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Who is advocating for children under six? Uncovering unmet needs in child advocacy centers

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ABSTRACT

Evidence suggests that children under the age of 6 years are affected by trauma, yet there are few studies available to determine how well their needs are addressed in the mental health system. Child Advocacy Centers (CACs) offer a promising avenue for expanding the system of care for very young children exposed to sexual and/or physical abuse. This study used a mixed-methods approach to examine the type and extent of CAC services for very young children in one state. Quantitative results revealed that the youngest children were less likely to be referred for counseling and less likely to already be engaged in counseling when an investigation is initiated. Qualitative results from interviews with CAC advocates suggest that advocates have variable perceptions regarding the effects of trauma on young children, and they do not consistently receive training in the mental health needs of traumatized children under 6. Our results confirm the need for an expanded system of service delivery for the youngest and most vulnerable child maltreatment victims.

1. Introduction

Child maltreatment is an alarmingly pervasive problem in the U.S., and the search for ways to eradicate it has proven frustrating and elusive. According to the National Child Abuse and Neglect Data System, during the 2012 fiscal year (the most recent year for which statistics are available), it was estimated that 6.3 million children were reported to Child Protective Services regarding a suspected case of maltreatment (U.S. Department of Health and Human Services, 2013). Nearly 47% of substantiated child abuse or neglect occurred among children under the age of 6. Furthermore, more than 84% of all child maltreatment deaths occurred among children 5 years of age or younger. Children younger than 6 are also disproportionately more likely to live in homes where they are exposed to domestic violence relative to older children (Fantuzzo & Fusco, 2007).

A common misperception among families—and even professionals who work in the field of trauma—is that very young children (i.e., children under 6) will not be affected by early stressful or traumatic events because they will not remember what happened, are resilient by nature, and/or will simply grow out of any emotional or behavioral problems that occur in early childhood (National Scientific Council on the Developing Child, 2010; Osofsky & Lieberman, 2011). These misperceptions may arise from overgeneralizations related to the types of fears children can simply outgrow as they mature (National Scientific Council on the Developing Child, 2010). However, a growing body of research suggests that very young children may be significantly impacted by trauma sustained in the first several years of life. Cross-sectional studies have found that traumatized children under the age of 6 are at risk for developmental delays, lower cognitive functioning, mental health problems, and trauma symptoms such as increased crying, difficulty regulating, posttraumatic play, restrictive play or exploration in the environment, sleep disturbance, high levels of fussiness, temper tantrums, clinginess and separation anxiety, and regression of previously acquired developmental milestones or skills (Mongillo, Briggs-Gowan, Ford, & Carter, 2009; Pears & Fisher, 2005; Scheeringa, Zeanah, Myers, & Putnam, 2003). The likelihood of mental health problems appears to grow with an increase in the number of traumas experienced (Finkelhor, Ormrod, & Turner, 2007).

A growing body of longitudinal evidence also supports these findings. For instance, children investigated for maltreatment prior to age 3 are at risk for deficits in social skills, daily living skills, and special education placement when school-aged (Scarborough & McCrae, 2010). In their prospective community sample, Keiley, Howe, Dodge, Bates, and Pettit (2001) followed children for nine years beginning in kindergarten and found that those who were physically abused by the age of 5 were more likely to develop both internalizing and externalizing problems than children who experienced physical abuse after the age of 5. Prospective studies also suggest that children younger than

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64 months who are exposed to interpersonal trauma show greater Posttraumatic Stress Disorder (PTSD) symptoms and lower developmental competence at school-age (Enlow, Blood, & Egeland, 2013) and have cognitive deficits that persist into middle childhood (Enlow, Egeland, Blood, Wright, & Wright, 2012). These cognitive deficits appear to be particularly pronounced among children who have experienced trauma in their first 2 years of life (Enlow et al., 2012). Moreover, a growing body of literature suggests that children will not simply outgrow the PTSD symptoms they experience in early childhood (Cohen & Scheeringa, 2009). On the contrary, if left untreated, very young children's trauma symptoms may become chronic, insidious, and unremitting (De Young, Kenardy, & Cobham, 2011).

Leading child development researchers now help us understand the mechanism by which repeated trauma impacts the young child's developing brain and body (National Scientific Council on the Developing Child, 2005, 2014). They refer to strong, frequent, and/or prolonged activation of the body's stress-response systems occurring in the absence of adequate support from an adult caregiver as "toxic stress". Major risk factors for the development of toxic stress include extreme poverty, ongoing physical and/or emotional abuse, chronic neglect, severe maternal depression, parental substance abuse, and family violence. Although trauma may be a contributor to toxic stress, it is important to note that trauma is not the only pathway by which toxic stress may manifest. Especially during early sensitive periods of brain development, toxic stress resulting from chronic abuse and neglect and other risk factors can lead to overproduction of neural connections in the areas of the brain involved in fear, anxiety, and impulsive responses, and underproduction in areas of the brain dedicated to reasoning, planning, and behavioral control (National Scientific Council on the Developing Child, 2005, 2014). Toxic stress disrupts brain architecture, affects other organ systems, and leads to adaptation in the body's stress-response systems so that these systems respond at lower thresholds to events that might not be stressful to others, resulting in over-activation of the stress-response system and increased risk of stress-related disease and cognitive impairment into adulthood (Shonkoff, Boyce, & McEwen, 2009).

