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Leigh de DeLorenzi  
*University of Central Florida*

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THE RELATIONSHIP BETWEEN CAREGIVER INTIMATE PARTNER VIOLENCE,  
POSTTRAUMATIC STRESS, CHILD COGNITIVE SELF-DEVELOPMENT, AND  
TREATMENT ATTRITION AMONG CHILD SEXUAL ABUSE VICTIMS

by

LEIGH DE ARMAS DELORENZI  
B.S University of Miami, 2003  
M.A. Rollins College, 2009

A dissertation submitted in partial fulfillment of the requirements  
for the degree of Doctor of Philosophy  
in the College of Education  
at the University of Central Florida

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Major Professor: Andrew P. Daire

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## ABSTRACT

Child sexual abuse (CSA) is a worldwide problem, with two-thirds of all cases going unreported. A wealth of research over the last 30 years demonstrates the negative emotional, cognitive, physical, spiritual, academic, and social effects of CSA. As a result, researchers and mental health professionals frequently attempt to measure the efficacy of treatment modalities in order to assess which treatments lead to better outcomes. However, in order to effectively study treatment outcomes, researchers must be able to track the status of child functioning and symptomology before, during, and after treatment.

Because high levels of treatment attrition exist among CSA victims, researchers are unable to effectively study outcomes due to large losses in research participants, loss of statistical power, and threats to external validity (Kazdin, 1990). Moreover, due to the high prevalence of concurrent family violence, caregivers with intimate partner violence are more than twice as likely to have children who are also direct victims of abuse (Kazdin, 1996). Caregivers ultimately make the decisions regarding whether or not a child stays in treatment, and therefore, it is important to examine the influence of both parent factors (e.g., intimate partner violence) and child factors (e.g., traumatization and/or disturbances in cognitive self-development) on treatment attrition. This two-pronged approach of examining both child and family characteristics simultaneously with attrition patterns offers a more complete picture for the ways concurrent family violence influences treatment than looking at child and caregiver factors separately.

The purpose of this study was to investigate the relationships between caregiver intimate partner violence, child posttraumatic stress (Trauma Symptom Checklist for Children [TSCC]; Briere, 1996), child cognitive self-development (Trauma and Attachment Belief Scale [TABS];

Pearlman, 2003), and treatment attrition. The statistical analyses in this study included (a) Logistic Regression, (b) Poisson Regression, and (c) Chi-square Test for Independence. Elevated TSCC subscale scores in *posttraumatic stress* predicted both an increased number of sessions attended and increased number of sessions missed. Elevated TABS subscale scores in *self-trust* predicted an increased number of sessions attended and decreased number of sessions missed. Elevated TABS subscale scores of *other-intimacy* and *self-control* predicted an increased number of sessions missed. Moreover, the presence of past or current caregiver intimate partner violence predicted a decrease in number of sessions attended. While no relationship existed between child posttraumatic stress or cognitive self-development and whether a child graduated or prematurely terminated from treatment, children with parents who confirmed past or current intimate partner violence were 2.5 times more likely to prematurely terminate from treatment.

*This dissertation is dedicated to the millions of brave women and children who survive abuse every day. May you be cloaked in the armor of love and steadfast courage on your journey toward peace and healing, and find comfort in words of Psalm 71:14 – “He shall redeem their soul from deceit and violence: and precious shall their blood be in his sight.”*

*This work is also dedicated to my parents, who on the day of my baptism, prayed for, “...the eyes of my heart to be enlightened so that I may know the hope to which He has called me.”  
(Ephesians 1:18)*

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## CHAPTER 1: INTRODUCTION

Family violence is the most prevalent form of violence in the United States (American Psychological Association, 1996; Tolan & Gorman-Smith, 2002; Tolan, Gorman-Smith, & Henry, 2006). Contrary to popular cultural family values that celebrate and promote safety, trust, love, dependability, intimacy, and protection (Tipton & Witte, 2005), family violence creates an atmosphere of fear, helplessness, and many times, traumatization among victims (Busby, Holman, & Walker, 2008; Hendy et al., 2003). Due to the serious public health and psychological ramifications of family violence (Chalk & King, 1998), scientists, mental health professionals, and victim advocates began highlighting the need for further research on ways to track traumatization associated with family violence over 30 years ago (Browne & Finkelhor, 1986; Gully, 2001; Kendall-Tackett, Williams, & Finkelhor, 1993; Maniglio, 2009; Tingus, Heger, Foy, & Leskin, 1996; Waterman, 1986). Research also established that families with one type of abuse (i.e., intimate partner violence; IPV) oftentimes have co-occurring child or elder abuse (Dixon, Browne, Hamilton-Giachritsis, & Ostapuik, 2010). Thus, a violent relationship between intimate partners creates an increased risk for abuse across family members, especially vulnerable populations like children.

Contextual, individual, and relationship risk factors for battered women are the same for victims of child abuse. These risk factors include poverty, deprived neighborhoods, stress, dysfunctional family patterns, parental discord, and violence between parents, among others (Tolan, Gorman-Smith, & Henry, 2006). Although children are at increased risk for additional forms of abuse by the same perpetrator in families with IPV (i.e., physical/sexual abuse; neglect), current theories and research perpetuate a segregated understanding for each of the major forms



of family violence (e.g., IPV, child abuse, and elder abuse) (Tolan et al., 2006), and therefore fail to provide a clear conceptualization for how these issues affect the family when occurring simultaneously (Loseke et al. 2005, Graham-Bermann & Edleson 2001).

Victims of family violence face a number of unique challenges when compared to victims of other forms of violence. In their article on family violence, Tolan et al. (2006) pointed out that most societies have a legal definition for family violence that differentiates it from other forms of violence. Unlike other violent offenses that occur between strangers (i.e., war, violent crime), IPV and intra-familial child abuse occurs between people who are either related or involved in an intimate relationship, creating confusing and/or paradoxical dynamics between family members who depend on one another for care and protection in the midst of unpredictable outbreaks of violence (Jouriles et al., 2001; Tolan et al., 2006). Furthermore, contrary to other forms of violence, victims and perpetrators in families with IPV oftentimes retain relationships before, during, and after violence occurs (Tolan et al., 2006). Because not all types of family violence are considered a crime (e.g., spanking, physical punishment, violence between siblings, etc.), the authors argue that studies and interventions should require more complex approaches than would normally occur for research on other types of violence.

A substantial link exists between IPV and co-occurring child abuse, both of which are capable of producing a variety of serious negative emotional, social, and psychological outcomes in the lives of both battered women and their abused children. Specifically, researchers document the co-occurrence of child sexual abuse (CSA), child physical abuse, and/or neglect as occurring in approximately 50% of IPV cases (Koverola & Morahan, 2000), bringing estimates of co-occurring abuse to 500,000 children each year. Literature on abuse victims establishes that mental health treatment provides significant long-term benefits, including improved

interpersonal relationships (Ducharme, Atkinson, & Poulton, 2000), enhanced stress management and self esteem (Cohen, Mannarino, Berliner, & Deblinger, 2000) increased personal safety knowledge (Briere, 1992; Lau & Weisz, 2003), and reduced risk for the intergenerational transmission of child abuse (Egeland, Jacaobvitz, & Papatola, 1987; Faller, 1989; Simons et al., 1991). Yet for child abuse victims, treatment attrition rates are high, with up to 60% of maltreated children terminating treatment before receiving any therapeutic benefits (Kazdin, Holland, & Crowley, 1997; Schottenbauer, Glass, Arnkoff, Tendick, & Gray, 2008). A growing body of literature recently emerged to uncover factors influencing treatment completion for maltreated children (Lau & Weisz, 2003; Miller, Southam-Gerow, & Allin, 2008; Staudt, 2007). Researchers identified demographic variables, parent variables, and abuse characteristics (i.e., age, gender, ethnicity, abuse severity, symptom severity, and caregiver support) associated with a child's treatment completion or premature termination (Berrigan & Garfield, 1981; Dover, Leahy, & Foreman, 1994; Finkelhor & Berliner, 1995; Harris, 1999; Haskett, Nowlan, Hutcheson, & Whitworth, 1991; Horwitz, Putnam, & Noll, 1997; Lester, Artz, Resick, & Young-Xu, 2010; Mogge, 1999; Pekarik & Finney-Owen, 1988; Reis & Brown, 1999; Ross & Lacey, 1961; Tingus et al., 1996.)

Furthermore, researchers found that child, therapist, and treatment characteristics account less for child attrition than parent, cultural, and SES variables (Armbruster & Kazdin, 1994). Given that parents make decisions regarding when to pursue or terminate treatment for their children, researchers should focus on parent variables in child attrition studies (Pekarik & Stephenson, 1988). Previous studies identified relationships between certain caregiver variables and child treatment attrition. For example, the children of caregivers with high parental motivation, positive parental expectations, low parental stress, and low maternal mental health

issues complete treatment more frequently than caregivers of children who do not complete treatment (Kazdin, Mazurick, & Bass, 1993). Furthermore, studies show that exposure to family violence may exacerbate treatment attrition for children who are not victims of other forms of direct abuse. Koverola, Murtaugh, Conners, Reeves, and Papas (2007) found that children exposed to family violence receiving outpatient services for emotional or behavioral problems faced an increased risk for premature termination. While studies show that children exposed to IPV have a higher risk of behavioral, emotional, and psychological problems than children not exposed to IPV (McDonald & Jouriles, 1991), few studies examine the relationship between caregiver IPV on treatment attrition for victims of child sexual abuse (CSA).

### **Problem Statement**

In a number of historical reviews, researchers reveal a link between trauma to children and mothers, describing their wellbeing as interdependent (see Edleson, 1991; Gordon, 1988; Pleck, 1987). However, conducting research on the impact of multiple types of abuse presents challenges due to considerable similarities and overlap of therapy outcomes between children exposed to IPV, and children who are direct victims of other types of abuse (Edelson, 1999; Saunders, 2003). Several studies show that different forms of family violence co-occur (Renner & Slack, 2006). In a retrospective study of adult survivors of childhood abuse ( $N = 17,337$ ), Dong et al. (2003) found that those who experienced CSA were also significantly likely ( $p < .05$ ) to have experienced childhood emotional and physical abuse, as well as exposure to IPV. Other studies have also recognized a frequent co-occurrence between family violence and various forms of childhood abuse (Clemmons, DiLillo, Martinez, DeGue, & Jeffcott, 2003; Higgins & McCabe, 2000; Moeller, Bachman, & Moeller, 1993; Scher, Forde, McQuaid, & Stein, 2004).

Yet, researchers investigating the effects of abuse on treatment outcomes tend to either examine all maltreated children as one sample, or they form samples containing child victims of a single type of abuse. As a result, researchers cannot account for the ways distinct forms of child abuse might affect associated treatment outcomes. Thus, for this dissertation, I will examine the relationship between caregiver IPV and attrition for victims CSA.

Research on trauma-focused cognitive behavior therapy (TF-CBT) reports that sexually abused children and their non-offending caregivers ( $N=100$ ) show a significant reduction of trauma-related symptoms  $F(1,85) = 9.57, p < .01$ , depression  $F(1,85) = 3.97, p < .05$ , and externalizing behaviors  $F(1,84) = 4.24, p < .05$ , as well as significantly greater use of parenting skills  $F(1,83) = 9.45, p < .01$  when compared to the control group (Deblinger, Lippmann, & Steer, 1996). Yet high treatment attrition levels prevent abused children from getting the treatment benefits they need (Kazdin & Wassell, 1998; Lau & Weisz, 2003; Phillips et al., 2000; Weed, 2007). In a longitudinal study on abused children and treatment outcomes, Lau and Weisz (2003) found that abused children ( $N = 161$ ) displayed poorer treatment persistence and earlier termination than non-abused children. The literature points to several possibilities for this occurrence within families with concurrent abuse. Firstly, unlike single-victim crimes, families with both IPV and child abuse have two or more victims, most frequently a mother (e.g., non-offending caregiver) and one or more of her children (Dong et al., 2003). As previously established in IPV literature (Rosenbaum & Leisring, 2003), a perpetrator of violence and CSA oftentimes creates a frightening and manipulative atmosphere of power and control over the victim(s), which can undermine the ability of the non-offending caretaker to shield the children from harm. Thus, because families with co-occurring IPV and CSA are typically disorganized, chaotic, and secretive, child victims of abuse are more frequently referred to treatment after it is

discovered by a third-party (e.g., law enforcement, school personnel, etc.) (Renner & Slack, 2006).

Therefore, in CSA cases where IPV is present, there exists a reduced likelihood that the parent-victim will come forward for help due to the risks it poses to the family, such as further physical or sexual harm to the non-offending caregiver and/or the child. Further evidence suggests that higher levels of parental stress are related to lower rates of attendance in therapy sessions (Andra & Thomas, 1998; Kazdin & Wassell, 1998) and higher attrition rates (Kazdin, 1990). In one study examining a sample of child victims of physical abuse, sexual abuse, or neglect who also witnessed IPV ( $N = 105$ ), McNamara (2001) concluded that parental stress interferes with parent's ability to keep their children in treatment. They also found that parent self-report of stress associated with their own parental functioning was the only predictor (across child symptoms, agreement of child and parent report, and parent stress) of child attrition. Other researchers hypothesize that reluctance to seek treatment may be due to the potential legal liabilities faced by a non-offending caregiver who reports abuse, potentially leading to loss of child custody (Koverola et al., 2007).

Another attrition consideration for this population deals with treatment formats that are incongruent with the needs of the victim. Statistics consistently reveal that battered women who flee violent partners frequently take their children with them. Moreover, service delivery for abused women and/or children typically occurs during serious family crisis, many times in domestic violence shelters. Annual statistics released on domestic violence shelters in the state of Florida reveal that the majority of residents are children (Florida Department of Children and Families, 2011). Families with disorganized, chaotic, and ongoing abuse dynamics are less equipped to deal with crisis when compared to more stable, less chaotic families, because going

to treatment actually contributes more stress to the crisis in abusive families (Humphreys, 2008). Research also shows that traumatized abuse victims need longer treatment than others in need of mental health services (Beutler, Williams, & Zetzer, 1994). Yet, battered women typically live in domestic violence shelters for a short period of time, and once they leave, they rarely have the resources available to adhere to treatment recommendations (Sullivan, Basta, Tan, & Davidson, 1992).

High treatment attrition is important to understand because it impedes research efforts seeking to examine treatment outcomes for abused children. Due to problems with treatment engagement and premature termination among maltreated children, researchers cannot retain a sample size large enough to publish on this population (Koverola, Murtaugh, Connors, & Reeves, 2007). For example, widespread attrition among CSA victims hinders therapy outcomes research (Flick, 1988; Howard, Krause, & Orlinsky, 1986; Kazdin, 1994) causing threats to internal validity from clients dropping out of their randomly assigned groups. As a result, researchers may incorrectly conclude that interventions cause the observed changes in outcomes, when in fact these changes result from unspecified attrition-related variables (i.e., socioeconomic status, family dysfunction) (Howard et al., 1986). Research on factors influencing attrition may help therapists increase their support to clients at higher risk for dropping out early in the relationship, as attrition leads to smaller sample sizes, loss of statistical power, and a loss of statistical significance due to loss of participants.

Furthermore, current research on treatment attrition generally focuses on adult populations. In one meta-analysis, Wierzbicki and Pekarik (1993) found that only 16 of 125 attrition studies examined children. Yet researchers estimate child therapy attrition rates to be between 50 and 75%, which are higher rates than those reported for adults (Viale-Val, Rosenthal,

Curtiss, & Marohn, 1984). Due to disparities between adult and child therapy, findings from the adult literature cannot be applied to children and adolescents who drop out of treatment (Kazdin, 1996; Lake & Levinger, 1960; Pekarik & Stephenson, 1988). Adults who seek treatment are generally self-referred, with intake, assessment, and therapy focusing primarily on the individual client. Conversely, children rarely identify and report their difficulties or refer themselves for treatment, and generally do not make the decision to continue or terminate treatment.

Although Lau and Weisz (2003) found that maltreated children more frequently prematurely terminate treatment without therapist consent, their study lumped together child victims of every type of maltreatment, yielding no information about the attrition trends of children with different types or combinations of maltreatment. Thus, while these findings support the notion that maltreated children receive an inadequate amount of interventions to address potentially serious emotional disturbances, CSA researchers should also examine the relationship between caregiver IPV and session attendance and completion rates of children from different subtypes of abuse.

While researchers know little about predictors of attrition for CSA victims, a few studies explore predictors of sexually abused children's entry into therapy. Haskett et al. (1991) and Tingus et al. (1996) found that White children keep their first appointment more frequently and have a higher rate of entry into therapy within six months, compared to Black or Hispanic children. Furthermore, frequently abused children between the ages of 7 and 13 removed from their abusive homes attend treatment more regularly (Haskett et al., 1991). Similarly, Lippert, Favre, Alexander, and Cross (2008) investigated factors associated with families who begin versus decline therapy for children who are sexually abused. They designed their study to explore reasons why many sexually abused children and adolescents never begin psychotherapy,

despite psychotherapy's ability to reduce symptoms associated with CSA (Deblinger et al., 1996; Saywitz, Mannarino, Berliner, & Cohen, 2000). They found that 46% of sexually abused children referred for therapy over a 6-month period never started within 2 months, and caregivers of Black children with lack of transportation decline services more frequently. While research on predictors of treatment entry provides important insight, no studies examine whether a relationship exists between caregiver IPV and specific treatment attendance patterns (e.g., number of sessions attended, number of sessions missed) of sexually abused children.

Historically, researchers explored the relationship between attrition and levels of posttraumatic stress among trauma survivors. Some studies in adults have confirmed a link between posttraumatic stress disorder (PTSD) and treatment attrition (Matthieu & Ivanoff, 2006). Yet, exposure to a traumatic event, such as child abuse, may or may not result in immediate symptoms of traumatization (e.g., PTSD or acute stress disorder). While some survivors of CSA may exhibit few symptoms of traumatization as defined in the *Diagnostic and Statistical Manual of Mental Disorders- 4<sup>th</sup> ed. (DSM IV-TR, American Psychiatric Association, 2000)*, many more child survivors of abuse and/or family violence may develop maladaptive beliefs about and attachments to themselves and others, which in turn, impairs attachment and influences relationships (McCann & Pearlman, 1990). These resulting maladaptive beliefs and attachments are a measure of a child's impaired cognitive self-development (Goodman & Dutton, 1996; McCann & Pearlman, 1990). Because the child's relationship with the therapist plays a role in treatment engagement, it is important for researchers to examine the relationship between posttraumatic stress and trauma-related cognitive schemas together in order to assess whether the combined effects of caregiver IPV and child CSA influences treatment attendance patterns. This two pronged approach of examining both child and family characteristics



simultaneously with attrition patterns may offer a more complete picture for the ways concurrent family violence influences treatment than looking at child and family factors separately. No studies were found examining whether a relationship exists between posttraumatic stress, trauma-related cognitive schemas, and treatment attrition among child victims of CSA with or without caregiver IPV. Understanding this relationship may help clinicians integrate custom treatment plans for sexually abused children and battered mothers within individual, group, and/or family therapy formats in order to bolster treatment engagement.

Studies on attrition rates for maltreated children often control for other, potentially confounding variables. Researchers report inconclusive findings on the impact of demographic variables and treatment attrition. In some studies with non-maltreated children, researchers found a relationship between demographic variables like ethnicity, family structure, socioeconomic status and increased rates of treatment termination (Kazdin & Mazurik, 1994). Yet, other studies comparing child treatment completers and non-completers found no differences on demographic variables (Pina, Silverman, Weems, Kurtines, and Goldman, 2003). Furthermore, no studies exist that control for demographic factors while investigating treatment attrition for CSA and IPV specifically as a pair.

In summary, clinicians should identify children at high risk for treatment dropout early so that they may offer additional support to increase the likelihood of treatment completion (Cohen, Berliner, & Mannarino, 2000). Early identification that occurs at the pre-treatment phase of therapy known as intake bolsters treatment outcomes (Maniglio, 2009). While treatment modality and therapeutic relationship factors (i.e., therapist compassion and client improvement) are important components to consider in treatment outcomes (Brown, 1994; Kazdin & Wassell, 1998; Rogers, 1951), family variables identified at intake have more predictive ability. For

example, treatment characteristics tend to influence relationship factors over the course of treatment, reducing their predictive ability and stability (Briere, 1992; Brown, 1994). Thus, because some pre-treatment factors act as predictors of various post-treatment responses, identifying pre-treatment factors at intake may potentially enhance treatment efficacy regardless of therapeutic modality (Sharp & Power, 1999).

Additionally, more specific studies should explore the relationship between caregiver IPV, child cognitive self-development, traumatization, and attrition patterns of CSA victims. Examining both child and family characteristics simultaneously with attrition patterns may offer a more complete picture for the ways concurrent family violence influences treatment. Koverola et al., (2007) examined treatment attrition trends of maltreated children in violent homes, but the study focused on a heterogeneous sample of children, all of whom had a history of family violence. Horowitz and colleagues (1997) conducted a study on factors affecting utilization of treatment for sexually abused girls. However, this study only examined female “completers,” and thus did not address associations between length of treatment and demographic or other variables. Furthermore, neither the Koverola et al. (2007) study nor the Horowitz et al. (1997) study explored the relationship of caregiver IPV and service usage of CSA victims.

Therefore, after reviewing the literature, no studies examine whether a relationship exists between caregiver IPV and the number of sessions attended and/or missed by a CSA victim. Additionally, I found no studies examining the relationship between caregiver IPV and the reason for a CSA victim’s treatment discharge (e.g., graduation or premature termination). Finally, I found no studies that examine the relationship between caregiver IPV, child cognitive self-development, and posttraumatic stress. Determining the relationship between caregiver IPV on posttraumatic stress, cognitive self-development, service usage, and reason for discharge

among victims of CSA will help clinicians make immediate and practical decisions about treatment planning before the therapeutic relationship begins.

### **Social Significance**

The current dissertation examines a sample of CSA victims with caregivers who either confirmed or denied past or current IPV. Definitions for IPV, historically labeled domestic violence (DV), vary from state to state. In the state of Florida, IPV is defined as "...any assault, aggravated assault, battery, aggravated battery, sexual battery, stalking, aggravated stalking, kidnapping, false imprisonment, or any criminal offense resulting in physical injury or death of family household member by another family or household member" (Fla. Stat. 741.28(2)). Furthermore, there exist both legal and clinical definitions for child abuse in the United States. The federal Child Abuse Prevention and Treatment Act (CAPTA, 2003), as amended by the Keeping Children and Families Safe Act of 2003, defines child abuse as "...any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse or exploitation, or an act or failure to act which presents an imminent risk of serious harm" (42 U.S.C.A. §5106g).

Both IPV and child abuse fit the description of a traumatic event, which is defined by the *Diagnostic and Statistical Manual for Mental Disorders (DSM-IV-TR*; American Psychiatric Association, 2000) as any event witnessed or experienced by an individual where there exists a real or perceived threat of death or serious injury, or where the physical integrity of the self or others is at risk. Likewise, according to trauma theorists McCann and Pearlman (1990), a traumatic event is: (a) sudden, unexpected, and non-normative, (b) exceeds the person's ability to

meet its demands, and (c) disrupts the individuals' frame of reference and other crucial psychological needs and thought patterns.

The basic categories of child abuse reported in the United States are (a) neglect, (b) physical abuse, (c) sexual abuse, and (d) psychological abuse (i.e., witnessing IPV). Neglect is currently the most common form of child abuse in the United States, followed by physical abuse, sexual abuse, and psychological abuse (Hamblen & Barnett, 2010; U.S. Department of Health and Human Services, 2010). The Centers for Disease Control and Prevention (CDC; 2005) estimates that one out of six boys and one out of four girls will be sexually abused before the age of 18, and that up to two-thirds of child abuse goes unreported. Out of approximately 5.5 million children referred to child protective agencies in the United States each year, authorities confirmed child maltreatment cases for 763,000 children in 2009 (Hamblen & Barnett, 2010; NIS-4, 2010; U.S. Department of Health and Human Services, 2010). Nearly 80,000 children were victims of sexual abuse in 2006 (U.S. Department of Health and Human Services, 2008), with an estimated 1 in 20 cases of sexual abuse identified by or reported to authorities (Kellogg, 2005). Moreover, between 3 and 10 million children witness IPV a year, (Jouriles, McDonald, Norwood, & Ezell, 2001), of which 40-60% also include other types of direct abuse (Edelson, 2001). Furthermore, a study on the IPV database of a large county police department revealed that children witnessed 44% of IPV events reported to police (Fantuzzo & Fusco, 2007). Recent reports reveal declining rates of abuse and neglect (Jones, Finkelhor, & Halter, 2006), however abuse and neglect-related child fatalities are increasing, with 1,740 child deaths reported for the year 2008 alone (U.S. Department of Health and Human Services, 2010).

Victims of CSA face higher risks for other negative childhood experiences (Finkelhor & Dziuba-Leatherman, 1994; Madu & Peltzer, 2000). In two studies on adult survivors of child

abuse ( $N = 25, 608$ ), Dong, et al. (2003, 2004) found strong relationships ( $p < .01$ ) between CSA and caregiver IPV, physical abuse, emotional abuse, or physical neglect. Furthermore, abuse in childhood can impact an individual's functioning over his or her lifespan in profound ways, often leading to difficulties in social, cognitive, physical, emotional, academic, and spiritual domains (Goldfinch, 2009; Tomlinson & Philpot, 2008). In addition to PTSD, researchers found that adult survivors of child abuse are at increased risk for developing anxiety disorders, major depression, substance abuse disorders, personality disorders, eating disorders, sexual disorders, dissociative disorders, self-mutilation behaviors, or committing suicide (Cole, Sarlund-Heinrich, & Brown, 2007; Chapman, Dube, & Anda, 2007). Consequently, approximately 80% of abused children meet the criteria for mental health diagnoses by the age of 21 (U.S. Department of Health and Human Services, 2010).

Abused children also face increased risks for accepting violence in adult intimate relationships as a result of distortions in cognitive schemas (Milner et al., 2010; Ponce, Williams, & Allen, 2004). Child victims of abuse are three times more likely to experience additional child abuse, and eight times more likely to experience sexual abuse if they live in a violent home (National Clearinghouse on Child Abuse and Neglect, 2004). Without adequate psychological help, abuse survivors face a significant risk of perpetuating the generational transmission of child abuse, including abusing their own children, or placing their children in high-risk situations (Briere, 1992; Egeland et al., 1987; Faller, 1989; Green, 1998; Simons, Whitbeck, Conger, & Chyi-In, 1991). The cyclical nature of child abuse is far-reaching, with over one third of abused children growing up to abuse their own children (U.S. Department of Health and Human Services, 2010).

Traumatic stress caused by child abuse can negatively influence physical health, as recent studies show that survivors of trauma have higher rates of life-threatening illnesses than the general population, including diabetes, cancer, heart disease, and gastrointestinal disorders (Kendall-Tackett, 2009). Moreover, the financial burden of child maltreatment in the United States is immense, with an estimated \$94 billion spent annually on mental health, medical, and legal costs associated with child abuse (The National Clearinghouse on Child Abuse and Neglect, 2004). Therefore, due to the profound impact child abuse can have on the individual, family, and community levels, there exists a need to continue research on the impact of child abuse on treatment attrition and traumatization.

### **Professional significance**

Trauma researchers first began studying the traumatization and treatment behaviors of child victims of maltreatment over three decades ago (Browne & Finkelhor, 1986; Gully, 2001; Kendall-Tackett, Williams, & Finkelhor, 1993; Maniglio, 2009; Tingus, Heger, Foy, & Leskin, 1996; Waterman, 1986). Researchers agree that trauma is a transformative phenomenon that can produce life-long negative consequences (Saakvitne, 1998). Yet, children often respond to trauma in different ways, with some children developing marked difficulties over the course of their life span, and others experiencing few negative consequences (Bell & Jenkins, 1991; DeVoe, Klein, Bannon, & Miranda-Julian, 2011). Health professionals first sought to identify and measure the effects of traumatic stress through various instruments and assessments in the early 80s when posttraumatic stress disorder (PTSD) initially appeared in the *Diagnostic and Statistical Manual of Mental Disorders- 3<sup>rd</sup> ed.* (DSM-III, American Psychiatric Association, 1980; Varra et al., 2008).

Social and behavioral scientists continue to explore and account for differences in individual reactions to trauma. However, due to complex differences in stressors, socio-cultural settings, ages, developmental stages, and biological and psychological resources, the task of measuring these responses proves difficult (Saakvitne, 1998; Kendall-Tackett, Williams, & Finkelhor, 1993). Historically, researchers approached this task by examining the following: (a) characteristics of the individuals (Anthony & Cohler, 1987; Hershkowitz, 2011), (b) differences in stressors or types of traumatic events (Gelinas, 1983; Yancey, Hansen, & Naufel, 2011), and (c) the unique interaction of the individual and his or her circumstances (Kauffman, Grunebaum, Cohler, & Gamer, 1979; Linehan, 1993; McCann & Pearlman, 1990; Rutter, 1983; Terr, 1990; Varra, Pearlman, Brock, & Hodgson, 2008; Yancey, Hansen, & Naufel, 2011).

Research demonstrates that abused children receiving treatment often experience measureable benefits on personal, interpersonal, and societal levels (Briere, 1992; Cohen & Mannarino, 2008; Ducharme et al., 2000; Finkelhor, 1998; Harvey & Taylor, 2010; Saywitz et al., 2000). As a primary goal, clinicians focus on ensuring child's safety and reducing or diminishing the effects of the traumatization on the child (Foa, Keane, Friedman, & Cohen, 2009; Glaser, 1991). However, clinicians face multiple complex challenges when treating families with abusive dynamics, due to client and abuse-specific factors that might influence the abused child's continuance in treatment. Parents and caregivers play a major role in treatment decisions and treatment success (Henggeler, 1994) as parents influence help seeking, treatment engagement, and treatment outcomes for children in significant ways (Morrissey-Kane & Prinz, 1999). Yet, family systems theory receives criticism for its ability to work effectively with families when the abuse occurs within the family (e.g., intra-familial child abuse) as compared to when the abuse occurs outside of the family (e.g., extra-familial child abuse) (Finkelhor, 1984).

Glaser (1991) listed three challenges inherent for child abuse treatment. First, the dependence of the child on the parent and family system requires treatment support for the entire family. Second, other dysfunctional relationships in the family must be addressed in addition to the abuse relationship. Lastly, secrecy and denial complicate the clinician's ability to effectively treat the family. As a result of these and other treatment complexities, 50% to 60% of maltreated children terminate treatment prior to experiencing the long-term benefits of therapy (Gully, 2001; Kazdin & Mazurick, 1994; Lau & Weisz, 2003).

Furthermore, families with abused children often deal with complex trauma. Complex trauma, also known as multiple trauma, describes the experiences of children who have survived more than one traumatic event. Many children, particularly in the child welfare system, are multiply-victimized, making it difficult for clinicians to identify a single event as the primary stressor (Kaysen, Resick, & Wise, 2003; Webb, 2006). Furthermore, Norris, Murphy, Baker, and Perilla (2003) found that individuals presenting with serious and chronic reactions to trauma also reported a greater number of traumatic events in childhood that often involved violence, along with greater depressive and somatic symptoms.

Complex trauma often confuses the diagnosis for maltreated children. Researchers agree that child abuse and family violence are traumatic events, but the abuse experience alone does not always lead to traumatization. In order to meet Criterion A for PTSD in the *DSM-IV-TR* (American Psychiatric Association, 2000), a child must experience a traumatic event and exhibit a traumatic reaction. Thus, a PTSD diagnosis is given only to the portion of traumatized children who exhibit the specific trauma reactions listed in Criterion B of the *DSM-IV-TR* (i.e. re-experiencing, avoidance, hyper-arousal). Studies estimate that 25% of children in the general population have experienced an extreme stressor like those described in Criterion A, but nearly



30% have experienced other events (i.e. parental arrest, forced separation from family) that also produced intense feelings of fear and helplessness in children (Costello, Erkanli, Fairbank, & Angold, 2002).

While the PTSD criteria provide useful guides for diagnosing children, they often apply during an isolated traumatic event, whereas many children with trauma histories experienced several types of traumatic events during their childhood (Clemmons, Walsh, DiLillo, & Messman-Moore, 2007; Kaysen et al., 2003). Because child survivors of multiple or chronic interpersonal traumas, such as CSA and family violence, present with a broader array of symptoms that are more difficult to categorize, they are frequently misdiagnosed with disorders that do not account for their history of trauma (Terr, 1991). For these reasons, researchers should consider how complex trauma influences both posttraumatic stress and cognitive schemas in studies of attrition for sexually abused children. In a review of 10 years of adult PTSD outcomes (Matthieu & Ivanoff, 2006), researchers found individuals with elevated pretest scores on PTSD assessments dropped out of treatment more frequently than those with lower trauma assessment scores. However, most studies examining the posttraumatic stress or cognitive schemas of sexual abuse survivors examine non-clinical adult populations (i.e. college students), not children (Write, Collinsworth, & Fitzgerald, 2009; Weed, 2007), and none were found to examine the influence of caregiver IPV on the trauma-related cognitive schemas of CSA victims.

Findings on adult survivors of CSA are not generalizable to children due to cognitive developmental differences. Furthermore, adult survivors of childhood sexual abuse must revisit memories of child abuse retrospectively. This exposes evaluation findings to potential distortions of memory, as research shows that adult memories of childhood abuse are not always accurate (Brown, Schefflin, & Whitfield, 1999). Thus, examining the cognitive schemas of clinical

samples of children within months of the abuse event could shed light on how beliefs are shaped immediately following their abuse.

Researchers also should examine the trauma-related schemas of sexually abused children, in light of several unique challenges faced by CSA victims. Research demonstrates that all types of abuse (i.e., physical abuse, psychological abuse, neglect, and sexual abuse) may cause immediate and long-term distress (Koss et al., 1994). Yet unlike victims of nonsexual traumas (e.g. terrorist attacks, natural disasters), sexual abuse victims often do not receive the support they need due to shame, fear, confusion, and a culture that often implicates the victim for their own sexual abuse (Wright, Collinsworth, & Fitzgerald, 2009). As a result, child often survive CSA as a secret tragedy where the victim endures the painful cognitive and emotional consequences of their abuse alone.

A victim's beliefs about themselves and the world can shift dramatically after sexual abuse and IPV exposure, particularly in the areas of safety, trust, and intimacy (Goodman & Dutton, 1996). For example, sexual trauma may teach victims that the world is unsafe and unpredictable, especially if the abuse occurred in a situation previously defined as safe, such as at home or at school (McCann & Pearlman, 1990). Therefore, sexually abused children often internalize the abuse, become depressed, isolate themselves, take on a sexual role with others, and are at increased risk for engaging in self-destructive behaviors and additional victimization over the course of their lifespan (Briere, 1992; Finkelhor, 1998). Treatment reduces these risks, and helps vulnerable child victims learn coping skills to help protect him or herself from future harm.

## **Theoretical Foundation**

A link exists between the variable of child abuse and the constructs of treatment retention and child abuse-related traumatization. Following is a description of two theoretical models that will help in guiding this study: (a) the barriers-to-treatment model (Kazdin et al., 1997) and (b) cognitive self-development theory (McCann & Pearlman, 1990), that serve as the foundation for examining relationships between CSA, caregiver IPV, child abuse treatment retention, and child abuse-related traumatization.

### **Barriers-to-Treatment Model**

The barriers-to-treatment model (Kazdin et al., 1997) proposes that families experience multiple barriers associated with participating in treatment, and that these experiences increase the risk for dropping out. In addition to family, parent, and child characteristics frequently studied as predictors of dropout, the barriers-to-treatment model proposes that practical obstacles to participation (i.e., lack of transportation), poor perceptions of treatment (i.e., caregiver's belief that treatment is unnecessary), and poor therapeutic alliances with the therapist all prevent families from continuing in therapy. Kazdin et al. (1997) argue that family, parent, and child factors identified at intake predict client dropout and premature termination. Furthermore, they assert an association between parent, child, and family characteristics and other barriers often experienced over the course of treatment (e.g., negative alliance with the therapist, poor motivation for treatment, seeing the treatment as irrelevant). In studies examining the impact of treatment barriers on client dropout for youths referred to treatment for oppositional behaviors, researchers frequently focus on parent and family domains assessed at intake because these factors influence dropout more than child characteristics (Armbruster & Kazdin, 1994).

