Research Article

Randomized Controlled Pilot Trial: Project Support Positive Parenting Module Following Sexual Abuse

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Abstract

Purpose: Support from a nonoffending caregiver can play a critical role in helping children recover from sexual abuse. However, many caregivers lack the skills to effectively support their child during the aftermath of a sexual abuse disclosure. This randomized controlled pilot trial examined a brief parenting intervention (Project Support Positive Parenting module) delivered by paraprofessionals to families waiting for intensive, trauma-focused therapy at a children's advocacy center. **Methods:** After a pretreatment assessment, 21 families were randomized to the intervention or a treatment-as-usual control group. Families also completed a posttreatment assessment. **Results:** Caregivers who received the Project Support module reported improved caregiver support and parenting self-efficacy, and their families were more likely to engage in trauma-focused therapy. Caregivers and service providers reported high levels of satisfaction with the program. **Discussion:** Although the results should be interpreted as preliminary, they offer promising evidence for brief parenting programs following a sexual abuse disclosure.

Keywords

parenting, childhood sexual abuse, nonoffending parents/caregivers, intervention

Every year, millions of children around the world are sexually abused (Stoltenborgh et al., 2011), with many also experiencing severe distress following the abuse (Chen et al., 2010; Jouriles et al., 2020; Pérez-Fuentes et al., 2013; Rancher, Smith, et al., 2022). Numerous studies have shown that emotional support from a nonoffending caregiver, often in the form of listening and attending to the child's concerns, can buffer children against some of the adverse effects of sexual abuse (Cyr et al., 2019; Gower et al., 2020; Zajac et al., 2015). Such findings are consistent with theory suggesting that caregivers' responsive listening to and comforting of their children enhances children's feeling of belonging, reduces children's distress, and improves children's ability to regulate their own emotions (Eisenberg & Strayer, 1990; King et al., 2018; Thompson, 1994). Caregivers also benefit from their supportive and responsive parenting; specifically, an increase in positive, empathic interactions with their child can distract caregivers from negative rumination, enhance their self-efficacy as a caregiver, and improve their relationship with their child (Lindsay et al., 2011; McGilloway et al., 2014; Wong et al., 2014). Unfortunately, many caregivers lack the skills to listen to and comfort their children effectively, or struggle to do so in the stressful period that typically follows a child's disclosure of sexual abuse (Holm & Hansen, 2003; Santa-Sosa et al., 2013). Many nonoffending caregivers are struggling with their own feelings during this time, which can diminish their parenting self-efficacy and their emotional availability for providing comfort and listening responsively to their children (Bux et al., 2016; Elliott & Carnes, 2001; Rancher, Are, et al., 2023).

Fortunately, there are empirically supported, trauma-focused treatments available to improve nonoffending caregiver support for a child who has recently disclosed sexual abuse (Elliott & Carnes, 2001; St-Amand et al., 2022; van Toledo & Seymour, 2013). In addition to improving nonoffending caregiver support, these treatments often include multiple components to help families recover from the abuse (e.g., providing psychoeducation on trauma symptoms, and teaching adaptive coping skills). Thus, most of these treatments are designed to last at least a couple of months, and often much longer (e.g., up to 20 sessions for Trauma-Focused Cognitive Behavior Therapy, Cohen et al.,

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2016). Additionally, these treatments are usually delivered by highly trained mental health professionals.

Unfortunately, a combination of factors, among them the limited availability of highly trained mental health professionals, often results in families who have been referred for trauma-focused treatment waiting months before they can begin receiving services (Jouriles et al., 2022; Theimer et al., 2020). Long waitlists can challenge caregivers' commitment to obtaining treatment, especially if they are waiting for a treatment that will likely take months to complete. That is, caregivers may feel discouraged or overwhelmed learning that it will be months before their family can begin receiving services, and then months more to complete treatment. Unsurprisingly, a large proportion of the families who receive mental health referrals after a child's disclosure of sexual abuse fail to receive treatment (estimates often are around or over 40%; National Children's Alliance, 2019). Empirically supported, trauma-focused treatments can only help caregivers and their families when the families engage in these services. Thus, an important challenge for both researchers and service providers is to increase families' engagement in these services.

A brief program that helps increase caregiver emotional support for their child after sexual abuse, delivered by paraprofessionals to families recently placed on waitlists for intensive trauma-focused services, may be one way to both provide immediate help to families and increase caregiver satisfaction with the agency as well as family engagement (i.e., attendance and active involvement) in later, lengthier treatments. Specifically, if caregivers are taught ways to listen to and comfort their child after a sexual abuse disclosure, and see that their child responds positively to their efforts, they are likely to feel more confident that they can effectively support their child's recovery. That is, they may experience increases in parenting self-efficacy. Additionally, by offering caregivers this help, the agency may be sending a message about how much they care, increasing both caregiver satisfaction with the agency and caregiver motivation to follow through on the referral for more intensive trauma-focused treatment for their child (Ofonedu et al., 2017; van Toledo & Seymour, 2016).

