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Which juvenile crime victims get mental health treatment?

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Abstract

Objective: To explore factors that facilitate the receipt of mental health treatment among juvenile crime victims.
Method: Telephone interviews were conducted with a national sample of 157 caretakers whose children had suffered a serious sexual or physical assault in the previous year.
Results: Twenty-two percent of caretakers had thought about getting professional counseling for their child victims, and 20% of the child victims actually received it. But half of the families who thought about it did not follow through on their consideration. Moreover, nearly half of those victimized children who actually received counseling did so without their families reporting that they had considered it in advance. The level of symptoms and parent-child relationship factors were related to considering counseling which was in turn strongly related to actually getting counseling. Other factors were independently related to receiving counseling, such as the victimization occurring at school and the victim being perceived as at fault to some degree. Advice to get counseling and medical insurance also played roles.
Conclusions: These findings suggested two pathways to counseling. One occurred via direct parental concern, and was associated with such variables as parental perceptions that the child was depressed or withdrawn or that the parent-child relationship had been negatively affected. The other pathway occurred independent of parental concern, most likely via school interventions, because this counseling was in conjunction with school victimizations.

Keywords: Treatment; Counseling; Sexual abuse; Assault

Introduction

Most juvenile crime victims do not receive mental health services. Yet a growing body of evidence links victimization with a considerable likelihood of potentially serious emotional or behavioral problems both in the immediate aftermath (Berton & Stabb, 1996; Boney-McCoy & Finkelhor, 1996; Singer, Anglin,

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Song, & Lunghofer, 1995) and in the long-term (Molnar, Buka, & Kessler, 2001; WHO Collaborating Centre for Evidence and Health Policy in Mental Health, 2001). Moreover, because there is experimental evidence that mental health treatment can help reduce problems (Cohen & Mannarino, 1998; Deblinger, 1996), it should be a priority to understand what facilitates or stands in the way of victims getting such treatment.

Unfortunately, little is known about the receipt of mental health services by juvenile crime victims. In the absence of previous research specific to crime victims, it is instructive to review the literature on the obstacles to treatment for symptomatic children in general, especially given the overlap between these two populations (disorders put youth at risk for victimization and vice-versa, Boney-McCoy & Finkelhor, 1996). Population-based epidemiological studies of youth find that only a small percentage of youth with diagnosable mental disorders receive any specific mental health treatment for their problems—findings range from 10% to 17% (Burns et al., 1995; Leaf et al., 1996). The underutilization of mental health services for juveniles has a variety of possible sources, which can be categorized as Definitional, Jurisdictional, Developmental, Emotional/Attitudinal and Material (Finkelhor, Wolak, & Berliner, 2001). Definitional factors refer to the reluctance to view symptomatic behavior as a mental health problem, instead such behavior may be viewed as a normal part of childhood, as school problems, as transient concerns, or may not be viewed as disruptive to the child's overall functioning. Most children with psychological problems, even those functionally impaired by diagnosable mental disorders, are not perceived by their parents as having mental health problems (Angold, Messer, Stangl, & Burns, 1998; Hoberman, 1992; Leaf et al., 1996). More serious symptoms are more likely to get a child to mental health services (Burns et al., 1995; Leaf et al., 1996; Wu et al., 2001), and problems that cause difficulty for parents (externalizing disorders) are more likely to be defined as requiring treatment than those that do not (Angold et al., 1998; Dulcan et al., 1990; Srebnik, Cauce, & Baydar, 1996; Wu et al., 2001).

Jurisdictional factors refer to the fact that juveniles have multiple authorities built into their lives—parents, teachers, schools, criminal justice authorities, child protective agencies, doctors—who mediate access to mental health treatment. Previous research finds that parents are more inclined to turn to physicians and teachers for help with their child's problems than to mental health care providers (Burns et al., 1995; Dulcan et al., 1990; Leaf et al., 1996). Schools—guidance counselors and school psychologists—are the major providers of mental health care to children and adolescents in the US (Burns et al., 1995; Glied, Hoven, Moore, Garrett, & Regier, 1997; Zahner, Pawelkiewicz, DeFrancesco, & Adnopoz, 1992).

Developmental factors include special orientations of children and youth that can inhibit formal help seeking, such as the emphasis adolescents place on autonomy and independence from adult interference. While age has not been found to predict which children get treatment once symptom levels are controlled, specific barriers to services may differ with age. Parents of younger children may not utilize treatment due to reticence in defining a problem as meriting mental health consultation (Pavuluri, Luk, & McGee, 1996). For older children, concerns about stigma or their personal autonomy may be more salient (Kuhl, Jarkon-Horlick, & Morrissey, 1997).

