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Families who begin versus decline therapy for children who are sexually abused☆

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ABSTRACT

Objective: 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.
Method: 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.
Results: 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.
Conclusions: 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.
Practice implications: 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.

Introduction

Considerable research documents the effect of child sexual abuse (CSA) on mental health. Kendall-Tackett and colleagues' review (Kendall-Tackett, Williams, & Finkelhor, 1993) found that CSA increases a child's subsequent risk of psychological symptoms, low self-esteem and difficult close relationships. A meta-analysis found that CSA increased a child's risk of developing PTSD and depression and of suicide (Paolucci, Genuis, & Violato, 2001), while research on a nationally representative

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sample showed that it increased the risk of mood, anxiety and substance abuse disorders, controlling for other childhood adversities (Molnar, Buka, & Kessler, 2001). It is well accepted that many, possibly all, children who are sexually abused need mental health intervention.

Research supports psychotherapy's ability to reduce symptoms associated with CSA (Deblinger, Lippman, & Steer, 1996; Saywitz & Mannarino, 2000). Cognitive-behavioral therapy of 8–12 sessions can reduce children's PTSD symptoms, fears, anxiety and depression and enhance their and their parents' coping (see Corcoran, 2004; Finkelhor & Berliner, 1995; Putnam, 2003 for reviews). Therapy also may help prevent the development of emotional and behavioral disturbances (e.g., fears, sleep disturbances), which as many as 30% of initially-symptom free children show 18 months post-initial assessment (Gomes-Schwartz, Horowitz, Cardarelli, & Sauzier, 1990).

Many children and adolescents who are sexually abused, however, never begin psychotherapy. The reasons are only partly understood. The present study examines children's entry into psychotherapy, drawing its sample from an urban Children's Advocacy Center (CAC) that is one of its community's main providers of therapy for child sexual abuse victims. The CAC studied provides low-cost or no-cost therapy based on financial need, removing actual cost as an obstacle to therapy. Using both case data and research interviews of parents, we sought to identify case variables and discover caregivers' perceptions and experiences that might illuminate why only some families make use of psychotherapeutic services.

Initiation of therapy for children who are sexually abused

Several studies show that referrals for sexually abused children only sometimes lead to psychotherapy. In a pilot study ($N = 68$), 58% of CSA victims and 43% of parents for whom therapy was advised began it within a few months (Lane, Dubowitz, & Harrington, 2002). Another study found that only 35% of 129 sexually abused youth attended their first therapy appointment (Haskett, Nowlan, Hutcheson, & Whitworth, 1991), and a third study showed that 62% of sexually abused children living at home (vs. 87% removed) had begun therapy by 6 months post-abuse evaluation and therapy referral (Tingus, Heger, Foy, & Leskin, 1996).

The results of the few studies that have examined predictors of sexually abused children's entry into therapy have varied according to outcomes measured and sample characteristics. Haskett et al. (1991) found that White children more often kept their first appointment, and Tingus et al. (1996) found that they had a higher rate of entry into therapy within 6 months, compared to Black or Hispanic children. In explanation, Haskett et al. (1991) and Tingus et al. (1996) cite Black adults' preference for informal over formal help (Chatters, Taylor, & Neighbors, 1989); yet, we found no research showing that, controlling for SES, Black adults use informal help more than do White adults. Tingus et al. (1996) showed that children between the ages of 7 and 13 and children who were abused more often had higher rates of entry into therapy. The rate of entry into therapy also increased when children were removed from the home and when police or child protective services (CPS) were involved. Haskett et al. (1991) found no effect of the child's age, but found that entry into therapy increased when caregivers had phones and when they believed therapy would help the entire family versus solely the child. An exploratory study found child behavioral disturbances and strong evidence of abuse to predict entry into therapy (Lane et al., 2002).

We know of no empirical studies of caregivers' perceptions related to children's entry into therapy following sexual abuse. Clinical articles suggest that caregivers' concerns about cost, time, distress, inconvenience and confidentiality may contribute to negative opinions about therapy and low rates of use (Horowitz, Putnam, Noll, & Trickett, 1997; Lane et al., 2002). A desire to leave the abuse behind and avoid embarrassment may also hinder entry into therapy (Finkelhor, Wolak, & Berliner, 2001), as may experiences with mental health services that left caregivers feeling disrespected (Kerkorian, McKay, & Bannon, 2006). It is also reasonable to suspect that beliefs about the nature of therapy may impact its use.