Programs designed to improve caregivers' abilities to listen to and comfort their children can be administered effectively in brief formats. In many parent-training programs, supportive and responsive parenting is often considered a foundational skill, taught first among other skills in the program (Forehand et al., 2014). However, most brief programs that focus on enhancing supportive and responsive parenting have only been evaluated with families recruited from the community (for review see, Tully & Hunt, 2016). Families referred for trauma-focused services after child sexual abuse are generally characterized by greater caregiver distress and child adjustment problems than families in community samples (Bux et al., 2016; Chen et al., 2010; Pérez-Fuentes et al., 2013; Rancher, Are, et al., 2023), and it is unknown whether the effects of brief parenting programs obtained in samples recruited from the community generalize to nonoffending caregivers after child sexual abuse disclosure.

The present research seeks to evaluate the Project Support Positive Parenting module (Rancher, McDonald, et al., 2023) in a sample of families waitlisted for trauma-focused services. This module is based on components of reflective functioning theory (Borelli et al., 2016) and social learning theory as applied to family interactions (Patterson & Oregon, 1982). Specifically, this module teaches caregivers attentive listening and comforting skills—parenting behaviors aligned with reflective functioning that help children feel that their emotions, desires, beliefs, and thoughts are understood and valued by their caregivers. Increasing a caregiver's capacity to make their child feel safe, heard, and understood is theorized to enhance the parent–child relationship and promote both child and caregiver well-being (Patterson & Oregon, 1982). The module was derived from a longer, efficacious parenting intervention for caregivers and children escaping from frequent and severe intimate partner violence (Jouriles et al., 2010, 2009, 2001; McDonald et al., 2006). The Project Support module is a three-to-four-session program designed to teach caregivers how to listen to and comfort their children. It has been shown to improve parental support in a sample of mothers recruited from the community (Rancher, McDonald, et al., 2023).

The current study was designed as a randomized controlled pilot trial that used mixed methods data across pre- and post-intervention assessments to examine the feasibility, acceptability, and preliminary efficacy of using the Project Support Positive Parenting module with nonoffending caregivers at a Children's Advocacy Center (CAC) soon after disclosure of child sexual abuse. The purpose of a pilot trial is to conduct a small-scale test of whether the research protocol is realistic, whether the methods and intervention are acceptable to providers and participants, and to inform whether a full-scale trial is feasible. Pilot trials are often considered an essential first step of a larger, definitive study and can include an assessment of preliminary outcomes as well as service satisfaction (see Drummond, 2017, for discussion). In this study, the program was delivered by paraprofessionals to families on a waitlist for intensive, trauma-focused services. We hypothesized that at the posttreatment assessment, caregivers who received the Project Support Positive Parenting module, compared to caregivers who received services as usual, would demonstrate greater improvements in (1) caregiver support and (2) parenting self-efficacy. Further, we hypothesized that receiving the Project Support module would predict (3) later engagement in trauma-focused therapy and (4) greater satisfaction with CAC services. Holmberg and Andersen (2022) suggest that adjusting for pre-treatment characteristics known to be associated with outcome variables can enhance the ability to draw reliable conclusions in randomized controlled trials (Holmberg &

Andersen, 2022). Given previous evidence that caregiver support can vary across child gender (Rosenthal et al., 2003), caregivers' relationship to the alleged perpetrator (Bolen & Gergely, 2015), and caregivers' psychological distress (Rancher, Are, et al., 2023), we evaluated the program while controlling for these variables. We also assessed the feasibility and acceptability of the Project Support module by examining service satisfaction among service providers.

Method

Participants

Participants were 21 caregivers (23–46 years old; $M = 33.57$, $SD = 5.88$) and their children (6–11 years old, $M = 8.33$, $SD = 1.65$). All were seeking services from a CAC in the southern United States following child sexual abuse and completed the CAC's routine family assessment between September 2019 and February 2020. The sample of caregivers was 48% Hispanic (10/21), 38% (8/21) Black/African American, and 14% White (3/21). Most caregivers, 86% (18/21) completed assessments and services at the CAC in English and 14% (3/21) in Spanish. All children completed assessments in English. The sample of children was 81% (17/21) female and most caregivers, 81% (17/21) reported themselves to be the child's mother. All caregivers indicated that their child had been living with them for 6 months or longer. Eligibility criteria included no history of autism or developmental delay, no history of traumatic brain injury, and the family was interested in receiving the intervention.

Procedures

The study was a randomized, controlled, assessor-masked, single-center trial with two parallel groups, the Project Support Positive Parenting module and a treatment-as-usual control group. The institutional review board of the last author's university approved all procedures. All caregivers were offered the program services free of charge. We used computer-generated variable-sized permuted block randomization (Efird, 2011) and a 1:1 allocation. As part of the routine services provided by the CAC, a primary, nonoffending caregiver and their child completed a broad assessment of family functioning, which is used to inform referrals for trauma-focused therapy and other supportive services (e.g., case management, financial assistance, etc.). For 75% (15/21) of families this assessment, which served as the pretreatment assessment for our study, occurred within 2 months of the sexual abuse disclosure.