Emotional/attitudinal factors are individual reactions that inhibit or motivate help seeking. Among these may be attitudes toward service providers or concerns about embarrassment or shame. Negative views of therapists or fears of admitting problems have been proposed as barriers to mental health help-seeking, but few studies have empirically examined these issues.

Material factors are the practical resources, such as money, health insurance, time, transportation and knowledge, which can inhibit or promote access to mental health services. Research on children's access

to mental health services is inconclusive in demonstrating a relationship between material factors and help seeking. Some research finds poverty to be associated with more mental health care for juveniles (Burns et al., 1995; Zahner & Daskalakis, 1997). Part of this is due to the higher incidence of juvenile mental health problems among the poor, but another part is the availability of subsidized payment systems, such as Medicaid (Burns et al., 1995; Cunningham & Freiman, 1996; Glied et al., 1997), and the targeting of community mental health services at vulnerable groups. Some have postulated a curvilinear relation between SES and the use of mental health services (Cohen & Hesselbart, 1993; Srebnik et al., 1996).

This inventory of factors associated with access to mental health services suggested a conceptual model for this study, more fully described elsewhere (Finkelhor et al., 2001), called the Two-Stage Model of Victim Help-Seeking. It suggests there is an initial Recognition Stage in the wake of victimization, in which the victim or victim's family places an interpretation on the episode and consequent emotional and behavioral impact that defines it as possibly relevant to some external social agency. This stage involves recognizing behavior or symptoms that would suggest a need and recognizing that a mental health agency would have a service to offer someone who had such a need. Then, if the experience or condition is recognized as being relevant to mental health services, in a second stage (the Consideration Stage), the victim or family weighs the benefits and costs of actually obtaining the help they have recognized as relevant. They are then subject to additional influences based on material factors, attitudes, social influence or prior experiences in deciding whether or not to obtain counseling. Such factors have been highlighted in other models of help seeking, including the Health Beliefs Model (Rosenstock, 1966), the health care access model of Anderson and Aday (Aday & Andersen, 1974; Aday, Andersen, & Fleming, 1980) and the Social Organization Strategy model (Pescosolido, 1992). Help seeking in the context of victimization is a special case, however, not fully considered by other models, that suggests the utility of an initial phase prior to the phase during which many of the considerations raised by such generalized models come into play. The current study is an effort both to examine the utility of the Two-Stage Model of Victim Help-Seeking and also to explore factors that could explain the recognition that mental health treatment is relevant to the victimization, and the subsequent receiving of mental health treatment.

We hypothesize that several factors are related to one or both stages of the Two-Stage Model of Victim Help-Seeking based on the literature on mental health help seeking for children. These include demographic characteristics of the respondent and victim, the victimization's impact on the child, attitudes toward professional counseling, and material factors that could potentially interfere with obtaining counseling, and utilization of other services following the victimization. We also hypothesize that certain characteristics of the victimization may promote help seeking from mental health professionals, just as it does for help seeking from law enforcement (see Finkelhor et al., 2001 for review, and also Finkelhor & Wolak, 2003).

Methods

Data for this study come from *The Survey of Police Reporting among Families of Child Assault Victims* (Reporting Survey). Survey respondents were initially identified through a larger survey, the Second National Incidence Study of Missing, Abducted, Runaway and Thrownaway Children (NISMART 2), conducted in 1999 (Hammer & Barr (forthcoming)). In this nationally representative sample of 16,577

households containing juveniles, NISMART 2 interviewers screened for episodes of physical and sexual assault against juveniles ages 0–17 that had occurred in the previous year. Assault was operationalized along the lines of the National Crime Victimization Survey (NCVS), the nation's most important and rigorous crime victimization study, and, in fact, the present survey used the two NCVS screeners that elicit episodes of assault (Bureau of Justice Statistics, 2000). The NCVS screeners also elicit reports of sexual assault and rape, but for sexual assault two additional screeners were added to capture forms of sexual abuse including less coercive episodes of sexual abuse that might not be elicited by the NCVS screeners.

> In the past 12 months, has there been a time when an older person, like an adult, and older teenager, or a babysitter deliberately touched or tried to touch your child's private parts or tried to make your child touch or look at their private parts, when your child didn't want it?
>
> [Has/have] [this child/any of these children] been forced or coerced to engage in unwanted sexual activity by someone [he/she/they] didn't know before, a casual acquaintance, or someone [he knows/she knows/they know] well?

