Reported Maltreatment Among Clinic-Referral
Children: Implications for Presenting Problems,
Treatment Attrition, and Long-Term Outcomes

ANNA S. LAU, PH.D., AND JOHN R. WEISZ, PH.D.

ABSTRACT

Objective: To examine the treatment implications of a reported history of maltreatment in a sample of 343 children referred to Los Angeles area mental health clinics for emotional and behavioral problems. Method: Child Protective Service records identified 161 of the 343 families as having a documented history of maltreatment. Parent reports of child behavior problems were obtained following clinic intake and at 2-year follow-up, and attrition was assessed via medical records. The authors examined the associations between a history of maltreatment and severity of child presenting problems, treatment attrition, and long-term mental health outcomes. Results: Compared to other clinic-referred children, youngsters with a history of maltreatment entered treatment with more externalizing behavior problems, were more likely to exit treatment early and without therapist consent, and continued to show greater externalizing problems 2 years later. Conclusions: Maltreated children have significant mental health needs that may not be well addressed currently in community mental health clinics. J. Am. Acad. Child Adolesc. Psychiatry, 2003, 42(11):1327–1334. Key Words: maltreatment, clinic-referred, presenting problems, treatment attrition, treatment outcome.

Child victims of maltreatment are highly represented among youths who receive treatment in community mental health clinics (CMHCs), where an estimated one in three families has a history of physical abuse (Walrath et al., 1998). However, there has been remarkably little research on how maltreated children fare in treatment relative to other children. A panel of child mental health experts recently identified maltreatment as a factor likely to influence success in treatment of youths with emotional/behavior problems (Phillips et al., 2000), but in their extensive literature search the panel did not find a single study of the relation between maltreatment and child treatment outcome. While studies are in short supply, there are many reasons to suspect that maltreatment within a clinic-referred family might affect patterns of presenting problems and potentially undermine both treatment attendance and outcome.

The possibility of elevated presenting problems is suggested by numerous studies linking maltreatment to problems of behavior, affect, and social functioning that span the internalizing and externalizing spectrums. Community studies have reported that the most common patterns in maltreated children are externalizing problems such as aggression (Dodge et al., 1990; Haskett and Kistner, 1991), disruptive behavior disorders (Famularo et al., 1992; Flisher et al., 1997), and attention-deficit/hyperactivity disorder (ADHD) (Glod and Teicher, 1996). In addition, maltreatment has been associated with internalizing conditions such as depression (Ackerman et al., 1998; Kaplan et al., 1998) and anxiety disorders (Green, 1998; Pelcovitz et al., 1994) in community samples.

However, few studies have focused on maltreated children in clinical samples, and the findings have been somewhat equivocal. In their sample of child psychiatric inpatients, Kazdin and colleagues (1985) found that

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Correspondence to Dr. Lau, UCLA Department of Psychology, 1285 Franz Hall, Box 951563, Los Angeles, CA 90095-1563; e-mail: alau@psych.ucla.edu. 0890-8567/03/4211–1327/2003 by the American Academy of Child and Adolescent Psychiatry.
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victims of physical abuse showed elevated levels of depression relative to non-abused inpatients on child self-report measures but not on parent ratings. Among clinic-referred children, Scerbo and Kolko (1995) found that a history of physical abuse was related to heightened aggression, but only when children also displayed other co-occurring emotional problems.

Given that overall levels of psychopathology are higher in clinical settings than in the community, restriction in the range of problem severity may help explain why maltreatment is not robustly related to increased problems in clinical samples. Alternately, it is possible that other unmeasured forms of maltreatment may have limited the ability to discriminate between the maltreatment and control groups in these studies. Growing evidence suggests that other subtypes of maltreatment, including neglect, sexual abuse, and emotional abuse, have deleterious effects on child adjustment comparable to those of physical abuse (e.g., Manly et al., 1994). The current study examined whether a reported history of a wider range of maltreatment experiences might be associated with heightened presenting problems in a large sample of clinic-referred children.

