THE TREATMENT HISTORIES AND SERVICE INVOLVEMENT OF PHYSICALLY AND SEXUALLY ABUSIVE FAMILIES: DESCRIPTION, CORRESPONDENCE, AND CLINICAL CORRELATES

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ABSTRACT

Objective: This study examines the treatment histories, and the service needs, concerns, and involvement of cases referred to Child Protective Services (CPS) following an allegation of child physical or sexual abuse in an effort to document their services experiences.

Method: Standardized clinical assessments were conducted with child victims and their caregivers at intake and at a second assessment following an initial service about 4 to 8 months later ($M = 6$ mos.). Group differences due to informant type and abuse allegation were examined at each assessment and across time.

Results: Thirty percent of the caregivers and children had a past history of psychiatric hospitalization. Reports from both informants at intake identified a range of perceived service needs, treatment goals, and obstacles to service participation. At the post-service assessment, children and their caregivers reported high rates of family (54%, 51%) and parent counseling (50%, 51%), and lower rates for child treatment (13%, 18%). Some significant differences between the two abuse subgroups were found in their patterns of service involvement and in their ratings of service goals and obstacles. Four variables predicted overall family service use at intake: child is Caucasian, low child anxiety, high parental distress, and parental abuse history as a child.

Conclusions: These findings extend initial descriptions of the service involvement of CPS families and bear implications for both practice and research on the delivery of services in CPS. © 1999 Elsevier Science Ltd

Key Words—Services for abused children, Treatment experiences of abusive families, Child abuse interventions, Services research.

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INTRODUCTION

MUCH OF OUR understanding of the services received by families with child victims of physical abuse (CPA) or sexual abuse (CSA) derives from the findings of early multi-site program evaluations that described various client samples, interventions, and providers (see Daro, 1988). These initial evaluations identified varied outcomes for different forms of abuse, client and service factors related to progress, and high re-abuse rates during treatment (about 30%). Given the use of few standardized measures and limited subtype analyses, further examination of service use and outcome in these subgroups seems warranted (Daro, 1993).

Documentation of the nature and impact of the service delivery system in child protective services (CPS) is an important research priority, especially as CPS attempts to extend its prior emphasis on investigation to the provision and evaluation of intervention services (see National Academy of Sciences, 1993, section 7–1, pp. 275–6; U.S. Advisory Board on Child Abuse and Neglect, 1990). Outcome studies documenting the benefits of abuse-specific treatments for physical and sexual abuse provide some therapeutic directions (see Becker et al., 1995; Cohen & Mannarino, 1996; Deblinger, Lippman, & Steer, 1996; Kolko, 1996a; National Academy of Sciences, 1993), but they have examined a small and unrepresentative sample of the clients receiving CPS services, thereby limiting any conclusions about the generality of their benefits. Indeed, data on the nature and effects of agency-provided services for children and families are often unavailable (Daro, 1993), though research information is needed to guide caseworkers to select interventions that match clients to appropriate treatments.

Understanding the treatment and service experiences of abusive families is an important component to ensuring the success of CPS involvement with families. Horowitz, Putnam, Noll, and Trickett (1997) provide novel treatment history data on 81 female CSA victims that indicate the high prevalence of service use in different modalities, differing perspectives of child progress provided by caregivers and therapists, and general satisfaction with services reported by the girls and their caregivers. This study is noteworthy for its large sample size and collection of parameters reflecting service experience and satisfaction, but included only sexually abused girls, limited service involvement measures, and no repeated measures. One recent survey of the treatment provided by mental health practitioners to physical abuse cases found that the family was viewed as the primary client most often and that the children received seven of an average of 23 sessions typically provided to these cases (Greenwalt, Sklare, & Portes, 1998). Additional studies that document the types of services received by children, parents, and families may bear implications for policy and practice, especially if certain types of needed services are received infrequently. For example, studies reporting child and parent interviews should examine informant correspondence to determine the reliability of service assessments. Interview studies of clinically referred families have reported favorable levels of reliability and validity on the Child and Adolescent Service Assessment (CASA; Ascher, Farmer, Burns, & Angold, 1996; Farmer, Angold, Burns, & Costello, 1994; Farmer, Burns, Angold, & Costello, 1997). Reports on similar standardized measures are needed to better understand the service involvement of abused children and their families (see Kolko, 1998a).

The service delivery experiences of CPS cases may be important to evaluate given their potential relationship to treatment participation (Haskett, Nowlan, Hutchesone, & Whitworth, 1991). Information regarding the service motivation, needs, and concerns of children and their caregivers, and the availability of services, may reveal potential obstacles to treatment amenability and participation. Sexual abuse victims have generally reported favorable experiences with various interventions, but negative experiences also have been documented (Berliner & Conte, 1995). Limited motivation or heightened obstacles could inhibit entry into and continued involvement in treatment.

Even the nature of the abuse allegation (i.e., physical vs. sexual) is a potent influence on a client’s service experiences. Interventions for physical abuse have primarily been directed at
parental sensitivity to children’s developmental needs, caregiver anger control, and social isolation (Kolko, 1996b; Oates & Bross, 1995), whereas interventions for sexual abuse generally target victim disclosure, attributions of the experience, and victims’ anxiety/fear management (Berliner & Elliot, 1996). Although few investigations have compared service use across abuse subtypes, one study identified patterns and perceptions of service use that varied by subtype (Garland, Landsverk, Hough, & Ellis-MacLeod, 1996). Children removed from their homes due to sexual abuse were more likely to receive services than those removed for neglect or caretaker absence, with the greatest likelihood of receiving services associated with having clinically significant behavior problems. Similar studies evaluating the service delivery experiences of physically abused children are not yet available, so whether parameters of service use and history differentiate sexually and physically abused children awaits empirical evaluation. Further, examination of the patterns of service use across time may identify different experiences in these subgroups. Such information may contribute to an understanding of the unique caseworker preferences for service referral associated with each abuse subtype. Certainly, the receipt of different services may contribute to different outcomes in the two abuse subtypes.