When households with juvenile assault victims were identified, NISMART 2 interviewers asked respondents for contact information for the Reporting Survey follow-up telephone interviews, which generally took place within a few weeks. The University of New Hampshire's Institutional Review Board approval was obtained for all procedures in both studies. During the follow-up interviews, interviewers obtained consent for participation in this study, confirmed the victimization episode reported in the previous interview, obtained further details about the episode, and then asked about mental health symptoms following the victimization, and whether counseling was considered and obtained for the child's symptoms. Although parental interviews have some limitations for obtaining complete inventories of victimizations and the assessment of certain symptoms, it was deemed for purposes of this study that parents would have the most comprehensive perspective across a full spectrum of child ages about details of treatment utilization and decisions surrounding such treatment.

Sample information

There was some attrition in the final sample from those identified as eligible in the NISMART 2 survey. Of those eligible in NISMART 2, 46% of respondents refused to give contact information. The remaining 258 households underwent additional screening for inclusion in the Reporting Survey. To be included at this second screening, the child victim had to suffer a completed sexual or physical assault or a serious attempt (involving a weapon or significant danger to the victim), and the victim had to be age 17 or younger at the time of the incident. Fifty-eight households were ineligible for inclusion based on these criteria or in a few cases because contact information was inadequate.

Finally, telephone numbers for 200 eligible households were provided to Reporting Survey interviewers. Of these numbers, 13% were ineligible because the designated respondent could not be reached. Of the remaining 174 households, 17 refused to be interviewed (10%), while 157 completed the interview (90%). All together there was considerable loss of eligible participants due to refusals to give follow-up contact information and refusal to be interviewed. But demographic comparisons (ethnicity, gender, education) of those who completed the interviews and those who did not (including both those who refused to give contact information and those who gave it but did not complete the interview for other reasons) revealed no significant differences between the two groups.

The final sample of 157 parents or caretakers in families with a juvenile assault victim was mostly female (84%) and White (87%), living with a spouse (58%), had some college education or more (64%) and lived in a household where the head of household was employed full time (79%). About a quarter of the households (28%) had incomes less than $25,000. Slightly less than half were living in small towns or rural areas. Nine tenths of the assaults reported by caretakers were physical assaults and one tenth were sexual assaults. Two thirds of the victims were male. Half of the victims were 12–17 years old, 39% were 6–11 years old and 11% were under the age of 6. In 48% of the victimizations, the victim was injured in the course of the episode. Family members made up 6% of the perpetrators, acquaintances 74% and strangers 20%. Twenty-one percent of the perpetrators were adults (over 17), and 85% of all perpetrators were male. About half of the victimization episodes occurred at school (47%).

Dependent variables

Since one goal of the research was to explore the possibility of a two-stage process, two variables were formulated to operationalize the outcome of each stage. For some of the analyses, each was treated as a dependent variable. The two dependent variables are dichotomous: (1) *Thought About Getting Counseling* (Yes or No) and (2) *Received Counseling* (Yes or No). Respondents were first asked if they had thought about getting professional counseling for their child after the assault. This represents the outcome of the Recognition Stage (seeing a mental health problem and a related community resource). Respondents were then asked if their child ever saw a counselor, psychologist or other mental health provider because of the assault. In response to a separate question some respondents stated their child received counseling at school because of the victimization episode. All respondents who indicated that their child received counseling, either at school or elsewhere, where coded as receiving counseling. This represents the outcome of the Consideration Stage (actually obtaining treatment).

Independent variables

Independent variables were formulated based on the literature on help seeking which suggests personal and demographic characteristics, symptom assessment variables, attitudes and beliefs and other social network factors play a role in help seeking.

Demographic characteristics. Characteristics of the respondent and child included in the analysis are the respondent's race, household income (low income—less than $25,000—and not low income), education level, and the type of area of residence. The child's age and sex were also included. The race/ethnicity indicator is dichotomous (minority or White) because there were too few non-White families to be subdivided by specific ethnicity.

Characteristics of victimization. The victimization characteristics examined in this study include: (1) Type of assault (physical or sexual), (2) Physical injury as a result of the assault (yes or no), (3) Duration of victimization (one incident or one of a series of incidents where the child was hurt or threatened by the same person/people over a period of time), (4) The respondents' perceptions of the seriousness of the assault. Seriousness was defined by asking respondents to rate the assault on a scale of 1–10, "with 1 being not serious at all and 10 being as serious as you can possibly imagine." Assaults rated at six or higher were coded as *highly serious* (mean = 5).

Other victimization characteristics examined were: the gender of the perpetrator, the number of perpetrators involved (single or multiple perpetrators), the victim's relation to the perpetrator (stranger or someone known to the victim), the location of the assault (school or other location), and whether the parent believed the victim was at fault to some degree for the assault (yes or no). The age of the perpetrator was examined with a dichotomous variable representing *adult perpetrator* (older than 17) versus *juvenile perpetrator* (17 or under).