In a study testing the barriers-to-treatment model, Kazdin et al., (1997) found that children who dropped out were more likely than those who completed treatment to have young, culturally diverse, poor, single parents who reported harsh child-rearing practices and had a history of antisocial behaviors in childhood. Furthermore, they found that dropouts demonstrated higher levels of parental stress than did completers. Researchers conducted this study for children in treatment for behavior problems, not maltreated children, and therefore future research should seek to understand how specific parent and family stressors (i.e., IPV) influence treatment dropout for sexually abused children. Furthermore, while researchers consider IPV a significant parent and family stressor, no studies were found that explore whether caregivers of sexually abused children reporting current or past IPV are more likely to prematurely terminate treatment than those without IPV.

### **Cognitive Self-Development Theory**

The current study's theoretical underpinning for measuring child cognitive self-development is cognitive self-development theory (CSDT; McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995; Saakvitne, Gamble, Pearlman, & Lev, 2000). CSDT addresses the question of why trauma shatters some survivors, while others emerge unscathed from their traumatic experiences. Developed while the authors treated survivors of child sexual and physical abuse, IPV, chronic illness, war, and other stressors, CSDT explores an array of variables associated with a person's trauma history to help mental health professionals understand why people have both unique and shared reactions to traumatic events. The theory of CSDT focuses on the interactions between a person and a situation, and emphasizes the positive and negative personal developments that occur from the exposure to a traumatic event.

CSDT fuses concepts from several theoretical frameworks, including trauma theory, self-

development theory, and constructivist educational theory. With its foundations in constructivism (e.g., Mahoney, 1981; Mahoney & Lyddon, 1988; Piaget, 1971), CSDT asserts that reality is subjective, and that humans play a role in actively creating their personal representational model of the world. Thus, reality is the looking glass through which one views the world, categorizes experiences, and assigns meaning to these experiences. Furthermore, CSDT focuses on three dimensions of the individual: the self, traumatic memories, and psychological needs and related cognitive schemas.

McCann and Pearlman (1990) emphasized the role of the “self” as a central element of CSDT, which they defined as the force behind personality and the joiner of the body and mind as a single unit. Further, they reasoned that the self develops from infancy into adulthood as it continuously assimilates and internalizes new information from the surrounding environment. The authors suggest that a child’s interaction with his or her primary caregiver through relationships plays a large role in the development of a child’s sense of self. Additionally, through learning that his or her needs will be met and gaining exposure to social norms by pleasing his or her primary caretaker, the child becomes increasingly independent within society-at-large. Hence, McCann and Pearlman (1990) believe that a person’s family of origin can shape a person’s view of him or herself, others, and the surrounding world.

CSDT describes the self as having several unique attributes. First, the self is comprised of basic capacities that function to maintain a positive self-esteem and inner sense of identity. Some examples of these basic capacities might be a person’s ability to tolerate strong emotion, sustain positive feelings about themselves, or calm oneself in times of stress (Kohut, 1977; Trippany, White-Kress, & Wilcoxon, 2004). Secondly, the self contains ego resources that regulate one’s interactions with the surrounding world. Some examples of ego resources are a person’s

intelligence, self-awareness, empathy, and ability to establish mature relations with others. CSDT identifies ego resources as a key component in enabling trauma survivors to protect themselves when facing future harm. For instance, a person's self-awareness and ability to foresee consequences may help a trauma survivor to establish appropriate boundaries between themselves and others or to make self-protective judgments.

Additionally, CSDT describes the self as having various psychological needs related to cognitive schemas and affected interdependently by trauma. These psychological needs motivate behavior. These psychological needs as follows: (a) frame of reference, or the need to develop a clear framework for understanding one's experiences; (b) safety, or the need to feel protected from harm; (c) trust, or the need to rely on another person to meet one's needs from time to time; (d) esteem, or the need to both value others and be valued by others; (e) interdependence or power, which is described as the need to control one's own behavior, as well as to exert control over others; and (f) intimacy, or the need to feel connected to oneself and to the larger community through individual relationships. These needs and schemas are a central focus of CSDT as it relates to the trauma survivor, because the authors believe that exposure to trauma interferes with one's ability to properly assess and meet his or her own needs in an appropriate manner.

Clinicians working with child victims of sexual abuse focus heavily on assessing and tracking the presence of traumatization in the child. However, not all sexual encounters experienced by children result in traumatization (Child Welfare Information Gateway, 2008). Therefore, in combination with assessing for trauma symptoms, it is important for clinicians and researchers to examine the influence of their sexual abuse on cognitive schemas. In other words, a child may not experience trauma symptoms from sexual abuse, but sexual abuse may leave the

child with cognitive distortions or problematic beliefs, such as, “*It is ok to touch others because it feels good.*” Furthermore, researchers should compare the posttraumatic stress and cognitive schemas of CSA victims with versus without caregiver IPV in order to illuminate the impact of caregiver IPV on a CSA survivor’s beliefs about themselves and the world around them, as well as their attachments to other people – including the therapist. Finally, CSDT contends that disturbances in trauma-related cognitive schemas can influence the therapeutic relationship, and therefore are important factors to consider in studies related to attrition.

### **Purpose of the Study**

In empirically supported therapies for CSA victims, over 80% of traumatized children show improvement within 12 to 16 sessions occurring once a week for 60 to 90 minutes (Cohen et al., 2000; Deblinger, Lippmann, & Steer, 1996). However, high treatment attrition levels prevent abused children from getting the full treatment benefits they need (Kazdin & Wassell, 1998; Lau & Weisz, 2003; Phillips et al., 2000; Weed, 2007). Scholars frequently attempt to research treatment attrition among maltreated children in order to bolster treatment outcomes. However, high rates of treatment attrition impede research efforts. Due to problems with treatment engagement and premature termination among maltreated children, researchers struggle to retain a sample size large enough to publish on this population (Koverola, Murtaugh, Connors, & Reeves, 2007). Moreover, when examining child treatment attrition, it is crucial to consider caregiver variables because caregivers usually make treatment decisions for their children.

Widespread attrition among CSA victims hinders therapy outcomes research (Flick, 1988; Howard, Krause, & Orlinsky, 1986; Kazdin, 1994) and causes threats to internal validity.

Furthermore, attrition may cause researchers to conclude incorrectly that therapeutic interventions cause the observed changes in outcomes, when in fact these changes result from unspecified attrition-related variables (i.e., socioeconomic status, family dysfunction) (Howard et al., 1986). Therefore, researchers should attempt to illuminate possible caregiver factors that influence attrition so that therapists may increase their support to clients and caregivers at higher risk for dropping out early in the relationship.

Although the literature suggests that several demographic, parent, and abuse-related factors influence a child's ability to obtain benefits in treatment, (i.e. age, gender, ethnicity, severity of abuse, severity of symptoms, and caregivers' support in treatment), no studies explore whether a relationship exists between caregiver IPV and a CSA victim's service usage, reason for discharge, cognitive self-development, and/or posttraumatic stress. Identifying these factors may help clinicians adjust their treatment plans to increase the likelihood for successful treatment. The purpose of this dissertation is to examine both child and family characteristics simultaneously with attrition patterns in order to provide a more complete picture for the ways concurrent family violence influences treatment. Specifically, this dissertation aims to determine: (a) whether a relationship exists between caregiver IPV, child cognitive self-development (e.g., self-safety, self-trust, self-esteem, self-control, other-intimacy, and other-control), and posttraumatic stress; (b) whether a relationship exists between child cognitive self-development (e.g., self-safety, self-trust, self-esteem, self-control, other-intimacy, and other-control), posttraumatic stress, and the number of sessions attended and/or missed by CSA clients; (c) whether a relationship exists between child cognitive self-development (e.g., self-safety, self-trust, self-esteem, self-control, other-intimacy, and other-control), posttraumatic stress, and a CSA client's reason for discharge; (d) whether a relationship exists between caregiver IPV and



the number of sessions attended and/or missed by CSA clients; and (e) whether a relationship exists between caregiver IPV and a CSA client's reason for discharge (i.e., graduation or premature termination).

### **Research Questions & Hypotheses**

To contribute to the knowledgebase in the fields of trauma research and counseling, and based on previous theory and research, the proposed research study seeks to answer the following research questions and hypotheses:

#### **Research Question 1**

What is the relationship between caregiver intimate partner violence (IPV; as reported to the National Children's Alliance Database [NCA Trak] by the therapist), posttraumatic stress (as measured by the posttraumatic stress scale of the Trauma Symptom Checklist for Children; TSCC; Briere, 1996), and child cognitive self-development (as measured by the self-safety, self-trust, self-esteem, self-control, other-intimacy, and other-control subscale scores of the Trauma and Attachment Belief Scale; TABS; Pearlman, 2003)?

**Null Hypothesis 1A.** No relationship exists between caregiver IPV, posttraumatic stress, and child cognitive self-development for victims of CSA receiving mental health services at a child abuse agency.

#### **Research Question 2**

What is the relationship between service usage (as recorded on the client discharge summary form), posttraumatic stress (as measured by the posttraumatic stress scale of the Trauma Symptom Checklist for Children; TSCC; Briere, 1996), and child cognitive self-

development (as measured by the self-safety, self-trust, self-esteem, self-control, other-intimacy, and other-control subscale scores of the Trauma and Attachment Belief Scale; TABS; Pearlman, 2003) among CSA victims?

**Null Hypothesis 2A.** No relationship exists between the number of session attended, posttraumatic stress, and child cognitive self-development for victims of CSA receiving mental health services at a child abuse agency.

**Null Hypothesis 2B.** No relationship exists between the number of session missed, posttraumatic stress, and child cognitive self-development for victims of CSA receiving mental health services at a child abuse agency.

### **Research Question 3**

What is the relationship between reasons for discharge (as recorded on the client discharge summary form), posttraumatic stress (as measured by the posttraumatic stress scale of the Trauma Symptom Checklist for Children; TSCC; Briere, 1996), and child cognitive self-development (as measured by the other-safety, other-intimacy, other-control, self-control, self-trust, and self-esteem subscale scores of the Trauma and Attachment Belief Scale; TABS; Pearlman, 2003) among CSA victims?

**Null Hypothesis 3A.** No relationship exists between the reason for discharge (i.e., graduation or premature termination), posttraumatic stress, and child cognitive self-development for victims of CSA receiving mental health services at a child abuse agency.

#### **Research Question 4**

What is the relationship between caregiver IPV (as reported to the National Children's Alliance Database [NCA Trak] by the therapist) and client service usage (as recorded on the client discharge summary form)?

**Null Hypothesis 4A.** There is no relationship between caregiver IPV and the number of session attended for victims of CSA receiving mental health services at a child abuse agency.

**Null Hypothesis 4B.** There is no relationship between caregiver IPV and the number of session missed for victims of CSA receiving mental health services at a child abuse agency.

#### **Research Question 5**

What is the relationship between caregiver IPV (as reported to NCA Trak by the therapist) and client reason for discharge (as recorded on the client discharge summary form)?

**Null Hypothesis 5A.** There is no relationship between caregiver IPV and client reason for discharge (i.e., graduation or premature termination) for victims of CSA receiving mental health services at a child abuse agency.

### **Methodology**

The researcher sought and received approval from the University's Institutional Review Board (IRB). Approval for this research was granted on May 3, 2011 (IRB- ID: SBE-11-07644) after the board determined that the following proposed activity is not human research as defined by Department of Health and Human Services regulations or Food and Drug Administration regulation standards.

## **Research Design**

The current study utilized a correlational research design. Correlational studies are useful when a researcher seeks to measure several variables simultaneously, but unlike experimental design, none of the variables are manipulated. Although researchers cannot infer causality in correlational studies, examining relationships between variables is often the first step toward demonstrating causality for future studies. In other words, things that are causally related must first be correlated.

## **Sampling and Participants**

The present study employs a purposive sampling procedure, which is based on previous knowledge of the population (Fraenkel et al., 2011). Researchers use purposive sampling methods when examining a specific set of criteria within a sample. Thus, the researcher of the present study selected child participants if they received services for sexual abuse, and completed the TABS and TSCC assessments at pretreatment. The present study analyzes data from an existing database containing information about clients receiving services between January 2009 and December 2011 at a child abuse agency in Central Florida. The University of Central Florida (UCF) Marriage and Family Research Institute (MFRI) is the authorized data evaluator for the child abuse agency, and I conducted all research under the supervision of MFRI executive director Andrew P. Daire, Ph.D. The study sample contains 158 victims of CSA between the ages of 9 and 17 who completed both the Trauma and Attachment Belief Scale (TABS) assessment and the Trauma Symptom Checklist for Children (TSCC) at pretreatment. The researcher selected this age range because the TABS is intended for children who are at least 9 years old, and the child abuse agency does not work with individuals older than 17 years old.

Moreover, this study obtained an appropriate sample size based on power analysis in order to reduce the likelihood of Type II errors. For a correlational study, Balkin (2011) defines power as the long-term probability of correctly rejecting a null hypothesis that there is no relationship between variables given the effect size, sample size, and alpha level. Power analyses are calculated before the study begins (e.g. *a priori*) in order to make intentional decisions to avoid accepting a statistical test that fails to reject the false null hypothesis (e.g. Type II error) (Onwuegbuzie & Leech, 2004; Balkin, 2011). Therefore, prior to conducting statistical analyses, I referred to Cohen's (1992) rules regarding sample size in order to identify a median effect size for correlational analyses (power = .80) at the .05 level. With a sample size of 158 participants, I exceeded the minimum recommended sample size (N=102) to ensure adequate power for all five research questions posed in the current study.

## **Instruments**

The researcher gathered information from five client sources for measuring the variables of service usage and reason for discharge, and the constructs of posttraumatic stress and trauma-related cognitive schemas. These sources include existing data from: (a) NCA Trak (b) the Intake Questionnaire, (c) the Trauma and Attachment Belief Scale (TABS), (d) the Trauma Symptom Checklist for Children (TSCC), and (e) the Discharge Summary Form. I include a brief overview of each form or instrument below.

**National Children's Alliance Database (NCA Trak).** The National Children's Alliance Database, otherwise known as NCA Trak, is a national data collection system developed specifically for child advocacy centers (CACs). Based on the information entered into the system, the CAC generates reports on child and caretaker demographics, child protective

services and law enforcement outcomes, screening and referral information, staff caseloads, client service usage (e.g., number of sessions attended and/or missed), session type (e.g., individual, group, family, or crisis), assessment information, the client's presenting information, and client allegations.

**Intake Questionnaire.** The child abuse agency includes the intake questionnaire in the admissions paperwork for clients at the child abuse agency. Clinicians fill out the questionnaire based on both parent and child interview responses to questions about (a) demographic information on both the child and caretaker(s), including whether the family has a history of past or current IPV, (b) details about the abuse and perpetrator, and (c) details about the child's baseline physical, emotional, cognitive, and psychological functioning.

**Discharge Summary Form.** The treating clinician completes the discharge summary form and places it in the client's file after services have ended. The form includes information about the number of sessions attended, whether the client graduated from services after successfully meeting treatment objectives, or whether the child prematurely terminated from treatment. According to the agency, a child prematurely terminates when they leave before meeting all of their treatment goals, the agency administratively discharges the client due to excessive absences, the client drops out of services, the agency finds the child inappropriate for services, or leaves due to special circumstances labeled as "other."

**Trauma and Attachment Belief Scale.** The Trauma Attachment and Belief Scale (TABS; Pearlman, 1996, 2003), formerly known as the TSI Belief Scale revision L (Pearlman, 1996, 2003) is an 84-item assessment designed to measure trauma-related cognitive schemas. Based on Constructivist Self-Development Theory (CSDT; McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995; Saakvitne et al., 2000), which posits that survivors of trauma adopt

maladaptive and dysfunctional beliefs about themselves and others after a traumatic event, the TABS incorporates CSDT and elements selected from existing theoretical and empirical literature on the associations among traumatic stress, cognitions, and needs. Specifically, the TABS measures disruptions in five psychological need areas: (a) safety, (b) trust, (c) esteem, (d) intimacy, and (e) control. The assessment presents items on a 6-point Likert scale, ranging from 1 (strongly disagree) to 6 (strongly agree). Raw scores are added into 10 subscales (e.g. self-safety, other-safety, self-trust, other-trust, self-esteem, other-esteem, self-intimacy, other-intimacy, self-control, and other-control). Evaluation on the TABS for reliability and validity (Pearlman, 2003; Varra, Pearlman, Brock, & Hodgson, 2008) yielded sound evidence of content, construct, and criterion validity. Reliability is also acceptable, with a Pearson  $r$  score of .75, and an internal consistency alpha score of .96.

Based in part on a recent factor analysis of the TABS (Varra, Pearlman, Brock, & Hodgson, 2008), this dissertation will examine subscales most closely associated with the “self,” including: (a) self-safety, (b) self-trust, (c) self-esteem, (d) self-control, (e) other-control, and (f) other-intimacy. According to the authors, two “other” items reflect a child’s view of self in relation to others, rather than one’s view of others. A high score on these subscales reflect a negative view of oneself, including doubting oneself, having disdain for oneself, and/or feeling powerless.

**Trauma Symptom Checklist for Children.** The Trauma Symptom Checklist for Children (TSCC) is a 54-item self-report instrument used with children between the ages of 8 and 16 to assess how often they have thoughts, feelings, and behaviors related to any traumatic events they have experienced (Briere, 1996). Items are rated on a 4-point Likert scale ranging from 0 (never) to 3 (almost all of the time). The measure includes six clinical scales (e.g.,

anxiety, depression, posttraumatic stress, sexual concerns, dissociation, and anger) and four subscales (e.g., sexual preoccupation, sexual distress, fantasy, and overt dissociation). The TSCC is one of the most commonly used measures for exploring sexual abuse sequelae in children and adolescents (Elhai, Gray, Kashdan, & Franklin, 2005). The assessment has moderate to high convergent and discriminant validity (Boyle, 2003) high construct validity, (Sadowski & Friedrich, 2000) and high internal consistency (Bal, DeBourdeaudhujj, Crombez, & Van Oost, 2005; Crouch, Smith, Ezzell, & Saunders, 1999; Lanktree & Briere, 1995).

### **Data Analysis**

I completed a preliminary analysis prior to conducting any statistical analysis in order to identify univariate and multivariate outliers or missing data. I also tested assumptions associated with statistical procedures, such as normality, collinearity and multi-collinearity, conducting all statistical procedures with SPSS. I employed the following data analyses for each of the research questions proposed in this study: (a) Research Questions 1 and 3 utilized a Logistic Regression (b) Research Questions 2 and 4 utilized a Poisson Regression for count data, and (c) Research Question 5 utilized a Chi Square Test for Independence.

### **Definition of terms**

*Child Advocacy Center.* Communities established child advocacy centers (CACs) over 23 years ago to address shortcomings and lack of coordination across agencies involved in treating child abuse victims (Tavkar & Hansen, 2011). Prior to CACs, child victims of maltreatment and their families often navigated through multiple agencies in order to substantiate child abuse allegations and prosecute alleged perpetrators. This increased anxiety for child victims and their



families because it required them to provide details of the abuse to several individuals, and placed a burden of frequent transportation on families commuting from one agency to the next (Jackson, 2004; Smith, Witte, & Fricker-Elhai, 2006). As a result, according to Yeaman (1986), CSA investigations exposed child victims to another form of child abuse known as system-induced trauma. In addition to providing medical screenings and legal consultations to victims of child maltreatment and their non-offending caretaker(s), CACs also provide access to mental health treatment through either on-site therapy or referrals to partnering mental health agencies. For the purposes of this study, I use the terms *child advocacy center (CAC)* and *child abuse agency* interchangeably.

*Child Sexual Abuse* – Child sexual abuse is typically defined from both clinical and legal definitions, with substantial commonality between these two types of definitions. Sexual abuse and exploitation is a subcategory of child abuse and neglect within the Federal definition of child maltreatment in the Child Abuse Prevention and Treatment Act (CAPTA, 2003; 42 U.S.C.A. §5106g). The legal definition is as follows: “...(a) the employment, use, persuasion, inducement, enticement, or coercion of any child to engage in, or assist any other person to engage in, any sexually explicitly conduct or simulation of such conduct for the purposes of producing a visual depiction of such conduct; or (b) the rape, molestation, prostitution, or other form of sexual exploitation of children, or incest with children” (CAPTA, 2003; 42 U.S.C.A. §5106g). Although clinical definitions of sexual abuse are related to statutes, clinicians pay special attention to whether the encounter has a traumatic impact on the child (Child Welfare Information Gateway, 2008).

*Intimate partner violence.* Historically labeled “domestic violence, “the state of Florida defines intimate partner violence (IPV) as, “...any assault, aggravated assault, battery,

aggravated battery, sexual battery, stalking, aggravated stalking, kidnapping, false imprisonment, or any criminal offense resulting in physical injury or death of family household member by another family or household member” (Fla. Stat. 741.28(2)). For the purposes of this study, agency staff record caregiver IPV into NCA Trak if (a) the caregiver verbally informs the therapist during the intake clinical interview that there was or is past or current IPV in the home, (b) the caregiver indicates on one of the written intake forms that there was or is past or current IPV in the home, or (c) if the child abuse agency receives paperwork on the caregiver from local law enforcement or child protective services that indicates that there was or is past or current IPV in the home.

*Maltreatment* – For the purposes of this study, the researcher uses *maltreatment* and *abuse* interchangeably. The federal definition of child abuse in the U.S. is, “...any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse or exploitation, or an act or failure to act which presents an imminent risk of serious harm” (CAPTA, 2003; 42 U.S.C.A. §5106g). While there are several types of child abuse (e.g. neglect, sexual abuse, and physical abuse), the researcher only examines CSA victims in order to meet the objectives of the present study.

*Reasons for discharge.* For the purposes of this study, the CAC describes reasons for discharge as (a) graduation, which occurs when a client successfully attained his or her treatment goals, as outlined in their treatment plan, and as judged by the therapist, (b) administrative discharge, which occurs when the CAC revokes or denies further treatment after the frequent appointment cancellations or no-shows (usually two-to-three sessions in a row), (c) dropout, which occurs when a client completes screening, intake, evaluation, and at least one session of therapy before declining future services, (d) termination after partial completion of goals, which

occurs when the child leaves services before meeting all of their treatment goals, and (e) other, which occurs when the child leaves services for other circumstances not listed above.

*Service usage.* For the purposes of this study, service usage describes the number of sessions attended and/or missed by the client. The variable “number of sessions missed” is the sum of (a) the number of sessions canceled, and (b) the number of times a client failed to show up for a session without prior notification (e.g., “no show”).

*Traumatic event* – The *Diagnostic and Statistical Manual for Mental Disorders* (DSM-IV-TR; American Psychiatric Association, 2000) defines a traumatic event within the diagnosis of PTSD as one in which a person witnesses or experiences an event where there is a real or perceived threat of death or serious injury, or threat to the physical integrity of the self or others. The person experiencing or witnessing event has a reaction of intense fear, helplessness, and horror, however a child may react with disorganized or agitated behavior. Child abuse falls under the domain of this definition, as it results in a serious threat to the physical integrity of a child, sometimes with the threat of death and serious injury, depending on the nature of the abuse. Trauma theorists McCann and Pearlman (1990) further define a traumatic event as: a) sudden, unexpected, and non-normative, (b) exceeding the person’s ability to meet its demands, and (c) disrupting the individuals frame of reference and other crucial psychological needs and thought patterns.

*Trauma-Related Cognitive Schemas* – The term *schema*, first popularized by Jean Piaget (1926), is based on constructivist learning theory and is defined as a cognitive framework or concept that helps organize and interpret information. In constructivist self-development theory (CSDT; McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995; Saakvitne et al., 2000), a trauma-related cognitive schema is a belief or set of beliefs about oneself or others that emerges

after a traumatic event. For the purposes of this study, trauma-related cognitive schemas are outlined by CSDT and include five basic human needs: (a) safety, (b) trust, (c) esteem, (d) intimacy, and (e) control. Pearlman and Saakvitne (1995) defined these five needs in the following ways: (a) Safety is the need to feel secure and free from harm in their environment, and the feeling that others may share this need for security also; (b) trust is the need an individual has to believe that they can depend on oneself, as well as believe their own perceptions and judgments, while also being able to depend on others; (c) esteem is the need to feel valued and respected by oneself, and to value and respect others; (d) intimacy is the need to feel deeply connected to oneself and others; and (e) control is the need to effectively manage one's own feelings and behaviors, and the need to feel capable of managing relationships with some reasonable effect on one's life or the life of others.

### **Limitations**

Some anticipated limitations of the study should be noted. For example, regarding the correlational analyses, etiological conclusions cannot be made about the observed relationships between caregiver IPV, service usage, reason for discharge, posttraumatic stress, and child cognitive self-development. Furthermore, because the present study uses archival data, the researcher cannot monitor data collection procedures at intake between client and clinician, which may threaten the validity of findings.

As is typical in many CAC's (Thackeray, Scribano, & Rhoda, 2010), the child abuse agency does not administer specific IPV assessments to caretakers, and therefore, the records contain little detail about the specific nature of past or current IPV, including the degree IPV exposure experienced by the CSA victim. Instead, the intake therapist records past or current IPV

into NCA Trak with a “yes” or a “no.” They record “yes” if (a) the caretaker verbally confirms past or current IPV in the home, (b) the caretaker indicates in writing the occurrence of past or present IPV in the home on intake paperwork, or (c) if a referring agency provides paperwork to the child abuse agency indicating the presence of past or current IPV in the home. Thus, NCA Trak provides no details on when the IPV occurred or the severity of the IPV, both important factors to consider when examining the impact of IPV on service usage, discharge, and traumatization.

Although efforts will be made to limit threats to internal and external validity within this research study, generalizability may be limited depending on the demographic features of the sample obtained from the child abuse agency. Moreover, all data collection instruments contain some measurement of error even with psychometrically sound qualities (e.g. reliability and validity). The use of self-report measures with children can be problematic because accurate results depend on the child’s ability to accurately comprehend and express thoughts and feelings (Michael & Merrell, 1998; Sadowski & Friedrich, 2000). Furthermore, it is exceedingly difficult, and in many cases impossible, to determine if symptoms like depression, anxiety, hyperarousal, or poor behavior arose after the children experienced a traumatic event, or if these difficulties were evident prior to the event. Yet research shows that child self-report instruments are the best measures for depressive or PTSD symptoms, because children more accurately report internalizing symptoms and distress than their caregivers (Moretti, Fine, Haley, & Marriage, 1984; Muris, Meesters, & Spinder, 2002; Wrobel & Lachar, 1998).

## Chapter Summary

Child maltreatment can profoundly impact an individual's life-long functioning and wellbeing. Even in the absence of PTSD symptoms, maltreatment is capable of shaping an individual's beliefs about and attachments to themselves and others in dysfunctional ways. Ethical clinicians rely on evidenced-based research to inform their practices. Yet due to numerous confounding variables within the research (e.g. cognitive developmental differences, family dynamic differences, abuse-related differences), measuring the psychological effects of child abuse proves complex and a difficult task. Furthermore, while previous studies reveal the benefits of CSA treatment, high attrition rates prevent children from receiving the help they need.

Clinicians benefit from being able to make practical, evidence-based treatment decisions early in their therapeutic relationships with children, especially if such decisions can reduce the likelihood of treatment attrition. While previous studies discovered a link between child, parent, and treatment variables and attrition rates for children, no studies were found that examine the impact of past or current caregiver IPV on a CSA victim's service usage, reason for discharge, cognitive self-development, or traumatization. Therefore, based on previous research, and grounded in both the barriers-to-treatment model (Kazdin et al., 1997) and cognitive self-development theory (McCann & Pearlman, 1990), the purpose of this dissertation is to determine whether relationships exist between past or current caregiver IPV and (a) posttraumatic stress, (b) child cognitive self development, (c) service usage, and (d) reason for discharge for victims of CSA receiving services at a child abuse agency.

## CHAPTER 2: REVIEW OF THE LITERATURE

Boote and Biele (2005) state that a literature review should (a) identify research gaps in existing literature, (b) place the research in the historical context of the field, (c) pinpoint relationships between ideas and practices, (d) provide a rationale for the significance of the problem, (e) present a thoughtful, thorough discussion of key terms, (f) relate ideas back to theory, and (g) synthesize ideas to produce a new perspective on the literature. In line with these guidelines, the following literature review includes an extensive overview of the theoretical and empirical research on treatment engagement and attrition for families of maltreated children, CSA, and IPV. I divided this literature review into two parts: Part I discusses the history, methodological research concerns, theories, and affects of CSA and IPV. In Part II, I discuss treatment resources, effective modalities and formats, and treatment attrition issues for child victims of maltreatment. For each area, I provide an overview of the literature, and narrow the focus to areas most relevant to the specific research questions of the current study.

### **The History and Effects of Family Violence**

#### **Concurrent Family Violence**

Concurrent family violence was not “discovered” by researchers until the late 1970s and 1980s. Prior to this, research, practice, and policy around the different forms of family violence developed into separate disciplines (Finkelhor, 1983; Edleson, 1999, Stanley & Goddard, 2004, p. 247). The Family Violence Research Program at the University of New Hampshire was among the first research programs to link different forms of family violence in their survey of intact families with a physically abused child (Straus et al., 1980; Straus, 1983; Straus and Gelles,

1986; Gelles, 1989). Straus et al. (1980) reported that the highest rate of physical child abuse occurred in families with the highest rates of violence between child-caring partners. Hotaling et al. (1989) also found that families with IPV had higher rates of violence between siblings, adding that children who experienced physical assault or observed IPV between parents were 18 times more likely to assault their parents.

Until recently, concurrent family violence received little research attention (Rossman and Rosenberg, 1998). In the late 1980s and mid 1990s, more studies began to uncover the link between IPV and child maltreatment. One study reported that violence by men towards a female partner was present in almost two-thirds of the families with child maltreatment present (Stark & Flitcraft, 1988). In another study of 104 children, Goddard and Hiller (1993) found a strong association between physical and sexual abuse of one child and accompanying sibling maltreatment in one family. This was also one of the first studies to establish a robust link between IPV and CSA, with 40% of the families reporting this combination of co-occurring abuse. Furthermore, Marker et al. (1999, p. 54) reported that ‘parental sociopathy’ predicted the CSA more strongly than parental substance use and overall family functioning.

While research has revealed a clear association between these two forms of family violence (e.g. Bowen, 2000; Edleson, 1999, Humphreys et al., 2001; Humphreys, 2003; Osofsky, 1995; McGuigan & Pratt, 2001; Rossman et al., 2000; Stermac et al., 1995) the strength of this association varies widely, both estimates of co-occurring CSA and IPV at between 30% and 70% of families. However, these variations are most likely explained by differences among abuse definitions, samples, and variable examined (Stanley & Goddard, 2004).

The current dissertation examines a sample of CSA victims with caregivers who either confirmed or denied past or current IPV. Because research on concurrent family violence is



limited, I will discuss the history and effects of CSA and IPV separately in the following sections.

### **The History of Family Violence America**

During the Victorian Era, social and sexual norms placed an emphasis on monogamous marriage and nurturing family practices, and yet IPV and child physical/ sexual abuse were not uncommon (Jamieson, 1998). Over the course of history, males overwhelmingly perpetuated abuse against wives and children. Laws and religious writings promoted the idea that men should have authority over women and children (McKie, 2005). Furthermore, various religions, political theories and parties, and social policies provided support for the marriage as the core relationship for the bearing and rearing of children, with the needs of the family members and maintenance of the home being met through the employment of one or more of the adults outside the home. Van Every (1995) discusses how the early American family system promoted the differentiation of sex roles, with husbands and fathers considered breadwinners, and wives as mothers and unpaid domestic workers who provided emotional support for the family members. Moreover, families who did not conform to this model were considered disorganized, a label that was applied more frequently to lower class households.

Early tolerance for physical abuse and other forms of violence in the home widely differs from today's standards. Mays (2004) points out that while physical violence of a husband toward a wife was universally condemned, only a few colonies formally outlawed it. The historical emphasis of the mother as the primary caretaker of children, along with societal pressures on families to conform to certain roles and images of the cohesive and supportive network perpetuated a shameful stigma among those who experienced or witnessed family violence

(Schneider & Schneider, 1994). As a result, cultural attitudes and assumptions about family life had an influence on the number of abuse reports in early society. Furthermore, early social service and government workers hesitated to intervene in family affairs due to fears of public backlash (McKie, 2005). Therefore, historians often struggle to capture a detailed historical perspective of family violence in the early colonies because most of the cases were never reported to authorities.

Battered women had few resources in colonial America, although some went to almshouses for shelter when they were in serious physical danger (Mays, 2004). Because a man's reputation was directly associated with his business success and community standing, an abused woman's only tool for stopping her abuse was to publicize it to the community. If rumors emerged about a man's violent behavior, patrons would typically avoid doing business with him. Thus, public humiliation through publicity of the violence was said to correct the behavior of abusive men toward family members in colonial America (Mays, 2004).

Each colony had differing legal perspectives on spousal abuse. For example, as noted by Mays (2004), Pennsylvania had no laws against marital violence, unless a woman was maimed or in fear for her life. Conversely Massachusetts had laws against marital violence, and even verbal abuse between spouses was punishable by whipping. Furthermore, there was no concept of marital rape in colonial America. Additionally, because early American men consumed a large amount of alcohol, usually beginning with a mug of beer at breakfast, alcohol was frequently cited as a factor in early domestic violence (Mays, 2004). Battering men often attempted to justify or minimize their behavior to police and judges, especially if the woman lacked evidence of serious injuries. Moreover, women who sought shelter at almshouses had to leave once their injuries were healed.

Unlike spousal abuse, the colonies had very few laws or social rules regarding corporal punishment of children, as many were seen as legitimate means of parental discipline. As long as a parent justified their physical abuse to a child on the grounds of child rebellion, they were safe from laws citing that physical punishment could not be inhuman, barbarous, or excessively cruel. On the contrary, a child's obligation to obey and respect a parent was expected into adulthood, and they could be prosecuted for physical or verbal abuse toward a parent even after the child married and lived in another home (Mays, 2004).

### **Child Sexual Abuse**

Finkelhor (2009) argues that children are the most criminally victimized population in American society. According to the U.S. Department of Justice National Crime Victimization Survey (NCVS; Baum, 2005) derived from detailed interviews with over 100,000 citizens annually between the years of 1993 and 2003, researchers found that the rate for aggravated assault, rape, and overall violence against youths 12-to 17-years-old more than doubled the rate for the general population. Furthermore, juveniles are two to three times more likely than adults in America to suffer violent rape, robbery, or aggravated assault.

Yet, prior to the late 1970's, researchers considered CSA uncommon (Putnam, 2003). Social historians suggest that members of the medical, legal, and social welfare communities suppressed societal awareness of CSA repeatedly for a century and a half. In the 1990s, researchers investigated the country's overall disinclination to recognize or take action on the problem of CSA (Conte, 1994). In their review of historical literature from the 18th and 19th centuries, Olafson, Corwin, and Summit (1993) found that early public and health professionals poorly received discussions on the effects of CSA. Olafson and colleagues found that this cycle

of acknowledgment-to-suppression continued into the 20<sup>th</sup> century, and linked the phenomenon to Freudianism, sexual modernism, and gender politics.

In the late 19<sup>th</sup> century, claims of sexual crimes against child laborers working in the fields and factories began to surface (Hillerstein, Hume, & Offen, 1981). Sexual predators targeted, assaulted, and exploited vulnerable child domestic servants, often resulting in adolescent prostitution (Sanger, 1937; Simpson, 1988). Slave owners subjected slave girls to rapes and forced “breeding” (Hellerstein et al., 1981, p. 196) and sold Chinese slave girls as prostitutes in San Francisco until the early 20<sup>th</sup> century (Hellerstein et al., 1981, p. 47). During this time, social welfare workers linked CSA with poverty, overcrowding, and the promiscuity of the poor, signifying the prevalent attitude in Victorian cultural ideals that focused on sexual purity and social propriety (Jeffreys, 1987).

