

Examining and Addressing Potential Barriers to Treatment Adherence for Sexually Abused Children and their Non-offending Parents

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Introduction

Child sexual abuse (CSA) is a problem increasingly faced by mental health treatment professionals. The recent intense media and research focus on CSA and its effects on children and families has given rise to a variety of interventions designed to provide support, psychoeducation, and strategies for prevention of future abuse or dysfunction after the abuse has been reported. Empirically validated parallel group treatment protocols involving victims and their non-offending caregivers are increasingly utilized by professionals and have been cited as highly effective interventions for CSA by various researchers (e.g., Celano, Hazzard, Webb, & McCall, 1996; Cohen & Mannarino, 1998; Reeker, Ensing, & Elliott, 1997; Stauffer & Deblinger, 1996). Unfortunately, many families who might benefit from such interventions fail to adhere to the treatment program long enough to attain significant benefits. Although many researchers have studied barriers to treatment adherence for individuals and families in general, the population affected by CSA presents a number of unique barriers worthy of examination.

The primary purpose of this presentation is to summarize the existing literature and knowledge gained from clinical experiences in considering barriers to adherence in the treatment of children and their caregivers. This presentation will incorporate findings and suggestions from the literature on treatment adherence, compliance, and acceptability with individuals, children, parents, and families as well as the more general literature addressing CSA. More specifically, this presentation will examine the potential for sets of varied factors to act as barriers to adherence in parallel group treatment protocols for families with a specific focus on those potential barriers unique to non-offending caregivers and their child victims of sexual abuse. It is important to note that many of these barriers to treatment adherence also have the potential to act as facilitators to adherence, but such a discussion is outside of the scope of this presentation. A secondary purpose is to examine ways to effectively address such barriers to adherence in order to improve treatment response and effectiveness.

Treatment Adherence

In the literature, the terms “treatment adherence” and “treatment compliance” are sometimes used interchangeably to describe the same phenomena (e.g., Butler, Radia, & Magnatta, 1994; Hansen & Warner, 1994). More recently, researchers have worked to formulate operational definitions of the phenomena to ease communication and promote empirical studies. For the purpose of this presentation, issues of treatment compliance that the reader deems distinct from the following definition of treatment adherence should not be assumed to be a part of adherence. Furthermore, “treatment acceptability” as defined by Kazdin (1980) involves the perceived appropriateness of treatment by potential clients. This is also distinct from treatment adherence and, in fact, will rather be addressed as a potential barrier to adherence.

Treatment adherence is typically measured through three distinct behaviors: attending treatment sessions, participating in treatment sessions, and doing work (e.g., therapeutic homework) outside of treatment sessions (Lundquist & Hansen, 1998). There are also certain precursors to adherence that might be best defined as aspects of “initial engagement” in

treatment. These include making a decision to seek psychological treatment, making a call for a psychological intake interview, getting introduced to the process of therapy, and attending treatment after the initial assessment meeting. Many of the barriers to adherence addressed in this presentation may also act as barriers to initial engagement in the treatment process. However, there are issues specific to treatment for child sexual abuse that are not related to treatment adherence as defined above and are not addressed in this presentation. These issues typically present themselves before treatment is ever initiated and include the caregivers or victims recognizing that any sexual abuse has occurred and also reporting the abuse to authorities or other professionals.

Barriers to Treatment Adherence

Many researchers have considered various practical, family related, individual, therapeutic, and sexual abuse specific factors as they relate to adherence in treatment for children and their families (e.g., Garcia & Weisz, 2002; Gelles, 2000; Hansen & Warner, 1994; Haskett, Nowlan, Hutcheson, & Whitworth, 1991; Heras, 1992; Manfred-Gilham, Sales & Koeske, 2002; Miller & Kelley, 1992; Mollica & Son, 1989; Nock & Kazdin, 2001; Ockene, 2001; Patton & Kivlighan, 1997; Pekarik & Stephenson, 1988; Wainberg & Cournos, 2000). Additionally, clinical psychology graduate students and their supervisors engaged in an ongoing clinical research and treatment program for CSA conducted at the University of Nebraska-Lincoln have discussed and addressed barriers to treatment adherence within the context of the program for over six years. Project SAFE (Sexual Abuse Family Education) is an empirically validated parallel group treatment protocol for sexually abused youth and their non-offending caregivers (Hecht, Futa, & Hansen, 1996). The protocol involves 12 weekly simultaneous separate groups for caregivers and children that provide support, psychoeducation, and strategies for prevention of future sexual abuse.

