TRAUMA-FOCUSED COGNITIVE BEHAVIORAL THERAPY FOR TREATING TRAUMATIZED CHILDREN IN AN UNDERSERVED REGION: AN OUTCOME STUDY

A Dissertation

by

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ABSTRACT

As childhood trauma can negatively impact a youth physically, mentally, and emotionally, it is imperative that they receive adequate post-trauma mental health care as soon as possible. For youth living in rural, underserved areas, however, various barriers limit their access to needed mental health services. When these youths are able to receive mental health care for their traumatic experience, the treatments they receive are typically ineffective in reducing their symptoms. This study examined the individuals that received trauma-focused therapies at a Child Advocacy Center located in a mental health provider shortage area. Descriptive analyses were used to identify differences in participants and examine the therapeutic outcomes of the trauma-focused therapies they received.

Female participants were found to be significantly older then male participants. Multiple traumatic experiences were reported by male participants at a significantly higher rate than in female participants and participants who reported experiencing only sexual abuse were significantly older than participants who experiences other types of trauma (i.e., physical abuse or multiple types of traumas). A paired-sample *t*-test of pre- and post-treatment assessments found significant decreases in four of the Trauma-Symptom Checklist for Children scale. These findings suggest that youth living in the Brazos Valley benefit from the trauma-focused therapies provided by Scotty's House Bravoes Valley Child Advocacy Center. This study provides information on the limitations of this investigation and suggestions for future research.

DEDICATION

This dissertation is dedicated to my amazing family who has loved, encouraged, challenged, and motivated me my whole life. Thank you for supporting my dream of becoming a “doctor”.

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CHAPTER I

INTRODUCTION

Child abuse is an international problem that impacts about 25% of the world's children (Cohen & Mannarino, 2008). In 2014, about 5.4 million American children under the age of 12 experienced violent victimization (Truman & Langton, 2015) and in 2014, child victimization resulted the death of 1,564 children (National Children's Alliance [NCA], 2015). Victimization, or exposure to a traumatic event, includes physical abuse, sexual abuse, motor vehicle accidents, domestic violence, community violence, medical procedures, natural disasters, and other events that place children, or their loved ones, in life-threatening danger (Cohen, 2010). As a significant number of American children are exposed to traumatic events during their lifetime (Leenarts, Diehle, Doreleijers, Jansma & Lindauer, 2013), it is becoming increasingly more common for children and adolescents to experience more than one traumatic event (American Psychological Association Task Force on Posttraumatic Stress Disorder and Trauma in Children and Adolescents [APA Task Force], 2008; Steinberg et al., 2014). Therefore, it is imperative that the field develop a better understanding of the impact trauma has on children and adolescents.

Children and adolescents vary in their reaction to traumatic events; influences such as developmental factors, previous traumas, access to resources, existence of pre-existing personal or familial problems, culture, and ethnicity contribute to individuals' post-trauma reactions (APA Task Force, 2008). Many youths exposed to trauma(s) may

experience some disturbances or demonstrate behavioral changes immediately after their exposure; however, most youths will recover within a short period of time and only about one in three of these children will meet criteria for a post-traumatic stress disorder (PTSD) diagnosis (Gerson & Rappaport, 2013). This study will focus on the youth who do experience clinically significant post-trauma stress reactions.

Youths exposed to trauma may experience a variety of post-trauma reactions. For example, exposure to both domestic violence and childhood sexual abuse has been associated with a variety of problems including anger, anxiety, depression, PTSD, post-traumatic stress syndrome, and low self-esteem (Green, 2009). Additionally, youths exposed to trauma could experience lifelong problems with employment, education, self-image, and other psychiatric disorders (Silverman et al., 2008). Of these reactions to trauma, one of the most studied is PTSD (Alisic et al., 2014; Cloitre et al., 2009; Leenarts et al., 2013; van Meijel et al., 2015). PTSD impacts both children and adults and is characterized by four major symptom clusters: Intrusion, avoidance, negative alterations, and arousal and reactivity (American Psychiatric Association [APA], 2013). Children experiencing PTSD typically present symptoms in a different way than adults (Cohen, 1998; Contractor et al., 2013; Dyregrov & Yule, 2006; Terr, 2013). Furthermore, children's symptomatic presentations vary by gender, age, and type of trauma (Contractor et al., 2013; Dyregrov & Yule, 2006; Feeny, Foa, Treadwell, & March, 2004).

A variety of therapeutic approaches exist to treat these children and their families. Interventions include cognitive behavioral therapies, medication, art therapy,

play therapy, and equine assisted psychotherapy. While there have been studies conducted on the various treatment modalities, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT; Cohen, Mannarino, & Deblinger, 2006) is the most studied and, currently considered the most effective treatment for children with PTSD (Cisler et al., 2016; Gerson & Rappaport, 2013; Silverman et al., 2008).

However, many children who experience a traumatic event and endorse trauma-related symptoms either do not receive needed care or receive a broad assortment of non-evidence based treatments (APA Task Force, 2008; Murray, Nguyen, & Cohen, 2014). Adolescents who have experienced trauma(s) are especially more unlikely to receive necessary care, as they are typically more reluctant to participate in psychotherapy (Gerson & Rappaport, 2013). These findings suggest that barriers hinder children and adolescents from initiating and receiving quality mental health care. Various barriers such as lack of insurance and transportation, poorer health statuses, and higher rates of poverty impede individuals, particularly those who live in rural or underserved areas, from obtaining adequate mental health care (Chang, Sequeira, McCord, & Garney, 2016; Randunovich & Wiens, 2012). The availability of qualified mental health professionals is also a barrier to care for youths living in rural areas.

Mental Health Provider Shortage Areas (MHPSA), or areas where access to quality mental health care is limited, exist throughout the United States, but Texas has the highest proportion of MHPSA in the nation (Health Resources and Service Administration [HRSA], 2014). In 2013, over two-thirds of licensed clinical psychologists in Texas were located in the five most populous counties and the rest of

the state had a ratio of 86,277 persons per clinical psychologist (Texas Department of State Health Services, 2014). Access to quality mental health care from a licensed psychologist is limited for many Texans.

Apart from this gap in services, there is also a large gap in the literature regarding children and trauma. Despite the many advances in child and adolescent focus studies over the past two decades, the majority of the field's knowledge of trauma-related psychological problems is still grounded in studies conducted on adults (APA Task Force, 2008). The research on childhood trauma is fragmented; different disciplines tend to conduct studies that are non-collaborative and lack integration to similar studies (D'Andrea, Ford, Stolbach, Spinazzola, & van der Kolk, 2012). For example, estimates of the rates of exposure to trauma and the impact these events have on children vary within the literature and depend on variables such as type of sample, trauma assessments, and source of information (Alisic et al., 2014). This gap in the literature could be explained by the several methodological challenges, such as the diversity in this population's symptom presentation, that limit the field's ability to conduct needed studies (Cohen, Berliner, & Mannarino, 2000).

Similarly, community based clinics that provide services to diverse populations are typically unable to conduct needed outcome studies. This is largely because doctoral level psychologists usually do not work in these clinics (McCord, Elliott, Brossart, & Castillo, 2012) and because these clinics typically lack the financial resources and time to support this activity (Cohen et al., 2016; McGurik & Button, 2013). Studies investigating the effectiveness of treatments on community samples are especially

important because most scholars argue that current treatments lack sensitivity to the various cultural components that impact therapy (Silverman et al., 2008). This lack of cultural sensitivity can explain why commonly used treatment modalities are generally more beneficial for children who are privileged with regards to health and socioeconomic status (SES; Osypuk et al., 2012). Moreover, therapists' belief that the research does not account for the complex clinical presentations typically seen in community mental health centers impedes providers' use of these treatments (Cohen et al., 2016).

Furthermore, as rural communities value relationships, effective treatment for these youth requires open communication between all the members of the youth's care team (Kenyon-George, 2017). While some communities have multidisciplinary teams and collaborative partnerships established between the various agencies that are involved in child abuse cases (i.e., law enforcement, CPS), others offer poor to no inter-agency communication (Murray, et al., 2014). One solution to this problem was the creation of Children's Advocacy Centers (CACs). CACs were created in 1985 to help reduce the stress child abuse investigations place upon children and their non-offending families by coordinating community agencies' response to childhood trauma reports (Smith, Witte, & Fricker-Elhai, 2006). They help reduce this stress by providing quality and free investigative and trauma-focused mental health services to youth who experience traumatic events, most notably child abuse. CACs have been used throughout the literature to provide information about the scope and nature of childhood traumas seen in

communities (Carlson, Grassley, Reis, & Davis, 2015). However, these studies represent mostly CACs located in urban areas as studies on CACs located in MHPSAs are lacking.

This study examines data from a CAC that serves the Brazos Valley, a region of seven counties in Central Texas. Six of these counties are considered to be rural and all of these counties are designated MHPSAs. Studying this specific region is important because recent reports state that 46.8% of children living in the Brazos Valley do not receive needed mental health care (Center for Community Health Development [CCHD], 2013). Further, as children living in rural communities are more likely to experience sexual abuse (Kenyon-George, 2017), it is important to empirically understand these children's unique mental health needs.

This proposed study examines the therapeutic responses of children and adolescents who receive an evidence-based psychological intervention provided at a CAC that offers free services to children referred for a reported trauma. The study was conducted with the permission and collaboration of the Scotty's House Brazos Valley Child Advocacy Center staff in Bryan, Texas. Although Scotty's House provides an array of therapeutic services (several of which will be described later in this proposal), the present study will be restricted to those who receive a cognitive-behavioral intervention designed for children who have experienced trauma. Clinic protocols require consistent measurement of child adjustment at intake (pre-treatment) and at completion of therapy (post-treatment); however, current records indicate that this kind of data is available on a relatively small number of participants. Therefore, the present study will utilize appropriate techniques to address the following questions:

1. What are the demographics and traumatic experiences of the youths, siblings, and mothers who were referred and/or evaluated for trauma-focused therapy at Scotty's House?
2. How do the youth participants that were referred and/or evaluated for treatment at Scotty's House compare with each other?
3. What are the demographics and traumatic experiences of children and adolescents who received trauma-focused cognitive behavioral therapy (TF-CBT)?
4. How are the children and adolescents who received TF-CBT different from those who received other therapies such as play therapy or equine-assisted therapy?
5. What were the differences in the youths' who completed a recommended protocol of CBT pre- and post-treatment Trauma Symptom Checklist for Children mean scores?

The first two questions will provide some information about the traumatic experiences and clinically important demographics of children and adolescents who were referred to and assessed for trauma-focused therapy at Scotty's House. Questions three and four will describe the youths who were assigned to the cognitive-behavioral intervention and identify any differences that might exist between them and the youths who received other types of trauma-focused treatment. The last question will examine the therapeutic outcomes of TF-CBT for children and adolescents treated by staff at a clinic that serves a predominately rural and underserved region. Therapeutic outcomes

will be determined by participants' pre-and post-treatment scores on the Trauma Symptom Checklist for Children (TSCC; Briere, 1996).

CHAPTER II

LITERATURE REVIEW

This chapter will focus on the impact trauma has on children and adolescents, specifically those who experience post-trauma symptoms. The chapter will begin with a discussion of the prevalence rate of child abuse in American. Then, a description of the unique impact trauma has on children and adolescents will be included, along with a description of PTSD. The differences in PTSD symptom presentation between children, adolescents, and adults will illustrate the need for effective, developmentally appropriate treatments. Current commonly used treatment approaches and a summary of efficacy studies will also be provided. A description of CACs and their impact on this particular population will follow. Last, this chapter will discuss health disparities and how they hinder children and adolescents from receiving the trauma-focused care they need.

Facts about Child Abuse

In 2014, Child Protective Services received roughly 3.6 million reports of suspected child abuse regarding an estimated 6.6 million children, investigated around 2.2 million of these reports, and identified 702,000 children as recipients of child abuse (National Child Abuse and Neglect Data Systems [NCANDS], 2016). Of the cases with proof of abuse, 75% of children were neglected, 17% were physically abused, and 8.3% were sexually abused (NCANDS, 2016). These numbers, however, may be an underrepresentation of the actual number of children who have been abused. Child abuse is often underreported because children and adolescents want to protect their perpetrator,

who is frequently a family member, and/or because they fear negative consequences such as relocation and not being believed (Murray et al., 2014). As child abuse impacts a substantial amount of children, it is often referred to as a silent or hidden epidemic (D'Andrea et al., 2012; Gerson & Rappaport, 2013).

Impact of Trauma

A majority of children and adolescents who experience a traumatic event will endorse some type of distress or exhibit changes in their behavior immediately after the event (Gerson & Rappaport, 2013). However, over time, these post-traumatic stress symptoms disappear for the majority of children (van Meijel et al., 2015). It is important to note that not all of these short-term reactions are problematic, as some post-trauma changes aid in adaptation and coping (APA Task Force, 2008). Although the majority of the children who experience trauma(s) are resilient and do not experience enduring psychological difficulties, about 30% of children expose to trauma will meet criteria for PTSD (Scheeringa, Zeanah, & Cohen, 2011). This study focuses on the children and adolescents who are negatively impacted by their traumatic experience(s).

Painful memories of the trauma may change the way children think, act, feel, and develop (Perry, 2000). Traumatic experiences can impair children's school functioning; specifically, children who experienced traumas tend to have more school absences and lower high school graduation rates than children who did not experience trauma(s) (Langley, Santiago, Rodriguez, & Zelaya, 2013). Children who experience sexual abuse often report depression, anger, guilt, shame, and inappropriate sexual preoccupations (Murray et al., 2014). Gerson and Rappaport (2013) found that adolescents who have

experienced sexual abuse are at higher risk for developing post-traumatic hallucinations and delusions. Children who experience physical abuse often engage in acts of physical aggression and experience interpersonal problems, specifically between themselves and their parents (Cohen et al., 2000).

Trauma can also impact individuals' self-capacities that contribute to problems with one's identity, impulse control, substance abuse, and self-harm (Briere & Spinazzola, 2005). Experiencing trauma as a child can hinder the development of healthy habits, which can contribute to unhealthy lifestyles in adulthood (Cushing, Brannon, Suorsa, & Wilson, 2014). As the brain is programed to respond to recurring and patterned stimulation such as fear, trauma can change the child's maturing brain by hindering the brain's typical development (Perry, 2000). This interruption causes a domino effect of under-development, resulting in impaired functional abilities, heightened "survival" responses such as hyperarousal and dissociation, and emotional dysregulation (Perry, Pollard, Blaicley, Baker, & Vigilante, 1995).

Post-Traumatic Stress Disorder

Commonly, children exposed to trauma(s) may experience the following behavioral disorders: Depression, substance abuse, some sort of anxiety disorder, and panic disorder (Cisler et al., 2012; Cohen, 1998; Langley et al., 2013). One of the most common reactions to a traumatic event is PTSD (Perry, 2000). PTSD, which was formally recognized as a behavioral diagnosis in 1980, was originally thought to only impact adults (Dyregrov & Yule, 2006; Perry, 2000). It was not until Lenore Terr's studies (1979, 1983) that PTSD was considered for children (Dyregrov & Yule, 2006).

Terr (1979, 1983) studied children kidnapped and held hostage and found that 30% of the children exposed to these traumatic events develop some sort of neuropsychiatric problem. This finding catalyzed research on trauma's unique impact on children.

As childhood PTSD is a relatively new psychological/psychiatric disorder (Terr, 2013), the literature on this topic is limited. The majority of the field's knowledge about PTSD is grounded in studies conducted on adults (APA Task Force, 2008). For instance, although the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV; APA, 1994) included age-related diagnostic considerations, its PTSD diagnostic criteria was established from and field tested on individuals 16 years of age and older (Scheeringa et al., 2011). Research, however, has increased over the last two decades and is reflected in the developmental considerations included in the DSM-5 (APA Task Force, 2008).

PTSD, according to the DSM-5 is a psychiatric disorder that can develop when an individual over the age of six years old either directly experiences, personally witnesses, learns of a loved one's experience, or is repeatedly exposed to a traumatic event(s) such as actual death, threat of death, serious injury, or violence (APA, 2013). Examples of traumatic events include natural disasters, violent crimes/community violence, domestic violence, sexual crimes, murder, fire, medical procedures, car accidents, and war. This study focuses on youths who experienced child abuse, a type of trauma that includes any action that results in harm to a child, places a child at risk for danger, or fails to prevent harm to a child or adolescent (U.S. National Library of

Medicine, 2016). Examples include sexual abuse, emotional abuse, physical abuse, and neglect.

Other diagnostic considerations include four major symptom categories: Intrusion, avoidance, negative alterations, and changes in arousal and reactivity. The individual must have at least one intrusion symptom such as recurrent thoughts, dreams, or flashbacks to the traumatic event and at least one avoidant symptom, which include efforts to avoid distressing memories or external reminders of the event. At least two negative alterations symptoms such as inability to remember important details of the traumatic event, cognitive distortions about the event, inability to experience positive emotions, constant negative state, or diminished interest in previously pleasurable activities must be present. The individual must also have at least two changes in arousal and reactivity evidenced by behaviors such as recklessness, hypervigilance, irritability, sleep disturbance, and exaggerated startled responses (APA, 2013). These symptoms are not attributable to another psychiatric or medical diagnosis, should persist for more than one month, and cause clinically significant impairment or distress in the individual's daily functioning (APA, 2013).

The DSM-5 also provides diagnostic criteria for dissociative symptoms. The first dissociative symptom is depersonalization, or when one continuously feels detached or as if they are an observer of their lives rather than an active participant. Derealization is when a person feels as though their surroundings are unreal, or dreamlike (APA, 2013). If one begins to meet full PTSD criteria after 6 months, the diagnostician must specify "with delayed expression".

Post-Traumatic Stress Symptoms (PTSS) are defined as "…a set of psychological and physiological responses of children and their families to pain, injury, serious illness, medical procedures, and invasive or frightening treatment experiences" (Kazak, Boeving, Alderfer, Hwang, & Reilly, 2005, p. 7406). PTSS is a common sub-clinical form of PTSD that is closely related to, but not synonymous with PTSD. It allows for a more expansive and normative explanation of the traumatic experience and its lasting effects on both the child and their family (Kazak et al., 2005). Simply, PTSS can be explained as a "multidimensional, spectrum level phenomenon" (Briere & Spinazzola, 2005, p. 403) that includes some symptoms from the PTSD diagnostic clusters (re-experiencing, arousal, and avoidance), which are reported to a somewhat clinical status. This broader conceptualization is helpful because it explains how an individual's anxiety is heightened after exposure to trauma, but eventually declines and becomes adaptive (Kazak et al., 2005).

PTSD is comorbid with depressive disorders (i.e., Major Depressive Disorder and dysthymia), substance use disorders, anxiety disorders, Attention-Deficit Hyperactivity Disorder, conduct disorders, oppositional defiant disorder, and borderline personality disorder (Cohen, 1998; Gerson & Rappaport, 2013). The following have been identified as risk factors for both PTSS and PTSD: Being female, previous stressful life events, perception of the severity of one's traumatic experience, conflict within one's family, the amount of social support received, personal or familial history of mental illness, lower intelligence, and the amount of emotion-focused coping skills the individual processes (Bruce, 2006; Dyregrov & Yule, 2006; Vrijmoet-Wiersma et al.,

2008). Additionally, the level of perceived stigmatization associated with the trauma and the appropriate trauma reaction one's culture allows are also considered risk factors for PTSD (Briere & Spinazzola, 2005). Risk factors specifically associated with PTSS include the following: High levels of anxiety, low self-efficacy, low parental resiliency, and low social support (Best, Streisand, Catania, & Kazak, 2001). For parents, risk factors associated with their development of a post-traumatic diagnosis include: High levels of distress, lack of education, displeasure with current financial status, previous traumatic experiences, and lower SES (Vrigmoet-Wiersma et al., 2008).

PTSD is rather uncommon in the general public, as most people who experience a traumatic event do not meet full criteria for PTSD (Meiser-Stedman et al., 2016; Perrin, Smith, & Yule, 2000). About 7-8% of the general adult population in the United States will meet diagnostic criteria for PTSD at some point in their lives (U.S. Department of Veterans Affairs, 2016). Inconsistent information exists about the prevalence rate amongst children and adolescents; studies indicate rates as high as 15.9% (Alisic et al., 2014) and low as 5% for older adolescents (Merikangas et al., 2010). Incident rates for children under the age of 10 are unavailable as the literature is lacking. Further, discrepancies exist in reports of which age group is most at risk for experiencing traumatic events. For example, NCA (2015) reported children one year old and younger experience more victimization than any other age group whereas Rosenberg, Jankowski, Fortuna, Rosenberg, and Mueser (2011) noted that adolescents typically report higher rates of victimization than any other age group.

