

Issues Affecting Utilization of Mental Health Treatment by Victims of Child Sexual Abuse and Their Caregivers

A Bibliography



April 2023

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Preferred citation: National Children’s Advocacy Center. (2023). Issues Affecting Utilization of Mental Health Treatment by Victims of Child Sexual Abuse and Their Caregivers: A Bibliography. Huntsville, AL: Author.

This project was supported by a grant awarded by the Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U.S. Department of Justice. Points of view or opinions in this document are those of the author and do not necessarily represent the official position or policies of the U.S. Department of Justice.

Scope

This bibliography lists citations and abstracts to publications covering a wide range of topics related to issues affecting access and utilization of mental health treatment services by victims of sexual abuse and their caregivers. International publications are included. This bibliography is not comprehensive.

Organization

Publications are listed in date-descending order. Links to publicly available publications are provided.

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Issues Affecting Utilization of Mental Health Treatment by Victims of Child Sexual Abuse and Their Caregivers

A Bibliography

Skar, A. M. S., Braathu, N., Jensen, T. K., & Ormhaug, S. M. (2022). [Predictors of nonresponse and drop-out among children and adolescents receiving TF-CBT: Investigation of client-, therapist-, and implementation factors](https://doi.org/10.1186/s12913-022-08497-y). *BMC Health Services Research*, 22(1), 1-13. <https://doi.org/10.1186/s12913-022-08497-y>

There is a paucity of evidence about effective implementation strategies to increase treatment response and prevent drop-out among children receiving evidence-based treatment. This study examines patient, therapist, and implementation factors and their association to nonresponse and drop-out among youth receiving Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). Youth (n = 1240) aged 6–18 (M = 14.6) received TF-CBT delivered by 382 TF-CBT therapists at 66 clinics. Odds ratio analyses were used to investigate whether pretreatment child (age, gender, number of trauma experiences, post-traumatic stress symptoms (PTSS), therapist (education), and implementation strategy factors (high-low, low-low, low–high intensity therapist and leadership training respectively) or tele-mental health training during the Covid-19 pandemic are associated with nonresponse (above clinical PTSS level post-treatment) and drop-out (therapist-defined early termination). Fidelity checks were conducted to ensure that TF-CBT was used consistently. One fourth of the children (24.4%) were nonresponders and 13.3 percent dropped out. Exposure to three or more traumatic experiences were related to nonresponse and drop-out. Higher baseline PTSS was related to a higher probability of nonresponse. There was no effect of therapist education or child gender on nonresponse and drop-out, whereas children over 15 years had a higher likelihood of both. After controlling for baseline PTSS, the effect of age on nonresponse was no longer significant. Drop-out was related to fewer sessions, and most dropped out during the first two phases of TF-CBT. Fidelity was high throughout the different implementation phases. High-intensity therapist training was related to a lower probability of both nonresponse and drop-out, whereas low therapist and leadership training were related to a higher likelihood of both. Multivariate analysis revealed higher child age and higher PTSS baseline scores as significant predictors of nonresponse, and number of trauma experiences (≥ 3) at baseline as the only predictor of drop-out. High-intensity therapist training seem key to prevent patient nonresponse

and drop-out. Leadership training might positively affect both, although not enough to compensate for less intensive therapist training. More complex cases (higher PTSS and exposure to more traumas) predict nonresponse and drop-out respectively, which underscores the importance of symptom assessment to tailor the treatment. The lack of predictive effect of therapist education increases the utilization of TF-CBT.

van der Hoeven, M. L., Assink, M., Stams, G. J. J., Daams, J. G., Lindauer, R. J., & Hein, I. M. (2022). Victims of child abuse dropping out of trauma-focused treatment: A meta-analysis of risk factors. *Journal of Child & Adolescent Trauma*. Advance online publication. <https://doi.org/10.1007/s40653-022-00500-2>

A substantial number of children who experienced child maltreatment drop out of evidence-based trauma-focused treatments (TF-CBT). Identifying child, family, and treatment-related factors associated with treatment dropout is important to be able to prevent this from happening and to effectively treat children's trauma-related symptoms. Methods: A quantitative review was performed based on a systematic synthesis of the literature on potential risk factors for dropout of trauma-focused treatment in maltreated children. Results: Eight studies were included, that examined TF-CBT, reporting on 139 effects of potential risk factors for dropout. Each factor was classified into one of ten domains. Small but significant effects were found for the "Demographic and Family" risk domain ($r = .121$), with factors including being male, child protective services involvement or placement, and minority status, and for the "Youth Alliance" risk domain ($r = .207$), with factors including low therapist-child support and low youth perception of parental approval. Moderator analyses suggested that family income and parental education may better predict the risk for TF-CBT dropout than other variables in the "Demographic and Family" domain. Conclusions: Our results provide a first overview of risk factors for dropout of trauma-focused treatments (TF-CBT) after child maltreatment, and highlight the role of the therapeutic relationship in this.

Herbert, J. L. (2021). [*Factors influencing therapy use following a disclosure of child sexual abuse*](#). Southbank VIC: Australian Institute of Family Studies. Commonwealth of Australia.

Identifying consistent factors that influence engagement or completion of therapy across studies allows services and policy makers in criminal justice, child protection, community support and mental health systems to make informed decisions about approaches to therapy referral and how to support families through challenges they have that could affect their capacity to engage with services. This paper presents findings from a review of the literature aimed at identifying factors that may influence either engagement with therapy or the completion of therapy following a disclosure of child sexual abuse to authorities. The lack of help inform the design of referral systems and interventions to improve the use of available therapy services.