Early societies for the prevention of cruelty to children established in the mid 1870’s further stereotyped “typical” CSA victims as poor children from uneducated families, as evidenced by the fact that CSA investigations focused primarily on poor, working class, immigrant families (Peck, 1987). Class and cultural norms of the late 19<sup>th</sup> century viewed CSA as a deplorable and scandalous act that only occurred among certain kinds of people, casting a shadow of shame and secrecy on victims. Workers in the mental health, medical, and legal fields often attributed CSA to mental illness or the result of “the female malady” (Showalter, 1987, p. 56). Furthermore, lawyers and judges legally dismissed many victims of CSA treated by mental health practitioners, as John Henry Wigmore (1904) illustrates in the following passage:

Modern psychiatrist have amply studied the behavior of errant young girls and women coming before the courts in all sorts of cases. Their psychic complexities are multifarious, distorted partly by inherited defects, partly by diseased derangements of

abnormal instincts, partly by bad social environments, partly by temporary physiological or emotional conditions that of contriving false charges of sexual offenses by men. (p. 736-737).

Thus, the medical, legal, and social welfare industries widely viewed victims of sexual trauma as having a medical condition with a biological basis, such as heredity, urban living conditions, or the female gender, and did not view CSA as the cause of psychological impairment (Goldstein, 1982; Zilboorg, 1941). Olafson et al., 1993 states that the focus on the individual, rather than the systemic causes of CSA, had a pervasive effect on society's attitude toward CSA. Masson (1984) asserts that social welfare workers framed allegations of CSA as false please for attention, further suppressing CSA victims by labeling them as liars. Subsequently, they also believed that any mental illness or perversion associated with sexuality resulted from sexual misconduct, not sexual victimization.

At the turn of the century, Sigmund Freud introduced his seduction theory (Breuer & Freud, 1957) breaking with previous medical discourse on the issue of CSA. Although later he built a sizable body of work on an entirely different hypothesis (Masson, 1984; Myers, 2006), Freud's seduction theory was the first to describe the persistent psychological effects of CSA (Myers, 2006; Olafson et al., 1993). Freud believed that "nervous energy" such as hysteria, obsessions, paranoia, and repressed memory were all "functional psychoses" caused by CSA (Masson, 1984; Freud, 1989, p. 109). Freud's seduction theory refuted the notion of victim false accusation by noting that it is only with reluctance and the expression of genuine emotion that adult survivors recall their experiences of CSA (Breuer & Freud, 1957). Freud stated that the trauma of incest occurred as a result of the power imbalance between perpetrator and child, and that women were hysterical due to their CSA experiences, not their gender (Breuer & Freud,

1957; Masson, 1984). Moreover, Freud dismissed conventional thinking about social class and CSA when he declared that incest occurred in all types of families, across all cultures and social classes, and declared psychoanalysis as the ultimate treatment for victims to absolve neurotic symptoms. However, Freud abandoned seduction theory after the scientific community largely rejected it.

Soon afterward, social welfare leaders of the time turned their attention to issues of inadequate food, shelter, clothing, and living conditions, diminishing the priority of issues like child physical and sexual abuse (Costin, 1992). Furthermore, states Costin, attention to CSA also declined due to ideological conflicts between family-focused agencies, lack of social services to support the juvenile court, widespread social and economic displacement during the Depression, and the rise of psychoanalytic theory, which frequently discredited the practice of protective work.

Even with Freud's advanced thinking on the issue of CSA, many still believed that the problem derived from the victim's perception of CSA. In one famous example, Alfred Kinsey, zoologist and founder of the Institute for Sex Research at Indiana University, found that 25% of 4000 female respondents reported sexual abuse by an older male in childhood, and 80% of these women described the experience as frightening (Kinsey, Pomerey, Martin, & Gebhard, 1953). In response, Kinsey wrote, "...it is difficult to understand why a child, except for its cultural conditioning, should be disturbed at having its genitalia touched" (p. 121). Conte (1994) surmised that Kinsey's questioning of the legitimacy of the women's fear response demonstrated how society placed the responsibility for the experience of sexual abuse on the victims themselves.

In her book on CSA, Bolen (2001) states that early theories on childhood sexual abuse focused primarily on father-daughter incest, and frequently attributed abuse to (a) seduction by the daughter, (b) collusion by the mother, and (c) incest as a symptom of family pathology. Early theorists based these notions on family systems theory that appeared in the professional literature in the 1960s and 1970s (Carper, 1979; Machotka, Pittman, & Flomenhaft, 1967). As was typical during the time period, early theorists often shifted blame away from the offender, stating that all members of the family, including the mother and the victim, played a role in the initiation and maintenance of father-daughter incest (Kadushin & Martin, 1988).

Blaming the victim of CSA became a trend in several early writings (Bolen, 2001). For example, Sigmund Freud's psychodynamic theory posited an internal etiology for CSA (Rush, 1996). Early psychological conceptualizations of CSA victims reveal the influence Freud's Oedipus complex, as clinicians often told victims reporting abuse that they were confusing their abuse memory with their fantasized desire for their unavailable love object (i.e., the father). In a later study, Krieger, Rosenfeld, Gordon, & Bennett (1980) divided incest victims into two groups: those who had encouraged the initiation or continuation of a sexual relationship, and those who had not. Moreover, if the abuse had occurred more than once, researchers assumed that the victim actively participated. Yates (1982) made similar statements when he concluded, "...the majority of youngsters have become not only victims but participants" (p. 482), furthering that children who did not report abuse reacted to the "gratification that the incest provides" (p. 482). In 1985, Jackson and Sandberg expressed concern about victim blaming in the professional literature:

The mere existence of a victim blame factor, however slight, reflects an apparent belief that incest victims may in some way be responsible for their own assault, and that

children... may be held less than fully innocent in their actions in sexual matters when approached by adults who are most often family members, relatives, or people they know well and trust" (1985; p. 54).

Cohen (1983) suggested that some victims of father-daughter incest initiated and participated in the abuse to keep a dysfunctional family together. In their presentation of incest as a symptom of family dysfunction, James and Nasjleti (1983) divided mothers into four groups: (a) the passive-child woman mother, (b) the intelligent, competent, distant mother, (c) the rejecting, vindictive mother, and (d) the psychotic or severely mentally retarded mother. However, they included no categories for innocent or supportive mothers. Moreover, in an early study on attribution of blame in CSA, Dietz and Craft (1980) concluded that 65% of social workers viewed the mother as equally responsible for incest as the abusing father, and believed that 85% of mothers gave their consent through ignoring the problem. However, empirical literature on non-offending mothers widely discredits the view that non-offending mothers are responsible for the sexual abuse of their children (Gavey, Florence, Pezaro, & Tan, 1990; McIntyre, 1981; Myer, 1985; Wattenberg, 1985).

Other historians argue that early cultural anxiety prohibited open recognition that CSA was a problem needing the immediate attention of social workers and lawmakers. Conte (1994) explains:

Clearly, complex psychological, cultural, and political processes are involved in recognizing and responding to childhood sexual abuse. Turning from the societal level to the individual level, the idea that individual experience, psychological problems, or other psychological processes influence a person's willingness to entertain the possibility that many children are sexually abused is consistent with current understanding in psychology



about how individuals deal with anxiety producing ideas or experiences... Thus, because child sexual abuse stirs up strong emotions, denial, minimization, and rationalization have always played a central role in the societal response to child sexual abuse. (p. 227).

At the turn of the century, child welfare weakened as feminism underwent a period of latency between 1920-1960 (Gordon, 1988; Costin, 1992). In the 1970s, however, feminists, mental health practitioners, and adult survivors of CSA began to publicly acknowledge the prevalence of CSA. Olafson et al. (1993) points out that feminists drew attention to the gendering of sexuality and CSA, stating, "...they explicitly linked the long silence about this violence to institutionalized patriarchy" (p. 17). The feminist movement emphasized systems of power and the institutionalization of gendered norms, such as male privilege, that allowed CSA to be common and accepted. It publicized the inequality between men and women in the formal (e.g. legal, medical) and informal (e.g., family) institutions that governed everyday life.

In addition to abused children, women victims of IPV often could not seek justice in the legal system because police considered these offenses as either private matters or fabrications by the victim (Diesen, 2009a,b; Simon, 1995, 1999). In a study examining 392 felony assaults in Chester, Pennsylvania between 1983 and 1984, researchers identified police as less likely to arrest men who assault their wives than men who commit other assaults (Fyfe, Klinger, & Flavin, 1997). In one example, they found that police did not arrest a batterer who dropped his wife over a banister that was several stories high. Prompted by the feminist movement, police lenience, police inaction, and civil litigation against police departments, reform movements in the late 1970s and early 1980s impelled many cities to adopt mandatory and presumptive arrest practices in order to rectify the legal treatment of IPV (Simon, Ellwanger, & Haggerty, 2010).

Researchers and feminist theorists attribute the previous lack of attention toward CSA

and IPV victims to societal male privilege. Finkelhor (1984) points out that while institutionalized male privilege existed both in the workforce and in the family, professionals such as doctors, lawyers, and judges most frequently ignored the widespread problem of CSA perpetrated by men. Accordingly, feminists linked the root of sexual violence with the sexual entitlement of dominant masculinity or male sexual privilege, and rejected the notion that only a few sexually deviant men perpetrated CSA (Brownmiller, 1975; Butler, 1978; Cossins, 2007). The feminist message of empowerment made it admirable to identify oneself as a CSA survivor, which in turn, ushered in a slew of studies documenting the prevalence and outcomes of CSA (Whittier, 2009).

Between the years of 1978 and 1984, researchers and mental health professionals paid increased attention to the issue of CSA after the publication of five pioneering books: *Conspiracy of Silence: The Trauma of Incest* (Butler, 1978), *Sexual Assault of Children and Adolescents* (Burgess, Groth, Holmstrom, & Sgroi, 1978), *Sexually Victimized Children* (Finkelhor, 1979), *The Best Kept Secret: Sexual Abuse of Children* (Rush, 1980), and *Sexual Exploitation: Rape, Child Sexual Abuse, Sexual Harassment* (Russell, 1984). The publication of these landmark books ushered in an era of increased CSA research and scholarship in the medical, mental health, social service, and legal professions (Conte, 1994).

During this pioneering period of the late 1970's and early 1980s, David Finkelhor emerged as one of the key researchers in the area of child victimization and CSA. His 1979 survey of college students caught the attention of researchers around the country, after he estimated that one in four females and one in five males were the victims of forced sexual contact before the age of eighteen. These early publications influenced an "explosion of research" (Conte, 1994, p. 225) as well as several congressionally mandated studies known today

as the National Incidence Study (NIS) series.

The NIS series provides estimates of the incidence child abuse and neglect in the United States, while also measuring changes in incidence from earlier studies (Conte, 1994). In 1974, Public Law (P.L.) 93–247 mandated the first NIS (NIS–1), reflecting data from 1979 and 1980. Lawmakers mandated the NIS–2 under P.L. 98–457 (1984) and reflects data from 1986. The NIS–3, mandated by the Child Abuse Prevention, Adoption, and Family Services Act of 1988 (P.L. 100–294) and the Child Abuse, Domestic Violence, Adoption and Family Services Act of 1992 (P.L. 102–295), reflects data from 1993. The Keeping Children and Families Safe Act of 2003 (P.L. 108-36) mandated the NIS–4, the most recent version, which reflects data from 2005 and 2006.

It is interesting to note that the method for counting child abuse cases varies widely across sources. For example, NIS studies tally child abuse cases differently than Child Protective Services (CPS), resulting in fluctuating and contradictory figures. The NIS studies included children who were investigated by CPS, but also obtained data on children who were not reported to CPS. Furthermore, NIS counted children who were screened out by CPS without investigation but who were recognized by community professionals as maltreated (U.S Health and Human Services, 2010). Thus, researchers examining child maltreatment should contemplate the method of measurement, as the information will vary depending on the data source (Begle, Dumas, & Hanson, 2010). For example, commonly used methods for obtaining child maltreatment incidence rates contain self-reports from caregivers and the number of referrals to CPS. Yet, these methods have numerous problems and limitations including caregiver hesitancy to disclose abuse or neglect (Ammerman, 1998) and difficulties in retrieving CPS administrative databases (Chaffin & Valle, 2003), which results in underestimated rates of abuse and neglect

(Chalk & King, 1998). The fluctuating incidence rates for childhood sexual abuse stirred debate among researchers about the many methodological dilemmas facing child abuse and neglect research. Subsequent sections of this literature review list these limitations in detail.

### **Intimate Partner Violence**

Researchers first began studying IPV, also known as intimate partner violence (IPV), fifty years ago, particularly in the areas of criminal justice, mental health, and social sciences (Barner & Carney, 2011). Prior to the mid-1800s, no laws existed in the colonial system of English Common law protecting women from assault or battery. In 1871, Alabama rescinded the “husbandly” right to physically punish a spouse before any other state (Fulgrahm vs. State, 46 Ala. 143). Shortly thereafter, states like Massachusetts, North Carolina, and Maryland passed laws forbidding spousal violence that included penal measures of corporal punishment, fines, and jail time for perpetrators (Lemon 2009; Martin 1976; Schechter 1982).

By 1914, a Chicago court separated IPV from other types of assault, introducing the requirement that perpetrators receive psychological treatment in addition to jail time, while victims of domestic abuse received aid from social workers (Dobash & Dobash, 1992). Responding to the “perpetrator-centric” criminal justice paradigm (p. 236), a ruling of a California superior court stated that the spousal abuse statute discriminated on the basis of gender, labeling the law unconstitutional because men who abuse women receive a felony count, while women who abuse men receive a misdemeanor (Martin 1976; Eisenberg & Seymour, 1979). To the dismay of many, however, this resulted in the dismissal of a domestic homicide case, but no further change of the law.

With increases in women's rights and the emergence of women's suffrage and feminism, an atmosphere of female empowerment led to a women's shelter movement in 1967 (Lemon, 2009). The first shelters operated from private residences and apartment buildings, and paved the way for national shelters and grassroots coalitions dedicating to securing funds to protect women and raise public awareness about IPV (Barner & Carney, 2011). The increased public awareness ushered in significant increases of victims seeking services, causing severe space limitations that resulted in the denial of nearly 70% of requests for services (Schechter, 1982). With the passage of laws such as the Victims of Crime Act (1984) and the Violence Against Women Act (Title IV, sec. 40001-40703 of the Violent Crime Control and Law Enforcement Act of 1994, HR 3355), shelters received more federal funding and compensation for victims (Lemon, 2009).

In the mid 1980s, public attention turned to widespread police refusal to intervene in IPV offenses (Diesen, 2009a,b; Simon, 1995, 1999), and lawmakers began enacting strict police protocols in relation to cases involving violence against women. In 1984, a domestic assault case in Connecticut receiving national attention (*Thurman vs. City of Torrington*), spurred a movement to increase police training, arrests, and enforcement of restraining orders. The U.S. District Court for Downstate Connecticut stated:

City officials and police officers are under an affirmative duty to preserve law and order, and to protect the personal safety of persons in the community. This duty applies equally to women whose personal safety is threatened by individuals with whom they have or have had a domestic relationship as well as to all other persons whose personal safety is threatened, including women not involved in domestic relationships. If officials have notice of the possibility of attacks on women in domestic relationships or other persons, they are under an affirmative duty to take reasonable measures to protect the personal

safety of such persons in the community...[A] police officer may not knowingly refrain from interference in such violence, and may not automatically decline to make an arrest simply because the assailant and his victim are married to each other. Such inaction on the part of the officer is a denial of the equal protection of the laws (595 F.Supp. 1521)

At the same time, however, community-based and therapeutic organizations continued to face difficulties with funding and government support as they evolved separately from law enforcement (Danis 2003; Goodman and Epstein 2005; Shepard 2005; Stover 2005; Wathen and MacMillan 2003). Funding issues still exist today (Barner & Carney, 2011). In one recent example, California Governor Arnold Schwarzenegger cut 100% of funds for IPV shelters, necessitating the allocation of emergency federal funding to maintain existing shelters (Stannard, 2009).

In recent years, congress amended IPV laws to focus on children affected by violence in the home, either as victims or as witnesses. Research shows a potential for children to be harmed by witnessing the occurrence of violence in the home, even if they are not direct victims of the violence (Child Information Gateway, 2009). Furthermore, children who live with IPV face increased risks for exposure to traumatic events, neglect, direct abuse, and losing one or both parents (Carlson, 2000; Edelson, 1999; Rossman, 2001). Subsequent sections of this literature review address the various childhood problems associated with IPV exposure.

### **Methodological Dilemmas**

Before discussing historical theories and research on the effects child abuse and their relation to treatment attrition, it is important to first outline the unique methodological dilemmas faced by child abuse researchers. Considerable controversy exists concerning the relationship

between child abuse and later negative outcomes (Maniglio, 2009). Researchers face several challenges when examining child abuse due to many complex factors, including self-selection biases for research participation, a lack of uniformity in definitions, varied classification of different forms of maltreatment, determination of appropriate comparison groups, and determining what constitutes a representative sample (Briere, 1992; Browne & Finkelhor, 1986; Ferguson, 1997; Putnam, 2003). In their review of the literature regarding studies from the 1970s and 1980s, Browne and Finkelhor (1986) called for several methodological improvements after concluding that many of the early child abuse studies contained sample, design, and measurement problems that invalidated their findings. They stated that most of the studies prior to 1986 lacked standardized outcome measures and adequate comparison groups, and described the empirical literature on the effects of CSA as “sketchy” (p. 75).

Furthermore, Manly (2005) points out that past research draws conclusions based on single subtypes of abuse without assessing for the co-occurrence of additional types of abuse. “Because of the high frequency of multiple subtype co-occurrence, research on maltreatment requires a well-conceptualized and empirically sound rationale for handling comorbidity to prevent it from obfuscating distinctions among subtypes and the relative contributions of each” (p. 432). Thus, examining the overlap of different abuse combinations helps researchers better understand the impact.

In his systemic review of reviews on the impact of CSA on health, Maniglio (2009) discussed these methodological issues in CSA research. He points out that many studies employ serious design and measurement problems, including poor sampling methods, absence of a control group, and inadequate control for effect modifiers and confounders (see Briere, 1992; Kilpatrick, 1987; Sharpe & Faye, 2006). While there have been dozens of published literature

reviews on CSA research in the last 20 years, many reviews are characterized by inaccuracies and bias (Rind & Tromovitch, 1997; Rind et al., 1998), while some do not specify data sources or criteria for including studies.

Meta-analytic reviews are more objective and use more rigorous and transparent approaches to reduce bias, inaccuracy, and subjectivity, yet some researchers criticize the combination of findings from studies that are too clinically or methodologically dissimilar for a meta-analysis (Centre for Reviews and Dissemination, 2008; Lipsey & Wilson, 2000; Maniglio, 2009), disguising genuine differences in effects (Higgins & Green, 2006). Thus, inconsistencies among studies and reviews cause interpretative difficulties, mistaken beliefs, and confusion among those turning to empirical literature for guidance (Maniglio, 2009). Below is a list of the most common methodological errors that have occurred in previous child abuse and attrition research.

**Sample.** Sample heterogeneity, or differences in sample characteristics across studies, frequently distorts CSA and IPV research findings. Many early CSA researchers based their studies on samples of either adult women seeking treatment, or children whose sexual abuse was reported to authorities. Self-selected samples potentially distort the sense of pathology most victims experience as a result of their abuse, especially if reports include only the most seriously affected victims. While Brown and Finkelhor (1986) called for more studies of victims not seeking treatment or who failed to report their abuse, they also cautioned against advertising in the media for “well adjusted” victims, as Tsai et al (1979) did, causing an equally misleading selection bias.

Furthermore, studies seeking to uncover characteristics that predict treatment dropout for victims of child abuse are limited by the use of variables of convenience (e.g., socioeconomic



status, marital status). Researchers examine these variables frequently because they are easy to retrieve from clinic data. Moreover, selecting overly broad predictors obscures the possible mechanisms involved in client attrition. Furthermore, studies on the effects of CSA and IPV often lack a true control group. Without a control group, researchers cannot assess how CSA or IPV victims differ from other children in the general population. Therefore, researchers suggest matching clinical sources with schoolmates, relatives, or unvictimized siblings.

**Instruments.** Early CSA studies utilized overwhelmingly subjective instruments. Beyond recommending the use of empirically standardized and objective measures, Brown and Finkelhor called for the development of “special sexual abuse outcome instruments” (1986, p. 76) in order for clinicians to show the true extent of pathology related to the experience of sexual abuse in childhood. Furthermore, a review of the literature for IPV measures revealed a shortage of instruments specifically designed to measure the phenomena of partner abuse, despite growing clinical and research interest.

**Special Populations.** Early researchers frequently made conclusions about the effects of CSA from studies examining “deviant” special populations, such as prostitutes (James & Meyerding, 1977; Silbert & Pines, 1981), sex offenders (Groth & Burgess, 1979), or psychiatric patients (Carmen, Rieker, & Mills, 1984). Browne and Finkelhor stressed the importance of avoiding the conclusion that sexual abuse causes “deviance,” but also conceded that many such offenders were abused in their backgrounds (1986; p. 76).

**Identifying the source of trauma.** A large number of external factors prevent researchers from concluding that changes are due to the independent variable. As a result, researchers should examine differences among clinics, therapist, therapeutic approaches, children, and parent engagement. As a result of these and other meaningful differences between

children who dropout of treatment and children who graduate, study findings are largely unreliable and inconsistent.

Furthermore, earlier studies failed to account for other factors that potentially contributed to trauma after sexual abuse. For example, family conflict or emotional neglect makes children more vulnerable to abuse and might exacerbate later trauma (Brown & Finkelhor, 1986). Moreover, painful social reactions after disclosure may intensify a traumatic reaction post abuse. Due to the difficulty of addressing retrospective long-term impact studies, researchers should use data on children that includes family information (i.e., pathology, IPV) predating the abuse.

**Definition.** Perhaps most problematic, a comprehensive, universal definition of CSA fails to exist in the literature. Holmes and Slapp (1998) found that many studies use different operational definitions of CSA, including: a particular age difference between child and perpetrator, abuse that includes force and coercion, or the use of physical contact (e.g. fondling or penetration). Some definitions require that the victim responds negatively to the abuse, and that perpetrators are viewed as authority figures over the child. In their review of the literature, Rind et al. (1998) found that fifty-nine studies used different definitions of CSA. The breakdown of their findings is as follows: (a) 70% of the studies defined CSA with various age discrepancies (i.e., perpetrator five years older, victim under the age of 12), (b) 73% of the studies defined it as including contact and/or noncontact (i.e. fondling or penetration versus exhibitionism), and (c) 24% percent of the studies viewed CSA as contact-abuse only. Therefore, until researchers utilize a universal operational definition of CSA across research studies, prevalence findings will lack generalizability to all victims of CSA.

**Preoccupation with long-term effects.** Finally, Brown and Finkelhor (1986) pointed out the “adultcentric” bias in childhood trauma studies. Earlier studies tended to overemphasize the

long-term impact of child abuse on adult survivors. Researchers should not dismiss childhood traumas if they have no measurable “long-term effects” because CSA and IPV cause immediate pain and confusion in the life of a child. In a more recent review of child abuse research, Putnam (2003) found that researchers derive statistics on the prevalence of CSA and IPV mainly from retrospective accounts from both clinical and nonclinical samples of adults who were abused as children. This further confuses prevalence findings as a function of (a) selection and response rate, (b) definition used, and (c) method of obtaining abuse history (e.g. self-report versus structured interview).

In one study involving child participants, findings far exceed the number of cases reported in official government victimization statistics at the time. In a survey of 2000 children aged 10 to 16 years, Finkelhor and Dziuba-Leatherman (1994) found that the rate for assault was three times higher and the rate for rape was five times higher than National Crime Survey (NCS, 1991). Furthermore, only about half of the respondents reported their abuse at the time of the survey. Finkelhor and Dziuba-Leatherman (1994) concluded that these discrepancies illustrate the advantages of using children as respondents, as opposed to adults abused in childhood.

### **Theoretical Models of Abuse**

Rotter (1954) emphasized the importance of theory in psychology, stating that theory provides a way of understanding pieces of an individual’s experience which otherwise might seem unrelated. It allows a clinician to make connections, to guide exploration, and to help a client acquire a framework for understanding his or her experience (McCann & Pearlman, 1990). The construction of theories on the causes and effects of CSA helps researchers and therapists identify important clinical factors regarding sexual offenders, as well as possible causal

mechanisms responsible for CSA (Ward & Siegert, 2002). While theories of trauma adaptation first surfaced in the 1800's, theoretical models focusing specifically on the impact of CSA did not appear in the United States until the 1980s (Chantler et al., 1993). The following theoretical review is not exhaustive, but rather examines several models from diverse viewpoints to emphasize contemporary thinking on the topic of CSA.

**Multiple Dynamics Models.** Some early theorists proposed conceptual frameworks known as *multiple dynamics models* focusing on the influence of multiple factors related to both the abusive situation and the abusive act. One such example is Summit's (1983) CSA accommodation syndrome, which, "...allows for the immediate survival of the child within the family but tends to isolate the child from eventual acceptance, credibility, or empathy within the larger society" (p. 179). CSA accommodation syndrome outlines common dynamics that result in the most frequently observed victim behaviors, and presents five states leading to negative outcomes: (a) secrecy, (b) helplessness, (c) entrapment and accommodation, (d) delayed, conflicted, and unconvincing disclosure, and (e) retraction. Within the *secrecy* and *helplessness* categories, the child learns that the abuse situation is bad or shameful, and that the child is at fault because the child cannot stop the abuse. This environment also increases the likelihood that abuse will go unnoticed or be ignored by other adults (Freeman & Morris, 2001). When the child does not seek or receive protection from the abuse, *entrapment and accommodation* occurs in which the child develops survival skills. Pathological dependence, domestic martyrdom (i.e. assuming the role of the parent or taking care of the rest of the family), self-punishment, self-mutilation, substance abuse, and multiple personalities represent coping behaviors thought to help the child function and survive the abuse event. When the child can no longer function within these accommodation mechanisms, *disclosure* occurs. Finally, Summit (1983) says

*retraction* (e.g. recanting the disclosure) occurs when adults do not believe the child, or when the child seeks to preserve the family.

Another popular example of a multiple dynamics model, Finkelhor and Browne's (1985) traumagenic dynamics model, provides a conceptualization for the impact of CSA based on four trauma-causing factors. The authors assert that while these dynamics occur in many types of trauma, CSA impacts children in a unique way. Finkelhor and Browne (1985) label these four dynamics (a) traumatic sexualization, (b) betrayal, (c) powerlessness, and (d) stigmatization. *Traumatic sexualization* describes the process through which a child's sexuality becomes inappropriately shaped due to the abuse, resulting in repetitive sexual behaviors, promiscuous or compulsive sexual behavior, a higher risk for prostitution, re-perpetrating the abuse to others, confusion about sexual identity, and eventually, an aversion to sex and intimacy. *Betrayal* occurs when a trusted non-abusing family member demonstrates the inability or unwillingness to protect the child from the sexual abuse, resulting in grief, depression, increased hostility and anger, and a proclivity for relationships that are psychologically, physically, or sexually abusive. *Powerlessness* develops when the child continually and ineffectively tries to avoid or stop the abuse. Lastly, *stigmatization* describes the shame and guilt that develops, for example, when a perpetrator or someone else blames or demeans the child for the abuse. While both of these models provided some of the first conceptual frameworks for understanding the effects of CSA, little empirical support exists for the contention that a specific CSA syndrome exists. Furthermore, both authors state that they used clinical experience, rather than any empirical or experimental data, to develop their theories (Freeman & Morris, 2001).

**Information-Processing Models.** Horowitz (1975) created the theory of information processing, which describes the cognitive and emotional reactions and physical responses to

trauma. The theory proposes that traumatic events cause a series of predictable phases of traumatic information processing, including strong emotional reactions and physical responses, which are followed periods of numbing and denial. After this comes an oscillatory period with stages of "... intrusive ideas or images, attacks of emotions, or compulsive behavior alternating with continued denial, numbing, or other indications of efforts to ward off the implications of this new information" (Horowitz, p. 769). Eventually, asserts Horowitz, the individual reaches a period of transition and integration, resulting in less frequent uncontrolled attacks of emotion, and increased stability of mood, conceptualization, and acceptance of the meaning of the event. Furthermore, until the traumatic event integrates into existing cognitive schemas, mental images of the event become stored in active memory, which has a fundamental tendency of repetition.

In another early theory of information processing, Burgess et al. (1987) developed a conceptual model of CSA based on the assumption that resolution of a traumatic event occurs only when an individual sufficiently processed it, allowing for storage of the information in the memory. Furthermore, until the memory of the event transfers from active, or present, to past memory, resolution of the trauma will not occur. Burgess et al. (1987) further contends that unresolved traumatic events lead to *trauma encapsulation*, causing an individual to continually experience the event at conscious and unconscious levels, making them vulnerable to PTSD. Burgess et al., list several examples of defense mechanisms leading to trauma encapsulation, including dissociation, fragmentation, drive disharmony, repression, splitting, suppression, and compartmentalization. *Dissociation* occurs, according to the authors, when the, "... mind fragments psychic integrity in the service of survival" (p.34), helping the child divert attention away from the sexual abuse event. Second, *fragmentation* of the ego occurs when a disturbance emerges in the integration of the different personality functions (e.g., sense of self, memory,

learning) causing a division or splitting of these functions. Third, *drive disharmony* occurs when a disruption emerges in the body's arousal mechanisms, leading to avoidance, hyperactivity, or continuous physical complaints. *Repression* occurs when an individual blocks the traumatic event from memory, rendering them unable to recall the event. Similarly, *suppression* describes the child's ability to recall certain aspects of the abuse only when cues are provided. *Splitting* occurs when a person's instincts conflict with the reality commands of the environment. Lastly, *compartmentalization* develops when projection or direct confrontation are the only pathways to the memory of the abuse. While the information processing model is based on a significant body of research (Freeman & Morris, 2001), the authors fail to provide ample explanation on what constitutes as "enough" processing so that the memory can move from active to past memory.

**Psychoanalytic Models.** Theories focusing on the aftereffects of trauma first surfaced in the late 1800s. Freud and Breuer (1885/1955) described three separate psychoanalytic theories of trauma: (a) unbearable affect theory, which focused on emotions that overwhelm the psyche and produce psychological aftereffects, (b) unacceptable impulse theory, which hypothesizes that traumatic events generate a struggle between the ego and some idea presented to it, and (c) repetition compulsion theory, which states that individuals re-experience a traumatic event in an attempt to master it, but simultaneously engage in avoidance behaviors.

In another psychoanalytic model of trauma, Krystal's (1978) theory of catastrophic trauma makes a distinction between adult and childhood responses to trauma, labeling adults as better equipped to anticipate and defend themselves when triggered by intense emotions. More specifically, adults possess the capability of anticipating and blocking overwhelming emotions before they occur. Children, on the other hand, cannot tolerate a flood of intense, overwhelming emotions, placing them in a psychological state of complete helplessness.

In another psychoanalytic theory, Lifton (1976) based his symbolization theory of trauma on survivors from war and natural disasters. He proposed that individuals cultivate images and symbols of their life experience that contribute to a sense of continuity or discontinuity, and that trauma disrupts these primary symbols. Furthermore, Lifton (1988) describes five manifestations of this disruption. While some of these mainly are applicable to victims of disasters, others are also applicable to survivors of CSA and IPV, especially the final three. The five manifestations are as follows: (a) the death imprint, or vivid memories of death or destruction associated with death anxiety, (b) death or survival guilt, in which a survivor experiences guilt over surviving a traumatic event where others did not, (c) psychic numbing, or the inability to feel as a defense against anxiety, (d) impaired human relationships, resulting in disconnectedness from other human beings, and (e) the need for transformation. Lifton (1988) describes the fifth manifestation by stating:

And here we come to the survivor's overall task, that of formulation, evolving new inner forms that include the traumatic event which in turn requires that one find meaning or significance. Formulation requires establishing a lifeline on a new basis. That basis includes proximate and ultimate involvements. The survivor seeks vitality both in immediate relationships and ultimate meaning, the one impossible without the other (p. 26).

In the 1970s, a self psychology perspective of PTSD emerged from the psychoanalytic tradition (Kohut, 1971, 1977). In his earliest works, Kohut asserted that the root of all severe psychopathology surfaces from repeated empathic failures by parental figures. To this end, traumatic stress theorists posited that self psychology is relevant to understanding the self



pathology that is sometimes associated with extreme trauma in childhood, including dissociative states like self-fragmentation, flashbacks, depersonalization, and derealization.

In the mid 1980's, researchers and clinicians explored the framework of PTSD to the consequences of CSA (Briere, 1992; Herman, 1992; Kiser et al., 1988; Lindberg & Distad, 1985; Wolfe et al., 1989). Sexual abuse meets the definition of trauma as defined by the *Diagnostic and Statistical Manual* (Lindberg & Distad, 1985; Wolfe et al., 1989), because many abusers engage in sexual acts with children resulting in pain and physical injury (e.g. vaginal or anal penetration) (Browne & Finkelhor, 1986). While the PTSD conceptualization adequately explains some of the presenting problems observed in some children, not all people experiencing PTSD display the symptoms outlined in the DSM (McLeer et al., 1988). Furthermore, not all sexual abuse results in traumatization, and focusing only on the potentially traumatic events of the abusive act may cause clinicians to ignore other situational factors that are important to consider. Therefore, the PTSD framework is not an overarching explanatory model for all negative effects of CSA (Freeman & Morris, 2001).

**Biological and Behavioral Models.** Theories on biological responses to trauma describe the physiological changes in the brain after trauma exposure. Van der Kolk (1988) created a theory based upon the animal model of inescapable shock. This model states that inescapable shock produces an enormous emission of neurotransmitters, followed by a depletion of these neurotransmitters. Van der Kolk states that this biological disruption results from receptor hypersensitivity in the brain, and creates over-responsiveness to trauma-related stimuli. These reactions are similar to symptoms of PTSD, including nightmares, flashbacks, dissociative episodes, and intrusive re-experiencing.

Other theorists explain the persistence of anxiety, avoidance, and hyperarousal associated with PTSD with classical conditioning and learning theory. According to classical conditioning theory (Pavlov, 1927), a threat experience emerges as an unconditioned stimulus that evokes a response of anxiety and fear. If a stimulus becomes associated with a threat, it can produce unpleasant emotional states and negative behaviors, even if the stimulus was previously perceived as non-threatening. Once a person learns avoidant behaviors that develop in response to “conditioned” stimuli, the pattern of negatively reinforced avoidance-seeking behaviors is difficult to extinguish, as noted in Kilpatrick, Veronen, & Resick’s (1982) longitudinal study on long-term reactions to rape. Furthermore, empirical support exists for Kilpatrick, Veronen, and Resick’s (1979) original hypothesis that fear and anxiety responses linger in some rape victims as a result of being classically conditioned by the experience. For example, Calhoun, Atkeson, & Resick, 1982) found that rape victims responded with extreme fear to rape stimuli (e.g. knives, genitals) and attack vulnerability stimuli (e.g., being alone, darkness).

Finally, the theory of learned helplessness (Walker, 1977) was proposed to help explain reactions including chronic depression, passivity, and futility in battered women. Seligman (1975) explained that learned helplessness occurs when people believe or assume their reactions will not change the future likelihood of environmental outcomes, which is consistent with predictions from social learning theory (Rotter, 1954). However, warns McCann and Pearlman (1990), while the theory is useful for conceptualizing some victim responses, it is not all-inclusive, nor does it account for the inconsistency in victim responses across different traumatic events.

**Developmental Models.** Many of the primary theoretical conceptualizations on the traumatic effects of child maltreatment have roots in John Bowlby’s (1973) attachment theory.