Caregivers indicated at the CAC intake whether or not they would be interested in participating in volunteer research opportunities. Research staff contacted caregivers by phone within 1-week of their family's intake assessment to introduce the study, complete eligibility screening, and among those eligible participants, informed consent procedures. Caregivers were informed that declining to participate would not disqualify them from receiving services at the CAC and they could withdraw from the study at any time, without penalty. After eligible caregivers provided consent, research staff opened a sealed container to determine the family's intervention condition. At the time of recruitment, we were able to contact 35 potentially eligible caregivers. Of these,14% (5/35) did not meet inclusion criteria. Among the 86% (30/35) eligible caregivers who agreed to participate, 30% (9/30) served as training cases for service providers. Of the remaining 21 families, 11 were randomized to receive the Project Support Positive Parenting module and 10 to receive treatment-as-usual, which served as the control group. Participant flow through the study is presented in Figure 1.

All 21 caregivers and their children were invited to complete the posttreatment assessment 4–6 weeks after the pretreatment assessment. Research staff conducting the posttreatment assessments were masked to group assignment. All measures were read aloud to the children to help ensure comprehension and accuracy.

Experimental Conditions

Project Support Positive Parenting module. We followed the intervention adaptation framework outlined by Card et al. (2011), consulted with family advocates at the CAC, and found the original goals of the program were consistent with the needs of the agency. To meet the needs of the presenting population, all study materials were translated into Spanish and subsequently back-translated to ensure linguistic and cultural accuracy. Training cases were used to further refine and adapt the program, including simplifying and tailoring the language of the materials.

Caregivers assigned to the Project Support Positive Parenting module received routine support services from the CAC and up to four, 60- to 90-min sessions focused on teaching caregivers two parenting skills—attentive listening and comforting. Attentive listening involves providing accurate and timely responses to show interest and keep the child engaged until they are ready to end the conversation. This skill involves both verbal and nonverbal listening behaviors including requests for clarification, reflecting what the child is saying, reflecting feelings, and simple verbal responses to encourage conversation (e.g., "Interesting!"). Comforting involves using the same attentive listening skills when the child is upset or distressed. Effective mastery of the listening and comforting skills also requires caregivers to withhold any nonlistening or noncomforting responses, such as interruptions, accusations, judgments, criticisms, or dismissive gestures.

The program is individually tailored to the caregiver's parenting abilities: caregivers with stronger skills, or those who mastered the skills more quickly, could complete the program in less time (i.e., fewer sessions) than those who needed more time to master the implementation of the skills. Service providers educated caregivers about the