Wamser-Nanney, R. (2021). Maternal support and attrition from child trauma-focused therapy. *Journal of Traumatic Stress*, 34(4), 840-850. <https://doi.org/10.1002/jts.22698>

Many children prematurely terminate from trauma-focused therapy (TFT), and attrition is a critical barrier in addressing the impacts of childhood sexual abuse (CSA). The field's knowledge of risk factors for dropout is growing; however, one aspect of the child's environment that remains unexamined is maternal support following the CSA disclosure/discovery. Maternal support has been theorized to play a valuable role in influencing children's outcomes after CSA and may be relevant in understanding attrition. The objective of the current study was to investigate the associations between children's symptoms, relationship to the perpetrator, and maternal support in relation to premature termination from TFT among 186 sexually abused children (Mage = 9.24 years, SD = 3.72, 67.3% female). Two operational definitions of attrition were used: (a) clinician-rated dropout (i.e., clinician's ratings of whether the child completed treatment) and (b) whether the child received an adequate treatment dose treatment (i.e., ≥ 12 sessions). Maternal marital status was the only factor associated with clinician-rated treatment dropout, OR = 2.35, whereas maternal support and blame/doubt were unrelated. Living farther from the clinic was tied to an increased risk of receiving an inadequate treatment dose, OR = 0.96. Replication of these findings is needed, particularly using a clinician-administered measure of caregiver support; yet, maternal emotional support and blame/doubt may not evince strong ties to dropout from TFT among sexually abused

children. Additional work is needed to discern if there are key subgroups for whom support is more strongly related to the risk of premature termination following CSA.

Eirich, R., Racine, N., Garfinkel, D., Dimitropoulos, G., & Madigan, S. (2020). [Risk and protective factors for treatment dropout in a child maltreatment population](#). *Adversity and Resilience Science*, 1(3), 165-177.

Many children start but do not complete trauma treatment, and there is little knowledge of factors that predict treatment dropout in children who have endured maltreatment. The current study examines the risk and protective factors associated with premature treatment dropout within a sample of 118 children (aged 3–18) referred to a Child Advocacy Centre due to maltreatment, specifically abuse and neglect. In this retrospective chart review, data on risk (i.e., adverse childhood experiences [ACEs] and number of presenting clinical symptoms at intake) and protective factors (e.g., peer support, caregiver support) were extracted from clinical files by two trained coders using a standardized data extraction protocol. Results revealed that, after adjusting for child age, ACEs score, and presenting clinical concerns, children with more protective factors were less likely to drop out of treatment (OR=0.40, 95% CI [0.24, 0.69]). Child age also emerged as a significant predictor of treatment dropout, such that older children were more likely to drop out of treatment prematurely (OR=1.16, 95% CI [1.01, 1.32]). Results suggest that older children and children with fewer protective factors present may benefit from increased retention efforts to reduce treatment dropout.

Theimer, K., Mii, A., Sonnen, E., McCoy, K., Meidlinger, K., Biles, B., ... & Hansen, D. J. (2020). [Identifying and addressing barriers to treatment for child sexual abuse survivors and their non-offending caregivers](#). *Aggression and Violent Behavior*, Online ahead of print. <https://doi.org/10.1016/j.avb.2020.101418>

Mental health treatment is a critical part of an effective and compassionate response to the disclosure of child sexual abuse (CSA). Given the vast negative consequences for children and families following CSA, engagement in treatment can benefit youth and their non-offending caregivers. Yet, these families face unique barriers to treatment initiation, adherence, and effectiveness. The identification of these barriers allows clinicians, researchers, and policy makers to increase treatment utilization, engagement, and value. The current review and its

recommendations derive from the existing literature combined with knowledge gained from a clinical research team with more than 20 years of experience offering a treatment program for CSA survivors and their non-offending family members. The review organizes barriers around factors related to individual characteristics of children and caregivers, perceptions and beliefs commonly held following CSA, and challenging family interactions in the context of individual and group treatment for CSA. Finally, barriers related to systemic and societal factors are examined given the importance of understanding the legal and cultural context in which families seek and engage in treatment. Recommendations for further research, suggestions for clinicians, and considerations for policy change to decrease the identified treatment barriers for families impacted by CSA are provided.

Wamser-Nanney, R. (2020). Risk factors for attrition from pediatric trauma-focused treatment. *Child Maltreatment*, 25(2), 172-181.

Rates of attrition from pediatric trauma-focused treatments are high, yet few studies have examined predictors of dropout. The aim of the study was to investigate whether higher levels of caregiver- and child-reported pretreatment difficulties predicted attrition from trauma-focused therapy. One hundred seventy-two children aged 6–18 ($M = 10.53$, $SD = 3.36$; 64% female, 64% Black) and their caregivers were included in the study. Two operational definitions of attrition were utilized: (1) clinician-rated dropout and (2) whether the child received an adequate dose of treatment (i.e., 12 or more sessions). Rates of clinician-rated attrition were high (76.2%); however, 73.8% received an adequate dose. Despite expectations, higher levels of rule-breaking and aggressive behavior were related to clinician-rated dropout ($d = 0.59$, $.63$, respectively) but were not significant predictors in a logistic regression model. Child-reported symptoms were unrelated to clinician-rated attrition. Higher levels of caregiver reported anxiety/depression, somatic complaints, and trauma-related difficulties corresponded with adequate dose ($ds = 0.52$ – 1.06). Yet only caregiver-reported sexual concerns predicted adequate dose in a regression model ($OR = 1.09$). Caregiver- and child-reported symptoms may be unrelated to clinician-rated treatment completion and appear to play a small role in understanding whether the child received an adequate dose of treatment.

Lai, B. S., Tiwari, A., Self-Brown, S., Cronholm, P., & Kinnish, K. (2019). [Patterns of caregiver factors predicting participation in Trauma-Focused Cognitive Behavioral Therapy.](#) *Journal of Child & Adolescent Trauma*, 12(1), 97-106.

This study examined patterns of caregiver factors associated with Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) utilization among trauma-exposed youth. This study included 41 caregivers (caregiver age $M = 36.1$, $SD = 9.88$; 93% African American) of youth referred for TF-CBT, following a substantiated forensic assessment of youth trauma exposure. Prior to enrolling in TF-CBT, caregivers reported on measures for parenting stress, attitudes towards treatment, functional impairment, caregiver mental health diagnosis, and caregiver trauma experiences. Classification and regression tree methodology were used to address study aims. Predictors of enrollment and completion included: attitudes towards treatment, caregiver trauma experiences, and parenting stress. Several caregiver factors predicting youth service utilization were identified. Findings suggest screening for caregivers' attitudes towards therapy, parenting stress, and trauma history is warranted to guide providers in offering caregiver-youth dyads appropriate resources at intake that can lead to increased engagement in treatment services.

