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ORIGINAL ARTICLE

Working with denial in families dealing with child abuse: A scoping review of the resolutions approach

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Abstract

The Resolutions Approach (RA) is a solution-based intervention that has a unique way of dealing with parental denial of child abuse occurrences. The aim of this scoping review is to summarise knowledge about the benefits of the RA and identify areas for future research. After describing the theoretical background, the intervention steps are illustrated. Next, results of a systematic literature search on the effectiveness and other clinical benefits of the RA are presented. Finally, we provide suggestions for future research. Our search identified two published articles and one dissertation. Findings indicate that the RA might be useful in stopping child abuse and in improving cooperation between families and professionals. Parents experienced more control over their situation, and guardians perceived the method to be transparent. The RA is a well-described method that respectfully deals with families in which a lack of safety is observed. Future empirical research on the RA is necessary.

KEYWORDS

Child abuse, denied child abuse, Resolutions Approach, scoping review

Practitioner points

- The Resolutions Approach aims to stop and prevent child abuse in families when there are different perspectives on the abuse.
- Our study reveals that there are signs of a clinical benefit of the RA in establishing a safe family environment for the child.
- Families experienced more control over their situation, while guardians perceived the method to be transparent.
- For most families participating in the RA, a supportive social network could be established.

INTRODUCTION

Child abuse is common worldwide (Stoltenborgh et al., 2015), and the consequences are severe and extend across the lifespan (Felitti et al., 1998; Mabanglo, 2002; Maguire et al., 2015). Child abuse comprises sexual, physical and emotional abuse and neglect, being a witness of chronic or severe domestic violence and educational neglect (Sedlak et al., 2010). To stop child abuse, it is considered essential that the different parties involved work together efficiently. Frequently, professionals and parents become entangled in discussions about possible perpetrators, denial, causes of abuse and severity. Such discussions can obstruct fruitful cooperation, thus preventing the resolution of child abuse in the families. To this end, the Resolutions Approach (RA) intervention was developed, not only to help stop child abuse in families but also to provide solutions for dealing with challenging processes of denial (Essex et al., 1996; Turnell & Essex, 2006).

The RA was introduced in the Netherlands in 2008 and 2009. Professionals from various mental health institutions were trained by Susie Essex. Those who have since worked with the method are generally positive about the approach. However, little is known about the method's effectiveness. Therefore, a scoping review was deemed appropriate to provide an overview of the existing evidence, regardless of its quality (Arksey & O'Malley, 2005; Tricco et al., 2018).

The major purpose of this paper is to summarise knowledge about the RA intervention and to identify areas that deserve future attention. Our main research question is: What is known about the clinical benefits of the RA in the existing literature? First, we describe the RA method, its theoretical underpinnings and the treatment process. The intervention steps are illustrated using a case example. Second, we report the results of a systematic search for empirical studies concerned with research on the RA. Third, we evaluate current knowledge and provide suggestions to guide further research.

THE RESOLUTIONS APPROACH

Rationale and main principles

Working as a family therapist in England, Susie Essex, one of the developers of the RA, noticed that when a family was suspected of child abuse, professionals were convinced that they could only work with the family when the parents confessed to the abuse. Essex saw that it was difficult for professionals to intervene when, on the one hand, there were concerns regarding the child's safety, but on the other hand, there were different opinions about the circumstances of the abuse.

These insights led to the development of the RA intervention to prevent professionals from doing too little when child abuse cannot be proven or doing too much when parents deny abuse (Essex et al., 1996; Turnell & Essex, 2006).

Several principles underlie the RA:

1. Perspective on denial

In the RA, denial is seen as a relational process in which several factors play a role: the abuse and the perspective on the abuse from the parents', victim's, bystanders' and professionals' point of view. In addition, confessing to child abuse can have dire consequences, for example imprisonment, the loss of a job, the removal of the children from the home and/or the loss of a relationship. Altogether, this makes denial a complex process rather than a feature of parents only. Within this context, parents might want to cooperate to prevent further abuse, although there is disagreement about the abuse between parents and professionals. Gumbleton (1997) argues that it is not the severity of the abuse but the quality of the collaborative relationship between parents and professionals that predicts the outcome of an intervention. For this reason, the RA focuses on the relationship between parents and professionals, allowing for the possibility that they might have different opinions about the abuse. The concerns expressed by children, family members and professionals about the child's safety are the starting point of the RA process (Essex et al., 1996; Gumbleton, 1997; Turnell & Essex, 2006).