Evidence suggests that the emotional and behavioral sequelae of abuse sustained in the first five years of life may be effectively addressed with interventions targeted towards ameliorating trauma symptoms and returning children's development to a healthy trajectory (Cohen, Mannarino, & Deblinger, 2006; Lieberman, Ghosh Ippen, & Van Horn, 2006). Various evidence-based treatments such as Trauma-Focused Cognitive Behavioral Therapy (Cohen et al., 2006), Parent–Child Interaction Therapy (Funderburk & Eyberg, 2011) and Child–Parent Psychotherapy (Lieberman et al., 2006) have been shown to be effective for use with preschool aged children who have experienced traumatic events (Chadwick Center for Children and Families & Child and Adolescent Services Research Center, 2014). Therefore, it is imperative that very young children who experience early abuse are referred for effective trauma services in a timely manner. Recent articles within the literature emphasize the need for an expanded and sensitive system of care for very young children who have experienced trauma in order to ensure these children receive needed intervention services (American Humane Association, 2011; National Scientific Council on the Developing Child, 2010; Osofsky & Lieberman, 2011).

One particularly promising avenue for enhancing such linkages to mental health services for very young trauma-exposed children is through Child Advocacy Centers (CACs). The CAC model has emerged as the "gold standard" for incorporating best practices for child abuse investigations and beyond. According to the National Children's Alliance (NCA), the accrediting body for CACs, the CAC model uses multidisciplinary investigative teams, trained child-forensic interviewers, videotaped interviews, highly trained medical forensic teams to conduct specialized examinations, victim/support advocacy, case review and tracking, and therapeutic interventions all within a child-friendly environment (Smith, Witte, & Fricker-Elhai, 2006). If mental health services are not provided on-site, the NCA requires the CAC to maintain linkages to community providers to increase families' access to these services (Cross et al., 2008; Jones et al., 2010). In addition, NCA accreditation standards require that forensic interviewers, whose interviews are used to inform a determination of abuse, receive specialized training in conducting developmentally appropriate interviews with very young children. However, no such training standards exist for victim/family advocates, whose role is to provide crisis assessment, investigative process and legal system education, concrete assistance, mental health referrals and other supports to children and families as they become engaged with the legal system following disclosure of abuse. Furthermore, very little is known about advocates' knowledge and perceptions related to the mental health needs of very young children following abuse exposure. However, CAC advocates are uniquely positioned to be a gateway for connecting very young children and their families with services needed to ameliorate adverse effects from toxic stress and trauma.

Although it remains unclear whether very young children are referred for therapy at the same rates as older children, findings from the first multi-site CAC evaluation project suggest that children of all ages who experienced sexual abuse and were interviewed at a CAC were referred for mental health services 72% of the time, whereas community comparison sites referred children just 31% of the time (Cross et al., 2008). Research is just beginning to explore factors that influence whether children actually begin receiving services or not (e.g., Lippert, Favre, Alexander, & Cross, 2008). Factors such as the type of abuse experienced, parents' willingness to initiate therapy, and victims' own openness to receiving therapy have all been considered as possible factors (Cross et al., 2008). Other factors such as the age of the child and the referral source's knowledge of the impact of abuse on early development have not yet been considered. Such factors may influence parents' willingness to have their child engage in therapeutic services.

The purpose of this mixed-methods paper is to examine the nature of CAC services for children under 6 in one state. Specifically, we used quantitative methods to explore age-based differences in demographics, trauma history, and referrals for mental health. Qualitatively, we used individual interviews to inquire about advocates' perceptions of their work with young children and how it differs from their work with older children and their families. We explored the ways advocates approach young children and their parents, their understanding of the impact of trauma on young children, their perceptions of parents' understanding of the impact of trauma, their experiences with referrals and services for mental health treatment for young children, and the emotional toll of working with very young maltreated children. Our goal was to identify training and support needed to ensure optimal services and service linkages in CAC settings for the youngest victims of abuse, thereby strengthening the broader system of care for traumatized infants, toddlers, and preschoolers.

2. Method

2.1. The AR BEST project

This study was conducted under the auspices of AR BEST (Arkansas Building Effective Services for Trauma), a program sponsored by the state legislature to improve outcomes of traumatized children throughout the state through collaboration among the University of Arkansas for Medical Sciences Psychiatric Research Institute; Commission on Child Abuse, Rape and Domestic Violence; and Children's Advocacy Centers of Arkansas. AR BEST, initiated in 2009, trains mental health professionals, advocates, child welfare staff and other stakeholders in evidence-based, trauma-informed practices; helps coordinate and support mental health services in CACs and the community for traumatized children; and monitors outcomes for children and their families.

