</i>
Outlook for the future	Viewing future as negative and hopeless	<i>There's a long way to go. (In Vivo)</i>
	Having ongoing difficulties	<i>Child still getting upset.</i>
	Noticing improvements and having positive outlook	<i>Being able to support child with self-harm.</i>
	Post-traumatic growth	<i>Made us stronger. (In Vivo).</i>

Appendix K: Empirical Paper NHS Ethics Research Protocol



Parents of child trauma survivors accessing services: exploring parents' experiences

Protocol Authors: Laura Wells (DClinPsy Student); Prof Matthias Schwannauer (Chief Investigator and Academic Supervisor); Dr Tara Pennington-Twist (Clinical Supervisor); Dr Gillian Radford (Clinical Supervisor)

Background information and Rationale

The prevalence of child sexual abuse (CSA) has been documented as ranging between 8-31% for girls and 3-17% for boys by Barth et al. (2013). Previous reviews have documented even higher occurrences, with Pereda, et al. (2009) reporting up to 53% of women and 60% men had experienced sexual abuse as a child. These experiences have been associated with a range of short and long-term difficulties, including clinically significant psychopathology. This can include depression, anxiety (including posttraumatic stress and obsessive-compulsive symptoms), dissociation, eating disorders, somatization, self-esteem and self-concept impairment, suicidal and self-injurious ideation or behaviour, substance abuse, engagement in high-risk behaviours, re-victimisation, and interpersonal problems (Maniglio 2009). With the high prevalence and significant effects of CSA, it is considered prominent public health concern. Thus, understanding factors which may help or hinder a child's recovery from trauma is vital to inform effective interventions.

Parents/Caregivers

Caregivers have also been found to be significantly affected by their child's CSA disclosure, for example, experiencing breakdown in supports (Van Toledo & Seymour, 2013), high psychological distress (Lewin and Bergin, 2001), and vicarious or secondary trauma (Fuller, 2016). These adverse effects on parents may impact their ability to support their child through this traumatic time. This is vital to consider, as research has also uncovered that parents and caregivers can act as protective factors with regards to children's response to traumatic event and can contribute to their recovery (Elliott and Carnes', 2001). To maximise caregivers' ability to support their child, their own unique and wide-ranging needs in their adjustment following disclosure need to be met (Van Toledo & Seymour, 2013). Ensuring they are able to utilise supports and access services is vital for their own wellbeing, as well of that of their child. Thus, understanding parents'/caregivers' experiences following disclosure, and considering factors which may help or hinder their adjustment to this traumatic event, is pertinent for future research.

Reflective function

One important psychological factor to consider is 'mentalisation' or Reflective Function (RF) (terms used interchangeably). This is described as the ability to make sense of one's own mental states, as well as the mental states of others, including thoughts, feelings and intentions (Fonagy et al., 2016; Fonagy & Target, 1997). Despite its origins in the early childhood experiences and attachment, RF has been found to improve following interventions that directly target mentalising capacities (Sadler et al., 2013; Kalland, Fagerlund, von Koskull, & Pajulo, 2016).

In the context of caregivers of child CSA survivors, research has started to explore the role of parent's

mentalisation. For example, Ensink et al (2016; 2017) have indicated links between lower maternal mentalisation and increased children's internalising and externalising behaviour. It appears that mentalisation may therefore be an important factor, however more investigation is needed to have a more in depth understanding of its role in parents' experience post disclosure, aside from associations with severity of child behaviours.

Theoretically, it appears that parents' mentalisation would play an important role in parents' adjustment following a traumatic event, such as a child's disclosure of CSA. Attributing mental states to others can make behaviours meaningful and predictable, enabling social interactions and relationships (Fonagy et al., 2016; Fonagy & Target, 1997). Mentalisation facilitates parents to understand thoughts, feelings and motivations of their child, in order to respond in an attuned manner to their needs. Furthermore, it helps make sense of their own thoughts and feelings as well as the minds of others in their support system. This is relevant to experiences of help-seeking, as Allen and Fonagy (2006) hypothesise that mentalisation plays an important a role in promoting recognition of requests for, or acceptance of, supports from others.

The present study

Despite the evident importance of understanding the experiences of parents of child CSA survivors, limited research has been conducted to explore this in depth. There is a gap in our knowledge with regards investigating what psychological factors may play a role in parents' adjustment and experiences following disclosure, for example, mentalisation. This will be addressed in this proposed mixed-methods study, through gathering in depth qualitative information in an interview with parents, and obtaining an approximate score of their mentalisation through a questionnaire.