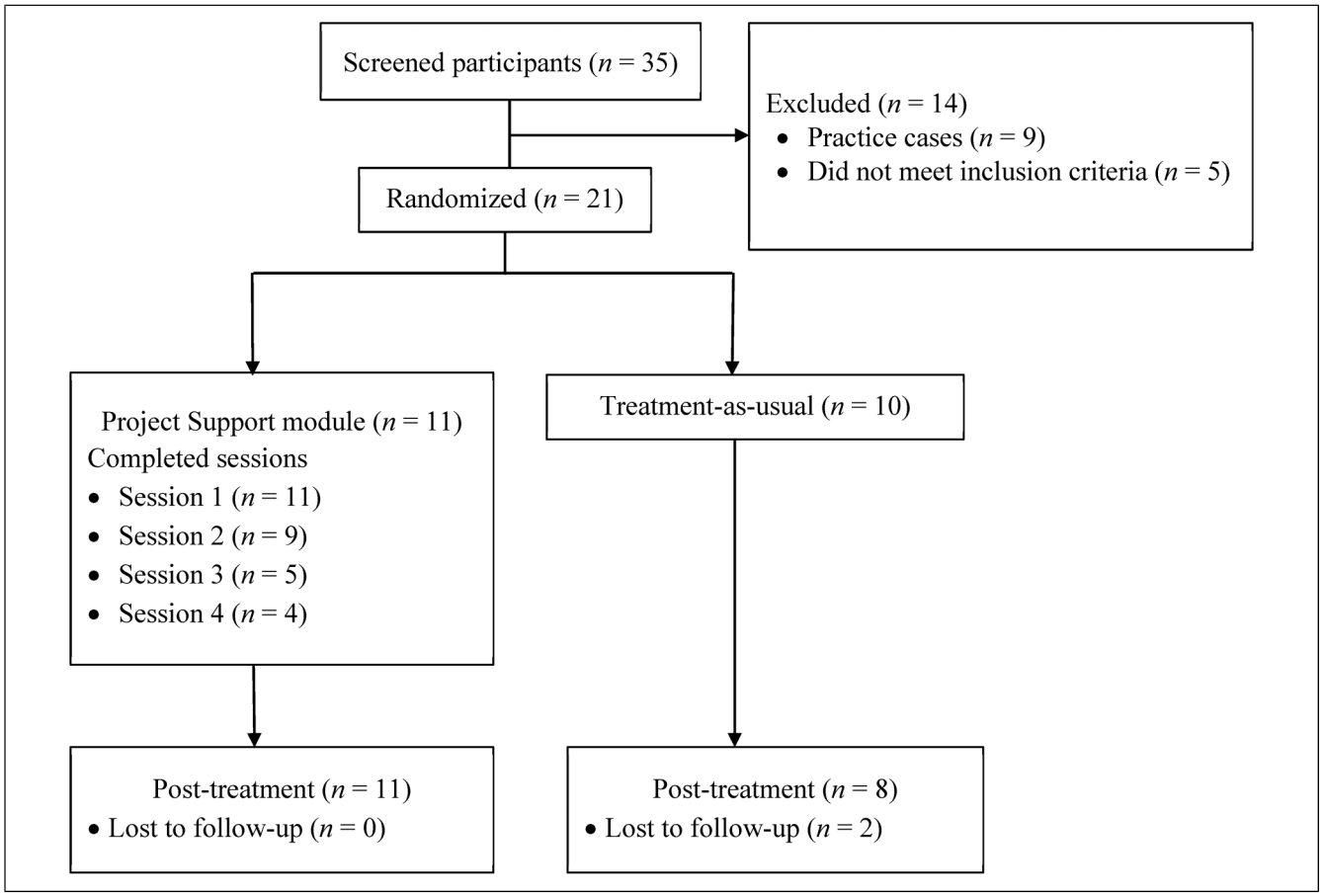

Figure 1. CONSORT diagram.

skills, using handouts to summarize their purpose and correct use; then engaged in an iterative process of modeling the skills, engaging the caregivers in behavioral practice using the skills; and providing stepped, tailored, supportive feedback designed to help caregivers gain mastery. Most session time was focused on behavioral practice and feedback, with caregivers learning and mastering the skills incrementally through role-plays with the service provider (for further refinement and feedback) and the child (for observation and determination of mastery).

Mastery was assessed by the service provider during 3- to 5-min interactions between the caregiver and the child, in which the caregiver was asked to demonstrate specific skills (attentive listening, comforting). Caregivers were deemed to have met mastery if they could provide at least six appropriate listening and/or comforting responses and refrain from providing any nonlistening/noncomforting responses. Caregivers who demonstrated mastery of the skills were considered to have received the full "dosage" of the intervention. This could happen in fewer than four sessions.

Delivery of the Project Support Positive Parenting module also involved the provision of emotional support and referrals for community resources, as needed. Additional informational materials about delivering the Project Support Positive Parenting module are available upon request to the first author.

Service providers were paraprofessionals; three were family advocates at the CAC and one was an advanced doctoral student in clinical psychology. Most family advocates had a bachelor's degree and had been employed by the CAC for an average of 35 months ($SD = 23.54$, range 18–72 months). Family advocates had extensive training in working with families and children who had experienced sexual abuse but had no prior experience providing clinical services, including a parenting intervention. All service providers participated in weekly, 90-min training sessions to obtain mastery of the content and delivery of the Project Support Positive Parenting module. The training involved reading and discussing the treatment manual, discussing theory on parent training and application of Project Support to the population at the CAC, watching video examples of treatment delivery, and behavioral practice in role plays, and demonstrating proficiency through in vivo practice. Throughout the study, service providers continued to receive ongoing training during 90-min weekly group supervision meetings. To help ensure treatment fidelity, all intervention sessions were video-recorded and coded. Treatment

fidelity was assessed based on adherence to the Project Support protocol across five domains: (a) skill instruction, (b) skill demonstration, (c) practice using the skill in role plays, (d) provision of tailored feedback and additional practice, and (e) caregiver opportunity to practice in vivo with child.

All caregivers assigned to the Project Support Positive Parenting module received the first attentive listening skill as prescribed in the Project Support protocol. In March 2020, in response to the onset of the COVID-19 pandemic, the CAC suspended all in-person services, which prematurely suspended intervention delivery for 36% (4/11) of caregivers. Thus, only about half, 55% (6/11) received instruction and demonstration of comforting, the second skill. On average, caregivers assigned to the Project Support Positive Parenting module attended 2.73 ($SD = 1.10$, range = 1 to 4) sessions. As noted above, the number of sessions is determined by the caregiver's mastery of the two skills; therefore, some caregivers may receive a "full dosage" in fewer sessions. The number of attended sessions in this study is consistent with previous evaluations of the Project Support Positive Parenting module among a sample of community mothers who attended an average of 2.52 ($SD = 1.18$) sessions (Rancher, McDonald, et al., 2023). Most, 82% (9/11) did not receive any additional routine support services, 9% (1/11) received a single supportive phone call, and 9% (1/11) received two supportive phone calls.

Treatment-as-usual control. Caregivers randomly assigned to the treatment-as-usual control group received routine support services from family advocates at the CAC. There was no overlap in service providers across the two experimental conditions. Nearly half of the caregivers, 40% (4/10) in the treatment-as-usual control group did not receive any additional services, 40% (4/10) received one contact (a supportive, "check-in" phone call), and 20% (2/10) received three or more supportive contacts (e.g., case management, financial assistance, etc.).