Actual involvement in services and the length of service use may be related to the specific type of abuse and other child, parent, family, and system factors. For example, specific child characteristics (e.g., child dysfunction, child placement) may increase the level of multi-system service use, including more restrictive types of treatment (Blumberg, Landsverk, Ellis-MacLeod, Ganger, & Culver, 1996), and may prolong time in foster care (Landsverk, Davis, Ganger, Newton, & Johnson, 1996). Research with sexually abused children also reveals that ethnicity and socioeconomic status, legal system involvement, and family acceptance of the need for treatment are associated with follow-through on therapy referral (Haskett et al., 1991; Tingus, Heger, Foy, & Leskin, 1996). Conversely, the lack of a coordinated process of referral, assignment, and monitoring may limit service participation (Humphries, 1995). Other work with female CSA victims shows that the number of sessions attended in therapy was predicted by related child factors (e.g., invasiveness of abuse experience, psychopathology), but not other systemic factors (e.g., family functioning; see Horowitz et al., 1997). Demographic, abuse history, and clinical factors also may influence the number of services actually received by a family. Indeed, the number of services received, rather than the receipt of any specific service, was related to positive client response in a community mental health center serving youth (Shapiro, Welker, & Jacobson, 1997). Thus, a related objective of this study is to empirically examine measures of abuse history/status and clinical functioning of the child and caregiver that predict overall family involvement in intervention services. It is hypothesized that parameters in both domains will contribute to this prediction.

To address the need to better understand the service experiences of CPS families and extend the literature on sexually abused girls in treatment (e.g., Berliner & Conte, 1995; Horowitz et al., 1997), this study will describe and compare reports of the service status and needs of families referred for CPA or CSA. In particular, we describe the past treatment histories, current service involvement, and service needs and concerns of child victims and their caregivers to highlight their respective involvement in common treatment modalities and the motivational supports and impediments that may influence service participation. Second, we examine group differences by informant (child vs. parent) and abuse subtype (physical vs. sexual), and changes from intake until the end of the first reported service, on these measures to understand any differences in their patterns of service involvement. As suggested by prior intervention research, differences may exist between physically and sexually abused children in the services they receive and their perceived obstacles to service involvement (Kolko, 1998b). Third, background characteristics and measures of clinical functioning are being examined as potential predictors of the number of services received. We hypothesized that child and parent/family variables would contribute to this prediction. Such information may offer implications for improving both policy and practice related to service delivery in CPS.
METHODS

Sample and Settings

Cases reported to Allegheny County Children and Youth Services (ACCYS; Pittsburgh, PA) with an initial allegation of CPA or CSA were selected if at least one member of their family was accepted for agency services or had already been receiving a service. In most cases, both the child victim and caregiver participated. All child and caretaker participants had to provide informed assent/consent and complete assessments. Of the 90 referrals to the Pittsburgh Service Delivery Study, 86 had at least some services data and were included in this study (see Kolko, 1998c).

Fifty-two children were alleged to have been physically abused (61%) and 34 were alleged to have been sexually abused (39%). There were 53 girls (62%) and 33 boys (38%) in the study. Forty-six of the children (54%) were African-American, 33 (38%) were Caucasian, and 7 (8%) were biracial. The mean age was 11.6 years ($SD = 2.9$). Alleged offenders included mothers (33%), fathers (26%), stepparents or paramours (22%), and other relatives/adults (19%). Forty-two percent of the cases were founded or indicated; 90% were accepted for further investigation. Most (75%) of the cases had a prior CPS report of an allegation of abuse, neglect, or other maltreatment risk (e.g., acting-out child). In terms of family constellation, nearly half of the families were headed by a single biological parent; 15% included both biological parents. Thirty-nine percent of the primary caretakers were never married; 25% were married, and 34% were either widowed or divorced. Most families received welfare (62%). Approximately one-half of the sample reported an overall annual family income of less than $10,000, with slightly more than one-fifth reporting incomes greater than $19,000 per year. The median family size was four members ($M = 4.5; SD = 2.3$; range: 1–10).

Procedures

Recruitment. Recruitment efforts were directed towards cases that met the following criteria: (1) child age between 7 and 18 years, (2) current allegation of physical or sexual abuse, and (3) caseworker report of family referral for or current involvement in services. Families were recruited through direct caseworker contact, mailings to prospective participants, and, per agency approval, calls to parents. Some cases involved only one of the informants due to special circumstances (e.g., child placement). All children and their caregivers completed approved assent/consent forms.

Assessment overview. Children and parents were interviewed by separate research associates at study intake (2–4 weeks after the allegation report) and 4 to 8 months after receiving an initial service ($M = 6$ mos.). The latter interview reflected the family’s experiences since the preceding intake assessment. Sixty-six cases were available for re-interviews. Both informants were compensated for their participation. Standardized measures evaluated: (1) abuse incident allegations and history (e.g., type and severity of abuse); (2) treatment and service involvement; and (3) child, parent, and family dysfunction (e.g., child behavior problems, parental practices, family relationships). Provider reports were collected, but are not being evaluated in this report.

Assessment of Abuse Allegation and History

CPS caseworkers completed forms in the Child At Risk Field system (CARF; Holder & Corey, 1986, 1993) at critical milestones in the case, per ACCYS guidelines. The Risk Management Intake Worksheet (#200) was completed on all cases to reflect basic intake information about each incident (e.g., demographics, incident details, consequences). The referral incident allegation (physical or sexual) was used to evaluate abuse subgroup differences. Three demographics (child
age, gender, race) and three intake form variables (allegation, substantiation status, prior CPS contact) were selected for examination as correlates of service use.

Assessment of Treatment and Service Involvement

Treatment History Assessment Items (THAI). Drawing upon other service utilization items (e.g., National Comorbidity Study; Kessler, 1994), the THAI was developed for this study to assess the past treatment history of the abused child and adults in the child’s home. Four general treatment modalities were surveyed (hospitalization, mental health services, medication for emotional, behavioral, or substance use problems, and medication for medical/health problems). Two questions examined whether the child or adult(s) continued in the service until its scheduled completion (i.e., goals were achieved, termination was mutually determined) and how helpful the services were (0 = not at all; 1 = somewhat; 2 = a lot).

Local Use of Services Instrument (LUSI). Also developed for this study, the LUSI was administered to children and parents at each assessment to document the specific services received by the family. Each informant was asked to identify which of 32 services they had received. The list was based on (1) a state-wide program monitoring form used to track all of the services provided to families receiving family preservation or shelter diversion (Department of Public Welfare, Form CY 844, March, 1992); and (2) recommendations from several ACCYS supervisors or community clinicians from provider agencies. The duration of each primary service was classified to determine the percentage of cases who reported a duration of < 6 months. Each service also was classified into one of six primary service categories that reflected both the setting and target of the intervention: (1) child placement (e.g., shelter); (2) crisis intervention services (e.g., family preservation); (3) family services (e.g., family therapy, family recreation, housing, legal services); (4) caregiver/adult services (e.g., individual counseling, marital counseling, drug & alcohol, life skills training, homemaker services); (5) child services (individual and group therapy, probation); and (6) miscellaneous (e.g., evaluation/testing).