Young adults have been found to have higher rates of both PTSD and PTSS (Dyregrov &Yule, 2006; Kazak et al., 2004). Studies indicated that 8% of girls and 3% of boys exposed to a traumatic event might meet criteria for a PTSD diagnosis (Merikangas et al., 2010). Females are consistently found to be more susceptible to developing PTSD, but males are consistently found to have higher exposure rates to traumatic experiences (Alisic et al., 2014; Bruce, 2006; Contractor et al., 2013). Interpersonal traumas, like sexual abuse and assault, have been found to increase a child's likelihood of developing PTSD (Alisic et al., 2014; Cisler et al., 2012). Furthermore, evidence suggests that traumas impacting a family's integrity are associated with increased rates of PTSD (Silva et al., 2014).

The United States has higher 12-month PTSD prevalence rates than reported in Europe, Asia, African, and Latin America (APA, 2013). This may indicate that one's culture impacts their likelihood for developing PTSD. For example, ethnic and racial minorities, specifically Hispanics, have been found to have a higher probability of developing PTSD than their Caucasian counterparts (APA, 2013). Roberts, Gilman, Breslau, Breslau, and Koenen (2011) found that in their study's sample, African Americans (8.7%) had the highest rate of lifetime prevalence of PTSD while Asian Americans had the least (4.0%). Furthermore, they found that African Americans and Hispanics had the largest risk for experiencing child maltreatment, particularly for witnessing domestic violence and were the least likely to seek mental health treatment (Roberts et al., 2011).

Childhood PTSD

Terr's studies (1979, 1983) were instrumental in the development of the PTSD diagnosis, specifically the age-related diagnostic considerations. Prior to the DSM-5, the field had not yet conducted enough empirical studies to truly understand the impact of trauma on young children (APA Task Force, 2008). The DSM-5, however, provides specific diagnostic criteria for PTSD for children ages six years old and younger. In addition to the diagnostic criteria of directly experiencing, witnessing, or learning of a traumatic event, these younger children must experience at least one symptom in each of the four symptom categories (APA, 2013). Differential symptom presentations, such as play reenactment, are listed in the diagnostic criteria.

These changes reflect the field's growing knowledge of the difference between the symptom presentation experienced by children and adults. While most adults typically experience fear, horror, anger, negative beliefs, or helplessness following their exposure to a traumatic event, children may react with disorganized behavior, increase agitation, developmental regression, or somatic symptoms such as stomach or head pain (Cohen, 1998; Dyregrov & Yule, 2006; Shaw, 2000). Similarly, instead of reporting the typical re-experiencing symptoms of flashbacks and nightmares, parents might note that their child engages in repetitive play, is fixated on certain words or phrases, or has develop schemas about the trauma that lead to self-hatred and anger (Briere & Spinazzola, 2005; Dyregrov & Yule, 2006). Children typically experience avoidance symptoms such as general numbness, amnesia, and low affect (Shaw, 2000). Also, children and adolescents may engage in binging and purging behaviors (Webster &

Palmer, 2000), self-mutilation (Briere & Gill, 1998), sexual promiscuity (Briere & Elliott, 2003), and omen formation (Green, 1985).

Symptom presentations also vary by specific ages ranges. Younger, pre-school aged children typically present with fewer PTSD symptoms (Friedman, 2013), engage in more externalizing behaviors such as repetitive play (Dyregrov & Yule, 2006), and demonstrate increased aggressive and oppositional behaviors (Cohen, 2010). Generally, school-aged children will become more concerned with their personal safety, become more socially withdrawn, and begin feeling personally responsible for the traumatic events (Shaw, 2000). These children may experience time distortions, report malignant recollections of the trauma, and engage in omen formation (Schwarz & Perry, 1994). Adolescents typically present with the following symptoms: Nightmares, numbing, irritability, anger outbursts, flashbacks, and poor concentration (Gerson & Rappaport, 2013). They also experience a foreshortened view of their futures (Dyregrov & Yule, 2006), depression, emotional disturbances, and belligerence (Green et al., 1991). As children mature and their ability to understand the trauma and its impact on them increases, their symptom presentations begin mirroring those of adults (Dyregrov & Yule, 2006).

Feeny et al. (2004) reported that children might present different symptoms based on the type of traumatic experience(s) they endured. These unique symptom presentations make diagnosing post-trauma reactions difficult as providers are required to differentiate between age appropriate behaviors and trauma induced behaviors.

Further, studies have found that youths who experienced multiple traumatic experiences tend to meet criteria for more than one psychiatric disorder (Hawkins & Radcliffe, 2006). Dual diagnoses make it even more difficult for clinicians to adequately diagnose and treat these youths. Continuing to learn about the unique impact trauma has on youths can help clinicians become more efficient in recognizing, diagnosing, and treating these children and adolescents.

Treatments

Research investigating the impact of trauma on children began in the 1970s with the creation of the National Center on Child Maltreatment and expanded in 2000 when Congress authorized the development of the National Child Traumatic Stress Network (Silverman et al., 2008; Steinberg et al., 2014). Child-focused trauma treatment research began in 1993 and has been steadily growing since then (Silverman et al., 2008). Although research on treatment approaches, namely evidence-based treatments, is continuously growing, strong empirical studies are still limited.

While various treatment modalities differ in their approach to addressing the needs of youth who have experienced traumas, all well-established modalities have the following trauma-specific components: Psycho-education, anxiety management, trauma reminders, narrative, cognitive and affective identification and processing skills, safety skills, focus on relationships, parent training, behavioral management, and emotional regulation (Amaya-Jackson & DeRosa, 2007; Cohen, 1998; Shaw, 2000; Silverman et al., 2008). Additionally, the field agrees that effective treatments for child abuse require an understanding that child abuse is not a disorder but rather an experience that can

cause disorders or syndromes (Finkelhor & Berliner, 1995). Overall, it is imperative that children who have been maltreated receive a treatment that is trauma-focused (e.g., focuses specifically on children's trauma and their reaction to the trauma) as treatments that are not trauma-focused have been associated with a higher rate of pre-mature termination and a lower rate of treatment response (Dauber, Lotsos, & Pulido, 2015). A brief overview of current treatment approaches is provided in the following section.

Natural Recovery. Children, especially those exposed to single-incident traumas, are often thought to be resilient enough to process their traumas without treatment (APA Task Force, 2008; Cohen & Mannarino, 2008). Some studies (Famularo, Fenton, Augustyn, & Zuckerman, 1996; Green et al., 1991) found that children's PTSD symptoms can dissipate overtime without treatment. Smith et al. (2007) suggests that monitoring one's symptoms alone may have a therapeutic effect. However, Konanur, Muller, Cinamon, Thornback, and Zorzella (2015) noted that while children can engage in coping mechanism that helps them following a trauma, these strategies are often unhealthy and unsustainable and can negatively impact their development. Further, they noted that natural recovery is unlikely to resolve the impact trauma has on children. The rate of natural recovery, however, lacks strong empirical support.

Medication. There is limited research on the effectiveness of medication as a stand-alone treatment approach for youth who have experienced trauma. According to the APA's PTSD practice guidelines, selective serotonin reuptake inhibitors (SSRIs) are the recommended first-line pharmacological intervention for PTSD (Ursano et al., 2004) for adults and adolescents (Huemer, Greenberg, & Steiner, 2017). Ipser and Stein

(2012) found that SSRIs (most notably paroxetine), venlafaxine (a selective noradrenergic reuptake inhibitor), and risperidone (an antipsychotic) were effective in reducing PTSD symptoms in adults. However, studies comparing the short term and long term effects of pharmacological versus psychological treatments are lacking (Polack et al., 2012).

There is also a lack of studies examining the impact of pharmacological treatments on children and adolescents impacted by trauma (Coffey, 2014; Gerson & Rappaport, 2013; Terr, 2013). Huemer et al. (2017) noted that the limited research that has been conducted on the use of medications as a treatment for youth with PTSD has focused on four main groups of medication: Second- generation anti-psychotics, SSRIs, mood stabilizers, and antiadrenergics. Benzodiazepines tranquilizers have been used as short-term treatment for children with PTSD, specifically when the child experiences sudden trauma-induced fears (Terr, 2013). However, benzodiazepines do not have adequate support of their effectiveness to treat PTSD (Isper & Stein, 2012) and are not commonly used to treat adolescents with PTSD (Gerson & Rappaport, 2013). Antipsychotics have been used as a temporary treatment for children experiencing post-traumatic psychotic features such as delusions and hallucinations (Terr, 2013). Yet, antipsychotic medication is not consistently found to be effective (Gerson & Rappaport, 2013). Morina, Koerssen, and Pollet (2016) conducted a meta-analysis on interventions used to treat youth with PTSD and found little support for the use of psychopharmacological treatments with this population. Although more studies are being conducted on the use of medication as a treatment, psychotherapies are still

generally considered to be the first line of treatment for children and adolescents who experienced trauma (Coffey, 2014; Cohen et al, 2000; Cohen et al., 2010; Gerson and Rappaport, 2013; Terr, 2013).

Client-Centered Therapy. Client-Centered Therapy (CCT) focuses on developing a trusting therapeutic alliance between the therapist, child, and parent that is supportive, self-affirming, validating, and empowering for both the child and their parents/caretakers (Deblinger, Mannarino, Cohen, & Steer, 2006). CCT posits that traumatic events violate children's and their families' senses of trust and disempowers them. The goal of this therapy is to create a trusting and empowering relationship, in which children and their families are allowed to determine if, when, and how they will address the details of their traumas (Cohen, Deblinger, Mannarino, & Steer, 2004). There is limited empirical data for CCT, specifically regarding its efficacy in treating children who have experienced trauma(s). The lack of research could be an artifact of CCT being more of a lens through which other treatments, primarily play therapy, conceptualize change. For example, in many randomized controlled trials (RCT) of treatments for childhood PTSD, CCT is often used as a control group of sorts against which other experimental treatments for children with PTSD are tested (Cohen et al., 2004; Silverman et al., 2008). It is important to note this treatment because it is widely used within the literature as a substitute for waitlist groups.

Art Therapy. Art therapy, rooted in psychoanalytic theory, encourages the use of art as a communication and therapeutic tool (Eaton, Doherty, & Widrick, 2007). In the first couple of sessions, children are encouraged to simply color, paint, or model.

Over time, the therapist asks the child to tell a story about their artwork and then helps the child interpret their story (Eaton et al., 2007). Art therapy can increase the child's comfort, aid in memory recovery, and help children organize their thoughts, which can increase their ability to detail their experiences (Dyregrov & Yule, 2006; Gross & Hayne, 1998). This treatment is especially beneficial when verbal communication may be too devastating for the child (Leenarts et al., 2013). Pifalo (2006) found that Art Therapy, in conjunction with Cognitive Behavioral Therapy is effective in reducing trauma-related symptoms. Limited research exists on the efficacy of art therapy; this is most likely because historically, trained doctoral-level psychologists do not typically receive training in Art Therapy (Eaton et al., 2007).

Play Therapy. Play therapy is based in Piaget's (1959) work which posits that children 11 years old and younger lack the ability to engage in abstract thinking, verbally express themselves, and understand multifaceted thoughts or emotions. Instead, children utilize games, art, and other play activities to either directly or symbolically process their emotions (Bratton, Ray, Rhine, & Jones, 2005). Play therapy has been found to reduce internalizing and externalizing behaviors (Flahive & Ray, 2007; Tyndall-Lind, Landreth, & Giordano, 2001). This treatment has been found to help reduce anxiety and depression (Baggerly, 2004; Shen, 2002; Tyndall-Lind et al., 2001), specifically in children who have experiences sexual abuse (Carpentier, Silovksy, & Chaffin, 2006; Tyndall-Lind et al., 2001). Ray, Bratton, Rhine, and Jones (2001) and Bratton et al. (2005) conducted meta-analyses of this literature and found that play therapy is an effective treatment for both genders, individuals of various ages, and in multiple settings. While there is

empirical support for play therapy, Garza and Bratton (2005) argue that most play-therapy studies fail to include diverse samples (e.g., Hispanics) in their studies.

Equine-Assisted Psychotherapy (EAP). EAP is a treatment modality that uses horses as a therapeutic aid. Horses help to stimulate communication with a child (Melson, 2002; Robin & ten Bensel, 1985) and promote self-esteem, trust, and hope (Chardonens, 2009). EAP has been associated with significant improvements in childhood depression (Kemp, Signal, Botros, Taylor & Prentice, 2014). Horses have been found to be helpful in reducing PTSD symptoms in Veterans; specifically, they help reduce symptoms of hypervigilance, allow individuals to become more comfortable and aware of their bodies, and facilitate assertiveness training (MacLean, 2011). There is some evidence that EAP may facilitate growths in emotion identification, problem-solving, and personal responsibility as effectively as play therapy and experiential learning (Schulz, Remick-Barlow, & Robbins, 2007). Additionally, Klontz, Leinart, and Klontz (2007) found that EAP helped children become more present-focused, overcome feelings of regret and guilt, reduced their fears about the future, increased their independence, and enhanced their self-efficacy. However, the evidence base for EAP is lacking and the theoretical mechanisms for change are not understood (Anestis, Anestis, Zawlinski, Hopkins, & Lilienfeld, 2014). EAP is an emerging treatment both in research and practice.

Psychological First Aid. Psychological First Aid (Pynoos & Nader, 1988) is a brief intervention commonly used by first responders. It was developed to help children process their trauma immediately after experiencing it (Cohen et al., 2000). Typically

provided in two to three sessions, this approach encourages facilitators to clarify the child's understanding of the trauma, normalize the child's reaction, support emotional expression, present simple problem-solving tools, and make appropriate referrals (Cohen et al., 2000). The strengths of this approach include the following: It allows first responders to obtain information that facilitates fast decision-making, it utilizes empirically supported strategies, and it emphasizes developmental and cultural differences (Cohen, 1998). There is not enough empirical support to determine the helpfulness of this initial intervention; however, most experts agree that this is an adequate first step intervention option for persons with no mental health training (Fox et al., 2012).

Cognitive-Behavioral Treatments (CBT). CBTs are the most empirically supported treatments approach for children and adolescents who have experienced trauma (Rosenberg et al., 2011). These brief, time-limited treatments are present- and problem-focused and involve components such as exposure to trauma and direct conversations about the trauma. In CBT, children learn to identify and challenge their cognitive distortions so they can discuss their trauma without fear or anxiety. CBT typically includes teaching parents the same stress-management and cognitive challenging techniques that are taught to the child. Parents are also taught how to better address and manage any trauma-induced behaviors (Cohen et al., 2000).

Leenarts et al. (2013) found that CBT was helpful in reducing children's PTSD symptoms and increasing children's body safety skills. Additionally, the authors concluded that CBT aided non-offending mothers by helping them reduce their own

maladaptive cognitions and negative emotional reactions. Furthermore, Terr (2013) found that CBT is an effective short-term therapy for treating children who have experienced trauma(s). There are several CBT treatments that have been developed for use with youth who experienced trauma.

Eye-Movement Desensitization and Reprocessing (EMDR). One of these treatments is Francine Shapiro's (1989) EMDR, which mixes cognitive therapy with an individual's direct eye movements. This eight-phase therapeutic approach posits that cognitive distortions cause pathology. In EMDR, the therapist moves their hands in a back and forth motion and asks the child to watch their hand movement as they imagine a scene from their traumatic experience. Children are asked to focus on their anxiety and vocalize words that illustrate this scene throughout the session (Rothbaum, 1997). The literature presents mixed reports on the effectiveness of EMDR (Cohen, et al., 2001). Some studies found EMDR to be an effective treatment (Dyregrov & Yule, 2006; Fernandez, 2007); others suggested that the eye movement component is unnecessary as the intervention is effective without it (Cohen, 1998; Cohen et al., 2000; Lohr, Tolin, & Lilienfeld, 1998). Lee, Gavriel, Drummond, Richards, and Greenwald (2002) suggest that EMDR is as effective as prolonged exposure in reducing PTSD symptoms. More research is needed to identify the efficacy of this treatment and its agent of change.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). Drs. Judy Cohen, Anthony Mannarino, and Esther Deblinger (2006) developed TF-CBT for children experiencing symptoms of PTSD, depression, anxiety, or other problems as a result of a traumatic event. This 12-week treatment plan includes individual child session,

individual parent(s) session, and joint child-parent(s) sessions. Beginning with psycho-education and parent training, this treatment seeks to educate children and their families on trauma and its impact on children. This first session helps normalize their experiences, thoughts, and feelings. Subsequent sessions include lessons on cognitive processing, relaxation skills, affective regulation skills, and cognitive coping skills. Treatment also includes completing a trauma narrative, gaining in vivo mastery of trauma related reminders, and future relapse and safety planning (Cohen & Mannerino, 2008). Every component of this therapy is offered to both the child and their parents in parallel and sometimes joint sessions.

TF-CBT is similar to systematic desensitization in its efforts to pair relaxation with a gradual exposure to the trauma (Cohen & Mannarino, 2008). Sixteen randomized control studies have evaluated the use of TF-CBT in treating youths (3-18 years) who have experienced a variety of traumatic experiences, including multiple and complex traumas (Cohen et al., 2016). Studies reported that TF-CBT is the most effective treatment for children with PTSD (Gerson and Rappaport, 2013; Leenarts et al., 2012; Silverman et al., 2008). Konanur et al. (2015) found that therapists with varying theoretical orientation and clinical experiences can effectively use TF-CBT to treat a demographically diverse group of school-aged children in a community-based mental health setting. They also found that the results of treatment were maintained at a six-month follow up (Konanur et al., 2015).

Deblinger et al. (2006) reported that TF-CBT was more effective in reducing PTSD symptoms and children's perceived shame than CCT. TF-CBT was also found to

be more effective than play therapy in reducing trauma-specific symptoms (Cohen, Mannarino, & Knudsen, 2005). Furthermore, TF-CBT has been found to be effective in treating minority youths who experienced traumatic events (Murray et al., 2014; Leenarts et al., 2013). Jensen, Holt, and Ormhaug (2017) found that youths with co-occurring depression and PTSD benefitted from TF-CBT. They also reported that at 18 months follow-up, youths treated with TF-CBT maintained therapeutic improvements (Jensen et al., 2017).

Information from Randomized Controlled Trials

As children and adolescents vary in their experiences, resources, reactions, and symptom presentations, no single treatment modality has been found to be effective for all children (Cohen et al., 2000; Cohen, 2010). Various treatment approaches, therefore, have been used to help children process and overcome their trauma and post-traumatic psychiatric disorder. Various randomized clinical trials (RCTs) have been conducted for these treatment approaches. To find these RCTs, this study searched PsycARTICLES, PsychINFO, Google Scholar, MEDLINE for various combinations of the following terms: "Child abuse", "childhood PTSD", "pediatric PTSD", "child sexual abuse", "child", "trauma", "TF-CBT", "play therapy", "trauma focused", "child", "adolescent", "treatment", and "CBT". This search included RCTs that were published between the years 1994- 2017. This study selected 1994 as the start date for the search because this is when age-related diagnostic criteria for PTSD were first included into the DSM.

Most meta-analyses of these treatments identify between 20-30 RCTs that meet their criteria for study (Harvey & Taylor, 2010; Silverman et al., 2008; Skowron &

Reinemann, 2005). Silverman et al. (2008, p. 162) reported that TF-CBT was the "only well-established treatment for children exposed to traumatic events." Kornor et al. (2008) concluded that while neither supportive counseling (e.g., CCT) nor TF-CBT met their criteria for clinical meaningfulness, limited evidence indicated that TF-CBT was more effective that supportive counseling. A meta-analysis that compared TF-CBT to play therapy found that TF-CBT was more effective than play therapy in producing symptom improvements on most measure; however, play therapy was found to be more effective in reducing externalizing behaviors (Slade & Warne, 2016). Further, Morina et al. (2016) found that trauma-focused therapies produce significant reductions in symptoms of PTSD at post-treatment assessment, but tend to have minimal impact on comorbid symptoms of depression.

Rodenburg, Benjamin, de Roos, Meijer, and Stams (2009) stated that when compared to other evidence-based treatments (e.g., CBT), EMDR adds a small, yet substantial value to traumatized children's treatment. Harvey and Taylor (2010) reported that studies that obtained information primarily from the child client had larger effect sizes than those that gathered information from parent/caretaker. Additionally, studies that involved parents/caretakers and utilized a manualized treatment approach had larger effect sizes and produced better post-treatment outcomes (Harvey & Taylor, 2010). There is some evidence that suggests that certain sexual abuse induced behaviors (e.g., aggressiveness and sexualized behaviors) are less amenable to counseling either because therapists are not adequately addressing these issues, or because they are inherently more resistant to change (Finkelhor & Berliner, 1995).