Measures

Caregiver support (pretreatment and posttreatment). Caregivers and their children completed complementary versions of the Maternal Support Questionnaire (Smith et al., 2017, 2010). Caregivers completed the 7-item emotional support subscale of the Maternal Self-Report Support Questionnaire (MSSQ; Smith et al., 2010) reporting on the support they provided their child (e.g., "Tried to make your child feel safe") in the past month on a 7-point scale (0 = *not at all like me* to 6 = *very much like me)*. Responses were summed to derive a total score. Scores on the emotional support subscale have been negatively associated with child adjustment problems (Zajac et al., 2015). The MSSQ has demonstrated measurement invariance across both mother and nonmother caregivers (Rancher, Smith, et al., 2022) and good internal consistency with α = .75–.76 (Wamser-Nanney, 2017; Zajac et al., 2015).

Children completed the nine-item emotional support subscale of the Maternal Supportive Questionnaire-Child Report (Smith et al., 2017) reporting on the support they received from their caregiver (e.g., "Helped me feel better about what happened to me") in the past month on a 4-point scale (0 = *not at all*, 1 = *a little bit*, 2 = *a lot*, 3 = *very much*). Responses were summed to derive a total score. Scores on the emotional support subscale have been negatively associated with child trauma symptoms in children as young as 6 years (Zajac et al., 2015). This subscale has demonstrated good internal consistency with α = .86–.88 (Rancher, Are, et al., 2023; Zajac et al., 2015).

Parenting self-efficacy (pretreatment and posttreatment). Caregivers completed the eight-item efficacy subscale of the Parenting Sense of Competence Scale (Johnston & Mash, 1989) reporting on their own parenting self-efficacy (e.g., "If anyone can find the answer to what is troubling my child, I am the one") in the past month on a 6-point scale (1 = *strongly disagree*, 2 = *somewhat disagree*, 3 = *disagree*, 4 = *agree,* 5 = *somewhat agree*, 6 = *strongly agree*). Responses were summed to derive a total score. Scores on the efficacy subscale have been negatively associated with child externalizing problems (Johnston & Mash, 1989) and the scale has demonstrated good internal consistency, α = .81 (Coleman & Karraker, 2003).

Engagement in therapy services (review of records). Once waitlisted families were invited to begin treatment for the child's trauma symptoms, therapy engagement was coded from a review of CAC records. Engagement was defined as whether or not the family attended two or more sessions, 0 = *attended ≤ 1 therapy session,* 1 = *attended ≥2 therapy sessions* (Nock & Ferriter, 2005). CAC records were examined at least 4 weeks after the caregivers completed the posttreatment assessment to allow sufficient time to attend services. We assessed interrater reliability on 29% of the sample and had a perfect agreement (Kappa = 1.00).

Caregiver relationship to alleged perpetrator (review of records). The caregivers' relationship to the alleged perpetrator of the child sexual abuse was coded from a review of the CAC's records. The relationship was coded: 0 = *alleged perpetrator is not a romantic partner*, 1 = *alleged perpetrator is a romantic partner*. We assessed interrater reliability on 29% of the sample and had a perfect agreement (Kappa = 1.00).

Caregiver psychological distress (pretreatment). Caregivers completed the 53-item global psychological symptoms scale on the Brief Symptom Inventory (BSI) (Derogatis, 1992) reporting on their psychological distress (e.g., "Feeling lonely even when people are around you") in the past month on a 5-point scale (1 = *not at all*, 2 = *a little bit*, 3 = *moderately*, 4 = *quite a*

bit, 5 = *extremely*). Responses were summed to derive a total distress score. Scores on the BSI have been negatively associated with parenting self-efficacy (Telef, 2013) and have demonstrated strong internal consistency with α = .96 (Im et al., 2020).

Services satisfaction (posttreatment). All caregivers completed 12 items adapted from the Service Satisfaction Scale (SSS; Athay & Bickman, 2012) assessing their satisfaction with services they received at the CAC (e.g., "Did you get the kind of services you think you need*?"*) in the past month on a 4-point scale (1 = *no, definitely not*, 2 = *no, not really*, 3 = *yes, generally*, 4 = *yes, definitely*). Responses were summed to derive a total score. Scores on the SSS have demonstrated good internal consistency with α = .83 (de Jong et al., 2021). Caregivers also completed open-ended questions on the services they received which were coded for common themes.

Table 1. Sample Characteristics by Experimental Condition at Pretreatment.

Variable	Project Support module (%)	Treatment-as-usual (%)
Child sex (female)	52.24	47.62
Caregiver relationship to child	30.14	35.62
Mother	47.62	33.33
Father	4.76	9.52
Uncle	0.00	4.76
Caregiver spoken language		
English	42.86	42.86
Spanish	9.52	4.76
Caregiver ethnicity		
White, non-Hispanic	4.76	9.52
Black, non-Hispanic	19.05	19.05
Hispanic	28.57	19.05
Caregiver highest level of education		
Less than high school	4.76	9.52
High school or GED	28.57	19.05
Associate's or Bachelor's degree	19.05	19.05
Severe sexual abuse (involved penetration)	14.29	19.05
Alleged abuser was a parent figure (yes)	4.76	14.29
Abuse duration was more than a year (yes)	4.76	9.52
	M (SD)	*M (SD)*
Child age	7.36 (1.43)	9.40 (1.17)
Caregiver age	31.45 (5.09)	35.90 (6.05)

Note. $N = 21$ (11 in Project Support module; 10 in treatment-as-usual). Results of t-test and chi-square analyses indicated no between-group differences on demographic variables ($ps > .08$) other than child age, $t(19) = 3.54$, $p = .002$.