2. Uncertainty about the specific facts of the case will probably remain

In undisputed cases of child abuse, it is best if parents take responsibility for their behaviour. However, the RA is designed for situations in which professionals and parents do not agree about the abuse allegations, a situation that unfortunately occurs on a regular basis. The RA circumnavigates this potential standoff between professionals and parents, allowing them to make plans for the future regardless of uncertainty about what happened in the past (Turnell & Essex, 2006).

3. Identify sources of protection in the network

The third and final principle is that the non-abusive parent and members of the social network are considered sources of protection. Essex points out that when one parent is accused of child abuse, the other is often seen as complicit. The RA assumes that the other parent and people in the network are not necessarily complicit but may already play a role in the safety of the child and that this role can be increased (Turnell & Essex, 2006). To illustrate the RA principles, below a case example is provided of a mother and her 7-year-old son.

Illustration of the RA: Case example Family A[1]

A seven-year-old child was living in a single-parent household with his mother. There was no contact with the father. The child told his schoolteacher that his mother hit him. Child Protective Services got involved after they were informed by the nearest neighbour. The neighbour confirmed that the mother hit her child regularly to discipline him. The general practitioner was unable to establish proof of any injuries. According to the school, the child was often absent. In

response to Child Protective Services's intervention, the court appointed a family guardian. The mother described how she loved her child very much and that she never hit him. Nevertheless, Child Protective Services decided to place the child with a short-stay foster family. Thereafter, the family guardian referred the family to the RA. The aim was for the child to live with his mother at home again. However, the family guardian did not know how to realise this if the mother denied hitting her child.

Treatment overview and process

As outlined in the book by Turnell and Essex (2006), the RA consists of seven phases, incorporating 20 sessions spread over a period of 12 to 18 months (Essex et al., 1996; Gumbleton, 1997; Turnell & Essex, 2006). To provide a brief overview of the treatment procedures, we describe these phases below.

1. Preparation

During the first phase, both the referrer and the parents receive information about the intervention so that they can decide if they consent to work with the approach. The RA aims to ensure that a child can live safely with their parents again. If the referrer does not consider this aim realistic, the family is not considered to be eligible for the RA. The RA offers parents an opportunity to demonstrate to social services that they can safely raise their child.

2. Establishing a cooperative relationship with the parents

The second phase is intended to develop a cooperative relationship with the parents. This is done by giving the parents the opportunity to tell their side of the story and explain how they became suspected of child abuse. During this phase, it is also discussed with the parents that it is essential to involve people from their social network in this process.

3. 'Words and pictures'

During the third phase, called 'words and pictures', the parents and RA therapist construct a graphical story based on four questions: Who's worried, what are they worried about, what happened then and what are we going to do about it? This document describes the potential situation and alleged behaviour that the parents were accused of. Furthermore, the opinion and perspectives of the parents, professionals and (potentially) other network members are depicted in this document. The RA therapist and parents share the document with the child(ren) and the network members who are involved in the RA process. In this way, the child(ren) and network figures are made aware of the allegations and parental views about them.

4. Preliminary guidelines for family safety

Now that it is clear to everyone involved that the parents have been suspected of child abusive behaviour, ways to organise family life so that both parents and professionals can be confident that the child(ren) will be safe in the near future are explored. This culminates in a plan agreed by the network members and professionals involved.

5. The family next door

In a role-playing game, parents play another family. The starting point of the role play is that parents have confessed to a form of child abuse. The therapist interviews the parents in their roles as the other parents. To clearly underline that this is a role-playing game and that parents are not questioned about their own situation, the roles are introduced step by step. Parents construct their role-playing scenario by choosing the type of car, house and job that they have. The purpose of this intervention is to increase knowledge about power dynamics, seduction (grooming) in cases of sexual abuse, the behaviour of the alleged perpetrator and the effects of this behaviour on the child without needing to acknowledge the parents' own involvement in such dynamics.