2.2. Quantitative and qualitative data collection methods

AR BEST collects key de-identified information on all children seen through Arkansas CACs, through a web-based system designed for this purpose. This system allows AR BEST to document the demographics of clients served; type of trauma(s) have they experienced; alleged perpetrator; child's custody status; and referrals for mental health services.

Advocates received training on the system prior to implementation, and after implementation they attended a follow-up training to troubleshoot problems with data collection and ensure consistency of interpretation of the items. The AR BEST project also made funding available to CAC directors to support staff time associated with data entry.

For purposes of this study, advocates at all 13 CACs in the state of Arkansas were contacted by phone to schedule an individual in-person interview with a research assistant to discuss their unmet needs in working with very young children. Advocates at three CACs failed to respond to four phone calls and/or email attempts, and therefore, their data are not included in this study. Therefore, the total number of CACs that participated was 10. At the time of this project, the majority of CACs had only one advocate. Two participating CACs had two advocates working at their centers, and both advocates were interviewed for the project. Therefore, the total number of advocates interviewed was 12. The interviews averaged 20 min; all were conducted in person.

The interview was developed in collaboration among the authors and was intended to provide insight into the processes involved in CAC advocates' work with very young children. Interview questions were tailored to each site based on how frequently the site was providing services to children under age 6 and included the specific number of very young children that had been registered to the AR BEST website. All CACs provided some type of services to children under the age of 6, and 8 of the 10 CACs provided services to children under age 3. Questions addressed topics including adaptations to the CAC advocacy process based on the age of the child, resources available for working with very young children, and training for working with very young children. Participants were allowed to diverge from interview questions. Probe and follow-up questions were used to further explore participant responses.

2.3. Analysis

2.3.1. Quantitative analysis

Descriptive statistics were used to describe the sample and examine the age ranges of children seen in the CACs. Children were grouped into three age categories (0 to 2, 3 to 5, 6 and older) based on their age at the time of their initial visit to the CAC. Chi Square tests for dichotomous variables were used to examine age-based differences in children's demographics, trauma history, and referral patterns.

2.3.2. Qualitative analysis

Interviews were coded using conventional content analysis as described by Hsieh and Shannon (2005). Two investigators independently read and identified key elements in three advocate interviews, grouped these elements by similarity, and jointly developed a code and definition for each. Using this coding system, the first interview was coded jointly and the codes were subsequently further refined. Using the resulting system, each investigator separately re-read and coded the second and third interviews, then met to check coding for reliability and discuss discrepancies to further refine the codes and definitions. A simple percentage-agreement method was used to calculate inter-rater reliability (i.e., calculating the percentage of statements in a given interview which were coded into the same category by both investigators). Discrepancies were resolved through discussion. Consistent with Bernard and Ryan (2010), this process was repeated for three more interviews, until 80% reliability was achieved, and the codes appeared able to subsume all of the interview data. The remaining six interviews were coded separately (three each) by each investigator. Each investigator then coded one of the other's interviews as a final reliability check; 84% agreement was attained on each of the final two interviews. Using the MaxQDA software program, coded sections were extracted from each interview and grouped together for further analysis. Two subcategories of one code were identified.

3. Results

3.1. Quantitative results

From July 2012 to June 2013, CAC staff registered 3633 children into the AR BEST system. These children ranged in age from 0 to 20, with an average age of 8.66 (SD = 4.41). We categorized children into three groups: 4.5% of the sample was 2 or under, 26.6% was 3 to 5 years old, and 69.0% was 6 or older. In terms of other demographics, 67.7% of the sample was female, and 8.9% was Hispanic in ethnicity. In terms of race, 77.1% was Caucasian, 11.0% was African-American, 5.0% was biracial, and 6.9% endorsed 'other'. Differences emerged between the groups for gender with the 3 to 5 year old group having significantly fewer females than males, χ^2 (2, $N = 3633$) = 23.47, $p < .001$. There were no differences among the three age groups on ethnicity, χ^2 (2, $N = 3215$) = 4.63, $p > .05$, or race χ^2 (2, $N = 3383$) = 1.30, $p > .05$.