Aspects of caregivers' interpersonal relationships may also affect their motivation to initiate therapy for their children who experience sexual abuse. The quality of caregivers' relationships with their children may affect their supportiveness (Schechter, Brunelli, Cunningham, Brown, & Baca, 2002) and perception of their children's needs. Inadequate support may increase caregivers' stress and render them less capable of attending to others (Schechter et al., 2002). Finally, seeking "outside" help may be unlikely when caregivers are unmotivated to talk openly to a therapist (Cohen, Deblinger, Mannarino, & de Arellano, 2001). They may respond to adverse events by closing the family system to outside influences or deny, avoid, and minimize the effect of the abuse. The impact of these factors on children's entry into therapy remains to be studied.

Finally, factors related to the therapy referral process, such as the timing of the therapy referral, may affect caregivers' motivation to initiate therapy. Timely referrals may increase the chance that a child will begin therapy. According to crisis theory, people are most open to help during the unfolding of a crisis, when their usual defense mechanisms are weakened (Golan, 1986). Late referrals may allow families to develop avoidant strategies, communicate that child therapy is a low priority, or both; to our best knowledge, however, the relationship between the timing of therapy referrals and whether sexually abused children begin therapy remains unexamined.

The present study

This study is the first to examine the contribution of the timing of therapy referral and of family functioning variables to CSA victims' entry into therapy. The study also examines the contribution of other factors related to the family as well as factors related to the child and the abuse. Additionally, whereas past studies used phone interviews (Tingus et al., 1996) or mailed questionnaires (Lane et al., 2002) to gather caregivers' perceptions, this study uses face-to-face interviews, which

may yield richer data given interviewers' ability to facilitate dialogue through their presence. The present study used data from families whose children were referred to therapy at the Dallas Children's Advocacy Center (DCAC), a nonprofit Children's Advocacy Center founded by a nonprofit public/private collaboration cofounded by the Dallas Police Department and the Dallas County District Attorney's Office. Referrals came mainly from police, CPS, and DCAC forensic interviewers. We studied children's entry into therapy 2–3 months post-referral, asking one broad and one narrower question: (1) How are families who decline versus initiate child therapy different with respect to their children; the abuse these children experienced; their families' demographics, response to the abuse, and functioning; and their perceptions of their children, families, therapy and DCAC? (2) Does a child's entry into therapy vary depending on the timing and source of the therapy referral?

Method

Subjects

We reviewed the DCAC, police and CPS case records of all children 3–17 years old who were referred to therapy at DCAC over the first 6 months of 2004 and whose sexual abuse investigation involved DCAC. We excluded the case records of children who (a) had entered foster care by the time of the referral, (b) were reported by CPS or caregivers to be receiving therapy elsewhere (as we were unable to confirm this; $N = 12$) or (c) had siblings already attending therapy at DCAC. We also excluded two cases of teenagers who had been declared independent by the state (i.e., caregivers were no longer legally responsible for them) and were self-referred. In the few cases where more than one child from a single family met study criteria, one child was randomly selected for the sample. Using these criteria, we identified 101 children who were eligible for the study and reviewed the case records of all.

Procedures

Therapy referral. A family's first visit to DCAC is generally for a forensic interview of a child (i.e., an investigative interview to assess the truth of allegations about abuse). After the interview, the child is referred for therapy if abuse was disclosed or is highly suspected. Children may also be referred to therapy when abuse is suspected and a child is uncooperative with an interview. Family members are referred, too, if they experience significant distress. Per DCAC policy, investigators and the interviewer meet after the interview to plan next actions, with no formal policy specifying who should make the therapy referral and how soon it should be made. When a referral is planned, caregivers are informed that they will receive the referral and instructions through the mail. Caregivers are then mailed a letter citing the referral and its source and describing the process and purpose of therapy, with a request for a telephone reply within 2 weeks. Therapists are assigned for families who respond to the letter.

Research consent and interview. Caregivers received a research interview consent form 2 months after being sent the therapy referral. When caregivers had initiated therapy, the child's therapist presented the consent form to caregivers and scheduled interviews to occur during the child's next therapy session, with the interviewer meeting with the caregiver as the child met with the therapist. At the time of the research interview, the interviewer then reviewed the consent form with the caregiver, and, with the caregiver's oral and written consent, presented a research assent form and family functioning questionnaire to the child, if over 8 years of age. Caregivers who had declined therapy were mailed a consent form and, if applicable, a child assent form, with a stamped, self-addressed return envelope. A follow-up call was made a week later to answer questions and arrange an interview. Case records were used to gather demographic data and data about the sexual abuse.

Interview consent forms were given to the first 76 of the 101 families for whom we had gathered case record data until we had collected a sample of 45 families for semi-structured interviews (45 was the limit due to grant funding). Of the 76 families receiving consent forms, 75% responded, 67% consented and 59% followed through, leading to a final sample of 45. By group, 30 caregivers who had initiated therapy received consent forms, 28 (93%) responded, and 26 (87%) consented; 46 caregivers who had declined therapy received consent forms, 28 (61%) responded and 25 (54%) consented. A total of 25 initiators and 20 decliners were interviewed (83% and 43%, respectively of those who received consent forms).