Steinberg, A. M., Layne, C. M., Briggs, E. C., Liang, L. J., Brymer, M. J., Belin, T. R., ... & Pynoos, R. S. (2019). Benefits of treatment completion over premature termination: Findings from the National Child Traumatic Stress Network. *Psychiatry*, 82(2), 113-127.

Objective: To evaluate potential differences in therapeutic outcomes between youths who completed a full course of treatment as planned compared to youths who terminated treatment prematurely. Method: Using longitudinal data from the National Child Traumatic Stress Network (NCTSN) Core Data Set, the present study examined demographic characteristics, trauma history, scores on standardized measures, and ratings of functional impairment and behavior problems in a large clinical sample of children and adolescents exposed to trauma who received treatment at NCTSN centers across the United States. Baseline and follow-up data were used to compare treatment completers ($n = 3,108$) and noncompleters ($n = 4,029$). Results: Both treatment completers and noncompleters received benefits from treatment by NCTSN mental health providers in that both groups showed significant decreases in mean scores from baseline to followup on all standardized measures. However, compared to noncompleters, treatment completers showed three types of significantly greater benefit at follow-up. These included: (a) greater rates of decline (i.e., steeper slopes) on all outcome measures; (b) greater reductions in the

odds of falling within the clinical range on standardized measures; and (c) greater reductions in the odds of exhibiting functional impairment and behavior problems at follow-up. In contrast, compared to treatment completers, noncompleters reported significantly higher rates of lifetime exposure to community violence, psychological maltreatment, physical abuse, neglect, sexual abuse, and sexual assault. Conclusion: These findings underscore the value of incorporating engagement and retention strategies in treatments for traumatized youths to maximize therapeutic benefit and raise the standard of care.

Tebbett, A. A., Brown, E. J., & Chaplin, W. F. (2018). Caregiver report of child symptoms predicts attrition in abuse-specific cognitive behavioral therapies. *Child Maltreatment*, 23(1), 54-62.

A common critique of empirically supported treatments for abuse-related psychopathology is attrition during critical phases of therapy (i.e., exposure). The goal of this study was to examine whether child and caregiver symptoms were predictive of attrition among families in abuse-specific cognitive-behavioral therapies (CBTs). Children (N = 104) and their caregivers completed baseline assessments of internalizing symptoms, externalizing problems, and post-traumatic stress disorder (PTSD) and were enrolled in abuse-specific CBTs. Logistic regressions were conducted with baseline symptoms as predictor variables and treatment status (attrition vs. completion) as the criterion variable. Caregiver report of child internalizing symptoms showed the predicted quadratic relation to attrition. Caregiver report of child externalizing symptoms at moderate and high (vs. low) levels was associated with attrition. Child self-report and caregiver self-report of symptoms were not associated with the dyad's attrition. These results underscore the importance of attending to caregivers' initial perceptions of children's symptoms in abuse specific therapy.

Ofonedu, M. E., Belcher, H. M., Budhathoki, C., & Gross, D. A. (2017). Understanding barriers to initial treatment engagement among underserved families seeking mental health services. *Journal of Child and Family Studies*, 26(3), 863-876.

This mixed method study examined factors associated with parents not attending their child's mental health treatment after initially seeking help for their 2–5 year old child. It was part of a larger study comparing two evidence-based treatments among low-income racial/ethnic minority families seeking child mental health services. Of 123 parents who initiated mental health treatment

(71% African American or multi-racial; 97.6% low-income), 36 (29.3 %) never attended their child's first treatment session. Socio-demographic characteristics, parenting stress, depression, severity of child behavior problems, and length of treatment delay from intake to first scheduled treatment session were compared for families who did and did not attend their first treatment session. Parents who never attended their child's first treatment session were more likely to live with more than four adults and children ($p = .007$) and have more depressive symptoms ($p = .003$). Median length of treatment delay was 80 days (IQR = 55) for those who attended and 85 days (IQR = 67.5) for those who did not attend their child's first treatment session ($p = .142$). Three themes emerged from caregiver interviews: (a) expectations about the treatment, (b) delays in getting help, and (c) ambivalence about research participation. Findings suggest the need to develop better strategies for addressing risk factors early in the treatment process and reducing the length of time families with adverse psychosocial circumstances must wait for child mental health treatment.

Piotrowska, P. J., Tully, L. A., Lenroot, R., Kimonis, E., Hawes, D., Moul, C., ... & Dadds, M. R. (2017). [Mothers, fathers, and parental systems: A conceptual model of parental engagement in programmes for child mental health—Connect, Attend, Participate, Enact \(CAPE\)](#). *Clinical Child and Family Psychology Review*, 20(2), 146-161.

Parenting programmes are one of the best researched and most effective interventions for reducing child mental health problems. The success of such programmes, however, is largely dependent on their reach and parental engagement. Rates of parental enrolment and attendance are highly variable, and in many cases very low; this is especially true of father involvement in parenting programmes. This paper proposes a conceptual model of parental engagement in parenting programmes—the CAPE model (Connect, Attend, Participate, Enact) that builds on recent models by elaborating on the systemic context. That is, we argue that a comprehensive model of parental engagement will best entail a process from connection to enactment of learned strategies in the child's environment, and involve consideration of individual parents (both mothers and fathers) as well as the dynamics of the parenting team. The model provides a framework for considering parent engagement as well as associated facilitators and mechanisms of parenting change such as parenting skills, self-efficacy, attributions, and the implementation context. Empirical investigation of the CAPE model could be used to further our understanding of parental

engagement, its importance for programme outcomes, and mechanisms of change. This will guide future intervention refinement and developments as well as change in clinical practice.

Sawrikar, P., & Katz, I. (2017). The treatment needs of victims/survivors of child sexual abuse (CSA) from ethnic minority communities: A literature review and suggestions for practice. *Children and Youth Services Review*, 79, 166-179.