Symptom variables. Four variables were chosen to explore the relation between the impact of the victimization on the child and the two dependent variables: (1) sadness, depression or withdrawal, (2) fighting or aggression, (3) negative impact on the parent-child relationship, and (4) positive impact on the parent-child relationship. *Sadness* and *aggression* were assessed through respondents' answer to the question, "Has there been any time when you thought your son/daughter was having one of these problems because of this episode . . . " If respondents acknowledged "sadness, depression or withdrawal," they were coded positively for *sadness*. If they acknowledged "fighting or aggression," they were coded positively for *aggression*. *Negative* and *positive impact on the parent-child relationship* were based on responses to the question: "How did the incident affect your relationship with your son/daughter?" Those responding that it caused some or a lot of difficulty were coded as experiencing *negative impact on parent-child relationship*. Those who responded that it brought them either a little closer or much closer were coded as experiencing *positive impact on parent-child relationship*. (In preliminary analyses these were shown to be independent dimensions and not part of the same continuum.)

Attitudes and beliefs. Several variables were used to examine caretaker attitudes, beliefs and prior experiences potentially related to the recognition and/or consideration of mental health services following victimization. These included respondents' knowledge of a mental health professional to call (yes or no), previous mental health treatment experience for the respondent or someone else in the family (yes or no), and whether the respondent believed a counselor would take the victimization seriously (four categories: *not at all* through *a lot*). Trust of counselors was assessed with responses to a question asking how much respondents trusted counselors at the time of the incident (four categories: *none at all* through *a lot*). An indicator of parental beliefs about the transience (or persistence) of symptoms was respondent's perception of the likelihood that the child's problems would get better over time without outside help (four categories: *very likely* through *very unlikely*). One variable representing a material factor that might interfere with receiving counseling was respondents' possession of medical insurance (yes or no).

Other help services and informal help seeking. The final set of variables included in the analyses represented social influence factors we believed could either lead to or impede mental health help seeking. These included help seeking from other services (other agency involvement), namely reporting the victimization episode to the police (yes or no) and seeing a medical professional due to the episode (yes or no). Direct advice was assessed with the question: "Did anyone advise you to get professional counseling for your child after this episode (yes or no)." Finally, two variables representing alternative informal help seeking by the child/victim were examined: Respondents' report of whether the child sought help for feelings about the incident from the parent (yes or no) and whether the child sought help from other family members or friends (yes or no).

Data analysis

Analysis was divided into multivariate prediction of each help-seeking stage: first, thinking about getting counseling (the Recognition Stage) and then, actually obtaining counseling (the Consideration Stage). In the first analysis, independent variables were entered into a forward stepwise logistic regression to determine which factors predicted thinking about getting counseling.

In the second analysis, the same sets of variables were entered into a logistic regression on receiving counseling, along with thinking about counseling as a predictor, also using a forward stepwise method. This method was chosen because of the large number of variables to be tested with a relatively small number of cases. The forward stepwise method allows variables to be entered one at a time and then removed based on their significance level, rather than entering the variables in the model together. Prior to performing the regression analyses, examination of a correlation matrix of all variables ruled out the existence of any highly correlated variables that might influence regression results (not shown).

As will be shown below, we found that a subset of cases did not fit neatly into the two-stage model. Results suggested two different pathways to receiving counseling. To explore factors related to each of these pathways, two more forward stepwise logistic regressions on receiving counseling were performed. The first regression model included only those families who thought about getting counseling and the second included only those who did not think about getting counseling.

Regression tables report an "Adjusted Relative Risk," which are the logistic odds ratios, adjusted by a method proposed by Zhang and Yu (1998) to approximate true relative risk when the outcomes of interest are common (greater that 10%) in the sample. Because of the exploratory nature of the analysis, logistic regression tables show all variables entering into the model at a p-value $= .10$ or lower.

Findings

Twenty-two percent of the sample ($n = 35$) said they thought about getting professional counseling for their son/daughter after the episode. Twenty percent of the sample ($n = 32$) said their child actually received counseling because of the episode. While the two groups were related ($\chi^2 = 26.74$; $p < .001$), they did not overlap as much as one might expect. In the families of respondents who thought about getting counseling, only 51% (17 of 35) received counseling. In other words, many families did not follow through on the consideration. But perhaps even more interesting and unexpected, of those children who actually received counseling, 44% (14 of 32) did so without their families reporting that they had thought about professional counseling in advance.

Independent variables related to the Recognition Stage

The regression showed six significant predictors of thinking about getting counseling (Table 1). If children experienced sadness, depression or withdrawal, parents were more likely to think about getting counseling for them.