Interviews were 25–60 minutes, and included the Self-Report Family Inventory (SFI; Beavers & Hampson, 1990) and the Eyberg Child Behavior Inventory (ECBI; Eyberg & Pincus, 1999), which were given to parents after the oral question-and-answer part of the interview. The first three authors of the present study as well as a fourth therapist at DCAC conducted interviews using a protocol adapted from DePanfilis and Ernst (1999). Each parent was interviewed by only one interviewer; however, several interviewers were needed to accommodate caregivers' schedules. One of the interviewers was responsible for all Spanish interviews. Interviewees were compensated $30 for their time.

DCAC has no IRB affiliations. Protocols for consent and participants' rights protection followed Timberlawn Psychiatric Research Foundation guidelines and the "Ethical Principles of Psychologists and Code of Conduct" (American Psychological Association, 1992). The Timberlawn Psychiatric Research Foundation approved our interview and study protocol.

Measures

Research categorization. Children were categorized as entering psychotherapy if DCAC records showed that they attended at least one session. DCAC routinely records family members' age, sex, race/ethnicity, 1- or 2-parent status and number of children at home. A research information sheet, given to caregivers separately from routine paperwork, asked them about parental employment, income and education. Police, CPS, and CAC documents completed by investigators describe the child-offender relationship, nature and duration of abuse, specific acts involved, age of onset of abuse, as well as the families' histories of abuse/neglect investigations. One author entered all the data from case records and, for quality assurance, checked the data for each case a second time. Another author then checked the accuracy of data abstraction for a randomly selected 30 of the 101 cases and found no errors.

CPS documents noted whether a child had been removed from the home during the investigation. Removal was categorized as none, placement with relatives, caregiver and child co-relocation, and temporary placement with relatives. Police, CPS investigators, or both asked caregivers whether they believed their child had been sexually abused and recorded their answers, which we coded as yes or no (when caregivers expressed doubts that the abuse had occurred, this was coded as a 'no'). In cases involving CPS, the question is part of an evaluation of caregivers' willingness and ability to protect the child. Maternal neglectful supervision was recorded; this judgment was made by the CPS worker before or at the time of the therapy referral and was specific to a mother figure's response to the abuse before or upon its discovery. Specifically, a CPS worker alleged maternal neglectful supervision when there was clear evidence that the mother figure knew of or suspected the abuse and made insufficient or no attempts to end it (e.g., a mother figure admitted that the child had told her of the abuse, but said that she did nothing about it because she had believed the child was lying).

Two measures of timing of referral to therapy were used to identify whether referral delays at either of two different periods may have had an impact on children's entry into therapy. One measure was the number of days between the date of the initial abuse report to police or CPS and the referral to therapy. Another was the number of days between the forensic interview and the referral to therapy.

Caregiver's interview. A semi-structured interview that lasted 25–60 minutes was designed for the study to explore the caregiver's support network; perceptions of, and relationship with, the child; and perceptions related to therapy. The nine questions pertaining to these areas of inquiry were (1) What kind of contact do you have with your own family? (2) Who do you turn to when you're facing a hard situation or going through a hard time? (3) What do you enjoy doing with your child (or children)? (4) Who does your child (the one who was interviewed at DCAC) remind you of? (5) What do you like about your child? (6) What do you wish were different about your child? (7) What do you think therapy or counseling is? (8) When do you think therapy or counseling is helpful to somebody? (9) How comfortable do you feel about sharing private, personal information with a counselor or therapist: very uncomfortable, somewhat uncomfortable, somewhat comfortable, or very comfortable? These matters may influence caregivers' ability and willingness to initiate therapy for their children. Several of the interview questions were also intended to facilitate rapport building between the interviewer and caregiver. The first author translated the interview and the Eyberg Child Behavior Inventory into Spanish. Two DCAC staff from natively Spanish-speaking families verified the translations as meaningful and accurate.

The interview had open- and closed-ended questions, the latter consisting mainly of ordinal-scale responses (e.g., very uncomfortable, somewhat uncomfortable, somewhat comfortable, very comfortable). Interviewers probed for clarity when there were unclear responses. One author, using the original interview record, entered the interview data; a psychology master's-level graduate student, blind to the study's purpose and groups, checked the accuracy of data entry for 100% of the cases.