One significant finding from an exhaustive literature review on child sexual abuse (CSA) and ethnic minority communities is that victims appear to be at higher risk for suicidality. This may be due to the many barriers to professional help-seeking in this group, most commonly associated with protecting the family's name. This makes their treatment needs particularly critical, after the barriers have finally been crossed. Of all their treatment needs, cultural competency is identified as essential. It asks for non-racist attitudes and practice, self-reflection and awareness, a 'multicultural framework' which recognises differences in power between mainstream and minority groups and respects the right to cultural differences, the provision of an interpreter trained in matters to do with sexual assault, choice about having an ethnically matched or non-matched service provider (and thus employment of workers from diverse backgrounds), the routine provision of training in cultural competency by management in service organisations, and mandatory data collection on variables related to ethnicity. A 'multicultural framework' is seen to be the most important of these elements, else it could lead to the vilification of collectivist and patriarchal cultures (which ethnic minority communities tend to be), threatening cultural safety. This adds trauma to the victim who has already suffered an abuse of power, and further alienates clients in critical need of clinical intervention.

Simon, V. A., Barnett, D., Smith, E., Mucka, L., & Willis, D. (2017). Caregivers' abuse stigmatization and their views of mental health treatment following child sexual abuse. *Child Abuse & Neglect*, 70, 331-341.

Many families do not utilize mental health services after the discovery of child sexual abuse (CSA), even when trauma-focused treatments are offered at low or no cost. Non-offending caregivers frequently serve as gatekeepers to youths' treatment, and their reactions to CSA may figure into decisions about treatment engagement. The current study examined caregivers' abuse stigmatization (i.e., self-blame and shame about their children's CSA) and associations with two

factors predictive of treatment engagement (motivation, obstacles). Participants were recruited from a Child Advocacy Center where they received forensic interviews and were offered services following CSA discovery. Participating caregiver-child dyads included 52 non-offending caregivers (83% biological parents) and their children (69% girls; Mage=10.94, SDage= 2.62). Caregiver abuse stigmatization was associated with higher motivation for treatment but also more obstacles to treatment. Further, abuse stigmatization moderated associations between children's PTSD symptoms and perceived obstacles to treatment. Among caregivers experiencing high abuse stigmatization, greater child PTSD symptoms were associated with more obstacles to treatment. Among caregivers experiencing low stigmatization, child PTSD was either associated with fewer treatment obstacles or was unrelated to treatment obstacles. Results highlight the potential significance of reducing parents' abuse stigmatization for increasing mental health service utilization following CSA discovery, especially for more symptomatic youth.

DeLorenzi, L., Daire, A. P., & Bloom, Z. D. (2016). Predicting treatment attrition for child sexual abuse victims: the role of child trauma and co-occurring caregiver intimate partner violence. *Counseling Outcome Research and Evaluation, 7*(1), 40-52.

Sexually abused children drop out of treatment more frequently than children receiving services for other issues. While researchers suggest that chaotic family dynamics may lead to inflated attrition rates in this population, other factors that potentially contribute to treatment attrition are virtually unknown. Therefore, the purpose of this study was to investigate the relationship between child and parent characteristics with attrition for sexual abuse victims (N = 132) and their nonoffending caregivers. Results indicate that children with parents who confirmed past or current intimate partner violence were 2.5 times more likely to prematurely terminate from treatment.

Fong, H. F., Bennett, C. E., Mondestin, V., Scribano, P. V., Mollen, C., & Wood, J. N. (2016). Caregiver perceptions about mental health services after child sexual abuse. *Child Abuse & Neglect, 51*, 284-294.

The objective of this study was to describe caregiver perceptions about mental health services (MHS) after child sexual abuse (CSA) and to explore factors that affected whether their children linked to services. We conducted semi-structured, in-person interviews with 22 non-offending caregivers of suspected CSA victims < 13 years old seen at a child advocacy center in Philadelphia.

Purposive sampling was used to recruit caregivers who had (n = 12) and had not (n = 10) linked their children to MHS. Guided by the Health Belief Model framework, interviews assessed perceptions about: CSA severity, the child's susceptibility for adverse outcomes, the benefits of MHS, and the facilitators and barriers to MHS. Interviews were audio-recorded, transcribed, coded, and analyzed using modified grounded theory. Recruitment ended when thematic saturation was reached. Caregivers expressed strong reactions to CSA and multiple concerns about adverse child outcomes. Most caregivers reported that MHS were generally necessary for children after CSA. Caregivers who had not linked to MHS, however, believed MHS were not necessary for their children, most commonly because they were not exhibiting behavioral symptoms. Caregivers described multiple access barriers to MHS, but caregivers who had not linked reported that they could have overcome these barriers if they believed MHS were necessary for their children. Caregivers who had not linked to services also expressed concerns about MHS being Retraumatizing and stigmatizing. Interventions to increase MHS linkage should focus on improving communication with caregivers about the specific benefits of MHS for their children and proactively addressing caregiver concerns about MHS. © 2015 Elsevier Ltd. All rights reserved.

Nanninga, M., Jansen, D. E., Kazdin, A. E., Knorth, E. J., & Reijneveld, S. A. (2016). Psychometric properties of the Barriers to Treatment Participation Scale–Expectancies. *Psychological Assessment, 28*(8), 898-907.