A greater understanding of experiences of parents/carers whose children are accessing services will help develop services for caregivers, with regards meeting their unique needs and promoting accessibility. Identifying psychological factors which may influence post-disclosure adjustment for these parents, such as mentalisation, will further inform services to consider targeting these areas to promote caregiver and child wellbeing in the future. We further hope to build on the emerging but limited existing literature around mentalisation in parents of CSA survivors with a more in depth understanding of the role of mentalisation on the wider experience of parents around following their child's disclosure.

Research Questions / Objectives:

- a) To explore the experiences of caregivers following their child's disclosure of CSA.
- b) To explore the role of the caregivers' 'mentalisation' in the support of children who experienced CSA and are involved in specialist services.

Methodology

Design

A mixed-methods design will be employed in the present study. An exploratory, qualitative, semi-structured interview will be utilised to explore the personal lived experience of non-offending parents following their child's disclosure of sexual abuse. In conjunction, participants will be asked to complete the Parental Reflective Functioning Questionnaire-A (PRFQ-A) which will provide a score of parental mentalisation (also known as 'reflective functioning')

Recruitment

Participants will be parents of child survivors of sexual abuse, whose children are currently accessing services. The sample will be recruited primarily from NHS Lothian CAMHS trauma service in Edinburgh (The Meadows) and West Lothian (No 54), but study participation will also be considered to be advertised across other NHS Lothian CAMHS services and East Lothian Social Work Service if required. East Lothian Social Work Service recruitment would be undertaken via the NHS Lothian psychologist based in that service.

The study will be introduced to these teams through email and the researchers attending team meetings. Potential participants will be identified and approached by the clinician currently working with their child in the first instance. Posters advertising the study will also direct potential participants to speak to their child's clinician about participation. The clinician will be familiar with the parent/carer, and be able to assess their suitability for the study.

The clinician will provide the potential participant with a research pack, which will include a) information sheets which outline the purpose and procedures of the current study, information on the topics covered within the interview, and practical details around the approximate timings and location of the interviews, b) the informed consent form to review before the initial appointment, and sign beforehand if they wish, and c) the researcher's contact details for queries and questions.

In the instance that parents/carers are not attending sessions with their child for that time period, clinicians may also telephone individuals in line with routine contact. If they are interested, they would be sent the research pack via post. In addition, posters will be put up in the waiting rooms of services of which recruitment is taking place. These will allow parents/carers to self-identify for the study, and will direct them to speak to their child's clinician with regards to study participation.

Participants who are interested in taking part will be provided at least 24 hours to read over the study information. Clinicians will speak to potential participants in their next routine contact, (e.g. in session or telephone), with regards to their interest in participation, and to answer any questions. If they are interested, they will ask if they consent for their contact details to be passed on to the researchers, in order for the researchers to make contact with regards to organising a time to meet, and to answer any further questions.

Inclusion criteria

- Parents/caregivers of young people (aged 0-17) who have experienced CSA.
- Age 18+ years
- Currently be engaging in services within CAMHS or Social Work.
- Can be biological parents, step-parents, adoptive parents, grand-parents, or other caregiver, if they had a direct caregiving role (i.e. living with the child) at the time of disclosure until the present.
- Able to give informed consent.
- A 'non-offending' parent/carer i.e. were not perpetrators of their child's abuse.
- That there has been at least 6 months since their child's disclosure

Exclusion criteria

- Non-English speaking.
- Been assessed as high risk to meet on a 1.1 basis, which would have been determined by the clinical team.

- Not attending the service due to declining interventions offered from the service (e.g. child is attending for intervention but parents have declined to engage). This is due to clinicians being unable to assess suitability or risk regarding the individual.
- Are currently involved in legal proceedings/court cases related to the disclosure.

Procedure

Participants will be offered initially to be met in a) the services in which they were recruited through (e.g. NHS Lothian CAMHS or Lothian Social Work) b) community services e.g. GP surgeries, or c) at home. As well as being seen in clinic rooms, participants may also be seen in a private room provided by the library which is situated in the same building as The Meadows service. It is viewed that this community space would provide an environment which differs from a health setting, which may allow more natural responses.

Written consent to participate in the study will be obtained at the arranged interview time prior to beginning the first interview. Participants will be given the option to consent to their GP being contacted (and thus provide their GP's contact details), and the option will be given to consent to be contacted at a later date for providing feedback on data analysis. Clinicians will also separately complete the 'background information' form either from the participant's file or with the participant in session. This will include demographic information and practical service engagement information e.g. time of referral, length of service use, and help-seeking pathway. Consent will be obtained on the consent form for the researcher to access this form. The researcher will not have access to any case files or therapy notes for the participant or their child.