Bowlby's work in behavioral science led to a paradigm shift in the understanding of the human system of behavior, which he described as biologically based and instinctive. He hypothesized that attachment behavior becomes activated by physical and environmental threats, including threats to relationships (e.g. rejection or separation from the primary caregiver). According to his theory, attachment is a system of behavior that exists between a primary caregiver (e.g. attachment figure) and their child (Bowlby, 1988; Bretherton, 1985). The purpose of the attachment system is to guarantee the child's proximity to the attachment figure in order to facilitate survival (Bolen, 2002). In his book on parent-child attachment, Bowlby (1988) states that young children exhibit behaviors (e.g. crying) in order to elicit caregiving behaviors from the attachment figure, thereby making the relationship both dyadic and reciprocal. Bowlby hypothesized that an attachment figure's response to a child's needs consequently shapes the infant's perception of the world. Thus, when attachment figures are responsive, children develop a strong sense of security (Bowlby, 1973). With safety, states Bowlby, comes an internalized security within the child to explore the surrounding world. This secure base is a central concept of attachment theory, enabling a child to separate from caregivers, explore the environment, and return to a warm and soothing caregiver. Hence, the goal of the attached person is *felt security* (Bretherton and Waters, 1985).

Within attachment theory, Bowlby introduced the concept of "working models," which are the child's unconscious perceptions of the attachment figure and his or her self (Crittenden, 1990). Accordingly, children develop expectations about his or her role in relationships as a function of these working models. These inner models of self, others, and the relationship between self and others serve as the foundation for personal-social development, with the most vital 'other' being the primary caregiver(s). Furthermore, a child's perception of his or her own

worthiness is determined from perceptions of the caregiver's availability, ability, and willingness to provide protection and care (Bowlby, 1973). Working models therefore serve as unconscious rules for guiding and organizing behaviors in relationships, which are constantly adjusted throughout life and experience (Crittenden, 1990; Bretherton, 1990).

To this end, children with insecure caregiver-child relationships develop an expectation that others are not trustworthy, while also recognizing that their needs will not be met.

Attachment theorists describe these insecure attachments between child and caretaker as avoidant, disorganized, and ambivalent. Conversely, in relationships that are secure, children adopt internal positive messages that originate from secure attachments (Bowlby, 1988).

Eventually, the child can use the positive symbolic representations of attachment figures to feel secure even without the physical presence of the caregiver. Therefore, as summarized by Bolen (2002), attachment is (a) physiologically based, (b) universal, (c) predictive of future relational patterns, (d) intergenerationally transmitted, and (e) directional (e.g., transferred in the direction from the attachment figure to the infant or child).

Alexander (1992) proposed that the attachment theory framework highlights some of the long-term effects of CSA. Alexander states that attachment theory (a) explains how abusive relationships may develop within the family structure, and (b) elucidates how abuse leads to various long-term consequences for adult CSA survivors. Accordingly, states Alexander, a history of insecure attachments for either abusive or non-abusive parents sets the stage for sexual abuse of the child to occur. Thus, a parent with a history of rejection during childhood, role reversal, or unresolved trauma has a diminished capacity to appropriately meet his or her own needs, or to meet the needs of others.

Researchers have studied the constructs of attachment theory since its inception in the 60s and 70s. Solomon and George (1999) concluded that there is enough evidence of predictive validity from longitudinal studies to suggest that attachment patterns of infants are a robust construct. Van Ijzendoorn and Sagi (1999) furthered that attachment patterns of infants are stable across cultures. Moreover, several researchers have built on Bowlby's original attachment theory. Ainsworth et al. (1978) identified and categorized different types of attachment behavior from observing children's responses to being reunited with their primary caregiver following a brief separation. These categories of attachment behavior are (a) secure, (b) insecure-avoidant, (c) insecure-ambivalent/ preoccupied, and (d) disorganized-disoriented.

Attachment theory views the event of child abuse as producing insecure attachments between child and caregiver (Crittenden & Ainsworth, 1989; Cicchetti & Toth, 1995; Styron & Janoff-Bulman, 1997), an indication for later social and emotional problems according to researchers of anxious attachment (Lewis et al., 1984). Furthermore, distorted patterns of relating shape the child's perception of the world, possibly resulting in a negative internal model of self (Schneider-Rosen and Cicchetti, 1984; Egeland and Erickson, 1987; Bowlby, 1988; Crittenden, 1988). Using an attachment framework, Bentovim (1988) details how significant harm can impact a child's view of self, future life, and future relationships.

Alexander (1992) linked subtypes of insecure attachments to long-term effects of CSA. For example, he hypothesized that insecure-avoidant attachment predisposes the adult survivor of sexual abuse to revictimization, difficulties with interpersonal relationships, hypervigilance, anxiety, phobias, and borderline personality disorder. Additionally, avoidant attachment may predispose a person to denial-based coping, memory avoidance, or an inability to express emotion or intimacy with others. Furthermore, disorganized attachment may lead to dissociative

coping style, PTSD, borderline personality disorder, or dissociative identity disorder. However, there is little empirical evidence linking sexual abuse to any one pattern of insecure attachment (Bacon & Richardson, 2001). As a result, researchers use theories containing a specific trauma focus (e.g., constructivist self-development theory) more widely in order to conceptualize the effects of CSA.

**Cognitive Models.** Aside from measuring posttraumatic responses to child abuse, there are several theories that focus on the impact abuse has on an abused child's beliefs and assumptions about him or herself and the world. Some of these theories attempt to explain PTSD by focusing on the impact that trauma has on schemas and defenses in regulating the processing of information. One cognitive model of trauma response is Janoff-Bulman's (1985) shattering of the assumptive world theory. Like other researchers who state that traumatic life events alter a person's basic beliefs and assumptions about themselves and the world, this theory focuses on three major assumptions that are disrupted by trauma: (a) the belief that one is not vulnerable to misfortune, (b) the perception of the world as meaningful, and (c) the perception of the self as a positive entity. This is closely related to Epstein's (1985) cognitive-experiential self-theory, which states that trauma affects:

...the degree to which the world is regarded as benign versus malevolent, the degree to which it is regarded as meaningful (including predictable, controllable, and just), the degree to which others are regarded favorably rather than a source of threat, and the degree to which the self is regarded as worth (p.2).

Furthermore, states Epstein, an individual must develop a modified theory of reality that can incorporate the traumatic experience in order to stabilize the disruptions of schemas resulting from PTSD.

Another common theory on trauma-related cognitive schemas is schema theory (Young et al., 1994, 2003). Young and colleagues discuss the role of early care in the development of particular beliefs and assumption held by an individual. They assert that physically, sexually, or emotionally abused children face increased risks for developing maladaptive schemas early in life. Examples of these schemas include *vulnerability to harm* (i.e., “I constantly feel that something bad is going to happen”) and *defectiveness* (i.e. “Something is wrong with me, and therefore I should not reveal myself to people”). Young et al., (2003) hypothesizes that early maladaptive schemas accumulate over time, shaping how an individual perceives their experience of the world and interacts with others, making them more susceptible to depression and other forms of mental illness.

Finally, constructivist self-development theory (CSDT) is the theoretical basis for the current study. Incorporating concepts from constructivism, social learning theory, object relations theory, and self psychology literature, CSDT posits that a trauma survivor’s view of themselves and the world are disrupted after a traumatic event, thereby affecting all future perceptions (McCann and Pearlman, 1990). CSDT differs from attachment theory in that it emphasizes the individual’s role as an active agent in creating and construing his or her reality, a view that is basic to any constructivist theory (Mahoney, 1981; Mahoney & Lyddon, 1988; McCann & Pearlman, 1990). Based on the philosophical thinking of Immanuel Kant, and the psychological works of Wilhelm Wundt, Alfred Adler, George Kelly, and Jean Piaget, constructivism suggests that an individual’s representational models of self and others actively create and limit new experience, thus determining what the individual will perceive as reality (Mahoney & Lyddon, 1988).

Developed by Lisa McCann and Laurie Anne Pearlman (1990) after working with victims of rape, childhood sexual and physical abuse, war, IPV, chronic illness, accidents, and other serious stressors, CSDT focuses on understanding the individual variations in adaptation to trauma. The authors define “adaptation to trauma” as a complex interplay between life experiences (e.g. personal history, specific traumatic events, sociocultural context) and the developing self (e.g. self capacities, ego resources, psychological needs, cognitive schemas about self and world) (p. 6). Furthermore, they hypothesize that trauma emerges after exposure to a non-normative or highly stressful event (or series of events) that disrupts the self. CSDT rejects the *core-symptoms* notion that all people have an easily identifiable syndrome following a traumatic event. Rather, the theory highlights each individual’s complex and unique response to trauma, where personal meanings and images of the event encompass the deepest parts of a person’s inner experience of the self and world (McCann & Pearlman, 1990).

The *Diagnostic and Statistical Manual for Mental Disorders* (DSM-IV-TR; American Psychiatric Association, 2000) defines a traumatic event within the diagnosis of posttraumatic stress disorder (PTSD) as one in which a person witnesses or experiences an event where there is a real or perceived threat of death or serious injury, or threat to the physical integrity of the self or others. The person experiencing or witnessing the event endures a reaction of intense fear, helplessness, and horror, however a child may react with disorganized or agitated behavior. Child abuse falls under the domain of this definition, as it results in a serious threat to the physical integrity of a child, sometimes with the threat of death and serious injury, depending on the nature of the abuse.

CSDT expands on this definition in several ways. Firstly, the CSDT definition of trauma reflects a deeply constructivist view of personality, that labels an experience as traumatic if the



individual perceives it so. Hence, as McCann and Pearlman state, "...one person's trauma may be another person's difficult experience" (p. 12). Thus, CSDT describes the characteristics of a traumatic event as (a) sudden, unexpected, and non-normative, (b) exceeding the individual's perceived ability to meet its demands, and (c) disrupting the individual's frame of reference and other central psychological needs and related schemas. This definition, however, does include some expected experiences, such as ongoing incest, if the event is considered non-normative in larger society. Adapted from Richard Lazarus's (1966) transactional model of stress, this definition emphasized the incongruity between the demands of the situation and the individual's perceived capacity to meet those demands.

*CSDT and Development.* The CSDT view of development is grounded heavily on object relations theory (Mahler, Pine, & Bergman, 1975) and self-psychology literature (Kohut, 1971, 1977). According to CSDT, an infant develops an increasingly differentiated sense of self and style relating to others as he or she interacts with significant people in his or her environment. Over the course of the life span, the individual develops a unique constellation of self capacities, ego resources, psychological needs, and cognitive schemas leading to psychological growth. As derived from object relations theory, CSDT posits that a child realizes he or she is a separate person that must sometimes participate in need-fulfilling activities after experiencing the mother's inability to perfectly understand what the child wants (Philipson, 1985). While initially a child needs others to provide emotional stability for the emerging self, they become increasingly able to meet their own physical and psychological needs with less external support after receiving appropriate validation and encouragement.

Drawing on Piaget's cognitive developmental theory (1971), CSDT states that as an individual grows and develops, they increasingly assimilate the surrounding environment into

their existing schemas of experience. These schemas are comparable to mental representations of self and others, similar to Bowlby's concept of working models. According to Piaget (1971), when the environment presents new information that cannot be assimilated into existing schemas, cognitive schemas become altered or accommodated. The complex interaction and balance between accommodation and assimilation yields to the evolution of the psychological system. McCann and Pearlman (1990) refer to this growth as "progressive self development" (p. 7). Thus, trauma disrupts, at least temporarily, an individual's psychological growth due to the psychologically challenging process of accommodating the trauma into their existing schemas.

Furthermore, CSDT expands on the social learning theory (Rotter, 1954) concept that the development of a unique self occurs through a process of reinforcement. For example, an infant gradually learns how to get important needs met (i.e. hunger, thirst) by pleasing the caretaker or engaging in whatever behaviors will prompt the appropriate reaction. Hence, in a positive early environment, the child will continue to develop the ability to get needs met while growing increasingly independent with the ability to maintain close and interdependent relationships with others (McCann & Pearlman, 1990).

CSDT also contends that life experience becomes encoded in the memory system, and the individual associates these memories with strong emotions and other vivid sensory impressions (Paivio, 1986; Brett & Ostroff, 1985). As a result, the pain of reemerging traumatic imagery creates a defensive propensity within an individual to avoid this material. An individual experiences reemerging traumatic imagery as painful because it challenges the self-resources and disrupts his or her psychological needs and cognitive schemas about self and world.

Furthermore, CSDT states that the previous developmental history of the individual, including the evolving self, needs, and schemas, shapes what is remembered about the trauma and how the

event is experienced and interpreted. Therefore, the process of healing and transformation requires bolstered self-capacities, balanced psychological needs, and modified schemas in order to incorporate new information in a way that enables the individual to experience pleasure and contentment in his or her life.

According to CSDT, the evolution of three separate complex psychological systems influences development. These systems include (a) the self, or an individual's sense of themselves as a knowing, sensing being, capable of regulating self-esteem and ego resources to negotiate relationships with others; (b) psychological needs, (e.g. frame of reference, safety, trust, esteem, intimacy, and power); and (c) cognitive schemas, which are conceptual frameworks for shaping and deciphering experience. McCann and Pearlman (1990) hypothesize that the self is the foundation of an individual's identity and inner life, encompassing (a) basic self capacities that maintain a sense of identity and positive self esteem, (b) ego resources, which regulate an individual's reactions to the world around them, (c) psychological needs that motivate behavior, and (d) cognitive schemas, which are the conscious and unconscious beliefs, assumptions, and expectations through which a person construes their experience (see Table 1.2). I describe these elements in more detail in the following sections.

Basic self-capacities are the first aspects of the self. McCann and Pearlman (1990) discuss four self-capacities that relate to survivors of trauma, including victims of CSA, central to understanding the internal experience of trauma. They describe the first self-capacity as the aptitude to regulate powerful emotions without self-fragmentation or acting out. In other words, a person possesses the capability of experiencing deep feelings of pain or anxiety without a major or permanent disruption to psychological functioning. McCann and Pearlman describe the second self capacity as the ability to be alone without being lonely (Winnicott, 1958), therefore

allowing the person to spend time alone without encountering overwhelming feelings of emptiness. Next, they describe the third self-capacity as the ability to calm oneself through the use of self-soothing techniques. This means that the individual can usually recuperate from emotional anguish without overreliance upon other people or external supports. Finally, the last self-capacity is the ability to face criticism or guilt without enduring intense self-loathing that might severely or permanently damage his or her sense of self worth.

The next aspects of the self are ego resources. Derived from Murray and Kluckhohn's (1953) definition, McCann and Pearlman describe these as conscious aptitudes used to relate to people and/or tasks outside of oneself in a constructive way. The first group of ego resources helps CSA survivors to process their traumatic experience in a therapeutic manner. They include intelligence, willpower, empathy, initiative, the ability to strive for personal growth, the ability to view things from multiple perspectives, and the ability to be introspective. The second group of ego resources helps aid the survivor to protect himself or herself from future harm, including the ability to predict consequences, the capacity to create mature relations with others, the ability to establish and enforce personal boundaries with others, and the ability to make self protective judgments. Therapy tends to be more effective with CSA survivors when their ego resources and self-capacities are well developed (McCann & Pearlman, 1990).

The third aspect of the self is psychological need. While psychological needs are not always within an individual's awareness (Murray & Kluckhohn, 1953), they motivate and shape behavior and interactions with others. CSDT adopts the following list of central psychological needs from Rotter's (1954, p. 74-77) social learning theory: (a) frame of reference, or the need to develop a clear and reliable framework for understanding one's experience; (b) trust/dependency, or the need to believe in the word or promise of another, and occasionally depend

upon others to meet one's needs; (c) esteem, or the need to be valued by others as well as to value others; (d) independence, or the need to control one's own behavior and rewards; (e) power, or the need to direct or exercise control over other things; and (f) intimacy, or the need to feel connected to others through relationships and/or belonging to a larger community (McCann & Pearlman, 1990). McCann and Pearlman hypothesize that CSA disrupts one or more of these needs, resulting in negative assumptions, beliefs, or expectations known as cognitive schemas.

CSDT labels cognitive schemas as the next aspect of the self. The term "schema" came into modern psychology through the writings of Head (1920), Piaget (1926), and Bartlett (1932), and is defined as the cognitive manifestation of psychological needs. Thus, in psychologically healthy adults, schemas are a set of expectations that flow and respond with the environment (Jordan, 1984). For CSA survivors and other victims of trauma, the most salient schemas are those related to the seven psychological needs listed above. Traumatic experiences impact and/or disrupt schemas in a manner that determines how the traumatic experience is coded in the memory. I list these aspects of the self, as described by McCann and Pearlman (1990), in Appendix A.

In conclusion, cognitive schemas, self capacities, ego resources, and psychological needs develop simultaneously and can impact one another. Westen (1989) found that negative schemas emerge if self capacities are underdeveloped, leaving the individual in a constant state of internal chaos and low self esteem. In another example, if a trauma survivor lacks the capability to sooth himself or herself, they will likely exist in a state of emotional turmoil. Conversely, if the survivor demonstrates impaired affect tolerance, they may feel nothing, as is the case with some trauma survivors. Hence, if an individual holds the self schema, "I can't handle emotion," it

could potentially lead to either severe anxiety or emotional numbing. Furthermore, McCann and Pearlman's (1990) summary of the major assumptions of CSDT is provided in Appendix A.

### **How Family Violence Affects Victims**

Epidemiologic and clinical studies began to identify negative sequelae associated with a history of CSA and IPV three decades ago, especially psychopathology (Molnar, Buka, & Kessler, 2001). Moreover, many of the studies examining the developmental impact of CSA and IPV indicate numerous of emotional, cognitive, and behavioral symptoms associated with the abuse experience. Frequently co-occurring adverse family conditions, such as marital strife, separation from biological parents, caregiver IPV, family mental illness, parental substance abuse, and physical abuse potentially result in multiplying effect on a child's traumatization (Mullen, Martin, Anderson, Romans, & Herbison, 1993; Briere & Runtz, 1990). Molnar, Buka, and Kessler (2001) found that the prevalence of psychiatric disorders among those reporting CSA was much higher than the general population. Moreover, the most frequently reported symptoms of maladjustment after sexual abuse are depression, anxiety, dissociation, conduct disorders, aggressiveness, and early sexual behavior (Bagley, 1991; Bagley & McDonald, 1984; Caffaro-Rouget, Lang, & van Santen, 1989; Dutton & Hart, 1992; Fromuth & Burkhart, 1989; Higgins & McCabe, 1994; Kolko & Moser, 1988; Mayall & Gold, 1995; Mullen, Martin, Anderson, Romans, & Herbison, 1994; Swanston, Tebbutt, O'Toole, & Oates, 1997; Trickett, McBride-Chang, & Putnam, 1994; Widom & Ames, 1994). However, even with these trends, no sexual abuse syndrome has been confirmed to emanate from CSA (Paolucci, Genuis, & Violato, 2001).

In addition to direct forms of child abuse, witnessing IPV may produce detrimental effects on a child's social-emotional development (Thackeray, Scribano, Rhoda, 2010), potentially leading to depression, anxiety, aggression, ADHD, difficulty relating to peers, and poor academic performance (McFarlane, Groff, O'Brien, & Watson, 2003; Wilson & Zak, 1986). Past or current caregiver IPV may also limit the caregiver's ability to protect their child from abuse (Thackeray et al., 2010). Forty percent of homes with IPV also have physical abuse (Appel & Holden, 1998), and several studies label caregiver IPV exposure as a risk factor for other forms of child abuse (Fantuzzo, Boruch, Beriama, Atkins, & Marcus, 1997; McCloskey, Figueredo, & Koss, 1995; Tajima, 2000). Moreover, if a child is exposed to caregiver IPV at an early age, they are at an increased risk for direct child abuse for up to 5 years (McGuigan & Pratt, 2001). Thus, researchers should consider past and/or current caregiver IPV as an important risk factor among cases of suspected child abuse (Thackery et al., 2010).

**Early Research.** In one of the earliest studies on the effects of CSA, DeFrancis (1969) found that only 24% were emotionally stable after the abuse. The other 66% were found to be emotionally disturbed after the abuse, with 52% mild to moderately disturbed, and 14% seriously disturbed. However, because these participants were drawn from court cases from the Prevention of Cruelty to Children services involving low-income families on public assistance, these findings lack generalizability to children from middle or upper class families at the time.

In another early study on 155 female adolescent CSA victims at the Harborview Medical Center in Washington, Anderson, Bach, and Griffith (1981) reported psychosocial complications in 63% of the patients, including sleeping and eating disturbances, depression, guilt, shame, anger, and phobias. These disturbances mostly emerged in victims who were sexually abused by a family member. Moreover, 66% of the sexually abused participants with a family perpetrator

experienced difficulties in school and displayed run-away behaviors. Yet, this study did not utilize standardized measures, and therefore, the findings are mainly subjective in nature.

In 1984, the Division of Child Psychiatry at the Tufts New England Medical Center conducted a study with standardized self-report measures that had published norms and test validation, allowing researchers to compare the characteristics of CSA victims with the norms for the general population of children. Researchers found that 17% of 4- to 6-year-olds met the criteria for “clinically significant pathology.” These findings reflected higher levels of disturbance than children in the normal population, but lower levels of disturbance than non-CSA victims receiving psychiatric care. Furthermore, researchers reported that 40% of children in the 7- to 13-year-old age group scored in the “seriously disturbed” range, especially in the area of neuroticism.

To date, several published reviews have been conducted in the area of CSA. Reviews by Browne and Finkelhor (1986), Kendall-Tackett et al. (1993), Jumper (1995), and Paolucci, Genius, and Violato (2001) are some of the most cited reviews in CSA research (Maniglio, 2009). Browne and Finkelhor (1986) reviewed studies attempting to empirically validate the effects of CSA within the literature. They found that CSA committed by father figures using force and genital contact imposed the most psychological damage to female victims. However, this narrative review failed to explore male CSA victimization, or to utilize precise selection, data coding, and analysis common in meta-analyses.

Kendall-Tackett et al. (1993) employed both a narrative and an empirical synthesis of 45 quantitative studies on CSA victims under 18 years old between 1988 and 1992. They found that sexually abused children had more fears, PTSD symptoms, behavior problems, sexualized behaviors, and poor self-esteem than non-abused children. Furthermore, abuse accounted for



15% to 45% of the variance in symptomology differences. No single symptom characterized a majority of CSA victims, furthering the argument that no single specific syndrome or traumatizing process exists among CSA victims. While this review made important contributions to CSA research, it had several limitations, including a narrow time frame (1988-1992), small sample sizes, and participants over the age of 18. Therefore, this review likely contains inclusion bias, low statistical power, and findings with little generalizability to children. Furthermore, researchers failed to utilize inferential statistical analyses on many important intervening variables, such as age at the time of assessment, perpetrator identity, and elapsed time between the abuse event and assessment.

In 1995, Jumper attempted to empirically summarize the existing state of research regarding the effects of CSA. He based his meta-analysis of 26 published studies on the impact of CSA on adult adjustment on outcomes including psychological symptomology, depression, and self-esteem. Findings indicated statistically significant relationships between CSA experiences and ensuing difficulties as measured by psychological symptomology, depression, and self-esteem. Furthermore, effect size estimates in all three analyses implied a significant rise in mental illnesses among those experiencing CSA across a variety of sampling methods, definitions of sexual abuse, publication dates, and participant gender. However, Jumper's meta-analysis focused on narrow outcome variables with a small number of studies on adults, thereby discounting short-term outcomes.

As a result of improved measures and methodological procedures, study findings on the impact of CSA have become more reliable over time. Paolucci, Genuius, and Violato (2001) conducted a meta-analysis in an attempt to clarify some of the conflicting information about six particular consequences of CSA (e.g., PTSD, depression, suicide, sexual promiscuity, victim-

perpetrator cycle, and poor academic performance.) The study yielded three major findings based on 25,367 participants and relatively narrow confidence intervals.

Firstly, researchers found a substantial effect of CSA on PTSD outcome ( $d=.40$ ), depression ( $d=.44$ ), suicide ( $d=.44$ ), sexual promiscuity ( $d=.29$ ), sexual perpetration ( $d=.16$ ), and academic achievement ( $d=.19$ ). Secondly, they discovered a 20% increase over baseline in PTSD outcomes, 21% increase in depression, 21% increase in suicide outcome, 14% increase in sexual promiscuity, 8% increase in the victim-perpetrator cycle, and 10% increase in academic difficulties for CSA survivors. The researchers found no mediational relationship between CSA outcomes and gender, socioeconomic status, type of abuse, age of abuse, relationship to perpetrator, and frequency of abuse. Additionally, the study failed to yield a significant difference in negative outcomes between male and female victims of CSA. Therefore, these results fail to support findings from other studies citing an increased risk for negative psychological outcomes depending on sexual abuse type, child age, repetition of abuse, and familiarity with the perpetrator. The authors suggest that future research should include contrast groups and the examination of specific mediator influences.

**Family Violence Response Patterns.** The literature on psychological responses to victimization reveals a variety of response patterns common among victims of CSA, IPV, and multiple traumas. While many studies and reviews strongly imply a casual relationship between child abuse and later psychopathology, describing survivors as extremely likely to experience numerous adverse effects, others voice caution, arguing that outcomes are inconsistent, and vary from person to person (Maniglio, 2009; Paolucci, Genuis & Violato, 2001; Rind & Tromovitch, 1997; Rind, Tromovitch & Bauserman, 1998; Sharpe & Faye, 2006; Smolak & Murnen, 2002).

The following section provides a breakdown of different emotional, cognitive, biological, behavioral, and interpersonal response patterns to CSA and IPV.

*Depression.* Researchers in the 1970's and 1980's established depression as a common reaction among adult survivors of childhood sexual abuse (Atkeson, Calhoun, Resick, & Ellis, 1982; Frank, Turner, & Duffy, 1979; Hilberman & Munson, 1977; Jumper, 1995; Mannarino & Cohen, 1986). In a cross-sectional probability survey of 3,132 household adults in two Los Angeles communities, Burnam, Stein, and Golding et al. (1988) found that childhood sexual assault predicted later onset of major depressive episodes. Additionally, researchers discovered an association between major depression in CSA survivors and higher probabilities of sexual assault later in life. McCauley, Kern, and Kolodner et al., (1997) found that 424 out of 1931 women seen in primary care practices reported childhood or adolescent sexual abuse and exhibited higher scores for depression. Furthermore, in a recent multilevel regression analysis, Glaser, van Os, Portegijs, and Myin-Germeys (2006) discovered 6.9% of participants who were sexually abused under the age of 10 developed depressive disorder, as compared to 3.3% of participants with no history of abuse. The authors also found that participants with a history of abuse continually reacted more strongly to small stressors occurring in the natural flow of everyday life, confirming previous findings that childhood trauma can impart long-lasting and enduring effects on adult psychological functioning.

*Fear and anxiety.* In one of the earliest studies on the impact of CSA, DeFrancis (1969) reported that 83% of participants reported feeling extremely fearful after their CSA. Years later in 1981, Anderson et al. found that 40% of CSA survivors reported feeling constantly fearful. However, because these studies had no standardized measures, the Tufts (1984) study served as the first methodologically sound study to report that 45% of 7-to 13-year-olds manifested severe

fears, compared with 13% of 4- to 6-year-olds. Moreover, they found that 36% of adolescents between the ages of 14- and 18-year-olds exhibited elevated scores on “ambivalent hostility,” or the fear of being harmed. In the same year, Ellis, Atkeson, and Calhoun (1981) found that adult female rape survivors abused in childhood scored significantly higher on fear and anxiety scales than the control group. Furthermore, in a longitudinal study of fear reactions in 150 female rape victims, Calhoun, Atkeson, and Resick (1982) found that participants scored significantly higher in overall fear scores than the control group immediately after their rape, and continued to have significantly higher fear scores 12 months after assault. Four additional studies in the mid 1980s showed that both child and adult survivors of CSA frequently experienced both generalized and specific fears and anxiety after their traumatization (Briere, 1984; Burgess, Hartman, McCausland, & Powers, 1984; Mannarino & Cohen, 1986; Sedney & Brooks, 1984). Burnam, Stein, and Golding et al. (1988) found that adult survivors of CSA were more likely than those first assaulted in adulthood to develop panic disorder and/or severe phobias. Likewise, in a survey of 1,157 adult women, Winfield, George, Swartz, and Blazer (1990) declared CSA a risk factor for panic disorder later in life.

At the height of the CSA research boom, Fergusson, Horwood, and Lynskey (1996) and McCauley, Kern, and Kolodner et al. (1997) found higher rates of various mental disorders, including anxiety disorder among participants reporting CSA. They also found that people with more severe CSA experiences (i.e., involving intercourse) represented the highest risk of developing anxiety disorder. Finally, Glaser, van Os, Portegijs, and Myin-Germeys (2006) found a 50% higher rate of panic disorder in CSA victims when compared to the control group.

*Decreased self-esteem.* Both adult and child survivors of CSA develop disruptions in self-esteem (Bagley & Ramsey, 1985; Courtois, 1979; Finkelhor & Browne, 1985; Gold, 1986;

Jumper, 1995; Mannarino & Cohen, 1986). In a longitudinal study, Tebbutt, Swinston, Oats, and O'Toole (1997) examined factors predicting the functioning of children over time in 68 sexually abused children ages 5-15 years. They found unchanging average levels of child-reported low self-esteem in a five-year period. Furthermore, for every child that showed improvement in self-esteem, an equal number of children demonstrated self-esteem declines at follow up. The researchers discovered an association between contact with the abuser 18 months after the abuse and even steeper declines in self-esteem. Thus, the authors concluded that treatment produced no effect on improving self-esteem.

In another study on the personal constructs of CSA survivors, Freshwater, Leach, and Aldridge (2001) found that CSA survivors' mean score on the Rosenberg Self-Esteem Scale indicated significantly lower self-esteem than the mean of the non abused group. Findings yielded a correlation between low self-esteem and self-destructive behavior in CSA survivors (Klonsky & Moyer, 2008). For example, in a study on the mediating mechanisms between childhood trauma and subsequent deliberate self-harm, Low, Jones, MacCleod, Power, and Duggan (2000) found that low self-esteem was correlated with future self-harming behaviors in survivors of CSA. Therefore, the researchers recommended self-esteem exercises as an important element of CSA treatment.

*Anger.* Another well-established CSA reaction in children is anger and hostility. In an early study CSA survivors, DeFrancis's (1969) reported that 55% of children showed behavioral disturbances such as active defiance, fighting with siblings or classmates, and aggressive behavior within the family. Similarly, Tufts (1984) researchers reported that nearly 25% of 4- to 6-year-olds and 45% to 50% of the 7- to 13-year-olds showed significantly elevated hostility levels on measures of aggression and antisocial behavior, with 35% of the children also

exhibiting hostility directed at others. Other researchers noted anger, rage, and fear of one's own rage among victims of rape and incest (Kilpatrick, Resick, & Veronen, 1981; Roth & Lebowitz, 1988). Briere (1994) stated, "In children, anger is frequently expressed in behavioral problems, with abused children and adolescents displaying significantly more difficulties in this area than what is found typically in the general population" (p. 58). Furthermore, child victims reported chronic irritability, sudden or overwhelming feelings of anger, and difficulties related to the expression of anger (Elliot & Briere, 1995; Friedrich, Beilke, & Urquiza, 1988; Bass & Davis, 2008).

*Guilt and shame.* Since the inception of CSA research, researchers frequently observe guilt and shame as common reactions to CSA. De- Francis (1969) observed that 64% of his sample expressed guilt, although this mainly reflected problems created by disclosure than the molestation itself. Anderson et al. (1981) reported guilt reactions in 25% of the victims. Both clinicians and researchers note that individuals with a history of CSA blame themselves for their abuse, as well as describe their sexual abuse in terms of their own actions instead of the actions of the perpetrator (Briere, 1989; Wyatt & Newcomb, 1990). Furthermore, several studies illuminated how many abuse victims would rather feel inappropriately guilty or shameful than helpless (Classen, Field, Atkinson, & Spiegel, 1998; Dallam et al., 2001; Field et al., 2001; Spiegel, 1986).

In addition to shame and guilt, the concept of stigma seems to encompass self-condemnation (Ginzburg, Arnou, Hart, Gardner, Koopman, Classen et al., 2006). Finkelhor and Browne (1986) define stigma as, "...negative connotations—for example, badness, shame and guilt that become incorporated into the child's self-image" (1985; p. 532). Briere (1989) also related stigmatization with self-blame, due to stigmatization being linked with secrecy

surrounding sexual abuse. Briere states that this, "...often conveys to the abuse victim the notion that she or he was involved in a shameful act and was, in fact, a guilty coconspirator" (p. 13). Freyd, Klest, and Allard (2005) found higher shame scores among a group of children abused by first-degree relatives (i.e., father, step-father, or sibling), portraying incest as a greater social taboo in comparison to being sexually abused by someone outside of one's immediate family.

*Biological response patterns.* Researchers have outlined several biological patterns associated with CSA in the empirical literature. In their chart review of female adolescent victims, Anderson et al. (1981) found that 17% of participants reported sleep disturbances and 5%-7% exhibited eating changes after the victimization. Similarly, in a study of child victims of intrafamilial sexual abuse, Peters (1976) reported that 31% had difficulty sleeping while 20% reported eating disturbances. Neither of these studies included a comparison group, so it is difficult to ascertain how these findings compare with the general population. Similarly, Smolak and Murnen (2002) found a small, significant association between CSA and eating disorders among females.

Experts assert that a relationship exists between chronic anxiety symptoms associated with post-trauma reactions and increased autonomic nervous system arousal in victims of severe child abuse who develop dissociative identity disorder (Braun, 1983). Children who incur both sexual and physical abuse may show evidence of injury to the central nervous system, which scientists associate with a wide range of neurobehavioral dysfunctions (Monane, Leichter, & Lewis, 1984). Traumatic stress can also negatively influence physical health, as recent studies show that survivors of trauma have higher rates of life-threatening illnesses than the general population, including diabetes, cancer, heart disease, and gastrointestinal disorders (Kendall-Tackett, 2009).

*Aggressive and antisocial behaviors.* Evidence exists that some victims of CSA develop aggressive or antisocial behavior patterns (Kazdin et al., 1985; Tufts New England Medical Center, 1984). Egeland, Yates, & Appleyard, (2002) found that abuse in early childhood led to alienation in preschool, which then predicted early onset externalizing problems in the elementary school years, ultimately resulting in antisocial behavior in adolescence. Researchers also found that sexual abuse in combination with neglect is a predictor of behavior problems in child survivors of sexual abuse (Dubowitz, Pitts, & Black, 2004).

*Dissociation.* King (2009) argues that some survivors of CSA dissociate to protect themselves from experiencing the sexual abuse, a coping mechanism that can be employed into adulthood when a CSA survivor feels unsafe or threatened. Dissociation takes many forms, including feeling confused or disoriented, enduring nightmares or flashbacks, experiencing partial or full amnesia concerning the abuse, or experiencing trouble feeling emotions (Ratican, 1992). Researchers are divided as to whether survivors can recover repressed memories of CSA in individuals suffering from full or partial amnesia. Some researchers theorize that the trauma of CSA can elicit repression as a coping mechanism, while others believe that recovered memories are false, or that the client is led to create them (King, 2009).

*Suicidal Behaviors.* CSA survivor groups frequently exhibit suicidal behaviors often associated with serious depression. In a random community sample of over 2,000 women, victims of sexual abuse represented the population with the most suicide attempts when compared to victims of any other crime (Kilpatrick, Best, Veronen, Amick, Villepontaux, & Ruff, 1985). Many other studies documented how CSA survivors frequently report a history of suicidal ideation or attempts (Briere, 1984; Bryer et al., 1986; Sedney & Brooks, 1984). In more recent studies that control for indicators of family instability, researchers identified sexual abuse



as a factor that accounts for almost 20% of the population attributable risk for suicide attempt in young people (Nelson, Heath, Madden et al., 2002; Dinwiddie, Heath, & Dunne et al., 2000). Brent, Oquendo, & Birmaher et al., (2002) found that parental sexual abuse also increased the risk of suicide attempt in children. Furthermore, research has uncovered relationships between the severity, frequency, and chronicity of sexual abuse and increased suicide risk (Ystgaard, Nestetun, & Loeb et al., 2004; McHolm, MacMillan, & Jamieson, 2003). In a 2008 study exploring the familial transmission of risk for suicidal behavior, Beth, Brodsky, & Mann, et al., found a correlation between sexual abuse histories among parents and suicidality, as well as other risk factors for suicide attempt in their offspring.

