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Understanding Barriers to Enrollment and Completion of Evidence-based Interventions for Trauma Exposed Youth: the Potential Predictive Role of Parental Trauma Exposure

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Trauma Exposure

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Abstract

Child trauma exposure (CTE) is an important public health concern in the U.S.; more than two-thirds of children report experiencing a traumatic event by the age of 16. CTE may have important acute and long-term physiological, developmental, behavioral, and psychological implications if not addressed. Trauma-focused cognitive behavioral therapy (TF-CBT) is the gold standard for treatment of child trauma and is well-supported for resulting in significant decreases in negative mental health outcomes associated with CTE. Despite the efficacy of evidence-based interventions such as TF-CBT, many children do not receive treatment due to a variety of contextual, logistical, and interpersonal barriers. This mixed-methods exploratory study examines possible predictors of enrollment and completion of TF-CBT, specifically parental trauma exposure, at a community organization that serves abused and traumatized children in the metro Atlanta area. Data were collected during individual assessments consisting of a computer survey and semi-structured interview (n=41). Data analysis focused on parental trauma exposure, and qualitative interviews were examined for common themes regarding intentions for their child's enrollment and completion of services. Results indicated that caregivers of children referred to services had relatively high (56.1%) rates of trauma exposure. Results from logistical regression indicate that parents with a trauma history were 10.5 times more likely to have a child enroll in therapy. These results indicate that parents with personal trauma histories may be more committed to their child receiving services, therefore public health efforts aimed towards educating parents without trauma histories may be beneficial.

Understanding Barriers to Enrollment and Completion of Evidence-based

Interventions for Trauma Exposed Youth: the Potential Predictive Role of Parental

Trauma Exposure

CTE Prevalence and Related Outcomes

Childhood trauma exposure (CTE) is an important public health concern in the

U.S. (Substance Abuse and Mental Health Services Administration [SAMHSA], n.d.).

CTE refers to a range of possible trauma experiences including child physical abuse,

child neglect, child sexual abuse, community and school violence, domestic violence,

natural disasters, terrorism, and traumatic grief. Trauma occurs when these experiences

are intense and threaten or cause harm to a child's emotional and physical well-being

(National Child Traumatic Stress Network [NCTSN], n.d.). According to the Centers for

Disease Control and Prevention (CDC, 2010) more than two-thirds of children report

experiencing a traumatic event by age 16. Furthermore, among a nationally

representative sample of 12-17 year olds, 8% reported a lifetime prevalence of sexual

assault, 17% reported physical assault, and 39% reported witnessing violence

(Kilpatrick, 2003). Research also suggests that among children exposed to trauma, the

majority of children experience multiple, co-occurring types of trauma (Finkelhor,

Ormond, & Turner, 2007). Additionally, results from a retrospective study conducted in

2003 suggest that 32.3% of women and 14.2% of men experienced sexual abuse as

children; 19.5% of women and 22.2% of men experienced physical abuse as children;

and 21% of respondents that experienced one type of trauma also experienced the

other (Briere & Elliott, 2003).These estimates are devastating considering both the

acute and long-term health outcomes associated with CTE.

CTE may impact a child's physiological, developmental, behavioral and psychological functioning, both short-term and long-term (Gregorowski & Seedat 2013; Coates, 2010; Overstreet & Matthews, 2011; Kessler, McGaughlin, Green, et al., 2010; Draper, Pfaff, Pirkins, et al., 2008; Widom, Czaja, & Dutton, 2008; Copeland, Keeler, Angold, & Costello, 2007; Finkelhor et al., 2003; Whitfield, Anda, Dube, et al., 2003; Pine & Cohen, 2002). Children exposed to trauma are at increased risk for developing physiological problems, such as biological distress and problems associated with the endocrine system and brain development (Coates, 2010). Research also suggests that exposure to chronic trauma during childhood disrupts and changes brain development in the neuro-endocrine and limbic systems and cerebral cortex (Coates, 2010). CTE also causes disruption within and between the limbic systems and cerebral cortex. The dysregulation of stress hormones can cause misinterpretation between perceived and real threats. As a result, portions of the brain responsible for processing information and learning lose ability to function (Coates, 2010). Clearly, CTE can have profound impacts on acute and life-long physiological functioning.

Developmental and behavioral difficulties can also result from CTE. Trauma exposure during childhood may have serious implications on developmental trajectories, such as cognitive impairments, executive functioning deficits, attention regulation, and behavioral outcomes such as lack of impulse control and subsequent victimization (Gregorowski & Seedat, 2013; Overstreet & Matthews, 2011; Widom, Czaja, & Dutton, 2008). Although results from several studies are inconclusive regarding the origin, children exposed to trauma have impaired abilities of sustained attention, memory, and executive functioning, even after controlling for the effects of PTSD (Beers & DeBellis,

2002; DePrince, Weinzieri, & Combs, 2009). Research suggests that CTE can also impact language development, self-awareness, and problems integrating new experiences with past actions (Gregowski & Seedat, 2013). Lack of impulse control may also be inhibited because children exposed to trauma may experience subsequent deficits in modulating affect (Cook, Spinazzola, Ford, et al., 2005; Van der Kolk, 2005; Bailey, Morgan, & Pederson, 2007). Victims of childhood trauma are also at increased risk for subsequent victimization. For example, Finkelhor et al. (2007) found that children were two to seven times more likely to be re-victimized in the second year of the study if they were victimized in year one, compared to children that were not victimized in year one. Similarly, in a large prospective cohort design, Widom et al. (2008) found that individuals abused and neglected as children were at increased risk for lifetime re-victimization, and childhood victimization increased risk for physical and sexual assault/abuse, kidnapping/stalking, and having a family friend murdered or commit suicide. In addition to increased risk for negative health outcomes and re-victimization, victims of child maltreatment, specifically, are also at increased risk for perpetrating violence later (Whitfield et al. 2003). The negative developmental and behavioral outcomes associated with childhood trauma exposure are extensive.

Research suggests that CTE has important implications on psychological functioning, and may result in psychological disorders such as post-traumatic stress disorder (PTSD), depression, anxiety disorders, substance abuse, personality disorders, eating disorders, and suicidal ideations (Coates, 2010; Draper et al., 2008; Briere & Elliott, 2003). Results from a longitudinal study conducted in North Carolina suggest that children exposed to trauma experience rates of affective, anxiety, and disruptive

behavior disorders at approximately twice the rates of children not exposed to trauma (Copeland et al., 2007). Results from a similar study indicate that as much as 80% of young adults who had been abused during childhood met diagnostic criteria for at least one psychiatric disorder by age 21, including post-traumatic stress disorder (Silverman, Reinharz, & Giaconia, 1996). Psychiatric disorders resulting from experiencing trauma are prevalent among adult victims of CTE.