Key results are summarized in Table 1. As shown, most children were visiting the CAC related to an allegation of sexual abuse. Percentages in Table 1 pertaining to the abuse type do not sum to 100% because, at intake, advocates were able to select multiple types of abuse when a child had experienced more than one type. The youngest children (ages 0 to 2) were more likely to be drug-endangered at the time of the first visit to the CAC, χ^2 (2, $N = 3196$) = 43.91, $p < .001$, whereas children 6 and older were more likely to have witnessed violence, χ^2 (2, $N = 3196$) = 7.64, $p = .02$. The youngest children were somewhat more likely to have been removed from the home at the time of the first visit to the CAC, χ^2 (2, $N = 3633$) = 6.34, $p = .04$. Children between the ages of 3 and 5 were more likely to be abused by a parent, and children older than 6 were less likely to be abused by a parent, χ^2 (2, $N = 3633$) = 17.94, $p < .001$. Further comparisons of offender type revealed additional significant differences between age groups, χ^2 (18, $N = 3633$) = 121.15, $p < .001$. Specifically, children ages 2 and younger were less likely to be abused by a step-parent or other known offender outside of the family, and more likely to be abused by an unknown offender. Children ages 3 to 5 were more likely to be abused by a parent or parent's boyfriend or girlfriend, and less likely to be abused by another person known to the family. Children ages 6 and older were more

Table 1
Age-based comparison of children interviewed in child advocacy centers.

	Children 0 to 2 years (N = 163)	Children 3 to 5 years (N = 965)	Children 6 years and up (N = 2505)
Type of trauma suspected			
Physical abuse[a]	10.7%	13.7%	9.9%
Sexual abuse	85.3%	85.0%	87.6%
Neglect	2.0%	2.0%	1.1%
Witness to violence[a]	1.3%	2.4%	4.2%
Drug endangered[b]	6.7%	1.1%	0.8%
Other	2.0%	2.3%	2.9%
Perpetrator[b]			
Parent/step-parent	27%	31%	24%
Other offender	73%	69%	76%
Referred for counseling[b]			
Referred	21.0%	41.1%	40.8%
Not referred	73.9%	38.1%	24.1%
Already in counseling	5.1%	20.7%	35.1%
Child removed from home prior to interview[a]	16%	9.5%	10.1%

[a] $p < .05$.
[b] $p < .001$.

likely to be abused by a known offender outside of the family, and less likely to be abused by a parent or unknown offender as compared with the other age groups.

There were also significant differences in referrals to counseling based on the age of the child, with the youngest children both less likely to be referred for counseling and also less likely to already be engaged in counseling, χ^2 (4, $N = 3516$) = 245.23, $p < .001$. When no referral to counseling was made, the primary reason given was that the child was not experiencing symptoms. This was given as the reason for 65.5% of children 0 to 2 who were not referred, for 78.6% of children 3 to 5, and for 75.1% of children 6 and older.

3.2. Qualitative results

Code definitions are found in Table 2. Codes include: Process, Community Messages, Referral Process for Mental Health Services, Treatment Attitudes, Perceived Effects of Trauma (which includes two subcodes: Parent Perceptions and Advocate Perceptions), Mental Health Training, and Emotional Toll. Responses from the semi-structured interviews with CAC advocates are found in Table 3. Two representative quotes from each code are presented. The codes are discussed in more detail below.

3.2.1. Description of codes

The first code, Process, related to the process by which advocates interact with families and forensic interviewers interview children. It also included any adaptations that are made to accommodate very young children and their families, including simpler language, developmentally appropriate office décor and furnishings, and rapport-building. Advocates tend to adjust their interview style with parents by using a soft, reassuring tone, taking more time to listen, and providing resources and psychoeducation. The Process code also included advocates'

Table 2
Code definitions.

Code	Definition
Process	The advocacy and forensic interview process for parents and their very young children including adaptations to the advocates' and/or forensic interviewers' interviews. Includes beliefs about children's developmental skills at various ages as they relate to the ability to be interviewed. Includes the circumstances under which or reasons children are seen at the CAC including the type of evaluation that is done for various ages.
Community messages	Reasons community or law enforcement would/would not refer children ages 0–5 to this agency.
Referral process for mental health services	How and/or whether children ages 0–5 are referred for treatment following the interview, and what options are available for this.
Perceived effects of trauma	
Advocate perceptions	Advocates' knowledge about the effects of trauma on children ages 0–5, including the possibility of spontaneous recovery and the age the child will remember, disclose, and/or be affected by the trauma.
Parent perceptions	Advocates' perceptions about parents' thoughts, beliefs, and reactions to trauma in children ages 0–5.
Treatment attitudes	Advocates' thoughts and beliefs about treatment in general or for trauma. Includes advocates' perceptions about parents' thoughts, beliefs, and ideas about treatment.
Mental health training	Any training received by or desired by advocate or CAC personnel related to mental health and/or trauma-related factors for children ages 0–5.
Emotional toll	Advocate's comfort level working with parents of very young children, including differences between working with these parents and parents of older children. Includes statements related to emotional toll and self-care when working with this population.

Table 3
Codes and advocate responses.