In an attempt to summarize the empirical literature involving treatment barriers and treatment adherence as well as incorporate discoveries based on clinical experiences from treating sexually abused youth and their non-offending caregivers, barriers to treatment adherence that may apply in cases focusing on CSA are categorized and listed with some brief description. Clearly, there is overlap between the different categories. However, the categories are delineated to promote a more complete consideration of the difficulties encountered by families in need of CSA treatment. It is not within the scope of this presentation to provide explanations from the research on the frequency of these presenting difficulties in treatment settings or to describe specifically how each might act as a barrier to treatment adherence. Rather, these barriers are summarized so that clinicians may review the list in considering potential issues that may arise in the course of treatment surrounding CSA and in formulating treatment approaches that may improve adherence through addressing barriers accordingly.

Practical treatment barriers

The following barriers are broadly defined as structural or financial issues that may limit treatment adherence or initial engagement:

- Low Social Economic Status
- Transportation problems (e.g., no car, inability for service providers to arrange transport to the clinic)
- Communication problems (e.g., no telephone, no specified contact at the clinic)

- Financial concerns (e.g., cost of services, cost of transportation, loss of wages due to attending therapy)
- Child care concerns (e.g., child care inconsistent, child care not provided at the clinic)
- Time unavailable (e.g., due to work schedules or other obligations)
- Number of children (e.g., potential conflicting needs or obligations)
- Scheduling conflicts when working with multiple families involved in a group treatment format
- Length of time between initial referral, initial contact, and the beginning of regular sessions (e.g., the longer this time period, the worse the adherence)
- Lack of prompting (reminders) for group

Family-related treatment barriers

The following barriers are broadly defined as issues specific to family functioning and systemic psychopathology that may limit treatment adherence or initial engagement:

- Level of family stress (e.g., the higher the stress, the worse the adherence)
- Social isolation of parent(s) (e.g., no support for child care, inability to seek out referral sources)
- Level of family cohesion (e.g., the lower the cohesion, the worse the adherence)
- Level of marital adjustment (e.g., poor marital relationships typically inhibit adherence)
- Family health problems (e.g., child or parental illness, both chronic and acute)
- Domestic assault between caregivers
- History of physical abuse or neglect against children
- Mother's supportiveness of treatment (i.e., despite children's desires)
- Father involvement in treatment (typically improves adherence)
- Nature/ quality of parent-child relationship
- Custody conflict between family members (e.g., legal battle)
- Caregiver perception of treatment need for entire family versus need for victim alone

Individual treatment barriers

The following barriers are broadly defined as issues specific to the functioning of individual children and/or caregivers that may limit treatment adherence or initial engagement:

- Treatment acceptability (i.e., the perceived appropriateness of treatment by potential clients)
- Perceived stigma or fear associated with mental health services
- Self-defeating behaviors
- Defensiveness among children
- Level of readiness for change (e.g., precontemplation, contemplation, preparation, action, maintenance)
- Cultural differences (e.g., language differences, values, beliefs, level of acculturation)
- Psychiatric comorbidity (e.g., child externalizing behaviors, parental mental illness or substance abuse)
- Psychopathy among caregivers (often leads to inconsistent adherence)
- Developmental considerations for both children and caregivers (e.g., level of intellectual functioning, presence of any developmental disabilities)

Barriers related to the therapeutic relationship

The following barriers are broadly defined as issues arising in the relationship between client(s) and therapist(s) that may limit treatment adherence or initial engagement:

- Therapist and client focus on transference and the nature of the feelings that arise within both child and caregiver groups
- Therapist-client rapport or “therapeutic alliance” for both child and caregiver groups (e.g., the poorer the alliance, the worse the adherence)
- Level of group cohesion for both child and caregiver groups (e.g., poor cohesion or consistent process issues impair adherence for group members)
- Possible gender mixing in child groups (e.g., given the CSA focus, children may become highly self-conscious in mixed groups, which can limit adherence)
- Therapist/child gender differences (e.g., may also lead to self-consciousness among the child victims during treatment or difficulty in establishing rapport)

Therapist/ agency related treatment barriers

The following barriers are broadly defined as issues specific to therapeutic service providers or agencies/clinics that may limit treatment adherence or initial engagement for clients:

- Therapist level of experience/ dedication to treatment modality (i.e., as these decrease, so does adherence)
- Therapist behaviors in treatment (e.g., teach/confront versus facilitate/support)
- Therapist lack of consideration of barriers (often a very salient barrier in and of itself)
- Treatment complexity (e.g., more complex approaches often impair adherence in group treatment settings)
- Use of manualized treatment (e.g., lack of individual flexibility)
- Treatment setting/environment (e.g., level of comfort/ lack of distraction/ public versus private clinic)
- Therapist perception of the family as a barrier (e.g., can impair therapeutic alliance or place too much focus on children’s needs)
- Semantic issues: How abuse or effects of abuse are addressed by therapist during treatment (e.g., labeling, “fallacy of victimization”- are victims “damaged goods” or is the potential for resiliency addressed)