Child behavior inventory. The Eyberg Child Behavior Inventory (ECBI; Eyberg & Pincus, 1999) is a common parent checklist measuring the presence of 36 child conduct-problem behaviors and assessing parents' problems with these behaviors. Test-retest reliability coefficients for its scales vary from .75 to .88, and interrater reliability coefficients from .61 to .79 (see Eyberg & Pincus, 1999). Correlations with the Externalizing scale of the Child Behavior Checklist (CBCL) range from .65 to .85 for the ECBI problem scores and from .72 to .86 for the ECBI intensity scores. ECBI scores have been found to correlate significantly but less highly with the CBCL Internalizing scores (.34–.81) (Boggs, Eyberg, & Reynolds, 1990).

Family functioning. The Self-Report Family Inventory (SFI; Beavers & Hampson, 1990) was used to evaluate parents' perceptions of family competence, conflict, communication, cohesion, leadership, and expressiveness. Children who were at least 9 years old also completed it. The SFI has well-documented validity and reliability (see Franklin, Cody, & Jordan, 2004). The 36 self-report ratings correlate well with outside observers' perceptions of the family. It has a Cronbach's alpha of .86, and test-retest reliabilities vary from .88 at 1 month to .80 at 3 months (see Hampson, Hulgus, & Beavers, 1991).

Interview data coding

Two authors collaborated on developing a coding scheme for responses to the open-ended interview questions. The first author then coded all interviews, blind to group classification. To verify unbiased coding, a psychology master's-level graduate student, blind to the study's purpose and groups, coded a randomly selected 27% of the interviews using the

caregiver responses that the interviewer had written on the original interview record. Cohen's κ for interrater reliability between the two coders (Cohen, 1960) exceeded .60 for 93% of the codes and exceeded 70 for 73% of the codes. One variable (frequency of family contact, including extended) had Cohen's κ of .40 and an 'other' code for another variable had Cohen's κ of 53. Six codes that had non-significant Cohen's κ were excluded from analyses.

Data analysis

We analyzed case record data to find child, family, abuse, and therapy referral variables that differed between the two groups. We selected potential predictors according to the findings and suggestions of earlier research. Specifically, we analyzed four child variables (sex, race/ethnicity, age at abuse onset, age at referral), three family variables (caregiver belief, allegations of neglectful supervision, presence of family history of abuse/neglect allegations), three abuse variables (severity, duration, frequency, abuser relationship), and two therapy referral variables (timing using two time periods) for a total of 12 case record variables. Pearson χ^2 tests, Fisher exact tests and *t* tests identified group differences. Predictors were entered into binary logistic equations to determine their unique association with child entry into therapy.

For the 45 families who were interviewed, χ^2 tests, Fisher exact tests and *t* tests identified psychological and social differences between therapy-initiating and therapy-declining caregivers. We attempted to conduct a logistic regression analysis on the significant predictors for the 45 families who were interviewed, but the small sample size led to a certain combination of values having a zero count, which disrupts the estimation procedure and leads to invalid estimates. As an alternative, we computed additional contingency tables for the two strongest predictor variables with the therapy initiation variable, with the contingency table for each predictor variable stratified by the other. Stratifying crosstab tables this way is an alternative method of statistical control.

Results

Descriptive statistics

Case records. Fifty-four percent of the entire sample of 101 children had at least one therapy session. For analyses, these were defined as the therapy initiators. The other 47% of the sample who had never begun therapy were defined as the therapy decliners. The sources for case record data were similar across groups (police, 75% of therapy initiators vs. 84% of decliners, $n = 95$; CPS, 100% of initiators and decliners; interview, 84% of initiators and decliners, $n = 81$; supplemental sheet, 89% of initiators vs. 84% of decliners, $n = 46$). It should be noted that referrals to therapy mainly came from CPS (40% of initiators vs. 37% of decliners) and DCAC (35% of initiators vs. 28% of decliners, $n = 88$); 33% of initiator and 18% of decliner caregivers were also, themselves, referred to therapy ($p = ns$). At the end of data collection, 30 of these (55%) children who had started therapy were still attending it; 15 (27%) had ended therapy prematurely, and 10 (18%) had finished therapy.

Analysis of case record data. Table 1 presents frequencies on several case variables separately for child therapy initiators and decliners. Significant differences between initiators and decliners are noted with asterisks. Initiators of therapy were less likely to be Black (33%) compared to decliners of therapy (50%) (Table 1). Furthermore, a higher percentage of initiators of therapy had cases involving allegations of maternal neglectful supervision (24%) versus decliners (4%).

The timing of referral to therapy seemed to be a predictor, as it differed between the two groups: referrals of decliners were on average almost twice as long after the child's forensic interview than referrals of initiators (Table 1). Because the referral pattern by DCAC (average number of days after interview = 5.5, $SD = 6$) differed compared to the referral patterns of police ($M = 20.4$ days, $SD = 32.6$) and CPS ($M = 27.4$ days, $SD = 21$), however, we analyzed the relationship between referral timing and entry into therapy controlling for referral source (DCAC vs. CPS vs. law enforcement), using a binary logistic regression analysis. In this analysis, we found no significant relationship between either referral timing or source and entry into therapy.