*Substance abuse and dependence.* Researchers associate CSA with increased likelihood of lifetime alcohol use, and label it a significant predictor of lifetime alcohol dependence (Sartor, Lynskey, Bucholz, McCutcheon, Nelson, & Waldron et al., 2007). These findings are consistent with previous studies linking CSA to lifetime alcohol use (Bensley et al., 1999; Harrison et al., 1997) and alcohol dependence (Dinwiddie et al., 2000; Kendler et al., 2000; Molnar et al., 2001; Nelson et al., 2002). In Burnam et al.'s (1988) cross-sectional probability survey of 3,132 household adults, sexual abuse predicted later onset of substance use disorders (e.g., alcohol and drug abuse or dependence). Furthermore, in a study of 60 women who did not abuse alcohol or drugs prior to their sexual abuse, Winfeld, George, and Swartz et al. (1990) reported that 100% of the sample abused alcohol after their first sexual assault. Furthermore, in a longitudinal study of co-occurring disorders among a population of CSA survivors, more than two-fifths (43.5%) of the sexually abused females met the diagnostic criteria for alcohol abuse-dependence by the age of 21, versus 7.9% of non-sexually abused study peers (Silverman, Reinherz, & Gianconia, 1996).

*Impaired social functioning.* Research suggests an association between CSA and both initial and long-term alterations in social functioning, (Briere, 1992), which arise from both conditioned responses to victimizations (i.e. distrust of others, anger at/ fear of those with greater power) and accommodations to ongoing abuse (i.e., avoidance, passivity) (Briere, 1994). In his article on immediate and long-term impacts of CSA, Briere (1994) states:

Sexual abuse usually occurs in the context of human relationships, with as many as 85% of cases perpetrated by individuals known to the victim. The violation and betrayal of boundaries in the context of developing intimacy can create interpersonal difficulties in many survivors. These intimacy problems appear to center primarily on ambivalence and fear regarding interpersonal vulnerability (pp. 61-62).

In a sample of 205 outpatient adults, the 23.4% of individuals reporting sexual abuse also exhibited a higher prevalence of impaired social functioning when compared to non-abused participants (Mancini, Van Ameringen, & Harriet, 1995). Furthermore, in Abdulrehman and DeLuca's (2001) study on the impact of CSA on adult social behavior, CSA survivors exhibited higher rates of impaired social functioning, including fewer friends and more social adjustment problems.

*Personality disorders.* Several researchers reported a moderate significant relationship between CSA and borderline personality disorder (Fossati, Madeddu, & Maffei, 1999; Herlbert, Apt, & White, 1992). Linchan (1993) described sexual abuse as a critical invalidating experience contributing to the development of borderline personality disorder in women. Furthermore, Herman, Perry, and van der Kolk (1989) found that 81% of study participants diagnosed with borderline personality disorder also survived sexual abused as children. Moreover, studies on patients receiving treatment for eating disorders (Swift, 1990; McLelland et a., 1992) and

substance abuse (Krinsley et al., 1992) reported significantly more patients with a history of CSA than non-abused patients.

*Sexual problems.* There are a range of sexual concerns that can develop in both child and adult survivors of sexual abuse. In one of the first studies utilizing standardized measures, Tufts (1984) reported that 27% of 4- to 6-year-old children scored significantly above clinical and general population norms on a sexual behavior scale that includes open masturbation, excessive sexual curiosity, and frequent exposure of genitals. Similarly, 36% of the 7-to-13 year-olds demonstrated higher levels of disturbance than clinical and general population norms for the same measure. Furthermore, researchers report that sexually abused children have more sexual behavior problems than physically abused children, emotionally abused children, and nonabused children (Fridrich, Grambsch, & Damon, et al., 1992; Kolko, Moser, & Weldy, 1988). Sexually abused children are also more likely to engage in a higher number of sexual behaviors, many of which are developmentally advanced and outwardly imitative of adult sexual activity (Briere, 1994; Gil & Johnson, 1993).

Arriola et al. (2005) found a significant association between CSA and future engagement in unprotected sex, sex with multiple partners, and trading sex for money, drugs, or shelter. Noll, Haralson, Butler, and Shenk (2011) argue that sexually abused females experience difficulty regulating thoughts, feelings, and behaviors, increasing the likelihood of high-risk, sexually impulsive behaviors, which also leads to a higher incidence of sexually transmitted infections (Heiman & Heard-Davison, 2004; Koenig & Clark, 2004). Furthermore, CSA places females at increased risk for adolescent pregnancy (Noll, Shenk, & Putnam, 2009). Adult survivors of CSA face an increased likelihood of sexual intimacy problems (Briere, 1984). These problems may manifest as sexual dysfunction related to fears of vulnerability and revictimization (Maltz &

Holman, 1987). Moreover, CSA survivors are more likely to have multiple, superficial, or brief sexual relationships that end as intimacy develops, contributing to the high incidence of sexual abuse histories found in adolescent and adult prostitutes who view their occupation as an extension of their childhood experiences (Bagley and Young, 1987).

*Intimate relationship problems.* Due to increased fears and decreased interpersonal trust of both men and women, research states that adult survivors of sexual abuse face the increased likelihood of remaining single, and once married, the increased likelihood of divorce or separation from their spouses than are those without CSA histories (Russell, 1986). CSA survivors frequently report low satisfaction and high levels of conflict and violence in intimate partner relationships (Davis & Petretic-Jackson, 2000; DiLillo, 2001; Rumstein-McKean & Hunsley, 2001). Sappington et al. (1997) found that children from abusive homes experience difficulty with escaping the abusive parent-child relationship. Furthermore, they theorize that some adult survivors of CSA enter into abusive relationships because they are attempting to recreate their home environment. Testa, VanZile-Tamsen, and Livingston (2005) discovered a link between sexual risk behaviors and difficulties in adult interpersonal relationships, reporting higher numbers of sexual partners and higher rates of STD's partially explained by the quality of women's intimate relationships. In a related example, researchers found that women who desire intimate relationships but who also experience difficulty forming lasting or satisfying partnerships face an increased likelihood for having many short-term sexual relationships (Davis & Petretic-Jackson, 2000). Hence, "... having more sexual partnerships may say more about a woman's relationship choices than about her sexual choices (Heiman & Heard-Davidson, 2004, p. 40).

*Revictimization.* Women with histories of sexual victimization face increased

vulnerability to future victimization (Classen, Palesh, & Aggarwal, 2005). Several studies determined a link between CSA and later sexual revictimization (Arriola et al., 2005; Neumann et al., 1996; Roodman & Clum, 2001). The recent NIS report (NIS 4, 2010) estimated that child victims of maltreatment are between two and ten times more likely to encounter violence in their lifetime. Furthermore, in an 18-year longitudinal study, 93 female participants were twice as likely than the non-abused control group to reencounter sexual and physical abuse by non-peers who were at least 4 years older (Barnes, Noll, Putnam, & Trickett, 2009). Hence, concluded the authors, CSA appears to place females at substantial risk for experiencing subsequent and relatively severe victimizations as compared to victimizations reported by females who did not experience childhood abuse. In another study examining 1009 adult male survivors of CSA, researchers found that CSA victims experienced adult sexual assault at higher rates than non-victims (Aosved, Long, & Voller, 2011).

*Victim-perpetrator cycle.* In a study on risk factors for CSA perpetration, Whitaker et al. (2008) reported a strong association between CSA histories and later CSA offending, when compared to those who committed a non-sexual offense, and those who committed no offense. Glasser, et al. (2001) found a positive correlation between the risk of being a perpetrator and reported CSA among 747 males. More specifically, out of the 747 males, 35% identified as perpetrators of CSA and had a history of CSA, while 11% experienced a history of CSA but did not perpetrate abuse. Furthermore, the same researchers found that being a victim is a strong predictor of becoming a perpetrator. Moreover, in a meta-analysis on sexual abuse history among adult sex offenders and non-sex offenders, Jespersen, Lalumiere, and Seto (2009) found that a history of sexual abuse significantly more prevalent among adult sex offenders than among adult non-sex offenders. However, they also found that offenders against adults faced a decreased

likelihood of reporting sexual abuse in childhood, and an increased likelihood of physical abuse than offenders against children. In an effort to explain this association, the authors posited that CSA influences learning, sexual development, and psychopathology in a manner that places victims at higher risk for imitating perpetrator behavior.

*Posttraumatic stress disorder.* A large portion of research studies on the effects of CSA examines PTSD outcomes among survivors. CSA fits the definition of a traumatic event in the *DSM-IV-TR* (American Psychiatric Association, 2003) because it causes some children to experience overwhelming fear, helplessness, and horror, and in some cases, the child perceives the abuse as life threatening. The *DSM-IV* field trials (American Psychiatric Association, 1994; Roth, Newman, Pelcovitz, van der Kolk, & Mandel, 1997) reported that PTSD as the most prevalent lifetime Axis I disorder seen in child CSA survivors, with rates from 20% of CSA survivors with PTSD only, and up to 53% of CSA survivors with both PTSD and complex PTSD symptoms. In the review by Paolucci et al. (2001), researchers found a significant relationship existed between CSA and PTSD within the empirical literature. George, Swartz, and Blazer (1990) examined the relationships between sexual assault and mental disorders in 1,157 women between the ages of 18 and 64, and identified sexual assault as a risk factor for the development of PTSD. Rowan, Foy, Rodriguez, and Ryan, (1994) examined the relationship between CSA and PTSD through investigating different characteristics of the abuse, such as frequency, duration, age of onset, use of force, perceived life threat, and the occurrence of penetration. They found that 69% of survivors met the criteria for PTSD in the *DSM-III-R* (American Psychiatric Association, 1987). In the same year, Wolfe, Sas, and Wekerle (1994) examined the relationship between the development of PTSD and selected victim and event characteristics of CSA. Comparing two groups of children, 44 with PTSD, and 46 without PTSD, researchers found

significant differences on variables of age, sex, duration of the abuse, and use of violence or coercion by the offender. They also found that the children with PTSD significantly differed from the control group regarding their fears, anxiety, depression, guilt, and shame related to the abuse. In a more recent study investigating the relationship between the age of self-reported CSA and PTSD among 79 adults, Tyrka, Carpenter, and Price (2010) found that the risk for developing PTSD was 10 times higher in patients reporting sexual abuse after the age of 12 than those reporting sexual abuse before age 12. Furthermore, researchers also found that CSA victims abused by family members have more symptoms of PTSD if they delayed disclosure, engaged in self-blame, or received more negative reactions after disclosing to others.

*Cognitive distortions.* Humans make significant assumptions about themselves, others, the environment, and the future based upon childhood learning (Briere & Elliot, 1994; McCann & Pearlman, 1990; Finkelhor, 1987). More often than not, children experience CSA as a negative event, leading to assumptions and self-perceptions that reflect an overestimation of danger and adversity in the world, and an underestimation of the CSA survivor's self-worth or abilities (Briere & Elliott, 1994; Briere & Runtz, 1993). Cognitive distortions stemming from CSA trauma typically occur in five areas: (a) safety, (b) trust, (c) esteem, (d) intimacy, and (e) power/control (McCann, Sakheim, & Abrahamson, 1998). Common psychological responses to these distortions include anxiety, social withdrawal, avoidant behavior, fear of betrayal, isolation, passivity, anger, and feelings of powerlessness (Owens, 2001). Smucker, Dancu, Foa, and Niederee (1995) found that many of the psychological effects of CSA (i.e. self-destructive behaviors, PTSD, anxiety, interpersonal difficulties, sexual dysfunction) begin with cognitive distortions about the self and the world. In a study on the effects of sexual victimization in childhood, Gold (1986) reported the most common cognitive distortions among CSA survivors

as chronic self-perceptions of helplessness, impaired trust, self-blame, and low self-esteem. Moreover, if the victim cannot physically or psychologically defend against the abuser, they may develop an expectation of injury and threats from the world around them. Common examples of cognitive distortions after CSA include, “this abuse happened because I am a bad person,” or “people cannot be trusted.” Child victims of CSA that go on to perpetrate sexual abuse to siblings or peers may develop cognitive distortions like, “It is okay to touch other people sexually because it feels good.” Moreover, adult perpetrators of CSA may develop cognitive distortions like, “children desire sexual activity,” “sex with children does not cause harm to a child,” or, “I am superior to others, and therefore able to have sex with whoever I want” (Marziano, Ward, Beech, & Pattison, 2007).

*Risk factors for Abuse in the Family.* Researchers, clinicians, and policymakers began investigating the impact of CSA experiences on human development in the 1970s (Frazier & Cohen, 1992; Hall & Hall, 2011; Kilko & Moser, 1988; Tong, Oates, & McDowell, 1987). While CSA occurs across all socioeconomic and ethnic groups (Finkelhor, 1993), various characteristics of the abuse may influence how a child survivor responds and adjusts over his or her lifetime. For example, higher levels of traumatization typically occur among younger survivors of violent abuse with chronic forced sexual penetration by a family member, as compared to older child survivors of fondling or molestation by a non-relative one time (Briere & Elliott, 1994; Browne & Finkelhor, 1986; Conte & Shuerman, 1987; Follette, Polusny, Bechtle, & Naugle, 1996; Ginzburg et al., 2006; Joseph, Williams, & Yule, 1995; Quas, Goodman, & Jones, 2003; Wyatt & Newcomb, 1990).

*Demographic factors.* While creating an exact demographic profile to describe sexually abused children proves impossible, researchers possess the capability to describe common



characteristics among victims. Some demographic factors can be clearly attributed to higher CSA risk, while research on others remains inconclusive. For example, a large number of reliable studies across various types of statistical analyses confirmed that girls more frequently become victims of CSA than boys. One study found that between 78% and 89% of CSA victims are female (Snyder, 2000). Conversely, many discrepancies exist in the data regarding CSA risk and age. Some studies report equal CSA risk potential among all children over the age of three (Bolen & Scannapieco, 1999; Crimes Against Children Research Center, 2001; U.S. Department of Children and Families, 2009). Other studies label teenagers as more likely to be sexually abused (Finkelhor et al., 2005), with one study stating that over 50% of sexually abused children occurring between the ages of 15 and 17 (Finkelhor, Hammer, & Sedlak, 2004). One national study examining law enforcement reports found that 14% of CSA victims fall in the 0 to 5 age range, 20% fall in the 6 to 11 age range, and 33% fall in the 12 to 17 age range (Snyder, 2000). Due to inconclusive research findings on age and CSA risk, most researchers caution that all age groups face risks.

Researchers also reported inconclusive findings on CSA risk factors and race, with some studies finding that black and white children experience equal incidences of sexual abuse (Sedlak & Broadhurst, 1996; Finkelhor, Hammer, & Sedlak, 2004), and other studies finding that black and Latino children face higher risks for CSA than white children (Finkelhor & Dziuba-Leatherman, 1994; Hanson et al., 2003). Additionally, a relationship exists between several family characteristics and increased CSA risk. For instance, more children from a lower socioeconomic status experience sexual abuse than children from wealthier families (Crimes Against Children Research Center, 2001; Finkelhor, Hammer, & Sedlak, 2004). Furthermore,

researchers linked other family characteristics, such as parental alcoholism, parental rejection, and parental marital conflict to CSA (Vogeltanz et al., 1999).

Studies examining CSA risk factors face several inherent limitations. For example, data estimates derived from child welfare sources more frequently report information about younger children. Moreover, while law enforcement agencies report more detailed estimates, they only include cases reported to police (U.S. Department of Children and Families, 2009). Because criminal prosecution could result in caregiver disclosure of CSA, there exists a high potential for nondisclosure in the general population (McGee, Wolfe, Yuen, & Carnochan, 1991). Therefore, since researchers utilize a vast majority of data based on child self-report, and most cases of CSA go unreported, researchers reporting findings on the relationship between demographic variables and CSA risk factors must rely primarily on available data.

## **The Benefits and Challenges of Child Abuse Treatment**

### **Child Advocacy Centers**

Child Advocacy Centers (CACs) most frequently offer services for families victimized by CSA. CACs offer a seamless continuum of services to families seeking assistance from child protection organizations. Clinicians established the first CAC in Huntsville, Alabama in 1985, and by 2007, more than 900 CACs existed nationwide (National Children's Advocacy Center, 2007). CACs most frequently provide services to child victims of sexual abuse and their non-offending caretakers, and work to improve efficacy to minimize the risk of further traumatization to the abused child during investigative procedures (Wolfeich & Loggins, 2007). These centers incorporate a multidisciplinary approach that is both child friendly and child focused. A team of CAC professionals, including law enforcement, social services, mental health providers, state

attorney's offices, and forensic examiners among others, often conduct business in private offices that incorporate play areas with colorful decor. In the event that a CSA victim needs a gynecological exam, many CACs provide on-site medical exams in rooms adorned with toys, cartoon characters, and child-friendly exam tables (i.e., a table shaped as a jungle animal, such as a smiling polar bear) to help the child feel calm, safe, and supported. However, existing CAC research remains largely descriptive, primarily focusing on demographic characteristics of clients, non-offending caregivers, and perpetrators, as well as CAC staff and client satisfaction (Jenson, Jacobson, Unrau, & Robinson, 1996; Kolbo & Strong, 1997; Wolfeich & Loggins, 2007). Thus, little empirical evidence exists on the efficacy of the CAC model.

The CAC all-in-one treatment approach helps prevent multiple, repetitive, and potentially traumatizing interviews, along with frequent travel obligations from one agency to another (Tavkar & Hansen, 2011). In addition to minimizing the potential for further traumatization, CACs also streamline the process of information sharing between agencies so that the family can quickly obtain the services they need. Abused and neglected children often linger in the child protection system, which can lead to revictimization if the non-offending caretaker allows the perpetrator back in the home. Researchers reported the average length of time from filing to final placement as between 4.9 years and 6.25 years (Bishop, Murphy, Jellinek, & Quinn, 1992; Jellinek, Little, Benedict, Murphy, & Pagano, 1995).

Despite the aim of CACs to increase timeliness of services, few studies examine whether CACs are more efficient than other child protection models, such as child protection services (CPS) or the Department of Children and Families (DCF). In a study on CAC efficiency, Wolfeich and Loggins' (2007) found that CPS cases used fewer days than CAC between the initial abuse report date and the agency's formal substantiation of the abuse. However CACs

used fewer days than DCF between the initial abuse report date and the agency's formal substantiation of the abuse. The authors attributed findings to the fact that CACs employ more comprehensive interdisciplinary investigations. In Florida, a child abuse allegation is "verified" (e.g. substantiated) as defined in sections 39.01(2) or (45) of the Florida Statutes if there exists robust evidence that the injury, harm, or threatened harm resulted from abuse or neglect. Conversely, a case becomes closed when there exists no credible evidence that the injury or harm resulted from abuse. Wolfeich and Loggins' (2007) found that CPS reported higher rates of abuse substantiations (76%) than CACs (68%), both of which listed significantly higher rates than DCF, with 32% of closed cases verified or with some indicators of abuse. The authors noted that only the most severe and complex cases receive services from CACs and CPS, making these cases more easily substantiated due to the likelihood of stronger evidence.

Furthermore, more research is needed to illuminate how CSA affects non-offending caregivers and non-abused siblings. As previously mentioned, there exists a multitude of research focusing on the difficulties experienced by child victims of CSA (e.g., Beitchman, Zucker, Hood, daCosta, & Akman, 1991; Beitchman et al., 1992; Finkelhor, 1990; Swanston et al., 2003; Wolfe, 2006). However, little is known about non-offending caregivers, aside from articles with a tendency to portray them in a negative manner (Corcoran, 1998). For example, the literature often depicts non-offending caregivers as agents of abuse denial, collusion, or indirect co-perpetration of CSA (Deblinger et al., 1993; Hefflin et al., 2000).

In their review, Tavkar and Hansen (2011) found few empirical studies supporting the negative view of non-offending caregivers. Instead, they found that non-offending caregivers frequently endure emotional suffering and/or trauma upon discovery of their children's sexual abuse (e.g., Corcoran, 1998; Deblinger et al., 1993; Manion et al., 1996; Newberger, Gremy,

Wateriaux, & Newberger, 1993). In addition to a range of symptoms and reactions, including depression, anger, anxiety, self-blame, guilt, helplessness, grief, PTSD, and shock (e.g., Elliott & Carnes, 2001; Manion et al., 1996), non-offending caregivers often experience social and economic consequences, such as loss of partner, loss of income, change of residence, dependence on government assistance, severe family disruption, stigma, and isolation (Elliot & Carnes, 2001). Similarly, non-abused siblings are subject to a range of adverse affects, depending on their proximity to and/or knowledge of the abuse (Baker et al., 2001; Swenson & Hanson, 1998). Thus, CACs aim to provide comprehensive mental health services to address the various needs of the entire family.

CACs tailor their services to the specific needs of CSA victims and their families after the assessment process. Manly (2005) states:

Ideally, multiple assessment methods and multiple sources of information should be integrated for a comprehensive portrayal of children's experiences. Utilization of multiple methods will require that standards be established for handling discrepant information and for developing best practices in accomplishing this integration (p. 427).

Based on assessment results, crisis intervention, brief individual therapy, and group interventions are common treatment formats within the CAC model's framework (Tavkar & Hansen, 2011). Agencies provide referrals for longer-term interventions to those clients who need services for the long-term effects of the abuse, such as ongoing depression, anxiety, self-injurious behavior, or suicidal ideation. Additionally, families with more specialized issues, such as unmanaged substance abuse/dependency, are candidates for outside referral. CACs generally refer a CSA client and his or her family to other specialized services if more pressing family issues must be addressed before the abuse.

## **Trauma-Focused Cognitive Behavioral Therapy**

The literature empirically validates only one treatment for victims of CSA: Trauma-focused cognitive-behavioral therapy (TF-CBT; Chaffin & Friedrich, 2004; Cohen, Deblinger, & Mannarino, 2005). Involving approximately 12 to 16 sessions, the creators of TF-CBT summarize interventions with the acronym PRACTICE, which stands for: (a) Psychoeducation, Parenting skills, (b) Relaxation skills, (c) Affective modulation skills, (d) Cognitive coping skills, (e) Trauma narrative and cognitive processing of the traumatic event(s), (f) In vivo mastery of trauma reminders, (g) Conjoint child-parent sessions, and (h) Enhancing safety and future developmental trajectory (Cohen & Mannarino, 2008). The following section presents a detailed description of the PRACTICE acronym, as adapted by TF-CBT creators Judith Cohen and Anthony Mannarino (2008).

**Psychoeducation.** TF-CBT begins with the therapist educating the parent and child about the treatment approach. This process begins at first contact with the family, and involves normalizing feelings, symptoms, reactions, and treatment trajectories. Psychoeducation in the initial assessment allows the therapist to impart information about the child's diagnosis and the treatment plan, and continues throughout treatment depending on the child and parent's unique needs. Education about CSA statistics (i.e., prevalence rates) may reduce the sense of stigmatization experienced by the family. Moreover, providing psychoeducation on victim's assistance programs through the criminal justice system may be an important catalyst for engaging families early.

**Parenting component.** After CSA, parents may become overprotective of their abused child, or to lose their sense of routine. TF-CBT offers a parallel parenting component in order to

assess and support parenting skills, especially as they related to potential behavioral challenges associated with the abuse, including enuresis, aggression, or noncompliance. The therapist collaborates with caregivers on basic parenting skills, such as the use of praise, selectively attending to children's positive behaviors, contingency and reinforcement programs, and the appropriate use of time out. The parenting component affords caregivers with needed normalization and personal emotional support without the child present.

**Relaxation skills.** Children benefit from being able to self-soothe when physically or psychologically stressed, and thus, individualized relaxation skills can help reverse some of the physiological reactions to a child's traumatic experiences (DeBellis et al., 1999). Some examples relaxation skills in TF-CBT include blowing bubbles (for younger children), yoga or mindfulness exercises (for older children), progressive muscle relaxation, deep breathing, praying, listening to relaxation tapes, singing, listening to music, playing sports, and reading funny stories. Therapists include parents to help develop relaxation skills in different settings (i.e., home, school, friends' houses, or playground). As children practice their chosen set of relaxation techniques, they report what worked or didn't work to the therapist until they have a set of techniques that work well for them.

**Affective modulation skills.** Cohen and Mannarino (2008) state that severely traumatized children oftentimes affectively restrict. In other words, some children cannot feel emotions, while others exhibit overly responsiveness to negative cues. Thus, one goal of TF-CBT aims to help children identify and expand their range of feelings through various games and exercises. Therapists assess each child's individual affective modulation skills, and work with parents to strengthen these skills.

**In vivo mastery of trauma reminders.** Victims of CSA frequently develop generalized avoidance behaviors in response to their trauma. For example, if a child experiences sexual abuse in a stairwell, they may exhibit fears and avoidance behaviors around stairwells. These avoidance behaviors can become problematic for the child, potentially interfering with everyday life (i.e., schools, shopping malls, and other buildings may require traveling up and down stairwells.) In vivo mastery of generalized trauma reminders involves the therapist slowly and safely preparing and exposing a child to cues associated with their abuse so that they can regulate their emotional reactions to the cue over time. These principals are similar to other graduated exposure programs (Kendall, 1990).

**Conjoint child-parent sessions.** Research shows that children benefit more when parents participate in their treatment (Deblinger et al., 1996; King et al., 2000). Therefore, therapist should conduct conjoint child-parent sessions for CSA victims with available parents. The child generally begins treatment talking primarily to the therapist about their abuse. Over time, the therapist shifts communication from child to parent, and serves as a third-party support for this process. Children often have questions about their abuse, but are afraid to talk to parents. The therapist assists the child in formulating important questions to ask the parents (i.e., “Do you think I am a bad kid?” or “Are you angry with me because of what happened?”), allowing parents to offer reassurance and praise to children during discussions on fears and cognitive distortions. Cohen and Mannarino (2008) also describe parent-child activities to consider for CSA victims with caregiver IPV. For example, after the caregiver receives therapist preparation for these activities, a child and parent may develop a Public Service Announcement about intimate partner violence, or create a quiz on healthy sexuality.



**Enhancing safety and future developmental trajectory.** Due to their increased risk for future victimization, sexually abused children need additional skills to keep them safe after therapy. The therapist develops these skills according to the child's unique needs, and encourages the child to practice in session with the therapist and parent. Topics frequently include healthy sexuality for CSA victims, IPV safety plans developed for the child's level of development, bullying safety skills, and drug resistance education.

Several studies have demonstrated the efficacy of TF-CBT with victims of CSA (Cohen & Mannarino, 1996, 1997, 1998; Cohen & Deblinger, 2004; Deblinger, Lippman, & Steer; 1996; King et al., 2000; Paul, Grey, Elhai, Massad, & Stamm, 2006). In their review of CSA treatments, Saywitz et al., (2000) concluded that abuse-specific cognitive behavioral therapies are most efficacious in alleviating many of the chief symptoms displayed by CSA victims. Furthermore, they noted that other forms of CSA treatment need more adequate testing in the field.

In an experimental study examining the differential efficacy of TF-CBT and child centered therapy for child CSA survivors with PTSD and related emotional and behavioral problems, Cohen, Deblinger, Mannarino, and Steer (2004) reported TF-CBT as significantly more effective in improving PTSD, depression, behavior problems, shame, and abuse-related attritions than child centered therapy. They also reported TF-CBT efficacy for use with non-offending caregivers, as the therapy helps caregivers cope with their personal distress while providing them with skills to effectively respond to their child's needs (Cohen & Deblinger, 2004).

In one earlier study, Cohen and Mannarino (1996) randomly assigned 69 children between the ages of 3 and 7 to either 12 sessions of TF-CBT with a parent component, or 12

sessions of nondirective supportive therapy (NST). Children in the TF-CBT group had statistically significant improvements in PTSD symptoms, depression, anxiety, aggression, and behavior issues, which were maintained at a 12-month follow up. Additionally, 43 young children receiving 12 sessions of CBT for sexually abused preschoolers (CBT-SAP) showed more improvements in internalizing, externalizing, and PTSD-related symptoms than the NST group (Cohen & Mannarino, 1997). Research also confirms TF-CBT efficacy with child sessions, parent sessions, and parent-child combined sessions. Deblinger et al, 1996 randomly assigned 100 CSA victims to one of four groups: (a) TF-CBT for children only, (b) TF-CBT for parents only, (c) TF-CBT for both parent and child, and (d) treatment as usual. When compared to the treatment-as-usual group, researchers found that the child sessions decreased more PTSD symptoms, while sessions with parent components reduced more child depression and externalizing behaviors. Furthermore, children continued to demonstrate reduction maintenance over a 2-year follow up period.

### **Exploring Trauma-Related Cognitive Schemas in Treatment**

In addition to addressing PTSD symptomology, treatment for CSA often explores trauma-related cognitive schemas that emerge after abuse. In their book *Risking Connections: A Training Curriculum for Working with Survivors of Childhood Abuse*, authors Saakvitne et al. (2000) outline seven basic treatment assumptions held by CSDT. First, they describe symptoms as adaptations. This means that reactions to trauma, such as dissociation, occur as a way to protect the survivor from overwhelming pain associated with experiences and memories of abuse. To this end, the survivor's symptoms represent efforts to cope with intolerable

circumstances. Hence, this adaptation model helps survivors recognize their own strengths and inner resources rather than defining their symptoms in a way that highlights weakness or failure.

For the second assumption of CSDT, the authors state that trauma shapes the survivor's basic beliefs about identity, worldview, and spirituality (Saakvitne et al., 2000). In order to make sense of a traumatic experience, trauma survivors frequently change their beliefs about themselves and the world. CSDT contends that because humans engage in meaning-making behaviors, and continually filter experiences through the lens of self- and other-beliefs, trauma profoundly affects the lens. Survivors often wrestle with questions such as "Why did this happen?" and "What does this experience mean?" At the same time, they frequently develop self-blaming beliefs, such as "It was my fault" and "I deserved it," as well as pessimistic explanations for the abuse, such as "The worst will always happen in life" and "Abuse is inevitable" (Saakvitne et al., 2000). These beliefs emerge from a survivor's efforts to make sense of their experiences, and thus, healing involves transformation of overgeneralized negative beliefs that infringe on personal growth or change.

Thirdly, states Saakvitne et al. (2000), trauma-related problems are treatable in the mental health system. CSDT asserts that even though not all survivors can be helped, the majority of clients can be helped if a clinician collaborates to understand their adaptations so that they can develop alternative ways to live and be safe in the world. However, cautions the authors, not all clinicians are able to work with child abuse clients effectively, as the work involves significant psychological and emotional demands on the professional helper.

CSDT represents an empowerment model that employs the client as an important member of his own treatment team, as evidenced by the fourth assumption of CSDT, which states that a therapeutic relationship between client and helper must be collaborative. Therefore,

the clinician should impart useful information to the client, but should not assume the role of expert or authority on all matters concerning the survivor. Furthermore, the fifth assumption of CSDT contends that therapeutic relationship should be characterized by (a) respect, (b) information, (c) connection, and (d) hope to the client.

Moreover, a description of each of the therapeutic traits listed in the fifth assumption, which form the acronym RICH, is as follows. A clinician conveys respect by upholding client confidentiality, ensuring session punctuality, using sensitive language, and validating the client's point of view. Clinicians should impart information as an important facet of treatment, because mental health counselors possess knowledge of useful resources, such as community- and survivor-led support groups, articles on trauma and healing, and strategies for managing common manifestations of traumatic stress. Saavitne et al. (2000) describe connection as careful listening, empathic understanding, and sensitive responses to client survivors of child abuse. They cite Jordon's (1991) definition of connection, which emphasizes the importance of empathy and mutuality in a growth-fostering relationship. Lastly, a helper communicates hope through highlighting a survivor's potential future self, while simultaneously supporting the client through their current hurt and despair.

Assumption six focuses on the needs of the helper, which must not be overlooked (Saavitne et al, 2000). Working with traumatized people requires a helper to utilize all of their cognitive, emotional, and spiritual resources. This requires replenishment achieved through mutual ongoing colleague support. To this end, a clinician working with traumatized clients should be well informed about vicarious traumatization, which may inflict a negative and painful effect on the inner experience of the counselor. Therefore, as stated in assumption seven of CSDT, counselors should vigorously attend to their own self-care, which requires ongoing self-

examination as to whether they possess adequate preparation for working with traumatized individuals.

### **Treatment Formats**

CACs offer a variety of interventions that are tailored specifically to the needs of CSA survivors and their families. While some families require crisis intervention immediately after abuse disclosure, others benefit from group therapy, brief or time-limited individual therapy, or referrals to other agencies that offer longer-term services. Upon review of the literature, Tavkar and Hansen's (2011) article existed as the only published work reviewing CAC interventions. Thus, I based the following discussion on Tavkar and Hansen's review of therapeutic modalities and interventions for CSA victims and their families receiving services at CACs.

In their book on CSA, Heflin et al. (2000) describe children and families as more open to receiving external support in the period of family crisis that immediately follows an abuse report. Research shows that the process of disclosure often produces anxiety in children, especially after participating in forensic, legal, and mental health evaluations. Hunter (2011) defines disclosure as the process of telling an adult about an incident of CSA, an event which clinicians largely consider traumatic (Finkelhor, 1988). While there exists a wide range of variables potentially impacting a child's decision to disclose their abuse (Kogan, 2004), researchers believe the level of childhood traumatization potentially delays disclosure (Somer & Szwarcberg, 2001). In London et al.'s (2008) literature review on disclosure, the authors describe boys, younger children, certain ethnic groups, and children with low levels of family support as less likely to disclose CSA. Female incest victims reported that they wanted to keep their abuse a secret in order to prevent a family crisis (Herman, 1981). Furthermore, Doraise (2002) found that intense

fears of not being believed and/or fears of being punished as more troubling to CSA victims than the actual threats they received by perpetrators to remain quiet.

The first two or three sessions of counseling, frequently labeled crisis sessions, aim to elucidate facts about the abuse, normalize responses to trauma, encourage expression of feelings, and promote simple problem-solving skills (Tavkar & Hansen, 2011). Clinicians also provide support and guidance to victims while they share information with their non-offending parent about their abuse (Grosz, Kempe, and Kelly, 1999). Non-offending caregivers play a critical role in shaping their child's post-abuse adjustment, and therefore a primary goal of the counselors is to help caregivers support their children in order to enhance their short and long-term functioning (Corcoran, 2004; Deblinger, Stauffer, & Steer, 2001; Deblinger et al., 1993).

Many studies discovered that non-offending caregiver's personal psychological distress diminishes their support to their child (e.g., Regehr, 1990; Tourigny, Hébert, Daigneault, & Simoneau, 2005), and therefore counselors must assess and support non-offending caregivers for stressors (i.e., mental health issues, intimate partner violence, secondary traumatization) so that they may positively influence their child's treatment (Tavkar & Hansen, 2011). Furthermore, while few studies exist on crisis interventions for non-offending caregivers, Regehr (1990) suggests offering them individual sessions without their children so that they may express their thoughts and feelings about the abuse, themselves, and the system. CAC's should generate additional crisis counseling, family sessions, recommendations, and treatment plans for non-abused sibling(s) of the CSA victim, as they may experience feelings of isolation, stigma, confusion, distress, and limited attention from parents (Baker et al., 2001; Grosz et al., 1999).

For preadolescent and teen victims of CSA, some researchers consider group therapy as the best treatment option (Grayson & DeLuca, 1995; Recker & Ensing, 1998). Group

interventions aim to reduce feelings of isolation, desires for secrecy, and social stigmatization (Tavkar & Hansen, 2011). Furthermore, cost-effective and efficient group interventions benefit CSA victims with few resources available (Avinger & Jones, 2007; Heiman & Ettin, 2001). Clinicians frequently derive group treatments for victims of CSA from a variety of theoretical models. However, sparse research exists in this area. Avinger and Jones (2007) conducted a review of the literature for group treatments between 1985 and 2005, and found only 10 studies specifically addressing group therapy for female victims of CSA. They identified TF-CBT and multidimensional groups as most effective for reducing symptoms of PTSD. Furthermore, the authors listed three main components of multidimensional groups as (a) skills, (b) psychotherapeutic components, and (c) education. Psychodrama reduces depressive symptoms, as well as provides children with an opportunity to process their abuse experience by staging, directing, and acting plays pertaining to their abuse experience. Group therapy for CSA victims helps children bond with other victims of CSA, receive necessary sex education, and increases self-esteem (Avinger & Jones, 2007).