The service providers completed eight items adapted from the SSS (Athay & Bickman, 2012) reporting on their satisfaction with the Project Support Positive Parenting module (e.g., "Did the Project Support Positive Parenting module help caregivers feel more confident as a caregiver to their child*?"*) on a 4-point scale (0 = *no, definitely not,* 1 = *no, not really*, 2 = *yes, generally*, 3 = *yes, definitely*). Providers also responded to open-ended questions about the Project Support Positive Parenting module, which were coded for common themes.

Hypotheses

Caregivers randomly assigned to the Project Support condition, compared to those assigned to the treatment-as-usual control condition, would demonstrate:

1. improvements in caregiver report of caregiver support on the Maternal Self-Report Support Questionnaire;
2. improvements in child report of caregiver support on the Maternal Supportive Questionnaire-Child Report;
3. improvements in caregiver report of parenting self-efficacy on the Parenting Sense of Competence Scale;
4. higher rates of engagement in trauma therapy as coded from CAC records;
5. higher rates of service satisfaction on the Service Satisfaction Scale.

Data Analysis

We conducted *t*-tests and chi-square analyses to evaluate the effectiveness of the randomization procedure. We used multilevel modeling (MLM) to evaluate the efficacy of the Project Support Positive Parenting module. MLM analyses allow data to be nested within individuals over time, include all participants, regardless of missing data, account for multiple sources of potential variance, and can produce unbiased parameter estimates even with small samples (Maas & Hox, 2005). We used restricted maximum likelihood estimation and the autoregressive error covariance matrix. We conducted separate MLM analyses for each of our dependent variables (caregiver-report and child-report of caregiver support, and caregiver-report of parenting self-efficacy) and included caregiver relationship to the alleged perpetrator, caregiver's psychological distress, and child gender as control variables. Time (*pretreatment* = 0, *posttreatment* = 1) and treatment group (0 = *Project Support module*, 1 = *treatment-as-usual control group*) were coded dichotomously. Each model included time, treatment group, and the Time × Treatment group interaction, representing the change over time between the Project Support module and treatment-as-usual control group. We examined the change over time within each condition for each dependent variable. We report effect size estimates (Cohen's *d*) for each between-group effect (Time × Treatment group).

We conducted logistic regression analyses to predict later engagement in therapy services (0 = *did not attend*, 1 =

attended), and linear regression to assess whether receiving the Project Support module was associated with service satisfaction at the CAC. We controlled for caregiver's relationship with the alleged perpetrator, caregiver's psychological distress, and the child gender. We report *Exp(B)* and squared semipartial correlations (sr^2) as measures of effect size for the logistic and linear regression analyses, respectively. We used directed content analysis (Bengtsson, 2016) to analyze the qualitative service satisfaction data. All qualitative data was coded based on a-priori themes by two independent coders who convened to discuss and resolve the final themes and presentation of exemplar data using open dialogue and consensus methods (Bengtsson, 2016).

Prior evaluations of the Project Support module in a community sample reported a medium- to large effect of the intervention on parent–child communication and parental support (d = .44 to .61; Rancher, McDonald, et al., 2023). A sensitivity power analysis with alpha set at .05, power at .80, and attrition rate at 14%, our sample size of 21 participants allowed us to detect a large effect size (d = .80).

Results

Sample Characteristics

Sample characteristics are summarized in Table 1. At the pretreatment assessment, there were no between-group differences on most of the dependent variables ($ps > .08$). However, caregivers assigned to the treatment-as-usual control group reported greater pretreatment parenting self-efficacy ($M = 41.70$, $SD = 5.29$) than those assigned to the Project Support condition ($M = 36.30$, $SD = 5.44$), $t(18) = 2.25$, $p = .037$. There were no between-group differences on the control variables ($ps > .32$) or the frequency of routine support services, $t(19) = 1.70$, $p = .11$.

Intervention Effects on Caregiver Support (Hypotheses 1 and 2)

Caregivers who received the Project Support module self-reported increases in caregiver support from pretreatment to posttreatment, $b = 1.99$, $t(12.33) = 2.86$, 95% CI [0.48, 3.50], $p = .014$, while those in the treatment-as-usual group reported no change over time, $b = 0.47$, $t(12.47) = 1.23$, 95% CI [−0.35, 1.29], $p = .24$; Time × Treatment group, $b = 2.46$, $t(12.37) = 3.10$, 95% CI [0.74, 4.18], $p = .009$, $d = .83$. There were no changes from pretreatment to post treatment for children's reports of caregiver support for either those who received the Project Support module, $b = 0.75$, $t(12.82) = 0.55$, 95% CI [−2.23, 3.74], $p = .59$, or those in the treatment-as-usual group, $b = 2.10$, $t(12.31) = 1.50$, 95% CI [−0.94, 5.13], $p = .16$; Time × Treatment group, $b = 1.34$, $t(12.70) = 0.69$, 95% CI [−2.89, 5.58], $p = .50$, $d = .34$. Estimated marginal means and standard errors derived from each MLM analysis are presented in Table 2.

