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Caregivers' Abuse Stigmatization and their Views of Mental Health Treatment Following Child Sexual Abuse

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Abstract

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; $M_{age} = 10.94$, $SD_{age} = 2.62$). 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.

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Keywords

sexual abuse; caregivers; stigma; PTSD; treatment barriers; motivation; shame; self-blame; child maltreatment. child advocacy center

Childhood sexual abuse (CSA) is a prevalent and insidious form of violence worldwide. In the United States (U.S.) alone, CSA is experienced by approximately 19.8 – 33.5% of females and 2.6% – 7.6% of males by the age of 17 years (Finkelhor, Shattuck, Turner & Hamby, 2014). There is extensive evidence that CSA renders youth vulnerable to a range of mental health and behavior problems that can persist into adulthood, with significant costs to individuals and society (Paolucci, Genuis, & Violato, 2001; Schilling, Aseltine, & Gore, 2007). Fortunately, there are effective treatments for reducing the potential negative mental health consequences of CSA. For example, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT; Cohen, Mannarino & Deblinger, 2006; Deblinger & Haflin, 1996) can significantly reduce mental health problems among child victims of CSA in 8–12 sessions, with durable improvements in abuse-related symptoms noted for up to a year post-treatment (Deblinger, Mannarino, Cohen & Steer, 2006). Non-offending caregivers (i.e., legal guardians who were not identified as perpetrators of the alleged CSA) are often gatekeepers to youths' enrollment and continuation in mental health treatment (Burnett-Zeigler and Lyons 2010; McKay and Bannon 2004). However, one-third to one-half of U.S. children do not receive mental health services after CSA, even when offered at low or no cost (Haskett, Nowlan, Hutcheson, & Whitworth, 1991; Lane, Dubowitz, & Harrington, 2002; Lippert, Favre, Alexander, & Cross, 2008; McPherson, Scribano, & Stevens, 2012; Tingus, Heger, Foy, & Leskin, 1996). Little is known about the reasons caregivers do and do not seek treatment in the wake of CSA. Identifying potentially modifiable factors that impede caregivers' initiation of therapy is especially important for efforts to bridge the gap between the number of youth who may need versus those who receive interventions that can reduce short- and long-term negative consequences of CSA.

The current study focuses on non-offending caregivers' abuse-specific reactions to their children's CSA. Specifically, we were interested in caregivers' feelings of shame and attributions of self-blame for their children's abuse, collectively defined as abuse stigmatization (Feiring, Taska, & Lewis, 1996). These negative emotions and appraisals about CSA may arise during the discovery processes and continue once the abuse and its discovery have ended. Recent findings suggest that abuse stigmatization may be common among non-offending caregivers; yet little is known about their implications for children's engagement in treatment (Fong et al., 2016; Holt, Cohen, Mannarino, & Jensen, 2014). Such reactions are important because they are potentially modifiable in ways that might increase caregivers' receptivity to trauma-focused services. Toward this end, we examined relations between caregivers' abuse stigmatization and two factors that predict treatment engagement and completion - motivation and perceived obstacles.

Correlates of Mental Health Service Utilization following CSA

Research on factors associated with mental health service utilization after CSA has largely focused on static features, such as child demographics, abuse characteristics, and agency

involvement (Haskett et al., 1991; Lane et al., 2002; Lippert et al., 2008; McPherson et al., 2012; Tingus et al., 1996). These data suggest that Caucasian compared to Hispanic and African American children and children ages 7–13 compared to younger children are more likely to enroll in treatment (Tingus et al., 1996). Youth with a history of penetrative or repeated CSA (Tingus et al., 1996), abnormal physical findings (Lane et al., 2002), out of home placement (Tingus et al., 1996), and greater agency involvement (Tingus et al., 1996) are also more likely to receive treatment. Caregivers with more children in the household and those with personal trauma or therapy experiences are also more likely to enroll in or complete trauma-focused therapy (Self-Brown, Tiwarj, Lai, Roby, & Kinnish, 2016). These findings identify which caregivers might seek mental health services; however, they do not explain *why* caregivers do or do not initiate treatment. Understanding the reasons motivating or hindering treatment initiation is vital for improving service utilization and family well-being following CSA.

Caregivers report various obstacles to treatment engagement that may account for decreased service utilization. These obstacles are consistent with theoretical models of therapy engagement and mirror those reported by caregivers in other therapy contexts (e.g., Reardon et al., 2017; Straudt, 2007). External obstacles, such as time or work demands, personal stressors, and therapist accessibility are common reasons for declining services following CSA, even when services are offered at little to no cost (Lippert et al., 2008). Lack of knowledge about how and where to access treatment is another common concern (Lane et al., 2002). Psychological obstacles related to the therapy process have also been reported. For example, caregivers may not perceive therapy as relevant or important following CSA. For most families in the United States, the immediate response to CSA involving children ages 16 years and younger, discovery is forensic, and involvement in the cascade of legal and child protection proceedings may overshadow views of CSA as a mental health risk or an event needing a mental health response. When comparing caregivers who did and did not initiate services following CSA, Lippert et al. (2008) found that caregivers who did not initiate services viewed therapy as less beneficial, were less trusting of therapy, and were more uncomfortable about disclosing personal information to a therapist.