Code	Sample responses
Process	The parents really control the interview because sometimes they don't want to talk about it at all, and sometimes the investigator hasn't told us very much about what happened. Sometimes we don't even know the allegation, so sometimes the parents will just unload on me and sometimes they just want to sweep it under the rug. For interviews, usually if the parents say they're verbal we'll try [to interview children under three], but then if they're not verbal we will do a medical exam. If there is any allegation of any type of penetration or suspicion of penetration we'll do medical anyway. As long as there are some allegations and there is an investigation open, and at parents' concern, we'll definitely at least get a medical in if we can't get an interview.
Community messages	I think one of the main reasons children [very young children] are brought here is because the investigators have such a hard time talking to them when they're that age. It's so hard for them to focus. When they come here we can have them in a more focused environment, and then there's language that's really difficult under three, or three to five, really. I don't know [why we're not seeing very young children]. I think that maybe the investigators feel that they wouldn't be good interviews. I think that's probably why we only see the ones that are really serious abuse because they have those declared statements of sexual abuse that you can't deny. I think there are some things investigators feel like they wouldn't give a good interview on, but with certain things they do.
Referral process	Most of the time I talk to the parents about [referring the child for therapy]. I talk to every parent that comes in about counseling and recommend it for everyone that comes in, but if we feel like the child has really been traumatized, we really push it more for the parents to get counseling. I think that if they're under three we have to call the counseling agency and say, "I'm referring a two-and-a-half-year-old," or a two-year-old, and let them know that they were verbal with us and they have been traumatized so we feel that it's really a need. I think a lot of counseling agencies don't see children under three, but if we call and say they need therapy, then they will accommodate that.
Perceived effects of trauma	
Parent perceptions	Every parent is different. There are some that have these reactions that their child's never going to be the same and they can never have a normal life, and that's not true, and then there are some that think, "Oh, they'll never remember," so it just depends on the parent. It's hard because it seems like sometimes it's almost like the parents [of very young children] are traumatized as much as the child and they just have a hard time dealing with the fact that someone has done this to their baby, so that is a hard age group to deal with the parents because they're just in shock that someone would do that to a child of that age.
Advocate perceptions	Yes, I think [trauma affects very young children] different[ly]. I think the very young ones, a lot of times they don't remember. They don't remember as well and it just seems like they're more resilient. They just bounce back and go on with their little playing with their toys and the older ones seem to dwell on it more. Kids are so resilient. The younger they are, a lot of times these little kids don't know what's happened is wrong, so like I said, it's important to give them education and the knowledge that these things aren't okay and how to handle them, but for the parent to know that later on it might affect them more than at this moment as a child.
Treatment attitudes	Very severe rape cases on very young children, I feel like through therapy and a good support system that they can be okay. They'll be fine and it's almost easier when they're very, very young than when they're in their teens. You know, you definitely have other parents who, you know, no matter the age, they want everything, every service that they can get for their child to help them. But I think with the very young kids you see more of, you know, "They're not going to remember it. They'll be okay. You know, we want to

Table 3 (*continued*)

Code	Sample responses
	move on. We don't want…we don't want to keep bringing it up so they will remember it." You know, that's what I hear a lot.
Mental health training	I don't think I've had any [training] specifically related to [early childhood mental health]. [I would like training in] all spectrums of services available, resources available, all updated research information concerning that age group and what best practices there are and new ideas that we could use for helping families of that age group.
Emotional toll	When it's really small children, I take [them] home with me on my mind. They really do keep me up at night. So, with some of the older ones, I'm not going to say it just rolls off my back or anything like that. It is harder for me to deal with the [littler ones]. I don't know that the emotional toll is different. It's certainly more shocking to hear a two-and-a-half-year-old disclose full penetration by an adult male than it is for an older child. It's just more shocking to hear those words come out of such a young child's mouth because they can't make that up. And not that other kids do, it's just definitely more shocking, but emotionally I think it's the same from two-and-a-half and three to 17. I don't think it ever gets any better to hear it.

perceptions of factors that influence whether a forensic interview is conducted. For instance, some advocates indicated their center only conducts forensic interviews for children ages 0 to 3 if the interviewer perceives the child has sufficient receptive and expressive language to participate based on informal assessments or the ability to separate from the caregiver. In CACs where no interview occurs, only medical exams are conducted.

The second code, Community Messages, described advocates' perceptions that their CAC may be communicating particular messages to the community that either encourage or discourage referrals to the CAC. Several of the CACs interview a relatively high number of children under 6, which advocates attribute to outreach efforts that promote their center as having interviewers trained to work with this age group or general outreach efforts that specifically demonstrate the center's expertise with this age group. Other CACs interviewing fewer children under 6 may not receive referrals because they have communicated to stakeholders they are uncomfortable working with this age group or believe that very young children are not reliable witnesses.

The third code, Referral Processes for Mental Health Services, described variability in the processes used to facilitate linkages between children who visit CACs and mental health service providers. Some advocates provide families with treatment information but ultimately require parents to contact the mental health agency themselves, whereas other advocates contact the agency directly and assist parents with scheduling an appointment. Other CACs have an on-site mental health professional who can provide services directly. Most advocates indicated that they refer all children and their caregivers for services regardless of age, whereas others indicated that they refer for treatment only if the child appears to be having difficulties (e.g., acting out, having nightmares, becoming excessively tearful, etc.) or communicates well enough to engage in treatment. Advocates reported referring families with very young children to play therapy and trauma therapy, but do not consistently recommend caregiver involvement in therapy. In some areas, advocates reported that mental health agencies refuse to provide treatment for children under age 3.