Maltreatment might also be associated with differences in treatment participation for a variety of reasons. The motivation of abusive parents to have their children attend treatment sessions may be undermined by concern about the risk of detection by therapists, all of whom are mandated reporters (Steinberg et al., 1997). In addition, a child’s consistent attendance at therapy sessions requires parents to be sincerely committed to the child’s well-being and motivated to support the treatment (e.g., taking time off work, driving the child to sessions). Such responsiveness may be lacking among parents who abuse or neglect their children. Finally, the climate of the abusive family has been characterized as stressful, disorganized, and chaotic (Egeland et al., 1980), all conditions that are known to reduce the likelihood that the full course of therapy will be completed (Kazdin, 1996). Although there are at least three reasons to suspect that children in abusive families may be at increased risk for treatment attrition, to our knowledge there is no published study testing this hypothesis.

Maltreatment within a family may also jeopardize treatment outcomes in many ways. First, when there is abuse at home, the therapist’s ability to help via child-focused interventions can be hindered because the stress experienced by the child is largely outside the therapist’s and child’s control. Indeed, the intractability of abuse in many parents has been well documented (Cohn and Daro, 1987; Oates and Bross, 1995); as such, collateral parent-focused interventions may be least effective with parents who have a history of harming their child (Willet et al., 1991).

A second possibility is that the stress and disorganization that often characterize abusive families may limit the family’s ability to support the child’s growth through therapy. Evidence from clinical trials suggests that parental stress and family dysfunction are associated with reduced benefit from otherwise efficacious treatments (Kazdin, 1995). Finally, the complex sequelae of maltreatment may include multiple problems (e.g., psychiatric comorbidity, attachment difficulties, skill deficits) that pose barriers to children’s ability to benefit from typical interventions (Duecherme et al., 2000). Supporting this point, Eltz and colleagues (1995) found that among psychiatric inpatient adolescents, a history of maltreatment was related to difficulties forming a therapeutic alliance, and that maltreated youths who developed a poorer alliance over time showed the least improvement in treatment.

The literature reviewed thus far suggests that maltreated children may experience poorer outcomes in treatment than their non-abused counterparts. However, some studies suggest that maltreated youngsters can benefit from treatment of the sequelae of abuse (Stevenson, 1999). For example, evidence from controlled trials supports the efficacy of group therapy for sexually abused children (Cohen and Mannarino, 1997), and some evidence indicates that multisystemic treatment can modify abusive parenting (Brunk et al., 1987). To the extent that community treatment incorporates key elements of efficacious interventions, maltreated youths may reap therapeutic gains. So, the literature leaves it unclear whether to expect an association between maltreatment and treatment outcome. We sought to shed light on this question.

The aim of the present study was to determine whether maltreatment history contributes to prediction of presenting problems, treatment participation, and outcomes after treatment in community mental health care, over and above the effects of known correlates of these phenomena, including socioeconomic disadvantage (Dumas and Waehler, 1983), ethnic minority status (Kazdin et al., 1995), parental psychopathology, and family stress (Griest and Forehand, 1982; Kazdin, 1995). Toward this end, we compared clinic-referred children with and without a reported history of mal-
therapy, and subsequent assessments were conducted at 6 months, interviewed just after their initial intake and before the start of

Analyses examining pre- and post-treatment problem levels contrasted the maltreated group versus the comparison group. However, in the analyses of treatment attrition, we sorted the 157 maltreatment cases, 83 (53.4%) included multiple types of maltreatment. Some 105 (64%) cases involved physical abuse, 36 (22%) involved sexual abuse, 84 (52%) involved neglect, and 59 (36%) involved emotional abuse. Thus the total sample examined in this study included 343 clinic-referred youths, 157 (45.6%) of whom were classified as maltreated through CPS record review and 186 (54.4%) of whom did not have such a documented history. Pertinent demographic and clinical characteristics of the sample are reported in Table 1.

In the maltreated subsample, 21 (13.4%) youth had experienced an out-of-home placement according to CPS records. This rate of placement is similar to that found in an ongoing national probability study of families investigated for maltreatment (Barth, 2003). However, at the baseline interview, only 10 (6.4%) were in out-of-home placement. In the maltreatment subsample, reports were filed with CPS prior to the baseline interview in 100 (63.7%) of the cases and after the baseline interview in 57 (36.3%) of cases: of these 57 cases, 45 (28.7%) had maltreatment reports filed during the 2-year period spanned by the interviews and 12 (7.6%) had their reports filed in the year following this 2-year period. We chose to include all these families in our maltreatment group because CPS report dates often do not correspond to the dates of first occurrence of maltreatment but reference incidents occurring at various times in the past due to delays in detection and reporting.