6. The final safety plan

In the final phase of the intervention, the preliminary plan is replaced by a final safety plan. The final safety plan describes a future living situation that allows both the professionals involved and the parents to be confident in the parents' capacity to care for the child(ren) safely.

7. Two follow-up sessions

Following the initial intervention, there is one follow-up session three months later and another six months later in which the implementation of the safety plan is evaluated.

Case Family A continued

At first, the mother resented that she had been accused of beating her child. By telling the story from her point of view, it became clear that the mother herself had been severely abused as a child by her parents. She was beaten with objects, such as a belt and a clog. The mother claimed that she never hit her child with an object but admitted to occasionally hitting the child when he was disobedient. According to her beliefs, hitting without an object is not physical abuse, and a pedagogical blow on a regular basis is acceptable. Moreover, she could not think of any alternative discipline methods. Gradually, the conversation shifted towards what Child Protective Services's opinion on this topic might be. Although the mother initially stated that she had no social network, a cousin, an aunt of the mother and a neighbour were identified. These women agreed to be involved in the RA with the family (Step 2).

Next, the following text was used to stimulate mutual awareness of the situation among the mother, the child and members of the mother's social network:

> Your teacher as well as the judge are worried about you. You told them that mum used to hit you. The judge does not allow parents to hit their children. That is why you live with your foster family. Mum says she has never wanted to hurt you. Now the judge wants to know that, in the future, you will not be hit again while living at your mum's.

As a first step, the case manager approved the document. Next, the parents, therapist and case manager shared the story with the child and the family's social network. Thus, the secrecy surrounding child abuse and domestic violence is broken (Step 3). Contact between the mother and the child

was established in the following step (Step 4). Initially, the mother and the child played together for a few hours in the family guardian's office. Subsequently, the child returned to the family home with the mother for a few hours at a time while the neighbour, aunt, or cousin were present. This was gradually expanded.

Then, (Step 5) the mother participated in a role-play exercise. She was asked to imagine that she had confessed to some other form of physical abuse. For example, she was posed questions about how the hypothetical role-play child would have experienced the abuse. What is the impact on a mother–child relationship when a mother hurts the child? How is the child's self-image affected by the abuse? How is the child's behaviour influenced by the abuse? By answering these questions, the mother demonstrated to the family guardian that she could talk about the consequences of child abuse. This contrasts with earlier attempts between the mother and the family guardian to talk about the subject; the mother did not say anything other than that she had not hit her child.

Finally (Step 6), the child returned to live at home. As per a pre-arranged agreement, the mother could call the neighbour, aunt or cousin at acute moments when she needed help. They would come and assess the situation and how they could help the mother. Every now and then, they would drop by unannounced. Furthermore, the mother discussed difficult pedagogical moments with a systemic therapist involved in the RA programme. Lastly, the child could go to the neighbour themself or call the neighbour, aunt or cousin if they felt unsafe.

During the follow-up (Step 7), the safety agreements were evaluated. In this family, this meant checking whether the mother still used the neighbour's, aunt's and/or cousin's help and whether there had been any occasions when the child contacted these network members.

The RA and signs of safety

It is almost impossible to do a scoping review on the RA without exploring its connection with the Signs of Safety (SofS) intervention. From the literature and our clinical experience, we observed that parts of the RA are often incorporated in the SofS. The SofS intervention was developed by Turnell and Edwards (1999) in Australia to give professionals working in youth protection a tool to create immediate safety for the child directly after child abuse has been signalled. Meanwhile in England, Essex et al. (1996) developed and tested the RA as a systemic therapeutic intervention aimed to create and enhance long-term safety in families after a legal process or in cases where there are concerns about a child's safety but insufficient evidence to start a legal process. Both interventions share an approach that seeks to clarify professional concerns, while also respectfully honouring parental views, thus allowing for collaboration between parents and professionals. The RA was developed to respond to situations where there is disagreement between professionals and parents about what actually happened, without jeopardising this cooperation. Together, Turnell and Essex wrote the book on the RA (Turnell & Essex, 2006). Based on previous literature and clinical practice, we have noticed that the RA and SofS are sometimes intermingled in clinical practice regarding child abuse.