Abuser oral-genital contact seemed to be a predictor, too; however, the χ^2 test was associated with a certain combination of values with a nearly zero count (11 of the 12 cases with alleged abuser oral-genital contact involved non-Black children), which would disrupt the subsequent binary logistic regression estimation procedure and lead to invalid estimates. We, therefore, computed additional contingency tables for the oral-genital contact variable with the therapy initiation variable, embedding each table within each level of the child's race (Black and non-Black). Stratifying variables this way is an alternative method of statistical control. Abuser oral-genital contact had no significant relationship to Black children's entry into therapy, Fisher exact test, $p = ns$, and was marginally statistically related to non-Black children's entry into therapy, Fisher exact test, $p < .08$.

In summary, only two case record variables were related to entry into therapy: child's race and the presence of allegations of maternal neglectful supervision. These two variables were entered into a binary logistic regression model, which correctly classified 63% of the cases (76% initiator, 45% decliner). The odds of entry into therapy were 2.1 times greater for non-Black versus Black children, though this was statistically non-significant ($p < .099$) and 13.9 times greater for children whose mother figures were accused of neglectful supervision ($p = .01$) (Table 2).

Table 1
Case data of initiators and decliners of child therapy

Variables	Total, *N*	Initiator (*N* = 55)	Decliner (*N* = 46)
Child			
Female	101	74.5%	85%
Black	101	33%[a]	50%*
White, Hispanic	98	54.5%	41.9%
White, non-Hispanic	98	12.7%	9.3%
Age at abuse onset (mean)	81	8.2	8.1
Age at referral (mean)	101	9.9	9.2
Family at referral			
Abuse/neglect hx	101	16%	22%
Primary caregiver believed child	84	81%	89%
Present alleged abuse			
Neglectful supervision	100	24%	4%**
Physical abuse	101	2%	2%
Severe sexual abuse categories	95–97		
Vaginal/anal intercourse		39%	33%
Child oral-genital		11%	12%
Abuser oral-genital		21%	2%**
Digital penetration		26%	21%
Duration > 1 week	66	65%	41%
Multiple incidents	78	71%	53%
Abuser			
Male	100	94.5%	96%
Age (mean)	97	28.6	28.6
White race	96	68%	44%
Relationship	100		
Parent/step-parent		16%	18%
Mother's paramour		11%	11%
Relative		34.5%	27%
Known adult		24%	31%
Known child/adolescent		11%	9%
Other		4%	4%
Referral timing (mean)			
Days from report	94	31	62
Days from interview	90	17	32**

[a] Because of rounding, the sum of the percentages slightly exceeds 100%.
* $p < .05$.
** $p < .01$.

Analysis of interview responses. The case data of the 45 interviewed families showed similar differences between study groups, compared to the larger sample of 101, suggesting that interviewed caregivers were representative of non-interviewed ones.

Of the 16 comparisons made, we found three differences between decliners and initiators (Table 3). When asked what they liked to do with their children, most caregivers who declined child therapy said that they liked going places with the child (e.g., going shopping, to the movies, out to eat) compared to fewer than half of therapy initiators who reported this. When asked what therapy was, few decliners said therapy was for emotional help or change, whereas over half of initiators said

Table 2
Final logistic regression predicting families' starting child therapy ($n = 97$)

Predictor	β	*SE*	Wald	*df*	Odds ratio	95% CI
Child Non-Black	.74	.45	2.72†	1	2.10	.87–5.06
Maternal neglectful supervision	2.63	1.07	6.05*	1	13.90	1.71–113.21

Note. Child race was dummy coded as 0 = Black, 1 = non-Black; and maternal neglectful supervision was dummy coded as 0 = no, 1 = yes. Child therapy referral responses were coded as 0 = decline and 1 = entry.
* $p = .01$.
† $p = .099$.

Table 3
Interviewed caregivers' common responses to open-ended questions[a] and child behavior and family functioning mean scores

Variables	$N = 44–45$	Initiator ($N = 25$)	Decliner ($N = 20$)
Frequent family contact		56%	50%
Turn to family/friends for support		64%	80%
Like playing/singing/recreating with child		71%	55%
Going places		37.5%	80%*
Reading/homework/teaching		21%	35%
Child reminds of other parent		16%	35%
Like child's personality		68%	60%
Everything		28%	30%
Wish child's personality different		40%	30%
Therapy is insight/cognitive change		48%	60%
Emotional help/change		56%	25%*
Feelings talk/venting		25%	40%
Dealing with problems		28%	35%
Helpful at/for any time		40%	30%
Comfort with therapy disclosure		76%	47%*,b
Personal CSA history		36%	20%
Child behavior (ECBI)			
Intensity		53.40	50.21
Problem	41	55.13	52.33
Family functioning (SFI)	41		
Competence		1.96	1.61†
Cohesion		2.20	2.08
Conflict		2.12	1.73*
Leadership		2.30	1.88
Expressiveness		1.86	1.44†