The victimization having a negative impact on the parent-child relationship was the strongest predictor of a parent thinking about counseling. Being advised to get professional counseling also appears very influential; parents who were advised to get counseling were about three times as likely as other parents

Table 1
Logistic regression predicting caretaker thought about counseling

Variable ($N = 157$)	B	Adjusted relative risk[a]	95% Confidence interval[a]
Sadness	2.378	3.65***	2.0–4.6
Negative impact on parent-child relationship	4.126	4.70***	3.0–5.0
Someone advised professional counseling	2.801	4.02*	1.4–4.9
Problems unlikely to improve over time	1.447	2.58**	1.4–3.7
Counselor would take seriously	1.696	2.88**	1.6–4.0
Positive impact on parent-child relationship	1.370	2.48**	1.3–3.6
Knew a mental health professional to call	2.165	3.43+	.90–4.8
−2 log likelihood	68.492		
Model χ^2	98.113***		
R^2 (Cox & Snell)	.47		
R^2 (Nagelkerke)	.71		

[a] Adjusted to correct for over-estimation of risk (Zhang & Yu, 1998).
+ $p \leq .10$.
* $p \leq .05$.
** $p \leq .01$.
*** $p \leq .001$.

to think about counseling. Believing it was unlikely that the child's problems would improve over time without help and that a counselor would take the episode seriously also predicted thinking about counseling. A positive impact on the parent-child relationship (brought them closer) made it more likely for parents to think about getting counseling. There was also a nonsignificant trend ($p < .10$) for a greater likelihood of thinking about counseling if respondents knew of a mental health professional to call.

Independent variables related to the Consideration Stage

We analyzed the operation of the Consideration Stage of help seeking by examining factors that were associated with actually receiving counseling. Independent variables were entered into a forward stepwise logistic regression on receiving counseling. Thinking about getting counseling was included as one of the independent variables in this model.

The regression shows that thinking about getting counseling is a significant predictor of receiving counseling. In addition, characteristics of the victimization episode predict receiving counseling. If the perpetrator was known to the victim, it was much more likely that counseling was received. If the incident occurred in school or the parent believed the victim was at fault for the incident to some degree, there was a greater likelihood of receiving counseling. Aggression or fighting following victimization made it almost twice as likely for counseling to be received.

Respondents who had no health insurance at the time of the victimization were less likely to report their child received counseling. Another predictor of receiving counseling is someone advising the parent to get professional counseling. If parents were advised to get help, victims were more than three times as likely to receive counseling. The demographic factors of race, income, educational level and residential locale were not associated with receiving counseling.

Table 2
Logistic regression predicting victim receiving counseling ($N = 157$)

Variable[a]	*B*	Adjusted relative risk[b]	95% Confidence interval[b]
Thought about counseling	2.777	4.0***	2.4–4.7
Known perpetrator	4.325	4.75**	2.73–4.98
Victim at fault to some degree	1.533	2.7*	1.3–4.0
Happened at school	1.594	2.6**	1.3–4.0
Aggression/fighting	1.562	2.7*	1.2–4.0
Had health insurance	4.490	4.79**	2.21–4.99
Someone advised professional counseling	3.876	4.6**	2.0–5.0
−2 log likelihood	91.375		
Model χ^2	67.400***		
R^2 (Cox & Snell)	.35		
R^2 (Nagelkerke)	.55		

[a] The variables are listed in the order they were entered into the regression equation.
[b] Adjusted to correct for over-estimation of risk (Zhang & Yu, 1998).
* $p \leq .05$.
** $p \leq .01$.
*** $p \leq .001$.

Counseling obtained without prior recognition

While thinking about getting counseling (Recognition Stage) strongly influenced receiving counseling (Consideration Stage), as shown in Table 2, there was a substantial group who received counseling (14 of 32) without their parents thinking in advance about getting it. Exploration of factors unique to this group suggested some distinctive characteristics. Among this group of cases, 86% of the victimizations occurred at school, 86% were boys and 100% were victims of physical assaults, and 79% of parents believed their children were at fault to some degree. In 42% of the cases, the school provided the counselor that the child attended (in 4 cases information on who provided counseling was missing). These associations suggest an alternative pathway to receiving counseling for this subset of cases.

To examine whether different factors were involved in receiving counseling for families who had not thought about getting counseling compared to those who did, two separate forward stepwise logistic regressions were performed on each subgroup (see Table 3). The first model shows the results of the logistic regression on receiving counseling for the 35 families who thought about getting counseling. Victimizations involving a known perpetrator, symptoms of sadness, depression or withdrawal, and being advised to get counseling all appeared as significant in the regression. There was also a nonsignificant trend toward a greater likelihood of receiving counseling for those who had health insurance.