There are various problems with the existing RCTs. Although these studies provide support for the trauma-focused treatments for children, they also exemplify the gap existing between science and practice. That is, RCTs present information that is difficult to implement in most mental health clinics (Castonguay, Youn, Xiao, Muran, & Barber, 2015). Most of these RCT have small sample sizes, tend to focus solely on children who experience sexual abuse, and often do not include children from minority groups (Dyregrov & Yule, 2006; Silverman et al., 2008). By studying a clinically heterogeneous group, most RCTs fail to account for the diversity of children's age, gender, and traumatic experience (Finkelhor & Berliner, 1995). This approach can yield unreliable information, especially because children's post-traumatic symptoms vary by age, trauma type, and gender. Due to ethical concerns related to withholding treatment, many RCTs use a bonafide treatment alternative (e.g., CCT) in lieu of a wait list or control group. This alternative results in a lack a clear understanding of whether the treatment or other variables (e.g. time) account for the symptom reductions (Cohen et al., 2000). Finkelhor and Berliner (1995) stated that many treatment studies include children with symptoms that are not as clinically significant as the symptoms children who have not been abused but meet criteria for depression and anxiety report.

More studies are needed to understand the unique impact trauma has on children living in urban versus rural areas (Kenyon-George, 2016; Parson, 1994). Future studies should investigate children who are unable to receive adequate mental health due to a substantial gap between the country's need for and obtainment of proper, evidence-based treatments (Burns et al., 2004). Practice-Oriented Research (POR; Castonguay,

Barkham, Lutz, & McAleavey, 2013), or research that is conducted as part of a clinic's routine treatment protocol, would produce more generalizable information (Castonguay et al., 2015).

Child abuse is a serious problem that impacts roughly 10% of American children each year (Fang, Brown, Florence, & Mercy, 2012). However, providing quality mental health care for these children is a long-standing mental healthcare challenge (Burns et al., 2004). One possible reason for this is that working with children requires that providers understand the impact child's parents/caregivers, culture, school, community, and SES have on their well-being and functioning and tailor interventions accordingly (Cushing et al., 2014). Providing quality, effective treatment for these children is difficult because current efficacy studies lack an appreciation for the impact culture has on a child's PTSD (Ford, 2008). The next section will demonstrate how systems such as geographic location, community, and SES impact children's lives and further complicate treatment. Health disparities, or barriers to quality health care, and their impact on these children and families will be discussed. This section will also include reasons why treatments provided to children living in rural or underserved areas are ineffective in reducing symptoms.

Health Disparities

A health disparity, for the purpose of this study, is defined as, "A chain of events signified by a difference in: (1) environment, (2) access to, utilization of, and quality of care, (3) health status, or (4) a particular health outcome that deserves scrutiny," (Carter-Pokras & Baquest, 2002, p. 427). Disparities can be based on individual factors such

SES, culture, language, level of education, geographical location, and access to transportation (McCord et al., 2012). These disparities impact the roughly 60 million Americans, about 19.3% of the United States population, who live in rural areas (United States Census Bureau, 2010) and the 48 million Americans (1 in 10 children), about 15.4% of the population, who are uninsured (American Cancer Society, 2015). Rural residents are often considered to be a vulnerable population as they often report having a chronic health condition, lacking health care services (e.g., medical, mental, and social health care services) in their community, living below the national poverty line, and lacking health care insurance (Brossart et al., 2013). In general, individuals with a lower SES experience more health disparities (Fiscella & Williams, 2004). For these individuals, access to care requires them to first overcome obstacles such as lack of transportation, geographic isolation, lack of insurance, linguistic difficulties, and low SES (Chang et al., 2016; Jones, Chilton, Hajek, Iammarino, & Laufman, 2006). These hurdles mark the first of many stressors that complicate a family's mental health care experience.

Culture also plays a large role in one's ability to receive quality care. For instance, racial and ethnic minorities tend to receive lower quality care and tend to experience higher rates of misdiagnosis (Ridley, 2005). Minorities are also often over-diagnosed with more severe psychopathological disorders than their Caucasian counterparts and tend to receive impersonalized care in which they have minimal contact with their mental health care providers (Ridley, 2005). Ethnic minorities are further hindered in their access to care because of their cultural and linguistic needs (Flores et

al, 2002). This problem impacts a large portion of Hispanics who currently comprise the largest minority group in the United States (United States Census Bureau, 2012). Hispanic children are additionally hindered because they are disproportionally more likely to lack health insurance, mental health literacy, and parental-supported help-seeking behaviors (Langley et al., 2013). Furthermore, these individuals, particularly those living in a rural area, experience an "acceptability barrier," as they often encounter a cultural stigma associated with mental health treatment as well as a fear of decreased anonymity when they present for treatment (Gonzalez & Brossart, 2015). Similarly, rural communities typically have higher prevalence rates of factors (e.g., poverty and unemployment) associated with crime yet report less crime than urban community and are more likely to conceal problems (Kenyon-George, 2016). This finding suggests that rural residents are less likely to report when a crime has been committed against them.

Systemic factors such as the degree to which health care organizations and providers prioritize attention and resources to addressing these concerns also impacts health disparities (Schoen et al., 2005). McCord et al. (2012) noted that mental health care providers are often aware of these health disparities and barriers to adequate care but typically fail to take necessary steps towards a solution. For example, qualified mental health care providers are less likely to practice in rural areas due to lower rates of compensation, limited referral sources, and increased ethical risks such as dual relationships (Hastings & Cohn, 2013; Helbok, Marinelli, & Walls, 2006). In some cases, unqualified, or non-doctoral level mental health professionals, whose knowledge of evidence-based treatments is unknown, may provide care that results in little benefit

to the client (Burns et al., 2004). Further, many mental health providers that work in rural areas are typically generalists (Kenyon-George, 2016). This means that psychologists that specialize in working with children are particularly scarce in rural areas (Shealy, Davidson, Jones, Lopez, & de Arrellano, 2015).

These disparities contribute to the characteristics that are used to define MHPSA (CCHD, 2013; HRSA, 2014). MHPSAs are determined, in part, on the proportion of "core mental health professionals"– including psychiatrists, clinical psychologists, clinical social workers, psychiatric nurse specialists, and marriage and family therapists - available to the population (a population-to-core mental health professional ratio greater than or equal to 30,000:1; HRSA, 2014). As of January 1, 2017, HRSA identified 4,627 MHPSAs in the United States; this means that an estimated 3,397 mental health providers are needed in these areas to remove the MHPSA designation (HRSA, 2017).

The highest proportion of counties designated as MHPSAs exists in Texas; as of 2017, 206 out of the 254 counties in Texas are designated as partial or full MHPSAs (Hogg Foundation for Mental Health, 2017). The disparity in mental health providers is also evident in the distribution of clinical psychologists throughout the state. In 2013, over two-thirds of licensed clinical psychologists in Texas were in the five most populous counties and the rest of the state had a ratio of 86,277 persons per clinical psychologist (Texas Department of State Health Services, 2014). In contrast, licensed professional counselors (LPCs) and clinical social workers had more favorable person-to-provider ratios of 1,647:1 and 6,870:1, respectively, indicating that they are more likely to live and practice in these underserved counties (Texas Department of State

Health Services, 2014). Residents of MHPSA, then, face barriers to both availability and accessibility of psychological services (Gonzalez & Brossart, 2015). When residents living in a MHPSA, especially those located in a rural region, are able to receive mental health care, it is often fragmented, inconsistent, and lacking in cultural competency (McCord et al., 2012).

These barriers are even more pronounced for youths in need of services, specifically in rural areas where child services and mental health research are scarcer than general mental health services (Boydell et al., 2006; Radunovich & Wiens, 2012). For example, youths, particularly those with a low SES, are more likely to experience multiple traumas, but are less likely to receive early intervention that could help prevent the developmental consequences trauma can cause (Langley et al., 2013). Adolescents with low SES typically experience more emotional disturbances, mostly likely because they experience more stressors and have fewer resources (Osypuk et al., 2012). Additionally, higher rates of suicide have been found in rural areas than in urban areas (Harris et al., 2016; Singh & Siahpush, 2002).

Community Mental Health Centers. There is evidence that children who receive "usual care" mental health treatments from community-based clinics do not show significant symptom improvement (Garland et al., 2013). This is because a variety of barriers at the provider, client, and organizational levels make translating evidence-based treatment recommendations into practice difficult (Cohen et al., 2016; McGuirk & Button, 2013). At the organizational level, barriers such as clinic needs, available resources, and metrics required for reimbursement impact organizations' ability to utilize

evidence-based treatments (Cohen et al., 2016). For instance, most tax supported health systems do not support effective psychotherapy because reimbursement is typically based solely on of the total number of clients seen and sessions held versus the outcome of therapeutic services (McGuirk & Button, 2013).

Similarly, the financial resources organizations allocate to training providers to implement evidence-based treatments have decreased as states face their own fiscal shortfalls (Fang et al., 2012). As a result, evidence- based treatments, which present a high financial and time demand on providers (McGurik & Button, 2013), are typically not used or provided with insufficient consistency or strength (Garland et al., 2013). Further, high staff attrition increases remaining providers' caseloads and limits their motivation for and time to receive the training needed to implement evidence-based treatments (Cohen et al., 2016). These barriers are particularly pronounced in rural areas where providers and resources are sparser and organizations typically experience more financial instability (Shealy et al., 2015).

Having limited resources and high demand for services can impact provider's ability to effectively treat their clients. For example, Mellman, Clark, and Peacock (2003) studied non-veteran clients being treated at community mental health centers for PTSD and found that providers were treating 77% of clients with aggressive pharmacological treatments, often utilizing prescribing patterns that do not correspond with the suggested prescribing guidelines. Similarly, Anderson, Neuwirth, Lenardson, and Hartley (2013) utilized data gathered from the 2002-2008 Medical Expenditure Panel Survey and found that children (ages 5-17 years) who were receiving care at a

community health setting were more likely to receive psycho-pharmacological treatment than counseling. Specifically, they noted that children in rural areas were more likely to being treated with medication by their primary care provider than children in urban areas. Polak et al. (2012) suggests that community mental health centers prefer pharmacological treatments to psychological treatments, possibly because of the limited access to and availability of trauma-focused psychological treatment options.

For therapist, their commitment to evidence-based treatments typically corresponds with the training they have received (Cohen et al., 2016). Most mental health training programs do not provide adequate training of evidence-based treatments, sufficient clinical experiences with these treatments, or enough supervision necessary to obtain a proficient knowledge of and ability to effectively utilize these treatments (Heck, Saunders, & Smith, 2015). This lack of needed training is even more pronounced for practicing therapist because barriers such as time constraints, lack of organizational support for receiving needed training, high cost of training, and beliefs about the usefulness of evidence-based treatments hinder their ability to obtain the needed training (Cohen et al., 2016). Provider "buy-in" to these treatments is particularly difficult to obtain as empirical studies on these evidence-based treatments seldom incorporate participants that match a mental health clinic's typically clinical presentation (McGurik & Button, 2013).

Further, client barriers impact providers' ability to successfully implement evidence-based treatments. Outpatient community mental health clinics, especially those serving families with low SES, experience higher rates (40-60%) of pre-mature

terminations (Gopalan et al., 2010). Factors that interfere with treatment adherence include parent characteristics (e.g., mental health problems), parents' perceptions (mainly regarding their parenting skills and the severity of child's behaviors), family stressors (e.g., domestic violence and substance abuse), socio-economic factors (e.g., lack of resources such as money and transportation), cultural practices (e.g., fear of stigmatization) and chronic illness (Ofonedu, Belcher, Budhathoki, & Gross, 2016). Low-income families experience additional barriers such as lack of interest in services, disbelief that services will benefit them, lack of trust in providers, and organizations' language and literacy requirements for participation (Schnirer & Stack-Cutler, 2011). In rural areas, the lack of mass transit and issues in making travel arrangements to the treatment site also undermine services.

Addressing this great need should be of top importance as studies have concluded leaving children's trauma-related symptoms untreated or treating them with ineffective therapy will most likely cause severe long-term effects (Dyregrov & Yule, 2006; Konanur et al., 2015). One way to begin reducing these health disparities is to build working relationships between various community providers. Community capacity, which is defined as "…the degree to which a context has structures and processes in place to help mobilize residents for action-the interaction of human, organization, and social capital" (Trickett, 2009, p. 412), can help communities identify and reduce community-wide needs (McCord et al., 2011). Children's Advocacy Centers (CACs) are an example of how community capacity works to develop integrated and coordinated solutions to identified problems in the community.

CACs were developed in the 1980s in response to a national movement that sought to improve the methods used to investigate and respond to child abuse cases (Cross et al., 2008). Through the creation of a multidisciplinary team comprised of local service providers, CACs are able to offer a "one-stop-shop" for children impacted by trauma and their non-offending family members, which improves the investigation, protection, treatment, and legal services these individuals receive (Bonach, Mabry, & Potts-Henry, 2010). This next section will describe CACs and illustrate how they are a first-step towards reducing disparities.

Children's Advocacy Centers

Prior to the establishment of CACs, standards for the investigation of child abuse reports were unorganized and inter-agency communication was severely lacking (Elmquist et al., 2015). This lack of inter-agency collaboration caused children and their families significant stress; they had to cooperate with multiple investigations, which required them to retell their story several times and endure repetitive questioning from several professionals from multiple agencies (Bonach et al., 2010). Identifying a need to coordinate more effective and collaborative care, the first CAC was created in 1985 in Huntsville, Alabama, under the guidance of former Alabama Congressman Robert E. Cramer (Elmquist et al., 2015). CACs are community-based, multi-disciplinary agencies established to reduce the stress child abuse investigations, treatments, and prosecutions typically place upon the children who experience abuse and their families (Cross et al., 2008).

CACs are accredited by the National Children's Alliance (NCA) and must contain these 10 core components: Multi-disciplinary team, cultural competency and diversity, forensic interview, victim support and advocacy, medical evaluation, mental health, case review, case tracking, organizational capacity, and child-focused setting (NCA, 2011). CACs utilize a multidisciplinary team comprised of law enforcement, child protective services, prosecuting attorneys, mental health providers, forensic medical professionals, and other child advocacy professionals. Representatives from this multidisciplinary team are trained to provide developmentally appropriate and culturally competent services to the children and families with whom they work and are required to routinely participate in case reviews so to ensure continuous open communication and coordination of care. Support and advocacy resources, such as crisis interventions and education of legal rights, medical evaluations, and specialized trauma-focused mental health services must be made available to children and their non-offending caregivers (NCA, 2011). In order to create a child-focused setting, CACs must be physically and psychologically safe environments and must have written policies and procedures that guarantee a separation between children and any person identified as an alleged offender. CACs must be easily assessable and located in facilities that allow team members opportunities for live observation of forensic interviews (i.e., through a two-way mirror).

As part of the cultural competency core component, CACs must conduct a community assessment, which helps providers learn about community they serve (NCA, 2011). This community assessment also aids the CAC in developing services that meet

their community's unique needs and recruiting staff, volunteers, and board members that mirror their community's demographics. Further, this assessment helps CAC become involved in current community efforts to care for their underserved population (NCA, 2011). For example, CACs in rural areas may be mobile so they can provide services to children whose lack of transportation hinders their ability to come to the CAC (Elmquist et al., 2015). This tailoring of services to meet community needs prompted the NCA to recognize the following seven areas in which they expect CACs would differ: Characteristics of the community, organizational base, developmental stage, processes for referrals, inter-agency involvements, inter-agency relationships, and agency goals (Conners-Burrow et al., 2012).

There are 795 CACs throughout the United States, with at least one CAC in each state (NCA, 2015). In 2015, CACs served approximately 311,688 children and adolescents; 114,953 were males, 195, 912 were females, and 832 were youths whose gender were undisclosed (NCA, 2015). In Texas, about 54.3% (138 of 254) of counties have access to a NCA accredited CAC (NCA, 2015). Statistics from 2015 report that 15,135 Texas youth were treated by a CAC; of these youths, 5,232 were males, 9,871 were females, and 32 individuals did not disclose their gender (NCA, 2015).

While CACs provide necessary services, the need for quality trauma-focused treatment is continues to be unmet. For example, Cross et al. (2008) found that CACs typically provided mental health services to only about 30% of children they serve. In a recent survey of 264 CAC directors, Wherry, Huey, and Medford (2015) found that only 30% of CAC directors reported providing in-house treatment and assessment services.

Further, only 35% of these directors either agreed or strongly agreed that their community had an adequate number of providers qualified to provide trauma-focused treatment and assessment services (Wherry et al., 2015). This suggests that even with CACs, access to quality care remains limited. Similarly, they found that only a minority of CAC had a referral coordinator, or a staff member responsible for making referrals to mental health treatment (Wherry et al., 2015). CAC directors included in this survey reported that the number one reason for referring a child and/or their family to treatment was the severity of the abuse they experienced and the number two reasons was the emotional response the child displayed in their forensic interview; referrals based on the results of a post-traumatic stress symptoms assessment was listed as reason number five (Wherry et al., 2015). This suggests that most CACs are not adequately identifying the children and families that could benefit the most from mental health treatment.

CACs have been used throughout the literature to provide information about the scope and nature of child abuse seen in communities (Carlson et al., 2015). However, most studies have primarily focused on the forensic interviews CAC provide (Wherry et al., 2015). Studies that focus on the psychological services CACs provide report shortcomings in treatments and providers' expertise in treating trauma. For instance, a recent survey found that 40% of CAC directors could not correctly identify PTSD symptoms (Wherry et al., 2015). In a similar study, Allen, Gharagozloo, and Johnson (2012) surveyed 240 CAC clinicians and found that although most clinicians (87%) could correctly identify TF-CBT as an evidence-based treatment, few could correctly identify other evidence-based treatments. Furthermore, the authors found that while most

clinicians knew that nondirective play therapy, art therapy, and sand-tray therapy were not evidence-based treatments, they were still more likely to use these treatments over evidence-based treatments such as TF-CBT (Allen et al., 2012). These findings suggest that while CACs are making strides to help these children and their families, more advances are needed. Specifically, more studies investigating the effectiveness of CACs in providing services to children and families living in underserved areas are need.

The Current Study

There are many children who have experienced trauma(s) that require specialized mental health care. As trauma impacts children in different ways than it does adults, it is imperative to understand how to effectively identify and address youths' unique post-trauma needs. Although there are various evidence-based treatment modalities available for work with these children, few have penetrated into clinical outpatient mental health services (McGuirk & Button, 2013). Community mental health clinics experience various limitations that hinder their ability to provide quality care for their clients (Cohen et al., 2016). Disparities in access to care, however, complicate these issues, as mental health providers with the specialized expertise to provide quality care are not available in underserved regions (McCord et al., 2012).

The current study will investigate the use of TF-CBT with children and adolescents who are referred for services provided by Scotty's House Brazos Valley Child Advocacy Center (SH), a non-profit CAC located in an underserved, predominately rural region. The investigation will begin by describing the participants included in this study and identifying any possible difference in the demographic and

traumatic experiences of these youths. Next, a description of the youth who are recommended to receive TF-CBT will be provided. The study will then analyze youths' scores on the Trauma Symptom Checklist for Children, which was administered at intake and termination, to evaluate their therapeutic response to the trauma-focused treatments they received. This analysis may provide insight into the potential benefits of TF-CBT provided to children and adolescents at the clinic.

CHAPTER III

METHODS

This proposed study received IRB approval from Texas A&M University Institutional Review Board (IRB; reference number 030587). It utilizes a database that includes all clients who received trauma-focused counseling at Scotty's House Brazos Valley Child Advocacy Center from 2011 to June 2016. The database was created from a post-treatment review the clients' counseling and forensic files. Participants include children who reported experiencing a traumatic event, their siblings, and their mothers. As this study utilizes an archived database, no parental permission was needed or required by the Texas A&M University IRB.

Definition of Rural Counties

This study will utilize the Census Bureau categorization of "urban" and "rural" areas. Per their definition, "An urbanized area is continuously built-up area with a population of 50,000 or more, comprising one or more central places and the adjacent densely settled fringes with a population density of more than 1,000 persons per square mile" (Farley et al., 2002, p. 189). They noted that any area that does not meet these criteria should be considered "rural." Based on the 2010 Census data on the counties in this region, this study defined one county as being urban and six counties as being rural. This categorization is consistent with other studies conducted on the Brazos Valley (Brossart et al., 2013).