Note: Lower means on the SFI indicate higher perceived functioning.
[a] The personal history of abuse question was closed-ended.
[b] Ordinal-scale response options.
† $p < .08$.
* $p \leq .05$.
** $p \leq .01$.

this. Finally, caregivers who declined versus initiated therapy for their children more often endorsed being uncomfortable disclosing personal, private information to a therapist. Reasons for declining child therapy included a work conflict (50%, $n = 10$), DCAC was inaccessible (40%, $n = 8$), child was symptom-free (15%, $n = 3$), caregiver was busy (15%, $n = 3$), or caregiver wanted to forget the abuse or wanted the child to forget it (15%, $n = 3$).

Analysis using standardized instruments. We compared caregivers initiating child therapy to caregivers declining it on the ECBI and the SFI (Table 3). Caregivers from both groups reported similar, low levels of child problem behaviors on the ECBI. Caregivers who declined child therapy reported lower scores on the SFI conflict, competence, and expressiveness scales (lower scores signify higher functioning) than those who initiated it.

Multi-variable analysis of interview data. The stratified crosstab tables revealed that enjoying going places with the child was associated with declining therapy, when caregivers did *not* identify therapy as emotional help, Fisher exact test, $p = .004$ (Table 4).

Because of our small sample size of interviewed caregivers, our statistical power for finding significant results for medium or smaller effect sizes was limited. At least 26 participants per group would have been needed to detect a medium effect size with statistical power of .80 at $\alpha = .05$ for Pearson χ^2 tests with 1 *df* (Cohen, 1992).

Discussion

Results showed that 46% of the abused children referred to DCAC for therapy over a 6-month period never started it within 2 months. Children least likely to begin therapy were Black versus non-Black and, contrary to what might be expected intuitively, were less likely to have mother figures alleged to have failed to protect the child from sexual abuse. In interviews, caregivers who had declined versus initiated therapy were also less likely both to view therapy as emotional help and to say that they enjoyed certain kinds of activities with their children.

Table 4
Subgroup analysis of caregivers' starting therapy for their children stratified by perception of therapy as emotional help ($n = 44$)

	Caregiver response	
	Initiator ($n = 24$)	Decliner ($n = 20$)
Subgroup who reported that therapy was for emotional help ($n = 19$)		
Enjoys going out		
Yes	8 (62%)	5 (38%)
No	6 (100%)	0 (0%)
Subgroup who did not report that therapy was for emotional help ($n = 25$)		
Enjoys going out		
Yes	1 (8%)	11 (92%)**
No	9 (69%)	4 (31%)

** $p = .004$.

Pre-referral differences between families who decline versus initiate child therapy

Child race. Although past studies suggest that children from minority groups are less likely to enter therapy (Haskett et al., 1991; Tingus et al., 1996), little attention has been paid to differences between specific minority groups. Contrary to Tingus et al.'s (1996) qualitative finding of lower rates of entry into therapy among Hispanics versus Blacks, the present study showed that the odds of therapy entry were over two times lower for Black children compared to a mainly Hispanic sample of White children, though this difference was statistically non-significant ($p < .099$). Nonetheless, our finding that Black children had this lower rate of entry into therapy compared to Hispanic children suggests that minority status alone might fail to explain fully the lower rates of entry into therapy among Black children.

An oft-given explanation for Blacks' lower use of therapy is their heavier reliance on informal versus formal help (Chatters et al., 1989), though it is unclear that this reliance is specific to Blacks. Although a higher percentage of Black (80%) versus non-Black (61%) caregivers said that they turned to friends or family for support during hard times, the difference was non-significant. Few Black (14%) and non-Black (17%) caregivers said they turned to authorities, therapists or the church.

Other research results that may assist with explanations of Black children's lower rate of entry into therapy include the finding that Black versus Latino adults may be less comfortable disclosing their own histories of abuse within a group (Fontes, Cruz, & Tabachnick, 2001), and yet, Black, versus White (non-Hispanic) or Hispanic, mothers may be more supportive of their children's abuse disclosures (see Kenny & McEachern, 2000). If their cultural community is especially "private" about abuse histories, Black mothers may see themselves as responsible for their children's recovery rather than others, including therapists.