Given vast differences in CSA responses among victims, and limitations in reliably predicting traumatic reactions, the onset of services should begin immediately to avoid exacerbating and/or prolonging symptoms (Saywitz, Mannarino, Berliner, & Cohen, 2000). In cases when clinicians deem group treatments inappropriate (e.g., severe psychopathology, safety issues), clinicians should instead offer time-limited individual interventions to CSA victims and their non-offending caregiver(s). Clients benefit from individual exploration of potentially upsetting thoughts, feelings, and reactions in private, one-on-one therapist relationships (Lanktree, 1995). Saywitz et al. (2000) concluded that time-limited interventions help clinicians focus on specific difficulties (i.e. trauma-related symptoms, cognitive distortions). Furthermore,

clinicians may effectively use time-limited interventions with children falling in the four typical categories considered for treatment: (a) those with no symptoms, (b) those with symptoms that fall below clinical significance, (c) those with serious isolated symptoms (i.e., PTSD, depression, sexual behavior problems), and (d) those meeting the full criteria for a mental disorder.

### **Treatment Challenges**

The mental health research community voiced concern about the high rates of premature treatment termination across different populations of children and families (Staudt, 2007). Because a relationship exists between client participation in treatment and outcomes (Baydar, Reid, & Webster-Stratton, 2003; Braswell, Kendall, Braith, Carey, & Vye, 1985; Gorin, 1993; Meyer et al., 2002; Nye, Zucker, & Fitzgerald, 1999), clients cannot benefit from therapy when they drop out or when mental health agencies dismiss them from treatment due to repeated “no-shows.” Families of maltreated children face increased vulnerability. In one study, only 30% of families in treatment for child abuse or neglect had a planned termination (Meezan & O’Keefe, 1998). With drop out rates ranging from 38.5% to 47.5% among families requesting services in outpatient or in home-based services (Donohue & Van Hasselt, 1999; Lutzker, Bigelow, Doctor, & Kessler, 1998), researchers increasingly examine correlates of drop-out and testing interventions to improve client engagement (Firestone & Witt, 1982; Kazdin, Muzurick, & Bass, 1993; Kazdin & Mazurick, 1994; Yatchmenoff, 2005).

The literature points to several possibilities for high attrition rates within families with concurrent abuse. Firstly, unlike single-victim crimes, families with both IPV and child abuse have two or more victims, most frequently a mother (e.g., non-offending caregiver) and one or more of her children (Dong et al., 2003). As previously established in IPV literature (Rosenbaum



& Leisring, 2003), a perpetrator of violence and CSA oftentimes creates a frightening and manipulative atmosphere of power and control over the victim(s), which can undermine the ability of the non-offending caretaker to shield the children from harm. Thus, because families with co-occurring IPV and CSA are typically disorganized, chaotic, and secretive, child victims of abuse are more frequently referred to treatment after it is discovered by a third-party (e.g., law enforcement, school personnel, etc.) (Renner & Slack, 2006).

Therefore, in CSA cases where IPV is present, there exists a reduced likelihood that the parent-victim will come forward for help due to the risks it poses to the family, such as further physical or sexual harm to the non-offending caregiver and/or the child. In one study examining a sample of child victims of physical abuse, sexual abuse, or neglect who also witnessed IPV, McNamara (2000) concluded that parental stress interferes with parent's ability to keep their children in treatment. They also found that parent self-report of stress associated with their own parental functioning was the only predictor (across child symptoms, agreement of child and parent report, and parent stress) of child attrition. Other researchers hypothesize that reluctance to seek treatment may be due to the potential legal liabilities faced by a non-offending caregiver who reports abuse, potentially leading to loss of child custody (Koverola et al., 2007).

Another attrition consideration for this population deals with treatment formats that are incongruent with the needs of the victim. Statistics consistently reveal that battered women who flee violent partners frequently take their children with them. Moreover, service delivery for abused women and/or children typically occurs during serious family crisis, many times in domestic violence shelters. Annual statistics released on domestic violence shelters in the state of Florida reveal that the majority of residents are children (Florida Department of Children and Families, 2011). Families with disorganized, chaotic, and ongoing abuse dynamics are less

equipped to deal with crisis when compared to more stable, less chaotic families, because going to treatment actually contributes more stress to the crisis in abusive families (Humphreys, 2008). Research also shows that traumatized abuse victims need longer treatment than others in need of mental health services (Beutler, Williams, & Zetzer, 1994). Yet, battered women typically live in domestic violence shelters for a short period of time, and once they leave, they rarely have the resources available to adhere to treatment recommendations (Sullivan, Basta, Tan, & Davidson, 1992).

**Barriers-to-Treatment Model.** The barriers-to-treatment model (Kazdin et al., 1997) proposes that families experience multiple barriers associated with participating in treatment, and that these experiences increase the risk for dropping out. In addition to family, parent, and child characteristics frequently studied as predictors of dropout, the barriers-to-treatment model proposes that practical obstacles to participation (i.e., lack of transportation), poor perceptions of treatment (i.e., caregiver's belief that treatment is unnecessary), and poor therapeutic alliances with the therapist all prevent families from continuing in therapy. Kazdin et al. (1997) argue that family, parent, and child factors identified at intake predict client dropout and premature termination. Furthermore, they assert an association between parent, child, and family characteristics and other barriers often experienced over the course of treatment (e.g., negative alliance with the therapist, poor motivation for treatment, seeing the treatment as irrelevant). In studies examining the impact of treatment barriers on client dropout for youths referred to treatment for oppositional behaviors, researchers frequently focus on parent and family domains assessed at intake because these factors influence dropout more than child characteristics (Armbruster & Kazdin, 1994).

In a study testing the barriers-to-treatment model, Kazdin et al., (1997) found that children who dropped out were more likely than those who completed treatment to have young, culturally diverse, poor, single parents who reported harsh child-rearing practices and had a history of antisocial behaviors in childhood. Furthermore, they found that dropouts demonstrated higher levels of parental stress than did completers. Researchers conducted this study for children in treatment for behavior problems, not maltreated children, and therefore future research should seek to understand how specific parent and family stressors (i.e., IPV) influence treatment dropout for sexually abused children. Furthermore, while researchers consider IPV a significant parent and family stressor, no studies were found that explore whether caregivers of sexually abused children reporting current or past IPV are more likely to prematurely terminate treatment than those without IPV.

Mental health and social work literature began discussing the process of client engagement in the 1950s (Roberts & Nee, 1974). Engagement generally occurs in the early phase of treatment, and includes joining, forming a relationship, establishing goals, developing trust, or "...some other aspect of the front end of the helping process" (Yatchmenoff, 2005, p. 85). Due to varying definitions of engagement, as well as large knowledge gaps in theory regarding the relationship between engagement and other treatment processes, there exists a gap in interventions aiming to increase engagement and retention for maltreated children (Staudt, 2007). Abused children usually do not initiate their own mental health services, and therefore, the majority of attrition literature on sexually abused children focuses on the primary caregivers responsible for taking the child to treatment (Costello, Pescosolido, Angold, & Burns, 1998). Additionally, primary caregivers often participate in treatment in order to address their own issues, improve parenting skills, and protect the well being of their children.

The literature differentiates between two primary components of engagement. The first component is behavioral, and consists of a client tasks in treatment, such as homework, participation in session, and appointment keeping (Karver, Handelsman, Fields, & Bickman, 2005). The second component is related to the client's attitude, and refers to believing that treatment is worthwhile and beneficial while demonstrating an emotional investment in the sessions. Low-income families with environmental and personal stressors, such as IPV in the caregiver relationship, may perceive that the costs of treatment outweighs the potential benefits, and thus will not engage in treatment unless they perceive the benefits outweighing the costs (Webster-Stratton, 1998).

The empirical literature presents varying conceptual frameworks for engagement (Littell et al., 2001). Some researchers define engagement as service usage behaviors, while others view engagement as an attitude that would likely result in greater benefit from services. A review of the literature revealed that researchers frequently use engagement interchangeably with various aspects of service usage, such as the initial acceptance of services (Carroll, Libby, Sheehan, & Hyland, 2001; Claus & Kindleberger, 2002; Meyers, Miller, Smith, & Tonigan, 2002). While the early stage of treatment is critically important to engagement, however, clinicians should not assume that engagement continues after it starts (Staudt, 2007). The literature also portrays engagement as client attendance patterns (Fiorentine, Nakashima, & Anglin, 1999; McKay, Stoewe, McCadam, & Gonzales, 1998), or client retention (Herinckx, Kinney, Clarke, & Paulson, 1997; McKay, Gonzales, Quintana, & Kim, 1999). However, in agencies or child advocacy centers treating abused children, clinicians often describe engagement as treatment compliance or adherence (Atkinson & Butler, 1996; Butler, Radia, & Magnatta, 1994; Famularo, Kinscherff, Bunshaft, Spivak, & Fenton, 1989; Swanson, Pantaloni, & Cohen, 1999).

Due to the many variations in definitions, inconsistency exists within the literature regarding measures of constructs related to engagement (Yatchmenoff, 2005). Researchers base most measures of engagement on service usage, frequency of sessions attended, duration of the therapeutic relationship, completion of treatment, compliance, or proportion of sessions attended out of all scheduled appointments (Atkinson & Butler, 1996; Butler et al., 1994; Dore & Doris, 1997; Dumas & Albin, 1986; Famularo et al., 1989; Fiorentine et al., 1999; McKay et al., 1998; Peled & Edleson, 1998; Rife, First, Greenlee, Miller, & Feichter, 1991). For the purposes of this study, engagement relates to specific measures of attendance and reasons for discharge as determined by the child abuse agency, and includes: (a) the number of sessions attended, (b) the number of sessions missed, (c) whether the client graduated from services (i.e., attained their treatment goals, per the therapist's recommendation), and (d) whether the client prematurely terminates from treatment (i.e., after administrative discharge due to excessive absences, dropping out of services, being rejected for services after a few sessions, leaving after attaining only some of their treatment goals, or leaving for other unspecified circumstances not listed above).

### **Chapter Summary**

This review of the literature examined past and current definitions, theories, and research on CSA, IPV, traumatization, and treatment engagement. There exists a need for more specific studies in order to explore the impact of caregiver IPV on the treatment outcomes and attrition rates of CSA victims. Koverola et al., (2007) examined treatment attrition trends of maltreated children in violent homes, but the study focused on a heterogeneous sample of children, all of whom had a history of family violence. Horowitz and colleagues (1997) conducted a study on

factors affecting utilization of treatment for sexually abused girls. However, this study only examined female “completers,” and thus did not address associations between length of treatment and demographic or other variables. Furthermore, neither the Koverola et al. (2007) study nor the Horowitz et al. (1997) study explored the influence of caregiver IPV on service usage, or compare findings to a control group of CSA victims without past or current caregiver IPV.

After reviewing the literature, I found no studies simultaneously examining whether a relationship exists between caregiver IPV, child trauma, and the number of sessions attended and/or missed by a CSA victim. Additionally, I found no studies examining the relationship between caregiver IPV and the reason for a CSA victim’s treatment discharge (e.g., graduation, premature termination). Finally, I found no studies examining the differences in trauma symptomology between CSA victims with past or current caregiver IPV, and CSA victims without caregiver IPV. Determining the influence of caregiver IPV on posttraumatic stress, cognitive schemas, reason for discharge, and service usage among victims of CSA will help clinicians make immediate and practical decisions about treatment planning before the therapeutic relationship begins. I discuss the methodology of this study in the following chapter.

### CHAPTER 3: METHODOLOGY

In empirically supported therapies for CSA victims, over 80% of sexually abused children demonstrate a reduction of trauma symptomology, depression, externalizing behaviors within 12 to 16 sessions occurring once a week for 60 to 90 minutes (Deblinger, Lippmann, & Steer, 1996). However, high treatment attrition levels prevent abused children from getting the full treatment benefits they need (Kazdin & Wassell, 1998; Lau & Weisz, 2003; Phillips et al., 2000; Weed, 2007). When examining child treatment attrition, it is crucial to consider caregiver variables because caregivers usually make treatment decisions for their children. Therefore, the purpose of this dissertation is to examine both child and family characteristics simultaneously with attrition patterns in order to provide a more complete picture for the ways concurrent family violence influences treatment for CSA victims.

Specifically, this dissertation aims to determine if a set of child trauma measures can predict (a) the presence of IPV, (b) the number of sessions attended and/or missed by CSA victims, and (c) whether or not a CSA victim will graduate or prematurely terminate from treatment. These child trauma measures examine disturbances in posttraumatic stress and child cognitive self-development (e.g., self-safety, self-trust, self-esteem, self-control, other control, and other intimacy). Similarly, this dissertation aims to determine whether the presence of past or current caregiver IPV can predict (a) disturbances in posttraumatic stress and child cognitive self-development, (b) the number of sessions attended and/or missed by CSA victims, and (c) whether or not a CSA victim will graduate (i.e., fulfilled all treatment goals) or prematurely terminated from treatment (i.e., after partially completed goals, administrative discharge, dropped out, being rejected for services, leaving as a result of special circumstances categorized

as “other”). In this chapter, I discuss the research questions, research design, sample participants, instrumentation, data collection, data analysis, and a summary.

### **Research Questions**

This study aims to investigate the relationship between caregiver IPV, service usage, reason for discharge, posttraumatic stress, and trauma-related cognitive schemas among CSA victims receiving services at a child abuse agency. To achieve this goal, I identified five research questions and seven null hypotheses that warranted investigation. Analyzing the hypotheses and answering the following research questions may illuminate any relationships that might exist between child trauma factors, family violence, and treatment attrition for CSA victims.

The first research question investigated the relationship between posttraumatic stress, child cognitive self-development, and caregiver IPV among CSA victims. The answer to this question demonstrated the relationship between the potential effects of CSA on the child and the presence of caregiver IPV. I examined the null hypothesis that no relationship existed between posttraumatic stress, child cognitive self-development, and caregiver IPV.

The second research question investigated the relationship between service usage, posttraumatic stress, and child cognitive self-development among CSA victims. Answering this question demonstrated the relationship between the potential effects of CSA and the number of sessions attended and/or missed by the child. To answer this question, I examined the two null hypotheses that (a) no relationship existed between number of session attended, posttraumatic stress, and child cognitive self-development, and (b) no relationship existed between number of session missed, posttraumatic stress, and child cognitive self-development.



The third research question investigated the relationship between reasons for discharge, posttraumatic stress, and child cognitive self-development among CSA victims. Answering this question demonstrated the relationship between the potential effects of CSA and whether the child graduated or prematurely terminated from treatment. To answer this question, I examined the null hypothesis that no relationship exists between reasons for discharge, posttraumatic stress, and child cognitive self-development.

The fourth research question investigated the relationship between caregiver IPV and client service usage among CSA victims. Answering this question demonstrated the relationship between the presence of past or current caregiver IPV and the CSA victim's treatment attendance patterns. To answer this question, I examined the two null hypothesis that no relationship exists between past or current caregiver IPV and the number of sessions attended and/or missed by CSA victims.

The fifth research question investigated the relationship between caregiver IPV and client reason for discharge among CSA victims. Answering this question demonstrated the relationship between the presence of past or current caregiver IPV and whether the CSA victim graduated or prematurely terminated from treatment. Thus, I examined the null hypothesis that no relationship exists between past or current caregiver IPV and treatment attrition for CSA victims.

### **Research Design**

This study utilized quantitative research methodology and employed a correlational research design. Correlational studies are useful when a researcher seeks to measure several variables simultaneously, but unlike experimental design, none of the variables are manipulated. Although researchers cannot infer causality in correlational studies, examining relationships

between variables is often the first step toward demonstrating causality for future studies. In other words, things that are causally related must first be correlated.

Regardless of research design, all studies face both threats to internal and external validity (Onwuegbuzie & McLean, 2003). When a researcher controls variables within a study to confirm that the study examines what it has intended to test, he or she is ensuring internal validity (Shadish, Cook, & Campbell, 2002). Furthermore, external validity refers to the generalizability of the study findings to the greater population of individuals (Shadish et al., 2002). Correlational research designs tend to have greater control of internal threats to validity, and less control over external validity (Fraenkel et al., 2011). Specific threats to internal and external validity for this study are discussed at length in the limitations section of this chapter.

In working with archival (e.g. existing) data, a researcher must confirm that the data collection occurred in a standardized, consistent manner in order to protect internal validity. Researchers must also pay close attention to how the data is transferred from its original source (e.g., Excel reports, client files) into statistical software for analysis. Therefore, I triple-checked entries to avoid errors after entering data into the Statistical Package for the Social Sciences (SPSS). Additionally, the proposed dissertation seeks to limit threats to external validity by ensuring that data is representative of a diverse sample of clients with varying ages, races, and household incomes. Yet other external factors, such as previous counseling experiences, time between the abuse event and treatment, and differences in cognitive development among study participants cannot be controlled and may influence the study results.

## **Sampling and Participants**

The target population for this study included CSA victims receiving treatment at a child abuse agency. I employed a purposive sampling method to select participants for this study. From an overall population of all clients receiving services between January 1, 2009 and December 31, 2011, I sampled CSA victims if they completed both the TSCC and TABS pretest assessments measuring their baseline level of posttraumatic stress and overall disturbance of trauma-related cognitive schemas. Trauma experts state that researchers should explore the effects of CSA using multiple assessments in combination with clinical interview. While a CSA victim may not exhibit posttraumatic stress, many still exhibit clinically significant disturbances in their trauma-related cognitive schemas (i.e., beliefs and assumptions about themselves, others, and the world around them.) Not only do posttraumatic stress and trauma-related cognitive schemas hold implications for the child's functioning, they hold implications for the therapeutic relationship, offering further support as to why these constructs should be assessed before treatment begins.

Clients received these assessments from agency staff if they were at least 8-years-old, which is the minimum age identified by both TSCC and TABS manuals as developmentally appropriate for assessment comprehension. Clients younger than 8-years-old took other assessments for young children that measured different constructs than those examined for this study. Furthermore, while the agency made efforts to administer both assessments to those clients who meet the age requirements, not all clients completed both TSCC and TABS pretests, especially if they were deemed inappropriate for services early in treatment. I selected participants for this study based on whether they took both assessments, and left out those who

did not meet the age requirement and/or only took one of the assessments. While NCA Trak does not generate reports containing each client's assessment scores, the program does indicate which clients received both assessments. In order to include these assessment scores within my dataset, I reviewed the charts and manually input the trauma scores of 158 clients who took both assessments, as indicated by NCA Trak.

This study obtained an appropriate sample size based on power analysis in order to reduce the likelihood of Type II errors. For a correlational study, Balkin (2011) defines power as the long-term probability of correctly rejecting a null hypothesis that there is no relationship between variables given the effect size, sample size, and alpha level. Power analyses are calculated before the study begins (e.g. *a priori*) in order to make intentional decisions to avoid accepting a statistical test that fails to reject the false null hypothesis (e.g. Type II error) (Onwuegbuzie & Leech, 2004; Balkin, 2011). Cohen (1992) argues that researchers should look at the power of a sample size to make sure they have enough in their sample to calculate truly an effect versus error. Confidence intervals, sampling error, variability, and total sample size can be used to calculate a sample size (Cohen, 1988). Therefore, prior to conducting statistical analyses, I referred to Cohen's (1992) rules regarding sample size in order to identify a median effect size for correlational analyses (power = .80) at the .05 level. With a sample size of 158 participants, I exceeded the minimum recommended sample size ( $N=102$ ) to ensure adequate power for all five research questions posed in the current study. The final sample included 158 CSA victims, 77 of which had caretakers that reported past or current IPV, and 53 of which had caretakers that reported no past or current IPV, and 27 of which had an "unknown" caregiver IPV status. Those with an "unknown" caregiver IPV status were not included in this study for several reasons. In order to prevent obscuring the results of this study, those clients with an "unknown" caregiver

IPV status were not included in analyses related to IPV. For those analyses (research questions 1, 4, and 5), the sample was reduced to 132 participants, which still exceeds the minimum power requirements for statistical procedures yielding a medium effects size.

Purposive sampling strengthens internal validity, as assessment results only reflect posttraumatic stress and trauma-related cognitive schemas of clients receiving services for sexual abuse, as opposed to physical abuse, neglect, or psychological abuse. However, purposive samples are not without limitations. For example, a researcher may set the criteria for a sample in such a way that could bias potential study findings (e.g. researcher bias; Fraenkel et al., 2011). The present study seeks to reduce researcher bias by selecting a diverse sample of participants (e.g. ethnicity, age, and socioeconomic status). I discuss the sample demographics and instrumentation used to answer the research questions in the next sections.

### **Sample Demographics**

The mean age reported for the sampled 158 children was ( $M = 13.04$ ,  $SD = 2.145$ ), with the range from eight to 18 years of age. The majority of the sample was female, 128 (81.5%) females, with only 29 (18.5%) males. Ninety-one children identified themselves as White (58%), 29 White Hispanic/Latino (18.5%), 28 Black/African American (17.8%), 3 Black Hispanic (1.9%), 4 Black/White Biracial (2.5%), 1 Asian (0.6%), and 1 child reported unknown racial-ethnic background (0.6%).

The mean age reported for the primary caregivers of the 158 sampled children was ( $M = 41.53$ ,  $SD = 9.28$ ), with a range from 26 to 71 years of age. Six (3.8%) had missing data for primary caregiver's age. Eighty-eight primary caregivers identified themselves as White (55.7%), 32 White Hispanic/Latino (20.3%), 33 Black/African American (20.9%), 1 Asian

(0.6%), and 4 caretakers reported unknown racial-ethnic background (2.5%). Seventy-nine (50%) primary caretakers identified themselves as the biological mother of the child in treatment, 50 (31.6%) as biological father, and 30 (14.7%) as another kind of relative. Three (2%) had missing data for primary caregiver's relationship to the child in treatment. Eighty-eight (55.7%) primary caretakers were female, and 67 (42.4%) were males. Three (1.9%) had missing information regarding caregiver gender. Furthermore, out of the 158 children sampled for this study, 54 primary caretakers denied past or current IPV, 77 confirmed past or current IPV, and 27 failed to report any information regarding past or current caregiver IPV.

Appendix B presents the participant demographic information based on whether they graduated or prematurely terminated from treatment.

### **Instrumentation**

All participants and their caregivers provided demographic, parent, and abuse-related information to the child abuse agency at intake. Furthermore, all participants completed pretest assessments to measure the constructs of posttraumatic stress and overall disturbance of trauma-related cognitive schemas. Empirically valid assessments include the best method to gauge true differences of well-defined constructs, such as posttraumatic stress and trauma-related cognitive schemas. Therapists for CSA victims input information about demographic, caregiver, abuse, and session characteristics into NCA Trak database, as well as on the discharge summary form. Both caregivers and therapists participated in recording demographic, caregiver, and abuse information on the intake questionnaire. Finally, the CSA victims themselves completed two pretest assessments measuring baseline posttraumatic stress and trauma-related cognitive schemas. I uploaded all data into SPSS, followed by analysis. Following is a list of instruments

used in this study.

### **Intake Questionnaire**

This study used the Intake Questionnaire, developed and used by the child abuse agency, which collected demographic and abuse-related information on the victim and caregiver. Specifically, the questionnaire gathered information on age, race, language, gender, the presence of caregiver IPV, substance abuse, education level, income level of household, marital status and caregiver relationship for each CSA victim and his or her caregiver(s). The questionnaire also provided details about the abuse, perpetrator, and the child's baseline physical, emotional, cognitive, and psychological functioning. The child abuse agency included the intake questionnaire in the admissions paperwork for clients. Both caregiver and/or clinician fill out the questionnaire based on both parent and child interview responses. The therapists administered the questionnaire to clients and caregivers after reading and signing an informed consent to treatment. Agency staff collected client data prior to clients receiving services, and then input data into the NCA Trak database.

### **National Children's Alliance Database (NCA Trak)**

The National Children's Alliance (NCA) Database, otherwise known as NCA Trak, is a national data collection system developed specifically for child advocacy centers (CACs) that have met the NCA standards for accreditation. A CAC receives accreditation if it meets the following ten standards: (1) A multidisciplinary team from various medical, law enforcement, legal, and mental health agencies, (2) case review, (3) medical evaluation, (4) forensic interviews, (4) victim advocacy, (5) mental health services, (6) therapeutic intervention, (7)

culturally competent and diverse staff members, (8) organizational capacity, (9) case tracking, and (10) a child-friendly facility (Thacheray, Scribano, & Rhoda, 2010). CAC's use the NCA Trak data collection and reporting system to store data on all of their clients.

This national data archive also provides opportunities for research on treatment efficacy and therapeutic outcomes. Based on the information entered into the system, the CAC generates reports on child and caretaker demographics, child protective services and law enforcement outcomes, screening and referral information, staff caseloads, client service usage (e.g., number of sessions attended and/or missed), session type (e.g., individual, group, family, or crisis), assessment information, the client's presenting information, and client allegations. The child abuse agency generated and provided these reports for analysis.

One limitation of utilizing NCA Trak data for research is that the database does not have the capability or infrastructure for computing its own statistical analyses. Therefore, researchers must first convert the reports to an excel spreadsheet and code the data before uploading them into SPSS for statistical analysis. The child abuse agency released no identifying information on clients or caretakers to the researcher within these reports.

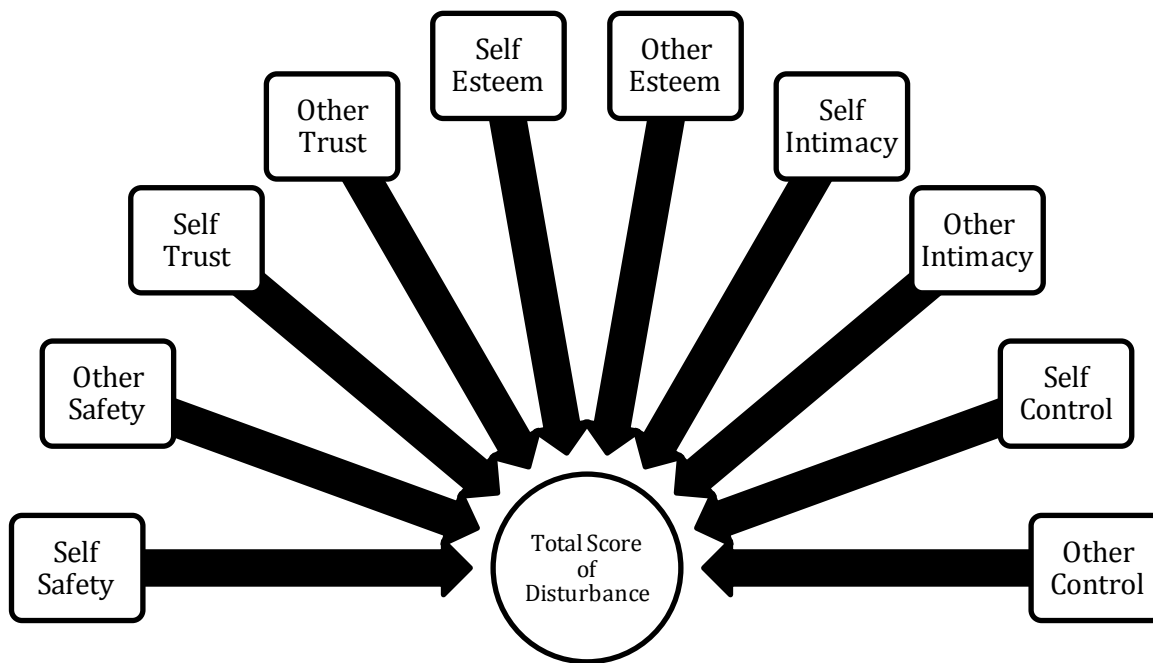
### **Trauma and Attachment Belief Scale (TABS)**

The Trauma Attachment and Belief Scale (TABS; Pearlman, 1996, 2003), formerly known as the TSI Belief Scale, Revision L (Pearlman, 1996, 2003) is an 84-item assessment designed to measure trauma-related cognitive schemas. Based on Constructivist Self-Development Theory (CSDT; McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995; Saakvitne et al., 2000), which posits that survivors of trauma adopt maladaptive and dysfunctional beliefs about themselves and others after a traumatic event, the TABS was



developed incorporating CSDT and elements selected from existing theoretical and empirical literature on the relationships among traumatic stress, cognitions, and needs. Specifically, the TABS measures disruptions in five psychological need areas: (a) safety, (b) trust, (c) esteem, (d) intimacy, and (e) control. The 10 subscales measuring these five needs reflect the expression of the need in perceptions of both the self and others (Varra, Pearlman, Brock, & Hodgson, 2008). Items are presented on a 6-point Likert scale, ranging from 1 (strongly disagree) to 6 (strongly agree).

Clinicians add raw scores into the 10 subscales (e.g. self-safety, other-safety, self-trust, other-trust, self-esteem, other-esteem, self-intimacy, other-intimacy, self-control, and other-control), and then add the subscales together to form the total score. Next, the clinician converts all scores into T scores with a mean of 50 and a standard deviation of 10. Missing or double marked responses default to the median substitution value that is bolded on the scoring sheet next to each individual item. Higher scores indicate higher levels of disturbance, as measured by the presence of these trauma-related cognitive schemas. Figure 1 contains a visual showing how the 10 subscales form the total score of cognitive disturbance analyzed in this study.



**Figure 1:** Scoring for the Trauma and Attachment Belief Scale

Based on recent factor analysis of the TABS (Varra, Pearlman, Brock, & Hodgson, 2008), this dissertation will examine subscales most closely associated with the Self factor, including: (a) self-safety, (b) self-trust, (c) self-esteem, (d) self-control, (e) other-control, and (f) other-intimacy. The two “other” subscales analyzed in this dissertation (e.g., other-control, other-intimacy) reflect a child’s view of self in relation to others, rather than one’s view of others (Varra et al., 2008). The authors reported a Cronbach’s alpha coefficient of .95 for the seven subscales within the Self factor. Furthermore, a high score on these subscales reflect a negative view of oneself, including doubting oneself, having disdain for oneself, and/or feeling powerless.

Not only is the instrument a helpful clinical tool that aids in identifying psychological themes in trauma-related cognitive schemas, it also highlights interpersonal and intrapersonal themes that are likely to emerge within the therapeutic process. Furthermore, the clinician uses the findings as a guide for developing the appropriate therapeutic approach for a particular client.

Published by Western Psychology Services, Inc., the TABS is also used to document progress and change within a particular client over the course of therapy. Because results are interpreted in a non-pathologizing manner, therapists collaboratively discuss results with clients and family members.

Researchers used both the TABS and its former version (e.g., the TSI Belief Scale) to study the cognitive schemas of a diverse variety of populations, including adult and child victims of direct trauma (Dutton, Burghardt, Perrin, Chrestman, Kelly et al., 1994; O'Shields, 1999), as well as professional helpers with vicarious traumatization providing services to traumatized adults and children. These professional helpers include therapists providing services to survivors of child abuse (Brady, 1998; Camerlengo, 2002; Dickes, 2001; Jones, 2009; Pinsley, 2000), female assault victims of IPV (Estassi, 2009), and terrorist attacks (McCabe-Bartley, 2006). Other studies used the TABS to measure vicarious traumatization in new therapists (Coyne, 2003), volunteer victim advocates (Slover, 1998), professional attendants of trauma-related conferences (Rooney, 2004), interpreters who work with torture survivors (Shlesinger, 2006), law guardians representing traumatized youth (Goldman, 2006), emergency nurses caring for trauma victims (Cowgur, 2007), caregivers of cancer patients (Chaunhan, 2008), and emergency dispatchers (Latter, 2004).

Pearlman (2003) designed the TABS using a theoretically guided and empirical approach. Normative data developed for the scale supports the TABS as a reliable and valid measure for both clinical and non-clinical populations. Additionally, the manual provides norms for both adults and adolescents. Evaluation on the TABS for reliability and validity (Pearlman, 2003; Varra et al., 2008) yielded sound evidence of content, construct, and criterion validity. Reliability is also acceptable, with a Pearson  $r$  score of .75, and an internal consistency alpha score of .96. In

a 2008 factor analysis on the TABS, Varra, et al. reported a three-factor solution (e.g., Self, Others, and Safety) that was relatively stable across two samples, reflecting important aspects of CSDT that are consistent with both previous empirical research and contemporary trauma theory. The Self, Others, and Safety subscales were at least moderately correlated (.43–.64) with high internal consistency. The three-factor solution had Cronbach's alpha coefficients of .95 (Self), .89 (Other), and .78 (Safety). The TABS reported the Cronbach's alpha reliability coefficients for the six examined subscales ranging from .76 to .87. In this sample, the six subscales of interest had alpha coefficients of (1) .90 for self-safety, (2) .90 for self-control, (3) .91 for self-trust, (4) .90 for self-esteem, (5) .90 for other-intimacy, and (6) .91 for other-control.

The first three research questions investigate constructs of child trauma and cognitive self-development in areas that previous research indicates are negatively affected by both CSA and family violence (McCann & Pearlman, 1990). These areas, which are central to CSDT, are as follows: (a) self-safety, (b) other-safety, (c) self-trust, (d) self-esteem, (e) self-control, (f) other-control, and (g) other-intimacy. Prior to discussing research questions, it is important to understand how these elevated scores are interpreted, especially in the context of the therapeutic relationship, and as described the TABS (Pearlman, 2003) professional manual. Exploring the relationships between these scales and attrition variables

**Self-Safety/Other-Safety Scales.** Disruptions in cognitive schemas can have a noticeable affect on the therapeutic relationship. Scales were selected for this study that were found relevant to child cognitive self-development in the context of family violence and/or sexual abuse. The professional manual of the TABS indicates that children with a high score on the self-safety scale often have experiences of violation of one's body, home, property, or loved ones (Pearlman, 2003). These disruptions coincide with the belief that there is no safe place, that one

is uniquely predestined for harm, and that future harm cannot be avoided. Furthermore, states Pearlman, trauma survivors often struggle to regulate their affect (Allen, 2001; Courtois, 2000, Saakvitne et al., 2000), survivors may become overwhelmed with strong feelings of rage, terror, anxiety, and/or grief. Children with elevated self-safety scores are struggling with issues of their own safety, and may worry that they may be victimized by another person or by themselves. Connors (2000), and Dieter, Nicholls, and Pearlman (2000) found that self-safety concerns are common who have suffered at the hands of others.

The other-safety scale was used as a substitute for the self-safety scale in research question one only, in order to correct a violation of linearity. Children with elevated other-safety scores are primarily concerned with the safety of their significant others. CSA victims who have siblings who are also being abused or caregivers engaging in IPV commonly elicit higher scores in this category. Pearlman (2003) points out that high other-safety scores could also indicate a child is worried about or struggling acting on impulses to harm others, as violent victimization activates the innate human capacity for aggressive behavior.

**Self-Trust Scale.** Respondents with elevated self-trust scores may be struggling to trust their own judgments and perceptions, and as a result, may rely heavily on others because they are skeptical of their own decision-making abilities or instincts. This scale was selected for the current study because it becomes elevated when a child is unable to protect their loved ones, which often includes an abused sibling or vulnerable parent. These experiences typically lead child survivors of abuse to doubt their own ability to think clearly or make sound judgments, and they frequently (and incorrectly) believe that his or her actions might have made a difference. This has implications for the therapeutic relationship, especially as it pertains to client

dependency on the therapist, or a client who tells a therapist (or caregiver) what they think others want to hear in order to avoid disappointing them, or to avoid getting into trouble.

**Self-Esteem Scale.** Disturbances in self-esteem are common among survivors of sexual abuse and/or family violence (cite). Children have a tendency to assume that their abuse was their fault or that they deserved it. In the concurrent family violence, children may feel responsible for their siblings or parent's safety and wellbeing due to a maladaptive belief that (a) they did not do enough to stop family violence despite their helplessness, or (b) they somehow cause the offender to physically or sexually abuse other family members through their words, beliefs, actions, or inaction. Children with low self-esteem generally lack empowerment in the therapeutic setting, placing them at increased risk for failing to meet their therapeutic goals.