Intervention Effects on Parenting Self-Efficacy (Hypothesis 3)

Caregivers who received the Project Support module reported no change in self-reports of parenting self-efficacy from pretreatment to posttreatment, $b = 1.52$, $t(15.83) = 0.79$, 95% CI [−2.26, 5.31], $p = .43$. Caregivers in the treatment-as-usual group reported decreased parenting self-efficacy over that period, $b = -4.93$, $t(13.19) = 2.14$, 95% CI [−9.47, −0.40], $p = .03$; Time × Treatment group, $b = -6.46$, $t(14.71) = 2.16$, $p = .032$, 95% CI [−12.34, −0.57], $d = -.68$. Estimated marginal means and standard errors are presented in Table 2.

Intervention Effects on Postwaitlist Engagement in Trauma Services (Hypothesis 4)

Most caregivers and their children 86% (18/21) participated in the study while they were on a waitlist for more intensive trauma-focused services, but 14% (3/21) had either declined interest in therapy or had not been referred because the CAC determined that child-centered trauma services were not indicated. Among the waitlist subgroup ($n = 18$), more families who received the Project Support module engaged in trauma therapy (65%; 5/8) compared to families who received treatment-as-usual while on the waitlist (30%; 3/10), $b = 1.09$, Wald = 4.03, 95% CI [1.03, 8.56], $p = .045$, $Exp(B) = 2.96$.

Intervention Effects on Caregiver Service Satisfaction (Hypothesis 5)

Caregivers in both the Project Support module ($M = 44.82$, $SD = 2.48$) and the treatment-as-usual ($M = 41.88$, $SD = 3.56$) groups reported high levels of satisfaction with services at the CAC (possible range 12 to 48). However, results of the regression analysis indicated that caregivers who received the Project Support module reported greater satisfaction, $b = 4.43$, $t(15) = 2.59$, 95% CI [0.66, 8.19], $p = .025$, $sr^2 = .38$, than those in the control group, controlling for caregiver relationship to the alleged perpetrator, caregiver psychological distress, and child gender.

When reporting what they found most useful, caregivers who received the Project Support module reported learning how to listen to and comfort their child. One caregiver commented, "learning how to listen to my child when she's telling me her story without me interrupting and taking the conversation a different way." Alternatively, caregivers who received the treatment-as-usual services provided brief responses more broadly about receiving "helpful resources," "advice," or "direct communication." None of the caregivers in either condition reported any services to be unhelpful. When asked what they would like to change, caregivers who received the Project Support module reported they found the program helpful, enjoyed working with the service providers,

Table 2. Estimated Marginal Means and Standard Errors of Dependent Variables in the Multilevel Modeling Analyses.

	Project Support module		Treatment-as-usual	
Variable	Pretreatment ($n = 11$)	Posttreatment ($n = 11$)	Pretreatment ($n = 10$)	Posttreatment ($n = 8$)
Caregiver support [C]	40.31 (1.38)	42.30 (1.42)	40.74 (0.74)	40.27 (0.73)
Caregiver support [Ch]	21.76 (1.22)	22.51 (1.41)	21.06 (1.43)	23.16 (1.32)
Parenting self-efficacy [C]	34.47 (0.73)	36.00 (1.29)	43.20 (1.59)	38.27 (2.18)

Note. Estimated marginal means are group means that are estimated from the fitted multilevel model. They account for the underlying model of the data and variance explained by the covariates. Covariates were included at their mean values. [C] Caregiver-report, [Ch] Child-report.

and would not change anything. In contrast, several caregivers in the treatment-as-usual control group expressed a desire for additional service providers or a shorter waitlist. One caregiver remarked, "add more staff so that clients may be seen more effectively and within a decent time frame, within a month's time." A review of agency records indicated no difference in the amount of time families spent on the waitlist for intensive therapy services, $p > .05$.

Acceptability to Services Providers

Service providers initially expressed doubts about the Project Support module related to the use of behavioral practice role-plays as a means of instruction, the timing of the services, and the focus on parenting. In discussing the role-play technique, one service provider commented, "before meeting with my first client, I didn't think that our caregivers would be willing to engage in that way. I thought that it may be too embarrassing for them to be that vulnerable." After administering and providing the Project Support module, many of the service providers reported they found the program content to be relevant and helpful for families and found the behavioral practice to be one of the most useful components. There were some lingering concerns about the timing (e.g., "I believe this is a great tool and can help build off what families are learning in therapy") and duration of the Project Support module (e.g., "I would add a few more sessions per client for them to really understand and take away the skills properly"). Overall service provider satisfaction was high ($M = 21.00$, $SD = 2.65$; possible range 0 to 24).