The fourth code, Perceived Effects of Trauma, broadly communicates advocates' perceptions of how trauma affects children. It does not include their thoughts/beliefs about treatment. The Perceived Effects of Trauma code contains two subcodes: Advocate Perceptions and Parent Perceptions. Advocates differed in their perceptions of how trauma affects very young children. Some advocates stated that children will be affected by abuse occurring at any age, whereas others suggested only children who are older than 4 or 5 when they are abused will be affected. Advocates also said other factors influenced trauma's effects including whether the child understands that what they experienced was abuse; the child's resiliency, which they believe may be more pronounced at a younger age; the child's support system; parental reactions to disclosure; and whether the child recognizes at a later age that what happened was abusive. The Parent Perceptions subcode of the Perceived Effects of Trauma code contains advocates' opinions about how parents perceive trauma affects very young children. A common response among advocates was that many parents believe very young children will forget about the abuse and will not be affected by it. Other advocates said that parents wonder if the abuse will adversely impact the child forever. Advocates responded that parents seem uncertain about what may constitute normal or concerning behavior following the abuse. The advocates' experiences with parents also suggest that the parents of very young children tend to be more upset by the abuse than parents of older children, and may therefore display a stronger emotional reaction than their children.

The fifth code encompassed advocates' Treatment Attitudes, including advocates' beliefs about treatment and their perceptions of parents' beliefs about treatment. Overall, advocates reported that they perceive therapy as beneficial, with early intervention following the trauma offering the best opportunity for ameliorating adverse effects of the trauma. However, some advocates said that because some very young children may not remember the abuse, they may not need treatment. Advocates also perceive that treatment should be age appropriate, and they supported a play therapy approach. Other advocates perceive that engaging parents in treatment is more important when treating younger children, although there is variability in parents' willingness to participate in the child's treatment. According to advocates, some parents believe that discussions of the abuse in treatment will make the child remember their experience, which predisposes them against therapy. Some advocates also believe that parents think very young children either do not need counseling, they do not think it will be effective because of the child's age, or they are uninformed about the deleterious effects of abuse that warrant treatment.

The sixth code that emerged, Mental Health Training, relates to the training experiences and needs of the advocates. Many advocates reported that they had no prior training on the mental health needs of children under 6 who have been traumatized, and they were uncertain if others, particularly mental health professionals in their CAC, have had training in early childhood mental health (ECMH) best practices. Some advocates assumed their on-site therapists had been trained in ECMH best practices but had not directly asked. Advocates indicated that they would like additional training related to general information about early childhood development, how trauma affects mental health, why therapy is important for young traumatized children, how therapy works with very young children, and various community resources that are available.

The final code encompassed the Emotional Toll that advocates' work with victims of abuse has on them. Some stated the emotional toll is greater when working with younger children because of the children's heightened vulnerability or because of parental distress, whereas others said that the age of the child does not matter—their work is always emotionally difficult. Advocates who have young children themselves find it particularly emotionally taxing to work with very young traumatized children. Although it was not specifically asked, some advocates reported trying to use self-care strategies to help them cope with the emotional toll.

4. Discussion

This study sought to quantitatively describe the characteristics of children under age 6 served in CACs and qualitatively explore the

experiences of CAC advocates in serving this population. To our knowledge, this is the first study of CAC advocates' experiences in working with a very young traumatized population, the results of which confirm the need for an expanded system of service delivery for the youngest and most vulnerable child maltreatment victims.

Like most children seen in CACs across the country, the majority of children seen by CACs in this state had been victims of child sexual abuse, although there were reports of concurrent physical abuse and other traumas. When age groups of children in this sample were compared, differences emerged on types of trauma exposure, perpetrators, and likelihood of removal from the home, suggesting that the abuse experiences and secondary stressors among children in various developmental stages may require different intervention approaches. It is important to acknowledge that some of these age differences may relate to a very young child's inability to communicate what they experienced. For example, a very young child's perpetrator may be more likely to be listed by the advocate as 'unknown' because the child cannot verbally express who it was. Similarly, very young children may be more likely to be brought to the attention of authorities after the home is investigated for a different reason (e.g., drug endangerment). By contrast, children age 6 or older may be more likely to tell investigators that, in addition to sexual abuse, they also witnessed violence between adults in their home, whereas young children may not be able to communicate this. Perhaps most concerning, our quantitative results suggest that very young children are less likely to receive treatment or be referred for treatment, with the most common reason being that the caregiver did not report child symptoms that would justify intervention. One possible reason for this may be that trauma symptoms manifest in young children differently than in older children or adults (De Young et al., 2011). For instance, very young children may present with posttraumatic play, restrictive play or exploration in the environment, sleep disturbance, high levels of fussiness, temper tantrums, clinginess and separation anxiety, and regression of previously acquired developmental milestones or skills (Scheeringa et al., 2003). If parents are not aware of these possible symptoms and/or an advocate has not had the proper training to inquire about these possible symptoms, then it is possible that the child will be perceived as asymptomatic. Furthermore, advocates and parents who are unaware that these are trauma symptoms may erroneously attribute the child's behavior to another cause and fail to seek services.