Participants will initially be invited to fill in the Parental Reflective Functioning Questionnaire (PRFQ). Following this, they will be asked to take part in the semi-structured interview regarding their post-disclosure experiences e.g. around thoughts and feelings, coping, and help-seeking. The researcher will openly explain again that the interviews will be recorded to enable accurate transcription, and that the material will be confidential and securely stored.

Time for verbal debriefing will be allocated at the end of the interview, and participants will be sign posted to their child's clinician or appropriate services if necessary. Interviews will be audio recorded on NHS encrypted devices for the purpose of interview transcription and data analysis.

The participant will be actively involved in the study for the duration of the meeting, and will also be invited back in the data analysis stage contribute their views on the themes identified in their interview, as well as the general findings, as a means of validation and triangulation of the researcher's findings.

Data collection methods

Data will be collected in one meeting with the participant. This will involve:

1. *The Parental Reflective Function Questionnaire - A (PRFQ - A; Luyten, Mayes, Nijssens, & Fonagy, 2017a)*

The original PRFQ is an 18-item questionnaire designed as a brief and easy to administer tool to measure reflective function of parents in the context of research (Camoirano, 2017; Patrick Luyten et al., 2017). Each item receives a score on the 7-point Likert Scale from 1 (strongly disagree) to 7 (strongly agree). It measures three factors associated with Parental Reflective Functioning (PRF): 1) Pre-mentalising, or a 'non-mentalising' stance, 2) Certainty of Mental States, which can range from hypermentalising (being overly certain of mental states)

or hypomenthalising (being very uncertain of mental states), and 3) Interest and Curiosity in mental states. This 3-factor structure has been supported by exploratory and confirmatory factor analysis, with good internal consistency (Patrick Luyten et al., 2017). Despite being recently developed, the scale has already been applied in a range of published research (Rostad & Whitaker, 2016; Rutherford et al., 2013). The PRFQ was originally developed for parents with children aged 0-5, however has recently been adapted with minor wording changes for application with older children (PRFQ-A). This scoring and three factor structure maintains the same with these changes (Luyten, P., Mayes, L. C., Nijssens, L., & Fonagy, P., 2017b).

Although other more in-depth measures of Reflective functioning are available, these were viewed as burdensome both emotionally (e.g. Adult Attachment Interview; Fonagy and Target, 1998) and timewise (e.g. Parent Development Interview, Slade et al, 2004) for participants. Therefore, the PRFQ was viewed as the most suitable tool for the scope of the present study.

2. *Parent experience interview*

A Semi Structured Interview guide will be developed for interviewer, with a selection of pre-selected open-ended questions identified. However, the majority of the interview will be driven by the information provided by the respondent (Charmaz, 2006). The interview will center around the parent's experience following their child's disclosure, focusing on the themes of their thoughts and feelings; how things changed post-disclosure; helpful and unhelpful factors at this time; their help-seeking pathway; their ways of coping; and their experience of services. Questions will be based on Charmaz (2006)'s suggestions for best practice interview question within this grounded theory and Smith's (2003) recommendations for questions yielding rich data (e.g. questions beginning with "tell me about", "how", "what", "when").

Analysis

A mixed-methods approach to analysis will be employed to meet the study objectives. PRFQ-A's will be rated to obtain a score of parental mentalisation. All interviews will be transcribed verbatim and anonymized for data analysis. Qualitative analysis drawing on grounded theory will be used for analysis of the interviews. Interview data will initially be reviewed and each segment be attributed a code. These codes will be synthesised and organised into broader themes around parent experience of child disclosure. Themes will be checked by supervisors, and participant volunteers, as part of the analysis.

The qualitative themes and mentalisation scores will be considered together, to explore the role of mentalisation in parent's experiences following their child's CSA disclosure. Taken together, this will build a theory around parent's post disclosure experiences, and consider this in the context existing theories of mentalisation.

Management of Risks to Project

There are five broad areas of consideration for the present research. These are outlined below, with steps on how these risks will be addressed, managed, and minimised:

1. Possibility of participant's remembering or becoming more aware of difficulties from the depth exploration of personal experience in the interview.