Expectations concerning barriers to children's psychosocial care seem to be major drivers when seeking help, but validated questionnaires measuring expectations are not available. Therefore, this study examined the psychometric properties of the parent and adolescent versions of the Barriers to Treatment Participation Scale–Expectancies (BTPS-exp), in terms of consistency, structure, parent–child agreement, and validity. The authors obtained data via questionnaires on 1,382 Dutch children aged 4–18 years (response rate 56.6%) enrolled in psychosocial care, and on 666 children (response rate 70.3%) from the community. Internal consistencies of the BTPS-exp total and subscales of both versions were good (lowest Cronbach's alpha .85). Fit of the data with the assumed scale structure was acceptable. Correlation coefficients between the parent and adolescent scores were low (Pearson's r total scale 0.25). Parents expecting multiple barriers was significantly more likely in non-Dutch ethnicity (odds ratio [OR] 1.4; 95% confidence interval

[CI] [1.1, 1.9]), in lower parental educational levels (primary education: OR 3.0; 95% CI [1.5, 6.1]; lower-level secondary education: OR 2.0; 95% CI [1.3, 3.1], both vs. university), in single parent families (1.3; 1.1–1.6), in case of child psychosocial problems (OR 1.3; 95% CI [1.0, 1.5]) and in adolescents with psychosocial problems (OR 2.1; 95% CI [1.4, 3.1]). Expecting multiple barriers did not affect the association between psychosocial problems and care enrollment. The authors conclude that the BTPS-exp has good psychometric properties regarding reliability and structure and is reasonably valid. Parents and adolescents have their own separate views, implying that it is valuable to assess both. Use of the scale might be helpful in providing direction to improve access to psychosocial care for children and adolescents.

Self-Brown, S., Tiwari, A., Lai, B., Roby, S., & Kinnish, K. (2016). Impact of caregiver factors on youth service utilization of trauma-focused cognitive behavioral therapy in a community setting. *Journal of Child and Family Studies*, 25(6), 1871-1879.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is an increasingly available evidence-based therapy that targets the mental health symptoms of youth who have experienced trauma. Limited research has examined how to engage and retain families in TF-CBT services in community settings. Using a mixed-methods approach, the goal of this exploratory study was to identify caregiver factors that impact youth enrollment and completion of community-delivered TF-CBT. The study included 41 caretakers of youth referred to therapy at a local child advocacy center following a forensic assessment substantiating youth trauma exposure. Caregiver factors examined include caregiver demographics, trauma exposure, and mental health symptomology. Results from multivariate logistic regressions indicate that caregivers reporting more children residing in the household were significantly more likely to enroll youth in therapy (OR 2.27; 95 % CI 1.02, 5.03). Qualitative analyses further explicate that parents with personal trauma or therapy experiences expressed positive opinions regarding therapy services for youth, and were more likely to enroll in or complete services. Findings suggest that caregivers with personal traumatic experience and related symptomatology view therapy as important and are more committed to their child receiving therapy. Future research on service utilization is warranted and should explore offering parental psychoeducation or engagement strategies discussing therapy benefits to parents who have not experienced trauma and related mental health symptomatology.

Murphy, R. A., Sink, H. E., Ake III, G. S., Carmody, K. A., Amaya-Jackson, L. M., & Briggs, E. C. (2014). Predictors of treatment completion in a sample of youth who have experienced physical or sexual trauma. *Journal of Interpersonal Violence, 29*(1), 3-19.

Despite significant advances in knowledge and availability of evidence-based models for child traumatic stress, many children simply do not complete treatment. There remain notable gaps in the services research literature about treatment completion among youth, particularly those who have experienced trauma and related sequelae. This study investigated the linkages among child physical and sexual trauma, posttraumatic stress disorder (PTSD) symptomatology, and treatment completion utilizing a clinical sample drawn from a large database from community treatment centers across the United States specializing in childhood trauma. Results from regression analyses indicated that neither the experience of sexual nor physical trauma directly predicted successful treatment completion. The links between sexual trauma and treatment completion, however, were mediated by PTSD avoidance symptoms. Children and youth experiencing sexual trauma reported higher levels of avoidance symptoms that were, in turn, significantly associated with a lower likelihood of completing trauma-focused mental health treatment. Practice implications are discussed and include strategies for clinicians to intervene during pivotal points of treatment to improve rates of service utilization and treatment completion.

Gonzalez, J. E. (2012). Influence of family and victim demographic factors on treatment completion for children exposed to abuse and family violence. *Undergraduate Research Journal, 6*(2), 94-101.

The Children's Bureau of Administration on Children, Youth, and Families (2010) estimates that over 75 million children disclose being victims of sexual abuse, physical abuse, neglect, psychological maltreatment, and medical neglect each year. However, for agencies that provide services to victims of child sexual abuse and neglect, successfully completing treatment for clients is challenging but imperative in decreasing the likelihood of the child or adolescent developing long-term emotional, psychological, and behavioral consequences (DePanfilis, 2006). According to McPherson, Scribano, & Stevens (2012), child survivors of sexual abuse are more likely to complete treatment if their mother attends sessions and supports the child throughout the counseling process. The present study examines the influence of demographic factors on treatment completion of 292 children who received services from a child advocacy center. The findings

identify differences between caregivers' type of relationships to the victims and appointment cancellations.

Gould, S. R., Beals-Erickson, S. E., & Roberts, M. C. (2012). [Gaps and barriers in services for children in state mental health plans](#). *Journal of Child and Family Studies*, 21(5), 767-774.

Significant gaps exist in children's mental healthcare, and barriers prevent access to existing services. Current federal initiatives call for state governmental agencies to recognize and resolve deficits in their systems of care. Previous work has acknowledged some of the problems in meeting the mental health needs of children within a system of care. This current project sought to discriminate between gaps (e.g., non-existent services) and barriers (e.g., problems that prevent access to existing services) within state mental health care plans. Because acknowledging barriers and gaps in mental health services is a step towards systems improvement, the present project describes how state governments recognize the limits of their children's mental health care systems. We analyzed state mental health plans submitted to the federal government in applications for block grant funds. Results illustrate that a varied number of gaps and barriers are acknowledged in state plans. Overall, 90% of state plans discussed barriers and 84% of state plans discussed service gaps. The gap most frequently recognized was lack of providers (74%), while lack of funding (52%) was the most common barrier. This project points to some recognition of system limits in the states and reflects potential efforts to create policies for system improvement for children and families.

Horwitz, S. M., Hurlburt, M. S., Goldhaber-Fiebert, J. D., Heneghan, A. M., Zhang, J., Rolls-Reutz, J., ... & Stein, R. E. (2012). [Mental health services use by children investigated by child welfare agencies](#). *Pediatrics*, 130(5), 861-869.