Service Needs and Concerns Report (SNACR). Children and their parents completed an evaluation of the level of perceived service needs, motivation and interests, goals or expectations, and obstacles. This form is based on prior work designed to evaluate the expectations of families receiving mental health services for their children’s behavioral problems (Kolko, 1997). The overall family problems severity score consisted of the sum of three, 3-point, Likert-scale items that evaluated the perceived severity of child, parent, and family problems (0 = no problems at all; 1 = some problems; 2 = a lot of problems). The service motivation and interests score reflected the sum of three, 3-point Likert scale items reflecting the respondent’s and perceived family’s willingness to participate, and a separate score based on two comparable items that reflected the interviewer’s impressions of the family’s motivation (0 = not at all; 1 = some; 2 = a lot). Respondents also provided ratings on 5-point Likert scales from 0 (not at all) to 4 (very much), as to the importance they ascribed to various treatment goals. They completed four items related to child-specific goals (e.g., self-control, communication) and four items related to parent or family goals (e.g., parental handling of personal problems, family problem solving). Finally, the perceived level of difficulty imposed by 10 treatment obstacles was rated on a 3-point Likert-scale (0 = not at all; 1 = some; 2 = very much) which reflected child obstacles (1 item), parent obstacles (4 items), family/outside obstacles (3 items), and resource obstacles (2 items). Two questions were asked regarding the family’s most preferred type of service (fill-in) and the importance of having the other informant involved in treatment (0–2 point scale). Alphas for all subscales at pretreatment were acceptable for child (.51–.69) and parent reports (.74–.92). Pearson correlations showed
positive relationships for the two-item subscales, $r = .21$ to $.42$; $p < .06$ to .01. Post-assessment alphas were generally higher for child and parent reports (all above .60; $M_s = .64$ to .79).

**Measures of Child, Parent, and Family Dysfunction**

Several child, parent, and family dysfunction measures were examined as potential predictors of the family’s total service involvement.

**Child.** The child dysfunction measures included the: (1) Child Behavior Checklist (CBCL; Achenbach, 1991) to reflect total problems and social competence; (2) Trauma Symptom Checklist for Children (TSC-C; Briere, 1996) to evaluate overall abuse-related symptoms (e.g., depression, sexual concerns, posttraumatic stress); and (3) Global Assessment Scale for Children (Kiddie-GAS; Shaffer et al., 1983) to assess overall adjustment (range: 1–100; clinical cutoff = 60).

**Parent.** Measures of caregiver dysfunction included the: (1) parental childhood abuse history scale on the Child Abuse and Neglect Interview Schedule (CANIS; Ammerman, Hersen, Van Hasselt, Lubetsky, & Sieck, 1994); (2) Brief Symptom Inventory (BSI; Derogatis & Melisaratos, 1983) to reflect overall parental distress; (3) Child Abuse Potential Inventory (CAPI; Milner, 1986); (4) positive parenting subscale of the Parental Practices Questionnaire (Loeber, Farrington, Stouthamer-Loeber, & Van Kammen, in press); (5) Drug Abuse Screening Test (DAST; Gavin, Ross, & Skinner, 1989) to reflect overall parental involvement in substance abuse; (6) child-completed Parent Perception Inventory (Hazzard, Christensen, & Margolin, 1983) to evaluate parental involvement in positive behaviors; and (7) Global Assessment of Functioning index of adult adjustment.

**Family.** Family measures included: (1) child ratings of family, teacher, and peer social support on the Survey of Children’s Social Support Scale (SOCSS; Dubow & Ullman, 1989); (2) an aggregate of child and parent ratings on the relationship subscales (e.g., conflict, cohesion) of the Family Environment Scale (FES; Moos, Insel, & Humphrey, 1974); (3) parent ratings on the Conflict Tactics Scales (CTS; Straus, 1990) to assess family violence; and (4) family stress items on the Children’s Life Events Inventory (e.g., separations, personal loss; see Chandler, Million, & Shermis, 1985).

**Data Analysis**

Descriptive statistics were computed to summarize child and caretaker measures obtained at each assessment. Chi-square tests or $t$-tests were used to examine differences by type of informant (child vs. parent) and by abuse allegation (physical vs. sexual). Parent-child correspondence in identifying individual services was examined using Cohen’s kappa. McNemar tests were computed to examine differences across time (from pre- to post-assessment). Analyses of variance (ANOVAs) with repeated measures could not be conducted due to the pattern of missing data when applying a factorial model ($n = 35$). Multiple regression was used to examine selected predictors of overall involvement in services. For each of the primary measures, we review reports on each measure for both informants and the abuse allegation groups at each of the two time periods before comparing any changes in the responses of these groups across time.

**RESULTS**

**Treatment History**

**Intake.** Table 1 shows the treatment histories of the abused children and adults living in their homes as reported by their parents on the THAI at intake (i.e., the period that preceded this incident) and
Service experiences of abusive families