RESEARCH ON THE RESOLUTIONS APPROACH

Literature search

In this section, we describe the results of a systematic search we conducted to identify studies concerned with the RA's clinical benefits. For the search strategy and selection process, we followed

the preferred reporting items for systematic reviews and meta-analyses (PRISMA) recommendations (Arksey & O'Malley, 2005; Liberati et al., 2009; Moher et al., 2009; Tricco et al., 2018), as depicted in Figure 1.

We searched for studies published between 1997 and March 2021. Studies were selected if they met the following criteria: (i) studies evaluating the RA and (ii) studies evaluating SofS and using one or more of the RA's sub-interventions. To be as comprehensive as possible, no exclusion criteria were formulated regarding the design of the studies; (quasi-)experimental designs as well as qualitative descriptive studies and single-case (experimental) designs were allowed. Furthermore, for the same reason, no restrictions were made regarding outcome variables in the studies. Finally, studies investigating SofS outcomes were tackled during the search because, as mentioned before, we expected that parts of the RA protocol could have been used in some of these studies. We asked Susie Essex, the authors Gumbleton, Hiles, Luger and Lusk and the universities they graduated from for dissertations concerned with the RA. We were able to retrieve three dissertations (Gumbleton, 1997; Lean, 2012; Lusk, 1996).

The following electronic databases were searched: PsycINFO (Ovid), Ovid Medline, Embase (Ovid), Ovid Evidence-Based Medicine Reviews (Cochrane Library), Published International