The second model shows the results of the logistic regression on receiving counseling for those 122 families who had not thought in advance about getting counseling. Two different factors predicted receiving counseling in this group: if the victimization occurred at school or the parent believed the victim was at fault to some degree there was a greater likelihood of the victim receiving counseling. None of the factors that predicted counseling for the families who thought about counseling in advance was significant for this group.

Table 3
Logistic regressions predicting victim receiving counseling using subgroups of sample

Variable	Model 1 Caretaker thought about counseling ($n = 35$)			Model 2 Caretaker did not think about counseling ($n = 122$)		
	B	Adjusted relative risk[a]	95% Confidence interval[a]	*B*	Adjusted relative risk[a]	95% Confidence interval[a]
Known perpetrator	2.449	3.72*	1.31–4.86	–	–	–
Sadness	1.853	3.07*	1.1–4.56	–	–	–
Someone advised counseling	2.025	3.27*	1.2–4.64	–	–	–
Had health insurance	2.525	3.79+	.57–4.93	–	–	–
Happened at school	–	–	–	1.842	3.06*	1.2–4.4
Victim at fault to some degree	–	–	–	1.527	2.68*	1.1–4.1
−2 log likelihood	33.958			72.379		
Model χ^2	14.534**			14.568***		
R^2 (Cox & Snell)	.34			.11		
R^2 (Nagelkerke)	.45			.22		

[a] Adjusted to correct for over-estimation of risk (Zhang & Yu, 1998).
+ $p \leq .10$.
* $p \leq .05$.
** $p \leq .01$.
*** $p \leq .001$.

Discussion

This study began by conceptualizing the pathway to mental health services for juvenile crime victims as a two-stage process, starting with an initial Recognition Stage within the family about the need for mental health services, followed by a Consideration Stage in which costs, benefits and other social influences play roles. The findings, however, suggest a more complicated process that entails two pathways. The first, which might be called an intrafamily pathway, operates through deliberate thinking about mental health services by the family. The second, by contrast, operates when the child becomes involved in services without any prior necessary recognition by the family. Schools appear to play a major role in this pathway, which could be termed the extra-family pathway and pertained to more than two fifths of the youth who received services. Figure 1 depicts the two pathways for juvenile victims receipt of subsequent counseling.

Along the first pathway (the left side of Figure 1), about half the families that thought about services actually followed through to obtain them. As hypothesized, there are certain factors particularly associated with thinking about services, and others associated with actually obtaining the services. The data also suggest a second pathway to receiving counseling. In this pathway, which might be termed an extra-family pathway, children got counseling in spite of the fact that their caretakers indicated they had not considered this option or the need for it. (See right side of Figure 1.) What is distinctive for these children is that their victimizations occurred at school and they were viewed as being at fault to some degree for the victimization. Schools appear to take the lead in this pathway as illustrated by the fact that 41% of all those receiving counseling received it at school (13 out of 32). This finding is consistent with previous studies that identify schools as major providers of mental health care in the US (Burns et al., 1995; Leaf