Caregiver Reactions to Child Sexual Abuse

Less studied, but potentially important to treatment engagement, are caregivers' reactions to their children's sexual abuse. The discovery of CSA can be quite distressing for caregivers (Carter, 1993; Elliot & Carnes, 2001; Everson, 1989; Kelley, 1990; Newberger, Gremy, Waternaux, & Newberger, 1999). Although most studies focus on caregivers' posttraumatic stress and general distress, abuse-specific stigmatization, including self-blame or guilt for CSA and feelings of shame are also quite common (Fong et al., 2016; Holt et al., 2014; Holt, Cohen & Mannarino, 2015). Caregivers' abuse stigmatization can be understood in light of theories that emphasize child protection as a primary role of caregivers (Bowlby, 1982; George & Solomon, 2008). When children are victimized, non-offending caregivers may blame themselves for failing to prevent the abuse and experience shame for failing in this core aspect of identity. Shame is a painful form of self-condemnation that is experienced as a desire to hide the damaged self from others (Feiring, Taska, & Lewis, 2002). Self-blame and shame for CSA are interrelated and have collectively been conceptualized as abuse

stigmatization (Feiring et al., 2002; Holt et al., 2015). Among children, abuse stigmatization is fairly common and may subside over the year following CSA discovery (Feiring et al., 2002). However, the persistence of abuse stigmatization is associated with various long-term psychosocial problems (BLINDED REFERENCES).

Less is known about the salience of caregivers' abuse stigmatization for their decisions about seeking child treatment following CSA. Research linking stigmatization with social disengagement and avoidance (Ehlers & Clark, 2000; Ketelaar & Au, 2003; Tangney, Steuwig, & Mashek, 2007: BLINDED REFERENCE), suggests that caregivers experiencing shame and self-blame for their children's CSA may be reluctant to seek mental health services. In support of this idea, that caregivers' endorsing high self-stigma, defined as devaluation of the self for having a child in need of treatment, reported a lower likelihood of attending parenting classes, even when they perceived their children as having mental health problems (Dempster et al., 2015). Caregivers' stigmatization may affect their decrease motivation for treatment or increase their perception of obstacles to treatment engagement. The motivational components of treatment engagement include perceiving need for change, desire for change, willingness to change, and belief in one's ability to change or hope (Miller & Rollnick 1992; Nock & Photos, 2006; Prochaska, DiClemente, & Norcross, 1992). Shame and self-blame for their children's CSA may also affect how caregivers' view potential obstacles to treatment (Dempster, Davis, Jones, Keating, & Wildman, 2015; Dempster, Wildman, & Keating, 2013). Caregivers experiencing abuse stigmatization may have heightened concerns about how therapists will view them, what therapists will ask of them, and the potential gains versus costs of treatment. Indeed, apprehension about the relevance of therapy, skepticism about its benefits, discomfort with personal disclosure, and concerns about being misunderstood or judged unfavorably by treatment providers are among the most commonly reported concerns about treatment following CSA disclosure. We expected that greater caregiver stigmatization would be associated with decreased motivation and more obstacles for engaging in treatment.

Caregiver Stigmatization in the Context of Youths' Posttraumatic Stress

Referrals to mental health services following CSA are often based on screenings of youths' posttraumatic stress or behavior problems. Research on families affected by CSA as well as specific forms of child psychopathology indicate that families are more likely to initiate treatment for children with more severe or urgent problems (Lane et al., 2002; Teague, 2002). This may be a clearer solution for caregivers who are not burdened by their own shame and self-blame for their children's sexual abuse. However, among caregivers struggling with abuse stigmatization, their own distress may be at odds with the perceived demands of treatment engagement, resulting in more treatment ambivalence. Compared to caregivers experiencing little or no stigma, they may be less motivated to initiate treatment and perceive greater obstacles to engagement. Such effects may be especially pronounced when considering psychological versus practical obstacles to treatment (Dempster et al., 2015). Accordingly, we expected that youths' PTSD symptoms would be more strongly related to higher motivation for treatment and fewer obstacles to engagement among caregivers with low versus high abuse stigmatization.

Current Study

Strengthening mental health service utilization to reduce the potential negative mental health consequences associated with CSA requires a trauma-focused approach to families' needs. Efforts to increase the number of families who enroll in treatment have the potential to make a large impact on the long-term adaptation of families. A first step is to identify specific and potentially modifiable barriers to mental health service utilization among families with recently discovered cases of CSA, especially for youth with elevated symptoms of distress.