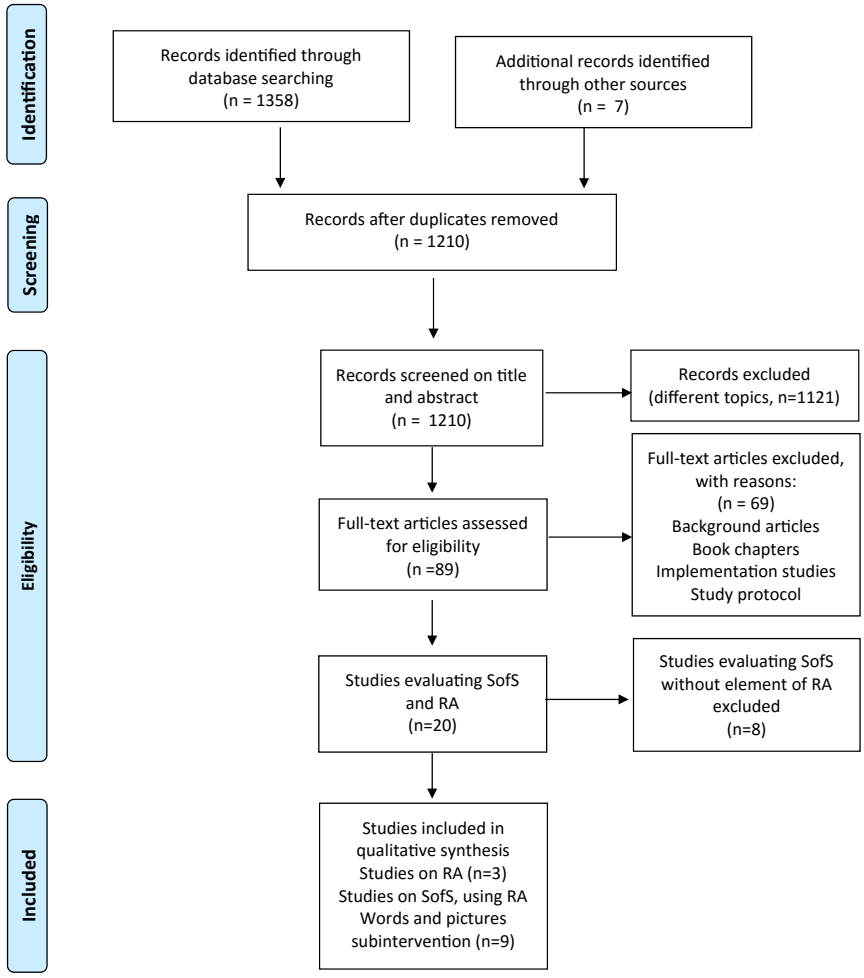

FIGURE 1 Prisma flow chart

Literature on Traumatic Stress (PILOTS), Google Scholar, Educational Resources Information Center (ERIC), Social Science Research Network (SSRN), Clinical Practice Guidelines (APA), the Agency for Healthcare Research and Quality (AHRQ) and the National Institute for Health and Care Excellence (NICE). Additionally, we consulted several Dutch databases, namely, the Dutch Article Database for Healthcare, the Database of Effective Social interventions, the Intervention Database of the Centre for Healthy Living, the Effective Youth Interventions Database and the Knowledge Centre for Child and Adolescent Psychiatry. Furthermore, we searched in the following trial registers: the WHO International Clinical Trials Registry Platform (ICTRP), AHRQ's National Guideline Clearinghouse and the ISRCTN registry. The following search terms and their combinations were used: 'Andrew Turnell', 'Steve Edwards', 'Susie Essex', 'John Gumbleton', 'Colin Luger' (author); 'Signs of Safety', 'SofS', 'Resolutions' AND 'Approach/family therapy/model/program(me)/services/work/consultancy/protection', 'Safe Together Step by Step (STSS) (interventions)', 'child*' and '(abuse* or mistreat* or violence or violent or protect* or safety or danger*)'.

Through the search mentioned above, 1,358 articles were retrieved (Figure 1). After screening for duplicates, 1,210 articles remained. The first author screened titles and abstracts for relevance based on the inclusion criteria and excluded 1,121 articles. Two authors (MM and TM) screened the remaining 89 full-text articles independently from each other; 69 articles were excluded because they failed to meet the inclusion criteria. The inter-rater reliability was 93 per cent. Disagreements were discussed and resolved by consensus. We found 20 studies investigating SofS; studies investigating implementation were excluded. The texts of the SofS studies were additionally inspected for the following information: (i) does the study explicitly mention use of RA techniques and (ii) does the text of the study imply use of RA techniques (i.e. RA and not SofS techniques are explicitly named but no reference to the RA protocol is made)?

Identification and selection of the studies

Based on the inclusion criteria, two dissertations (Gumbleton, 1997; Lean, 2012) and an article (Hiles & Luger, 2006) describing studies on the RA were included in this review. The latter study presented two separate studies both concerned with evaluation of the RA. Although we contacted authors and universities, we were unfortunately unable to obtain the original reports of these two studies.

We used the PICOS format (population, intervention, comparison, outcome, study design) to gather information from the studies systematically (Methley et al., 2014). Concerning the population, we extracted the data on type of participant (child, parents, guardians, network members) and type of abuse, the number of families included and the number of families who completed the intervention. With regard to the intervention, we extracted information on the type of (sub)-intervention under investigation. Finally, we extracted information on methodological characteristics, such as study design, (primary and secondary) outcome variables and assessment methods. Data were extracted by MM and AS independently with high agreement. An overview of the studies included and the data extracted can be found in Table 1. We used the AMSTAR checklist (Shea et al., 2017) to evaluate this review (Supplement 1).

In addition, nine studies were found that evaluated SofS intervention with an additional component of the RA (Words and pictures). These studies are indicated in the reference list with an asterisk. As indicated in these reports, the major goals of these studies were to evaluate the SofS intervention (Baginsky et al., 2017, 2019, 2020; Bunn, 2013; Holmgard Sorensen, 2013; Pichler & Wurm, 2012; Skrypek et al., 2012; Tierolf et al., 2020; Vink et al., 2017).

TABLE 1 Sample Characteristics of Included RA Studies

Study	Population	Type of abuse	RA completers	Duration of RA	Control comparison group	Outcome variable	Assessment method	Outcome
Gumbleton (1997)	17 families 38 children	Sexual abuse Physical maltreatment	15 families	NA	Re-referral rates in literature	a. Re-referrals 6 months after treatment b. Cooperative partnership between parents and social workers	a. Child protection registers, social services files b. Semi-structured qualitative interview	a. 93% of the included children experienced no further abuse b. Parents appreciated the cooperation with the RA therapists
Hiles and Luger (2006)	Study 1: 10 parents (out of 7 families) Study 2: 7 guardians (of 10 families)	NA	NA	6–8 months	No	Study 1: (a) Cooperative partnership between parents and social workers Study 1: (b) Parental satisfaction with the intervention Study 2: Guardians' experiences	a. Semi-structured qualitative interview b. Semi-structured qualitative interview Study 2: Semi-structured qualitative interview	a. The relationship with parents/professionals improved b. Parents were satisfied with the intervention, reporting more control over their lives Study 2: The RA process is observable for the guardians; new solutions became visible for the families according to the guardians
Lean (2012)	6 parents out of 5 families 9 network members out of 5 families	Unexplained non-accidental injuries Physical maltreatment Sexual abuse	6 parents out of 5 families 9 network members out of 5 families	NA	No	a. Resilience b. Experiences of the network members with the RA	a. Semi-structured qualitative interview b. Semi-structured qualitative interview	a. Family resilience augmented in 4 out of 5 families b. The RA facilitated contact between network members and professionals