The objective was to examine the rates and predictors of mental health services use for a nationally representative cohort of youths who had been investigated for alleged maltreatment. Data came from caregiver and caseworker baseline and 18-month interviews in the second National Survey of Child and Adolescent Well-being. These interviews took place from March 2008 to September 2008 and September 2010 to March 2011. Data on family and child characteristics and service use were gathered and examined by using weighted univariate and multivariate analyses. Children had

numerous challenges: 61.8% had a previous report of maltreatment, 46.3% had poor socialization skills, and 23.9% had a mental health problem measured by the Child Behavior Checklist (CBCL). At baseline, 33.3% received some mental health service and this varied by age, with younger children receiving fewer services. This percentage decreased to 30.9% at the 18-month follow-up, although the youngest children had increases in services use. For younger children, race/ethnicity, out-of-home placement, chronic physical health problems, low adaptive behaviors, and CBCL scores in the clinical range were related to use. For children ≥ 11 , out-of-home placement, high CBCL scores, and family risk factors predicted services use at 18 months. Mental health services utilization increases as young children come into contact with schools and medical providers or have more intensive involvement with child welfare. Minority children receive fewer services adjusting for need. Over the 18-month follow-up, there was a decrease in service use that may be a result of the tremendous financial challenges taking place in the United States.

McPherson, P., Scribano, P., & Stevens, J. (2012). Barriers to successful treatment completion in child sexual abuse survivors. *Journal of Interpersonal Violence*, 27(1), 23-39.

Child sexual abuse (CSA) often requires psychological treatment to address the symptoms of victim trauma. Barriers to entry and completion of counseling services can compromise long-term well-being. An integrated medical and mental health evaluation and treatment model of a child advocacy center (CAC) has the potential to reduce barriers to mental health treatment. Objective: (a) to describe characteristics between CSA patients who engage versus those who do not engage in mental health treatment and (b) to identify factors associated with successful completion of mental health treatment goals. For design/setting, a retrospective cohort study was conducted of CSA patients (ages 3-16 years) referred to mental health services following a CAC assessment. Outcome variables included linkage with treatment and completion of treatment. Independent variables included demographics, abuse characteristics, and therapist characteristics. Data were abstracted from the CAC and billing databases. Results: Four hundred ninety subjects were evaluated. Subjects were as follows: predominately female (74%), White (60%), and more than half received Medicaid (56%). Mean age was 8.4 years. About 52% linked with mental health services and 39% of patients that successfully linked with mental health services completed therapy. Successful linkage was independently associated with referrals to other counseling

services (AOR 8.4 [2.5, 27.7]). Successful completion of therapy was independently associated with caregiver participation in therapy (AOR 3.2 [1.8, 6.0]) and if the patient was referred to other counseling services (AOR 4.1 [1.9, 8.5]). There were no differences between subjects that linked and/or completed therapy and those that did not with regard to demographic characteristics or abuse severity. Conclusion: In contrast to previous reports, efforts at our CAC seem to overcome linkage barriers in this population. However, there remain challenges in achieving successful completion of treatment goals in this population. Engaging caregivers' involvement in therapy services had a positive effect with successfully achieving treatment goals.

Villagrana, M., & Palinkas, L. A. (2012). Caregivers' endorsement of barriers to mental health services for children and youth in child welfare. *Journal of Family Social Work*, 15(2), 111-125.

The purpose of this study was to examine the three most common types of caregivers in the child welfare system (birth parents, relative caregivers, and foster parents), an active child welfare case, caregivers' endorsement of barriers to mental health services and mental health service use by caregivers for the children under their care. The sample consisted of 430 dyads (caregivers and their children). Results indicate that an active child welfare case, provider characteristics, and accessibility of services predicted mental health service use for children. Implications for the child welfare and mental health systems are discussed.

Walker-Descartes, I., Sealy, Y. M., Laraque, D., & Rojas, M. (2011). Caregiver perceptions of sexual abuse and its effect on management after a disclosure. *Child Abuse & Neglect*, 35(6), 437-447.

The aim of the study was to examine caregiver management strategies for child sexual abuse (CSA) when presented with hypothetical scenarios that vary in physical invasiveness. One hundred fifty-three caregivers were given 3 scenarios of CSA with 7 management strategies presented in the 21-item Taking Action Strategies (TAS) scale. Caregivers were asked to rate strategies according to their willingness to carry out each action with rating of 5 = greater likelihood of carrying out the action specified while a rating of 1 = a lower likelihood of carrying out that action. CSA scenarios included exposure to pornography/ masturbation, fondling, and penetration while management strategies including fighting the accused, blaming the child, and outreaching to the authorities. Repeated measures ANOVA was used to compare mean TAS scores for the

management strategies across CSA scenarios. The difference between TAS scores across the abuse scenarios was statistically significant ($p < .001$). Mean TAS scores reflected greater preference for taking action if the abusive act was perceived as more physically intrusive (exposure to pornography/masturbation-TAS 3.5, fondling-TAS 3.7, penetration-TAS 3.8). Caregivers reported being less willing to handle a disclosure of CSA without outreach (TAS 2.5 and 2.0 for fighting and blaming the child, respectively) and more willing to manage a disclosure with outreach to authorities (TAS 3.8, 4.5, and 4.7 for outreaching to Child Protective Services [CPS], to the child's healthcare provider and police, respectively). A predictor of caregiver outreach to authorities identified was the caregiver having past interactions with CPS. Perception of the physical invasiveness of CSA and demographic factors can impact caregiver management strategies after a disclosure. Results suggest that several factors influence caregiver management of sexual abuse. These factors warrant further study, as they are potential contributors to declining trends in CSA cases observed. Other implications include the need for educational efforts targeting caregivers. These interventions should focus on dispelling myths about the perceived physical invasiveness of CSA. These perceptions should not mitigate a caregiver's decision to involve the authorities in their management after a disclosure. Lastly, despite criticisms of the child protective systems, caregivers with past encounters with CPS view these related agencies as valuable resources. © 2011 Elsevier Ltd. All rights reserved.