The current study focused on caregivers receiving services from a Child Advocacy Center (CAC) following the discovery of CSA. CACs serve as a best practice model for coordinating a multidisciplinary response to CSA. In addition to providing forensic interviews and medical evaluations, many CACs seek to identify and help distressed families by providing mental health screenings, information about the relevance of child therapy, and referrals to low or no-cost trauma-focused therapies. Many also provide trauma-focused therapy to the families they serve as well and reduce obstacles to engagement by providing transportation or in-home services. Although data indicate that CACs reduce the time of investigation and criminal proceedings following CSA discovery, it is unclear whether they increase the chances children will obtain needed mental health services (Lippert et al., 2008).

The goal of the study was to establish whether caregivers' abuse-specific reactions of shame and self-blame were relevant for understanding mental health service utilization following the discovery of CSA. We examined two key correlates of treatment initiation and completion that have been demonstrated to be amenable to intervention: motivation for treatment and perceived obstacles to engagement. We expected that greater stigmatization would be associated with less motivation and more perceived obstacles to therapy, particularly psychological obstacles about the therapy process itself. Because CSA affects both caregivers and youth, we believed it was important to understand how their unique and combined effects on caregivers' views of therapy. Although child maladjustment might typically encourage a more positive orientation towards therapy, it may heighten ambivalence among caregivers experiencing high stigmatization. We therefore expected that caregiver stigmatization would moderate relations between child symptoms and view of treatment such that child symptoms would be most strongly associated with positive attitudes (high motivation/low obstacles) when stigmatization was low.

Method

Sample Selection and Characteristics

Participants for the current study included 52 youth (69% female) aged 6–15 years ($M = 10.94$, $SD = 2.62$) and their non-offending caregivers (82% biological parents; 10% non-biological parent; 6% custodial grandparent; 2% other relative) who received forensic interview services at an urban, midwestern Child Advocacy Center (CAC) for newly discovered cases of alleged CSA. Eligible families were identified by CAC personnel providing advocacy services to non-offending caregivers during the child's forensic interview as: youth between 6–16 years of age, in the custody of a non-offending parent or

caregiver, and fluent in English. CAC staff talked to families and obtained permission for the research project staff to contact them to discuss the study. Study personnel made contact with 58 of 60 interested families, and one was ineligible due to the child being diagnosed with an intellectual disability. Of the remaining 59 families, 55 families agreed to be in the study, and 52 completed the study. The 3 non-completing families failed to show for their scheduled and re-scheduled appointments and were subsequently lost to contact.

The sample was demographically similar to that of the broader population seen at this CAC and the city it serves. The majority of families identified as African American (78% youth, 76% caregivers), followed by Hispanic (12% youth, 6% caregivers), Caucasian (4% youth, 12% caregivers), and bi-racial (6% youth, 6% caregivers). Seventy-seven percent of caregivers had a high school education or equivalency diploma, 23% had not completed high school, and 9% earned a post-high-school technical degree. Approximately half (52%) of youth had previously received mental health treatment for emotional or behavior problems. Information about abuse characteristics was not obtained in this study due to the ongoing nature of the investigations and a need to maintain separation between forensic and research procedures. Caregivers did answer questions pertaining to their certainty that their child had been sexually abused, and the vast majority of caregivers (98.08%) were confident that CSA occurred.

Procedure

All procedures for this study were generated in collaboration with CAC staff and approved by the institutional review boards of the academic institution where the research took place as well as the Department of Community Health for the state in which the research occurred. Participating families were seen at our research lab within 8 weeks of their forensic interview; and transportation assistance was provided as needed. Caregivers provided written informed consent, and youth provided written informed assent for their participation. Both were informed that the research study had no bearing on the investigation of their CSA cases or the services they might receive from the CAC.

Assessment data were gathered by trained staff members who interviewed caregivers and youth separately in private offices. All data except for caregiver stigmatization was obtained by the interviewer. Caregiver provided information about their abuse stigmatization as part of a computer-assisted self-interview. All questions were read aloud to participants either by the interviewer or audio-computer-assisted interviewing. After the assessment, the interviewer scored the standardized measures of child symptoms (e.g., PTSD, internalizing, externalizing), and caregivers were offered the opportunity to receive feedback on their child's functioning. Participants received \$50 for the assessment, and youth also picked out an inexpensive prize (e.g., school supplies, game, or toy).

Measures

Demographic Risk—Caregivers provided information to interviewers about their employment, educational, and marital status. Following prior work, we created a cumulative risk index (CRI; Sameroff, Seifer, Baldwin, & Baldwin, 1993) of socio-demographic factors associated with psychosocial functioning or perceptions of mental health services. A point

was assigned for each of the following dichotomized variables and then summed to create the CRI: single parent status (i.e., unmarried or unpartnered), low education (i.e., less than a high school diploma or GED), and being unemployed. The possible and observed scores ranged from 0 to 3 ($M = 1.87$, $SD = 1.02$).