Analyses examining pre- and post-treatment problem levels contrasted the maltreated group versus the comparison group. However, in the analyses of treatment attrition, we sorted the 157 maltreatment cases according to whether the caregiver accompanying the child to treatment was the perpetrator of the abuse (if so, the case was defined a parent-perpetrator family). The comparison group was contrasted with the 100 parent-perpetrator families and 57 parent-non-perpetrator families for all attrition analyses, because we suspected that most factors thought to contribute to attrition among maltreated children (e.g., parents’ fear of maltreatment detection and reporting, reduced commitment to child well-being) may be specific to abusive parents.

Procedures

After families provided written informed consent, they were interviewed just after their initial intake and before the start of therapy, and subsequent assessments were conducted at 6 months, 12 months, and 2 years post-intake, regardless of whether families continued treatment. For the current study we selected families who had ended treatment by the 2-year assessment, so our outcome analyses focused on that final assessment.

Data collection for the maltreatment variables involved record abstraction of CPS archives. Identifiers (i.e., names, addresses, Social Security numbers) were entered into CPS information systems to match study participants to documented CPS cases. We did not rely on CPS decisions regarding substantiation or service provision to guide our definition of maltreatment, as these indices are known to be of poor reliability (intrarater agreement often <.25) (Lindsey, 1994). Instead, we used the Maltreatment Classification System to code CPS report narratives to determine maltreatment caseness (see below).

Precautions taken to minimize the risk to participants associated with collecting information from CPS records were overseen by the institutional review boards at the CPS agency and the University of California at Los Angeles. Both institutions waived requirements for obtaining informed consent for accessing CPS records, since the study protocol included strict data-handling procedures to protect against breaches of confidentiality (e.g., restricting access to CPS records).
files and datasets to two research assistants and the first author, abstracting records at secure CPS locations, use of encrypted identification numbers that could not be linked back to identifying information in subject tracking databases). The results of the record search were kept confidential and were not shared with treating clinicians.

Measures

Maltreatment was coded from CPS records using the Maltreatment Classification System (MCS) (Barnett et al., 1993). The MCS provides definitions of multiple types of maltreatment (e.g., physical abuse, sexual abuse, emotional maltreatment). Severity ratings are made on a 5-point scale using objective criteria for each level of severity on each type of maltreatment. Interrater reliability was good for maltreatment type classification (κ = 0.82) and severity ratings (intraclass correlations of 0.88, 0.82, 0.77, 0.52, and 0.79, for physical abuse, sexual abuse, failure to provide, lack of supervision, and emotional maltreatment, respectively) based on 47% (n = 76) of the maltreatment cases. Children were included in the maltreated group if their records yielded a maltreatment severity rating of 1 or higher. Examples of severity ratings of 1 include physical abuse, the child received bruises after being hit with a belt; failure to provide, the child missed meals because of caregiver negligence.

Parents reported on behavior problems using the Child Behavior Checklist (CBCL) (Achenbach, 1991). The CBCL consists of 118 child problem behaviors rated on a 5-point scale. The CBCL yields broad-band scales for internalizing and externalizing problems that are internally consistent (α = .89 and 0.93, respectively), with good 1-week test–retest reliability (r = 0.89 and 0.93, respectively), and validity in discriminating between clinic-referred and non-referred children (Achenbach, 1991).

Following treatment termination, clinic records were abstracted to obtain total number of sessions attended, total time in treatment, whether the therapist agreed with the decision to terminate treatment, and treatment modality. Therapist consent to terminate was coded from indications in case notes that termination was planned (e.g., final notes addressed termination issues versus termination occurring as a result of repeated no-shows); interrater reliability for coding this item was good (κ = 0.87 on 10% of the sample).

Parents reported their own psychological symptoms using the Brief Symptom Inventory (BSI) (Derogatis, 1992); the 53 items, rated on a 5-point scale using objective criteria for each level of severity on each type of maltreatment, are internally consistent (κ = 0.82) and severity ratings (intraclass correlations of 0.88, 0.82, 0.77, 0.52, and 0.79, for physical abuse, sexual abuse, failure to provide, lack of supervision, and emotional maltreatment, respectively) based on 47% (n = 76) of the maltreatment cases. Children were included in the maltreated group if their records yielded a maltreatment severity rating of 1 or higher. Examples of severity ratings of 1 include physical abuse, the child received bruises after being hit with a belt; failure to provide, the child missed meals because of caregiver negligence.

