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Who is advocating for children under six? Uncovering unmet needs in child advocacy centers

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ABSTRACT

Evidence suggests that children under the age of 6 years are affected by trauma, yet there are few studies available to determine how well their needs are addressed in the mental health system. Child Advocacy Centers (CACs) offer a promising avenue for expanding the system of care for very young children exposed to sexual and/or physical abuse. This study used a mixed-methods approach to examine the type and extent of CAC services for very young children in one state. Quantitative results revealed that the youngest children were less likely to be referred for counseling and less likely to already be engaged in counseling when an investigation is initiated. Qualitative results from interviews with CAC advocates suggest that advocates have variable perceptions regarding the effects of trauma on young children, and they do not consistently receive training in the mental health needs of traumatized children under 6. Our results confirm the need for an expanded system of service delivery for the youngest and most vulnerable child maltreatment victims.

1. Introduction

Child maltreatment is an alarmingly pervasive problem in the U.S., and the search for ways to eradicate it has proven frustrating and elusive. According to the National Child Abuse and Neglect Data System, during the 2012 fiscal year (the most recent year for which statistics are available), it was estimated that 6.3 million children were reported to Child Protective Services regarding a suspected case of maltreatment (U.S. Department of Health and Human Services, 2013). Nearly 47% of substantiated child abuse or neglect occurred among children under the age of 6. Furthermore, more than 84% of all child maltreatment deaths occurred among children 5 years of age or younger. Children younger than 6 are also disproportionately more likely to live in homes where they are exposed to domestic violence relative to older children (Fantuzzo & Fusco, 2007).

A common misperception among families—and even professionals who work in the field of trauma—is that very young children (i.e., children under 6) will not be affected by early stressful or traumatic events because they will not remember what happened, are resilient by nature, and/or will simply grow out of any emotional or behavioral problems that occur in early childhood (National Scientific Council on the Developing Child, 2010; Osofsky & Lieberman, 2011). These misperceptions may arise from overgeneralizations related to the types of fears children can simply outgrow as they mature (National Scientific Council on the Developing Child, 2010). However, a growing body of research suggests that very young children may be significantly impacted by trauma sustained in the first several years of life. Cross-sectional studies have found that traumatized children under the age of 6 are at risk for developmental delays, lower cognitive functioning, mental health problems, and trauma symptoms such as increased crying, difficulty regulating, posttraumatic play, restrictive play or exploration in the environment, sleep disturbance, high levels of fussiness, temper tantrums, clinginess and separation anxiety, and regression of previously acquired developmental milestones or skills (Mongillo, Briggs-Gowan, Ford, & Carter, 2009; Pears & Fisher, 2005; Scheeringa, Zeanah, Myers, & Putnam, 2003). The likelihood of mental health problems appears to grow with an increase in the number of traumas experienced (Finkelhor, Ormrod, & Turner, 2007).

A growing body of longitudinal evidence also supports these findings. For instance, children investigated for maltreatment prior to age 3 are at risk for deficits in social skills, daily living skills, and special education placement when school-aged (Scarborough & McCrae, 2010). In their prospective community sample, Keiley, Howe, Dodge, Bates, and Pettit (2001) followed children for nine years beginning in kindergarten and found that those who were physically abused by the age of 5 were more likely to develop both internalizing and externalizing problems than children who experienced physical abuse after the age of 5. Prospective studies also suggest that children younger than

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64 months who are exposed to interpersonal trauma show greater Posttraumatic Stress Disorder (PTSD) symptoms and lower developmental competence at school-age (Enlow, Blood, & Egeland, 2013) and have cognitive deficits that persist into middle childhood (Enlow, Egeland, Blood, Wright, & Wright, 2012). These cognitive deficits appear to be particularly pronounced among children who have experienced trauma in their first 2 years of life (Enlow et al., 2012). Moreover, a growing body of literature suggests that children will not simply outgrow the PTSD symptoms they experience in early childhood (Cohen & Scheeringa, 2009). On the contrary, if left untreated, very young children's trauma symptoms may become chronic, insidious, and unremitting (De Young, Kenardy, & Cobham, 2011).

Leading child development researchers now help us understand the mechanism by which repeated trauma impacts the young child's developing brain and body (National Scientific Council on the Developing Child, 2005, 2014). They refer to strong, frequent, and/or prolonged activation of the body's stress-response systems occurring in the absence of adequate support from an adult caregiver as "toxic stress". Major risk factors for the development of toxic stress include extreme poverty, ongoing physical and/or emotional abuse, chronic neglect, severe maternal depression, parental substance abuse, and family violence. Although trauma may be a contributor to toxic stress, it is important to note that trauma is not the only pathway by which toxic stress may manifest. Especially during early sensitive periods of brain development, toxic stress resulting from chronic abuse and neglect and other risk factors can lead to overproduction of neural connections in the areas of the brain involved in fear, anxiety, and impulsive responses, and underproduction in areas of the brain dedicated to reasoning, planning, and behavioral control (National Scientific Council on the Developing Child, 2005, 2014). Toxic stress disrupts brain architecture, affects other organ systems, and leads to adaptation in the body's stress-response systems so that these systems respond at lower thresholds to events that might not be stressful to others, resulting in over-activation of the stress-response system and increased risk of stress-related disease and cognitive impairment into adulthood (Shonkoff, Boyce, & McEwen, 2009).