**Self-Control/ Other-Control Scales.** Elevated scores in the areas of self-control and other-control are linked to traumatic experiences during which one was unable to help while other people suffered, which are common among children forced to watch parent or sibling abuse. Likewise, these disturbances may result from being forced to engage in harming others against their will, as sometimes happens in situations of childhood abuse. A child with restricted freedom or helplessness may exhibit symptoms of depression, irritability, or rage over feelings of being trapped by others, and thus, self-control disruptions may result in fear of losing control over one's emotions or behaviors. Children with high self-control scores may also be experiencing certain trauma-related symptoms (such as flashbacks, nightmares, and intrusive imagery) causing them to believe they are "going crazy" (Pearlman, 2003, p. 19). These disturbances have implications for the therapeutic relationship because these children have an intense need to control one's actions, feelings, and behaviors.

Similarly, children for whom other-control scores are elevated feel uncomfortable when they are not in charge, and have a strong desire to control other people. Pearlman (2003) states that children with high other-control scores may become enraged or aggressive, or may simply withdraw, if they are unable to control others. Furthermore, these children are often in conflict with others, especially those who demand their own independence. Therefore, therapists may find this type of client challenging, as these children frequently test the therapeutic relationship. Elevated scores in other-control are also linked to administrative discharge or outside referral because therapists commonly refer clients to other therapists if they perceive the child is not ready for trauma work.

**Other-Intimacy Scale.** Traumatic events that often give rise to disruptions in intimacy include the loss of an important attachment figure (e.g., death of a parent or other caregiver, or sudden traumatic loss of a loved one), alienation from others (e.g., being made to feel different in a traumatic context, such as when a sexual abuse perpetrator tells the victim he or she is special or different), and loss of community (e.g., a child being taken from his home or family without explanation or preparation, or an adult being terminated from a job under seemingly unfair, abrupt, or otherwise traumatic circumstances). People with elevated intimacy subscale scores are often withdrawn from others and avoid personal conversations or experiences that might invite emotional closeness. Feelings of isolation, loneliness, grief, detachment, and fear of connecting with others often accompany intimacy disruptions. A person with intimacy disruptions will have difficulty allowing him or herself to be known by a therapist.

**Other-Intimacy.** Finally, children who score high on the other-intimacy scale may be disconnected and isolated from others either interpersonally or emotionally. This has implications for the therapeutic relationship because, as Pearlman (2003) states, “For these

people, interpersonal situations are highly demanding and even frightening” (p.20). Achieving emotional intimacy is an important element of therapy because it aids the rapport building process between client and counselor. However, because those with elevated disturbances in other-intimacy schemas prefer to keep emotionally distant and avoid closeness with other people, treatment is particularly challenging for these children. Moreover, while the therapist may perceive the therapeutic relationship as genuine, children who avoid intimacy in the therapeutic relationship may have little ability to transfer the experience of therapy beyond the session. Conversely, this type of client may attend therapy sessions but leave his or her innermost struggles and feelings “in the waiting room” (p. 20). Therefore, high scores in other-intimacy cognitive disruption may prevent a child from attaining his or her therapeutic goals.

### **Trauma Symptom Checklist for Children**

To measure the construct of posttraumatic stress, I analyzed the posttraumatic stress scale of the Trauma Symptom Checklist for Children (TSCC; Briere, 1996). According to the TSCC manual, the posttraumatic stress scale consists of items “...reflecting classic posttraumatic symptoms, such as intrusive thoughts, sensations, and memories of painful past events, nightmares, fears of men or women, and cognitive avoidance of negative thoughts and memories” (Briere, 1996, p.13). Furthermore, the manual states that children with elevated posttraumatic stress scores are often preoccupied with one or more traumatic event from the past, frequently describing intrusive and persistent recollections and sensory re-experiencing of these events. Not only can these symptoms disrupt normal daily functioning for a CSA victim, they can lead to anxiety, distractibility, and/or irritability. Furthermore, children with elevated posttraumatic stress scores often report repetitive thinking about a traumatic event, blaming him-



or herself for the event, and/or imagining how the event could have been avoided or changed. Moreover, the TSCC manual states that fear, tension, jumpiness, emotional avoidance, derealization, and feelings of “going crazy” (p. 13) are common among those with elevated posttraumatic stress scores.

The TSCC is a useful measure for the psychometric assessment of traumatic symptoms in children and adolescents, helping clinicians understand a child’s symptomology over time. The 54-item self-report instrument is easy to administer, score, and interpret for children between the ages of 8 and 16 reporting the frequency of their thoughts, feelings, and behaviors related to any traumatic events they have experienced (Fernandez, 2001). Children rate items on a 4-point Likert scale ranging from 0 to 3. A score of 0 means that the child never has the indicated thought or emotion, 1 means that the child sometimes has the indicated thought or emotion, 2 means the child has the thought or emotion lots of times, and 3 means that the child has the thought or emotion almost all of the time. While 4-point likert scales typically have lower validity than 6 or 7-point likert scales, the authors sought to intentionally implement developmentally appropriate choices for children who may not be able to discern between overly broad or specific range of frequencies. The use of self-report measures with children poses challenges because children require accurate comprehension and expression perceived thoughts and feelings (Kurt & Merrell, 1998; Sadowski & Friedrich, 2000).

The normative sample consisted of three separate groups of children: (a) 2,399 school children participating in a study on the impacts of neighborhood violence in six different locations in Illinois and Colorado, (b) 387 children participating in a study on stressful life events, and (c) 222 children with relatives receiving medical treatment at the Mayo clinic in

Minnesota. Out of the 3,008 children in the normative sample, 53% were female. Furthermore, 44% of the children were Caucasian, followed by 27% Black, and 22% Hispanic.

The measure includes six clinical scales (e.g., anxiety, depression, posttraumatic stress, sexual concerns, dissociation, and anger) and four subscales (e.g., sexual preoccupation, sexual distress, fantasy, and overt dissociation). Additionally, due to motivational and response distortion tendencies inherent in self-report measures (Boyle, 2003), two validity scales are included to protect against children who mark either 0 or 3 indiscriminately, when compared to the response rates of the normative sample. A T-score of 70 or above in the underresponse scale, or a T-score of 90 in the hyperresponse scale makes the assessment null and void. Scale scores are totaled and converted to T-scores based on tables provided in the assessment manual. Due to significant age and gender effects, the manual provides separate norm tables for boys and girls, which are also divided by the two age groups of 8-to-12 year olds and 13-to-16-year-olds. The TSCC does not provide a total score of overall disturbance.

Briere (1996) designed the six clinical scales to measure a variety of symptoms associated with traumatic responses. The anxiety scale is used to identify generalized anxiety, hyperarousal, worry, or a sense of impending danger. The depression scale identifies feelings of sadness, loneliness, and suicidal thoughts. The anger scale identifies angry thoughts and behavior. The dissociation scale identifies the presence of daydreaming and emotional numbing, and is divided into two subscales: overt dissociation and fantasy. The sexual concerns scale estimates the frequency of sexual thoughts and negative responses to sexual stimuli, and is also divided into two subscales: sexual preoccupation and sexual distress. Finally, the posttraumatic stress scale examines the presence of symptoms on all three PTSD symptom clusters, including

as nightmares and intrusive thoughts, as described in the *DSM-IV-TR*'s Criterion B of the PTSD diagnosis.

The TSCC is sensitive to caregiver or family conflict, with elevated scores found for children exposed to violence or parental divorce. Furthermore, the posttraumatic stress subsection is particularly helpful at identifying symptoms that may arise after CSA (Sadowski & Friedrich, 2000), and more closely correlates with the “hyperarousal” and “intrusive thoughts” subsections than the “avoidance” subsection on the Children’s Impact of Traumatic Events Scale-Revised (CITES-R), another measure that assesses for PTSD symptom in children (Crouch et al., 1999; Sadowski & Friedrich, 2000). Therefore, because posttraumatic stress is often reported in both CSA victims and child witnesses of IPV, I focused primarily on this scale from the TSCC.

The TSCC is one of the most commonly used measures for exploring sexual abuse sequelae in children and adolescents (Elhai, Gray, Kashdan, & Franklin, 2005). The assessment has moderate to high convergent and discriminant validity (Boyle, 2003) high construct validity, (Sadowski & Friedrich, 2000) and high internal consistency (Bal, DeBourdeaudhujj, Crombez, & Van Oost, 2005; Crouch et. al, 1999; Lanktree & Briere, 1995). Because of its sound reliability and validity, researchers use the scale to validate other measures related to sexual abuse, such as the Child Report of Treatment Issue Resolution (Nelson-Gardell, 1997). Furthermore, while the TSCC assessment manual reports a Cronbach alpha reliability score of .85 for the posttraumatic stress scale, the Cronbach alpha reliability score for posttraumatic stress in this study was higher at .91.

As with most standardized measures, the TSCC is not without limitations. First, the normative sample hails primarily from Midwestern states, decreasing the generalizability to

broader samples. Moreover, the manual did not report estimates of test-retest reliability, and therefore, would benefit from additional measures of stability. While Briere (1996) developed and based each of the scales on theory and empirical research, the scale needs a confirmatory factor analysis to verify the factor structure of the assessment. Finally, future research should determine whether separate norms are needed for different cultural or racial groups.

### **Discharge Summary Form**

The treating clinician completed the discharge summary form and placed it in the client's file after services ended. The form includes information about the number of sessions attended, and whether the client graduated after successfully meeting treatment objectives or prematurely terminated from services. According to the agency, a child prematurely terminates when they leave before meeting all of their treatment goals, are administratively discharged due to absences, the client drops out from services, the agency finds the client inappropriate for services, or the client leaves due to special circumstances labeled as "other." Clinicians then upload the information into the NCA Trak database.

### **Procedures**

Upon Institutional Review Board's (IRB) approval, I contacted the director of mental health services at the child abuse agency to establish onsite data collection dates. The collection of archival data occurred between July 2010 and January 2012. Since the researcher used existing data, no incentives were offered to any participants. For this study, the child abuse agency generated sanitized reports from NCA Trak on all clients that participated in treatment between the dates of January 1, 2009 to December 31, 2011. These reports included information

on type of abuse, client and caretaker demographic information, service usage, reason for discharge, referral source, law enforcement outcomes, and assessment administration dates.

The child abuse agency collected data on their clients at various points during their treatment. Prior to the client beginning treatment, they filled out forms and questionnaires within the agency's intake paperwork packet. The therapist administered and scores both the TABS and TSCC assessments to those clients who meet the age requirement (i.e., at least 9 years old) at intake, 12 sessions, 6 months, and post treatment. For this study, however, I only analyzed scores from the pretests administered at intake, which measure baseline levels of trauma and cognitive disturbance. The treating therapists collected information on service usage, attendance, and reason for discharge on a weekly basis, and entered the information into the NCA Trak database.

For this study, I analyzed T-scores for both the TABS and TSCC as apposed to mean scores. According to Pallant (2007), T-scores are a better indicator of how the sample compares to the norm groups for each assessment, however, a researcher may choose to analyze mean scores to prevent the likelihood that missing assessment items will decrease the overall sample size. Because my assessments have a built in procedure for supplanting missing items with recommended replacement scores based on the norm sample, missing items were not an issue in this dissertation.

The child abuse agency generated sanitized reports from NCA Trak on all clients that participated in treatment between the dates of January 1, 2009 to December 31, 2011. These reports included information on type of abuse, demographic information, service usage, reason for discharge, and assessment administration dates. After completing the necessary background checks with the local sheriff's department, I traveled to the agency approximately ten times to record all assessment scores into a spreadsheet organized by client number. Other than client

numbers, I recorded no client identifying information on the spreadsheet. The agency stored all reports on a laptop with a password encryption in order to prevent other parties from viewing the files. The director of the mental health department oversaw all data transferring, and securely stored all reports and spreadsheets on site until she evaluated and approved the information. Once approved, the mental health director of the agency emailed all sanitized reports and spreadsheets to the research team via email. I handled data in a manner to protect confidentiality of client information and of the data itself. Furthermore, after study completion, I deleted e-mailed reports and emptied the trash folders so only printed hard copies of the data remained.

### **Data Analyses**

After the data collection process, the data was entered into a database and analyzed by Statistical Package for the Social Sciences (Version 18) using Logistic Regressions, Poisson Regressions, and a Chi-Square for Test for Independence. I also completed a preliminary analysis, or data screening process, prior to conducting any of the statistical analyses for this study (Tabachnik & Fidell, 2007) to assess the fit between the distribution of the variables and the assumptions of the statistical analysis, such as normality, homogeneity of variance, linearity, and multi-collinearity. In order to meet the assumptions for some analyses, various modifications were made to the variables of interest. Variable modifications will be discussed in detail as they relate to each research question in the following section.

### **Research Question 1**

The first research question asks: What is the relationship between caregiver intimate partner violence (IPV; as reported to the National Children's Alliance Database [NCA Trak] by

the therapist, posttraumatic stress (as measured by the posttraumatic stress scale of the Trauma Symptom Checklist for Children; TSCC; Briere, 1996), and child cognitive self-development (as measured by the self-safety, self-trust, self-esteem, self-control, other-intimacy, and other-control subscale scores of the Trauma and Attachment Belief Scale; TABS; Pearlman, 2003)?

**Null Hypothesis 1A.** No relationship exists between caregiver IPV, posttraumatic stress, and child cognitive self-development for victims of CSA receiving mental health services at a child abuse agency. To explore the relationships in Null Hypothesis 1A, I conducted a logistic regression, which is used when analyzing relationships between one dichotomous dependent variable (i.e., Caregiver IPV: Yes/No), and two or more continuous independent variables (i.e., posttraumatic stress score of the TSCC and the self-safety, self-trust, self-esteem, self-control, other-intimacy, and other-control subscale scores of TABS) (Hair, Black, Babin, & Anderson, 2010). For a Logistic Regression with seven independent variables, a sample size of 102 was acceptable for identifying a median effect size (power = .80) at the .05 level (Cohen, 1992).

Upon screening the data for violations of assumptions related to linearity, independence of errors, and multi-collinearity, the subscale of self-safety was identified as violating the assumption of linearity. In order to correct this, I removed the self-safety subscale and replaced it with another TABS subscale related to safety (e.g., other safety) that did not violate the assumption of linearity. The other-safety subscale was chosen as a replacement for the self-safety subscale because it examines the child's assumptions pertaining to the safety of other people. Moreover, other-safety is relevant in the context of the current study's stated purpose of exploring the relationship between trauma-related cognitive schemas and the presence of caregiver IPV among CSA victims. After these subscales were switched, no violations of assumptions were identified.

## **Research Question 2**

The second research question asks: What is the relationship between service usage (as recorded on the client discharge summary form), posttraumatic stress (as measured by the posttraumatic stress scale of the Trauma Symptom Checklist for Children; TSCC; Briere, 1996), and child cognitive self-development (as measured by the self-safety, self-trust, self-esteem, self-control, other-intimacy, and other-control subscale scores of the Trauma and Attachment Belief Scale; TABS; Pearlman, 2003) among CSA victims?

**Null Hypothesis 2A.** No relationship exists between the number of session attended, posttraumatic stress, and child cognitive self-development for victims of CSA receiving mental health services at a child abuse agency. A Poisson Regression is used when analyzing relationships between one continuous “count” dependent variable (i.e., number of sessions attended) and two or more continuous independent variables (i.e., posttraumatic stress score of the TSCC and the self-safety, self-trust, self-esteem, self-control, other-intimacy, and other-control subscale scores of TABS) (Gall, Gall, & Borg, 2007). Specifically, Poisson Regression is appropriate for “determining the correlation between a set of predictor variables and a criterion variable that is in the form of a frequency count” (Gall, Gall, & Borg, 2007, p. 354). For a Poisson Regression with seven independent variables, a sample size of 102 was acceptable for identifying a median effect size (power = .80) at the .05 level (Cohen, 1992).

**Null Hypothesis 2B.** No relationship exists between the number of sessions missed, posttraumatic stress, and child cognitive self-development for victims of CSA receiving mental health services at a child abuse agency. The dependent variable (e.g., number of sessions missed) was formed by calculating the sum of sessions canceled and sessions no-showed by each client.



Similar to Null Hypothesis 2A, I conducted a Poisson Regression to explore relationships between the continuous dependent variable, or “count” variable” (i.e., number of sessions missed) and two or more continuous independent variables (i.e., posttraumatic stress score of the TSCC and the self-safety, self-trust, self-esteem, self-control, other-intimacy, and other-control subscale scores of TABS) (Pallant, 2007). For a Poisson Regression with seven independent variables, a sample size of 102 was acceptable for identifying a median effect size (power = .80) at the .05 level (Cohen, 1992).

### **Research Question 3**

The third research question asks: What is the relationship between reasons for discharge (as recorded on the client discharge summary form), posttraumatic stress (as measured by the posttraumatic stress scale of the Trauma Symptom Checklist for Children; TSCC; Briere, 1996), and child cognitive self-development (as measured by the self-safety, self-trust, self-esteem, self-control, other-intimacy, and other-control subscale scores of the Trauma and Attachment Belief Scale; TABS; Pearlman, 2003) among CSA victims?

**Null Hypothesis 3A.** No relationship exists between reason for discharge (i.e., graduation or premature termination), posttraumatic stress, and child cognitive self-development for victims of CSA receiving mental health services at a child abuse agency. To explore the relationships in Null Hypothesis 3A, I conducted a Logistic Regression, which is used when analyzing relationships between one dichotomous dependent variable (i.e., graduation or premature termination), and two or more continuous independent variables (i.e., posttraumatic stress score of the TSCC and the self-safety, self-trust, self-esteem, self-control, other-intimacy, and other-control subscale scores of TABS) (Hair, Black, Babin, & Anderson, 2010). For a

Logistic Regression with seven independent variables, a sample size of 102 was acceptable for identifying a median effect size (power = .80) at the .05 level (Cohen, 1992).

#### **Research Question 4**

The fourth research question asks: What is the relationship between caregiver IPV (as reported to the National Children's Alliance Database [NCA Trak] by the therapist) and client service usage (as recorded on the client discharge summary form)?

**Null Hypothesis 4A.** There is no relationship between caregiver IPV and number of sessions attended for victims of CSA receiving mental health services at a child abuse agency. To explore the relationships in Null Hypothesis 4A, I conducted a Poisson Regression, which is used when analyzing relationships between one categorical or dichotomous dependent variable (i.e., caregiver IPV: Yes/No) and one or more continuous or categorical predictor independent count variables (i.e., number of sessions attended) (Pallant, 2007). For a Poisson with three independent variables, a sample size of 76 was acceptable for identifying a median effect size (power = .80) at the .05 level (Cohen, 1992).

**Null Hypothesis 4B.** There is no relationship between caregiver IPV and number of sessions missed for victims of CSA receiving mental health services at a child abuse agency. Similar to null hypothesis 4A, I conducted a Poisson Regression, which is used when analyzing relationships between one categorical or dichotomous dependent variable (i.e., caregiver IPV: Yes/No) and one or more continuous or categorical predictor independent count variables (i.e., number of sessions missed) (Pallant, 2007). For a Poisson with three independent variables, a sample size of 76 was acceptable for identifying a median effect size (power = .80) at the .05 level (Cohen, 1992).

## **Research Question 5**

The fifth research question asks: What is the relationship between caregiver IPV (as reported to NCA Trak by the therapist) and client reason for discharge (as recorded on the client discharge summary form)?

**Null Hypothesis 5A.** There is no relationship between caregiver IPV and client reason for discharge (i.e., graduation or premature termination) for victims of CSA receiving mental health services at a child abuse agency. To explore the relationships in Null Hypothesis 5A, I conducted a Chi Square Test for Independence, which is used when analyzing relationships between one categorical dependent variable (i.e., caregiver IVP: yes/no) and one categorical independent variable (i.e., graduation or premature termination) (Pallant, 2007). For a Chi Square Test for Independence with 2 degrees of freedom, a sample size of 107 was acceptable for identifying a median effect size (power = .80) at the .05 level (Cohen, 1992).

## **Limitations**

I received approval from the University's Institutional Review Board (IRB) after they determined that the proposed research utilizing existing, retrospective data did not constitute human research as defined by Department of Health and Human Services regulations or Food and Drug Administration regulation standards (see Appendix A). Furthermore, because the data was archival, the IRB did not require an informed consent for the participants covering the purpose of the study, investigators' qualifications, voluntary nature of research, contact for questions, and possible risks or harm incurred in the process of research (Department of Health and Human Services, 2009). For over 80 years, the systematic investigation of historical records has guided clinical research (Butler & Quinlan, 1958; Wu & Ashton, 1997) especially for

epidemiological investigations (Haley et al., 1980; Jansen et al., 2005) and mental health research (Hellings, 2004; Rajeev, Srinath, Girimaji, Seshadri, & Singh, 2004).

However, some important considerations should be noted. First, Hess (2004) and Jansen et al. (2005) pointed out that research on archival data requires the researcher to utilize data sets often not collected for the purpose of research. Despite the utility of researching existing datasets, its application is somewhat limited, sometimes yielding questionable findings. As a result, retrospective research is often undervalued and underutilized in the field of mental health (Gearing, Mian, Barbr, & Ickowicz, 2006). In their article presenting a methodology for conducting retrospective chart review research in child and adolescent psychiatry, Gearing, Mian, Barbr, and Ickowicz (2006, p. 127) listed some of common methodological limitations to include, "...incomplete documentation, difficulty interpreting information found in documents, problematic verification of information, difficulty establishing cause and effect, and variance in the quality of information recorded by medical professionals." Moreover, the researcher cannot monitor the accuracy of data collection between the individuals recording the data. Despite these limitations, retrospective research on existing data offers numerous advantages, including inexpensive and easy access to rich datasets. Furthermore, it prevents a researcher from potentially causing harm to vulnerable populations such as abused children (Hess, 2004; VonKoss Krowchuk, 2004; Moore & Richardson, 1995; Wu & Ashton, 1997; Worster & Haines, 2004).

The most critical consideration for researching existing data on abused children is maintaining confidentiality. To manage this risk, the child abuse agency did not allow any data with identifying client information off their property. Instead, they provided all data via email without any identifying client information. Furthermore, the researcher did not release the name

of the child abuse agency in this study. The findings were written in a manner that does not reveal the location or setting of the child abuse clinic in order to protect the identities of any children or caretakers receiving services within the study time period.

Threats to both to internal validity exist in my study. Threats to internal validity reduce a researcher's confidence in stating that a relationship exists between the independent and dependent variables. Threats to external validity reduce a researcher's confidence in stating whether the study's results are applicable to other groups. Researchers utilizing an experimental or quasi-experimental design use control groups to reduce threats to internal and external validity. However, because I am utilizing a correlational research design that explores relationships, I am not able to utilize a control group or manipulate variables because the data is archival. Another primary threat to internal validity is the presence of extraneous or confounding variables in the sample, such as length of time between traumatic event and onset of treatment, varying risk and protective factors between families, and prior counseling experiences. An example of a threat to external validity is generalizability, which may be limited depending on the demographic features of the sample obtained from the child abuse agency. Moreover, all data collection instruments have some measurement of error even with psychometrically sound qualities (e.g. reliability and validity). The use of self-report measures with children can be problematic because the assessments require an ability to accurately comprehend and express thoughts and feelings (Kurt & Merrell, 1998; Sadowski & Friedrich, 2000). Furthermore, it is exceedingly difficult, and in many cases impossible, to determine if symptoms like depression, anxiety, hyperarousal, or poor behavior arose after the children experienced a traumatic event, or if these difficulties were evident prior to the event. Yet research shows that child self-report instruments are the best measures for depressive or PTSD symptoms, because children are better

at reporting internalizing symptoms and distress than their caregivers (Moretti, Fine, Haley, & Marriage, 1984; Muris, Meesters, & Spinder, 2002; Wrobel & Lachar, 1998).

### **Chapter Summary**

This chapter describes the research questions of this study. In addition, the chapter outlines the research methodology and design. The study consists of a correlational design. I describe the sample population of 192 CSA victims receiving treatment, and discuss the psychometric properties of each of the instruments used for assessment in this study (TABS; TSCC). Finally, I explained the data collection and analysis procedures, and outlined, the potential limitations of this study.

## CHAPTER FOUR: RESULTS

Concurrent CSA and family violence is well documented in child abuse literature, and produces serious mental health implications for the child that can last a lifetime. Trauma-focused child abuse treatment is effective at reducing child trauma symptomology and increasing parenting skills, yet high attrition prevents (a) children and families from receiving the support they need, and (b) researchers from effectively studying treatment outcomes. While several studies already focus on the effects of CSA for adult survivors and associated adult attrition patterns, few studies have examined child treatment attrition for CSA victims. Furthermore, researchers should examine both child and caregiver characteristics simultaneously in order to better understand the relationship between CSA and attrition. This study investigated the influence of child posttraumatic stress, cognitive self-development, and caregiver IPV on treatment attrition. The results of five research questions posed and seven null hypotheses tested are presented here. Along with the results, the following section presents preliminary analysis protocols, a breakdown of the descriptive demographic data, and a review of the data gathering procedures.

### **Data Gathering**

Data analyzed for this study includes instruments completed by both CSA victims and their caregivers receiving services at a child abuse agency in Central Florida between January 1, 2009 and December 31, 2011. Data collection took place between July 2010 and January 2012, and reflected trauma scores and demographic information for 158 CSA victims who took both the TABS and TSCC pretest. The majority of children between the ages of 8-17 who are referred for services are asked to complete these two trauma assessments during their first visit to the

agency. Moreover, results from the TABS and TSCC inform therapists about cognitive disturbances or symptomology in the areas of safety, trust, esteem, intimacy, control, anger, depression, posttraumatic stress, anxiety, disassociation, and sexual concerns. Caretakers and therapists fill out the intake questionnaire together during the initial clinical interview.

Immediately following the first clinical interview, the therapist records the information in the NCA Trak database.

NCA Trak revealed that the sample was predominately female (81%), and that roughly half of sample (49%) had caregivers who confirmed past or current IPV in their relationship. Conversely, 34% of the children had caregivers who denied past or current IPV, and 17% neither confirmed nor denied past or current IPV. Slightly more female caregivers (32%) confirmed IPV than male caregivers (24%). Moreover, Table 3 below presents service usage differences between those who graduated and those who prematurely terminated from treatment.

**Table 1: *Service Usage by Discharge Status***

<i>Premature Termination Group (N = 79)</i>					
	Child Age	Caregiver Age	# Attended	# Missed	Total Scheduled
M	13.22	41.00	6.30	4.63	10.93
SD	2.02	9.55	7.03	5.94	12.97
Range	9-18	26-17	0-35	0-31	0-66
<i>Graduation Group (N = 53)</i>					
	Child Age	Caregiver Age	# Attended	# Missed	Total Scheduled
M	12.58	41.90	16.81	7.60	24.41
SD	2.28	9.67	15.26	7.29	22.55
Range	7-17	30-69	0-66	0-27	0-93



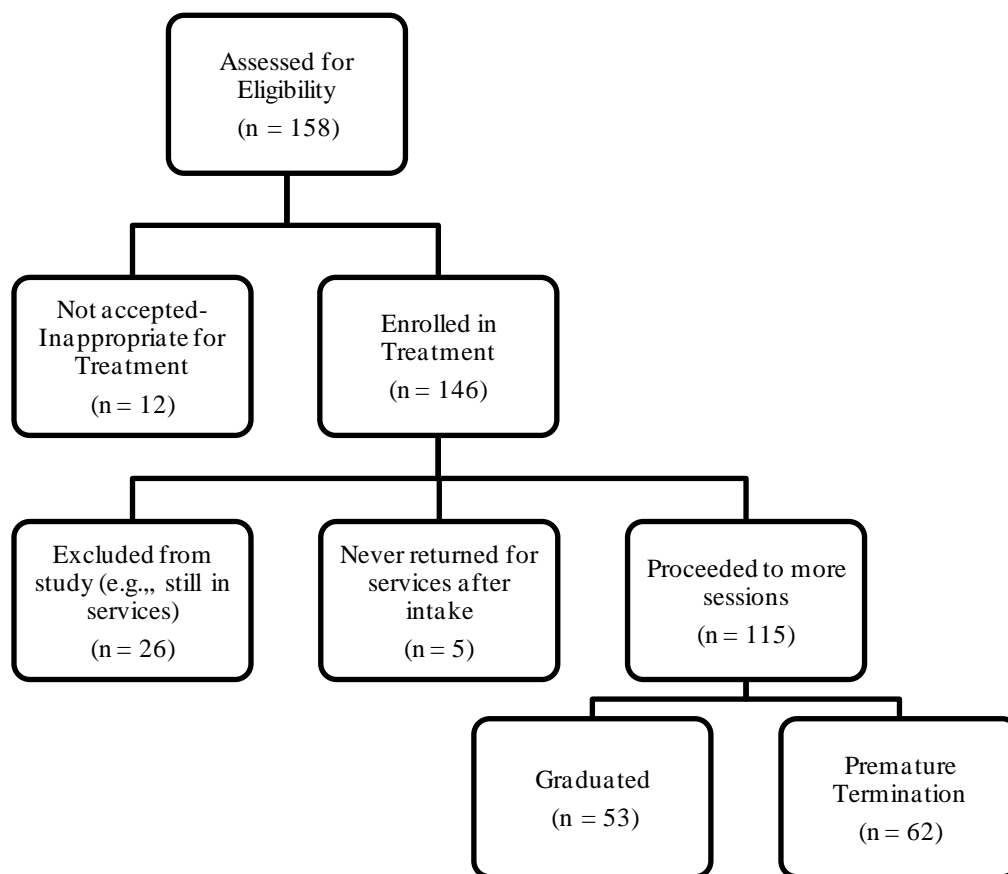


Figure 2: Agency Attrition Trends

Figure 1 shows the retention and attrition patterns for the children sample for this study. Based on information recorded in NCA Trak and on the discharge summary forms, 158 children were assessed for eligibility out of this sample. Of those, 12 were not accepted for treatment and referred to other services, and the remaining 146 children were enrolled for treatment. However, it is important to note that some portion of the sample was removed for each research analyses depending on if they possessed traits that disqualified them from consideration. These traits were (a) if the child was still in treatment, and/or (b) if the child had unknown caregiver IPV status. I

examined only those children with caregivers who confirmed or denied IPV in order to avoid speculating or mislabeling those children who were in the “unknown” caregiver IPV group. Furthermore, children still in treatment should not be included in analyses exploring reasons for discharge or service usage because they have (a) neither graduated nor prematurely terminated, and (b) have not completed attending sessions. Keeping these children in the dataset would convolute the findings and potentially cause the researcher to make false conclusions about the influence of caregiver IPV and attrition-related variables.

Details on the number of children removed from each research question are as follows. For research question one, which analyzed relationships between caregiver IPV and trauma symptomology, I removed 27 children from the sample with unknown caregiver IPV status, bringing the total sample analyzed from 158 to 131 children. For research question 2, which analyzed relationships between service usage and trauma symptomology, I removed 26 children who were still in treatment, bringing the total sample analyzed from 158 to 132. For research questions three, four, and five, which analyzed relationships between caregiver IPV, service usage, and reason for discharge, I removed a total of 51 children who were both still in treatment with unknown caregiver IPV status, bringing the total sample analyzed from 158 to 107.

Overall, out of 146 children enrolled, a total of 67 children were considered premature terminators and 53 children graduated. Children labeled as premature terminators either (a) were administratively discharged due to excessive absences or 30-day inactivity, (b) dropped out of services, (c) left after partially, but not fully, completing their treatment goals, (d) were referred by the agency to other types of services, or (e) left for special circumstances not listed above. Because the lives the children receiving services for CSA are frequently inconsistent and/or unstable, the agency continuously monitors and reevaluates each child’s needs and treatment

goals. For example, if something arises in a child's life that needs to be a priority over their trauma work or has an effect on their ability to be safe, vulnerable, and/or process what is necessary relating to their abuse, the agency may decide to refer the child to another service that will best suit their needs. More specifically, the mental health director of the agency stated that a child is either not accepted for treatment or referred to other types of services in the middle of treatment if one or more of the following occur: (a) a child needs more intense treatment (i.e., a residential facility), (b) a child is deemed resistant or not ready for trauma work, (c) a child's basic needs are unmet, (d) housing becomes unstable, (e) divorce or co-parenting issues are affecting the child, (f) a child's safety is sacrificed by treatment, (g) illness or death of a parent occurs, (h) a child exhibits suicidal or homicidal ideations, and/or (i) a child abuses substances.

Because therapists do not enter assessment scores into NCA Trak, I visited the child abuse agency ten times over a 17-month period to record TABS and TSCC assessment scores into a Microsoft Excel spreadsheet. This spreadsheet was stored and password-protected on the child abuse agency computers, and was examined, sanitized, and approved by the Mental Health Director before being emailed to me for research purposes. Furthermore, I retained no identifying information of the clients or their caretakers.

## **Results of Analysis**

### **Preliminary Analysis**

The preliminary analysis conducted identified any outliers exerting excessive influence on the data, as well as sought out missing data. Before each analysis, I examined various tables and frequency outputs to ensure the statistical assumptions were met. No missing data existed, and one outlier with a Mahalanobis distance score of 33.47 was removed from the data because it

exceeded the critical value (24.32) for analyses with 7 predictor variables (Pallant, 2007). For research questions 2 and 3, this reduced the total sample size from 158 to 157.

Next I evaluated any violation of assumptions related to logistic and Poisson regression analyses. No violations of assumptions existed for (a) sample size, (b) linearity, (c) multicollinearity, and (d) independence of errors. However, variables associated with service usage (i.e., number of sessions attended; number of sessions missed), were not normally distributed, and thus violated the assumption of normality. Count variables are frequently positively skewed and heteroskedastic by nature (Gall, Gall, & Borg, 2007). For example, in a study examining attrition within an agency where attrition is an established problem, it is expected that clients will either never attend a session (scores of 0), or attend one session (scores of 1). Thus the distribution will likely be stacked toward smaller values (i.e., scores 0 through 5) and decrease as the number of sessions increase. In these instances, it is not appropriate to transform the data by using the square root or log of the variables because it will not solve the issue of positive skewness, and in fact will obscure the nature of the expected distribution. Thus, for these variables, a Poisson Regression is utilized for “determining the correlation between a set of predictor variables and a criterion variable that is in the form of a frequency count” (Gall, Gall, & Borg, 2007, p. 354).

For the logistic regressions utilized in research question 1, the variable of self-safety violated the assumption of linearity. This was determined after a preliminary analysis revealed that the intercept of the variable and its natural log were statistically significant. For research question 1, self-safety was replaced with a similar scale related to safety (e.g., other-safety) after I deemed that the use of this scale was relevant to the current study’s objective of examining cognitive disturbances related to issues of family violence. Replacing self-safety with other-

safety resolved the issue of non-linearity. An examination of linearity scatter plots, studentized residual plots, Box M and Levene's test found no other violations. Table 3 presents the means, standard deviations, and Cronbach alpha scores for each predictor scale. Table 4 presents the correlations between predictor variables.

Table 2: *Basic Descriptive Statistics and Cronbach Alpha*

Variable	<i>M</i>	<i>SD</i>	$\alpha$
TSCC Posttraumatic Stress	51.71	11.34	.91
TABS Self-Safety	50.68	12.30	.90
TABS Other Safety	47.54	11.35	.91
TABS Self Trust	53.13	12.11	.91
TABS Self Esteem	51.72	12.04	.90
TABS Other Intimacy	52.56	11.32	.90
TABS Self Control	51.30	11.19	.90
TABS Other Control	49.75	10.39	.91

Table 3: *Correlations Between Predictor Variables*

	SS	ST	SE	SC	OI	OC
PTS	.578	.361	.414	.605	.511	.479
SS		.485	.684	.644	.624	.493
ST			.599	.578	.548	.522
SE				.726	.799	.545
SC					.780	.688
OI						.602

### **Research Question One and Null Hypothesis**

The first research question examined whether factors associated with disturbances in child cognitive schemas and trauma symptomology (i.e., posttraumatic stress; disturbances in other-safety, self-trust, self-esteem, self-control, other intimacy, and other control) are related to whether a caregiver confirms or denies past or present IPV. To answer this research question, I tested the null hypothesis that no relationship exists between caregiver IPV, posttraumatic stress, and child cognitive self-development for victims of CSA receiving mental health services at a child abuse agency. I utilized a logistic regression for this analysis, which requires one dichotomous dependent variable (Caregiver IPV: yes/no), and two or more continuous independent variables (i.e., posttraumatic stress score of the TSCC and the other-safety, other-intimacy, other-control, self-control, self-trust, and self-esteem subscale scores of TABS) (Hair, Black, Babin, & Anderson, 2010).