Within the last decade, much research has been devoted to exploring the relationship between CTE and PTSD, one of the most commonly identified outcomes associated with trauma exposure (Overstreet & Matthews, 2011). "PTSD is an anxiety disorder characterized by painful recall of the traumatic event, emotional numbing, avoidance of trauma reminders, and persistent psychological arousal" (APA, n.d.). A review of research on children exposed to trauma conducted in 2010 suggests that between 13% and 20% of preschool children suffer from PTSD, and 3% to 53% of school-age children and adolescents suffer from PTSD; these rates vary depending on type of trauma (Sheeringa, Zeanah, & Cohen, 2011). Researchers agree that these numbers may not capture the full picture. In addition to those youth who meet criteria for PTSD diagnosis, many trauma exposed children exhibit subclinical PTSD symptoms and suffer clinically significant emotional distress and impairments (Overstreet & Matthews, 2011; Copeland et al., 2007; Cohen, Deblinger Mannarino, 2004). Symptoms of PTSD among children include bedwetting despite being toilet-trained before, forgetting how or being unable to talk, acting out the scary event during playtime, or being unusually clingy with a parent or other adult. Teens usually show similar symptoms to adults, but may also develop disruptive, disrespectful, or

destructive behaviors (National Institute of Mental Health [NIMH] n.d.). Given the high

prevalence of CTE, is it important to note that not all children exposed to trauma

develop psychological impairment or PTSD; but among those children who do develop

impairment, the life-time implications may be devastating.

Mental Health Treatment for CTE: Trauma-Focused Cognitive Behavioral Therapy

Researchers conducted a systematic review of seven common interventions

used to treat childhood trauma exposure: individual cognitive behavioral therapy, group

cognitive-behavioral therapy, play therapy, art therapy, psychodynamic therapy, and

pharmacologic therapy. Results from the study indicated both forms of cognitive

behavioral therapy as the most effective in reducing psychological harm among children

and adolescents exposed to trauma (Wethington, Hahn, Fuqua-Whitley, Sipe, Crosby,

Johnson, et al., 2008). The use of evidence-based interventions, specifically cognitive

behavioral therapy, provides public health practitioners with important tools to reduce

the burden of mental health impairment among victims of CTE.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is the gold standard for

treatment of child trauma and is well-supported for resulting in significant negative

youth outcomes associated with victimization (Cohen, Mannarino & Knudsen, 2005;

Deblinger, Lippman, & Steer, 2004; Cohen, Deblinger, Mannarino & Steer, 2004;

Deblinger, Stauffer & Steer, 2001; King, Tonge, Mullen, Myerson, Heyne, Rollings, et

al., 2000). In fact, the National Child Traumatic Stress Network states that TF-CBT "has

the strongest research evidence of any treatment model for traumatized children"

(2012). Twelve randomized controlled trials of TF-CBT have been completed (Dorsey,

Conover, & Cox, 2014). Results from a systematic review of TF-CBT conducted in 2012

suggest that children with CTE that receive TF-CBT in comparison to other trauma interventions (such as Cognitive Behavioral Intervention for Trauma in Schools, Recovering from Abuse programs, Family Cognitive Behavioral Therapy, etc.) showed significantly less symptoms of PTSD, depression, and behavior problems immediately following completion. Furthermore, children who completed TF-CBT were significantly more likely to show decreased PTSD symptoms 12-months after completing therapy (Wethington et al., 2008). Evidence also suggests that victimized youth who participate in TF-CBT with their caretakers are less at risk for violence re-victimization and perpetration (Cary & McMillen, 2012).

TF-CBT is a comprehensive intervention that focuses on meeting the psychosocial needs of children and their caretakers who have experienced or witnessed a traumatic event, such as sexual abuse, traumatic grief, domestic violence, terrorism, or multiple traumatic events. The curriculum of TF-CBT addresses the multiple domains of trauma impact including PTSD, depression, anxiety, externalizing problem behaviors, relationship and attachment problems, school problems, and cognitive problems (Cohen, Mannarino, & Deblinger, 2006). TF-CBT also teaches skills for regulating affect, behavior, thoughts and relationships, trauma processing. The intervention is based on leaning and cognitive theories, and addresses the distorted beliefs and attributions related to the trauma and provides a supportive environment in which children are encouraged to talk about their traumatic experience (Cohen, Mannarino, & Deblinger, 2006; Cohen, Mannarino, & Knudsen, 2004; Cohen, Deblinger, Mannarino, & Steer, 2004). The intervention typically takes between 12 and 16 weeks to complete

and can be implemented with children that range in age from 3 to 21 years old (Cohen, Mannarino, & Deblinger, 2006).

Purpose of the Current Study

Despite research and evidence supporting the efficacy of interventions focused on addressing and preventing negative mental health consequences associated with CTE, many barriers for enrollment and completion of services exist (Kazdin & Blase, 2011; Becker, Greenwald, & Mitchell 2011; Davey & Watson 2008; Staudt, 2007; Staudt, 2003). Among helping professionals, a primary concern when providing services to children and their families is getting them to attend sessions and complete treatment (Staudt, 2003). As Gopalan et al. (2010) state, "Conservative enrollment estimates indicate that approximately 1/3 of children referred for services fail to engage in an initial intake appointment ". Additionally, nearly one-half of families who enroll a child or adolescent in mental health services drop out before completing treatment (Nock & Ferriter, 2005). Such low rates of enrollment and completion of services have important public health implications as children cannot benefit from even the best practices if they do not enroll and complete the treatment.

Traumatized children may not receive available services due to a range of contextual, interpersonal, and intrapersonal factors that serve as barriers for enrollment and completion (Staudt, 2007). Access to services (such as cost and location), personal beliefs and expectations for therapy, perception of mental health diagnosis, family environment, and cultural factors, may all serve as barriers to enrollment and completion of therapeutic interventions. Furthermore, enrolling in and completing services is particularly challenging for families who face socio-economic disadvantages

and ethnic minority status (Rodriguez, Hoagwood, Gopala, Olin, McKay, Marcus, et al., 2013; Gopalan et al., 2010; Kazdin & Blasé 2010; Davey & Watson, 2008; Prinz & Miller, 1991). For example, possible barriers to services cited by low-income families include transportation, time, childcare, dislike of therapy or services, disagreement about diagnosis or treatment, and personal beliefs and expectations for therapy (Koroloff, Elliott, Koren, & Friesen, 1994).