Evidence suggests that the emotional and behavioral sequelae of abuse sustained in the first five years of life may be effectively addressed with interventions targeted towards ameliorating trauma symptoms and returning children's development to a healthy trajectory (Cohen, Mannarino, & Deblinger, 2006; Lieberman, Ghosh Ippen, & Van Horn, 2006). Various evidence-based treatments such as Trauma-Focused Cognitive Behavioral Therapy (Cohen et al., 2006), Parent–Child Interaction Therapy (Funderburk & Eyberg, 2011) and Child–Parent Psychotherapy (Lieberman et al., 2006) have been shown to be effective for use with preschool aged children who have experienced traumatic events (Chadwick Center for Children and Families & Child and Adolescent Services Research Center, 2014). Therefore, it is imperative that very young children who experience early abuse are referred for effective trauma services in a timely manner. Recent articles within the literature emphasize the need for an expanded and sensitive system of care for very young children who have experienced trauma in order to ensure these children receive needed intervention services (American Humane Association, 2011; National Scientific Council on the Developing Child, 2010; Osofsky & Lieberman, 2011).

One particularly promising avenue for enhancing such linkages to mental health services for very young trauma-exposed children is through Child Advocacy Centers (CACs). The CAC model has emerged as the "gold standard" for incorporating best practices for child abuse investigations and beyond. According to the National Children's Alliance (NCA), the accrediting body for CACs, the CAC model uses multidisciplinary investigative teams, trained child-forensic interviewers, videotaped interviews, highly trained medical forensic teams to conduct specialized examinations, victim/support advocacy, case review and tracking, and therapeutic interventions all within a child-friendly environment (Smith, Witte, & Fricker-Elhai, 2006). If mental health services are not provided on-site, the NCA requires the CAC to maintain linkages to community providers to increase families' access to these services (Cross et al., 2008; Jones et al., 2010). In addition, NCA accreditation standards require that forensic interviewers, whose interviews are used to inform a determination of abuse, receive specialized training in conducting developmentally appropriate interviews with very young children. However, no such training standards exist for victim/family advocates, whose role is to provide crisis assessment, investigative process and legal system education, concrete assistance, mental health referrals and other supports to children and families as they become engaged with the legal system following disclosure of abuse. Furthermore, very little is known about advocates' knowledge and perceptions related to the mental health needs of very young children following abuse exposure. However, CAC advocates are uniquely positioned to be a gateway for connecting very young children and their families with services needed to ameliorate adverse effects from toxic stress and trauma.

Although it remains unclear whether very young children are referred for therapy at the same rates as older children, findings from the first multi-site CAC evaluation project suggest that children of all ages who experienced sexual abuse and were interviewed at a CAC were referred for mental health services 72% of the time, whereas community comparison sites referred children just 31% of the time (Cross et al., 2008). Research is just beginning to explore factors that influence whether children actually begin receiving services or not (e.g., Lippert, Favre, Alexander, & Cross, 2008). Factors such as the type of abuse experienced, parents' willingness to initiate therapy, and victims' own openness to receiving therapy have all been considered as possible factors (Cross et al., 2008). Other factors such as the age of the child and the referral source's knowledge of the impact of abuse on early development have not yet been considered. Such factors may influence parents' willingness to have their child engage in therapeutic services.

The purpose of this mixed-methods paper is to examine the nature of CAC services for children under 6 in one state. Specifically, we used quantitative methods to explore age-based differences in demographics, trauma history, and referrals for mental health. Qualitatively, we used individual interviews to inquire about advocates' perceptions of their work with young children and how it differs from their work with older children and their families. We explored the ways advocates approach young children and their parents, their understanding of the impact of trauma on young children, their perceptions of parents' understanding of the impact of trauma, their experiences with referrals and services for mental health treatment for young children, and the emotional toll of working with very young maltreated children. Our goal was to identify training and support needed to ensure optimal services and service linkages in CAC settings for the youngest victims of abuse, thereby strengthening the broader system of care for traumatized infants, toddlers, and preschoolers.

2. Method

2.1. The AR BEST project

This study was conducted under the auspices of AR BEST (Arkansas Building Effective Services for Trauma), a program sponsored by the state legislature to improve outcomes of traumatized children throughout the state through collaboration among the University of Arkansas for Medical Sciences Psychiatric Research Institute; Commission on Child Abuse, Rape and Domestic Violence; and Children's Advocacy Centers of Arkansas. AR BEST, initiated in 2009, trains mental health professionals, advocates, child welfare staff and other stakeholders in evidence-based, trauma-informed practices; helps coordinate and support mental health services in CACs and the community for traumatized children; and monitors outcomes for children and their families.