Caregiver Stigmatization—Caregivers' abuse stigmatization was assessed via computer assisted audio interviewing using a scale that included 6 items indexing self-blame for their child's sexual abuse (e.g., "I could have prevented this from happening to my child.") and 6-items tapping shameful reactions (e.g., "I feel ashamed of myself"; "I want to go away by myself and hide."). Each item was rated on a 3-point scale indicating how well the statement described their reactions ("Very True", "Somewhat True", "Not at all True"), with higher scores indicating greater endorsement. Consistent with theory, the scores for self-blame and shame were significantly related ($r = .78$, $p < .001$), and the overall scale showed good reliability (Cronbach's $\alpha = .92$). In an effort to increase caregivers' sense of privacy while responding, this and other caregiver measures not included in this study were completed by audio-assisted computer interviewing methods while the interviewer was in another room (Miller, Cooley, & Seage, 2000).

Youth Posttraumatic Stress—Interviewers administered the UCLA PTSD Index for DSM–IV–Revised: Parent Version (UPID; Pynoos, Rodriguez, Steinberg, Stuber, & Frederick, 1998) to obtain caregiver reports of youths' posttraumatic stress. The UPID is 48-item assessment tool of trauma exposure and PTSD symptoms for children ages 6–18 years. Because we were interested in youth responses to CSA experiences, interviewers administered only the symptom questions, asking caregivers to answer regarding their children's reactions to their sexual abuse. The UPID has good convergent validity with other measures for PTSD (.70–.82) and high sensitivity (.93) and specificity (.87) in detecting PTSD. High internal consistency (Cronbach's α of .90) and test–retest reliability coefficients of 0.84 have been reported (Steinberg, Brymer, Decker, & Pynoos, 2004). Cronbach's α for current sample was .84.

Caregiver Motivation for Treatment—Caregiver motivation for child therapy was assessed by the interviewer using the Parent Motivation Inventory (PMI; Nock & Photos, 2006), a 25-item measure in which caregivers indicate their level of treatment motivation on a five-point scale (1 = strongly disagree; 5 = strongly agree). Items form a unidimensional scale that taps three components of motivation: (1) desire for child change (e.g., "I want my child's behavior to improve"), (2) readiness to change (e.g., "I am willing to change my current parenting techniques and try new ones"), and (3) perceived ability to change (e.g., "I believe that I am capable of learning the skills needed to change my child's behavior"). Research on the PMI supports a unidimensional measure with strong internal consistency and test-retest reliability (Nock & Photos, 2006). Reliability in the current sample was also strong (Cronbach's $\alpha = .91$).

Perceived Obstacles to Treatment—Interviewers administered the 14-item Obstacles to Engagement Scale (OES; Dumas, Nissley-Tsiopinis, & Moreland, 2007) to caregivers to assess the extent to which personal and intervention obstacles may interfere with child

treatment. The OES items were originally developed to assess perceived obstacles to attending parenting interventions. In the current study, we instructed parent to answer about factors that might interfere with from taking their child to a therapist or counselor in relation to CSA events. Item content remained the same with the exception of replacing the term “parenting program” with “therapy” in three items. The OES has four subscales: (1) Personal or family stressors and obstacles (4 items, e.g., “Would alcohol or drug problems in your family stop you from attending?”); (2) Relevance of and trust in the intervention (4 items, e.g., “Would fear of being misunderstood stop you from attending?”); (3) Intervention demands (4 items, e.g., “Would the belief that therapy does not work stop you from attending?”); and (4) Time and scheduling demands (2 items, e.g., “Would having to find time to go to meetings for several weeks in a row stop you from attending?”). Caregivers rated each item on a 4-point scale ranging from 1 “Definitely no” to 4 “Definitely yes.” In the present sample, Cronbach α ’s for the subscale scores were .79, .81, .76, and .64 respectively.

Missing data analyses indicated that less than 6% of data were missing on any given variable and that data was missing completely at random. Data were imputed in IBM SPSS 23 using Expectation Maximization imputation, which is of comparable accuracy to other imputation methods for data missing at random (Mu & Zhou, 2011; Lin, 2010). Reported results utilize the full imputed dataset.

Results

Descriptive Information

Child age, child gender, and family demographic risk were largely unrelated to caregiver reports of child PTSD symptoms, abuse stigmatization, treatment motivation or treatment obstacles. The one exception was that caregivers of girls reported fewer obstacles related to time/scheduling demands ($r = .31, p = .03$). Having a child who received mental health services before CSA discovery was associated with more severe PTSD symptoms ($r = .56, p < .001$) but was unrelated to caregivers’ abuse stigmatization, treatment motivation or any of the four treatment obstacle scales.