The results of our study also shed light on the current functioning of a portion of the system of care for maltreated young children — Child Advocacy Centers. Our results suggest that the CAC model has areas of strength and weaknesses in serving the youngest trauma victims and their families. With regard to strengths, the advocates interviewed appear to be hard working and committed to assisting victimized children and families through the legal process associated with the investigation. Their comments show considerable insight about trauma, which suggests they are listening to the children and families that present to them. They appear to empathize with children and families, and be emotionally impacted by working with them. They attempt to adjust their interpersonal style to be sensitive to young children and their parents. They also appear willing to receive training to improve their ability to intervene effectively with these families. Such strengths are important foundation stones for this emerging system.

Despite these strengths, there are ways in which CAC practices may be improved to strengthen the broader system of care. First, advocates in our sample acknowledged that they lack consistent training in typical child development and the mental health needs of traumatized children 5 and under. Advocates' perceptions of the effects of trauma on young children were variable and sometimes incomplete; this is consistent with the notion that misperceptions related to the mental health needs of very young children are common (National Scientific Council on the Developing Child, 2010; Osofsky & Lieberman, 2011). As mentioned previously, this lack of accurate knowledge may directly impact the manner in which advocates interact with families and the information they share with parents which, in turn, may influence parents' decisions to seek treatment for their child. Educating advocates and parents alike about the manifestation of trauma symptoms in very young children is a critical factor in increasing mental health linkages. Further training in typical child development, mental health problems that may result from early abuse, and factors and processes that promote resilience among young children is warranted. Trauma screening measures that assess trauma symptoms as they manifest in early childhood are also necessary to assist advocates in their efforts to identify children in need of mental health services.

A second way to bolster the system is to capitalize upon information sharing among CACs and outside investigative agencies. Although some CAC advocates perceived that their agencies have communicated to the public that they are better equipped and trained to conduct investigative interviews with young children, many CAC advocates stated that their agencies have directly communicated with external stakeholders (i.e., police investigators) that they are not comfortable interviewing young children. Since CACs are a key gateway by which children under 6 may begin to receive mental health treatment, equipping CACs with the necessary knowledge and confidence to investigate allegations of abuse among very young children is paramount so that they may better promote their services for this population.

A third way in which CAC practices may improve the system of care for traumatized infants and toddlers is for advocates to consistently refer families to receive a mental health assessment from a provider trained in infant or early childhood mental health evidence-based practices, and assist the family with setting an initial intake appointment with a provider. A major barrier to advocates linking children with services is that advocates may either be unaware of available mental health resources in their communities for very young children, or they may have difficulty finding therapists willing to treat these children. Some advocates in the present study were also unaware of evidence-based trauma treatments such as Child–Parent Psychotherapy (Lieberman et al., 2006), Parent–Child Interaction Therapy (Funderburk & Eyberg, 2011), and Trauma-Focused Cognitive Behavioral Therapy (Cohen et al., 2006), which have received empirical support for use with very young, traumatized children and their caregivers to various degrees. Although some advocates in our study acknowledged the importance of parental involvement in treatment, others were unaware of the importance of the parent–child relationship in ameliorating the effects of early trauma (Gosh Ippen, Harris, Van Horn, & Lieberman, 2011). Due to a host of challenges, evidence-based treatments vary in how widely disseminated they are, which may make referrals to appropriately trained mental health professionals challenging (Chaffin & Friedrich, 2004).

The system may also be improved by enhancing education about self-care for those individuals who interact with and treat child trauma victims and their families. Individuals in helping professions, such as CAC advocates, are at an increased risk for vicarious traumatization and secondary traumatic stress as a result of bearing witness to and empathizing with horrific stories of interpersonal trauma (Newell & MacNeil, 2010). In the present study, some advocates reported greater distress from hearing the abuse stories of very young children, whereas others stated that it is always difficult to hear about abuse experiences no matter the age of the child. Despite this distress, advocates did not consistently mention ways in which they engage in self-care. Learning basic self-care strategies, such as gaining support from family and friends, exercising, eating a healthy diet, getting sufficient sleep, and generally maintaining overall physical health, serve to protect against the deleterious effects of vicarious traumatization and secondary traumatic stress (Newell & MacNeil, 2010). Future trainings should emphasize how advocates may enhance their own self-care.