Table 1. Treatment Histories of Parents and Children Reported at Intake and After Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Intake Overall</th>
<th>Physical</th>
<th>Sexual</th>
<th>After Services Overall</th>
<th>Physical</th>
<th>Sexual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Inpatient Tx.</td>
<td>22 30.6</td>
<td>12 26.7</td>
<td>10 35.7</td>
<td>3 6.4</td>
<td>2 7.1</td>
<td>1 5.3</td>
</tr>
<tr>
<td>Child Outpatient Tx.</td>
<td>16 30.9</td>
<td>10 22.2</td>
<td>6 21.4</td>
<td>6 12.8</td>
<td>3 10.7</td>
<td>3 15.8</td>
</tr>
<tr>
<td>Child Meds—behavior</td>
<td>7 10.9</td>
<td>4 8.9</td>
<td>3 10.7</td>
<td>8 17.0</td>
<td>5 17.9</td>
<td>3 15.8</td>
</tr>
<tr>
<td>Child Meds—health</td>
<td>10 16.1</td>
<td>4 8.9</td>
<td>6 21.4</td>
<td>6 12.8</td>
<td>3 10.7</td>
<td>3 15.8</td>
</tr>
<tr>
<td>Any modality</td>
<td>32 43.8</td>
<td>19 42.2</td>
<td>13 46.4</td>
<td>13 27.7</td>
<td>6 21.4</td>
<td>7 36.8</td>
</tr>
<tr>
<td>Servs. completed</td>
<td>24 75.0</td>
<td>10 71.4</td>
<td>14 77.8</td>
<td>24 75.0</td>
<td>15 75.0</td>
<td>9 75.0</td>
</tr>
<tr>
<td>Services helpful</td>
<td>11 40.7</td>
<td>4 28.6</td>
<td>7 53.8</td>
<td>17 54.8</td>
<td>9 50.0</td>
<td>8 61.5</td>
</tr>
<tr>
<td>Parent Inpatient Tx.</td>
<td>24 32.9</td>
<td>13 28.9</td>
<td>11 39.3</td>
<td>4 8.5</td>
<td>2 7.1</td>
<td>2 10.5</td>
</tr>
<tr>
<td>Parent Outpatient Tx.</td>
<td>11 22.4</td>
<td>8 17.8</td>
<td>3 10.7</td>
<td>8 17.0</td>
<td>4 14.3</td>
<td>4 21.1</td>
</tr>
<tr>
<td>Parent Meds—behavior</td>
<td>13 19.1</td>
<td>10 22.2</td>
<td>3 10.7</td>
<td>4 8.5</td>
<td>2 7.1</td>
<td>2 10.5</td>
</tr>
<tr>
<td>Parent Meds—health</td>
<td>11 19.6</td>
<td>6 13.3</td>
<td>5 17.9</td>
<td>10 21.3</td>
<td>4 14.3</td>
<td>6 31.6</td>
</tr>
<tr>
<td>Any modality</td>
<td>25 34.2</td>
<td>14 31.1</td>
<td>11 39.3</td>
<td>12 25.5</td>
<td>7 25.0</td>
<td>5 26.3</td>
</tr>
<tr>
<td>Servs. completed</td>
<td>25 89.3</td>
<td>15 88.8</td>
<td>10 90.9</td>
<td>19 76.0</td>
<td>14 77.8</td>
<td>5 71.4</td>
</tr>
<tr>
<td>Services helpful</td>
<td>14 58.3</td>
<td>8 57.1</td>
<td>6 60.0</td>
<td>14 58.3</td>
<td>9 69.2</td>
<td>6 54.5</td>
</tr>
</tbody>
</table>

Note. Tx. = treatment; Meds = medication; Servs. = services.

Table 1 also shows the treatment histories of the abused children and adults since intake (i.e., once their initial services were completed). After services. Table 1 also shows the treatment histories of the abused children and adults since intake (i.e., once their initial services were completed). About one-third of the children received at least one form of service. Few children had been hospitalized and about 15% had participated in outpatient treatment or received medication. Treatment had been completed for about three-fourths of these cases and perceived as not or minimally helpful by nearly one-half of the children. A higher proportion of children referred for sexual (than physical) abuse were involved in some intervention after intake, \( \chi^2 \left( 1, n = 47 \right) = 4.04, p < .05 \). As with the children, few adults (25%) had received any services. Treatment had been completed for three-fourths of these participants. Ratings of low perceived helpfulness were reported by approximately one-half of the adults. Chi-square tests revealed no significant abuse allegation differences in the caregivers recent treatment histories.
Changes across time. McNemar tests were conducted to evaluate differences from intake to service completion in the treatment experiences of the two informants and the two abuse subgroups. There were no significant differences for either child or parent reports. Among the physical abuse cases, parents reported higher ratings of service helpfulness over time, \( p < .02 \); yet, fewer of them had received any treatment by post-service assessment, \( p < .04 \). The perceived helpfulness of parental treatment only tended to increase over time, \( p < .065 \). There were no significant changes over time in the treatment histories of sexually abused children or their caretakers, but parents tended to have less inpatient treatment by post-service assessment, \( p < .065 \).

Description of Local Services Received

Informant correspondence. Table 2 presents the level of child-parent correspondence for services received in each primary category taken from intake reports on the LUSI (kappa). There was very good agreement as to whether the family received in-home crisis intervention, and good agreement for family, parent, and child services. Correspondence regarding child placement services was low, in part, because few reports were made. Even though there was fairly good informant correspondence, the following section presents the reports of each informant separately in order to better understand their unique perspectives.

Intake. Table 3 describes the proportion of cases who received each specific service and any service within one of the six primary service categories as reported by children and parents on the LUSI at intake assessment. Child reports revealed that about one-half of the cases received family counseling and one-third received individual parent counseling. Child therapy and child placement were noted for approximately 17% and 12% of the cases, respectively. According to the children, few parents had received any services for substance abuse or general parent education. No child reported any evaluations, medication, children’s support groups, or specific concrete services (e.g., homemaker, financial assistance). The percentage of cases who reported a duration of at least 6 months for the most common services varied, as follows: crisis intervention (14.3%), family counseling (17.9%), individual parent treatment (29.4%), and child treatment (60.0%).

Caregivers reported similar levels of service involvement to those reported by their children. Specifically, less than one-half of the parents reported family therapy and very few caregivers noted any individual therapy, substance abuse treatment, or parent education. Nearly 20% of the caregivers reported that their children had received their own therapy and 7% reported some type of child placement. No parent reported any evaluations, concrete services, legal services, or medication. Thus, both children and parents reported that their families had received a subset of the many services that were available through the CPS agency. The percentage of cases where parents

<table>
<thead>
<tr>
<th>Service</th>
<th>Kappa</th>
<th>Percent Agreement</th>
<th>Disagreements</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Placement</td>
<td>.25</td>
<td>91</td>
<td>4</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>In-home Crisis</td>
<td>.68</td>
<td>91</td>
<td>2</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Family Services</td>
<td>.53</td>
<td>77</td>
<td>7</td>
<td>13</td>
<td>5</td>
</tr>
<tr>
<td>Parent Services</td>
<td>.54</td>
<td>77</td>
<td>3</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Child Mental Health</td>
<td>.58</td>
<td>87</td>
<td>3</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Evaluation</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Note: \( n = 53 \); - = too few cases reported.