Therapist attributes and the relationship between the therapist and family/child are also both important factors related to enrollment and completion of services. As Gopalan et al. state, "Poor therapeutic alliance is another substantial barrier in engaging and retaining families in child mental health treatment" (2010). Additionally, trauma-focused treatment may have its own barriers due to the nature of post-traumatic symptoms of avoidance and pessimism about the future (Becker, Greenwald, and Mitchell, 2011).   Caregiver characteristics such as parental and family stress, mental health, social support, past experiences with mental health treatment, and having a personal history of unresolved trauma may also serve as important barriers to enrollment and completion of therapeutic interventions for trauma exposed youth (Dorsey, Conover, & Cox 2014; Becker et al., 2011; Self-Brown, LeBlanc, David, Shepard, Ryan, Kelley, & Hodges, 2012; Yehuda, Halligan, & Bierer, 2001).

The purpose of this paper is to explore parental trauma exposure as a possible barrier for enrollment and completion of TF-CBT for children exposed to trauma. For caretakers, psychopathology, depression, lower quality of life, stress, and parenting problems have been shown to be barriers to seeking mental health services for children who are at need of services (Yeh, McCabe, Hough, Dupuis, & Hazen, 2003; Owens,

Hoagwood, Horwitz, Leaf, Poduska, Kellam et al., 2002; Kazdin & Wassell, 2000). Although prior research has documented that parental trauma exposure impacts parenting behavior and risk for child development of PTSD symptoms (Self-Brown et al., 2012; Yehuda, Halligan, & Bierer, 2001), no published studies to date have examined how previous trauma exposure in caregivers may negatively or positively impact whether or not a traumatized child enrolls in or completes therapeutic interventions.

In this project, we will examine the role of parental trauma exposure on enrollment and completion of therapy for trauma exposed youth at The Georgia Center for Child Advocacy (GCCA). GCCA is a community organization that serves children exposed to trauma in the Atlanta metropolitan area. Youth are referred to GCCA from local law enforcement and DFCS agencies for video-taped forensic interviews. Youth with substantiated cases of abuse and trauma receive referrals for therapeutic services. GCCA provides TF-CBT by trained therapists at no-cost to the families of abuse or trauma, public transportation passes to increase access to services, and childcare services for those families who have more than one child that may not be engaging in services. Despite these attempts to decrease barriers for enrollment and completion, fewer than half of referred children ever engage in therapy. Of those children who do attend at least one session, only approximately 30-35% successfully completes therapy.

I hypothesize that children of caretakers with significant trauma history will be less likely to enroll or complete treatment due to the potential barrier that poor parental mental health may pose. Personal coping strategies and resiliency after parental trauma experiences may impact a parent's likelihood of enrolling in or completing treatment for their child. Based on the existing literature, it seems plausible that parents with past

trauma exposure would be more likely to suffer from poorer mental health, and or may think that therapy is less necessary in response to trauma exposure, which they perceive as a more normal part of life experiences. Parents with their own trauma history may be more likely to suffer from their own PTSD, or other symptomatology, and more likely to avoid therapy services, including those for their children. The therapeutic context may pose a barrier for a child enrolling in or completing therapy if a parent utilizes avoidant coping strategies for their own trauma experiences. Alternatively, if a parent was previously exposed to trauma and felt like they effectively coped without therapeutic engagement, he/she may also be less likely to enroll their child in therapy for trauma exposure. As a result of these combined possibilities, I propose that these parents will be less likely to have a child engage in therapy.

Method

Participants

Participants were 43 (5 males, 38 females) caregivers-child dyads referred for therapy services at GCCA due to the child experiencing trauma and demonstrating related posttraumatic stress symptomatology. Of the 43 participants, two were excluded from the statistical analyses because of incomplete or missing data. Caregiver participants had a mean age of 38, and 93% of the sample was African American. Fifty one percent of caregivers were single and not living with a partner; 22% were married; 12% were divorced; 10% were separated; and 5% were single living with a partner. The sample was predominantly of low socio-economic status with 73% reporting a yearly household income of less than $35,000. Approximately 42% of caregivers reported their highest educational attainment as high school or a GED, 32% reported some college, 12% graduated from a 4-year college or university, 10% graduated from a community or

junior college, and 5% attained a graduate or professional degree. More than half of the participants were unemployed; of those participants that were employed 45% worked less than 40 hours per week.

Materials

      Demographic Questionnaire. Participants provided information on gender, age, race, marital status, educational attainment, yearly income, employment status, and household size.

      Posttraumatic Stress Diagnostic Scale (PDS). The PDS is a 49 item self-report scale that screens adults' trauma history and assesses PTSD symptomatology. The trauma screen asks whether or not an individual has experienced a particular traumatic event. PTSD symptom items are assessed on a 0-3 scale (0-not at all or one time, 1=once a week or less, 2=two or four times a week, 3=five or more times a week), according to self-reported frequency of problematic occurrence during the past month. This scale served as a measure of caretaker trauma exposure *(See Appendix A).*

      Structured Interview. Trained assessors completed structured interviews that asked questions about factors related to treatment enrollment and completion for which standardized measures do not exist. These included involvement with child protection, treatment expectations, beliefs about their child's need for treatment, cultural beliefs about mental health treatment, myths and beliefs about trauma and abuse, and logistical barriers to treatment. For the purpose of this paper, I examined the transcripts of the caregivers who reported a history of trauma on the following questions asked during the structured interview: "Have you ever been a victim of abuse/trauma? And [If yes,] "How do you think your abuse affected you?" and "How has your experience impacted your decision-making regarding treatment for your child?" *(See Appendix B)*

Client Record Review. Once a month, the clinical coordinator for GCCA pulled charts for those children of caregivers who completed a survey and interview. Charts were reviewed for service utilization patterns including whether the child enrolled in therapy, the number of sessions attended, and service completion.
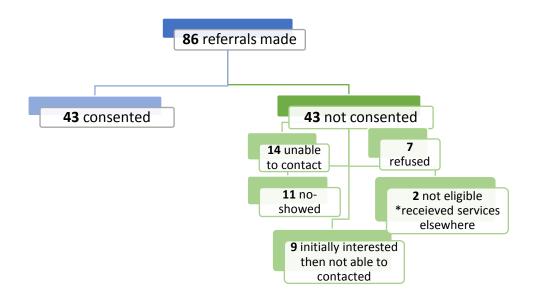
Procedure

Caregiver participants were recruited for the study after a child in their custody completed a forensic interview at the GCCA. Caregiver inclusion criteria included: parent, legal guardian, or foster parent with legal custody who is primary caregiver of a child or adolescent referred for TF-CBT at the GCCA and resides in the same household with the referred child. Caregiver exclusion criteria included limited proficiency in English, significant cognitive impairment, or inability to comprehend the consent form.