The interview will be asking about the parents' experiences following disclosure, and will not be asking about sensitive details of the child's disclosure or abuse. Participants will also have already discussed the topics of the interview in their routine assessment sessions with the service, and so this will not be the first time discussing these areas. These will therefore be topics in which participants are comfortable

with and expecting to be covering. Extra care will be given to ensure participants fully understand what they will be asked to do in the information sheet and consent form, including the specific themes which will be discussed in the interview. Participants will also be actively involved with a clinician, who will risk assess their suitability for participation in the study based on their background and current situation.

If participants have any concerns or are feeling distressed, they will be signposted to the appropriate supports and services. As the participants will all be actively engaged with CAMHS and social work services at the time of the research, this will be directing them to their child's case holder in CAMHS or social work, and any difficulties will be managed routinely by these services. Time will be allocated for debriefing at the end of the interview, to allow space to the participant to share any concerns and be signposted appropriately. The researcher will be working closely with services to ensure that the risk to each participant is minimised.

2. Disclosure of new risk related information e.g. child protection issues; previously undisclosed abuse details; criminal activity; active risk of self-harm/suicide.

This is anticipated to be unlikely, due parents already being involved in services focused around their child's trauma, and will be risk assessed by their child's clinician their suitability for participation in the study based on their background and current situation. Additionally, an inclusion criteria is there needs to be 6 months since disclosure, and not currently be involve in court/legal proceedings. Nevertheless, any risk information disclosed in the interviews will be passed on to the participant's child's clinician. This will be clearly outlined in the information sheet and consent form, and will be discussed with the participant at the end of the interview. The participant will further be signposted to the clinician for support if required. Any disclosures or risk information will be routinely managed by services, who follow standard procedures and make appropriate referrals with regards to managing this risk and sharing of information e.g. following child protection pathways; onward referrals.

3. Informed consent.

Due to the potentially sensitive nature of the interview, extra care will be given to ensure participants fully understand what they will be asked to do, and the specific themes which will be discussed in the interview. If a participant is unable to provide fully informed written consent, they will not be included in the study. Participants will be encouraged to communicate any dissatisfaction or unhappiness they feel during the research. The research team will allow participants to discuss fully any problems they may be having and will allow them to withdraw from the study if they would prefer not to continue. The statutory responsibilities with regard to risk management and the associated limits to study confidentiality will be made clear during the process of obtaining consent. As is standard, information will only be shared where there is concern for the participant's safety, or the safety of another person.

3. Confidentiality of service user information.

To ensure confidentiality, all personal information will be coded, no personal details will be revealed to anyone outside the NHS Lothian research team, and we will ensure that participants will not be able to be identified through the anonymised data. Personal information which is required to be retained, such as consent forms, will be securely stored in NHS Lothian, and will be kept separately to the coded and unidentifiable data. Audio recordings will be removed from the recording device at the earliest possible opportunity. Recordings and transcripts will be stored on a secure NHS drive, and only fully de-identified transcripts will be

4. Participant under-recruitment/drop out after first session.

Due to the nature of the study's method, the number of participants is anticipated to be low. However, the risks with regards to recruitment lies with the time-consuming nature of the interview meeting. Therefore, participation in the study will aim to be as easy as possible for the participant. For example, organizing interviews at familiar venues, preferably coinciding with other appointments they may have. To increase motivation in study participation, travel expenses will be reimbursed. Additionally, it will be important to have clear information sheets so participants are aware of the potentially sensitive nature of the interviews. This will ensure they are prepared for the areas of discussion in the interview, to prevent any unexpected topics which trigger withdrawal from the study. Furthermore, if it is not possible to recruit the required number solely from the NHS Lothian trauma service, then recruitment will be broadened to other CAMHS services and the East Lothian social work team.

5. Lone worker risks associated with undertaking interviews in participant home.

The initial aim will be for interviews to be organized in the services from which participants were recruited. However, in the instance that this is not possible for participants, we will strive to be as flexible as possible to accommodate participant availability and commitments. Therefore, interviews at participant homes may be offered. In this scenario, the researcher will adhere to the NHS Lothian Lone Worker Policy, and have undertaken the necessary lone worker training. This will include 'safe and well' procedures, informing the clinical supervisor or other member of the clinical team of the time and location of interviews, and when they have been completed safely. This will all be undertaken within the realms of patient confidentiality. Routine risk assessment undertaken by the service will be referred to regarding home visits for individual participants.

Dissemination

The results of the proposed study will initially be reported as a doctoral thesis in a portfolio format. This will include a systematic review and empirical research project, which is due to be completed in May 2019. The thesis will be available for the general public via open access archives of the University of Edinburgh.