Table 2. Child–Parent Correspondence for Services Reported at Intake (LUSI)
reported a duration of at least 6 months for the most common services generally paralleled the children’s reports: crisis intervention (0.0%), family counseling (18.5%), individual parent treatment (37.5%), and child treatment (57.1%). Based on an aggregation of both informants’ reports, 10 cases (12.1%) received no formal services, 39 (47%) cases received one service, 22 (26.5%) received two services, eight (9.6%) received three services, and four (4.8%) received four services.

The responses on the LUSI for the two abuse allegation subgroups are also shown in Table 3. Both subgroups reported similar levels of individual parent treatment, child therapy, and child placement. Three children per group were placed in foster care. Physically abused children tended to report greater involvement in family counseling, \( \chi^2 (1, n = 58) = 3.09, p < .08 \), but less parental involvement in outpatient drug/alcohol treatment, \( \chi^2 (1, n = 58) = 3.38, p < .07 \), than sexually abused children. Children from both abuse subgroups reported an average of 1.5 services, \( t < 1.0, ns \). Nearly 25% of both samples reported two or more services.

A similar pattern was found for caregiver reports, with one exception. Although caregivers of sexually (vs. physically) abused children reported a higher percentage of child placement at pretreatment, the difference did not remain significant upon application of Yates correction, \( \chi^2 (1, n = 58) = 3.15, p < .14 \). Like their children, parents of both subgroups reported an average of slightly more than 1.5 services, \( t < 1.0, ns \). Nearly 40% of both samples reported two or more services.

After services. Table 4 shows the type(s) and amount of services received since intake at the post-service assessment. Approximately one-half of the children reported family counseling and individual parental treatment. Less than one-fifth of the children indicated any involvement in individual treatment, and even fewer reported any crisis intervention. One-half of the parents reported any family or individual therapy, with less than 20% of the parents reporting any child treatment or crisis services. Children did not report any involvement in many of these services.
especially parent-directed services.

Overall, a high percentage of children and parents acknowledged involvement in some type of mental health service. Based on both informant’s reports, 23 cases (27.7%) received no formal services, 25 (30%) cases received one service, 21 (25%) received two services, six (7.2%) received three services, four (4.8%) received four services, and four (4.8%) received five or more services. T-tests revealed no abuse allegation differences in the number of services received based on the two informants’ reports.

Child reports for the two abuse subtypes were similar for some services, but not others. Both groups acknowledged minimal placement, and parent and family treatment. Sexually abused children reported greater involvement in individual child treatment, \( \chi^2 (1, n = 46) = 6.67, p < .01 \), and tended to report greater involvement in parent services, \( \chi^2 (1, n = 47) = 3.15, p < .08 \), than physically abused children. Children from both abuse subtypes reported a total of approximately 1.5 services, \( t < 1.0, ns \) on average. More than 35% of both samples reported two or more services.

Parent reports in the two abuse subgroups were also similar for most services, such as parent counseling and family therapy. However, parents of physically abused children reported greater involvement in crisis services than sexually abused children, \( \chi^2 (1, n = 45) = 6.48, p < .01 \). Conversely, parents of sexually abused children tended to report greater parental involvement in inpatient drug/alcohol treatment, \( \chi^2 (1, n = 45) = 3.14, p < .08 \). Parents from the two abuse subtypes reported a total of approximately 1.5 services, \( t < 1.0, ns \), on average.

Changes across time. Changes in the proportion of cases receiving each of these service categories from intake until post-service assessment were examined for reports by children and their

<table>
<thead>
<tr>
<th>Service</th>
<th>Overall</th>
<th>Physical</th>
<th>Sexual</th>
<th>Overall</th>
<th>Physical</th>
<th>Sexual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Placement</td>
<td>5</td>
<td>11.0</td>
<td>3</td>
<td>12.0</td>
<td>2</td>
<td>9.5</td>
</tr>
<tr>
<td>Child placement</td>
<td>5</td>
<td>10.9</td>
<td>3</td>
<td>12.0</td>
<td>2</td>
<td>9.5</td>
</tr>
<tr>
<td>In-home Crisis</td>
<td>4</td>
<td>8.7</td>
<td>4</td>
<td>16.0</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Family</td>
<td>25</td>
<td>54.3</td>
<td>16</td>
<td>64.0</td>
<td>9</td>
<td>42.9</td>
</tr>
<tr>
<td>Family therapy</td>
<td>25</td>
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<td>16</td>
<td>64.0</td>
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<td>42.9</td>
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<td>0</td>
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<tr>
<td>Case manager</td>
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<td>2</td>
<td>8.0</td>
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<tr>
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<td>0.0</td>
</tr>
<tr>
<td>Parent</td>
<td>23</td>
<td>50.0</td>
<td>9</td>
<td>36.0</td>
<td>14</td>
<td>66.7</td>
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<tr>
<td>Individual therapy</td>
<td>22</td>
<td>47.8</td>
<td>9</td>
<td>36.0</td>
<td>13</td>
<td>61.9</td>
</tr>
<tr>
<td>Group therapy</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>D/A outpatient</td>
<td>1</td>
<td>2.2</td>
<td>0</td>
<td>0.0</td>
<td>1</td>
<td>4.8</td>
</tr>
<tr>
<td>D/A inpatient</td>
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<td>0.0</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Support group</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
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<td>0.0</td>
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<tr>
<td>Parent education</td>
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<td>0</td>
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<td>0</td>
<td>0.0</td>
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<tr>
<td>Medication</td>
<td>1</td>
<td>2.2</td>
<td>1</td>
<td>4.0</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Child</td>
<td>6</td>
<td>13.0</td>
<td>1</td>
<td>4.0</td>
<td>5</td>
<td>23.8</td>
</tr>
<tr>
<td>Individual therapy</td>
<td>5</td>
<td>10.9</td>
<td>0</td>
<td>0.0</td>
<td>5</td>
<td>23.8</td>
</tr>
<tr>
<td>Partial program</td>
<td>1</td>
<td>2.2</td>
<td>1</td>
<td>4.0</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Support group</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Evaluation</td>
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<td>0.0</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
</tr>
</tbody>
</table>

Note. D/A = drug/alcohol; MH = mental health. Several services were not reported by either informant (see text). n = 46 (child) and 45 (parent).
caregivers using McNemar tests. There were no significant changes in service involvement for child or parent reports. For all reports combined, there were no significant changes over time; however, parents tended to receive more services by post-service assessment based on the combined reports of the two informants, *p* = .057.