Table 1 provides descriptive information for the primary study variables as well as their bivariate associations. Greater caregiver abuse stigmatization was associated more youth PTSD symptoms. Greater caregiver stigmatization and youth PTSD were each associated with greater motivation for treatment. However, only caregiver stigmatization was associated with perceived treatment obstacles. Greater stigmatization was associated with more obstacles related to relevance and trust of treatment, intervention demands, and time/scheduling demands. Neither caregiver stigmatization nor youth PTSD were associated with obstacles related to personal/family stressors. Motivation for child therapy was unrelated to any of the obstacles to therapy scales. The obstacles scales were positively related to one another.

Predicting Motivation for and Obstacles to Treatment Engagement—The primary goal of this study was to examine whether caregiver abuse stigmatization and youth PTSD symptoms showed unique or interactive associations with motivation and obstacles

for child treatment. Toward this end, we ran a series of regressions predicting either treatment motivation or obstacles from caregiver stigmatization, youth PTSD symptoms, and the interaction of the two predictors. Independent and moderator variables were centered via standardization prior to analyses. As neither child nor family demographic variables were associated with the dependent variables, no covariates were included in the model. Significant interactions were probed using the Johnson-Neyman (J-N) technique within the SPSS PROCESS macro, which allows researchers to make inferences about the regions of significance of the effect of X on Y. These regions of significance indicate the level of the moderator variable below and above which the effect of interest is present or absent. Whereas traditional methods rely on arbitrary points of low and high levels of the moderator, (e.g., $M \pm 1$ SD), the J-N technique estimates the conditional effect of the independent variable at values of the continuous moderator that correspond to percentile scores within the sample distribution of the moderator. These percentiles will always fall within the range of the data of a given sample.

Table 2 shows the results of the regressions predicting caregiver attitudes toward child treatment. When interaction effects were non-significant, reduced main effects models are reported. Higher levels of caregiver stigmatization and child PTSD symptoms were each associated with greater motivation for treatment, and no interaction was observed. When predicting obstacles to therapy, caregiver stigmatization and youth PTSD again emerged as significant predictors; however, three of the four models showed a significant interaction between stigmatization and PTSD. Specifically, abuse stigmatization moderated associations of youth PTSD symptoms with obstacles pertaining to trust/relevance of treatment, intervention demands, and personal/family stressors. Neither caregiver stigmatization, youth PTSD symptoms, nor their interaction significantly predicted obstacles related to time and scheduling demands.

Figures 1 illustrates the interactions with plots of the associations between youth PTSD and obstacles related to trust/relevance of treatment at low (10th percentile), moderate (50th percentile), and high (90th percentile) levels of caregiver abuse stigmatization within the sample. At low and moderate levels of abuse stigmatization, youth PTSD symptoms were unrelated to obstacle ratings. However, among caregivers reporting high levels of abuse stigmatization, more severe youth PTSD symptoms were associated with *greater* obstacles related to trust/relevance of therapy, $b = .038$, $SE = .017$, $t(1,48) = 2.01$, $p = .05$. J-N analyses indicated that the relation between youth PTSD symptoms and obstacles related to trust/relevance of therapy transitioned from non-significant to significant at the 80th percentiles of the distribution of caregiver stigmatization, $b = .038$, $SE = .017$, $t(1,48) = 2.01$, $p = .05$.

Figures 2 illustrates the interactions with plots of the associations between youth PTSD and obstacles related to intervention demands at low (10th percentile), medium (50th percentile), and high (90th percentile) levels of caregiver abuse stigmatization. For caregivers reporting low levels of abuse stigmatization, stronger youth PTSD symptoms were associated with lower obstacle ratings, $b = -.0395$, $SE = .0146$, $t(1,48) = -2.45$, $p = .018$. However, among caregivers reporting high levels of abuse stigmatization, stronger youth PTSD symptoms were associated with *greater* obstacles related to intervention demands, $b = .045$, $SE = .021$,

$t(1,48) = 2.05, p = .05$. J-N analyses indicated that the relation between youth PTSD symptoms and obstacles related to intervention demands transitioned from non-significant to significant at the 56th percentiles of the distribution of caregiver stigmatization, $b = .023, SE = .011, t(1,48) = 2.01, p = .04$.

Figure 3 illustrates the interactions with plots of the associations between youth PTSD and obstacles related to personal/family stressors at low (10th percentile), medium (50th percentile), and high (90th percentile) levels of caregiver abuse stigmatization. For caregivers reporting low levels of abuse stigmatization, more youth PTSD symptoms were associated with lower obstacle ratings, $b = -.042, SE = .016, t(1,48) = -2.67, p = .011$. However, among caregivers reporting high levels of abuse stigmatization, more severe youth PTSD symptoms were associated with *greater* obstacles related to intervention demands, $b = .054, SE = .018, t(1,48) = 3.07, p = .004$. J-N analyses indicated two regions of significance in the relation between youth PTSD symptoms and obstacles related to personal/family stressors: (1) at and below the 48th percentile of the distribution of caregiver stigmatization ($b = -.03, SE = .013, t(1,48) = -2.01, p = .05$) and (2) at and above the 76th percentile of the distribution of caregiver stigmatization ($b = .03, SE = .012, t(1,48) = 2.01, p = .05$).