RESULTS

Maltreatment and Presenting Problems

Analyses of covariance (ANCOVAs) were run to examine the effect of maltreatment status on internalizing and externalizing scores while controlling for parental psychopathology and stressful life events. Stress (F1,295 = 14.3, p < .001) and parental psychopathology (F1,295 = 25.5, p < .001) were positively associated with externalizing problems. Youths in the maltreatment group had higher T scores on externalizing problems than did comparison youth (F1,295 = 7.66, p = .006). Stress (F1,295 = 7.2, p = .008) and parental psychopathology (F1,295 = 43.9, p < .001) were the only significant correlates of internalizing problems. There was no significant difference in internalizing problems between the two groups after accounting for the control variables. Adjusted means of externalizing and internalizing problems for the maltreatment and comparison groups are displayed in Table 2. These means are adjusted for covariates entered in the ANCOVA: stress and parental psychopathology. In terms of clinical significance, a higher proportion of children in the maltreatment group reached the clinical cut-off on externalizing problems than in the comparison group (45% versus 33%) (χ2,1,342 = 5.24, p = .02).

Maltreatment and Treatment Attrition

Logistic regression analyses were conducted to determine whether families in the maltreatment group were at differential risk of treatment attrition. Three different operational definitions of attrition were used: dropout: discontinuing after intake before any treatment sessions were conducted; early termination: discontinuing treatment before receiving the median number of sessions (median in this sample: 8 sessions), and unilateral termination: discontinuing treatment without the consent of the therapist. Three logistic regression models were used to predict these dichotomous depen-

<table>
<thead>
<tr>
<th>Table 2: Internalizing and Externalizing Presenting Problems by Maltreatment Status</th>
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<tbody>
<tr>
<td>Presenting Problem</td>
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<tr>
<td>---------------------</td>
</tr>
<tr>
<td>Externalizing</td>
</tr>
<tr>
<td>Internalizing</td>
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</tbody>
</table>

* Adjusted for covariates: parental psychopathology and stressful life events.
and parental psychopathology and stress. In addition, receipt of the median number of treatment sessions was entered as a control variable for treatment participation. At follow-up, the only control variable significantly associated with parent report of externalizing problems was parental psychopathology ($F_{1,245} = 5.3, p = .02$). Maltreated youths were rated as having more externalizing problems than comparison youths ($F_{1,245} = 5.5, p = .02$). Internalizing problems at follow-up were significantly associated only with parental psychopathology ($F = 6.6, p = .01$). No differences emerged for internalizing problems at follow-up between the maltreatment and comparison groups. Treatment participation was not associated with either internalizing or externalizing problems at follow-up. Adjusted mean scores on internalizing and externalizing scales for the maltreatment and comparison groups are displayed in Table 4. These means are adjusted for the covariates entered in the ANCOVA: stress, parental psychopathology, and treatment participation. Similar to baseline, there was a higher proportion of youths in the maltreatment group (20%) who fell within the clinical range on externalizing problems than in the comparison group (10%) ($X^2_{1,245} = 4.85, p = .03$).

Longitudinal analyses were also conducted to examine whether the trajectories of externalizing problems differed between the maltreated and comparison groups. Random regression models were used to characterize the longitudinal course of externalizing problems across four time points (intake, 6-month, 12-month, and 2-year follow-up). After controlling for age, gender, family income, and treatment dose, the results indicated no differences in the slopes of problem trajectories between the maltreated and comparison groups. Gender was the sole variable influencing the rate of change in externalizing problems. Interestingly, treatment dose was unrelated to problem trajectories, and there was no treatment by maltreatment status interaction on problem trajectories. A detailed descrip-

### TABLE 3

<table>
<thead>
<tr>
<th>Maltreatment Status as a Predictor of Treatment Attrition</th>
<th>B</th>
<th>SE.B</th>
<th>OR (95% CI)</th>
</tr>
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<tbody>
<tr>
<td>Drop-out</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perpetrator parent*</td>
<td>0.54</td>
<td>0.42</td>
<td>1.21 (0.748, 3.94)</td>
</tr>
<tr>
<td>Nonperpetrator parent*</td>
<td>0.42</td>
<td>0.62</td>
<td>1.52 (0.454, 5.09)</td>
</tr>
<tr>
<td>Early termination</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perpetrator parent*</td>
<td>1.04**</td>
<td>0.41</td>
<td>2.82 (1.27, 6.26)</td>
</tr>
<tr>
<td>Nonperpetrator parent*</td>
<td>-0.20</td>
<td>0.44</td>
<td>0.82 (0.349, 1.93)</td>
</tr>
<tr>
<td>Unilateral termination</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perpetrator parent*</td>
<td>0.96**</td>
<td>0.34</td>
<td>2.61 (1.34, 5.09)</td>
</tr>
<tr>
<td>Nonperpetrator parent*</td>
<td>1.16**</td>
<td>0.41</td>
<td>3.19 (1.43, 7.17)</td>
</tr>
</tbody>
</table>