Clinical Overview

Scotty's House (SH) is an accredited CAC that provides free forensic and counseling services to children and families living in the Brazos Valley. SH is located in Bryan, Texas, which is in Brazos County. It serves six rural counties and one urban county in the Brazos Valley, all of which are designated as MHPSAs. The median household income for these counties ranges from $40,879 to 68,840 in the rural counties and is $39,060 in the urban county (United States Census Bureau, 2010). About 26% of the urban county's residents and 11% to 25% of the rural counties' residents live below the national poverty level (United States Census Bureau, 2010), which in 2010 was $22,050 for a family of four (U.S. Department of Health and Human Services, 2010). About 17% to 25% of rural residents and 20% of urban residents under the age of 65 reported no health insurance (United States Census Bureau, 2010). A recent health survey of the region identified the following community issues: Lack of reliable and affordable transportation, lack of local social and health care services, job shortages, and a shortage of affordable housing options (CCHD, 2013). This survey also revealed that 43% of residents must travel over 20 miles for medical care and 47% of children living in the Brazos Valley did not receive needed services for emotional problems or delinquent behavior (CCHD, 2013).

Opened in 1995, SH is funded by the United Way, community impact grants, fundraising, and private donations. In order to create a safe environment, SH has a strict policy that prohibits any alleged perpetrators from coming on site. Per NCA's guidelines, the forensic and counseling services are separated so to maintain clear

boundaries between the investigation and the treatment of the child's reported abuse (NCA, 2011). Requirements for services are that the abuse or other traumatic experience must have been reported to the proper authorities, and the family must be living within the Brazos Valley. As reporting the abuse is a requirement for services, referrals to SH may only come from child protective services or local law enforcement. Initial referrals are primarily for the center's forensic services.

Upon receiving a forensic referral, SH organizes a multidisciplinary team led by an in-house qualified Forensic Interviewer. The Forensic Interviewer meets with the child and their non-offending caregiver to obtain details about the abuse and/or traumatic event. Other members of the team are invited to watch the interview through a two-way mirror. This interview is also taped and made available to team members. SH mental health providers are typically available for crisis counseling if needed during the forensic interview. Continuous open communication exists between the CAC and local law enforcement, CPS, prosecuting attorneys, and other individuals involved with the family's child abuse case.

During their forensic interview, families are provided information about the CAC's counseling service, which is offered free of charge to all children as well as their non-offending caregivers and siblings. When a family agrees to therapy, a referral is sent to Dr. Denise Peterson, the Lead Counselor (and a Licensed Professional Counselor), who then assigns the case to one of the center's counselors. The assigned counselor contacts the family and schedules an intake counseling session with the client's non-

offending caregiver(s). Services are provided either at SH, in the child's school, the Leon County Health Resource Center in Centerville, TX, or at a local horse office.

Currently, SH has one Licensed Professional Counselor (LPC) and two Licensed Professional Counselor Interns (LPC-Interns) on staff. Doctoral and masters level practicum students also provide counseling to children and families. Five practicum students attended Texas A&M University's American Psychological Association Accredited counseling and school psychology doctoral programs (two counseling psychology, three school psychology) and five were completing their terminal masters' degrees at Sam Houston State University (one clinical mental health, one counseling psychology, one family and marriage counseling, and two professional counseling). Practicum counselors receive weekly hour-long individual supervision from Dr. Peterson and participate in weekly group supervision where they share clinical experiences and receive feedback from peers. Some practicum students receive additional supervision from one of their program's clinical faculty professors. For the purpose of this study, providers will be placed into two categories: LPCs and therapist-in-training (i.e., LPC-Interns and practicum students).

Although the majority of counseling occurs at the CAC, some counselors dedicate specific days of the week to travel to the various counties and provide counseling services at either the child's school or at a community health resource center. Traveling to these counties helps reduce transportation barriers. Counseling is trauma-focused in nature; therefore, non-trauma related concerns are typically referred to other providers. All counselors at the center are required to complete an online TF-CBT

training (http://tfcbt.musc.edu/; Smith & Saunders, 2005) to learn how to utilize TF-CBT with children and non-offending caregivers.

Participants

Clients. There were 269 individuals (referred to as participants) who completed intake paperwork with the intention of initiating counseling services at the CAC between 2011 and 2016. Of this number, 232 children and adolescents were the direct recipient of the reported trauma (youth participant); 12 were siblings of the youth participant (referred to as siblings), and 25 were mothers of the youth participant (referred to as mothers).

Type of Counseling. Although the center's treatment of choice is TF-CBT, play therapy, mixed therapeutic approaches, and EAP are also used with participants. The center had no systematic approach to assigning participants to a specific type of counseling. Counselors selected their treatment approach based on their evaluation of the participant. For example, the participants' age and their developmental and cognitive abilities were used to determine appropriate treatment. Counselor preference, previous training, and comfort with TF-CBT also impact providers' treatment selection.

Measures

Two measures were used interchangeably by clinic staff to assess participant adjustment pre-treatment (administered either at the intake, before, or during the first session) and at post-treatment (administered at the completion of therapy). A second assessment occasionally occurred to monitor participants' progress during therapy, at the "mid-point" of treatment. Of the two measures, one required the youth's participating

caregiver to complete the instrument based on their observations of the youth's behavior. The other measure was administered to the participant, who independently completed the instrument. Both measures are described below; however, the current study intends to examine data available from the Trauma Symptom Checklist for Children.

Trauma Symptom Checklist for Children. The Trauma Symptom Checklist for Children (TSCC; Briere, 1996) is a 54-item self-report measure administered to youth ages 8 to 16. The TSCC takes between 15-16 minutes to complete and assesses how often the youth experiences thoughts, feelings, and behaviors typically associated with traumatic experiences by asking them to rate each item on a four-point scale: 0 indicates "Never" and 3 indicates "Almost All the Time" (Briere, 1996). This assessment has two validity scales (Under-response and Hyper-response) and six clinical scales (Anxiety, Depression, Anger, Posttraumatic Stress, Sexual Concerns, and Dissociation). Additionally, it has four subscales: Sexual Preoccupation, Sexual Distress, Fantasy, and Overt Dissociation (Briere, 1996). Norms are provided according to youth's age and gender. For all scales except the Sexual Concern scale and its subscales, a T-Score of 65 or above is indicative of "clinically significant" symptomology. On these scales, a T-Score between 60 and 65 may represent subclinical symptomology and/or be suggestive of some level of difficulty (Briere, 1996). For the Sexual Concern scale and its two subscales, a T-Score of 70 is indicative of "clinically significant" symptomology (Briere, 1996).

The TSCC was standardized on a large racially and socioeconomically diverse non-clinical sample population of 3,008 American children and adolescents living in

urban, suburban, and inner city areas (Briere & Elliott, 1997; Liotta, Springer, Misurell, Block-Lerner, & Brandwein, 2015). It was normed for both boys and girls and norming was evaluated separately for children ages 8 to 12 and 13 to 16. Specific studies were conducted on 17 year olds to adjust norms (Lanktree et al., 2008). Internal consistency ranges from (Cronbach's α) .77 to .89 (Briere, 1996; Briere & Elliott, 1997; Hawkins & Radcliffe, 2006; Liotta et al., 2015; Matulis et al., 2015). Studies indicate the TSCC is reliable in both clinical and non-clinical samples, and has high construct and discriminant validity (Lanktree et al., 2008; Matulis et al., 2015; Sadowski & Friedrich, 2000; Ubogy & Olson, 2014). The TSCC has been found to be concurrent with Child Behavior Checklist (*r*s between .22-.23; Achenbach, 1991) and Child Depression Inventory (*r*s = .64; Kovacs, 1979), which suggest good concurrent validity (Hawkins & Radcliff, 2006).

The introduction of the TSCC in 1996 filled a gap in the field as assessment instruments that measured post-traumatic stress symptoms for children and adolescents were basically unavailable (Martinez, Polo & Zelic, 2014). The TSCC is considered to be the most reliable measure of sexual concerns for children ages 8 to 15 (Sadowski & Friedrich, 2000). The TSCC has been used in both clinical work and in research, and has been translated into various languages (Matulis et al., 2015). SH provides the TSCC in English and Spanish. However, only one youth participant included in this study completed the TSCC in Spanish at mid-point of therapy. Consequentially, no comparison of TSCC completed in English and Spanish were possible. The TSCC is commonly used in agencies that work with child abuse and child protection (Pifalo,

2006). For purposes of the present study, scores from the 10 clinical scales will be used to assess symptoms at pre- and post- treatment. This approach is consistent with the literature's use of this measure (e.g., Babel et al., 2016; Konanur et al., 2015; Pifalo, 2006; Ruiz, 2016).

Trauma Symptom Checklist for Young Children The Trauma Symptom Checklist for Young Children (TSCYC; Briere, 2005) is a 90-item measure administered to the parent/caretaker of children 3 to 12 years old. Caregivers rate the presences of each trauma symptom using a 4-point Likert scale (1= Not at All to 4 = Very Often). The TSCYC includes two validity scales (Atypical Response which measures over responding and Response Level which measures under reporting) and eight clinical scales (Post-Traumatic Stress-Intrusion, Post-Traumatic Stress-Avoidance, Post-traumatic-Arousal, Sexual Concerns, Dissociation, Anxiety, Depression, and Anger/Aggression). Additionally, the TSCYC includes a norm-referenced item, which assesses the amount of time the reporting caretaker spends with their child (Lanktree et al., 2008). The composite score, Post-Traumatic Stress-Total (PTS-TOT), represents the sum of the Post-Traumatic Stress-Intrusion (PTS-I), Post-Traumatic Stress-Avoidance (PTS-AV), Post-traumatic-Arousal (PTS-AR) subscales. PST-TOT raw scores of 40 or greater are indicative of PTSD (Briere, 2005).

The TSCYC was also normed on a diverse sample that is representative of the national sample (Briere et al., 2001). Internal consistency alphas for the TSCYC range between .81 and .92 (Wherry, Graves, & Rhodes King, 2008). The Child Behavior Checklist (Achenbach, 1991), Child Sexual Behavior Inventory (Friedrich, 1997), and

Child Dissociation Checklist (Putnam, Helmers, & Trickett, 1993) have been found to have good concurrent validity (*r*s between .55 and .82) with the TSCYC (Stover & Berkowitz, 2005). Studies conclude that scales on the TSCYC and the TSCC converge in their evaluation of the child's symptom presentation, specifically for the following scales: Anxiety, Anger, Dissociation, and Sexual Concerns (Lanktree et al., 2008; Wherry et al., 2008).

Procedure

The clinical intake at the CAC begins with counselors contacting the youth's non-offending caregiver(s) and scheduling an intake session with them. This intake interview usually lasts about an hour and includes several components. First, counselors explain confidentiality and obtain informed consent for counseling services. Next, the caregiver completes an intake interview guide in which they provide demographic information. Then, the caregivers are invited to share their understanding of their child's trauma, report symptoms and behavior changes they have noticed, and provide relevant child and family history. Caregivers of children between the ages of 3 and 12 years old complete the TSCYC during their intake. Counselors end this intake session by providing psycho-education on trauma and its impact on children as well as teaching parents skills intended to help them address trauma-related behavioral changes.

At the second session, counselors obtain assent from the youth and conduct an intake interview with them that includes asking them about their life before and after the trauma. Current coping strategies and goals for counseling are also discussed. Counselors then begin implementing TF-CBT treatment by engaging in psycho-

education. Important information about trauma, its impact on children and families, and TF-CBT is provided to both the child and their caregivers. The intake sessions also include time for youth age 8 or above to complete the TSCC.

Following sessions include parallel child and caregiver sessions dedicated to teaching and practicing relaxation skills, affective modulation skills, and cognitive coping skills. Homework assignments encourage youths and caregivers to practice the skills learned in session at home. These skills help facilitate the transition from skills training to trauma-specific discussions. It is around this time that counselors ask youths and their caregivers to complete the mid-treatment TSCC and TSCYC, respectfully. In these more trauma-focused sessions, youth begin creating a trauma narrative, most often in written form. Based on participants' age and ability (i.e., ability to read and write), other avenues such as creating comic strips might be used to document their traumatic experience. This narrative aims at helping youth see themselves as more than just "victims" by equipping them to reduce avoidance, recognize cognitive distortions, and create a broader understanding of the trauma (Cohen & Mannarino, 2008). This process includes in vivo techniques aimed to help the youth begin mastering trauma reminders. Once the youth is ready, they are encouraged to share their narrative with their caregivers in a joint parent-child session. The last component of TF-CBT focuses on teaching and practicing safety skills and future planning. At termination, both the youth and their caregiver are asked to complete the TSCC and TSYSC.

The center does not currently engage in any follow up contact with the families who have terminated mental health services. Youths and their families are encouraged to

contact the center as needed in the future for trauma-related counseling. As the center only provides trauma-focused counseling, counselors will make referrals to other local providers for any additional non-trauma psychological concerns.

Analysis

The current database was developed with the assistance of several counseling psychology doctoral students with the oversight and input of Dr. Peterson and clinic staff. In developing this database several issues became apparent; these issues include a lack of adherence to expected and recommended protocols in systematically administering and collecting measures from participants. In addition, various clinical issues circumvented a successful completion of the recommended TF-CBT protocol, resulting in attrition. For example, of those referred for TF-CBT and who completed the initial measure, nine cases were closed because of "no shows," ten were referred elsewhere for services, three relocated, ten discontinued services, and four cases did not have a recorded reason for termination.

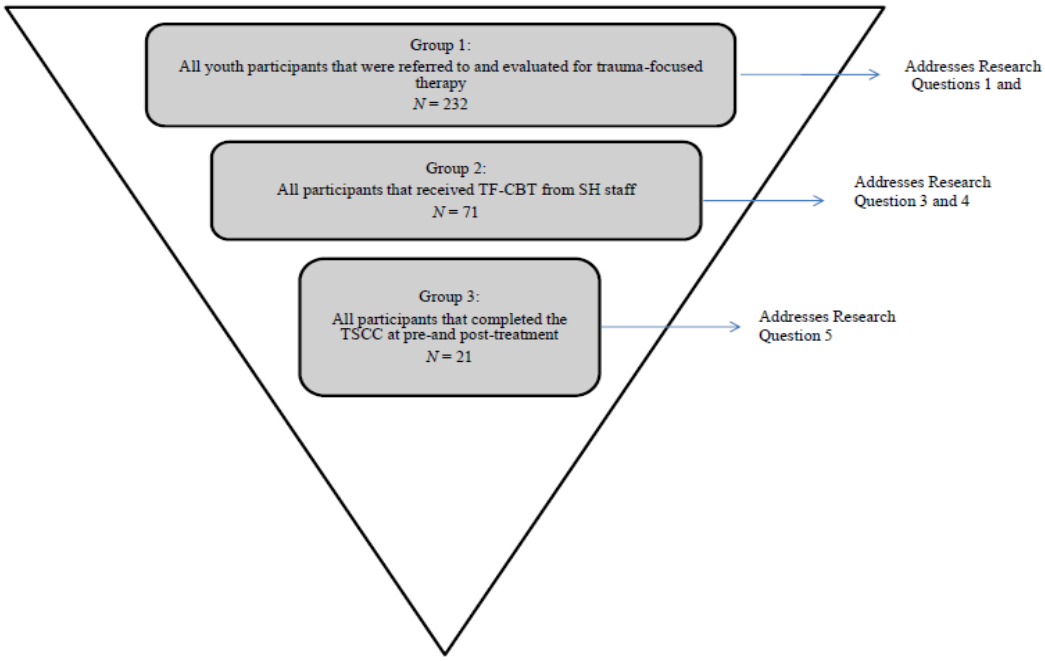
Only 21 participants completed the TF-CBT protocol and completed the TSCC at intake and at termination. However, one case was "referred out" after 23 sessions, another was terminated after 15 sessions due to relocation, and another participant was "discontinued" after 32 sessions. Twelve participants completed a recommended protocol of TF-CBT (number of sessions ranged from 21 to 39). Further, only seven participants completed the TSCYC at pre-treatment and at "completion" of the protocol. As there are fewer TSCYC than TSCC, this study will focus its analysis on the participants that completed the TSCC.

Initial data analysis will report clinically important demographic information of all participants included in this study (Group 1; $N = 232$), the 71 participants that received TF-CBT (Group 2), and the 21 participants who completed the TSCC at intake and termination (Group 3). Means comparison test (e.g., t-tests) and chi square analyses will examine possible differences between participants in these three groups. This study will utilize these analyses to address the following research questions:

1. What are the demographics and traumatic experiences of the youths, siblings, and mothers who were referred and/or evaluated for trauma-focused therapy at Scotty's House?
2. How do the youth participants that were referred and/or evaluated for treatment at Scotty's House compare with each other?
3. What are the demographics and traumatic experiences of children and adolescents who received trauma-focused cognitive behavioral therapy (TF-CBT)?
4. How are the children and adolescents who received TF-CBT different from those who received other therapies such as play therapy or equine-assisted therapy?
5. What were the differences in the youths' who completed a recommended protocol of CBT pre- and post-treatment Trauma Symptom Checklist for Children mean scores?

Figure 1 provides a visual representation of these analyses and identify which research question they address.

Figure 1. Participant Groupings and Associated Research Questions



Participants were divided into categories to assess for differences. To assess for age, participants were divided into the following three categories: Pre-School Aged (0-5 years old), Elementary Aged (6-12 years), and Adolescents (13-19 years). Other categories created for analyses include: Ethnicity (Caucasian and Minority), County of Residency (Urban and Rural), and Type of Trauma (Sexual Abuse Only and Other Types of Trauma).

Analysis of treatment outcomes will be restricted to the 21 participants who completed the TSCC at pre- and post-treatment. This will require the use of techniques appropriate for small sample sizes. Following the example of a study conducted by

Gonzalez and Brossart (2015) on treatment outcomes in response to telepsychology services, this study will include a series of paired-samples *t* tests of the pre-treatment and post-treatment TSCC scores. Analyses will examine differences in TSCC mean scores based on characteristics such as age, ethnicity, and gender.

CHAPTER IV

RESULTS

This chapter will begin with a description of the 232 youth participants that were referred to and evaluated for trauma-focused therapy from SH. Information about youth participants' biological parents, types of trauma(s) experienced, alleged perpetrators, and types of treatments received will be included in this description. Possible differences between these youth participants will be explored using means comparison test (e.g., *t*-tests) and chi square analyses. This information will give readers an understanding of the population this CHC serves.

Next, a description of the 71 participants that received TF-CBT will be provided. *T*-tests and chi square analysis will be utilized to determine possible differences between the participants recommended for TF-CBT and other types of treatments such as play therapy and EAP. This information will address the question: What are the characteristics of participants who were assigned to a protocol of TF-CBT?

Then, treatment outcomes of the 21 participants who completed the TSCC at pre-treatment and at the completion of treatment will be analyzed using paired-sampled *t* tests of the pre-treatment and post-treatment TSCC mean scores. Analyses will examine differences in TSCC mean scores based on characteristics such as age, ethnicity, and gender. This information will answer the question: What measureable benefits did the children and adolescents who completed a recommended protocol of trauma-focused therapy from SH staff report?

The last portion of this chapter will provide a description of 232 youth participants' treatment engagement and retention. This section will report how many youth participants completed recommended treatment and list the reasons why youth participants terminated prematurely. This information will help identify barriers to care.

Description of Group 1: All Youth Participants Referred to and/or Assessed for Trauma-Focused Treatment at SH (*N* = 232)

This section provides information about all the youth participants whose files contained completed intake paperwork. Demographic information about youth participants' mothers and siblings is provided; however, the focus of this section is on the youth participants. Some youth participants included in this section completed their intake paperwork during their forensic interview but did not attend their scheduled intake appointment. Other youth participants attended their intake appointment, but did not attend follow-up therapy sessions. Most youth participants included in this section attended their intake appointment and at least a couple follow-up sessions.

Demographic Information. Youth participants (*N* = 232) were primarily Caucasian (56.5%) and female (74.6%). Youth participants' ages ranged from 3 to 20 years (*M* = 10.0, *SD* = 4.12). The mean age for the female youth participants was 10.6 (*SD* = 4.1) and the mean age of the male youth participants is 8.5 (*SD* = 3.8). Of these youth participants, 75.8% reportedly lived with at least one biological parent, 14.3% reportedly lived with at least one grandparent, 3.0% reportedly lived with foster parents, and .4% reportedly lived with an adoptive parent. The majority of youth participants reported living in a rural county (53.4%) and 46.6% lived in an urban county. Additional

demographic information for youth participants, siblings, and mothers are presented in Table 1.

Diagnoses. Diagnoses for primary and secondary diagnoses were also assessed. Primary diagnoses refer to the clinical diagnosis for which the youth participants is receiving treatment at SH. Secondary diagnoses include any diagnoses the youth participant reportedly had prior to their traumatic experience; youth participants' secondary diagnoses were diagnosed by providers outside of SH and were not the focus of therapy at SH. An example of a primary diagnoses would be PTSD and an example of secondary diagnoses would be Attention-Deficit Hyperactivity Disorder, that was diagnosed before trauma and is being managed by another provider.