Discussion

The current study is among few that examine caregivers' abuse stigmatization and the first study we know of to examine the implications of caregivers' abuse stigmatization for children's mental health treatment. Our findings highlight the importance of abuse stigmatization for understanding caregivers' motivation for and obstacles to initiating mental health services in the wake of CSA discovery. Whereas higher levels of youth distress and caregiver abuse stigmatization were each associated with greater motivation for therapy, caregiver stigmatization moderated associations between youth distress and obstacles to therapy.

One implication of these findings is that motivation for therapy and obstacles to treatment engagement are interrelated but distinct aspects of caregivers' orientation towards mental health services with different correlates (Nock and Photos, 2006). Our bivariate findings indicated that caregivers who experienced greater abuse stigmatization reported more motivation for therapy but also more obstacles. Greater abuse stigmatization was related to viewing therapy as less relevant or trustworthy, more demanding on their cognitive and emotional resources, and more complicated by more personal and family stressors. Caregivers who viewed their children as more symptomatic were more motivated to engage for therapy. However, youth symptoms were unrelated to treatment obstacles. Whereas youth symptom severity has been associated with fewer treatment obstacles and higher levels of treatment engagement among families who voluntarily seek treatment for behavior problems in community clinics (i.e., non-forensic) samples (e.g., Salloum et al., 2016; Teagle 2002), such relations may not be assumed among families in the wake of CSA discovery who are receiving forensically based services. Unlike the caregivers in most studies of child clinic samples, who have already expressed some level of interest in mental health services, caregivers at CACs are in the throes of a stressful forensic process that they may not have initiated or was not initiated with the intent of seeking mental health

services. Alternatively, symptom severity may be unrelated to perceived obstacles but positively associated with initiating services.

A more complex picture of the relation between youth symptoms and treatment obstacles emerged when youth symptoms were viewed in the context of caregivers' abuse reactions. As anticipated, severity of youths' PTSD symptoms was inversely related to treatment obstacles pertaining to intervention demands and personal stressors for caregivers who were relatively unburdened by their own abuse stigmatization. For caregivers experiencing high abuse stigmatization, more severe youth symptoms predicted *more* treatment obstacles (with the exception of time/scheduling demands). Feeling high shame and self-blame for your child's abuse while also noting high levels of child distress may elevate caregivers' concerns that they will negatively evaluated by therapists, increase pessimism about what therapy can offer their children, and raise doubts about their ability to successfully meet the demands of therapy. The positive correlation between stigmatization and youth PTSD symptoms raises the possibility that youth symptoms may amplify the avoidance associated with stigma in ways that make treatment seem less manageable. These results are noteworthy, as families with highly distressed youth and caregivers are likely to be in high need of services.

Caregivers' responses to their children's CSA have significant implications for parenting and child adjustment, and additional research is needed to understand which caregivers are most vulnerable to abuse stigmatization following the discovery of their children's CSA (Cohen & Mannarino, 2000; Deblinger, Steer, & Lippmann, 1999). Our results are consistent with those of Holt and colleagues, who found that self-blame and shame are common among non-offending caregivers (Holt et al., 2014; Holt et al., 2015). Many youth have similar reactions to their CSA (Feiring & Taska, 2005). Although youths' stigmatization often subsides over the year following abuse discovery, its persistence is an important mechanism linking CSA to a range of long-term psychosocial problems (Feiring et al., 2009; Feiring et al., 2010; Feiring et al., 2013; Menke et al., in press; BLINDED REFERENCE). Early intervention may be just as important for caregivers' as for youths' abuse stigmatization. Supporting non-offending caregivers in ways that reduce their abuse stigmatization may not only benefit caregivers' well-being but also facilitate child adjustment following CSA through a variety of means including by breaking down barriers to treatment engagement. CAC's may be an ideal location to initiate parental intervention concerning self-blame and shame while their child is participating in the forensic interview.

Information about predisposing factors to abuse stigmatization would be useful for identifying caregivers in greatest need of support. Caregivers with childhood histories of maltreatment, for example, may be vulnerable to abuse stigmatization, especially if their feelings about their own abuse are not resolved (Menke et al., in press; BLINDED REFERENCES). Research on longitudinal relations among caregivers' abuse stigmatization, youths' reactions to CSA (including youth stigmatization), mental health service utilization and subsequent psychosocial adjustment are important for understanding the short- and long-term implications of caregiver stigmatization for family functioning following CSA. Relatedly, studies of case disposition would deepen our understanding of the impact of caregiver stigmatization on the initiation and completion of mental health services (Fung et al., 2016). Although the current findings speak to factors related to caregivers' mental health

service utilization, their interpretation is limited by the concurrent nature of the assessments and lack of information regarding which caregivers went on to initiate treatment.