Maternal neglectful supervision. CPS allegations of maternal neglectful supervision that preceded or co-occurred with the therapy referral were positively related to a child's entry into therapy. To understand this finding, it helps to consider that cases involving alleged maternal neglectful supervision share two attributes: (1) evidence that a mother figure failed to report known abuse or to protect the child, despite being aware of the chance of abuse and (2) the mother figure's signing of a CPS safety plan declaring that she will protect her child by, among other actions, getting therapy for the child. For the present sample, a safety plan co-occurred with maternal neglectful supervision allegations 100% of the time, suggesting that the use of such plans is partly intended to ensure that certain children enter therapy. It is likely that caregivers' concerns that they may lose their children unless they comply with the therapy recommendation partly explain the apparent success of these plans at achieving this compliance. Although our research falls short of an evaluation of such safety plans, it does suggest that they may effectively increase rates of children's entry into therapy. No relationship was found between a caregiver's CSA history and response to the child's referral, consistent with research on maternal responses to sexually abused children (Deblinger, Stauffer, & Landsberg, 1994).

Differences between interviewed caregivers who initiated versus declined child therapy

Most interviewed caregivers (80%) declining child therapy initially saw its relevance, suggesting reasons other than a general attitudinal stance against therapy for their declining it (see Finkelhor et al., 2001). Our findings suggest these reasons may revolve around caregivers' focus of attention. On the one hand, these caregivers may focus on mediating activities when with their children. Caregivers who declined, versus initiated, child therapy more often described activities that involved "going places" as what they enjoyed doing with their children, whereas other responses appeared more child-centered—talking to the child; playing, singing or recreating with the child; teaching, reading or doing homework with the child; or simply being together with the child. Given this contrast, we tentatively suggest that the "going places" response might reflect parent- versus child-centeredness to the extent that going places involves the child's accompanying the caregiver as she pursues her own interests. On the other hand, caregivers who decline child therapy may overlook the emotional benefits of therapy, as they less often described therapy as emotional help or change. Together, these findings suggest a need for attention to be given to caregivers' awareness of their children's needs and how therapy can help meet them.

Of note, interviewed initiators and decliners reported similar, low levels of child problem behaviors, but decliners reported lower levels of family conflict and higher levels of family competence and expressiveness. Thus, their perception of low child problem behavior and higher family functioning may help explain why decliners were decliners.

Barriers to child therapy. Eighty percent of interviewees who declined child therapy believed, during the abuse investigation, that their child needed it. Most obstacles to therapy that caregivers identified were practical ones, suggesting that a larger number of options for therapy locations and delivery may need to be developed. For some families, more active case outreach than giving referrals to therapy (i.e., notifying families that therapy has been made available to them at a particular organization) may be needed.

Limitations. We are unable to be entirely certain whether the differences found after caregivers had initiated or declined therapy existed prior to their response to the therapy referral. Additionally, interviewed decliners may have differed from the larger group of decliners. Though 83% of caregivers whose children began therapy were contacted for an interview, only 43% of the caregivers who had declined therapy were contacted. Further, decliners who were interviewed were more accessible than non-interviewed ones (the phone numbers for 27% of non-interviewed therapy-declining families were invalid and unlisted at follow-up), suggesting different life circumstances between the interviewed and non-interviewed decliners. Finally, our results focus on initiation of therapy at one center, limiting their generalizability.

Conclusions

We believe further study will show that working with caregivers of sexually abused children who decline therapy for these children demands recognizing both the caregivers' and children's needs. If professionals can better identify which sexually abused children are unlikely to get *and* continue therapy, they can begin to evaluate different ways of working with their families to change this. At this time, the present study, consistent with past research, indicates that nearly half of sexually abused children referred to therapy never start it and that Black children are overrepresented among these children.