Note: OR = odds ratio; CI = confidence interval.
* Reference group = comparison non-maltreated group.
**p < .05; *p < .01.

Maltreatment Status on Internalizing and Externalizing Problems at 2-Year Follow-up by Maltreatment Status

<table>
<thead>
<tr>
<th>Problems at Follow-up</th>
<th>Adjusted Mean (SE)</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Comparison</td>
<td>Maltreatment</td>
<td></td>
</tr>
<tr>
<td>Externalizing</td>
<td>55.9 (1.3)</td>
<td>63.2 (2.3)</td>
<td>7.29</td>
</tr>
<tr>
<td>Internalizing</td>
<td>52.2 (1.4)</td>
<td>55.9 (2.5)</td>
<td>1.63</td>
</tr>
</tbody>
</table>

* Adjusted for covariates: parental psychopathology, stressful life events, and treatment participation.


DISCUSSION

The results suggest that even in a sample of youths who had problems significant enough to lead to clinic referral, those with a history of reported maltreatment could be differentiated from comparison youths on severity of presenting problems, attrition from treatment, and outcomes 2 years later. At intake, maltreated youths showed more severe presenting problems than comparison youths in the externalizing spectrum. While clinic-referred youths likely share a variety of risk factors for mental health problems, including parental psychopathology and family stress, maltreatment is associated with additional risk. Our findings regarding elevated levels of presenting externalizing problems in maltreated youths diverge somewhat from those of previous studies using clinical samples. Kazdin and colleagues (1985) found that a physical abuse history was not related to differences in parent-reported internalizing and externalizing problems among inpatient youths, and Scerbo and Kolko (1995) reported that physical abuse was related to heightened aggression only when clinic-referred children also displayed internalizing symptoms. We conducted further analyses to test for this interaction in our data. We ran an analysis of variance testing the effects of maltreatment, internalizing problems exceeding clinical cut-off at intake, and their interaction on externalizing scores at intake. Results indicated a main effect of internalizing symptoms but no significant interaction.

These differences in findings could reflect any of several methodologic differences between our study and the two previous investigations. Our sample was drawn from CMHCs in a large urban area, whereas Kazdin and colleagues (1985) studied inpatients and Scerbo and Kolko (1995) sampled from a university-based summer treatment program for children with disruptive behavior disorders. Another method difference is that the previous studies focused specifically on physical abuse, whereas we included multiple forms of maltreatment. It is possible that these studies included children in their control groups who may have been victims of neglect, sexual abuse, or emotional abuse, all of which are associated with increased symptomatology. By measuring multiple subtypes of maltreatment, our analyses may have permitted a more thorough differentiation of children at heightened risk by virtue of maltreating familial environments. To explore the possible role of this between-study method difference, we reanalyzed our data to contrast the problems and outcomes of those children with a history of physical abuse versus comparison children. Results were similar to those presented, indicating that physically abused children had more externalizing but not more internalizing problems at intake and follow-up relative to comparison children. Hence, the fact that previous investigators focused specifically on physical abuse is not likely to account for the difference between their findings and ours.