Youth who completed a forensic interview at GCCA and the forensic results indicated substantiated trauma (i.e. sexual abuse, witnessing of violence) were referred to GCCA therapeutic services for TF-CBT. At the time of the referral, the forensic interviewer who assisted the caretaker provided a form to the caregiver on which he/she indicated willingness to be contacted about the research project. Caregivers that indicated a willingness to be contacted were called by research personnel and were provided with a description of the current project. Specifically, caregivers were informed that GCCA and GSU were conducting a research project to learn more about how GCCA can better serve families. Research staff used a script to explain the study to caregivers and answer questions regarding the assessment process *(See Appendix C).*

After verbal consent was obtained over telephone, participant interviews were scheduled and conducted at the GCCA. Caretaker interviews consisted of two parts: 1) one computer survey administered via QDS™ (Questionnaire Development Software) which included the demographic questionnaire and PDS and 2) one face-to-face structured interview. At the end of the interview participants were compensated $55 for their time and travel. Service utilization was assessed once a month for up to a year following the interview. Research personnel conducted chart reviews to examine the service utilization patterns of each child in the care of the participants. In the chart review researchers gather information on whether the child enrolled in treatment, the number of sessions attended, utilization of therapeutic services, and service completion.

An attempt was made to contact a total of 86 caregivers regarding participation in the study. 43 caregivers (50%) were contacted and consented to participate in the study. Of the referrals that did not participate, 14 were unable to be contacted, 11 scheduled assessments but no-showed, 9 initially expressed interest but were subsequently unable to be reached, 7 refused, and 2 were not eligible because services were sought elsewhere.

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Results

All quantitative statistics were conducted using SPSS 18 for Windows. All qualitative work was conducted using transcribed audio-recorded interviews. Specifically, I read the raw data specific to parental trauma and generated thematic codes within and across participant related to trauma exposure and attitudes towards enrolling child in therapy.

Description of the Predictor Variable: Trauma Exposure

Results indicated high rates of trauma exposure among participants; 56.1% reported a trauma history (reported experiencing at least one traumatic event). Of those who reported trauma history, 19.5% were involved in a serious accident, 12.2% experienced a natural disaster, 31.7% were non-sexually assaulted by a family member or someone they knew, 22.0% were non-sexually assaulted by a stranger, 36.6% were

sexually assaulted by a family member or someone they knew, 19.5% were sexually

assaulted by a stranger, 24.4% reported having sexual contact with someone five or

more years older when they were younger than 18, 4.9% reported experiencing a life-

threatening illness, and 7.3% reported "Other" trauma (i.e. "losing custody of children",

being kidnapped, child being molested, child physical abuse).

Description of the Outcome Variable: Therapeutic Enrollment

Frequencies of therapeutic engagement were computed to examine overall

enrollment levels among participants. Overall enrollment levels were moderate. Records

of service utilization indicated that 69.2% of participants referred for therapy

subsequently enrolled in services. Of the 30.8% referred for services that never

enrolled, 12.8% (5 participants) refused services and 17.9% (7 participants) expressed

initial interest in services but never engaged with providers.

Description of Outcome Variable: Therapeutic Completion

Frequencies of therapeutic completion were computed to examine completion

levels among participants. Overall, completion levels were low. Records of service

utilization indicated that 29.6% of participants who enrolled in services completed. Of

the 70.4% who enrolled in services but did not complete, 33.3% (9 participants) enrolled

in services but dropped out and 37.0% (10 participants) transferred to another provider.

Two additional participants are still currently enrolled in services and not included in this

analysis.

Logistic Regression: Enrollment

Multivariate logistic regression was run to examine the relationship between

three demographic characteristics and parental trauma history and the outcome variable

enrollment. Results indicated that caregivers with more children living in the same

household were significantly more likely to enroll a child in therapy. Furthermore, a

significant relationship emerged between parental trauma history and enrollment;

parents with trauma history were 10.5 times more likely to enroll a child in therapy.

Table 1
Logistic regression: Demographic and Parental Trauma Exposure Characteristics Associated with Enrollment in TF-CBT

Characteristic	*B*	*SE*	*Wald*	OR	95% CI
Caregiver age	.054	.047	1.333	1.056	.963-1.158
Caregiver Education	.375	.275	1.861	1.454	.849-2.491
Number of children in home	.938	.451	4.317	2.554*	1.055-6.185
Trauma history	2.357	1.057	4.974	10.555*	1.330-83.739

Note. N=39. The trauma history variable has no trauma history as the reference category. Trauma history is dichotomously coded, with a code of 0 reflecting no trauma history disclosure and a code of 1 reflecting at least one traumatic experienced disclosure.

*p < .05

Logistic Regression: Completion

Multivariate logistic regression was run to examine the relationship between

three demographic characteristics and parental trauma history and the outcome variable

enrollment. No significant relationships emerged.

Table 2
Logistic Regression: Demographic and Parental Trauma Exposure Characteristics Associated With Completion of TF-CBT

Characteristic	*B*	*SE*	*Wald*	OR	95% CI
Caregiver age	.026	.044	.343	1.026	.942-1.117
Caregiver	-.139	.313	.196	.871	.472-1.607

Education					
Number of children in home	.141	.297	.225	1.151	.643-2.061
Trauma history	1.353	.950	2.029	3.870	.601-24.903

Qualitative Analyses

Transcriptions of semi structured interviews were reviewed to examine three items specifically: 1) "Have you ever been a victim of abuse/trauma?", [If yes,] 2) "How do you think your abuse affected you?" and 3) "How has your experience impacted your decision-making regarding treatment for your child?" Based on qualitative data, 52% of those participants who disclosed trauma during the computer survey disclosed trauma during the face-to-face interview. Of those participants who disclosed trauma during the structured interview, 57% enrolled in services, 19% never engaged in services, and 24% completed services. Transcriptions of the 52% who disclosed trauma were reviewed for this thesis to help the researcher further examine the role of parental trauma exposure relevant to making decisions of enrolling and completing child treatment when a child has experienced trauma. Transcriptions for those participants who disclosed trauma during the computer survey but not during the face-to-face interview could not be further reviewed due to the close-ended structure of the question. Those participants who stated "No" as the response to the question, "Have you ever been a victim of abuse or trauma?" were not further questioned about trauma history.

Participants who enrolled in or completed services were more likely to express strong feelings or reactions when asked about their own abuse or trauma experiences.

In addition, those participants who enrolled in or completed services were also more likely to have been victims or close family members to victims of physical or sexual abuse or assault. Most caregivers cited struggling with their own abuse or trauma as reason for seeking treatment for their child. Several caregivers state not wanting their children to feel alone or not being able process the trauma similarly to them. For example, one participant stated:

> "I'm not going to let her feel that way- neglected and rejected and ignored. I don't want her to feel ignored. I want her to feel like everybody is listening to her, and that what happened to her is important, and that she is important, and that it is going to get better. You know, I don't want her to have to deal with it like I had to. I had to grow up and manage it on my own for 10 years."