Most youth participants had no primary (72.8%) or secondary (63.8%) diagnoses documented in their counseling or forensic files. This lack of primary or secondary diagnosis, however, is an artifact of counselors' decision to not provide a diagnosis. Depression (4.7%) and PTSD (8.2%) were the most common primary diagnoses. The most common secondary diagnoses were ADHD and medical conditions (e.g., asthma) at 11.2% and 9.1% respectively.

Type of Abuse. During the forensic interview, 75.9% of youth participants made an outcry of abuse (i.e., reported experiencing a traumatic event) while 16.8% failed to make an outcry (i.e., denied being abused or experiencing a traumatic event). About 45.7% of youth participants reported experiencing multiple traumatic events whereas 22.4% reported experiencing one singular traumatic event. Many youth participants reported experiencing only one type of trauma; of these participants, 78.0% reported

Table 1

Demographic Statistics of All Individuals Referred to and/or Assessed for Trauma-Focused Therapy at SH

	Participant (*N* = 232)		Sibling (*N* = 12)		Mother (*N* = 25)	
Age						
Mean	10.0		10.42		41.9	
Std. Deviation	4.12		3.3		10.5	
	n	%	*n*	%	*n*	%
Gender						
Male	59	25.4	5	41.7		
Female	173	74.6	7	58.3	25	100.0
Ethnicity						
Caucasian	131	56.5	9	75.0	17	68.0
Hispanic	51	22.0	3	25.0	5	20.0
African American	23	9.9			3	12.0
Asian	2	.9				
Native American	2	.9				
Biracial	19	8.2				
County						
Burleson	14	6.0	2	16.7	1	4.0
Robertson	29	12.5	1	8.3	2	8.0
Brazos	108	46.6	7	58.3	17	68.0
Grimes	19	8.2	1	8.3	1	4.0
Washington	9	3.9			2	8.0
Madison	16	6.9	1	8.3		
Leon	29	12.5			2	8.0
Limestone	1	.4				
Austin	2	.9				
Freestone	2	.9				
Milam	2	.9				
Waller	1	.4				

enduring only sexual abuse, 5.6% reported experiencing only physical abuse, 3.0% only witnessed domestic violence, and .4% only experienced child endangerment (i.e., being exposed to drugs or living in dangerous homes). Multiple types of traumas (i.e.,

experiencing both sexual and physical abuse) were reported by 7.3% of youth participants.

Description of Youth Participants' Biological Parents. Most youth participants' biological parents were reported to be divorced (30.2%) or unmarried (21.6%); a smaller percentage of youth participants (17.7%) reportedly had married parents. Information about biological parents' education was largely missing from youth participants' files; no information was provided for 40.5% of youth participant's biological mothers and 51.3% of youth participants' biological fathers. Many biological mothers were reported to have completed high school or obtained a GED (23.4 %) and 22.7% were reported to have at least some post-high school education (e.g., some college experience, an Associates' degree, or a Bachelor's degree). For biological fathers, 23.4% were reported to have a high school diploma or GED and 11.3% reportedly had some post-high school education.

Information provided about youth participants' biological mothers indicated that 21.1% have not experienced a trauma in their lives. Of the 55.8% of biological mothers that reportedly experienced a trauma, 26.7% reportedly experienced multiple types of traumas, 12.1% experienced domestic violence, 9.5% experienced sexual abuse, 3.0% experienced emotional abuse, .4% experienced childhood neglect, and 2.2% experienced physical abuse. For biological fathers, 77.6% of reports indicated no previous traumas; of the 18.8% that did experience abuse, 2.6% experienced emotional abuse, 3.4% reportedly experienced domestic violence, 1.7% experienced neglect, 6.0% experienced multiple traumas, .9% experienced physical abuse, and 3.4% reportedly experienced

sexual abuse. No drug use was reported for 58.6% of youth participants' biological parents; however, reports indicate that 20.3% of youth participants' biological fathers and 8.2% of the biological mothers reported drug use. No criminal difficulty was reported for 61.2% of participants' biological parents. However, 22.4% of participants' reports indicate that the biological father experienced criminal difficulty and 8.6% of biological fathers were incarcerated at time of intake. It is important to note that the participating caregiver, who may not be the youth participants' biological parent and might not know about biological parents' previous experiences, provided this information.

Alleged Perpetrator Characteristics. Alleged perpetrators' ages ranged from 6 years to 78 years, with a mean age of 29.4 (*SD* = 14.8). Most alleged perpetrators were Caucasian (49.6%) males (88.8%); 51.7% of these alleged perpetrators were youth participants' male relatives. The most frequent relationships to alleged perpetrator(s) were: Youth participant's biological father (14.5%), step-father (10.3%), and cousin (8.2%). Most youth participants reported only one alleged perpetrator; however, 11 (4.7%) youth participants reported multiple perpetrators.

Type of Treatment. Therapists treated 31.2 % of youth participants with play therapy and 26.4% with TF-CBT. Most youth participants (64.2%) received treatment at SH and 29.4% received treatment either at their school, at the horse arena, or at the Leon County Health Resource Center in Centerville, TX. LPCs provided treatment to 78 youth participants whereas LPC-Interns provided treatment to 99 youth participants, and graduate students (i.e., masters and doctoral students) provided treatment to 51 youth

participants. Table 2 provides additional information about the type of treatment provided and location of treatment.

Differences in Group 1 Youth Participants' Demographic Information and Traumatic Experiences (N = 232)

Differences in Youth Participants (N = 232) Based on Demographic Information.

A one-way ANOVA revealed a statistically significant difference in youth participants' age based on their gender [$F(1, 229)$] = 6.7, p =. 01). An independent sample test revealed that female youth participants were significantly older (t = -3.5; p = .001) than male youth participants. A chi-square analysis discovered that there is a disproportionally higher percentage of elementary-aged (6-12 yrs.) youth participants in this study than is expected by chance. This study also included more Caucasian and minority adolescent (13-19 yrs.) participants than expected by chance (χ^2= 6.3, p = .04). There is a disproportionately lower percentage of non-Caucasian male youth participants and higher percentage of non-Caucasian female youth participants (χ^2= 4.6, p =. 03) than expected by chance. The higher percentage of urban residing minority youth participants and rural residing Caucasian youth participants is more disproportionate than is expected by chance (χ^2= 15.9, p =.00).

Table 2

Summary of the Type of Counseling Received and Location of Treatment

	Participant (*N* = 232)		Sibling (*N* = 12)		Mother (*N* = 25)	
	N	%	*N*	%	*N*	%
Counseling Type						
Intake Only	50	21.5	2	16.7	2	8.0
TF-CBT	61	26.3	3	25.0	7	28.0
Play Therapy	79	34.1	5	41.7		
EAP	5	2.2			2	8.0
Individual	15	6.5	2	16.7	7	28.0
Mixed	16	6.9			1	4.0
Parent Training					5	20.0
Unknown	3	1.3			1	4.0
Service Location						
Scotty's House	149	64.2	11	91.7	21	84.0
School	28	12.1				
Horse Arena	5	2.2			2	8.0
Leon County Health Center	4	1.7			1	4.0
Multiple	25	11.8				

Differences in Youth Participants' (*N* = 232) Traumatic Experiences. A means comparison test revealed significant differences in the number of traumas reported based on youth participants' gender ($t = 1.9$; $p = .05$); specifically, this analysis noted that the male youth participants reported experiencing more traumatic events than the female youth participants. No statistical difference was found between the number of traumas experienced and the types of trauma experienced ($t = -1.6$; $p = .1$). Further, no statistical difference was found between the number of traumas experienced and county of residence (i.e. urban or rural county residency; $t = .3$; $p = .8$).

A one-way ANOVA identified a statistically significant difference [$F(1, 230) = 6.4$; $p = .01$] in the type of trauma (sexual abuse only versus other types of traumas) experienced and youth participants' age. Youth participants that reported experienced sexual abuse only were found to be significantly older ($t = 2.5$; $p = .01$) than the youth participants who reportedly experienced other types of abuse. A chi square analysis found that a lower percentage of adolescents reportedly experienced other types of abuse than is expected by chance, $\chi^2 = 6.5$, $p = .04$. A one-way ANOVA revealed a statistically significant [$F(1, 230) = 17.2$; $p = .00$] difference in the type of trauma experienced based on gender. Female youth participants were found to be significantly more likely to experience sexual abuse only ($\chi^2 = 16.1$, $p = .00$) than expected by chance.

Description of Group 2: Participants Who Received TF-CBT (*N* = 71)

In total, 71 participants (youth, siblings, and mothers) received TF-CBT. Participants that received TF-CBT were primarily female (83.1%) and lived in the Brazos County (52.1%). Their mean age is 16.0 ($SD = 9.0$). Most of these participants were either Caucasian (38.0%) or Hispanic (36.6%) and lived with either both biological parents (16.9%) or with at least one biological parent (57.7%). Records indicated 42 participants (59.2%) reported multiple traumatic experiences. The majority (74.6%) reported experiencing sexual abuse only. Therapists-in-training provided treatment to the majority of these participants (70.4%).

Most of these participants' biological parents were reported to be divorced (36.6%); 16.9% were reported to be married, 16.9% were reported to be unmarried, and no information about biological parents' marital status was provided for 18.3%.

Mother's educational background was unknown for 46.5% of these participants. The information provided about mother's education revealed that 18.3% of participants' mothers had a high school education, 11.3% reportedly had some college education, and 4.2% earned a bachelor's degree. Information about these participants' fathers' education was unknown for 64.8% of participants; 15.5% of biological fathers were reported to have graduated from high school, 4.2% had some college experience, and 1.4% earned a bachelor's degree. No maternal history of previous traumatic experiences was reported for 23.9% of these participants' mothers; 18.3% of these participants' mothers reportedly experienced multiple traumatic events in their lives. With regards to these participants' fathers, no history of traumatic experience was reported for the majority of these participants' fathers (88.7%).

Differences in Group 2 Participants' Demographic Information and Traumatic Experiences (*N* = 71)

A *t*-test revealed that participants that received TF-CBT were significantly older (M = 16.0, SD = 9.0, t = 2.8, p = .006) than the participants that received other types of treatments (M = 12.0, SD = 10.9). Participants that received other types of treatments reported experiencing more traumatic experiences than those that received TF-CBT (t = -3.8, p = .001). No other statistically significant differences in these participants were found.

Description of the Participants that Received TF-CBT and Completed Treatment Protocol (*N* = 28).

Of the 71 participants that received TF-CBT, 39.4% (*N* =28) completed the recommended treatment protocol, per clinician's report. Most of the participants who successfully completed the TF-CBT protocol were females (82.1%) who lived in a rural county (53.6%) and received treatment at SH (67.9%) from a therapist-in-training (85.7%). Their ages ranged from 7 years to 43 years (*M* = 14.8, *SD*= 8.1) and most were either Caucasian (35.7%) or Hispanic (39.3%). Multiple traumatic experiences were reported by 57.1% of these participants and most reported experiencing sexual abuse only (67.9%). Most (67.9%) lived with at least one biological parent and 10.7% lived with both biological parents. With regards to participants' parents' marital status, most were reportedly divorced (42.9%) or unmarried (17.9%). Table 3 provides demographic information of the 71 participants that received TF-CBT and the 28 participants who received TF-CBT and completed recommended treatment protocol.

Table 3

Demographic Statistics of Participants who Received TF-CBT (N= 71) and the Participants that Received TF-CBT and Completed Treatment Protocol (N= 28)

	Participant Who Received TF-CBT (*N* = 71)		Participant Who Received TF-CBT and Completed Treatment Protocol (*N* = 28)	
Age				
Mean	16.0		14.8	
Std. Deviation	9.0		8.1	
	N	*%*	*N*	%
Gender				
Male	12	16.9	5	17.9
Female	59	83.1	23	82.1
Ethnicity				
Caucasian	27	38.0	10	35.7
Hispanic	26	36.6	11	39.3
African American	5	7.0	3	10.7
Asian	2	2.8		
Biracial	10	14.1	4	14.3
Unknown	1	1.4		
County				
Urban	37	52.1	13	46.4
Rural	34	47.9	15	53.6

Information Gathered From Participants' TSCC at Intake and Termination (*N* = *21)*

Description of Participants with Completed TSCCs. For those completing the TSCC, 59 participants completed the TSCC at intake. Table 4 illustrates the TSCC mean scores for these 59 participants that completed the TSCC at intake. 20 participants completed the TSCC at the mid-point of therapy, and 22 participants completed the

TSCC at termination. For 35 participants, intake was the only time they completed the TSCC. Similarly, three participants completed the TSCC only at the mid-point of therapy and one participant completed the TSCC only at termination. 21 participants completed the TSCC at intake and at termination and three participants completed the TSCC at intake and at the mid-point of therapy. Only 14 participants completed the TSCC at all three recommended time points. This section will focus on the 21 participants who completed the TSCC at intake and termination.

Table 4

Descriptive Statistics of TSCC Scores at Intake (N = 59)

	Minimum	*Maximum*	*Mean*	*Standard Deviation*
Anxiety	35	82	55.3	11.4
Depression	32	84	52.8	11.4
Anger	35	72	50.9	9.6
Posttraumatic Stress	33	78	55.8	11.1
Dissociation	39	87	54.3	10.8
Overt Dissociation	40	85	56.2	10.5
Fantasy	36	79	49.0	10.8
Sexual Concerns	36	101	53.6	15.5
Sexual Preoccupation	36	77	48.9	10.4
Sexual Distress	41	111	60.8	21.3
Underresponse	39	76	49.9	9.1
Hyperresponse	46	111	57.4	17.0

Table 5

Demographic Information of the Participants who Completed Pre-and Post-Treatment TSCC (N = 21)

	N	%
Gender		
Female	14	66.7
Male	7	33.3
County of Residency		
Urban	11	52.4
Rural	10	47.6
Ethnicity		
Caucasian	6	28.6
Biracial	2	9.5
African American	2	9.5
Hispanic	10	47.6
Unknown	1	4.8

Of these 21 participants, 20 were youth participants and 1 was a sibling of a youth participant. Seven (33.3%) of these participants were males and 14 (66.7%) were females. Their ages ranged from 8 years to 17 years, with a mean age of 13.0 (*SD* = 2.6). Most of these participants experienced sexual abuse only (71.4%) and were Hispanic (47.6%). Many (52.4%) were residents of an urban county. Therapist-in-training provided services to 76.2% of these participants; the majority received TF-CBT (*N*=18*;* 85.7%) at SH (81.0%). About 57.1% of them successfully completed the recommended treatment protocol. Table 5 provides demographic information for these 21 participants.

Summary of Participants' Pre- and Post-Treatment TSCC Scores (*N* = 21). The majority of participants reported subclinical symptoms (T Score < 60) on all TSCC scales at intake. On the Anxiety scale, three participants had clinically significant scores

(*T*-Score ≥ 65). Results indicate that clinically significant scores were found for four participants on the Depression scale, one participant on the Anger scale, and four participants on the Posttraumatic Stress scale. Three participants indicated clinically significant scores on the Dissociation scale, five participants had clinically significant scores on the Overt Dissociation scale, and two participants had clinically significant scores on the Dissociation-Fantasy scale. On Sexual Concern scale, three participants scored in the clinically significant range (*T*-Score ≥ 70) whereas no participants had clinically significant scores on the Sexual Concern-Preoccupation scale. Four participants had clinically significant scores on the Sexual Concern-Distress scale.

At termination, no participants' scores were in the clinically significant range on the Anger or Sexual Concern-Preoccupation scales. The following scales had two participants score in the clinically significant range: Anxiety, Posttraumatic Stress, Dissociation, Overt Dissociation, Dissociation-Fantasy, and Sexual Concern-Distress. On the Depression scale, only one participant scored in the clinically significant range. Only one participant had a clinically significant score on the Sexual Concern scale at termination.

Comparison of Pre- and Post-Treatment Mean Scores. A paired-samples t-test was conducted to compare TSCC mean scores at pre- and post-treatment. Results are displayed in Table 6. There was a statistically significant reduction ($p \leq .05$) in mean scores on four of the ten clinical scales (Anxiety, Posttraumatic Stress, Sexual Concerns, and Sexual Distress). An almost statistically significant difference in pre- and post-treatment means was found in the Depression scale ($t = 2.0$, $p = .057$).

Table 6

Comparative Analysis of Pre- and Post-Treatment TSCC Scores (N = 21)

TSCC Subscales	Pre-Treatment		Post- Treatment		*t*	*df*	Sig. (2 tailed)	Effect Size
	M	*SD*	*M*	*SD*				
Anxiety	57.3	9.6	49.4	9.9	4.1	20	.001	.81
Depression	53.5	12.9	48.0	10.4	2.0	20	.057	.47
Anger	47.7	9.1	45.1	7.7	1.3	20	.203	.31
Posttraumatic Stress	53.8	10.6	49.8	11.0	2.2	20	.037	.37
Dissociation	54.0	12.5	51.2	11.6	1.1	20	.300	.23
Overt Dissociation	56.5	12.1	53.3	10.8	1.2	20	.258	.28
Fantasy	47.1	11.4	48.3	10.1	-.5	20	.622	.11
Sexual Concerns	52.5	15.3	46.1	11.9	2.2	20	.041	.47
Sexual Preoccupation	47.4	8.9	45.4	9.6	1.0	20	.309	.22
Sexual Distress	59.3	21.9	49.7	16.3	2.2	19	.038	.50
Underresponse	53.1	9.7	54.2	10.3	-.4	19	.666	.11
Hyperresponse	55.4	16.2	52.1	11.1	1.4	19	.176	.24

Cohen's *d* values were calculated to measure the effect size intervention had on these reductions. This study utilized Cohen (1988) definitions of effect sizes; "small" effect size is defined as $d = .2$, "medium" as $d = .5$, and "large" as $d = .8$. The intervention had a large effect ($d = .81$) on the Anxiety scale, a medium effect ($d = .5$) on the Sexual Distress scale, and a small effect ($d \leq .2$) on the following scales: Depression, Anger, Posttraumatic Stress, Dissociation, Sexual Concerns, and Sexual Preoccupation.

Post-Hoc Analysis of TSCC Mean Scores

Differences in TSCC Scores Based on Demographic Factors. A one-way MANOVA was conducted to determine any differences in the TSCC pre-treatment mean

scores or post-treatment mean scores based on participants' demographic characteristics. Table 7 details results of these analyses. The analysis on pre-treatment TSCC mean scores indicated there was no statistical difference based on the following factors: Participants' age, gender, ethnicity, type of treatment received, and type of trauma experienced. A statistical difference between participants' post-treatment TSCC scores based on gender was identified, $F(12, 7) = 4.4$, $p = .03$, Wilk's $\Lambda = .12$, *Partial* $\eta^2 = .88$.

Table 7

Differences in Pre- and Post- Treatment TSCC Means: Results of One-Way MANOVA (N = 21)

	Pre-Treatment				Post-Treatment			
	$F(12, 7)$	p	Wilk's Λ	η^2	$F(12, 7)$	p	Wilk's Λ	η^2
Gender	1.9	.20	.26	.77	4.4	.03*	.12	.88
Age	.93	.56	.38	.62	1.3	.36	.30	.70
Ethnicity	2.0	.18	.22	.78	1.7	.24	.25	.24
Type of Treatment	1.6	.29	.27	.73	2.6	.10	.18	.82
Type of Trauma	.93	.56	.39	.62	1.2	.43	.33	.67

Note. *$p < .05$

A follow-up one-way ANOVA test was utilized to identify which scales had significant differences based on participants' gender. This analysis found significant differences in the Anxiety scale and suggested that male participants had higher mean

scores on the Anxiety scale than did female participants. Table 8 provides more information on this analysis.