Among physically abusive families, there was a reduction over time in the proportion of children who reported involvement in their own, individual mental health services, *p* = .03. No such difference was reported by sexually abused children. Understandably, caregivers of physically, *p* = .006, and sexually, *p* = .04, abused children reported less overall involvement of family members in mental health services by the post-service assessment.

### Prediction of total number of services received

To identify potential predictors of service use, Pearson correlations or chi-square tests were computed to determine the relationships between several key clinical characteristics (three CPS intake variables, three demographics, 15 clinical functioning variables) and the total number of individual services reported by children or their caregivers at each time period. Only four variables were significantly related to overall service involvement, namely, child race, *χ²*(1, *n* = 83) = 9.13, *p* < .003, child anxiety on the RCMAS, *r*(63) = −.28, *p* < .03, parental distress on the BSI, *r*(83) = .24, *p* < .03, and parental childhood abuse history, *r*(74) = .26, *p* < .03. The four variables were then entered into a multiple regression analysis. The number of services received at intake was predicted by all four variables, *F*(4, 51) = 5.76, *p* < .0007; *Multiple R* = .56, *Adjusted R²* = .26. Caucasian children (*β* = .27) with lower levels of anxiety (*β* = −.26), and parents with heightened distress on the BSI (*β* = .22) and more abusive experiences as children (*β* = .20) received more services at intake. Three of these variables predicted the number of services reported at post-service assessment, *F*(3, 59) = 3.72, *p* < .02; *Multiple R* = .40, *Adjusted R²* = .12, with beta weights as follows: child is Caucasian (*β* = .25), parental distress (*β* = .22), and (low) child anxiety (*β* = −.20).

### Service Needs and Concerns

#### Intake

Ratings on the SNACR are presented in Table 5. At intake, the children reported moderate concerns about individual and family problems, with considerable variability. Both the children and evaluators perceived a high level of child motivation to participate in services. The children also reported moderate ratings about the need to address child and parent/family goals during treatment.
They identified parent factors (e.g., parent too busy, parent does not think counseling will help) as the largest obstacles to successful treatment participation, with less significance assigned to child and family obstacles (e.g., child disinterest, existing services). Caregiver ratings were generally similar to those of the children; however, caregivers assigned higher ratings to the severity of family problems, $F(1, 54) = 8.06, p < .005$, and the importance of targeting child behavior and competencies as treatment goals, $F(1, 53) = 8.64, p < .004$. Children acknowledged greater obstacles to parental treatment participation than did parents, $F(1, 51) = 4.12, p < .05$, though the reverse was not true with respect to ratings of child-imposed obstacles to participation, $F(1, 52) = 1.16, ns$.

SNACR ratings for the two abuse subgroups also were compared using independent-samples $t$-tests. There were no statistically significant group differences on any of these variables. However, Table 5 shows that physically abused children seemed somewhat more concerned about targeting their own behavior in treatment and reported more serious parental obstacles to treatment participation than sexually abused children. Further, caregivers of physically abused children reported greater interest in targeting parental/family problems during intervention than caregivers of sexually abused children. Overall, the two subgroups showed comparable ratings as to the importance of various treatment needs, goals, and obstacles.

**Table 6. Service Needs and Concerns Reported by Children and Parents After Services**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Child Overall</th>
<th>Child Physical</th>
<th>Child Sexual</th>
<th>Parent Overall</th>
<th>Parent Physical</th>
<th>Parent Sexual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Problems (6)</td>
<td>2.6 2.1</td>
<td>2.7 2.4</td>
<td>2.3 1.9</td>
<td>3.3 2.2</td>
<td>3.2 1.7</td>
<td>4.5 2.3</td>
</tr>
<tr>
<td>Treatment Goals</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child (16)</td>
<td>4.7 3.6</td>
<td>5.9 3.4</td>
<td>3.2 3.4</td>
<td>4.1 3.6</td>
<td>3.5 3.6</td>
<td>5.0 3.5</td>
</tr>
<tr>
<td>Parent/family (16)</td>
<td>4.7 3.8</td>
<td>5.3 3.7</td>
<td>4.1 3.9</td>
<td>3.0 2.9</td>
<td>3.0 2.6</td>
<td>3.0 3.8</td>
</tr>
<tr>
<td>Treatment Obstacles</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child (2)</td>
<td>0.2 0.5</td>
<td>0.2 0.5</td>
<td>0.1 0.4</td>
<td>0.4 0.7</td>
<td>0.4 0.7</td>
<td>0.3 0.6</td>
</tr>
<tr>
<td>Parent (8)</td>
<td>2.2 2.8</td>
<td>1.9 2.4</td>
<td>2.6 3.5</td>
<td>1.4 2.1</td>
<td>1.6 2.2</td>
<td>1.0 1.8</td>
</tr>
<tr>
<td>Family (6)</td>
<td>0.8 1.2</td>
<td>0.7 0.9</td>
<td>1.2 1.5</td>
<td>0.6 1.0</td>
<td>0.5 0.8</td>
<td>0.7 1.3</td>
</tr>
<tr>
<td>Few resources (4)</td>
<td>0.3 0.8</td>
<td>0.3 0.7</td>
<td>0.5 1.1</td>
<td>0.7 1.1</td>
<td>0.7 1.1</td>
<td>0.7 1.2</td>
</tr>
</tbody>
</table>

*Note.* Numbers in parenthesis refer to the maximum scores possible for that subscale. Treatment motivation items were not surveyed after services.

After services. At the post-service assessment, children maintained moderate ratings of family problems and the importance of targeting child and parent treatment goals, again with considerable variability (see Table 6). They reported modest concern about parent treatment obstacles and minimal concern regarding child or family obstacles. Parent ratings reflected moderate concern about the severity of family problems. There was much variability in their perceptions of the need to target goals related to both their children and themselves. In general, parents reported minimal child, parent, or family obstacles to service participation. There were no significant informant differences on these ratings; however, parents tended to report a higher level of family problems than children, $F(1, 40) = 3.35, p < .07$.