Further dissemination of the study's results will take the form of a research article submitted to a relevant and reputable journal. At this early stage, *Child Abuse and Neglect* (impact factor 2.293) or the *Journal of Child Sexual Abuse* (impact factor 0.649) have been identified as possible options for submission. The researcher will also develop a range of communication formats to summarise the findings from the present study, for example, an accessible PowerPoint presentation or brief report. These will be offered as a means of presenting results to the NHS teams of which parents were recruited, as well as within the Social work services where appropriate. An easy read summary of the proposed study's findings will also be prepared and circulated to the staff teams which were involved in the study. At the end of the study, participants will be asked if they would like to be sent a summary of the results, and will also be provided with details around requesting the results in the future, which can be via the service or contacting the research team.

Following completion of the empirical study, the trainee will aim to identify relevant conferences to attend and present, in order to disseminate findings further.

References

- Barth, J., Bermetz, L., Heim, E., Trelle, S., & Tonia, T. (2013). The current prevalence of child sexual abuse worldwide: A systematic review and meta-analysis. *International Journal of Public Health*, 58(3), 469–483.
- Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. London: Sage Publications.

- Elliott, A. N., & Carnes, C. N. (2001). Reactions of nonoffending parents to the sexual abuse of their child: a review of the literature. *Child Maltreatment, 6*(4), 314–31.
- Ensink, K., Bégin, M., Normandin, L., & Fonagy, P. (2017). Parental reflective functioning as a moderator of child internalizing difficulties in the context of child sexual abuse. *Psychiatry Research, 257*, 361–366.
- Ensink, K., Bégin, M., Normandin, L., Fonagy, P., & Bégin, M. L. (2016). Maternal and child reflective functioning in the context of child sexual abuse: pathways to depression and externalising difficulties. *European Journal of Psychotraumatology ISSNOnline) Journal, homepage, 2000–8198*.
- Fonagy, P., & Target, M. (1997). Attachment and reflective function: Their role in self-organization. *Development and Psychopathology, 9*, 679–700.
- Fonagy, P., & Target, M. (1998). Reflective-functioning manual, version 5.0, for application to adult attachment interviews. *University College London, 1–47*.
- Fuller, G. (2016). Non-offending parents as secondary victims of child sexual assault. *Trends and Issues in Crime and Criminal Justice, (500)*, 1–7.
- Kalland, M., Fagerlund, Å., von Koskull, M., & Pajulo, M. (2016). Families First: the development of a new mentalization-based group intervention for first-time parents to promote child development and family health. *Primary Health Care Research & Development, 17*(1), 3–17.
- Lewin, L., & Bergin, C. (2001). Attachment behaviors, depression, and anxiety in nonoffending mothers of child sexual abuse victims. *Child Maltreatment, 6*(4), 365–75.
- Luyten, P., Mayes, L. C., Nijssens, L., & Fonagy, P. (2017a). The parental reflective functioning questionnaire: Development and preliminary validation. *PloS one, 12*(5), e0176218.
- Luyten, P., Mayes, L. C., Nijssens, L., & Fonagy, P. (2017b). The Parental Reflective Functioning Questionnaire – Adolescent version. University of Leuven, Belgium.
- Pereda, N., Guilera, G., Forns, M., & Gómez-Benito, J. (2009). The international epidemiology of child sexual abuse: A continuation of Finkelhor (1994). *Child Abuse and Neglect, 33*(4), 635–641.
- Rostad, W. L., & Whitaker, D. J. (2016). The association between reflective functioning and parent–child relationship quality. *Journal of Child and Family Studies, 25*(7), 2164–2177.
- Rutherford, H. J., Goldberg, B., Luyten, P., Bridgett, D. J., & Mayes, L. C. (2013). Parental reflective functioning is associated with tolerance of infant distress but not general distress: Evidence for a specific relationship using a simulated baby paradigm. *Infant Behavior and Development, 36*(4), 635–641.
- Sadler, L. S., Slade, A., Close, N., Webb, D. L., Simpson, T., Fennie, K., & Mayes, L. C. (2013). Minding the baby: Enhancing reflectiveness to improve early health and relationship outcomes in an interdisciplinary home-visiting program. *Infant Mental Health Journal, 34*(5), 391–405.
- Slade, A., Aber, J. L., Bresgi, I., Berger, B., & Kaplan, M. (2004). The parent development interview—revised. *Unpublished protocol. The City University of New York*.
- Smith, J. A. (2003). *Qualitative Psychology: A Practical Guide to Research Methods*. SAGE Publications.