Child well-being and recovery were also strong motivators cited by all caregivers who experienced trauma. Several participants cited their own trauma and subsequent therapy experiences as motivators for enrolling their child in therapy services. Those caregivers who experienced trauma and did not engage in therapy cited their own subsequent drug use and negative coping skills as reason for enrolling their child in services after trauma. For instance, one participant explained:

> "I mean, I smoke. I got into drugs pretty heavy. I've not been with a decent man my whole entire life. If there's a jerk in the room, you know, I'm going to choose that guy to like. I've never been with a man that's been worth a crap, never. And I think that has a lot to do with why I don't want [name of child] to go through the same things".

Participants who never engaged in services were more likely to state communication with others as either alternatives or barriers to engaging in therapy. Two participants stated family members as alternative coping mechanisms to therapeutic interventions such as stating, "Usually just talking to close friends or family, and praying about it [helped]". One participant cited past sources of mistrust when communicating about previous trauma experiences as a possible barrier to engaging in therapy. In addition, two participants stated stigma associated with trauma exposure and therapy as possible barriers to engaging in services. For instance, one participant referenced her personal trauma and therapy by stating:

"With my specific therapy I was raped twice…and I never reported it. I never told anyone…My mother later told me that she was raped when she was a teenager. She didn't tell us when we were teenagers, so I think, you know, that had a lot to do with it. Not communicating and educating your kids to things."

All three caregiver participants whose children completed services were victims of sexual abuse or assault. Additionally, two of the three participants' whose children completed therapy also cited a maternal history of sexual abuse. Two of the three participants who completed services never engaged in any therapeutic intervention after their own; the third participant who did engage in services does not remember details from the treatment.

Discussion

To our knowledge, this study is one of the first to attempt to examine the predictive role of parental trauma exposure in the association with child enrollment and completion of TF-CBT following CTE. Previous research has documented an association between parental trauma exposure and development of PTSD in offspring

following community violence exposure (Self-Brown et al., 2012; Yehuda et al., 2001),

but none have attempted to establish a relationship between parental trauma exposure

and enrollment and completion of therapy services for their child. My hypothesis that

parental trauma exposure would have a negative impact on the enrollment and

completion of TF-CBT for their trauma exposed child were not supported. In fact,

parents with a trauma history were more likely to have a child enroll in therapy.

Role of Parental Trauma Exposure on Engagement and Completion of TF-CBT

        Overall, enrollment levels among participants were moderate. However,

completion levels among participants were low. Dropping out of services and

transferring to other service providers evenly accounted for the high rates of attrition.

Overall, children of participants were more likely to enroll in services if the parent

reported prior trauma exposure. High rates of trauma exposure were reported among

this sample of caregivers, with approximately 56% reporting at least one traumatic

event. Specifically, the majority of reported trauma experiences related to sexual abuse

or assault.

        Caregivers with parental trauma exposure were 10.5 times more likely to enroll

their child in services than parents without trauma exposure. Although parental distress

and poorer mental health are cited in existing literature as barriers to enrollment and

completion of therapeutic interventions, results from this study indicate that parental

trauma exposure may promote enrollment and completion of services for their children

(Self-Brown et al., 2012; Becker et al., 2011; Gopalan, 2010; Gardner et al., 2009;

Staudt, 2003; Yehuda et al., 2001). These findings suggest that parents who have their

own trauma history may understand the important impact and deleterious

consequences associated with CTE, and thus more likely to have a child enroll or

complete therapy. While the researcher hypothesized that parents with trauma exposure may be more likely to avoid therapeutic interventions, this does not appear true in this sample. This may have important implications for clinicians who implement TF-CBT. Screening tools used to assess parental trauma exposure could be used to target parents without trauma histories for interventions that educate parents on consequences of CTE and how TF-CBT helps to alleviate these outcomes. These tools could also be used to further engage families with caregivers exposed to trauma by helping practitioners reiterate the need for therapy services after a traumatic event.

Interestingly, no significant finding emerged for therapy completion. In this study, only eight children completed therapy so the limited power likely significantly impacted results. Existing literature suggest that many factors come into play that influence completion such as access to services, family environment, race and ethnicity, socioeconomic status, parental distress, parental mental health, and therapist attributes (Dorsey, Conover, & Cox 2014; Rodriguez et al., 2013; Self-Brown et al., 2012; Becker, Greenwald, and Mitchell, 2011; Gopalan et al., 2010; Kazdin & Blasé 2010; Davey & Watson, 2008; Yehuda, Halligan, & Bierer, 2001; Prinz & Miller, 1991;). Although results from this study did not indicate significant relationships, further research is needed to better understand how these contextual, interpersonal, and intrapersonal factors serve as barriers to enrollment and completion of TF-CBT.

Based on the qualitative data, participants that disclosed trauma during the face-to-face interview were more likely to enroll and complete services. Those participants who disclosed trauma exposure and enrolled and completed treatment were more likely to express strong feelings regarding their own trauma history and its impact on decision-

making regarding therapy for their child during the face-to-face interview. Qualitative analyses also revealed further understanding about the types of trauma experienced among those participants that reported a trauma history, specifically the impact that parental sexual trauma may have on subsequent enrollment and completion of therapy services for their child. These analyses highlighted the impact of parental experience on the subsequent intent and reasons to enroll their child in services.

ADDITIONAL STUDY FINDINGS

Higher rates of enrollment were significantly associated with more children living in the same household. Specifically, caregivers with greater numbers of children living in the same household were 2.5 times more likely to enroll their child in therapy. This finding may suggest that parents with higher rates of family stress may be more likely to seek help. Contrary to previous research no demographic factors, particularly race or ethnicity and education level, were found to be significant predictors of completion (Becker et al., 2011; Davey & Watson, 2008; Staudt, 2003). This may be partially due to a homogenous sample.

Interestingly, although participants disclosed high amounts of trauma during the computer assessment, they were less likely to disclose trauma experiences during the face-to-face interview. These findings support existing literature that assert that people are more likely to disclose sensitive information during a computer administered survey than during a face-to-face interview (Islam, Topp, Conigrave, van Beek, Maher, White, et al., 2012). These findings suggest the importance of mixed methods research is clearly important when dealing with trauma exposure as a predictor or outcome variable.