The ratings assigned by physically versus sexually abusive families are also shown in Table 6. Both groups of children rendered modest ratings of family problems. Physically abused children tended to assign higher ratings to the need to target children’s psychological skills than sexually abused children, $F(1, 22) = 3.87, p < .06$, but both groups rendered similar ratings regarding parent targets and the impact of service obstacles, $F(1, 42) = 2.16, ns$. Parent ratings indicated a modest need to target children’s skills, but there were no significant subgroup differences on any of these items.
Changes across time. Paired-samples t-tests found no significant pre-post changes on the SNACR for child or parent reports. Across subgroups, physically abused children reported over time less importance to targeting child, $t(47) = 4.27, p < .0001$, and parent/family goals, $t(47) = 4.93, p < .0001$, and fewer parental, $t(64) = 1.97, p < .05$, and family resource obstacles to participation, $t(56.86) = 2.00, p < .05$. They also tended to acknowledge fewer child-related obstacles to service involvement over time, $t (63) = 1.80, p < .07$. Sexually abused children also reported less importance over time to targeting child-specific, $t(28) = 3.85, p < .001$, and parent/family goals, $t(28) = 4.62, p < .0001$, and fewer child-related service obstacles, $t (31) = 2.39, p < .02$. Finally, parents of physically abused children reported less importance over time to targeting child, $t (44) = 7.46, p < .0001$, and parent/family treatment goals, $t (43) = 8.32, p < .0001$, as did the parents of sexually abused children, $t (23) = 4.49, p < .0001$, $t (18) = 3.08, p < .005$.

DISCUSSION

This study identified treatment histories and the services received by a sample of families referred to a county CPS agency following an allegation of physical or sexual abuse. Children and their caregivers described past and current service use, and rated the importance of various service needs, goals, and obstacles in semi-structured interviews. There was good child-caregiver correspondence in reports of the services they received. Some significant differences emerged in the reports of the two informants and the two abuse subgroups on items reflecting treatment history, service involvement, and service goals and obstacles.

Child and Parent Experiences

One-third of the children and caregivers had a lifetime history of psychiatric hospitalization and almost 60% of them had outpatient treatment in the year that preceded the referral incident. This hospitalization rate was higher than the rate reported by Horowitz and colleagues (1997) for sexually abused children who received individual therapy. Many of these inpatient and outpatient experiences were perceived as only minimally helpful, conveying dissatisfaction with prior treatment. Quite plausibly, limited helpfulness may contribute to heightened recidivism rates and/or referral to additional services with additional costs. The fact that families continued to participate in services, despite this level of dissatisfaction, may be due to being mandated for services. Of course, it is not possible to determine the reason(s) for this limited helpfulness, but it did not appear to reflect premature termination (reported by 25% of the sample). Although poor response to prior interventions is a maltreatment risk field in the CARF (Holder & Corey, 1986), it is possible that this was only minimally considered by caseworkers. Perhaps the assessment of prior treatment may warrant greater consideration when developing a family’s service plan.

As would be expected, there was considerable variability in ratings of the severity of family problems, motivation to participate in services, and significance of child, parent, and family obstacles to service involvement. Caregivers were significantly more interested in targeting their children’s behavior than were their children, whereas children were significantly more concerned about parental treatment obstacles than were their caretakers. Given these differences, assessment of the service amenability of both children and parents may be helpful. As reported by Horowitz and colleagues (1997), mothers’ involvement in services primarily reflected their desire to be helpful to their daughters (61%), but was sometimes simply a response to being required to participate (36%). Nearly one-half of the sexually abused girls in that study were perceived as showing a negative attitude about therapy participation, but the children, not than parents, showed improved attitudes following child treatment. To the extent that these potential preferences can be addressed in treatment, higher levels of participation and more successful outcomes may result,
especially in interventions where multiple family members are involved. Similarly, greater attention
to clients’ motivation and satisfaction with services may enhance our understanding of the
factors that influence service use. Ultimately, family interventions that address diverse targets and
obstacles, such as multisystemic therapy (see Henggeler, Schoenwald, & Pickrel, 1995), may be
most likely to address multiple family problems.

The generally good parent-child correspondence on our service involvement measure compares
with other studies that have used related instruments, such as the CASA (Farmer et al., 1994, 1997).
Families generally received only a few services. Family counseling was the most common service
reported by both informants, followed by parent-directed services, especially individual counsel-
ing. The high percentage of cases receiving these two services is not surprising given increasing
attention to the need to target family-ecological problems and the tendency to emphasize parental
treatment in cases of physical abuse, which reflected two-thirds of our sample (see Daro, 1993).
With some families reporting up to six different services and providers, greater coordination and
monitoring of all treatments may be justified.

In contrast to Horowitz and colleagues (1997) who reported individual therapy for 94% of their
sexually abused girls, only 13% of our child victims received some form of child treatment since
intake. Their higher rate may have been due to the availability of several local sexual assault
centers, relative to our community which only has one such center, and the fact that very few of
our cases reported law enforcement involvement which has been associated with increased service
referral (Tingus et al., 1996). The small percentage of cases receiving child treatment may also
reflect caseworkers’ perceptions that family or parent services are more important for the improve-
ment of children’s adjustment and the heightened emphasis placed in the CARF risk assessment on
parental factors (see Holder & Corey, 1986, 1993). And, yet, individual child factors are among
some of the few variables that contribute to child treatment referral and participation (Horowitz et
al., 1997), foster care referral (Garland et al., 1996), and return from foster care following abuse
(Blumberg et al., 1996). Indeed, different risk profiles are associated with distinctive service
intervention patterns (Jagannathan & Camasso, 1996). Although we cannot determine how many
children actually needed treatment, it is plausible that some children did not receive needed services
to address specific abuse sequelae or risk factors associated with their own behavior. That only 30%
of the treatment sessions provided by mental health practitioners were devoted to physically abused
children in a recent survey seems to be in accord with these findings (Greenwalt et al., 1998);
unfortunately, that study is limited by the absence of the percentage of cases in which child, parent,
or family treatment was provided, the exclusive focus on mental health therapy (e.g., individual,
group), and the low response rates (less than 20%) for two of the three professional groups
surveyed.

There were few or no reports by both informants of the use of specialized evaluations, parent
education, substance abuse treatment, medication, children’s support groups, legal services, or
several concrete services. The few reports of treatment for substance abuse is surprising given the
prevalence of this problem among CPS families (Murphy et al., 1991). Potential obstacles to
service referral include the failure to identify the families’ need for services (Jacob & Laberge,
1997), existence of biases against individual or other clinical services (Adams-Tucker, 1984), gaps
in available services (Humphreys, 1995), and early closure (Tingus et al., 1996). To the extent that
families are underserved, such findings bear implications for clinical practice and public policy
designed to increase family evaluation and service referral.

