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Research article

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.

1. Introduction

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 & Heflin, 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,

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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 and those who receive interventions to 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.

1.1. 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 be enrolled 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 inhibit service utilization following abuse discovery. 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; Staudt, 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.

1.2. 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; Elliott & Carnes, 2001a, 2001b; Everson et al., 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, 1980; 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 (Feiring, Cleland, & Simon, 2010; Feiring, Simon, & Cleland, 2009; Feiring, Simon, Cleland & Barrett, 2013; Simon & Feiring 2008).

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:), 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, Dempster and colleagues found 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, Davis, Jones, Keating, & Wildman, 2015). Caregivers' stigmatization may decrease motivation for treatment or increase perceived obstacles to treatment engagement. The motivational components of treatment engagement include perceiving need for change, desire for change, willingness to change, and

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