Other potential limitations to the current study are also worth noting. For example, because many of our study families' CSA cases remained under investigation at the time of their participation, we were unable to ascertain the relevance of abuse substantiation or abuse severity for caregivers' attitudes about therapy. McPherson et al. (2012) reported that neither abuse severity nor substantiation were associated with treatment engagement in a sample of 490 families referred to treatment at a midwestern CAC. Although additional studies that include information about abuse characteristics will be useful, McPherson and colleagues findings lend some confidence to our conclusions. In addition, the sample size for this study was modest, and it is unknown how characteristic participating families were in terms of their reactions to CSA or attitudes towards treatment. The external validity of the study is limited to individuals for whom the abuse was reported to the appropriate authorities and who lived with non-offending caregivers. Our findings warrant replication with larger samples that have a more balanced representation of racial-ethnic groups. Finally, the non-experimental data and concurrent assessment of caregiver stigmatization, youth PTSD, and attitudes towards treatment prohibit conclusions about temporal or causal relations between study variables. We acknowledge the results rely on self-report methodology and that multi-method assessments (e.g., youth report, structured diagnostic interviews) would provide stronger measurement of our constructs.

Clinical Implications

A number of studies support the importance of early intervention for reducing the potential negative psychosocial consequences associated with CSA (Deblinger, et al., 2006; Feiring et al., 2010; Feiring et al., 2009; Feiring et al., 2013; BLINDED REFERENCE). However, engaging families in treatment in the wake of CSA discovery remains a significant problem. Child advocacy centers (CACs) are a common point of connection to trauma-informed assessment and intervention in many communities. They have the opportunity to play a vital role in reducing obstacles to treatment engagement. Many CACs screen the children they see for trauma symptoms and use the results to make referrals to mental health treatment. Our results suggest that screening caregivers for abuse stigmatization may also be important for bridging the treatment gap, especially when children are symptomatic. For caregivers who feel stigmatized and have symptomatic children, the most salient obstacles do not appear to be the practical barriers that CACs often address through low/no-cost treatment, transportation assistance, or in-home services. Rather, they are concerns about whether therapy is relevant to them, the process and consequences of personal disclosures, and the other stressors in their lives. Acknowledging and addressing feelings of shame and attributions of self-blame could help caregivers cope with their own distress and better support their children. If caregivers who feel stigmatized are more motivated to hide, deny, or escape reminders of stigmatizing events (e.g., Ehlers & Clark 2000; Feiring et al., 1996; Ketelaar & Au, 2003; Tangney et al., 2007), they may be less receptive to information about mental health treatment. They may also be less engaged in their child's treatment, a critical component of youth improvement in trauma-focused therapies (Deblinger et al., 2006; Yasinski et al., 2016). Just as youth with shame and self-blame for CSA may misinterpret

changes in caregivers' expectations, caregivers with similar reactions might be more prone to interpret feedback on their children's distress or treatment recommendations as condemnations of their parenting (Deblinger & Runyon, 2005). Such possibilities suggest that understanding how caregivers internalize the meaning of their child's CSA may be critical for those seeking to connect families to mental health services as well as for clinicians providing treatment.

A unilateral approach treatment referral for families with newly discovered cases of CSA may be less than optimal for insuring youth receive needed services. Identifying, acknowledging and addressing attributions of self-blame and feelings of shame could help caregivers cope with their own distress and increase receptivity to information about the relevance, process, and requirements of trauma-informed treatment. Active listening to how caregivers internalize the meaning of CSA for themselves as parents and empathic reflective responses to their concerns may help caregivers feel validated and accepted. The positive association of stigmatization and motivation suggests that finding ways to capitalize on caregivers' motivation for treatment may be an effective gateway for identifying and processing their reactions to CSA, perceived obstacles to engagement. For example, individualized feedback that articulates potential ambivalence (e.g., "So, you view mental health treatment as important for children who have been sexually abused, but you are also concerned about how a therapist might think about you as a parent.") could be very clarifying amidst the stressors of abuse discovery. These and other motivational strategies (e.g., Miller and Rollnick 2002; Prochaska et al., 1992) may offer opportunities to provide feedback and education about caregiver-specific reactions or perceived obstacles to engagement. This type of approach is also consistent with various models of trauma-focused interventions, such as TF-CBT (Cohen et al., 2006; Deblinger & Haflin, 1996), which emphasize education and skill-building as a critical first phase of intervention and are significantly more effective when caregivers also completes their portion of the treatment (Deblinger et al., 2006; Yasinski et al., 2016).

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Figure 1.

Caregivers' abuse stigmatization moderates the relationship between youth PTSD symptoms and obstacles related to trust/relevance of therapy: Regions of significance and simple slopes analyses.