Strengths of Investigation

The present study addressed limitations in existing literature on barriers to enrollment and completion of interventions for youth exposed to trauma by examining the potential relationship between parental trauma and subsequent enrollment in therapy for children after trauma. To our knowledge, this study is the first to examine parental trauma exposure as an indicator of child enrollment and completion. Additionally, this study was innovative in its use of a mixed-methods design. Both quantitative and qualitative data were utilized, therefore enriching the context of parental trauma experiences and reasons for enrolling and completing treatment for their children.

Limitations

This study had several limitations. First, the power and effect size of results are limited due to small sample size (N=39). Although odds ratios and relationships can be computed from the data, these estimates included very wide confidence intervals reflecting the small sample size. Second, the service utilization records do not allow for the differentiation between transferring to another service provider and not completing services. Due to the nature of service provision it is difficult, if not impossible for GCCA to track the enrollment or completion of therapy at other agencies. For the purpose of this study, those participants who transferred to other agencies and completed therapy were not included in the completion analyses. Third, this study only examined the role of parental trauma exposure for one caregiver. The possible implications for another or other caregiver's trauma exposure should also be explored.

Future Directions

Future research examining the role of parental trauma exposure as a barrier or predictor of child enrollment and engagement in therapeutic interventions is needed. Future studies are needed to confirm the possible promotion of therapeutic interventions for trauma exposed youth by caregivers exposed to trauma. Future studies should utilize more in-depth questions related to parental trauma exposure as part of a structured interview. These questions should be open-ended and allow caregivers to explain trauma histories at greater length and allow assessors to ask more in-depth follow-up questions regarding the trauma. Additionally, clarifying the definition of trauma at the beginning of the interview may prove beneficial. If a further predictive relationship between parental trauma exposure and enrollment or completion of TF-CBT is validated, researchers and practitioners should work to develop a psycho-educational component for those caregivers without prior trauma exposure. This psycho-education component should serve as a tool to educate caregivers not exposed to trauma about the consequences of childhood trauma exposure and the importance of early intervention. In order to screen for the use of the psycho-educational component, practitioners should incorporate a parental trauma screener into the therapeutic intake process. This screening process could serve dual use as a screener for the added psycho-education component and also as a referral source for caregivers exposed to trauma to receive appropriate treatment, since research suggests parental trauma exposure may serve as a barrier for continued engagement in their child's services (Becker et al., 2011).

Agencies and practitioners should also focus on de-stigmatizing the therapeutic process and fostering therapeutic alliances with families of trauma exposed youth.

Educational components that focus on de-stigmatizing mental health services and possible mental health impairments associated with CTE should be incorporated into the intake process. Since caregivers and families of trauma exposed children are also an active part of the therapeutic process and vital for successful completion of services, positive relationships between the therapist and caregiver should be established. Relationships between the therapist and parent are important predictors of successful completion and engagement in therapy (Dorsey, Conover, & Cox, 2014; Ericzen et al., 2013; Gopalan et al., 2010; Staudt, 2007; Staudt, 2003). Caregivers and families should be educated about the outcomes of childhood trauma exposure and feel included and engaged in services for the child receiving services. Moving forward, providers of TF-CBT and other evidence-based interventions may want to also consider adding an engagement component to the intervention. Although this study does not directly address engagement, recent research indicates that it may be an important construct in completion of evidence-based interventions (Dorsey, Conver, & Cox, 2014; King, Currie, & Petersen, 2014; Gopalan et al., 2010; Staudt, 2007).

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Appendix A
Do not make any marks in this booklet.

This booklet contains 49 items. Use the separate answer sheet to record your responses to the items. For each numbered item, find the corresponding number on your answer sheet and fill in the circle that matches your answer. Use a pencil and fill in the circles on the answer sheet with a heavy, dark mark. Do not make any marks outside the circles. If you want to change an answer, erase it carefully and then fill in your new choice. Do not make any marks in this booklet.

As you mark each answer, be sure that the item number in the test booklet matches the item number on the answer sheet.

PART 1

Many people have lived through or witnessed a very stressful and traumatic event at some point in their lives. Indicate whether or not you have experienced or witnessed each traumatic event listed below by marking Ⓨ for Yes or Ⓝ for No on the answer sheet.

1. Serious accident, fire, or explosion (for example, an industrial, farm, car, plane, or boating accident)
2. Natural disaster (for example, tornado, hurricane, flood, or major earthquake)
3. Non-sexual assault by a family member or someone you know (for example, being mugged, physically attacked, shot, stabbed, or held at gunpoint)
4. Non-sexual assault by a stranger (for example, being mugged, physically attacked, shot, stabbed, or held at gunpoint)
5. Sexual assault by a family member or someone you know (for example, rape or attempted rape)
6. Sexual assault by a stranger (for example, rape or attempted rape)

7. Military combat or a war zone
8. Sexual contact when you were younger than 18 with someone who was 5 or more years older than you (for example, contact with genitals, breasts)
9. Imprisonment (for example, prison inmate, prisoner of war, hostage)

10. Torture
11. Life-threatening illness
12. Other traumatic event

13. If you answered Yes to Item 12, specify the traumatic event on the answer sheet.

IF YOU MARKED YES TO ANY OF THE ITEMS ABOVE, CONTINUE. IF NOT, STOP HERE.

PART 2

14. If you marked Yes for more than one traumatic event in Part 1, indicate *which one bothers you the most.* If you marked Yes for only one traumatic event in Part 1, mark the same one on the answer sheet.

    1. Accident
    2. Disaster
    3. Non-sexual assault/someone you know
    4. Non-sexual assault/stranger
    5. Sexual assault/someone you know
    6. Sexual assault/stranger
    7. Combat
    8. Sexual contact under 18 with someone 5 or more years older
    9. Imprisonment
    10. Torture
    11. Life-threatening illness
    12. Other traumatic event

Below are several questions about the traumatic event you marked in Item 14.

15. How long ago did the traumatic event happen? (mark ONE)
    1. Less than 1 month
    2. 1 to 3 months
    3. 3 to 6 months
    4. 6 months to 3 years
    5. 3 to 5 years
    6. More than 5 years

For the following questions, mark Ⓨ for Yes or Ⓝ for No on the answer sheet.

During this traumatic event:

16. Were you physically injured?
17. Was someone else physically injured?
18. Did you think that your life was in danger?

19. Did you think that someone else's life was in danger?
20. Did you feel helpless?
21. Did you feel terrified?

PART 3

Below is a list of problems that people sometimes have after experiencing a traumatic event. Read each one carefully and choose the answer (0–3) that best describes how often that problem has bothered you IN THE PAST MONTH. Rate each problem with respect to the traumatic event you marked in Item 14.