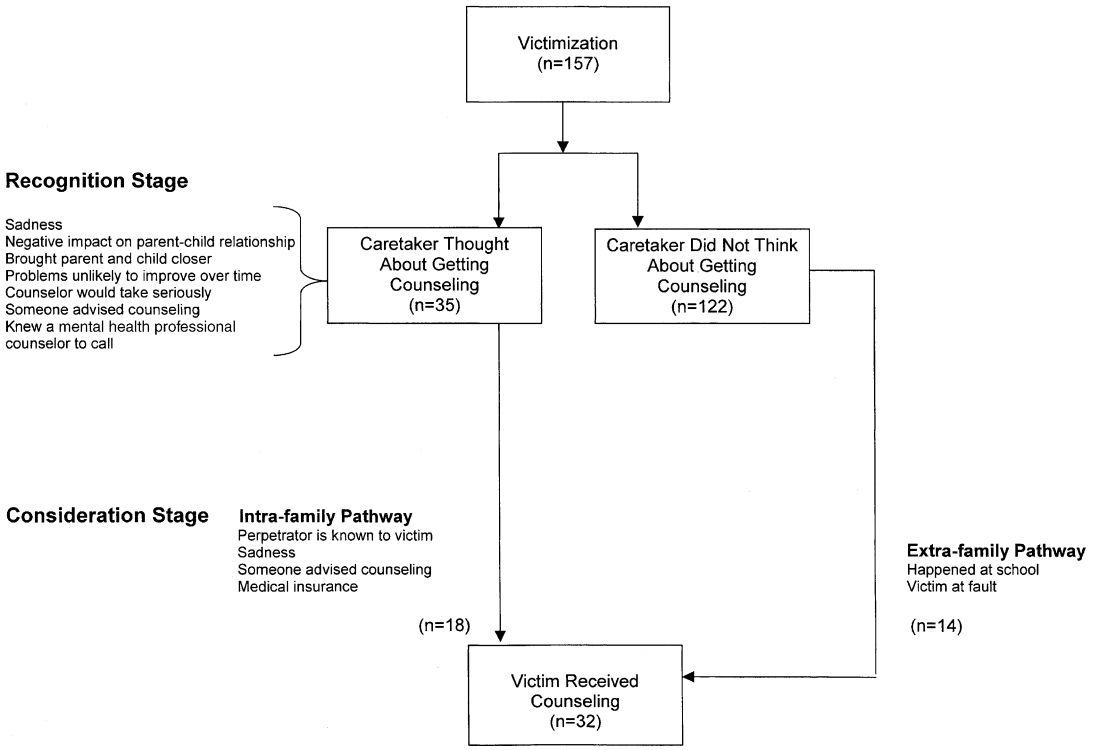

Figure 1. Pathways to receiving mental health services for juvenile crime victims.

et al., 1996). More importantly, schools appeared to initiate mental health services for juvenile victims, in some cases whether or not parents recognized the need for it. The relatively large proportion of children receiving treatment without families recognizing the need (44%) suggests the inadequacy of help-seeking models for children that consider only family dynamics and parental decision-making. However, because the original conceptualization and methodology were not explicitly designed with this pathway in mind, many questions remain about how school counseling decisions intersect with parental decision-making. One would presume that families at some point are approached by schools, assess the need from their own perspective and consent to treatment. More consideration needs to be given to incorporating this into the conceptualization of the Recognition phase.

Schools are clearly a valuable resource for families of juvenile victims in both recognizing and providing needed mental health services. However, the importance of victim culpability in this extra-family pathway to counseling raises the question of whether schools were referring these youth to counseling because they were perceived by the school as offenders (or disruptive influences) rather than as victims suffering from victimization related trauma. These may be very different kinds of victims, for example, the bully-victims, provocative victims or aggressive-victims referred to in the literature on bullying (Olweus, 2001; Schwartz, Proctor, & Chien, 2001), and the interventions they received may be more efforts to control their aggressivity and emotional dysregulation. Further research is necessary to understand whether schools play an important role in help seeking for all juvenile victims or mainly for those who are seen as “trouble makers” or causing fights, for example.

Limitations

In consideration of these findings, a variety of caveats should be borne in mind. A considerable loss of eligible participants in constructing the survey warrants some caution in generalizing from the sample, but it should be kept in mind that the vast majority of studies on child victimization, and especially those on treatment, are typically based on far less representative, regional and agency based samples. The source of the current sample is nationwide and from random digit dial telephone recruitment.

The present study also had a relatively small sample for the number of factors that it was designed to examine, increasing the risk of Type 1 error. Conclusions about pathways are speculative and exploratory, as they involve small groups. Given that this is the first study of this type using a national probability sample of victimization, not obtained through the mediation of any agency or service provider, we believe the findings, while suggestive in nature, can serve to guide further research.

Other problems relate to the cross-sectional nature of the data. Some amount of recall bias may be introduced by asking parents to reflect back upon their perceptions of the victimization's impact at the same time they were asked to reflect back on their help seeking decision making process. In addition, we only have the point of view of the caretakers and their decision-making; we do not know about the decision-making processes of other relevant actors. This study shows the importance of school decision-making, and, therefore, future research should attempt to incorporate a broader range of interested parties, including school officials, to understand their contribution to families' mental health help-seeking. Still another problem is the possible influence of considerations that were not assessed or well measured in the study. The questionnaire had only limited information on the characteristics of children and their families.

Practical implications

This study confirms that most juvenile victims of assaults do not receive counseling. Even among those who did experience some negative impact, only a minority got even one mental health consultation. There is evidence that treatment can be effective for crime victims in general and child victims in particular (Deblinger, 1996; March, Amaya-Jackson, Murray, & Schulte, 1998), and, therefore, the promotion of mental health help-seeking among the population of juvenile crime victims has empirical justification.

The findings of this study suggest ways in which this could be facilitated. First, families were more likely to think about getting counseling if they viewed mental health counselors as likely to take the episode seriously. There was a nonsignificant trend to think about getting counseling if they knew a mental health professional. Both of these factors suggest that increasing public awareness of the function and location of mental health services for juveniles may promote help-seeking. Mental health institutions could produce public education materials that give an accurate and positive image of the kind of reception and attention that victims could expect to receive from mental health counselors. On a broader level, a program of education and public awareness about the seriousness of crime victimization and its potential impact on juveniles could help both parents and mental health professionals who treat children to define experiences of assault as serious matters.