Note: Low Stigma = 10th percentile; Medium Stigma = 50th percentile; High Stigma = 90th percentile. J-N analyses indicated that the relation between youth PTSD symptoms and obstacles related to trust/relevance of therapy transitioned from non-significant to significant at the 80th percentiles of the distribution of caregiver stigmatization, $b = .038$, $SE = .017$, $t(1,48) = 2.01$, $p = .05$.

Figure 2.

Caregivers' abuse stigmatization moderates the relationship between youth PTSD symptoms and obstacles related to intervention demands: Regions of significance and simple slopes analyses.

Note: Low Stigma = 10th percentile; Medium Stigma = 50th percentile; High Stigma = 90th percentile. J-N analyses indicated that the relation between youth PTSD symptoms and obstacles related to intervention demands transitioned from non-significant to significant at the 56th percentiles of the distribution of caregiver stigmatization, $b = .023$, $SE = .011$, $t(1,48) = 2.01$, $p = .05$.

Figure 3.

Caregiver abuse stigmatization moderates the relationship between youth PTSD symptoms and obstacles related to personal/family stressors: Regions of significance and simple slopes analyses.

Note: Low Stigma = 10th percentile; Medium Stigma = 50th percentile; High Stigma = 90th percentile. J-N analyses indicated two regions of significance in the relation between youth PTSD symptoms and obstacles related to personal/family stressors: (1) at and below the 48th percentile of the distribution of caregiver stigmatization ($b = -.03$, $SE = .013$, $t(1,48) = -2.01$, $p = .05$) and (2) at and above the 76th percentile of the distribution of caregiver stigmatization ($b = .03$, $SE = .012$, $t(1,48) = 2.01$, $p = .05$).

Table 1

Descriptive statistics and bivariate correlations.

Main study variables	Mean	SD	Observed Range		Correlations						
			1	2	3	4	5	6	7		
1. Youth PTSD symptoms	22.32	13.07	1–60	---							
2. Caregiver Abuse Stigmatization	1.59	0.57	1–3	.38**	---						
3. Motivation for Child Treatment	4.26	0.51	2.5–5	.47**	.42**	---					
4. OES: Trust/Relevance of Therapy	1.75	0.85	0–3	.18	.36**	.02	---				
5. OES: Intervention Demands	1.67	0.67	0–3	-.05	.29*	-.09	.64**	---			
6. OES: Personal/Family Stressors	1.41	0.79	0–3	.05	.08	.03	.41**	.42**	---		
7. OES: Time/Scheduling Demands	1.78	0.98	0–3	.13	.24+	-.04	.27*	.35**	.13	---	

Note. OES = Obstacles to Engagement Scale.*
p < .05,**
p < .01.

Table 2

Results of standardized regression models predicting caregiver attitudes toward child treatment from additive and interactive effects of youth PTSD symptoms and caregiver abuse stigmatization.

	β coefficient	SE	t	F (df)	Cohen's f^2
Caregiver Motivation for Child Treatment					
Intercept	3.66	0.39	9.45**		
Youth PTSD	0.02	0.01	2.82**		
Caregiver Stigma	0.26	0.19	2.17*		
Full Model				9.91*	(3, 49) .41
OES Relevance/Trust Therapy					
Intercept	-0.79	1.31	-0.60		
Youth PTSD	0.06	0.26	2.33*		
Caregiver Stigma	-2.04	1.07	-2.09*	3.79* ^a	(2, 50) .15
PTSD x Stigma	0.06	0.23	2.44*	5.96* ^b	(3, 49) .13
Full Model				4.78**	(3, 49) .30
OES Intervention Demands					
Intercept	0.46	1.07	0.43		
Youth PTSD	0.03	0.02	1.40		
Caregiver Stigma	-1.43	0.87	-1.71	2.52* ^a	(2, 50) .11
PTSD x Stigma	0.04	0.02	2.22*	4.88* ^b	(3, 49) .13
Full Model				3.57*	(3, 49) .23
OES Personal/Family Stressors					
Intercept	-2.49	1.17	-2.12*		
Youth PTSD	0.08	0.23	3.38**	4	
Caregiver Stigma	-3.38	0.95	-3.55**	0.16 ^a	(2, 50) .09
PTSD x Stigma	0.08	0.20	3.72**	13.82** ^b	(3, 49) .29
Full Model				4.98*	(3, 49) .30
OES Time/Schedule					

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	β coefficient	SE	t	F (df)	Cohen's f^2
Intercept	1.95	.85	2.29 *	1.56	(2, 50) .06
Youth PTSD	0.01	.02	0.35		
Caregiver Stigma	0.38	.26	1.58		
Full Model					

Note.

^aF (df) for main effects model (no interaction);

^bF change (df) for interaction;

⁺ p < .10,

^{*} p < .05,

^{**} p < .01.