Bringewatt, E. H., & Gershoff, E. T. (2010). Falling through the cracks: Gaps and barriers in the mental health system for America's disadvantaged children. *Children and Youth Services Review*, 32(10), 1291-1299.

The system for providing mental health services to children is fragmented and complex, and children and their families face multiple barriers to accessing care. This is especially true for children in low-income families, who have the greatest rate of mental health disorders but have the highest underutilization of services. The first section of this paper describes the unmet need for children's mental health services, including reasons for the disproportionate need among low-income children. The second section provides a brief overview of the history of children's mental health policies. The third section outlines the types of services available to children, highlighting the problems with this service delivery system. This is followed by a discussion of barriers that

families face in accessing care. The paper concludes with recommendations for improving this fragmented system of service delivery. © 2010 Elsevier Ltd. All rights reserved.

Hill, A. (2009). Factors influencing the degree and pattern of parental involvement in play therapy for sexually abused children. *Journal of Child Sexual Abuse, 18*(4), 455-474.

Although much has been written about the role of therapists in children's recovery from child sexual abuse, relatively little attention has been paid to the role of nonoffending parents. This study investigated the work of a team of therapists who sometimes included such parents in therapy sessions with children. The study sought to understand what factors were influencing the degree and pattern of parental involvement and to understand what effect these patterns of parental involvement were having on the process and outcomes of therapy. The study successfully identified a range of factors influencing the patterns of parental involvement, but more research will be needed to understand the effect on outcomes.

Lippert, T., Favre, T., Alexander, C., & Cross, T. P. (2008). Families who begin versus decline therapy for children who are sexually abused. *Child Abuse & Neglect, 32*(9), 859-868.

The objective was to identify child characteristics, factors related to the therapy referral, and caregivers' psychological and social variables that predict sexually abused children's beginning therapy following a therapy referral. Investigators abstracted data from case records of 101 families whose children were referred to a Children's Advocacy Center for therapy because of sexual abuse. Face-to-face interviews were conducted with a subsample of 45 caregivers 2–3 months after the referral to therapy. Case record and interview variables were entered into bivariate and multiple variable logistic regression analyses to identify predictors of entry into therapy. Only 54% of children had started therapy by 2 months post referral. The odds of entry into therapy were 2.10 times greater for non-Black versus Black children and, contrary to what would be expected, 13.90 times greater for children whose mother figures were accused of neglectful supervision. Among those interviewed (n = 45), caregivers who initiated child therapy more often saw therapy as giving emotional help and reported that they themselves felt comfortable making disclosures to a therapist. They also differed with respect to the activities they liked to do with their children. Many children who experience sexual abuse and are referred to therapy never begin it. Black

children are overrepresented among these. In-depth interviews may reveal more subtle differences between families initiating and declining therapy than case records. High rates of non-initiation of psychotherapy for sexually abused children indicate the need to identify how these rates could be reduced. To this end, the present study suggests the usefulness of focusing attention on engagement of Black families and on proactive involvement with caregivers identified as potentially unsupportive of their children. © 2008 Elsevier Ltd. All rights reserved.

Miller, L. M., Southam-Gerow, M. A., & Allin, R. B. (2008, August). [Who stays in treatment? Child and family predictors of youth client retention in a public mental health agency.](#) In *Child & youth care forum* (Vol. 37, No. 4, pp. 153-170). Springer US.

The present study examined possible predictors of youth client retention in therapy in a large community-based sample. We used several conceptualizations of retention, including (a) “intake retention” (i.e., returned to treatment after intake session); (b) “mutual termination” (i.e., termination agreed upon by family and therapist), (c) “mean treatment duration” (i.e., completing the mean number of sessions in the agency), and (d) “total treatment duration” (i.e., total number of sessions). Archival data from over 400 children and adolescents who sought treatment at a large public mental health clinic were analyzed using regression analyses. Although different predictors were identified across the various conceptualizations, a few robust predictors emerged including ethnicity and client symptom severity. Clinical implications and future research directions are discussed.

Nock, M. K., & Photos, V. (2006). Parent motivation to participate in treatment: Assessment and prediction of subsequent participation. *Journal of Child and Family Studies*, 15(3), 333-346.

Treatment motivation is required for virtually all psychosocial treatments because clients must participate actively in the treatment process. In child and family treatments, it is the parent who must be motivated to manage treatment participation; however, no measures are currently available for evaluating parent motivation for treatment. The authors developed and evaluated a brief rating scale, the Parent Motivation Inventory (PMI), to measure parent motivation to participate in treatment. Results supported a uni-dimensional measure with strong internal consistency and test-

retest reliability. Increases in parent motivation predicted the perception of fewer barriers to treatment participation, which was significantly associated with greater treatment attendance. The PMI provides a reliable and valid method of assessing parents' motivation to participate in treatment and has implications for the prediction and potential modification of barriers to treatment and treatment participation.

Hill, A. (2005). Patterns of non-offending parental involvement in therapy with sexually abused children: A review of the literature. *Journal of Social Work, 5*(3), 339-358.

This review explores the international literature on therapeutic work with sexually abused children. The emphasis is on the nature, extent and outcomes of non-offending parental involvement in such work. The context is an increasing recognition of the significant influence that non-offending parents may have on their children's recovery and, at the same time, the serious impact on parents themselves of finding out about the sexual abuse of their children, including the impact on their relationships with their children. The article identifies a number of distinct approaches to therapy that differ widely in the nature and extent of non-offending parental involvement. The diversity of approach reflects the variety of underlying theoretical orientation. The implications for children's recovery are discussed. Involving non-offending parents in therapeutic work with their sexually abused children may be important in promoting successful outcomes. It is argued that the perceived benefits of some of the approaches under review may be used flexibly, and in combination, to make significant advances in practice.

James, S., Landsverk, J., Slymen, D. J., & Leslie, L. K. (2004). [Predictors of outpatient mental health service use—the role of foster care placement change](#). *Mental Health Services Research, 6*(3), 127-141.