⓪ Not at all or only one time
① Once a week or less/once in a while
② 2 to 4 times a week/half the time
③ 5 or more times a week/almost always

22. Having upsetting thoughts or images about the traumatic event that came into your head when you didn't want them to

23. Having bad dreams or nightmares about the traumatic event

24. Reliving the traumatic event, acting or feeling as if it was happening again

25. Feeling emotionally upset when you were reminded of the traumatic event (for example, feeling scared, angry, sad, guilty, etc.)

26. Experiencing physical reactions when you were reminded of the traumatic event (for example, breaking out in a sweat, heart beating fast)

27. Trying not to think about, talk about, or have feelings about the traumatic event

28. Trying to avoid activities, people, or places that remind you of the traumatic event

29. Not being able to remember an important part of the traumatic event

30. Having much less interest or participating much less often in important activities

31. Feeling distant or cut off from people around you

32. Feeling emotionally numb (for example, being unable to cry or unable to have loving feelings)

33. Feeling as if your future plans or hopes will not come true (for example, you will not have a career, marriage, children, or a long life)

34. Having trouble falling or staying asleep

35. Feeling irritable or having fits of anger

36. Having trouble concentrating (for example, drifting in and out of conversations, losing track of a story on television, forgetting what you read)

37. Being overly alert (for example, checking to see who is around you, being uncomfortable with your back to a door, etc.)

38. Being jumpy or easily startled (for example, when someone walks up behind you)

39. How long have you experienced the problems that you reported above? (Mark only ONE on the answer sheet.)
   1. Less than 1 month
   2. 1 to 3 months
   3. More than 3 months

40. How long after the traumatic event did these problems begin? (Mark only ONE on the answer sheet.)
   1. Less than 6 months
   2. 6 or more months

Go on to the next page.

PART 4

Indicate if the problems you rated in Part 3 have interfered with any of the following areas of your life DURING THE PAST MONTH. Mark Ⓨ for Yes or Ⓝ for No on the answer sheet.

41. Work
42. Household chores and duties
43. Relationships with friends

44. Fun and leisure activities
45. Schoolwork
46. Relationships with your family

47. Sex life
48. General satisfaction with life
49. Overall level of functioning in all areas of your life

BARRIERS TO SERVICE INTERVIEW PROTOCOL

As we described before, we are looking to understand more about factors that help our clients receive services and factors that interfere with our clients receiving services. We're doing this study because we want to better understand what children and families who have experienced abuse and trauma need and how we can help them. We're talking with you because we were hoping you might be able to help us understand this better. I realize that some questions I ask may be personal. Please remember that you don't have to talk about anything that is uncomfortable for you. Just let me know if you don't want to answer a question.

A. INTRODUCTION AND SUMMARY OF CHILD TRAUMA

OPENING QUESTIONS --Responses to these questions will help the interviewer target the remainder of interview. Not all of the questions below or the wording of the questions will be appropriate to all situations. Interviewers will be trained to use respondent's information and language about the relationship to inform word choice and question choice.)

1. Could you start by saying what happened that brought you and your family to the Georgia Center? (*nature of abuse/trauma, relationship to perpetrator, frequency/ severity/duration/oto, etc*.)

2. Given what has happened, what do you think are the most important ways that the Georgia Center can help you and your family now?

   Q-What are your biggest needs?

   Q-What are your child's biggest needs?

[*If they have not mentioned mental health services above*] One of the services offered at the Georgia Center is therapy or counseling. I'm going to ask you some questions about your thoughts and experiences regarding therapy.

[*If they have mentioned mental health services above*] You mentioned the need for counseling services for you/[your child]/your family. I have some questions I'd like to ask you about your thoughts and experiences about therapy/counseling. (*use whatever term they use*)

General Beliefs About Therapy --*Beliefs about therapy in general.*

1. What do you think about therapy or mental health services, in general?
   [*obtain open-ended response, then prompt for pos/neg, if not provided*]

   Q--Do you think such services can help people?

   Q--Do you think such services can be harmful to people or make situations worse?

2. What do you think of a person who seeks counseling or mental health treatment?

   Q--Do you think it is okay or not okay to talk to someone else about your problems or difficulties?

   Q--For someone who does obtain counseling, do you think it is okay or not okay to share with others their experiences in counseling?

   Q--Do you think there are certain types of people who benefit more from mental health services? If so, what characteristics define them?

3. Have you ever known someone who participated in therapy? Tell me about that. (*alt.-- did they talk to you about it? What were their thoughts or experiences with therapy?*)

4. [*If they have not indicated their own therapy experience in Q4*] How about you, have you ever been in any kind of counseling? [*If so,*] what was that like for you?
   [*obtain open-ended response, then prompt for pos/neg, if not provided*]

   Q--Did it help you in any way?

   Q--Was there something about it that you did not like?

5. Do you think children can benefit from therapy? In what ways?

Specific Beliefs About Therapy for an Abused/Traumatized Child --*Beliefs about their child's need for services.*

1. What are some different ways that [*Sexual Abuse/Trauma*] can impact children and families? [*alt. you have mentioned x,y,z. are there are any other ways that sexual abuse can impact children and families*?]

    Q--How has it affected [*your child*]?

    Q--Your family?

2. There are many reasons that a person <u>might</u> obtain therapy for their child to help them deal with [*abuse/trauma*] like what [*child's name*] has experienced, and many reasons a person <u>might not</u> obtain therapy services for their child after abuse/trauma.

    Q--What are some reasons you can think of that a person would <u>not</u> obtain therapy services for their child after abuse/trauma?

    Q--What are some reasons they <u>would</u> obtain therapy services?

    Q—[*If position not clear*] What are you thinking about therapy for [*child's name*] right now?

3. [*See Questions 4 and 5 above, General Beliefs. If "yes" to either:*] How do you think [*your own therapy experience/the therapy experiences of others*] has contributed to your decision-making regarding therapy for your child?

4. Have you known any other children or adults who were [*abused/traumatized*] or were you a victim of [*abuse/trauma*]? [*If yes,*] how do you think [*your/their*] abuse/trauma affected [*you, them*]?

    Q--What helped [*you/them*] to cope with [*your/their*] abuse/trauma experience?

    Q--What made it more difficult for [*you, them*] to deal with it?

    Q--How has [*your, their*] experience impacted your decision-making regarding treatment for your child?

5. Do you think it is important or not important for [*parents/caregivers*] to be involved <u>in some way</u> in the therapy for children and/or interact with the therapist?

    Q--How Come?

    Q—[*if says it is important*] <u>How</u> do you think they should they be involved?

6. How do you think children, in general, feel about being in therapy?

    Q--How about [*your child*]--Have you asked them?

    Q--[*If so*,] what was their response?

    Q--[*If not*,] what do you think their views of it are?

    Q--How important are [*your child's*] thoughts and feelings about therapy in deciding if you will obtain therapy for him/her?