Table 8

One-Way Analysis of Variance of Post-Treatment TSCC Scores by Participants' Gender (N= 21)

	Males $N = 7$		Females $N =14$		*df*	*SS*	*F*	*p*
	M	*SD*	*M*	*SD*				
Anxiety	57.1	10.1	45.6	7.4	1	624.9	9.0	.01*
Depression	53.0	13.6	45.5	7.9	1	262.5	2.6	.12
Anger	48.1	8.9	43.6	6.9	1	94.5	1.6	.22
Posttraumatic Stress	55.4	12.4	47.0	9.5	1	331.5	3.0	.10
Dissociation	57.6	12.4	48.0	10.1	1	427.5	3.6	.07
Overt Dissociation	59.0	12.6	50.4	8.9	1	342.9	3.3	.09
Fantasy	52.4	9.3	46.2	10.2	1	180.2	1.8	.19
Sexual Concerns	50.6	16.2	43.9	8.9	1	205.9	1.5	.24
Sexual Preoccupation	48.3	10.0	44.0	9.5	1	85.7	.9	.35
Sexual Distress	56.5	25.5	46.8	10.4	1	396.3	1.5	.23
Underresponse	47.5	6.0	57.0	10.6	1	379.1	4.2	.06
Hyperresponse	57.2	12.6	49.9	10.0	1	224.4	1.9	.18

Note. * $p < .05$

A two-way MANOVA was used to identify differences in pre-and post-treatment TSCC scores based on the interaction between participants' ($N = 21$) demographic characteristics; no difference was found in the interaction between participants' gender and ethnicity, gender and age, gender and type of trauma experienced, or age and type of trauma experienced. A difference in pre-and post-treatment TSCC scores was found based on participants' age and their ethnicity, $F(12, 5) = 10.8$, $p = .01$, Wilk's $\Lambda = .04$, *Partial* $\eta^2 = .96$. Similarly, a difference based on the interaction between participants age

and ethnicity [$F(12, 5) = 5.64$, $p = .03$, Wilk's $\Lambda = .07$ *Partial* $\eta^2 = .93$] was identified. Table 9 provides more information on the results of this analysis.

Table 9

Differences in Pre- and Post-Treatment TSCC Means: Results of Two-Way MANOVA (N = 21)

	Pre-Treatment				Post-Treatment			
	$F(12, 5)$	p	Wilk's Λ	η^2	$F(12, 5)$	p	Wilk's Λ	η^2
Gender x Ethnicity	1.15	.47	.27	.73	1.15	.47	.27	.73
Gender x Age	2.68	.14	.13	.87	2.68	.14	.13	.87
Gender x Type of Trauma	.77	.68	.35	.65	1.51	.34	.25	.78
Age x Type of Trauma	.39	.91	.51	.49	1.41	.37	.23	.78
Age x Ethnicity	10.80	.01*	.04	.96	5.64	.03	.07	.93

Note. $*p <. 05$

A two-way ANOVA was used to identify in which TSCC scales the interaction between participants' age and ethnicity led to a significant difference in mean scores. Results from this these analyses are presented in Table 10. Significant differences in pre-treatment TSCC mean scores based on this interaction were identified in the following scales: Depression, Posttraumatic Stress, and Underresponse. The two-way ANOVA was also conducted on the post-treatment TSCC mean scores; this analysis found no statistically differences in post-treatment TSCC mean scores based on this interaction.

Table 10

Between-Subjects Effects of Participants' Ethnicity and Age on TSCC Scores (N = 21)

	Pre-Treatment					Post-Treatment				
	df	*SS*	*F*	*p*	η^2	*df*	*SS*	*F*	*p*	η^2
Anxiety	1	3.60	.05	.83	.00	1	27.23	.38	.55	.02
Depression	1	672.40	4.81	.04*	.23	1	63.34	.59	.46	.04
Anger	1	169.47	2.62	.13	.14	1	80.28	1.99	.18	.11
Posttraumatic Stress	1	336.40	6.33	.02*	.28	1	23.51	.28	.60	.02
Dissociation	1	38.68	.25	.62	.02	1	172.23	1.61	.22	.09
Overt Dissociation	1	55.23	.40	.53	.03	1	90.00	.85	.37	.05
Fantasy	1	.34	.00	.96	.00	1	122.50	1.59	.23	.09
Sexual Concerns	1	1.00	.00	.95	.00	1	14.40	.12	.74	.01
Sexual Preoccupation	1	116.74	1.42	.25	.08	1	5.14	.06	.81	.00
Sexual Distress	1	28.90	.07	.79	.00	1	31.80	.14	.72	.01
Underresponse	1	411.74	5.46	.03*	.26	1	186.34	1.99	.18	.11
Hyperresponse	1	199.51	1.93	.18	.11	1	288.01	3.78	.07	.19

Note. * $p < .05$

A review of the Estimated Marginal Means indicated that Caucasian adolescents (M = 70.0, SD = 8.4) had higher mean scores on the Depression scale than minority adolescents (M = 48.0, SD = 3.9). On the Posttraumatic Stress scale, Caucasian participants [adolescents (M = 66.0, SD = 5.2) and elementary school aged participants

Table 11

Estimated Means for Interaction of Participants' Age and Ethnicity on TSCC Scales (N = 21)

	Pre-Treatment				Post-Treatment			
	Elementary-Age *M* (*SD*)		*Adolescents* *M* (*SD*)		Elementary-Age *M* (*SD*)		Adolescents *M* (*SD*)	
	Caucasian	Minority	Caucasian	Minority	Caucasian	Minority	Caucasian	Minority
Anxiety	67.7 (4.9)	57.8 (3.4)	63.5 (6.0)	51.7 (2.8)	62.3 (4.9)	49.8 (3.5)	51.0 (6.0)	44.0 (2.8)
Depression	50.0 (6.8)	55.3 (4.8)	70.0 (8.4)	48.0 (3.9)	46.0 (6.0)	52.8 (4.2)	46.0 (7.4)	44.4 (3.5)
Anger	50.7 (4.6)	50.0 (3.3)	56.5 (5.7)	42.1 (2.7)	47.7 (3.7)	51.2 (2.6)	45.5 (4.5)	39.6 (2.1)
Posttraumatic Stress	60.3 (4.2)	58.3 (3.0)	66.0 (5.2)	44.7 (2.4)	60.7 (5.3)	54.7 (3.7)	53.0 (6.5)	41.9 (3.1)
Dissociation	58.3 (7.1)	58.0 (5.1)	55.0 (8.7)	48.1 (4.1)	53.3 (6.0)	59.7 (4.2)	51.5 (7.3)	44.0 (3.5)
Overt Dissociation	61.3 (6.7)	59.5 (4.8)	60.0 (8.3)	50.3 (3.9)	55.3 (6.0)	60.5 (4.2)	52.5 (7.3)	47.7 (3.4)
Fantasy	51.7 (6.7)	53.0 (4.7)	42.5 (8.2)	43.2 (3.9)	49.3 (5.1)	55.5 (3.6)	47.5 (6.2)	42.0 (2.9)
Sexual Concerns	61.7 (8.8)	59.3 (6.2)	49.5 (10.8)	46.1 (5.1)	46.7 (6.4)	55.3 (4.5)	37.0 (7.8)	41.7 (3.7)
Sexual Preoccupation	46.7 (5.2)	52.3 (3.7)	49.5 (6.4)	43.8 (3.0)	43.3 (5.5)	51.7 (3.9)	37.5 (6.7)	43.4 (3.2)
Sexual Distress	75.0 (11.8)	69.7 (8.3)	49.0 (14.4)	49.3 (6.8)	54.7 (8.9)	60.2 (6.3)	43.0 (10.9)	42.6 (5.1)
Underresponse	54.7 (5.0)	47.5 (3.5)	44.0 (6.1)	58.2 (2.9)	51.3 (5.6)	50.0 (4.0)	46.5 (6.8)	59.6 (3.2)
Hyperresponse	83.7 (5.9)	52.5 (4.2)	62.5 (7.2)	46.2 (3.4)	69.0 (5.0)	52.2 (3.6)	46.5 (6.2)	47.6 (2.9)

(*M* = 60.3, *SD* = 4.2)] had higher scores than minority participants [adolescents (*M* = 44.7, *SD* = 2.4) and elementary school aged participants (*M* = 58.3, *SD* = 3.0). Minority adolescents (*M* = 58.2, *SD* = 3.0) had higher scores on the Underresponse scale than Caucasian adolescents (*M* = 44.0, *SD* = 6.1) and Caucasian elementary school aged participants (*M* = 54.7, *SD* = 5.0)] had higher scores on the Underresponse scale than minority elementary school aged participants (*M* = 47.5, *SD* = 3.5). Table 11 illustrates results of this analysis.

Engagement and Retention of All Individuals Included in This Study (*N* = 269)

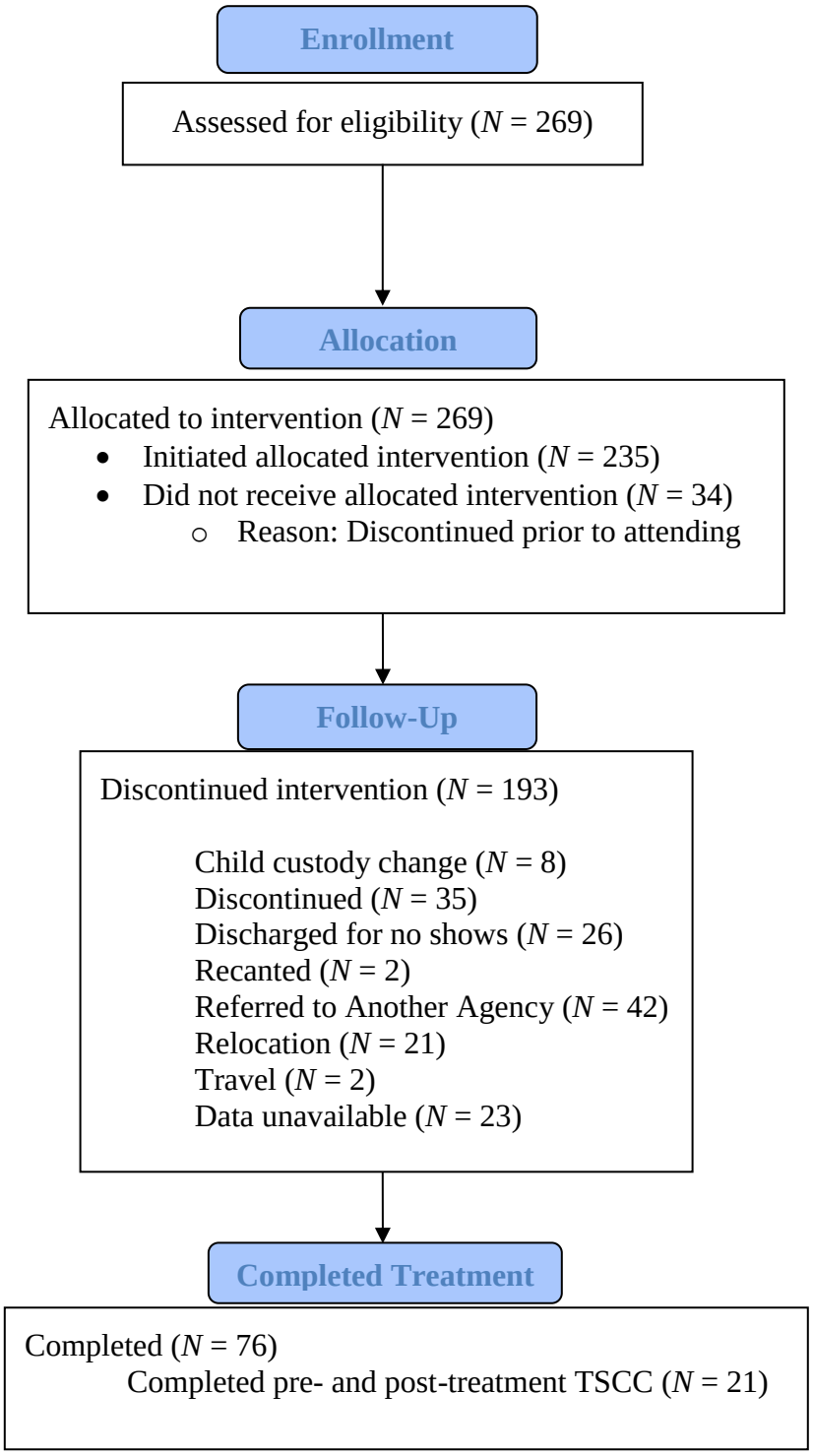
Figure 2 reports the number of participants (youth, siblings, and mothers) who initiated, terminated prematurely, and successfully completed treatment at SH. Successful completion of therapy, as defined by the clinic protocol, means that the participant met all established therapeutic goals, exhibited a reduction in trauma-related symptoms, and the counselor determined the participant no longer required trauma-focused counseling. This information was gathered from participants' termination report, which was created by their individual therapist.

Mental health services were recommended for the 269 participants. Of this number, 34 participants completed intake paperwork and/or attended intake, but never initiated treatment. Of the participants who initiated mental health services at the SH, 159 did not complete the recommended clinical protocol. The most frequent reasons for pre-maturely terminating services included: Therapist making a referral to another service or agency (*N* = 42), family or caretaker opting to discontinue treatment (e.g., citing busy schedules, belief that the youth no longer needed treatment; *N* = 35), being

discharged by the clinic for number "no shows" (clinical protocol allows therapist to discontinue services after 3 consecutive "no shows"; *N* = 26), and family relocating to an area outside of SH's catchment zone/changes in custody (*N* = 29). Reasons for pre-mature termination were not documented for 23 participants. Only two participants reported that they discontinued treatment because of travel.

Only 76 participants (28.3%) completed the recommended treatment protocol provided by the clinic. Of these 76 participants, 67 (88.2%) were youth participants, 6 (7.9%) were mothers of the youth participants, and 3 (3.9%) were siblings of youth participant. These participants were primarily Caucasian (*N* = 40, 52.6%), female (*N* = 64, 84.2%), and residents of a rural county (*N* = 43; 56.6%). Their ages ranged from 3 to 65 years (*M* = 13.1, *SD* = 11.1). Most participants received either play therapy (*N* = 29, 38.2%) or TF-CBT (*N* = 28, 36.8%) by a therapist-in-training (*N* = 58, 76.3%) at SH (56.6%). Half of these participants reported experiencing multiple traumas whereas 23.7% reported experiencing only one traumatic event and 26.3% did not have the number of experienced traumas documented in their files. These individuals attended between 4 and 56 sessions (*M* = 20.3, *SD* = 11.0) and had limited (between 0-4) "no shows" recorded in their charts. The county in which participants live did not have a statistically significant impact on treatment retention ($t = 1.2$, $p = .25$).

Figure 2. Engagement and Retention of All Individuals Referred to and/or Assessed for Trauma-Focused Therapy at SH



Summary of Findings

This chapter first provided a description of all individual (N = 269; youth participants and participants' siblings and mother) who were referred to and/or assessed for trauma-focused treatment at SH was included in this study. This information answered the first research question: What are the demographics and traumatic experiences of the youths, siblings, and mothers who were referred and/or evaluated for trauma-focused therapy at Scotty's House? Then, more specific demographic information and a description of only the youth participants' (N = 232) traumatic experiences were provided. Results indicate that most youth participants included in this study were female and Caucasian. Most reportedly lived with at least one biological parent, experienced multiple traumatic experiences, and experienced only one type of abuse: Sexual abuse. The majority of youth participants reported their abuse during their forensic interview and most youth participants reported having one perpetrator, who was most frequently identified as being a male relative. Information about youth participants' biological parents was largely missing; the information that was reported indicated most biological parents obtained at least a high school education. Reports indicated that many biological mothers had previously experienced multiple traumatic events in their lives whereas most biological fathers were reported to have no previous traumatic experiences. Most youth participants' biological parents were reported to be divorced or unmarried.

Mean comparison tests and chi square analyses were utilized to answer research question 2: How do the youth participants (N = 232) that were referred and/or evaluated

for treatment at Scotty's House compare with each other? Analyses (one-way ANOVA) revealed a statistically significant difference in youth participants' age based on their gender. This finding was further explored through an independent sample test, which found that female youth participants were significantly older than male youth participants. A mean comparison test indicated that male youth participants reported experiencing more traumatic events than the female youth participants reported. Further, youth participants that reported experiencing sexual abuse only were found to be significantly older than the youth participants that experience other types of abuse or multiple types of abuse.

A description of the 71 participants that received TF-CBT was also provided. This answered research question 3: What are the demographics and traumatic experiences of children and adolescents who received TF-CBT. Similar to the larger sample, most of these participants were female who experienced multiple traumatic events. These participants were mostly either Hispanic or Caucasian and the majority of these participants reported experiencing sexual abuse only. Most of these individuals lived with at least one biological parent, were residents of an urban county, and received treatment at SH, by a therapist-in-training. Mean comparison tests were used to answer research question 4: How are the children and adolescents (N = 71) who received TF-CBT different from those who received other therapies such as play therapy or equine-assisted therapy? Analyses identified that participants that received TF-CBT were significantly older than and reported experiencing more traumatic experiences those who received other types of treatments such as play therapy or EAP.

Of the 71 participants that received TF-CBT, only 28 reportedly completed the recommended treatment protocol. These 28 participants were similar to the larger sample with regards to type of abuse experiences, number of traumatic experiences reported, and parents' marital status. Similarly, these participants were mainly females. Many of these individuals lived in rural counties (*N = 15*, 53.6%); this finding differs from the description of the 71 participants who received TF-CBT as the majority of those participants reported living in an urban county (*N = 37*, 52.1%). Most participants were either Hispanic (39.3%) or Caucasian (35.7%). These data are interesting because the larger study was found to be primarily Caucasian. County of residency (e.g., urban or rural) did not have a significant impact on treatment retention.

This chapter then assessed the measurable benefits of the treatments participants received. Information was gathered from the 21 participants that completed the TSCC at pre- and post-treatment. Similar to the larger study, this group contained mainly female participants who lived in an urban county and reportedly experienced sexual abuse only. Unlike the larger sample, these participants were primarily Hispanic. Most participants' scores on the TSCC scales at pre- and post-treatment were not in the clinically significant range (*T*-Score $\geq$ 65).

A paired-sample *t*-test compared TSCC mean scores at pre- and post-treatment to answer research question 5: What were the differences in the youths' (*N* = 21) who completed pre- and post-treatment Trauma Symptom Checklist for Children mean scores? This analysis revealed a statistically significant reduction in means scores on the following clinical scales: Anxiety, Posttraumatic Stress, Sexual Concerns, and Sexual

Distress. Cohen's *d* values were used to determine the impact intervention had on these reductions. A large effect size was found on the Anxiety scale, a medium effect size was found on the Sexual Distress scale, and a small effect size was found on the Depression, Anger, Posttraumatic Stress, Dissociation, Sexual Concerns, and Sexual Preoccupation scales. This suggests that treatments received were helpful in reducing posttraumatic symptoms. However, this finding should be interpreted with extreme caution as the small number of participants included in the analyses violates statistical assumptions.

MANOVAS were utilized to identify differences in TSCC scores based on participants' (N = 21) demographic factors such as age, gender, and ethnicity. No statistically significant differences in participants' pre-treatment TSCC mean scores based on these factors were found. A statistically significant difference was found in participants' post-treatment TSCC scores based on their gender. A follow-up one-way ANOVA identified that male participants had higher TSCC scores on the Anxiety scale than did female participants. Further, a statistically significant difference was found in both pre- and post-treatment TSCC scores based on the interaction between participants' age and their ethnicity. A follow-up two-way ANOVA identified significant differences in the pre-treatment TSCC mean scores on the following scales: Depression, Posttraumatic Stress, and Underresponse. No statistical differences were identified in the follow-up two-way ANOVA on post-treatment scores. This suggests that the interaction between participants' age and ethnicity impact their responses on the TSCC. It is important to note that this finding should also be interpreted with extreme caution as the analyses included a small number of participants, which increases the risk for error.

CHAPTER V

SUMMARY

Youths who experience traumas may require mental health services for subsequent feelings of helplessness, confusion, shame, fear, and distrust (Malchiodi, 2015). However, youths living in MHPSAs encounter systematic and structural barriers in accessing qualified providers for needed services. For instance, many youths report having limited or no available mental health services in their communities (Shealy et al., 2015). These disparities may be more pronounced in states like Texas, which have a high percentage of counties designated as MHPSAs and a large rural-residing population (United States Census Bureau, 2012). This study sought to provide descriptive analysis of the youth participants who received trauma-focused therapies at a CAC located in a MHPSA that provides services to six rural counties and one urban county.

This study began by providing a description of the 232 youth participants who were referred to and/or evaluated for trauma-focused therapy at SH. The majority of youth participants were Caucasian females, who lived with at least one biological parent. These demographic and clinical characteristics are similar to NCA statistics (NCA, 2015) and samples reported in studies of CACs in urban settings (Carlson et al., 2015; Edinburgh, Pape-Blabolil, Harpin, & Saewyc, 2015; Edinburgh, Saewyc, & Levitt, 2006; Jones, Cross, Walsh, & Simone, 2007; Vanderzee, Pemberton, Conners-Burrow, & Kramer, 2016) and CACs in rural setting (Smith et al., 2006). The mean age of 10.0 of

youth in the present study is also commensurate to the mean ages reported by similar studies (Bonach et al., 2010; Conners-Burrow et al., 2012; Dauber et al., 2015).