Abbreviations: NA, not available; RA, Resolutions Approach.

Results of the scoping review

All the studies included used a qualitative design, employing semi-structured qualitative interviews. One study also used quantitative data (Gumbleton, 1997). The studies examined families where there had been allegations of unspecified child abuse (Hiles & Luger, 2006) or sexual abuse and physical maltreatment (Gumbleton, 1997; Lean, 2012). Different outcome variables were used. One study examined child safety (Gumbleton, 1997). This study operationalised child safety by counting the number of re-referrals six months after treatment and comparing this to the re-referral ratios mentioned in the literature. Other operationalisations used were the increase of cooperation between parents and social workers (Gumbleton, 1997; Hiles & Luger, 2006); the growth of family resilience (Lean, 2012); and the parents' (Hiles & Luger, 2006), network members' (Lean, 2012) and guardians' (Hiles & Luger, 2006) experiences with the intervention.

Regarding the treatment integrity, two out of the three studies emphasised that the programme phases were followed but that some adjustments were made to adapt the programme to individual families' situations (Gumbleton, 1997; Hiles & Luger, 2006). The articles did not expand on what specific adjustments were made. Only one study mentioned how the research was funded.

The included studies provided some indications of the RA's clinical benefit: the re-referral rate after the RA proved to be significantly lower than the re-referral rate found in the literature (Gumbleton, 1997), and the RA was effective in building cooperation between parents and professionals (Gumbleton, 1997; Hiles & Luger, 2006). Furthermore, four out of five families were deemed to develop resilience, although to different degrees (Lean, 2012). The following processes may have augmented family resilience: holding helpful beliefs, creating supportive patterns and communicating well. On the other hand, processes, such as ongoing emotional struggles, renegotiating parental roles and living with disadvantages, could have hampered familial resilience.

In addition, the users appeared to be satisfied with the intervention. Parents felt that their relationship with the professionals had improved, they had gained more self-confidence and better understood the professionals' concerns regarding their family. They reported more control over their lives and perceived that the process of cooperation with social workers had been restored (Hiles & Luger, 2006). Referrers expected the RA professional to bring change to situations where families had become mired in the legal process in order to make the familial situation safer for the child. Furthermore, family guardians anticipated that the RA professional would be able to work with the different subsystems of the family. The family guardians appreciated that they could be present at some sessions and could thus observe the RA process with the family. They concluded that during the process, new possibilities became apparent through which the family gained more control over their own situation (Hiles & Luger, 2006).

SofS studies involving one component of the RA

While conducting the search, we noticed that nine articles investigating another intervention to stop child abuse (SofS) also included a component of the RA in the SofS protocol, namely, 'words and pictures'. They did so because originally, SofS did not include specific techniques or modules for including children in the process. 'Words and pictures' was incorporated to engage children while assessing their insecurity and developing the safety plan (Baginsky et al., 2017; Bunn, 2013; Pichler & Wurm, 2012). In addition, 'words and pictures' was used as a tool to inform the network members about safety concerns (Bunn, 2013; Pichler & Wurm, 2012).

DISCUSSION

This scoping review provides an overview of the results of previous research on the RA. Consistent with the scoping review methodology, we explored the research literature on the RA/SofS comprehensively and included three studies on the RA. Based on these studies' outcomes, there are some indications that the RA might be useful for stopping and preventing child abuse. The re-referral rate after the RA proved to be significantly lower than the re-referral rate found in the literature, the RA was effective in building cooperation between parents and professionals and most families grew more resilient. In the studies investigating the experiences of parents, network members and guardians, general satisfaction with the intervention was found. Specifically, the families experienced more control over their situation, while the guardians perceived the method to be transparent.