7. (*For someone supportive of therapy*) What do you think might help someone else, who is unsure about therapy, understand the importance of therapy for a child who has been [*abused/ traumatized*]?

    (*For someone not supportive of therapy for their child*) Under what circumstances, if any, do you think you <u>might want</u> [*your child*] to receive therapy?

    Is there anything about the situation, that if it were different, you would want [*your child*] to receive therapy (*e.g. different reaction by your child, different perpetrator, different behaviors, different kind of abuse/trauma, etc.*)?

8. (*If this has not already been discussed*) What do others in your support network (family, close friends) think and feel about therapy, in general, and about [*your child*] receiving counseling now after the [*abuse/trauma*], more specifically?

9. Are there any specific cultural factors or beliefs that impact your views about therapy, in general, and therapy services for [*your child*] after their abuse/trauma, specifically?

C. LOGISTICAL BARRIERS

1. What are some things in your everyday life that might prevent you or your family members from participating in therapy? (*alt: Are any of the following a concern for you: work schedule, school schedules, other children in home, transportation difficulties—no car or travel distance, [others]*?

2. What might make it easier for your family to participate in therapy?

D. OTHER BARRIERS

1. It is not uncommon for DFCS to become involved with families after abuse/trauma incidents like what brought yours to the Georgia Center. Is DFCS currently involved with your family or have they been involved before?

   Q—How do you feel about that?

   Q--How does this affect your views of therapy services for your child and family? Does it make it less likely or more likely your child will receive services or does it not have any impact at all?

   Q--Has therapy been mandated, now or in the past?

   Q--How do you feel about that?

E. OTHER FACTORS

1. When [*your child*] came in for the Forensic Interview, the Forensic Interviewer met with you after the Interview. Is there any information that would have been helpful for the interviewer to share with you at that time about therapy services?

2. We recognize that that can be a difficult day for some families. Is there a better way the information could be communicated to you?

Is there anything we didn't ask about that you think is important to tell us about your experience with this?

Appendix C

Telephone Script

Hello. How are you? My name is _____ and I am working with the Georgia Center. I am contacting you and your family because at your visit, you checked that it was ok to contact you about research at the GA center. We are currently conducting a project for which you can earn $55 for 1-2 hours of your time. Would you be interested in hearing more?

Great!   The current project that we are working on is designed to help us learn more about how the Georgia Center can better serve the families. We are trying to learn more about what things influence people's decisions about whether to participate in therapy. As a part of the project, you will complete an interview and a survey on a computer. It should take approximately 1-2 hours to complete and you will receive $55 in compensation. Does this sound like a project that you would like to participate in?

What age is your child who was seen at GCCA? [if 8 or over say] We would also like to invite your child to participate in the study. He/she will be asked to answer some questions on the computer about his/her thoughts feelings and behaviors. Would you be able to bring your child into the appointment as well?

[If so] In order for your child to participate in the study, we will need consent from all legal guardians. Who are the primary legal guardians for your child? [if only 1 guardian, move to scheduling appointment].

[if more than 1] You will be asked to complete a formal consent form for your child at the time of the interview. However, because your child has two legal guardians, we need consent from him/her as well. Can we speak to the other guardian to try and get verbal consent over the telephone for your child to participate? [If they do not reside in the same household] Do you know a good way to reach her/him?

If parent agrees,

Will you be brining any additional children to the appointment?

I have an appointment available on _____at _____ . Does that work for you? I will call you 24 hours in advance to confirm.

Telephone Script for Additional Legal Guardian

Hello. How are you? My name is _____ and I am working with the Georgia Center. I am contacting you and your family because at your child's visit, a legal guardian checked that it was ok to be contacted about research at the GA center. I have spoken with _____ and he/she gave me your name and contact information so that I may contact you for your informed consent for _____ to participate. Although you will not be required to attend the interview to complete a formal consent form for your child, it is necessary for us to obtain a verbal consent over the phone for you child to participate in the study. If it is okay, may I go over the consent process with you over the phone now?

[If yes] I will begin by telling you a little about the study. The title of the study is: Understanding Barriers to Enrollment and Completion of Evidence-Based Interventions for Youth at Risk for Violence Perpetration and Victimization

The study is being sponsored by the Emory Center for Injury Control (Funding Agent)

Purpose: Your child is invited to participate in a research study. This project is a partnership between Georgia Center for Child Advocacy (GCCA) and Georgia State University (GSU). The goal of the project is to understand the reasons families with youth who have experienced abuse decide to enroll in and complete treatment. Your child is invited to be in this study because he/she was offered services by GCCA and because you have agreed to participate in the study. Your child is one of the 100 children who will be asked to consent to this study. If you agree to give consent for your child, he/she will be asked to complete a computer survey that will take approximately 30 minutes. Your child will complete this survey in a separate room at GCCA. If you agree to give consent for your child to participate, the research team will also review your child's GCCA record to get information on what services were provided.

Procedures: If you agree that your child can be in this study, he/she will complete computer questions today. Your child will be asked to complete an assent form.

Risks: The main risk for your child is a loss of privacy. GCCA and the GSU research team will take care to make sure your child's responses are kept private. Section VI below tells you how this will be done. In addition, the questions that your child will be asked as part of the assessment may be upsetting. If your child feels upset based on the questions, please inform the research assistant and you and your child will be given information about the free family therapy that is offered through GCCA.

Benefits: There will be no direct benefit to your child for participating in this study. There may be benefit to other children and families based on what we learn. We hope to learn more about how to make GCCA services more available to parents and youth.

Voluntary Participation and Withdrawal: Your child does not have to be in this study. If your child chooses to be in this study and changes his/her mind, he/she can drop out at any time. Whatever he/she chooses, your family will not lose any benefits to which you are entitled.

Privacy: We will keep your child's records private, as required by law. Drs. Self-Brown and Kinnish, and two graduate research assistants at Georgia State University will have access to the information you provide. Information may also be shared with those who make sure the study is done correctly (GSU Institutional Review Board, the Office for Human Research Protection (OHRP). Your child will be given a study number and all his/her information will be filed under the study number. All files will be kept secure. A list that links your child's name and his/her identification number will be kept in a locked office at GSU. The list will be destroyed when the study is over. The records of your child will be tracked for approximately 6 months to determine whether he/she was enrolled and/or completed services.

Questions or Concerns: Call Dr. Shannon Self-Brown of Georgia State University at 404-413-1283 if you have questions about this study. If you have questions or concerns about your child's rights as a participant in this research study, you may contact Susan Vogtner in the Office of Research Integrity at 404-413-3513 or svogtner1@gsu.edu.

If you are willing to allow your child to volunteer for this research, please say "yes".

Thank you for your time!