Several limitations emerged within our study. First, although multiple attempts were made to garner participants from all CACs across the state, some CACs did not respond to our attempts to contact them, and therefore their responses could not be included. It may be the case that

additional or different qualitative codes may have emerged with the inclusion of the additional CACs in the state. In addition, our results may not fully generalize to other states, especially those with different CAC organizational structures and training practices. Second, our quantitative sample primarily consisted of children who have been sexually abused since children tend to be referred to CACs for sexual abuse allegations. Therefore, our sample represents a specialized subset of abused children which limits generalizability. Third, because of confidentiality ascribed to our qualitative participants, we were unable to link the quantitative and qualitative data in our study. Such a linkage may have provided information regarding perceptions of referral rates and actual referral rates in an individual CAC. Fourth, our study contained no objective measure of advocates' knowledge of early childhood development or mental health. Inclusion of such a measure would have provided specific areas of knowledge deficiencies among the advocates and informed future training needs. Fifth, although we anticipated that the interviews would take approximately 45 min to complete, our average completion time was 20 min. Many advocates expressed having limited time due to their other responsibilities. This pressure may have resulted in brief answers. We were unable to offer compensation to advocates for their time, which may have offset this pressure. Longer interviews may have allowed us to gather additional information pertaining to the system and ways to improve it. Sixth, our study did not include parent's views, only advocates perceptions of parent's views. Future studies should include parent perspectives in order to further illuminate the service system for very young children. Finally, this study did not include a measure of the number of children who actually began receiving mental health treatment after their visit to the CAC. We have since changed our system to enable us to track the number of children who actually begin receiving mental health services, but this was not available at the time of the study.

In sum, this study used a mixed method approach to describe the characteristics of children seen in CACs and the experiences of the advocates who interact with them. We echo recent calls within the literature to create an expanded and sensitive system of care for very young traumatized children to ensure these children receive needed intervention services (American Humane Association, 2011; National Scientific Council on the Developing Child, 2010; Osofsky & Lieberman, 2011). Our results suggest significant effort is needed to increase the knowledge and training provided to CAC advocates related to the effects of trauma and subsequent mental health needs among very young children. Such knowledge may be passed along to parents which, in turn, may increase the number of very young children who begin receiving mental health treatment following an allegation.

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Appendix A. Qualitative interview questions

A.1. Clarifying information

Interviewees were first asked a clarifying question regarding the number of young children in the 0 to 3 and 0 to 5 age groups seen at their CAC: “I understand that at [your] CAC, you have seen [number] children under the age of 5 in the last 5 years. Of those, [number or percentage] are under 3. Is that consistent with your experience?”

A.2. Initial (“grand tour”) question

Under what circumstances do you see children under 3?

A.3. Probe questions (followed by further probe questions to be used if necessary)

1. What sort of developmental skills does your agency require of a child in order to be seen?
2. This question varied based on whether a CAC had seen more or less than the average number of children under age 3:
    a. *If the CAC had seen less than the average number of cases*: Some CACs have seen hundreds of cases, why do you think you are not seeing these children? Help me understand what some of the barriers might be.
    b. *If the CAC had seen more than the average number of cases*: Some CACs have only seen a few cases, why do you think you are seeing these children? What is it that your CAC is doing that sends a message that you know how to work with families with very young children who have been abused?
3. How do you adapt your interview with the parent for a child under 3 vs. a 3 to 5 year old?
    a. What are you doing differently for each one?
        i. If the advocate/interviewee has not seen a particular age group, ask: What might you do differently for [insert age group]?
    b. How does your interview differ from your interview with school aged children?
4. What is your referral process for therapy? How does it vary for children under 3 vs. children 3 to 5?
5. Who decides whether a child should be referred for therapy?
    a. How do you determine whether a child under 5 needs to be referred for services following an allegation of abuse?
    b. What factors do you consider?
    c. How does it vary for children under 3 vs. 3 to 5?
6. How are the resources in your community able to meet the mental health needs of very young children?
7. How do you talk about the problems a very young child may have as a result of the trauma with their parents or caregivers?
8. What is your sense about parents' willingness to allow a young child to participate in therapy?
    a. How do parents feel about actively participating in their child's treatment?
9. How do you think trauma affects very young children?
    a. *Inquire about differences between under 3, 3 to 5 age groups.*
    b. At what age do you believe children will remember a trauma?
    c. At what age do you believe children will begin to be affected by trauma?
    d. Are very young children more likely to recover on their own without intervention? At what age?

e. How do you think parents think trauma affects very young children?

10. Please tell me about your comfort level working with parents with very young children.

a. *Ask about 0 to 1(preverbal), 2 to 3, 4 to 5 year olds separately.*

11. What training have you had pertaining to the mental health needs of children under 5 who have been traumatized?
12. What additional training would you like to receive in order to increase your confidence in working with very young children and their families?
13. Has anyone at your agency been trained in early childhood mental health best practices?
14. How does working with very young children affect you?

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