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References

American Psychological Association. (1992). Ethical principles of psychologists and code of conduct. *American Psychologist*, *47*, 1597–1611.
Beavers, W. R., & Hampson, R. B. (1990). *Successful families: Assessment and intervention*. New York: W.W. Norton.
Boggs, S. R., Eyberg, S., & Reynolds, R. A. (1990). Concurrent validity of the Eyberg Child Behavior Inventory. *Journal of Clinical Child Psychology*, *19*(1), 75–78.
Chatters, L. M., Taylor, R. J., & Neighbors, H. W. (1989). Size of informal helper network mobilized during a serious personal problem among Black Americans. *Journal of Marriage and the Family*, *51*, 667–676.
Cohen, J. (1960). A coefficient of agreement for nominal scales. *Educational and Psychological Measurement*, *10*, 37–46.
Cohen, J. (1992). A power primer. *Psychological Bulletin*, *112*(1), 155–159.
Cohen, J. A., Deblinger, E., Mannarino, A. P., & de Arellano, M. A. (2001). The importance of culture in treating abused and neglected children: An empirical review. *Child Maltreatment*, *6*(2), 148–157.
Corcoran, J. (2004). Treatment outcome research with the non-offending parents of sexually abused children: A critical review. *Journal of Child Sexual Abuse*, *13*(2), 59–84.
Deblinger, E., Lippman, J., & Steer, R. (1996). Sexually abused children suffering posttraumatic stress symptoms: Initial treatment outcome findings. *Child Maltreatment*, *1*(4), 310–321.
Deblinger, E., Stauffer, L., & Landsberg, C. (1994). The impact of a history of child sexual abuse on maternal response to allegations of sexual abuse concerning her child. *Journal of Child Sexual Abuse*, *3*(3), 67–75.
DePanfilis, D., & Ernst, J. S. (1999). *Interview coordinator's manual: Specifications for facilitating research interviews*. Baltimore, MD: Family Connections.
Eyberg, S., & Pincus, D. (1999). *Eyberg child behavior inventory & Suttter-Eyberg student behavior inventory-revised*. Odessa, FL: Psychological Assessment Resources.
Finkelhor, D., & Berliner, L. (1995). Research on the treatment of sexually abused children: A review and recommendations. *Journal of the American Academy of Child and Adolescent Psychiatry*, *34*(11), 1408–1423.
Finkelhor, D., Wolak, J., & Berliner, L. (2001). Police reporting and professional help seeking for child crime victims: A review. *Child Maltreatment*, *6*(1), 17–30.
Fontes, L. A., Cruz, M., & Tabachnick, J. (2001). Views of child sexual abuse in two cultural communities: An exploratory study among African Americans and Latinos. *Child Maltreatment*, *6*(2), 103–117.
Franklin, C., Cody, P. A., & Jordan, C. (2004). Validity and reliability in family assessment. In A. R. Roberts & K. R. Yeager (Eds.), *Evidence-based practice manual* (pp. 436–443). New York: Oxford University Press.
Golan, N. (1986). Crisis theory. In F. Turner (Ed.), *Social work treatment: Interlocking theoretical approaches* (pp. 317–361). New York: The Free Press.
Gomes-Schwartz, B., Horowitz, J. M., Cardarelli, A. P., & Sauzier, M. (1990). The aftermath of child sexual abuse: 18 months later. In B. Gomes-Schwartz, J. M. Horowitz, & A. P. Cardarelli (Eds.), *Child sexual abuse: The initial effects* (pp. 132–170). Newbury, CA: Sage.
Hampson, R. B., Hulgus, Y. F., & Beavers, W. R. (1991). Comparisons of self-report measures of the Beavers System Model and Olson's Circumplex Model. *Journal of Family Psychology*, *4*(3), 326–340.
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*, 467–476.
Horowitz, L. A., Putnam, F. W., Noll, J. G., & Trickett, P. (1997). Factors affecting utilization of treatment services by sexually abused girls. *Child Abuse & Neglect*, *21*, 35–38.

Kendall-Tackett, K. A., Williams, L. M., & Finkelhor, D. (1993). Impact of sexual abuse on children: A review and synthesis of recent empirical studies. *Psychological Bulletin*, *113*(1), 164–180.
Kenny, M. C., & McEachern, A. G. (2000). Racial, ethnic, and cultural factors of childhood sexual abuse: A selected review of the literature. *Child Psychology Review*, *20*(7), 905–922.
Kerkorian, D., McKay, M., & Bannon, W. M. (2006). Seeking help a second time: Parents'/caregivers' characterizations of previous experiences with mental health services for their children and perceptions of barriers to future use. *American Journal of Orthopsychiatry*, *76*(2), 161–166.
Lane, W. G., Dubowitz, H., & Harrington, D. (2002). Child sexual abuse evaluations: Adherence to recommendations. *Journal of Child Sexual Abuse*, *11*(4), 17–33.
Molnar, B. E., Buka, S. L., & Kessler, R. C. (2001). Child sexual abuse and subsequent psychopathology: Results from the national comorbidity survey. *American Journal of Public Health*, *91*(5), 753–760.
Paolucci, E. O., Genuis, M. L., & Violato, C. (2001). A meta-analysis of the published research on the effects of child sexual abuse. *The Journal of Psychology*, *135*(1), 17–36.
Putnam, F. W. (2003). Ten-year research update review: Child sexual abuse. *Journal of the American Academy of Child & Adolescent Psychiatry*, *42*(3), 269–278.
Saywitz, K. J., & Mannarino, A. (2000). Treatment for sexually abused children and adolescents. *American Psychologist*, *55*(9), 1040–1049.
Schechter, D. S., Brunelli, S. A., Cunningham, N., Brown, J., & Baca, P. (2002). Mother-daughter relationships and child sexual abuse: A pilot study of 35 dyads. *Bulletin of the Menninger Clinic*, *66*(1), 39–60.
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.