Abuse Subtype Experiences

Few significant differences were found between cases who were referred for physical versus
sexual abuse in their past treatment histories and perceived service needs, goals, and obstacles at
intake. The two subgroups received fairly similar types of services, but some interesting differences
did emerge. There was a tendency for sexually abused children to be placed out of the home at intake assessment. Sexually abused children were more likely to receive child-directed treatment and physically abusive families were more likely to receive in-home crisis services, such as family preservation. By post-service assessment, a higher proportion of sexually than physically abusive families had received services, which may reflect caseworkers’ perceptions of a greater need for service among sexual abuse cases, especially when the state law defines all such abuse as a crime. These findings are similar to those reported in Finkelhor’s (1983) national study that found greater involvement of sexually abused children in foster placement and physically abused children in casework counseling. In contrast, he found greater use of home-based services in cases of sexual abuse. Removal of sexually abused children may be due to its social stigma and an inadequate understanding of the family’s role in such cases (e.g., safety, privacy rules), whereas the limited involvement of physically abused children in individual therapy may reflect a lack of recognition of its psychological sequelae.

Fewer families received services at post-assessment, suggesting that many services had ended soon after intake; however, it cannot be determined whether the services were planned to be short-term in duration. Certain factors may mitigate against lengthy involvement in services, such as a repeated history of abuse or removal of the child. With respect to specific services, fewer physically than sexually abused children received individual therapy by post-service assessment. These findings may implicate a perspective among caseworkers that physical abuse is more appropriately treated at intake with intensive, family-based, crisis services, but that child victims of sexual abuse require their own specialized services at a later time. Despite the potential merit of this service-needs perspective, the benefits to providing individual services to physically abused children and crisis or family services to sexually abusive families should not be overlooked.

Greater service use at intake was found for Caucasian children, children with less anxiety, and parents with both a history of abuse in childhood and heightened psychological distress, and all but the latter variable predicted overall service use at post-assessment. Other studies of sexually abused children have found a higher proportion of Caucasians among those who are referred for services (Haskett et al., 1991; Tingus et al., 1996). Children with low anxiety may be less likely to refuse services. Parental distress and abuse history are common treatment targets that enhance the likelihood of being referred for services by caseworkers. These conditions may also enhance parental motivation to participate in family services. The number of services that a family receives may be important to evaluate as some evidence shows that the number, rather than any specific treatment, is associated with positive response among nonabused youth (Shapiro et al., 1997).

Given our small sample size and geographic restrictions, other studies are needed to enhance our understanding of the feasibility, efficacy, and consumer satisfaction of the services received by physically and sexually abusive families. Accordingly, studies must now examine how service delivery parameters and experiences relate to limited clinical response and heightened placement/risk in abusive families, especially if the cost-effectiveness of innovative services for specific forms of maltreatment is to be documented. Subsequent analyses from this study will examine predictors of treatment course and outcome, and the relationship of service delivery to outcome. Such information may be needed to impact policy by identifying helpful CPS operations and promoting the utility of the service delivery process.

Obstacles to understanding the service status of each case significantly impeded data collection in this study, such as the failure to recall key details (e.g., type of service, therapist, agency name). A second challenge entails identifying services that began after the abusive incident as many families were receiving services before and after the abuse incident that brought them into the study. Thus, it was not always possible to tell if these services were exactly the same, if services were added but were the same type, or if a new type of service was added. Finally, because service involvement and provider names were infrequently documented in case records, compliance with service recommendations and other parameters of service involvement was difficult to evaluate.
Advances in both methodology and the service delivery process ultimately are needed to promote the timely and judicious involvement of abused children and their families in treatment.

Acknowledgements—The authors express their appreciation to Mary Garland, Bruce Noel, and Marc Cherna of Allegheny County Children & Youth Services, and to the research staff of the Pittsburgh Service Delivery Study: Jerome Barron, Trish Brungo, Michelle Dawson, Irma Illustre, Kevin Lynch, Amy Madden, Cathy Rich, and Kathy Smith.

REFERENCES


Les enfants et leurs parents ou gardiens ont respectivement utilisé de façon considérable les services psychiatriques. Les évaluations lors de la prise de contact indiquent un besoin de services, de buts thérapeutiques et des investigations de reports. Unpublished Instrument.


**RÉSUMÉ**

**Objectif:** Cette étude a examiné le traitement prodigué dans des cas d’allégations d’abus physiques ou sexuels rapportés aux autorités de la protection de l’enfance. L’étude a aussi voulu documenter les besoins, les inquiétudes et les engagements pris au niveau de ces cas, afin d’évaluer les services offerts.

**Méthode:** L’étude a eu recours à des mesures cliniques normalisées administrées à deux groupes, des enfants victimes et les personnes qui les avaient à charge, ceci à la prise de contact et après un intervalle de 4 à 8 mois suivant un programme de services. Les différences ont été notées par rapport à la source du signalement et à la nature des allégations, au moment de la prise de contact et durant toute la période du traitement.

**Résultats:** Trente pour cent des enfants et des personnes qui les avaient à charge avaient été hospitalisés pour des soins psychiatriques. Les évaluations lors de la prise de contact indiquent un besoin de services, de buts thérapeutiques et des obstacles aux services. Les enfants et leurs parents ou gardiens ont respectivement utilisé de façon considérable les services
de consultation familiale (47%, 39%) et parentale (33%, 48%) et moins fréquemment les services aux enfants (17%, 19%). On note des différences importantes entre les deux types de victimes par rapport aux services qu’ils utilisent et l’importance qu’ils accordent aux buts thérapeutiques et aux obstacles. On retient quatre variables qui prédisent l’utilisation de services à la famille à la prise de contact: (1) l’enfant est de race blanche; (2) un niveau d’angoisse inférieur chez l’enfant; (3) un niveau de détresse élevé chez le parent et (4) un parent qui a connu une agression lorsqu’il était enfant.

Conclusions: Ces constats confirment les descriptions initiales des services fournis aux familles par les autorités de la protection des enfants. Ils sont importants au niveau de la pratique et de la recherche sur les services de protection de l’enfance.

RESUMEN

Spanish abstract not available at time of publication.