Our findings indicate that maltreatment is associated with poorer treatment persistence. Membership in the maltreatment group was not related to drop-out following intake but was associated with unilateral and early termination. It is possible that drop-out was not related to maltreatment, because CPS puts pressure on families to keep their initial appointment, but CPS vigilance and advocacy may diminish after linkage is established with a mental health provider. Children brought to treatment by maltreating parents were almost three times as likely to attend less than the median number of treatment sessions and to terminate their treatment against therapist advice. There are multiple interpretations of these findings. Abusive parents may resist contact with clinicians for fear of being reported for maltreatment. Second, maltreating parents may not have the level of concern for their child’s well-being required to maintain consistent attendance. Third, the stressful and disorganized climate of the abusive family may compromise commitment to treatment. Finally, maltreating parents may terminate early because they do not feel the treatment is credible or effective. Abusive parents may hold views about child management that are incongruent with the ideals inherent in traditional child mental health treatment (Oates and Bross, 1995). Conflicting philosophies about parenting and the treatment of children might contribute to attrition among maltreating families. Surprisingly, we also found that maltreated children brought to treatment by non-abusive parents were also more likely to unilaterally terminate treatment compared to non-maltreated children. It is possible that clinicians may value long-term trauma-focused treatment, whereas non-perpetrating parents may be reluctant to dwell on past abuse and may prefer to terminate when certain problem behaviors abate. Whatever the reason for our attrition findings, one implication seems clear: maltreated children (particularly those brought to

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treatment by maltreating parents) face an elevated risk of treatment that ends earlier than other children’s treatment, and before their therapists believe therapy is complete.

In addition to increased treatment attrition among maltreated children, we found poorer long-term outcomes. Our data at clinic intake showed higher levels of externalizing problems among maltreated children than comparison children, our analyses of problem trajectories showed a similar time course for maltreated and comparison children, and our follow-up data showed that even after 2 years, by which time all youths had completed treatment, maltreated youngsters had made no progress toward closing the gap in problem severity.

It is interesting to note that treatment dose appeared unrelated to outcomes at 2-year follow-up for both the maltreatment and comparison groups. This finding is consistent with other studies of community-based treatment, where the mental health outcomes of children receiving substantial amounts of treatment appear no better than those of children receiving negligible amounts of treatment (e.g., Andrade et al., 2000; Weisz et al., 1995). Our study examined treatment-as-usual as it occurred naturalistically in CMHCs, where the standards of practice and types of interventions used are not well documented. Further study is needed to determine whether maltreatment compromises treatment outcomes in well-specified evidence-based interventions.

Limitations

While the findings highlight important possibilities to be examined in future research, results must be interpreted in the context of study limitations. First, while we used a well-researched protocol for culling indices of maltreatment from archives, the initial means of group classification relied on CPS records. Although widely used (Drake and Johnson-Reid, 1999), this method of identification may result in the inclusion of victimized children in the comparison group whose maltreatment has not been reported, as well as an underestimate of the extent of abuse and neglect in the maltreatment group. As such, our study may be a conservative test of the associations between maltreatment, presenting problems, and outcomes.

Second, our study focused on children receiving treatment in five CMHCs in Los Angeles. Since the practices of CMHCs and child protection agencies vary widely from place to place, the generalizability of our findings may be limited. Replication of these findings is needed. Third, our sample size precluded a detailed examination of the relation of various subtypes of maltreatment and gradations of maltreatment severity in the prediction of clinical outcomes. Fourth, parental substance abuse is a common correlate of child maltreatment, and we cannot rule out the possibility that unmeasured parental substance abuse in our sample contributed to the negative outcomes observed in our maltreated group. Finally, we had limited information about the services received. We did not observe the nature of psychosocial treatments offered, nor did we have specific information about medication treatment. These data do not reflect whether care was consistent with evidence-based practice. Further study is needed to determine whether maltreated children experience poorer outcomes when evidence-based treatments are provided. These areas of inquiry represent important directions for future research.

Clinical Implications

Notwithstanding these limitations, our findings regarding treatment attrition and pretreatment and follow-up levels of psychopathology suggest that maltreated children have significant mental health needs that may not be well addressed currently in CMHCs. These findings highlight the importance of identifying and addressing barriers to care for children and families with a history of maltreatment. Therapists who are reluctant to report suspected maltreatment for fear of disrupting the therapeutic alliance should note that the history of maltreatment itself might engender a risk of poor commitment to treatment. As such, intensive efforts to build alliance are indicated irrespective of the reporting issue. Further study is needed to identify ways of engaging these families in treatment and tailoring effective interventions to their needs. Finally, our record abstraction indicated that only 7.5% of the sample received a medication evaluation with a psychiatrist at these CMHCs. Given the numbers of children in the sample with ADHD and anxiety and depressive disorders, it is possible that outcomes may have been compromised by inadequate access to medication treatment. This access issue may be particularly damaging for maltreated youths who present with more severe problems and are at greater risk of discontinuity of treatment.

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