This study examined the relationship between placement change and outpatient mental health service use. It is based on (1) conceptual propositions about the impact of the foster care living context on mental health service use, and (2) empirical knowledge about the adverse consequences of placement change. Results of the study, which were based on a cohort of 570 children in foster care in San Diego County, suggest an association between placement changes in child welfare and use of outpatient mental health services. Specifically, an increase in the number of placement changes predicted a greater rate of outpatient mental health visits. The study further found that

children who experienced behavior-related placement changes received more outpatient mental health visits than children who experienced placement changes for other reasons. Follow-up analyses of the 144 children who experienced any behavior-related placement changes further indicated that the rate of outpatient mental health service use almost doubled in the 90 days following the first behavior-related placement change. Findings from this study have implications for the practice, policy and research fields in child welfare as well as mental health.

Thompson, V. L. S., Bazile, A., & Akbar, M. (2004). African Americans' perceptions of psychotherapy and psychotherapists. *Professional Psychology: Research and Practice*, 35(1), 19-26.

Do you have a multicultural practice? Do you understand the attitudes and expectations African Americans hold about mental health services? The attitudes and beliefs of 201 African Americans regarding psychotherapists, psychotherapy, and barriers to treatment were explored by means of focus groups. Key barriers to service utilization included stigma, lack of knowledge, lack of affordability, lack of trust, impersonal service, and lack of cultural understanding. Participants reported that race should not matter in therapy, but they often believed that psychologists were insensitive to the African American experience. The implications of participants' reports for meeting African American mental health and therapy needs are considered.

Staudt, M. M. (2003). Mental health services utilization by maltreated children: Research findings and recommendations. *Child Maltreatment*, 8(3), 195-203.

Many maltreated children have, or are at risk for, emotional and behavioral disorders. Some of these children need mental health services but do not receive them because of service delivery and use barriers. Knowledge about the factors related to service utilization is needed to increase access to and use of services. Studies on mental health services utilization by maltreated children in foster care or otherwise monitored by child protective services are reviewed to ascertain service use correlates. Children in foster care had higher use rates than comparison groups of Aid to Families With Dependent Children not in foster care. Need and non-need variables predicted service use. Race was the most consistent non-need predictor. Future research needs include the development of conceptual models to guide research on service access and use. More work is needed on the

conceptualization and operationalization of mental health services, need for services, and service use.

Horowitz, L. A., Putnam, F. W., Noll, J. G., & Trickett, P. K. (1997). Factors affecting utilization of treatment services by sexually abused girls. *Child Abuse & Neglect*, 21(1), 35-48.

This study describes the naturalistic therapy experiences of a sample of sexually abused girls and the relationship of these experiences to demographic factors, abuse experiences, psychopathology, and family functioning. The sample consisted of 81 sexually abused girls, aged 6 to 16, participating in a longitudinal study of the effects of sexual abuse. Results indicated strong effects for abuse experiences and child psychopathology on the total amount of therapy received. Patterns of treatment utilization were associated with ethnic minority status, but these differences are confounded by differing abuse experiences for racial groups in the sample. Other patterns of treatment utilization are discussed, as well as issues for further research and implications for treatment providers. ©1996 Elsevier Science Ltd.

Kazdin, A. E., Holland, L., & Crowley, M. (1997). Family experience of barriers to treatment and premature termination from child therapy. *Journal of Consulting and Clinical Psychology*, 65(3), 453-463.

Barriers to participation in treatment were proposed as a basis for dropping out of treatment among children seen in outpatient therapy. Families (N = 242) of children referred for treatment for oppositional, aggressive, and antisocial behavior participated. The main findings were that (a) barriers to participation in treatment contributed significantly to dropping out of therapy; (b) perceived barriers to treatment were not explained by family, parent, and child characteristics that also predicted dropping out; and (c) among families at high risk for dropping out of treatment, the perception of few barriers attenuated risk. Parent perceptions of the difficulties of participating in treatment (including stressors and obstacles associated with treatment, perceptions that treatment is not very relevant, and a poor relationship with the therapist) influenced who dropped out. (APA PsycInfo Database Record © 2016 APA, all rights reserved)

Tingus, K. D., Heger, A. H., Foy, D. W., & Leskin, G. A. (1996). Factors associated with entry into therapy in children evaluated for sexual abuse. *Child Abuse & Neglect*, 20(1), 63-68.

It is widely accepted that therapeutic intervention is an important and effective component in the treatment of the sexually abused child. The goal of this study was to identify children who are at risk for not receiving mental health services following sexual victimization. Nine-hundred and seventy-two children were followed for 6 months, and intervention by the Department of Children's Services (DCS), law enforcement agencies, and mental health professionals was monitored. Those children who were most likely to enter therapy were Caucasian, between the ages of 7 and 13, had cases in which DCS or law enforcement were involved, were placed outside the home, and experienced abuse of greater frequency. Implications of this study for intervention with child sexual abuse victims are discussed. Recommendations are made for future research.

Haskett, M. E., Nowlan, N. P., Hutcheson, J. S., & Whitworth, J. M. (1991). Factors associated with successful entry into therapy in child sexual abuse cases. *Child Abuse & Neglect*, 15(4), 467-476.

Given the well-documented, long-term, negative mental health consequences of child sexual abuse, it is important that children receive counseling following abuse. Often, the social worker's responsibility is to ensure that abused children are appropriately referred for counseling following disclosure of sexual abuse. There are multiple factors that could facilitate or hinder this process, and identification of these factors is important in assisting families in becoming engaged in therapy. The purpose of this study was to (1) determine the extent of the problem of sexual abuse victims failing to keep their first scheduled therapy appointment and (2) identify factors associated with failure to attend. Subjects were 129 consecutive child sexual abuse clients referred to long-term therapy by counselors at a crisis intervention center. Those who attended their first therapy session (n = 84) were found to differ from those who did not (n = 45) on the basis of their race, the center to which they were referred (private or public), whether the family had a telephone in the home, and whether the child's mother agreed that the family needed counseling. Implications of this study for increasing attendance at therapy are presented and recommendations are made for further research.