Discussion and Applications to Practice

This randomized controlled pilot trial provides evidence for the preliminary efficacy and acceptability of the Project Support Positive Parenting module for nonoffending caregivers following child sexual abuse. It also demonstrates the feasibility of conducting a randomized controlled trial in a CAC setting as we were able to contact 35 potentially eligible caregivers, 86% of whom participated as training cases or in the randomized controlled trial. Caregivers who received the Project Support module self-reported increases in caregiver support ($d = .83$) from pretreatment to posttreatment, while caregivers in the treatment-as-usual control group self-reported no change in caregiver support over that period. Further, caregivers who received the Project Support module reported consistent levels of self-efficacy from pretreatment to posttreatment, while caregivers in the treatment-as-usual control group reported decreases in self-efficacy from pretreatment to posttreatment ($d = .68$). There were no differences in child reports of caregiver support from pretreatment to posttreatment for either the Project Support module or treatment-as-usual control group.

Findings further indicated that among those on the waitlist for intensive trauma-focused therapy services at the CAC, caregivers who received the Project Support module were more likely to engage in those services ($Exp(B) = 2.96$). Providing additional supportive services to families on a waitlist for mental health treatment is uncommon (Biringer et al., 2015). In fact, over the past few years, efforts to provide any services to families have been challenged by the national shortage of licensed mental health professionals (Nenn, 2022). The present findings are promising as they highlight the acceptability and feasibility of training paraprofessionals to provide a brief program that provides some relief and enhances motivation to begin trauma treatment once the waitlist period ends.

It is noteworthy that caregivers who received the Project Support module reported higher rates of service satisfaction, compared to caregivers in the treatment-as-usual condition. Considered with the findings reported above, it suggests that during the aftermath of a sexual abuse disclosure, caregivers may both appreciate and benefit from additional resources and services, as opposed to feeling burdened by them. The higher rates of caregiver satisfaction may also be an explanation for the increased engagement in trauma-focused therapy services at the CAC. Although it is unknown how a brief parenting program would compare to other interventions that are specifically designed to increase engagement in services (e.g., motivational interviewing; Sterrett et al., 2010), it is doubtful that these interventions that target increasing engagement would result in improvements in supportive parenting, which may be extremely valuable while families are having to wait for services. Future research may consider examining how best to connect families with evidence-based treatment, especially if such treatments only become available after a lengthy waiting period.

It is worth noting that the service providers who delivered the Project Support module had some initial concerns about the program, particularly the use of behavioral practice in role-play exercises. Such techniques are critical for rapidly and effectively teaching skills and are central to the effective administration of the Project Support module (Rancher et al., 2021). In general, role-play exercises are a common technique used to educate clinicians (Merrick, 2006). The service providers' initial reservations are consistent with those of providers of Project Support (the full intervention, not the module used in the present study) in Sweden, who initially had doubts about the use of role-play instruction (Draxler et al., 2020), but later found them to be central to the effectiveness of the program. Service provider buy-in for intervention techniques can play a critical role in intervention acceptability and feasibility (Chorpita et al., 2015). Similarly here, after the service providers learned how to teach the skills using iterative cycles of behavioral practice in role-plays, they found it to be incredibly valuable. In some ways, this sentiment reinforces the importance of experiential learning, as the more providers engaged in the behavioral practice with the caregivers, the more they felt comfortable and saw the utility of the technique. Still, this may be particularly important to consider when training paraprofessional service providers who do not have previous experience with clinical training and role-play exercises.

There are some noteworthy limitations to the present study. Foremost, the small sample size limits our confidence in the replicability of our findings as we cannot rule out whether unique sample characteristics are driving the pattern of observed effects. Relatedly, our small sample only allowed us to detect large effect sizes and prohibited evaluation of individual differences (e.g., caregiver gender, preferred language) in the intervention effects. Our sample of caregivers was diverse with complex family dynamics that may benefit from different styles of engagement or intervention. Additionally, as noted above, in March 2020 we had to prematurely suspend our in-person delivery of the Project Support module due to COVID-19. Although we think the present results are promising, if we had been able to continue providing the Project Support module we may have observed additional effects or encountered additional feasibility issues. Finally, because we had only a small set of outcome variables, we have limited information on the behaviors and constructs that the Project Support module influences. For example, future research could determine whether the enhanced caregiver support had observable effects on the children's distress or trauma symptoms.

In conclusion, the current randomized controlled pilot trial offers some promising preliminary support for the efficacy, feasibility, and acceptability of the Project Support Positive Parenting module for caregivers and their children following a child sexual abuse disclosure. We found the Project Support module can be effectively delivered by paraprofessionals to improve caregiver support, maintain parenting self-efficacy, and promote later engagement in trauma treatment. It was well accepted and perceived as helpful by caregivers as well as service providers at a children's advocacy center. The current trial also suggests the feasibility of conducting a larger, randomized controlled trial in a CAC setting to attempt to replicate and extend the current findings. Although the current results should be interpreted with appropriate caution, as they are preliminary and subject to replication, this study holds promise for improving the ways the field addresses the needs of nonoffending caregivers and their families following disclosure of child sexual abuse.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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