Second, help-seeking was heavily influenced by advice, suggesting that the various professionals who come into contact with juvenile crime victims (police, medical professionals, child welfare agencies, school personnel) can promote help seeking by recommending mental health consultation to victimized youth and their families. Though not all juvenile victims need mental health treatment, making the

recommendation to consider mental health services may increase parents' awareness of signs of distress subsequent to victimization and thus make it more likely that juveniles receive needed services.

Third, it did not appear that specific family characteristics were associated with lower levels of help-seeking: for example, families in more remote rural locations or minority group families. But, there was less counseling among those who did not have health insurance. Future research needs to examine this further, because it is a barrier potentially amenable to specific and highly feasible interventions, such as improved victim compensation systems.

Finally, this study highlights the important role schools play in access to mental health services. Schools provided much of the counseling children received and appeared to be an influential path to counseling even for victims whose families did not consider this option. Those concerned with the response to juvenile crime victims need to work with schools to help ensure that mental health needs of victims are satisfied. Increasing the number of mental health professionals to be located in school facilities is key to many juvenile victims receiving mental health services. Educating school personnel regarding the impact of victimization may help ensure that school referrals are generated not only for issues of academic performance or disruptive school behaviors, but for the more subtle signs of depression or anxiety that victims of assault may experience.

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Résumé

Objectif: Explorer les facteurs qui aident les jeunes victimes de crimes à profiter de soins mentaux.
Méthode: On a mené des entrevues téléphoniques auprès d'un échantillon de 157 personnes dont les enfants à leur charge avaient été victimes de sérieuses agressions sexuelles ou physiques durant l'année précédente.

Résultats: Vingt-deux pour cent des participants avaient songé à obtenir un counseling professionnel pour leurs enfants victimes et 20% des victimes ont effectivement reçu de l'aide. Cependant, la moitié des familles qui y avaient songé n'ont pas poursuivi. De plus, pour presque la moitié des enfants victimes qui ont bénéficié d'un service de counseling, l'idée n'est pas venue de leur famille. On a noté un lien entre d'une part, la nature des symptômes et la relation parent-enfant et d'autre part, le fait d'avoir songé à obtenir de l'aide. En revanche, y songer portait à obtenir ces services. D'autres facteurs ont aussi été identifiés, c.-à-d. si l'agression s'était produite à l'école et si la victime se sentait responsable de ce qui lui était arrivé. Le fait d'avoir une assurance-maladie et qu'on ait recommandé d'obtenir de l'aide étaient aussi des facteurs.
Conclusions: Ces constats portent à croire que deux faits auraient mené au counseling. En premier lieu, le fait que les parents étaient inquiets et qu'ils trouvaient que leur enfant était déprimé ou replié sur lui-même ou que la relation parent-enfant avait souffert; en deuxième lieu, le counseling était le résultat de facteurs outre les inquiétudes des parents, c.-à-d. le résultat d'interventions via l'école dans le cas ou l'agression avait eu lieu dans le contexte scolaire.

Resumen

Objetivo: Explorar los factores que facilitan la recepción de tratamiento de salud mental entre victimas jóvenes de crimen.
Método: Se llevaron a cabo entrevistas telefónicas con una muestra de 157 cuidadores cuyos hijos/as habían sufrido una agresión severa de tipo sexual o físico a lo largo del último año.
Resultados: Un 22% pensó en acceder a asesoramiento profesional para sus hijos/as víctimas, y un 20% de los niños/as víctima recibieron dicho apoyo. Pero la mitad de las familias que lo pensaron no pusieron en marcha esta intervención. Además, casi la mitad de los niños/as víctima que recibieron tratamiento lo hicieron sin que sus familias notificaran que lo habían considerado previamente. El nivel de síntomas y factores de la relación padre-hijo estaba relacionado con pensar en recibir asesoramiento, que a su vez estaba fuertemente relacionado con realmente conseguir dicho asesoramiento. Otros factores que estaban independientemente relacionados con recibir asesoramiento son el hecho de que la victimización se hubiera producido en el colegio y el que la víctima sea percibida como parcialmente culpable. El consejo para conseguir asesoramiento y seguro médico también jugó un papel importante en el proceso.
Conclusiones: Estos hallazgos sugieren dos maneras distintas de conseguir asesoramiento profesional. Si se da la preocupación parental, ésta está asociada a variables como las percepciones parentales de que el niño/a está deprimido o está siendo introvertido o que la relación padre-hijo/a se ha visto negativamente afectada. La otra vía de conseguir asesoramiento tiene lugar sin que se de una preocupación por parte de los padres. En estos casos se da una mayor probabilidad de que haya intervención escolar, porque el asesoramiento tiene relación con el hecho de ser víctima en el centro escolar.