Most youth participants reportedly experienced sexual abuse perpetuated by a family member, with biological fathers identified as the largest group of alleged perpetrators. The frequency of youths reporting that they experienced multiple traumas, percentage of youths making a verbal outcry of their abuse, and the percentage of male relatives as reported perpetrators is also congruent with other studies of CACs (e.g., Edinburgh et al., 2006; Jones et al., 2007, Vanderzee et al., 2016). Mean comparison tests found that male youth participants reported experiencing more traumas than did female youth participants. This finding is consistent with prevalent rates documented in other similar studies (e.g., Alisic et al., 2014; Bruce, 2006; Contractor et al., 2013; Kenyon-George, 2017).

These similarities imply that the population served by the CAC in the present study parallels those served by other CACs. This study's findings also support findings that suggest rates of trauma in rural mental health settings are similar to those seen in urban mental health settings (Kenyon-George, 2016). Further, analysis found no differences in youth participants based on the types of trauma they reported experiencing and their geographic location (i.e., urban or rural county). Thus, residency (i.e., living in an urban or rural county) – presumably, an indicator of access to quality, trauma-focused treatment - may be a major difference between these two groups.

The 12 siblings and 25 mothers who sought treatment at the CAC illustrates the impact trauma has on the entire family. This finding demonstrates the need for providers

to adequately assess and provide treatment to youths' non-offending family members. Specific attention should be provided to youths' biological parents, especially because there was evidence of prior traumatic experiences among biological mothers (55.8%) and fathers (18.8%). Understanding parents' reactions to their own traumatic experience(s), in addition to the trauma(s) their child experienced, is particularly important when utilizing TF-CBT, a treatment that requires considerable parent involvement. For instance, Yasinski et al. (2016) found that parents' reactions during the narrative phase of treatment predicted decreases in their children's externalizing and internalizing behaviors. The authors also found that parental avoidance and blame in the early stages of treatment tended to predict worsening externalizing and internalizing behaviors. Helping parents address their feelings about the trauma can equip them to better help their child throughout treatment. Future work should investigate the extent to which therapists address parents' post-trauma symptoms and beliefs. An investigation on how addressing parents' trauma-related thoughts and behaviors impacts these youths' treatment would also provide relevant insight into best practices.

Further, systematically assessing for post-traumatic stress symptoms in youths' siblings and caretakers could benefit youths' treatment as it can identify and address trauma related barriers to care. This is especially important in populations where multigenerational traumas are prominent (Kenyon-George, 2017). For instance, avoidance of trauma reminders, a diagnostic criterion for PTSD, could impact both youths' and their parents' desire to participate in treatment. Mental health care providers

should be cognizant of these barriers and make efforts to reduce these barriers. Reducing the rate of pre-mature termination seems to be a high priority task.

Although all SH providers are required to complete an online TF-CBT training, few participants (N = 71, 26.4%) included in this study received this treatment. Means comparisons revealed that participants who received TF-CBT were significantly older than those who received other types of treatment such as play therapy, individual, or EAP. This finding is interesting because TF-CBT has been found to be an effective treatment for children 3-18 (Cohen et al., 2016; Kenyon-George, 2017). Future studies should seek to survey providers to determine how participants' age factors into their treatment planning.

A study that investigates providers' reasons for selecting a certain treatment for each youth would be helpful to identify any therapist barriers to the implementation of evidence-based practices. This type of study may help identify if any therapist trauma avoidance was occurring. Cohen et al. (2016) noted that therapists sometimes avoid implementing trauma-focused treatment either because they feel as though concentrating on the child's behavior is easier or because they feel as though other treatments would be less painful than to engage in therapy that explores the child's traumatic experiences. Further investigation with this particular CAC would be helpful, particularly because this study found that participants who received other types of treatments reported experiencing more traumatic events than those who received TF-CBT. More information is needed to gain a better understanding of barriers to implementing TF-CBT in this CAC.

It is important to note that pre-and post-treatment TSCC mean scores suggest that all treatments provided were effective in reducing symptomology. A two-way MANOVA indicated that no difference in TSCC mean scores existed based on type of counseling received or provider. However, this study did not possess sufficient data to indicate whether TF-CBT was superior to other types of treatments. This type of research should be conducted in the future to corroborate findings from other studies that have indicated that TF-CBT is more effective in reducing trauma-specific symptoms than play therapy (e.g., Cohen et al., 2005). These analyses should be interpreted with extreme caution as the small number of participants included in these analyses increased the margin of statistical error. Further exploration with a larger number of participants, perhaps using group comparisons would provide more information.

Interestingly, therapists-in-training (i.e., doctoral students, masters' students, and LPC Interns) were found to be more likely to utilize TF-CBT than the LPCs included in this study. There are many reasons that could explain why therapists-in-training utilized this evidence-based treatment more consistently than the licensed professionals at SH. First, the therapists-in-training are currently attending accredited graduate programs that focus on teaching students about evidence-based practices and why they are important to use. Many of the graduate students included in this study attend school and counseling doctoral programs that place strong emphasis on integrating science into practice through evidence-based practices. This training could have influenced these therapists' treatment selection (Luebbe, Radcliffe, Callands, Green, & Thorn, 2007). Additional

studies should survey graduate students on the impact their training has on their treatment selection.

Similarly, these therapists-in-training are under the supervision of a licensed professional. This means that their work in the clinic is discussed with and approved by the more experienced senior provider. Most graduate students in this study received supervision from one of their program's clinical professors in addition to the supervision they received from SH's Lead Counselor. For these graduate students, two professionals were checking their work to ensure quality and adherence to SH's policies and procedures. Future studies that investigate supervisors' role in treatment selection and adherence to organizations' policies and procedures could help illustrate this finding further. This type of information would be useful, particularly because Luebbe et al. (2007) surveyed graduate students and found they reported that supervisors' advice was the biggest influence in their treatment planning. Supervisors' belief in evidence-based practices, therefore, could explain why therapist-in-training provided most of the TF-CBT treatments included in this study.

Limitations

Results of this study revealed several limitations that require specialized mental health expertise often lacking in underserved areas. For example, 72.8% of youth participants lacked diagnostic information. According to the Lead Counselor at SH, diagnoses are not commonly reported because the treatments provided are trauma-focused in nature and address trauma symptomology including anxiety, excessive startle response, anger, and depression. She also noted that, as there are no billing requirements,

diagnostic codes do not need to be reported in the notes. This study would have benefitted from having diagnostic information as that would have given more information about the types and severities of symptoms youths were experiencing and the level to which participants' symptoms impacted their daily functioning. Information about their post-trauma functioning could also help future studies gain a better understanding of the impact treatment had on the youth. Further, information regarding participants' secondary diagnoses and how they impact their current treatment would be useful. This information is especially important because lack of symptom/diagnostic complexity in efficacy studies is often cited as reasons why community mental health providers do not utilize evidence-based practices (Cohen et al., 2016).

Further, many participants' files lacked completed intake paperwork; specifically, most files did not have an intake interview guide completed by participants' caregivers. Allocating more time and effort into ensuring required paperwork is completed would not only benefit treatment planning, it would also benefit future research. This feedback was provided to SH Lead Counselor who began implementing new policies and procedures that would ensure more complete files. It is hoped that conducting sporadic file checks will help ensure that each client has completed paperwork and that all required assessments are completed.

Similarly, the lack of information on participants and their biological parents impacted the findings of this study. For instance, as most information about participants' biological parents was missing, it was difficult to adequately assess for the impact parents' previous traumatic experiences, their level of education, current or previous

mental health problems, and previous or current drug use has the participants' post-trauma functioning, adherence to recommended treatment, and traumatic experiences. Future studies would benefit from exploring parental characteristics and their impact on these youths. Investigations such as these could be compared to similar investigations conducted in CACs located in urban areas to identify any possible differences in regional areas.

Of the 269 participants referred for counseling, only 28.3% were in therapy long enough to completed their trauma-focused treatment and terminated due to their sufficient progress. Clinicians documented various reasons to explain participants' decision to terminate pre-maturely. Among these reasons, only two participants reported travel as the reason they discontinued treatment early. This seemingly indicates that recruitment and retention barriers may be impacting participants' ability to initiate and continue needed counseling services more than geographic barriers. These barriers are commonly experiences by many mental health care providers and other CACs (Wamser-Nanney & Steinzor, 2017). Future studies could benefit from surveying participants and their families to identify barriers to treatment adherence. Perhaps follow-up calls months conducted after termination would help the CAC identify barriers that impact their clientele, which would equip them to partner with families to overcome them.

Collaborating with caretakers is an important first step to reduce the rate of pre-mature termination. Research suggests that engagement strategies such as exploring caregivers' apprehensions and beliefs about mental health treatment, working with caregivers to identify and overcome barriers to treatment adherence, and utilizing

caregivers' strengths help to significantly reduce the no-show rate for first therapy appointment (Langley et al., 2013). Efforts should be made to collaborate with families in order to improve treatment adherence. For example, Konanur et al. (2015) suggests the use of a brochure that explains the sequel of TF-CBT and presents scientific support for its success. They also suggest therapists organize evening groups that provide an overview of TF-CBT to help parents understand the treatment and "buy-in" to its usefulness. SH attempted to provide a caregiver psycho-educational group, such as the group Konanur et al. (2015) suggested; however, despite various attempts, the group was unsuccessful in obtaining sufficient participants. Future studies should investigate how interventions that engage and educate caregivers impact families' engagement and retention.

A major limitation of this study was its small number of participants. The analyses conducted on the 21 participants that completed the pre-and post-treatment TSCC and the subsequent post-hoc analyses should be viewed cautiously. This is because the high number of statistical tests utilized and the low number of participants included in the analyses increases the likelihood of error. This study conducted these analyses despite knowing that doing so would violate statistical assumptions. Future studies could benefit from replicating this study's analyses with a larger number of participants.

A larger sample size, with more completed assessments would also be recommended as this would provide more information on this CAC's clientele and the therapeutic benefits they obtain from the trauma-focused treatment provided by SH staff.

SH could benefit from investigating barriers that keep clinicians from administering the TSCC and TSCYC at intake, the mid-point of therapy, and at termination. One possible explanation is might be that the TSCC and TSCYC are rather lengthy and take a considerable amount of time to complete. Utilizing other trauma-focused assessments, particularly those that are shorter and take less time to complete may be one way this clinic could increase the number of completed assessments. Recommendations for continued research on this population have been made to SH to help ensure the continued exploration of this CAC.

Further, another limitation is that this study only included one CAC. Obtaining information from other CACs that provide services to individuals living in MHPSAs would be beneficial, as it would allow for more generalizable information. A comparison of the CAC to community mental health clinics would also be beneficial because it would illustrate the similarities and differences between these two service providers. Future studies should also seek to explore how this CAC differs from other CACs in Texas, particularly those who provide services to families in an urban area. This comparison would help identify barriers and characteristics unique to the underserved population and its providers.

Conclusion

About 60% of American youth experience at least one traumatic event in their lifetime and about 37% experience multiple traumatic events (Dauber et al., 2015). Traumas are events in which an individual directly experiences, personally witnesses, learns of a loved one's experience, or is repeatedly exposed to a traumatic event(s) such

as actual death, threat of death, serious injury, or violence (APA, 2013). Traumatic events include natural disasters, violent crimes/community violence, domestic violence, sexual crimes, murder, fire, medical procedures, car accidents, and war. This study focused on youths who experienced child abuse, a type of trauma that includes any action that results in harm to a child, places a child at risk for danger, or fails to prevent harm to a child or adolescent (U.S. National Library of Medicine, 2016). Examples include sexual abuse, emotional abuse, physical abuse, and neglect.

Immediately after a traumatic event, most youths endorse some distress or exhibit changes in their behavior (Gerson & Rappaport, 2013). Symptoms can include intrusive thoughts, increased arousal, and avoidance of anything trauma related (APA, 2013). The majority of these youths may not experience enduring psychological difficulties; however, a considerable minority will endure persistent distress that may require professional attention (APA Task Force, 2008). Without treatment, symptoms may become chronic and contribute to poorer quality of life through the individual's life (Cisler et al., 2016).

Providing services to individuals in need of them is a longstanding mental healthcare challenge (Burns et al., 2004; Kazdin & Blasé, 2011). In his 1999 report, former Surgeon General David Satcher issued the first Surgeon General's report on mental health, which stated that although many evidence-based treatments exist, almost half of Americans in need of treatment do not receive it because of a wide variety of barriers (U.S. Public Health Service, 1999). An estimate suggests that it can take up to 17 years for evidence-based treatments to reach clinical practice (Beidas & Kendall,

2014). Several barriers such as the availability of clinicians trained in evidence-based treatments, costs associated with receiving necessary training, and clinicians and organizations' beliefs about evidence-based practices limit organizations and therapists from providing evidence-based treatments to individuals who could benefit from them (Cohen et al., 2016).

Moreover, many youths will not receive needed services due to macro- and micro-environmental barriers that impede access to treatment including lack of qualified mental health providers in the immediate area, low SES (and corresponding lack of third-party and insurance coverage), time demands, and a lack of transportation and childcare for families (Kazdin & Blasé, 2011; Robinson et al., 2017). Other issues, such as disparities in policies and funding, undermine the ability of existing clinics and programs to provide quality care, implement evidence-based treatments, or maintain ongoing evaluations of program effectiveness (Texas Department of State Health Services, 2014). These barriers are prominent for individuals living in MHPSAs, specifically MHPSAs located in rural communities where mental health providers, resources, and specialty knowledge are scarcer (Kenyon-George, 2016). It is important to address these issues as studies show that individuals, especially children, living in rural areas have more indicators of poor mental health and have more extensive mental health needs when they present for mental health treatment (Robinson et al., 2017).

CACs are currently considered the "gold standard" for applying best practices to the investigations and treatment of child abuse (Vanderzee et al., 2016). They were developed, in part, to ameliorate many of these issues by providing quality and

coordinated investigative and mental health services to children and adolescents who reported experiencing trauma. CACs are community-based, multi-disciplinary agencies that provide integrated and coordinated services commiserate with community needs, demographics, and resources (NCA, 2015). Currently, there are 795 CACs throughout the United States, with at least one CAC in each state (NCA, 2015). Although research conducted in CACs has contributed valuable information about the scope and nature of youth trauma (e.g., Carlson et al., 2015), much of this work has been confined to CACs in urban settings and focused on assessing aspects of the forensic interview. Studies utilizing samples from CACs operating in MHPSA and investigating the effectiveness of mental health treatments provided are lacking. The present study aimed to describe the youths referred for trauma-focused counseling at a CAC in a MHPSA. In addition, the study also reported the measurable benefits participants obtained from the trauma-focused treatments they received. This information may help the field appreciate the characteristics of these youths and families and the issues they present in this clinical setting.

This study found that its participants were demographically similar to participants included in studies on other CACs (Carlson et al., 2015; Conners-Burrow et al., 2012; Edinburgh et al., 2015; Konanur et al., 2015; Vanderzee et al., 2016). The reported number and types of trauma(s) experienced and the gender of and relationship with alleged perpetrators were also commensurate with findings from similar studies on other CACs (Edinburgh et al., 2006; Jones et al., 2007, Vanderzee et al., 2016). These similarities suggest that SH serves a population is similar to the populations other CACs

serve. Further, these similarities lend support to Kenyon-George's (2016) finding that participants receiving treatment in mental health settings located in rural communities tend to reported rates of trauma that are similar to those reported by participants who are being treated in an urban mental health setting. Future studies should investigate this further by directly comparing the population served by a CAC in a rural location to a CAC in an urban area. This information could help inform providers who are reluctant to use information gathered from RCTs because they feel these studies do not account for the diversity seen in their clinic.

This study found that youth living in underserved areas benefit greatly when they are able to receive trauma-focused treatment following traumatic experience(s). The statistically significant reductions found in the Anxiety, Posttraumatic Stress, Sexual Concerns, and Sexual Distress scales suggests that treatment helped participants reduce their trauma-related worries. Future studies, conducted with a larger sample size, could provide more information on the benefits participants receive from these trauma-focused treatments. This study was limited on its ability to compare the measurable benefits participants who received TF-CBT experienced versus the benefits participants who received other types of therapies such as play therapy or EAP received. Additional studies should also compare measureable benefits based on type of treatment received.

This study had an attrition rate of 71.7%. This finding is comparable to other studies on TF-CBT, which report attrition rates that range from 33% to 77% (e.g., Cohen, Mannarino, & Iyengar, 2011; Konanur et al., 2015; Scheeringa, Weems, Cohen, Amaya-Jackson, & Guthrie, 2011; Wamser-Nanny & Steinzor, 2017). Of the

participants that completed treatment recommendations, most were Caucasian females who reported experiencing multiple traumas and attended a mean number of 20.3 sessions (*SD* = 11.0). These findings are similar to that found in Wamser-Nanney and Steinzor (2017) study, which examined attrition from TF-CBT provided at a CAC in St. Louis, Missouri. The following are the most frequently documented reasons counselors provided to explain this study's participants' premature termination: Family was referred to another agency for another type of counseling, caregiver believed that child no longer needed services, families reported busy schedules, and changes in child custody. These reasons are also similar to those found in other studies on treating childhood trauma (Konanur et al., 2015).

Despite the large number of studies on TF-CBT, few studies have focused on identifying predictors of premature termination from TF-CBT. Wamser-Nanney and Steinzor (2017) noted that the few studies that have examined these predictors found that older children, children with more traumatic experiences, and children of lower SES were more likely to terminate TF-CBT prematurely. However, these authors noted that these studies had small sample sizes, which provided inadequate statistical power to determine group differences (Wamser-Nanney & Steinzor, 2017). More studies are needed to identify factors that impact completion of TF-CBT. This information can help mental health providers identify and address barriers to treatment adherence and help increase the likelihood that these youths complete recommended treatment.

This study found that most participants that received TF-CBT, completed the TSCC at intake and termination, and those who successfully completed the

recommended protocol received treatment from a therapist-in-training. A possible reason for this finding could be that there were more therapist-in-training than LPCs included in this study; sub sequentially, most participants received treatments from an LPC-Intern or graduate student. Another reason is that therapists-in-training are under the supervision of a licensed provider who helps ensure they are following SH's protocols and procedures. Supervisors' endorsement of evidence-based treatments and continuous assessment could also impact the therapists-in-training's treatment planning and clinical practice (Luebbe et al., 2007). A limitation of this study is that no information about factors that impact clinicians' treatment planning and use of assessments were measured. Future studies should focus on how therapists' training and stage of their professional career impact their use of evidence-based practices, use of assessments, and adherence to clinic's policies and procedures.

Future Directions

Former Surgeon General David Satcher urged the field to work towards reducing the mental health disparities that impacts individuals with mental health needs by providing evidence-based, cost-effective, easily accessible, and culturally appropriate mental health services to all individuals (U.S. Public Health Service, 1999). Although advancements have been made, the need to develop psychological approaches that benefit the majority of people, the majority of the times are still lacking (Yates, 2011). Kazdin and Blasé (2011) suggest that the field needs to make major shifts in its research and clinical practices in order to truly provide quality care to individuals with mental health needs. Specifically, they propose a paradigm shift towards a comprehensive,

collaborative model of care that utilizes a public health approach and expands methods of service delivery (Kazdin & Blasé, 2011).

Sloan, Marx, and Keane (2011) identified ways the U.S. Department of Veterans Affairs (VA) has developed and implemented programs to expand access to quality mental health treatment that may benefit CACs' efforts. Programs utilized by the VA includes providing services through telehealth technologies, training paraprofessionals such as military chaplains to deliver brief psychological interventions that can serve as an entry way to more intensive treatment if needed, and encouraging the use of Smartphone applications that teach coping skills, provides psycho-education, and help individuals track symptoms (Sloan et al., 2011). The VA is also investing resources into developing online and in-person trainings on the delivery of evidence-based practices. Further, the VA has allocated resources to provide continual support to their clinicians through on-going consultation and peer-support services, which are provided by experts in evidence-based treatments. The VA has found that open communication between VA clinical managers has helped clinics share best practices on implementing evidence-based practices. They also found that on-going evaluations of treatment outcomes has helped ensure providers are utilizing these evidence-based practices and has informed the VA of the effectiveness of their various efforts.

The finding that other types of treatments were used more commonly than TF-CBT is important to note because it illustrates a common problem faced by many CACs and community mental health centers (Allen et al., 2012; Cohen et al., 2016; Wherry et al., 2015) and lends support to the need to increase providers' ability and willingness to

utilize evidence-based practices. This need to increase the use of evidence-based treatments was the catalyst to many of the abovementioned changes the VA has made over the last couple of years (Sloan et al., 2011). CACs could benefit from exploring how they can use the VA's efforts as a model with which they can make changes to improve the care they are able to provide youths who have experienced trauma and their families. The following paragraphs will describe ways SH could implement some of the strategies that have been found to be effect in the VA.