According to Essex, three processes are essential in increasing the safety of the child in the family: (i) a cooperative relationship between professionals and parents, (ii) involving the social network and (iii) breaking the secrecy on child abuse (Turnell & Essex, 2006). The included studies pay attention to the first two processes. The studies show that a cooperative relationship between parents and professionals was successfully established, and in most of the families, a supportive social network could be realised. However, none of the studies investigated the association between changes in cooperative partnership, involving the social network and (the severity of) child abuse. Therefore, it cannot be concluded that cooperative partnership or involving the social network serve as mechanisms of change. The third process, breaking the secrecy on child abuse, was not investigated in the included studies as an outcome for a mechanism of change. These processes warrant further attention in future research studies on the RA.

Child abuse is common worldwide, and the consequences of child abuse are severe and may be felt throughout the individual's lifespan (Felitti et al., 1998). Moreover, research to date shows that there are still too few effective methods to stop and prevent child abuse (van der Put et al., 2018). Therefore, effective interventions to stop child abuse are urgently needed. Little research has been done on the RA, and the research that has been conducted is predominantly qualitative. It is therefore too early to conclude that the RA is effective in stopping child abuse. However, the available studies show that the RA can contribute to children's safety within their families. The RA may be considered a method worthy of further investigation.

To our knowledge, this is the first scoping review on the clinical benefits of the RA. An issue that we have been unable to address sufficiently is how the RA was implemented in the included studies. The information we could derive on the treatment integrity from the studies was very scarce. As the goal of the RA is to increase the safety of the child in question, safety could be considered the most important parameter for measuring success. It is therefore striking that only one of the included studies operationalised safety. In studies on the effectiveness of interventions for child abuse, different outcome variables are used. Future research should consider how to operationalise child safety or the reduction of maltreatment. Greater consistency in objectifying safety within families is important to facilitate comparison between studies and the possibility of executing meta-analyses on the effectiveness of the RA and SofS. The conflict tactic scales (CTSs) (Straus et al., 2003) may be a good choice. The CTSs are frequently used in partner violence research as well as in studies on the prevalence of child abuse in the United States (Straus et al., 2003) and the Netherlands (Euser et al., 2013). The advantage of CTSs is that the actual occurrence of aggressive acts is measured and that both parents and children are informants.

Furthermore, the studies we included are predominantly qualitative studies and included no randomised controlled trials. This is probably because it is difficult to recruit and motivate families where there are allegations of child abuse to participate in research. To overcome this

problem and take the first step towards quantifying the effects of the RA, small-scale designs may be helpful. Single-case experimental designs (SCEDs) for instance, can be used to study treatment effects on a case-by-case basis. As a result, fewer participants and no control groups are needed. Moreover, a SCED is well suited to investigate innovative approaches in heterogeneous and complex populations (Maric et al., 2012; Norell-Clarke et al., 2011).

Implications for clinical practice

Because there are still too few evidence-based interventions addressing child abuse, and there are signs that the RA could be beneficial to children's safety in families, it is important to gain more experience with this method. Furthermore, we found that the SofS intervention and the RA have become intermingled to some extent. In a number of studies, the 'words and pictures' element of the RA had been added to SofS. To test the clinical significance of the RA, it is crucial to maintain its treatment integrity.

CONCLUSION

The RA is an intervention that aims to stop and prevent child abuse in families when parents deny the abuse. The RA seems a valuable intervention to stop and prevent child abuse but merits further empirical investigation.

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CONFLICT OF INTERESTS

The authors declare no potential conflicts of interest with respect to the research, authorship and/or publication of this article.

ETHICAL CONSIDERATIONS

The studies included in our scoping review complied with ethical standards, as far as we have been able to determine. One of the studies explicitly mentions approval by an ethical committee. The other studies reported that the participants were provided with information regarding the study, gave their active consent, and it was stated that participation was voluntarily.

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ENDNOTE

[1] This case is a composite case, including typical features of cases seen using this approach. Similarities with other people are coincidental.

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