Sexual abuse specific barriers

The following barriers are defined as issues that are frequently and specifically related to families presenting for treatment for child sexual abuse that have the potential to limit treatment adherence and initial engagement:

- Parental history of sexual abuse (e.g., can create a separate emotional or therapeutic issues that limit adherence)
- High level of parental self-focus in group (e.g., on their own abuse history or problems that assaults on the children created for them)
- Continued parental relationship with perpetrator (e.g., present a variety of therapeutic issues making treatment adherence difficult)
- Level of belief of sexual abuse story by parent (e.g., disbelief of the victims’ stories often prevents engagement)

- Parental acceptance of child behaviors (e.g., in response to the abuse or investigation; sexual behaviors)
- Level of parental knowledge regarding age-appropriate sexual development
- Parental acceptance/beliefs regarding sex education (which is often a component of CSA treatment)
- Whether treatment was court-ordered (e.g., court-ordered caregivers tend to be less motivated)
- Parental perceptions/ biases regarding sexual abuse and treatment of sexual abuse in a group context (e.g., “Who will find out my child was abused?”)
- Child relationship to perpetrator (e.g., continuing relationships can impair adherence)
- Intensity/duration of sexual abuse (often related to level of post-abuse adjustment)
- Post-traumatic symptoms with child victims (must be addressed early to maintain treatment adherence with children)
- Child perceptions of whether they were abused (e.g., often differ from legal definitions and parental perceptions, especially if children were groomed over a long period of time before abuse occurred)
- Legal status/issues (e.g., where the case is in the legal system can affect level of disclosure and treatment acceptability)
- Differences within the parent and caregiver groups regarding the perceived intensity or effects of abuse (e.g., “less intense” abuse victims and their caregivers may feel they are different from other group members, experience less cohesion, and be less motivated to attend)
- Stigma of sexual abuse/ level of shame for both caregivers and child victims (e.g., the worse the stigma or shame, the more problems that often occur with adherence)

Addressing Barriers to Treatment Adherence with Suggestions for Research and Practice

Clearly, based on both empirical findings and clinical experience, there is a broad variety of factors and issues that may act as barriers to treatment adherence or initial treatment engagement within the population of sexually abused youth and their non-offending caregivers. Many researchers have addressed the issues of adherence and barriers to treatment for children and families over the last twenty-five years. Many more have addressed issues surrounding the effects and treatment of child sexual abuse during that time. However, this examination is not nearly complete. Given the complexity and heterogeneity of clinical presentations of families dealing with CSA and the further intricacies of group treatment for CSA, much more research and therapeutic expansion needs to occur. The following represents an important, albeit incomplete, list of suggestions for future research and clinical practice to effectively address barriers to treatment within the population considered in this presentation:

Suggestions for Research

- Research on CSA affected families and “initial engagement”
- Continuing research on CSA-related expectancies and adherence with victims and caregivers
- Research on CSA as a more systemic problem (e.g., effects on family, community, etc.) in relation to treatment adherence
- Further examination of the relationship between adherence and acceptability within a CSA affected population

- Continued research investigating recognition and reporting of CSA by caregivers

Suggestions for Clinical Practice

- Address expectations surrounding CSA in pretreatment meetings with families
- Obtain funding in clinics to provide solutions to practical problems (e.g., financial, transportation, etc.) preventing treatment adherence
- Provide concurrent treatment for comorbid issues such as individual psychopathology (e.g., internalizing disorders, substance abuse), caregiver history of CSA, domestic violence, and family dysfunction
- Promote therapist training/education and sensitivity (e.g., train to play a supportive role, educate regarding CSA-specific issues, group therapy training, educate regarding barriers)
- Develop interventions to increase treatment acceptability among caregivers and victims
- Develop relationships with community agencies (e.g., CPS, Child Advocacy Centers, Head Start) to involve therapists with victims before treatment and increase community acceptance of interventions and the therapeutic alliance
- Promote adaptability in treatment length and structure to address changing issues with different clients
- Develop age appropriate sexuality education within treatment interventions and foster effective family communication surrounding sexuality issues
- Survey clients to elicit constructive feedback and improve services
- Involve former clients (both caregivers and children) as “assistants” in future groups or with initial contacts
- Promote increased father involvement in treatment

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