As MHPSAs lack qualified doctoral-level providers, it is imperative to increase efforts to train master's level clinicians practicing in these areas in trauma-focused assessments and evidence-based practices. The NCA could incorporate strategies that have worked for the VA to achieve this goal. Avenues such as online courses and trainings and on-going consultations and supervision conducted via videoconference technologies should be considered either in lieu of or in conjunction with face-to-face trainings (Cohen et al., 2016; Wherry et al., 2015). These efforts have been shown to be effective mechanisms of education. For example, Heck et al. (2015) surveyed 67,201 individuals who completed the online TF-CBT *Web* (www.musc.edu/tfcbt; Smith & Saunders, 2005) training and found that mental health professionals can obtain proficient TF-CBT knowledge through the online course. They also found that students, master's level providers, and early career providers had the highest training completion rates (Heck et al., 2015). This finding suggests that online trainings are an effective way to equip younger generations of mental health providers with the skills to effectively treat youth who experience trauma(s).

Kazdin and Blasé (2011) urge psychologists to expand their "portfolios" of interventions to extend services to those who have difficulties accessing them. Evidence to date indicates that long-distance technologies can be used effectively to treat an array of clinical problems among children and adolescents (Gloff, LeNoue, Novins, & Myers, 2015). Indeed, mental health programs have used videoconferencing technologies to treat youths and families who have experienced trauma (Jones et al., 2014). More specifically, Shealy et al. (2015) successfully utilized videoconferencing technologies to provide TF-CBT to treat youths who experienced trauma, including youth who experienced multiple traumatic events. More studies should investigate the use of advanced technologies to increase access to care in underserved areas.

The NCA could explore ways to encourage and support the use of telehealth technology in service delivery, training opportunities, intra-agency collaboration, and supervision. This system-wide approach seems to mirror that used by the VA, who made changes at an organizational level. However, if this large-scale approach is not feasible, CACs could partner with local providers that utilize telehealth technologies to learn how to use them to train and supervise clinicians and provide trauma-focused services to youths and their families. For example, SH could collaborate with the Telehealth Counseling Clinic, a clinic that provides free counseling services to children, adolescents, and adults living in the Brazos Valley, to catalyze their use of this means of service and training delivery.

Atkins and Frazier (2011) recommended that the field adopt a public health framework in which mental health providers partner with communities to coordinate

efforts to promote mental health. Future work may involve implementing protocols and procedures to evaluate the effectiveness of the treatment received by youths at SH. The VA implemented policies and procedures that allowed for continuous evaluation of the methods they were using to train providers and the impact evidence-based treatments had on the Veterans they were serving. CACs could implement such systematic record keeping and assessment of outcomes practices. Such information might prove critically important with community stakeholders who are invested in maintaining and perhaps expanding clinic operations. Further, this information could help decrease some of the hesitations therapist, clients, and organization have with regards to evidence-based treatments.

Information about the effectiveness of treatments could also be critical for on-going advocacy and requests for support as it could excite community stakeholders to help CACs in their efforts. Engaging community stakeholders is a hallmark of community capacity building, in which community leaders, agencies, and entities in underserved areas collaborate to identify existing community needs and explore possible resources and solutions (Trickett, 2009). Community capacity building has played an essential role in developing CACs throughout the United States (NCA, 2011) and telepsychology services in the Brazos Valley (McCord et al., 2011). These strategies reflect how psychologists can actively inform policies that address the structural conditions that contribute the disparities in access to mental health services in underserved areas (Thoits, 2010).

Another way in which CACs use the VAs efforts as a model is by equipping local providers to aid in early detection of symptoms and early intervention. SH can achieve this goal by training providers working in community and clinical settings such as primary care offices, social service agencies, and emergency room to conduct routine screenings and implement targeted interventions with individuals (Atkins & Frazier, 2011). Just like the VA trained paraprofessionals that have regular access to Veterans in providing brief psychological interventions, SH should work on identifying and training paraprofessionals that have continuous and frequent access to children and adolescent. This effort is similar to the approach presented by Langley et al. (2014), which suggested that the field can increase access to care is by providing more school-based services. They posit that school-based programs, with an established partnership between teachers, school administrators, clinicians, and parents, can help increase access to effective treatments, especially to youths who are impacted by health disparities (Langley et al., 2014).

CACs such as SH provide a necessary first step towards reducing health disparities. By partnering with communities to provide free, easily accessible, evidence-based, and culturally competent forensic and mental health services to youths who have experienced trauma and their families, CACs help reduce the stress associated with child abuse investigations and provide referrals to needed services in a quick and efficient manner. Future studies are needed to identify the effectiveness of their efforts in reducing the impact trauma has on youths and their families. This information can help

improve the services CACs provide and expand the field's ability to provide quality mental health treatments to all youths impacted by trauma.

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APPENDIX

SCOTTY'S HOUSE
Brazos Valley Child Advocacy Center
Where the healing begins

Client Information Form

Today's Date: _____

Child's Name: _____

Child's Street Address: _____

City_____ State_____ Zip Code_____ County_____

Child's Date of Birth: _____ Child's Gender: _____ Age of child: _____

Child's Race: (Please check one of the following)

_____American Indian/ Alaska Native _____American Indian/ Alaska Native& White

_____Asian _____Asian & White

_____Black /African American _____Black /African American & White

_____Native Hawaiian / Other Pacific Islander

_____White _____American Indian/ Alaska Native & Black /African American

____ Race Combination not included in above categories-Specify_____

Child's Ethnicity: (please check the following)

(This information is required by federal funding.)

_____ Hispanic/ Latino

_____ Not Hispanic/ Latino

School/Daycare_____

Parent /Guardian Information

Your Name: _____

Your Street Address: _____City_____ State___ Zip Code_____ County_____

Relationship to child: _____ Your Date of Birth: _____

Home Phone #: _____ Work Phone #:_____ Cell Phone #: _____

Please circle which numbers messages can be left at: Home Work Cell

_____ _____

Parent/Guardian Signature **Date**

Scotty's House
Release of Liability

Clients

Scotty's House is unable to assume any liability on behalf of clients. Please read the following statements releasing Scotty's House from liability and indicate your understanding by your signature below.

LIABILITY RELEASE

I AGREE to respect the persons, privacy and possessions of the clients, staff, and volunteers of Scotty's House and to ensure that my children do the same.

I RECOGNIZE that I alone am responsible for my safety and health, the safety and health of my children, and the safety and healthy of any others persons who might accompany me. I alone am responsible for my (our) possessions. The staff and/or volunteers at Scotty's House cannot safeguard or be responsible for me, my children, those accompanying me, or our possessions.

In respect to the services provided by Scotty's House to me and to those accompanying me, **I UNDERSTAND** that Scotty's House assumed no liability or responsibility whatsoever in connection with the services provided, for any act of omission or commission which might be constituted as negligence; nor for any loss, theft, or injury to persons or property; nor, during any transportation by staff, volunteers, or clients to or from any location; nor for any illness, damage, or inconvenience sustained by me, my children, or others accompanying me.

I AGREE to hold Scotty's House, its staff, employees, interns, agents, volunteers, contributors, officers and board of directions harmless from any and all claims, demand, debts, responsibilities, and/or liability relating to me, my children, or those accompanying me.

By singing below, I certify that I have read and understand the above release of liability.

Name: _____ Date: _____

Witness: _____ Date: _____

Scotty's House CAC
Release of Confidential Information

Client: _____ SS#: _____ DOB: _____

I understand that the purpose for this release of information is to facilitate my access to services. I understand that by law I need not consent to the release of information, however, I choose to do so willfully and voluntarily. I also understand that I may revoke this consent at any time, except to the extent that action has already been taken in reliance upon it. I understand that I have the right to limit the information that is released. **(Limitations MUST be included on the back of this page).** By signing, I agree that all persons and agencies exchanging information shall be free from liabilities that may arise from this act. This authorization shall expire 180 days from the date listed below.

I hereby authorize: _____

To release records to: _____
_____
_____

The type of information to be released is indicated below (X):

_____ Discharge Summary _____ Verbal Information _____Other (Specify Below)
_____
_____

I hereby authorize: _____
_____
_____

To release records to:_____

The type of information to be released is indicated below (X):

_____ School Records _____ Discharge Summary _____ Psychosocial History
_____ Legal Records _____ Psychological Report _____ Verbal Information
_____ Psychiatric Evaluation
_____ Other (Specify) _____

Client's Signature: _____ Date: _____
Parent/Guardian: _____ Date: _____
Staff Witness: _____ Date: _____

Psychosocial History- Child

General Information:

Client Name:_____ Age: _____ Sex:_____ Date of Birth:_____

Child's School:_____ Grade:_____ Principal/Counselor:_____

Father's Name: _____ Age: _____ Education: _____ Job: _____

Mother's Name: _____ Age: _____ Education: _____ Job: _____

Child lives with: Name: _____ Relationship:_____

Does this individual have legal custody? _____

Address: _____ Telephone: _____

Best time to call: _____ Can I leave a message? _____

Are biological parents: Unmarried? _____ Engaged? _____ Married? _____ Separated? _____ Divorced?_____

When? / Why? _____

Describe the client's contact with the absent parent(s): _____

Names of all persons living in the home: Age: Sex: Race: Relationship:

Are there other family members not living in the home? No _____ Yes_____
If yes, please explain: _____

Psychological Information:

To what extent has the client had any of the following problems (*denotes intense problems):

Previously:	**Recently:**	**Comments:**
_____	_____	Sleep disturbances/nightmares _____
_____	_____	School problems _____
_____	_____	Somatic complaints_____
_____	_____	Sexual Acting-Out_____
_____	_____	Bed Wetting/soiling
_____	_____	Poor Peer Relationships
_____	_____	Nervous habits such as thumb sucking/nail biting/etc.
_____	_____	Fearful of certain places or people or of being alone
_____	_____	Short Attention Span
_____	_____	Overactivity
_____	_____	Changes in Eating
_____	_____	Temper Tantrums/Explosive Episodes/etc.
_____	_____	Self-Inflicting Injuries
_____	_____	Sadness/crying easily/etc
_____	_____	Clinging/Whining
_____	_____	Withdrawn/Shynes
_____	_____	Tiredness/Low energy/etc

_____	_____	Aggression/Oppositional behavior
_____	_____	Zoning Out/Daydreaming/Difficulty concentrating
_____	_____	Poor self esteem
_____	_____	Substance Abuse (alcohol, drugs, or tobacco
_____	_____	Running away from home
_____	_____	Truancy/ Skipping school or classes
_____	_____	Lying/Cheating/Stealing/etc.
_____	_____	Difficulties with the law/ Charges filed on youth
_____	_____	Violating home rules (e.g. curfew, chores)
_____	_____	Acts overly mature or adult-like for ag
_____	_____	Constipation
_____	_____	Cruelty to animals
_____	_____	Unusually self-conscious about body
_____	_____	Thoughts of suicide or attempts
_____	_____	Other_____

List any prior psychological diagnosis, hospitalizations, etc., including time frame:

Is / Has the client ever been in therapy:
Therapist: Agency:
Phone:

DEVELOPMENTAL HISTORY:

Where there complications during the pregnancy or delivery? Explain.

What was the child's gestation and birth weight?

Describe developmental milestones and /or important events in the child's life: (crawling, walking, talking, bathroom training, first grade, etc.)

Medical History/Problems:

Who is the primary care physician? _____ phone:_____ _____

Medical history: (list any of the child's significant illnesses, hospitalizations, or special medical needs.)

List any current medications, dosages, length of time on medication, who prescribed medicine, and the condition medicine is helping to remedy:

Have health problems impacted the child's school attendance, performance, or activities? Explain.

SCHOOL HISTORY/PREFORMANCE:

Describe the child's current school performance. (Were their failing grades, honor role, ISS, AEP, problems with teachers, awards, etc. during this semester?)

How many days has the child been absent in the last semester? If more than **six**, please explain

Has the child ever been suspended? When? Why?

Is the child in any special classes? Explain.

Is there a teacher or counselor the youth talks to while at school? Please give name and position.

FAMILY HISTORY:

List any important changes in the child's history that may have affected the child such as death, divorce, separation, multiple moves, illnesses of caretaker, financial instability, school changes:

Describe the marital history of each parent: Include number and lengths of previous marriage(s).

Is there a family history in the family of origin or current family of:

_____Physical Abuse	Family member/ age: _____
_____Sexual Abuse	Family member/age: _____
_____Emotional Abuse	Family member/age: _____
_____Neglect	Family member/age: _____
_____Drug Abuse	Family member/age: _____
_____Alcoholism	Family member/age: _____
_____Domestic violence	Family member/age: _____
_____Psychiatric difficulties	Family member/age: _____
_____Criminal difficulties	Family member/age: _____
_____Other: _____	Family member/age: _____

List all agencies in which family member are currently involved:
Name: Agency: Phone:

Family's Religious Affiliation? _____ Practicing: YES_____ NO_____

List Client/ Family Strengths (Please list as many as possible):

What do you hope for the youth to gain through counseling?(Be as specific as possible).

How will you know if this goal is obtained?

Is there any other information that you feel the counselor should know?

Information provided by: _____ Date: _____

Relationship:_____

Counselor: _____ Date: _____

Scotty's House
Client Information and Consent form
Ally Sequeira, M.Ed.
Counselor

We are pleased that you have decided to pursue counseling at Scotty's House. This document is designed to provide you with necessary information about the counselor and the counseling relationship.

Therapeutic Expectations and Professional Relationship:
We accept only those clients whom we believe have the desire to commit to work on certain issues with a counseling professional. Scotty's House guidelines place other restrictions on eligibility and length of service. You are encouraged to discuss any concerns and/or questions about your counseling with the counselor. It is important to note that engaging in the therapeutic process produces change and may release strong emotions. Sometimes you/your family members may feel worse before you/they feel better. You have the right to inquire about the professional credentials and experience of your counselor. Additionally, you have the right to refuse particular recommendations. You have the right to end counseling at any time. Should you decide to terminate counseling, it is recommended that you discuss your intentions with the counselor so that a closing session can be scheduled. Although sessions may be very intimate, psychologically, it is important to realize that the relationship is professional rather than social. Contact, other than chance meetings, will be limited to appointments that you arrange with the counselor. (_____) **Client/Guardian Initial**

Emergencies
Scotty's House **does not** provide emergency service. An emergency is defined, in this case, as:

- A client or their family member(s) experiencing thoughts about harming him/herself (which includes having a plan to harm or attempting to harm him/herself).
- A client or their family member(s) experiencing thoughts about harming someone else (which includes having a plan to harm or attempting to harm someone else).

How to respond to an emergency:

- When someone is in immediate danger of harming him/herself or others at ANYTIME of day or night call **911**

When someone has *thoughts* of hurting him/herself or others the following phone numbers may be used:

- **Brazos Valley MHMR at 979-822-6467 or** for nights/weekends/holidays **at 979-361-9815** (_____) **Client/Guardian Initials**

Recording and Review of Counseling Sessions:
Continuing education, consultation, supervision and professional peer review are an important part of providing quality and ethical counseling services. It is understood that elements of the counseling sessions, including audio recordings of certain sessions, may be shared with other appropriate professionals. Every effort will be made to protect confidentiality in accordance with professional ethics. (_____) **Client/Guardian Initials**

Counselor Qualifications

I hold Bachelors of Arts degrees in Psychology and History from The University of Alabama, Tuscaloosa, AL (2012) and a Masters of Education (M.Ed.) degree in Educational Psychology from Texas A&M University, College Station, TX (2013).

Client Signature:_____ **Date:**_____

Parent/Guardian Signature:_____ **Date:**_____

Counselor Signature:_____ _____ **Date:**_____

Scotty's House
Agreement of Confidentiality

Scotty's House provides services to children and families who have experienced child abuse. We recognize that effective child abuse intervention requires a cooperative effort between professionals. Professionals from the following agencies meet regularly to form a multi-disciplinary team that reviews each investigation of reported child abuse:

1. Child Protective Services – Department of Family and Protective Services (DFPS)
2. Law Enforcement
3. The Criminal District Attorney's office
4. Scotty's House Team members Scotty's
5. Scotty's House counselors may also share information with their counselor consultant.

All information shared within the team meetings and consultation sessions is kept strictly confidential.

Records:
Your file will contain all forms filled out by you, plus a log and record of events of services provided. It may also contain a release of information form, if needed, and any information provided by you, such as drawings, letters, photos, etc.

Case records will be regarded as confidential and will be kept under lock and key in Scotty's House office and shall not be removed from Scotty's House unless authorized by a release from you or if authorized by the Executive Director, Board President, the Center's Attorney, or a member of the Multi-Disciplinary Team acting in an official capacity.

Records will be retained, after termination of services, for 10 years past the child client's 18th birthday or for a total of seven years for adult clients. When they are no longer needed, they will be shredded to protect confidentiality. If litigation, claim, or audit involving these records begins before the seven-year period ends, the records will be maintained until the matter is resolved.

Release of Information:
No information may be released about you to anyone except a staff member; volunteer who may be involved directly in providing services to you, or a Multi-Disciplinary Team member. This includes board members and monitoring agencies associated with funding sources.

Information may be released to a specific person or agency during a specified period of time if you sign a release of information form. Scotty's House may release information subpoenaed by the courts ONLY if approved by the Executive Director, Board President, or Center Attorney. All efforts will be made to maintain client confidentiality in these cases.

Limits of Confidentiality:
Scotty's House is required by law to report child abuse, suspected child abuse, elder abuse, or abuse of disabled persons to the proper authorities. Scotty's House also cannot keep threats of suicide or homicide confidential. In addition, we must report all criminal activity that affects the safety or well-being of a child. Also reportable is information about prior counselors who have

exploited the client either sexually or monetarily. Lastly, we must break confidentiality if a judge orders us. (A subpoena does not require you to break confidentiality, a judge's order can.)

Client Responsibility for Confidentiality:
You are responsible for protecting the confidentiality of other clients by not revealing their names or information about them to anyone while you are receiving services or afterward. This includes those clients you may meet individually or in a group.

I have read and agree to abide by Scotty's House Client Confidentiality Agreement.
Client:_____ Date:_____
Counselor :_____ _____ Date:_____

Counseling Services Referral Process

All counseling referrals will be processed by Cameron Collins, Family Services Coordinator

In House
During the interview a member of Scotty's House staff will conduct crisis intervention with the child's caregiver. At that time, the caregiver will be provided information regarding SH counseling services and the benefits of counseling. If the family is interested in counseling, Cameron Collins will send a referral to Denise Peterson, Clinical Services Coordinator. Denise Peterson will determine if the client referred will be seen at Scotty's House or referred to an outside counselor. If there is a wait list at the time of the referral, the family will be notified and given the option to be placed on the wait list or to be immediately referred to an outside counselor.

Transfer from another CAC
Clients who have received services from another CAC may be transferred to SH for counseling. The referring CAC must complete the External Counseling Referral Form before services can be provided.

Referral from Law Enforcement
Law enforcement may refer a child not seen at SHCAC if:

- There is an open law enforcement case
- The child was sexually and/or physically abused
- The child was a witness to a violent crime
- The child was drug endangered

Law enforcement must complete the External Counseling Form before services can be provided.

Victim Support and Advocacy

Victim's Advocate: Victim support and advocacy services routinely made available to all CAC clients and their non-offending family members as a party of the Multidisciplinary Team response. This may include but not limited to:

1. Crisis intervention and ongoing support services on-site or through linkage agreements with other appropriate agencies or providers through all stages of investigation and prosecution
2. Attendance and/or coordination of interviews and/or case review
3. Greeting and orientation of children to CAC
4. Education regarding the dynamics of abuse, multidisciplinary response, investigation, prosecution, and treatment
5. Information regarding the rights of crime victims and local services and is consistent with legal, ethical, and professional standards of practice
6. The CAC/MDT's written documents include availability of victim support and advocacy services for all CAC clients
7. A designated, trained individual(s) provides comprehensive, coordinated victim support and advocacy services including, but not limited to:
   a. Court preparation
   b. Court accompaniment
   c. Crime victims compensation
   d. Assistance with access to services such as protective orders, housing, public assistance, domestic violence intervention, and transportation
8. Short-term and long-term support and follow up contact regarding case status
9. Provide referrals for mental health and medical treatment, if not provided at the CAC

Types of counseling:

- Crisis Intervention
- Parent Support/Consultation-behavioral concerns
- TF-CBT
- Play Therapy
- Expressive Therapy
- Equine Assisted Psychotherapy