The full model containing all seven predictors was not statistically significant,  $\chi^2(8, N = 131) = 5.219, p > .05$ , indicating that the model was not able to distinguish between caregivers who confirmed or denied IPV. As shown in Table 5, none of the independent variables made a unique statistically significant contribution to the model. Thus, scores related to posttraumatic stress and disturbances in child cognitive-self development were not related to whether a caregiver confirmed or denied IPV, and therefore, the null hypothesis is retained.

*Table 4: Relationship Between Trauma / Cognitive Schema Disturbance and Caregiver IPV*

						95% CI for Odds Ratio		
	$\beta$	SE	Wald	df	$\rho$	Odds Ratio	Lower	Upper
Constant	-.92	1.08	.72	1	.40	.40		
Posttraumatic Stress	-.00	.02	.33	1	.91	1.0	.96	1.04
Other Safety	.01	.02	.33	1	.57	1.0	.97	1.06
Other Intimacy	.03	.03	.62	1	.43	1.0	.96	1.09
Other Control	.03	.03	.94	1	.33	1.0	.97	1.08
Self Control	-.04	.03	1.5	1	.22	.96	.90	1.02
Self Trust	-.01	.02	.24	1	.62	.99	.95	1.03
Self Esteem	.01	.03	.25	1	.61	1.0	.96	1.07

### **Research Question Two and Null Hypotheses 2A-2B**

The second research question investigated whether factors associated with disturbances in child cognitive schemas and trauma symptomology (i.e., posttraumatic stress; disturbances in self-safety, self-trust, self-esteem, self-control, other intimacy, and other control) predict the

number of sessions attended and/or missed by CSA victims. Null Hypotheses 2A and 2B state that no relationships exist between posttraumatic stress, child cognitive self-development, and number of sessions attended or missed. To test this hypothesis, a Poisson Regression was used, which requires one continuous dependent variable (i.e., number of sessions attended or missed), and two or more continuous independent variables (i.e., posttraumatic stress score of the TSCC and the self-safety, self-trust, self-intimacy, self-esteem, and self-control subscale scores of TABS) (Pallant, 2007). I chose Poisson regression because the values of the dependent variable (i.e., sessions attended, sessions missed) are count data, positively skewed by design, and violate the assumption of normality in a regular linear regression. Poisson regression is used with rate data, where the rate is a count of sessions attended or missed for CSA victims in treatment, divided by the log of some measure of *exposure*, otherwise known as the *offset variable* (Cameron & Trivedi, 1998). Therefore, for this analysis, the offset variable is represented by the log of total sessions scheduled in order to provide a frame of reference for the total number of sessions attended or missed out of the total number of sessions scheduled for each client. Furthermore, when interpreting results for Poisson Regressions, researchers present incident rate ratios in order to address how the predictor variable (e.g., trauma scores) affects the likelihood of an additional one unit increase in the dependent variable (e.g., number of sessions attended or missed).

For Null Hypothesis 2A, the likelihood ratio  $\chi^2$  for the Poisson Regression model was statistically significant (83.148,  $df = 7$ ), suggesting that the model fit the data better than the null model (see Table 6). The predictor variables of *posttraumatic stress* and *self-trust* ( $p < .05$ ). Specifically, *posttraumatic stress*, Wald  $\chi^2 (1) = 59.28, p \leq .001$  predicted *number of sessions attended*, along with *self-trust*, Wald  $\chi^2 (1) = 3.90 p = .048$ . Thus, (a) as posttraumatic stress



increases, the number of sessions attended also increases, and (b) as *self-trust* disturbance increases, the number of sessions attended decreases. Specifically, the coefficient for *posttraumatic stress* is .025, which means that the expected increase in the log count for one-unit increase in *posttraumatic stress* is .025. Hence, the percent change in the incident rate of number of sessions attended is an increase of 2.5%. In order to better understand the practical significance of these findings, consider the following example. Child A has a posttraumatic stress score of 65 and Child B has a posttraumatic stress score of 70. Because the incident rate of number of sessions attended *increases* by 2.5% per unit increase of posttraumatic stress score, Child B will attend approximately 12.5% more sessions (e.g.,  $5 \times 2.5\% = 12.5\%$ ). Moreover, the coefficient for *self-trust* is -.006, which means that the expected decrease in the log count for one-unit increase in *self-trust* disturbance is .006. Hence, the percent change in the incident rate of number of sessions attended is a decrease of 0.6%. To better understand the practical significance of these findings, consider that Child A has a self-trust score of 65 and Child B has a self-trust score of 70. Because of the incident rate of the number of sessions attended *decreases* by 0.6% per unit increase of self-trust disturbance, Child B will attend approximately 3% fewer sessions than Child A (e.g.,  $5 \times -0.6\% = -3\%$ ).

Table 5: *Predicting Sessions Attended by Trauma/ Cognitive Schema Disturbance*

Predictor	$\beta$	$\rho$	Wald $\chi^2$
Posttraumatic Stress	.025	.000	59.28**
Self-Safety	-.005	.095	2.78
Self-Trust	-.006	.048	3.80*
Self-Esteem	.002	.680	.171
Self-Control	.008	.098	2.74
Other-Intimacy	-.006	.133	2.25
Other-Control	-.006	.105	2.63

\* $\rho \leq .05$

\*\* $\rho \leq .001$

To explore the relationship between number of sessions missed and trauma scores (Null Hypothesis 2B). As done for the previous analyses, a Poisson Regression was conducted to accommodate the rather typical distribution of count data (number of sessions missed). The likelihood ratio  $\chi^2$  for the Poisson Regression model was statistically significant (50.27,  $df = 7$ ), suggesting that the model fit the data better than the null model (see Table 7). Similar to Null Hypothesis 2A, predictor variables of *posttraumatic stress* and *self-trust* were statistically significant ( $p < .05$ ). In contrast to the previous analysis, *self-control* and *other-intimacy* were also statistically significant ( $p < .05$ ). Among statistically significant predictors, *posttraumatic stress* had a  $p$  value less than .001. Specifically, *posttraumatic stress*, Wald  $\chi^2 (1) = 13.01$ ,  $p \leq .001$ , predicted *number of sessions missed*, while *self-trust*, Wald  $\chi^2 (1) = 6.21$ ,  $p = .013$ , *self-*

*control*, Wald  $\chi^2(1) = 3.78, p = .052$ , and *other-intimacy*, Wald  $\chi^2(1) = 3.75, p = .053$  were notable factors as well in the prediction of number of sessions missed. Thus, (a) as *posttraumatic stress* increases, the number of sessions missed also increases, (b) as *self-trust* disturbances increase, the number of sessions missed decreases, (c) as *self-control* disturbances increase, the number of sessions missed increase, and (d) as *other-intimacy* disturbances increase, the number of sessions missed decrease.

Table 6: Predicting Sessions Missed by Trauma/ Cognitive Schema Disturbance

Predictor	$\beta$	$\rho$	Wald $\chi^2$
Posttraumatic Stress	.016	.000	13.01**
Self-Safety	.006	.144	2.14
Self-Trust	-.010	.013	6.21*
Self-Esteem	-.001	.877	.024
Self-Control	.013	.052	3.78*
Other-Intimacy	-.011	.053	3.75*
Other-Control	.004	.480	.499

\* $\rho \leq .05$

\*\* $\rho \leq .001$

In summary, disturbances in *posttraumatic stress* predicted an increase in number of sessions attended for CSA victims, with the percent change in the incident rate of number of sessions attended increasing by 2.5%. Posttraumatic stress also predicted an increase in number of sessions missed, with the percent change in the incident rate of number of sessions missed

increasing by 1.6%. Elevated *self-trust* scores predicted a decrease in both sessions attended and sessions missed. Specifically, the percent change in the incident rate of number of sessions attended is a decrease of 0.6%, and the percent change in the incident rate of number of sessions missed is a decrease of 1.0%. Disturbances in *self-control* and *other-intimacy* were also able to predict a decrease in number of sessions attended. Thus, the null hypotheses 2A and 2B are both rejected. For *self-control*, the percent change in the incident rate of number of sessions missed is increased by 1.3%, and for *other-intimacy*, the percent change in the incident rate of number of sessions missed is a decrease of 1.1%. For example, if Child A has a self-control score of 65 and Child B has a self-control score of 70, Child B will miss 6.5% *more* sessions than Child A (e.g.,  $5 \times 1.3\% = 6.5\%$ ). Conversely, if Child A has an other-intimacy score of 65 and Child B has an other-intimacy score of 70, Child B will miss 5.5% *fewer* sessions than Child A (e.g.,  $5 \times -1.1\% = -5.5\%$ ).

### **Research Question Three and Null Hypothesis**

Research question three explored the relationship between reasons for discharge, posttraumatic stress, and child cognitive self-development among CSA victims. The answer to this question revealed whether factors associated with disturbances in child cognitive schemas and trauma symptomology could predict whether a CSA victim graduated or prematurely terminated from treatment. In order to address the null hypothesis that no relationship existed between reason for discharge, posttraumatic stress, and child cognitive self-development, I conducted a Logistic Regression. For this analysis, a researcher needs one dichotomous dependent variable (i.e., graduation or premature termination) and two or more continuous independent variables (i.e., posttraumatic stress score of the TSCC and the self-safety, self-trust,

self-intimacy, self-esteem, and self-control subscale scores of TABS) (Hair, Black, Babin, & Anderson, 2010).

The full model containing all seven predictors was not statistically significant,  $\chi^2(8, N = 131) = 15.10, p > .05$ , indicating that the model was not able to distinguish between those who graduated or prematurely terminated from treatment based on trauma scores (see Table 8). Furthermore, the model as a whole correctly classified 63.6% of cases. As shown in Table 9, none of the independent variables made a unique statistically significant contribution to the model (posttraumatic stress, self-safety, self-trust, self-esteem, self-control, other-intimacy, and other control). Thus, scores related to trauma symptomology and disturbances in child cognitive-self development were not able to predict whether a CSA victim graduated or prematurely terminated from treatment, and therefore, the null hypothesis is retained.

*Table 7: Predicting Reason for Discharge by Trauma / Cognitive Schema Disturbance*

	$\beta$	SE	Wald	df	$\rho$	95% CI for Odds Ratio		
						Odds Ratio	Lower	Upper
Constant	-.386	1.19	.103	1	.75	.68		
Posttraumatic Stress	.024	.024	1.00	1	.32	1.0	.98	1.07
Other-Safety	-.002	.03	.007	1	.93	1.0	.95	1.05
Other-Intimacy	-.013	.04	.001	1	.71	1.0	.92	1.06
Other-Control	.000	.03	.000	1	.99	1.0	.95	1.06
Self-Control	-.020	.04	.311	1	.58	.98	.92	1.05
Self-Trust	.009	.02	.160	1	.69	1.0	.97	1.06
Self-Esteem	-.001	.03	.001	1	.98	1.0	.94	1.06

#### **Research Question Four and Null Hypotheses 4A-4B**

The fourth research question explored the relationship between client service usage and caregiver IPV. The answer to this question revealed whether a caregiver's past or current IPV status predicted the number of sessions attended and/or missed by a CSA victim. To address the first null hypothesis that no relationship exists between caregiver IPV and number of sessions attended by a CSA victim, I conducted a Poisson Regression. For this analysis, a researcher needs one continuous dependent variable (i.e., number of sessions attended, missed), and two or more continuous or categorical independent variables (i.e., caregiver IPV: yes/no) (Pallant, 2007). I chose Poisson regression because the values of the dependent variable (i.e., number of sessions attended or missed) represent count data, which would violate the assumption of normality in a normal linear regression because they are positively skewed. As with research question two, the offset variable is represented by the log of total sessions scheduled in order to provide a frame of reference for the total number of sessions attended or missed out of the total number of sessions scheduled for each client. Furthermore, when interpreting results for Poisson Regressions, researchers present incident rate ratios in order to address how the predictor variable (e.g., caregiver IPV) affects the likelihood of an additional one unit increase in the dependent variable (e.g., number of sessions attended or missed).

For Null Hypothesis 4A, the likelihood ratio  $\chi^2$  for the Poisson Regression model was statistically significant (6.54,  $df = 1$ ), suggesting that the model fit the data better than the null model (see Table 9). A closer examination of the parameter estimates showed that, all other things being equal, if a caregiver confirms past or current IPV, Wald  $\chi^2(1) = 6.56, p = .010$ , the number of sessions attended decreases by .156 units when compared to those who denied past or

current IPV. Thus, when compared to the no IPV group, the expected log count for number of sessions attended for the yes IPV group decreases by .16. Furthermore, the output in parameter estimates indicates that the incident rate for the yes IPV group is .86 times the incidence rate for the no group, holding all other variables at constant.

However, for Null Hypothesis 4B examining the relationship of caregiver IPV status and number of sessions missed, the likelihood ratio  $\chi^2$  for the Poisson Regression model was not statistically significant (.150  $df = 1$ ), suggesting that the model did not fit the data better than the null model. A closer examination of the parameter estimates revealed that caregiver IPV status, Wald  $\chi^2 (1) = .150, p = .699$ , was not a statistically significant predictor for the number of sessions missed.

Table 8: *Predicting Sessions Attended or Missed by Caregiver IPV status*

Predictor	$\beta$	$\rho$	Wald $\chi^2$
(For Sessions Attended)			
IPV Denied/Confirmed (Coded 0-1)	-.156	.010	6.56*
(For Sessions Missed)			
IPV Denied/Confirmed (Coded 0-1)	.032	.699	.150

0 = Denied Caregiver IPV; 1 = Confirmed Caregiver IPV

\* $\rho \leq .05$

### **Research Question Five and Null Hypothesis**

The fifth research question explored relationship between caregiver IPV and client reason for discharge. The answer to this question revealed whether a caregiver's IPV status is related to whether a CSA victim graduates or prematurely terminates from treatment. In order to address

the null hypothesis that no relationship exists between caregiver IPV and reason for discharge, I conducted a Chi-square test for independence.

The Chi-square test for independence (with Yates Continuity Correction) indicated a statistically significant association between reason for discharge and caregiver IPV,  $\chi^2 (1, N = 107) = 4.208, p < .05, \phi = -.218$ . The crosstabulation (see Table 11) reveals that children of caregivers who denied past or current IPV were just as likely to graduate from treatment as they were to prematurely terminate from treatment. However, among children of caregivers who reported past or current IPV, a higher proportion (71.4%) prematurely terminated from treatment. This seems to represent the fact that, based on the odds ratio, the odds of a CSA victim prematurely terminating is 2.5 times higher if their parents confirm past or current IPV than those children with parents that denied IPV. Upon closer examination of the data, it is interesting to note that, immediately following screening for treatment eligibility, 100% (n=11) of those children who were not accepted for treatment within this sample had caregivers who reported past or current IPV.



Table 9: *Caregiver IPV and Reason for Discharge Crosstabulation*

	Premature Termination	Graduated	Total
No Caregiver IPV			
Count	22	22	44
(%)	50%	50%	100%
% of Total	21%	21%	41%
Yes Caregiver IPV			
Count	45*	18*	63
(%)	71%	29%	100%
% of Total	42%	17%	59%

\* $p \leq .05$

### Summary

This chapter presented the results of the data gathering, data screening, preliminary analyses, demographics, variable information, and results of each analysis. This study examined five research questions and seven null hypotheses. The results of the first research question found no relationship between caregiver IPV, disturbances in child cognitive schemas, and/or trauma symptomology (i.e., posttraumatic stress; disturbances in other-safety, self-trust, self-esteem, self-control, other intimacy, and other control), and thus retained the null hypothesis. The second research question rejected the null hypothesis that no relationships existed between service usage (i.e., number of sessions attended, number of sessions missed), disturbances in child cognitive schemas, and/or trauma symptomology (i.e., posttraumatic stress; disturbances in self-safety, self-trust, self-esteem, self-control, other intimacy, and other control). Increased

disturbances in posttraumatic stress and self-trust predicted number of sessions attended. Moreover, increased disturbances in posttraumatic stress, self-trust, self-control, and other-intimacy predicted number of sessions missed. Specifically, all other things being equal, children with (a) elevated scores in posttraumatic stress lead to an increased percent change of 2.5% in the incident rate of number of sessions attended and (b) elevated scores in self-trust lead to a decreased percent change of 0.6% in the incident rate of number of sessions attended. Furthermore, those children with (a) elevated scores in posttraumatic stress had an increased percent change of 1.6% in the incident rate of number of sessions missed (b) elevated scores in self-trust had a decreased percent change of 1.0% in the incident rate of number of sessions missed, (c) elevated scores in self-control had an increased percent change of 1.3% in the incident rate of number of sessions missed, and (d) elevated scores in other-intimacy had a decreased percent change of 1.1% in the incident rate of number of sessions missed.

The third research question retained the null hypothesis that no relationships existed between reasons for discharge, disturbances in child cognitive schemas, and/or trauma symptomology (i.e., posttraumatic stress; disturbances in self-safety, self-trust, self-esteem, self-control, other intimacy, and other control). Research question four rejected null hypothesis 4A that caregiver IPV status did not predict number of sessions attended. Specifically, when compared to the no IPV group, the expected log count for number of sessions attended for the yes IPV group decreases by .16, and the results indicated that the incident rate for the yes IPV group is .86 times the rate for the no IPV group, holding all other variables at constant. However, the null hypothesis 4B was retained, because caregiver IPV status did not predict number of sessions missed. Finally, research question five rejected the null hypothesis that no relationship existed between caregiver IPV and reason for discharge. More specifically, the odds of a CSA

victim prematurely terminating is 2.5 times higher if their parents confirm past or current IPV than those children with parents that denied IPV. Chapter five provides a thorough discussion, review of the results of the analyses, and included a discussion of the findings, potential limitations of the results, questions for future research, and implications of the findings.

## CHAPTER FIVE: DISCUSSION

This chapter reviews the research questions and results of the analyses, and compared results to other research findings presented in Chapter Two. Limitations of the present study and implications for counselor educators, mental health professionals, and future research are discussed. The current study investigated the influence of both child and parent factors on treatment attrition for CSA victims receiving mental health services. To explore this, five research questions and seven null hypotheses examined relationships between caregiver IPV, disturbances in child cognitive schemas, trauma symptomology, service usage, and reason for discharge among CSA victims in treatment. Kazdin et al.'s (1997) barriers-to-treatment model and McCann and Pearlman's (1990) cognitive self-development theory supplied the theoretical base to explore these parent and child factors.

CSA is a worldwide problem, with two-thirds of all CSA cases going unreported. Because CSA has serious health implications for child victims and their families, federal lawmakers made child abuse a crime, with punishments ranging from mandated mental health services for the child, loss of child custody, and/or imprisonment. Businesses, nonprofit organizations, community organizations, individual citizens, and government agencies regularly donate funds to facilitate the establishment, management, research, and maintenance of child advocacy centers (CACs) in every state in the U.S. A wealth of research over the last 30 years demonstrates the negative psychological, physical, spiritual, academic, and social effects of CSA. As a result, researchers and mental health professionals shifted their focus from measuring the effects of CSA to measuring the efficacy of treatment modalities in order to assess which treatments lead to better outcomes.

In order to effectively study treatment outcomes, researchers must be able to track the status of child functioning and symptomology before, during, and after treatment. However, because high levels of treatment attrition exist among CSA victims, researchers are unable to effectively study outcomes due to large losses in research participants, loss of statistical power, and threats to external validity (Kazdin, 1990). Therefore, researchers should explore child and caregiver factors at intake that may potentially predict premature termination to help boost support to those families at higher risk for premature termination as soon as possible.

Previously, researchers examined the relationships between premature termination, demographic factors, and abuse characteristics, such as type, duration, severity, and frequency (Finkelhor, 1984, Mogge, 1999). While these studies yielded mixed findings, researchers hypothesizing that caregivers ultimately make the decisions regarding whether a child stays in treatment or not. In the 1990s, researchers began discussing the high prevalence of concurrent family violence, stating that caregivers with IPV are more than twice as likely to have children who are also abused (Kazdin, 1996). This serves as the rationale for the current study examining the influence of both parent factors (e.g., IPV) and child factors (e.g., traumatization and/or disturbances in cognitive self-development) on treatment attrition. This two pronged approach of examining both child and family characteristics simultaneously with attrition patterns may offer a more complete picture for the ways concurrent family violence influences treatment than looking at child and caregiver factors separately.

The barriers-to-treatment model hypothesizes that families of abused children face several obstacles to obtaining treatment, such as parental stress, marital strife, stigma, lack of transportation, and parental attitudes that their abused children do not need treatment. Pearlman's cognitive self-development theory hypothesizes that traumatic events like CSA, in addition to

symptoms of posttraumatic stress, can lead to disruptions in child cognitive self-development. These disruptions in trauma-related cognitive schemas have implications for the therapeutic relationship because they shape a child's beliefs about themselves, others, and the world around them in the areas of safety, trust, esteem, intimacy, and control. For example, if a child is distrustful of others, feels unsafe, and cannot achieve intimacy with others after surviving sexual abuse, this could negatively influence the therapeutic relationship, and as a result, prevent a child from reaching his or her therapeutic goals.

Upon reviewing the literature, only a few studies formally assess children for multiple exposures to (a) the same type of violence (i.e., CSA) (b) different forms of violence (i.e., concurrent IPV and CSA), or (c) other types of traumatic events (i.e., witnessing the arrest of a caregiver, being separated from a caregiver, or grieving the sudden death of a loved one). Yet recent literature suggests that the majority of children experience or witness at least one traumatic event before the age of 18 (Koverla et al., 2007; Saunders, 2003). Furthermore, researchers of multiple family violence hypothesize that children exposed to a single episode of abuse are the minority, with most victimized children reporting more than one exposure. Therefore, it is not surprising that more than half (59%) of the children serviced in the current study had more than one form of violence in the family.

Moreover, relatively few studies have focused on the attrition patterns of maltreated children. Studies on non-maltreated children found conflicting information about the influence of demographic factors and child maltreatment. In one study, children in treatment for anxiety disorders were more likely to prematurely terminate from treatment if they were ethnic minorities living in single parent households (Kazdin & Mazurik, 1994). However a more recent

study found no relationships between child demographics and whether they completed or terminated from treatment (Pina, Silverman, Weems, Kurtines, & Goldman, 2003).

Beyond exploring demographic factors, this study sought to explore the relationships of posttraumatic stress, trauma-related cognitive schemas, and attrition patterns. These constructs were assessed using psychometrically sound, valid and reliable assessments, created specifically for child victims of trauma. Out of the studies on multiply victimized children and attrition that do exist, researchers tend to either study a single subtype of abuse, or lump children with all types of abuse together in one sample (e.g., Lau & Weisz, 2003; Koverla, 2007). Thus, they fail to account for the unique ways specific combinations of abuse influence outcomes and/or attrition. The literature commonly refers to these combined effects of multiple abuses as *overlap*.

The following sections review the research questions and results of the analyses, and compare these findings to other studies found in Chapter Two. Limitations of the present study and implications for researchers, practitioners, and counselor educators are also discussed.

## **Discussion of Analysis and Findings**

### **Research Question One**

The first research question investigated relationships between caregiver IPV and several trauma variables, calculated from the posttraumatic stress scale (Briere, 1996) and other-safety, self-trust, self-esteem, self-control, other-intimacy, and other-control scales (Pearlman, 2003), among CSA victims in treatment. A Logistic Regression found no significant relationships between variables, suggesting that levels of posttraumatic stress and disturbances in cognitive self-development were statistically similar among CSA victims who had caregivers confirm past or current IPV, and those with caregivers who denied past or current IPV. A closer examination

of mean scores (see Table 11) between those CSA victims with confirmed caregiver IPV and those with caregivers who denied IPV reveals slightly higher mean TABS scores among the *Yes IPV* group, indicating slightly higher levels of cognitive schema disturbances in the group of CSA victims with confirmed caregiver IPV. However, these differences were not strong enough to statistically differentiate between those with CSA alone, and those with concurrent family violence.

Table 10: *Means/ Standard Deviations of Trauma Scores by Caregiver IPV Status*

Scale	Yes IPV (n = 63) M (SD)	No IPV (n = 44) M (SD)
TSCC		
Posttraumatic Stress	51.11 (11.23)	51.27 (10.26)
TABS		
Other-Safety	48.71 (11.78)	47.34 (11.12)
Self-Trust	53.30 (12.40)	52.34 (12.49)
Self-Esteem	52.51 (12.40)	49.02 (12.06)
Self-Control	51.24 (10.93)	50.66 (11.20)
Other-Intimacy	53.30 (11.38)	50.14 (11.02)
Other-Control	50.86 (10.12)	47.80 (10.05)

The above-reported mean scores are statistically similar to other studies on child sexual abuse. In Brown's (2007) study on TSCC scores of CSA victims before, during, and after treatment, the author reported mean posttraumatic stress scores of 52.59 at intake. The author also reported that the children were heterogeneous in symptomology across groups, which echoes the findings of the current study. Yet, no previous published studies report TABS scores of CSA victims specifically, so it is not possible to determine how these mean scores in trauma-related cognitive schemas compare to other studies. Therefore, future studies should be done to determine how this sample compares to other CSA victims in treatment.



The current findings are also similar to those found in previous studies on maltreated children and attrition. Koverla et al. (2007) found in child self-report of posttraumatic symptoms or cognitive-intelligence functioning. These similarities in level of traumatization and cognitive schemas are most likely a result of the heterogeneous sample in this study. In other words, all children selected for this study were receiving services for CSA, and over half of them had caregivers who reported past or current family violence. Furthermore, epidemiological studies are increasingly noting similarities for children who are exposed to direct victimization as well as intimate partner violence (Edelson, 1999; Saunders, 2003).

While no other studies examine TSCC scores in the manner of this study, Briere (2004) conducted a similar study with relatable findings. Using multivariate analysis of variance to determine whether differences in TSCC raw trauma scores existed between adolescents sexually abused by intra-or extrafamilial perpetrators, Briere (2004) found that no statistical differences existed between groups. Furthermore, Briere ran a multiple regression to determine whether type of abuse predicted trauma-specific symptoms, and found that less family cohesion significantly influenced more posttraumatic stress ( $\text{Adj. } R^2 = .13, F(2,9) = 7.9, P < .001$ ). However, the authors concluded that no significant symptom differences existed between adolescents abused by an intra-or extrafamilial perpetrator. The authors concluded that the groups of children were either (a) too similar, or (b) the predictors were not specific enough. These findings are relevant to consider for this study because the current research question examined differences between trauma scores for children with additional forms of violence in the home, and those without. Like Briere's findings, this study did not find differences between groups in the TSCC scores, supporting the notion that further, more specific variables and analyses are warranted. These and other issues are discussed at length in the following sections.

## **Research Question Two**

Research question two explored whether relationships existed between service usage (i.e., number of sessions attended and number of sessions missed), posttraumatic stress, and cognitive schema disturbances in the areas of self-safety, self-trust, self-esteem, self-control, other-intimacy, and other-control. Previous research grounded in trauma theory establishes that, in addition to posttraumatic symptomology, child abuse often causes maladaptive disturbances in the beliefs and assumptions a child has about him or herself, and can also have a negative influence his or her relationships (e.g., attachments) with other people. Because cognitive schema disturbances may negatively influence the therapeutic relationship, and consequently influence treatment attendance, the current research question set out to test the null hypothesis that no relationships exist between posttraumatic stress, cognitive schema disturbance and the number of sessions attended or missed by a CSA victim receiving treatment. Two Poisson Regression revealed that both overall models were statistically significant, with two scores predicting the number of sessions attended, and four scores predicting the number of sessions missed. Specifically, disturbances in posttraumatic stress and self-trust predicted sessions attended, while scores in self-safety, self-esteem, self-control, other-control, and other-intimacy had no relationship with number of sessions attended. Moreover, posttraumatic stress, self-trust, self-control, and other-intimacy predicted the number of sessions missed, while scores in self-safety, self-esteem, and other control had no relationship with the number of sessions missed. A review of each statistically significant relationship is presented in the next section, followed by a discussion of scores that did not predict number of sessions attended.

### **Scales Predicting Service Usage.**

*Posttraumatic stress.* According to the assessment manual (Briere, 1996), elevated scores on the posttraumatic stress scale indicate that a child is likely experiencing classic posttraumatic symptoms, such as nightmares, fears of men or women, intrusive thoughts, sensations, and memories of painful past events that in turn lead to cognitive avoidance of negative thoughts and memories. Furthermore, these symptoms are powerful enough to disrupt normal daily functioning, creating fear, anxious distractibility, irritability, self-blame, tension, jumpiness and/or repetitive thoughts about the upsetting events.

In this study, higher posttraumatic stress scores were associated with a statistically significant increase in attended sessions *and* missed sessions. While initially these results seem contradictory, a closer look at the data reveals that these children attending more sessions also missed more sessions. For example, post hoc exploratory analysis revealed that the 20 children with the highest posttraumatic stress scores (T-score > 65) attended a mean of 18.90 sessions and missed a mean of 8.85 sessions. Nine of these children were still in treatment at the time of data collection, while the remaining 11 children stayed in treatment for a mean of 22.5 months. At the time of data collection, eight of these children attended more than 15 sessions while also missing roughly half of the total sessions scheduled. Four children with high posttraumatic stress scores attended the same number sessions that they missed, and six missed more sessions than they attended.

The post hoc also revealed that the vast majority of premature terminators (68%) left services within the first six sessions of treatment. Thus, at first glance, one might be tempted to make assumptions about a child's treatment outcomes based on the number of sessions missed,

when in reality, these large numbers of missed sessions may simply indicate longer treatment periods. These findings contradict previous findings that, among maltreated children with caregivers reporting high psychological distress,  $F(2,70) = 3.3, p = .04$ , no relationship exists between posttraumatic stress and service engagement (Koverla et al., 2007). Additionally, authors of the same study found that caregivers were more likely to bring the child to therapy and complete the course of recommended intervention if their child with posttraumatic stress also exhibited defiance, aggression, or acting out (Koverla, et al., 2007). The authors concluded that externalizing behaviors served as a more visible cry for help, or “louder voice,” among traumatized children, which compelled even highly stressed or economically disadvantaged caregivers to see their child’s treatment through to the end. Thus, for the current study, it is possible that with increased child distress (elevated posttraumatic stress symptoms) came increased caregiver efforts to seek help for their child. However, without data on the caregivers, it is impossible to know for sure.

*Self-Trust.* In the current study, elevated scores in self-trust cognitive schema disturbance predicted a decrease in session attendance and an decrease in sessions missed. Unlike posttraumatic stress, disturbances in self-trust schemas are related to a child attending treatment less while also missing sessions less. In a post hoc exploratory analysis, 32 children had clinically significant disturbances in self-trust (T-score > 60) and attended a mean of 12.22 sessions, while missing a mean of 6.59 sessions. Interestingly, these children missed the same average number of sessions as the children who prematurely terminated from treatment, and attended approximately six fewer sessions than those with posttraumatic stress disturbances. Not surprisingly, approximately half of these children (53%) prematurely terminated, while the other

46% graduated. Thus, these findings possibly suggest that those with increased self-trust disturbances attend treatment for shorter periods of time.

In the professional assessment manual, Pearlman (2003) states that shattered trust is the “inevitable fallout” from traumatic experiences involving other people (p. 18). Furthermore, the betrayal of the relationship may be far more damaging than the actual physical harm (Gelinas, 1983). For abused children, disrupted trust can form in situations of abandonment (i.e., a parent suddenly leaving or placing the child in foster care), broken promises (i.e., a battered caregiver telling a child numerous times that she will leave her abuser, but fails to take action), or extreme unresponsiveness to normal dependency (i.e., a child who is unable to rely on a caregiver for basic protections against physical and/or emotional harm). Children with disturbances in trust schemas may present in therapy as fearful to trust the counselor, chronic anger or bitterness, disappointment in others, and ambivalence about others’ dependency. Furthermore, those with elevated self-trust scores on the TABS may also be struggling to trust their own judgments or perceptions, and therefore rely heavily on the counselor (or caretaker) to make decisions for them. For abused children, higher self-trust disturbances often suggest a history in which the victim’s perceptions of reality were denied (i.e., a mother denying the presence of intimate partner violence to a child who hears and sees the violence on a regular basis). Conversely, the child may have been placed in a position to care for a sibling or a vulnerable parent, while also not being able to protect them from abuse.

Self-trust cognitive distortions in abused children are also linked to accepting IPV later in life. One study on adult survivors of maltreatment who later experienced IPV stated that childhood family violence resulted in adults who were less adept at reading internal cues, tolerating ambiguities, soothing themselves, or trusting their perceptions, all of which adversely

affected the development of nonviolent conflict resolution techniques in later adult relationships (Athens, 1992). Post hoc examination of the data revealed that 17 of the 32 children with self-trust disturbances had caregivers who confirmed IPV. Unfortunately there are no prior studies measuring relationships between cognitive schemas and service usage of abused children, so more research needs to be done to further explore the relationship between self-trust distortions and attrition patterns among abused children.

*Other-Intimacy.* In the current study, elevated other-intimacy scores were associated with decreased sessions missed, but no relationship existed between other-intimacy scores and the number of sessions attended. This seems to indicate that these children were in treatment for a shorter period of time. Post hoc exploration of the data reveals that the 29 children who scored in the clinically significant range for *other-intimacy* scores (T-score > 60) attended a mean of 13.5 sessions, and 62% prematurely terminated from treatment. These children attended a mean of 16 total months in treatment, six months less than those children with elevated posttraumatic stress scores. The TABS assessment manual states that children with elevated intimacy scores are often withdrawn from others and avoid personal conversations or experiences that might invite emotional closeness. These disturbances can result from the death or sudden loss of a key attachment figure (i.e., parent, sibling), or a loss of community (i.e., a child being removed from his home or family without explanation or preparation) (Pearlman, 2003). In the example of childhood sexual abuse, the author states that a child may form intimacy distortions if a sexual abuse perpetrator tells the victim he or she is special or different, causing the child to feel alienated from others in a traumatic context.

Children with elevated intimacy schema disruption may present to therapy feeling isolated, lonely, detached, grief-stricken, and fearful of connecting to the therapist. Interpersonal

situations, such as the therapeutic relationship, can be experienced as highly demanding and frightening for children with other-intimacy schema disruptions. In an effort to adapt, children will often engage in acquaintanceships (but not friendships) in order to avoid emotional closeness, or grow into adults who prefer sexual encounters outside of a loving sexual relationship.

Therefore, counseling is particularly challenging for children with elevated other-intimacy scores. Therapists may experience these children as only partially involved in the therapeutic process, or unwilling to open up about personal thoughts and feelings, especially as it pertains to their abuse. In many CACs, therapists are trained to look for cues that the child is (a) unwilling, or (b) not ready to do the necessary therapeutic work to address their trauma. The mental health director of the agency in the current study stated that therapists will not push children into participating in therapy if they are resistant, unready, or incapable of doing the work necessary to participate in counseling and/or process their feelings associated with their trauma. As a result, these children are often referred to other services that are more appropriate for the child's needs and/or stage of readiness. No other studies exist that have looked at the relationships between other-intimacy related schema disturbances and service usage, and therefore, more research needs to be done to better understand this relationship.

*Self-Control.* The final statistically significant predictor of service usage was self-control schema disturbance. Findings indicate an association between elevated self-control scores and more sessions missed, however self-control schemas were not related to the number of sessions attended. In a post hoc exploratory analysis, children with clinically significant scores (T-score > 60) missed an average of 8.5 sessions, about the same as those with elevated posttraumatic stress, and almost 2 sessions more than those with self-trust, other-intimacy, and other-control schema

disruptions. The TABS assessment manual states that children with self-control disruptions present in therapy as fearful and anxious over losing control over one's emotions or behaviors, especially if that child dissociates to cope with their trauma. Due to the intergenerational transmission of CSA, some children may re-perpetrate their abuse on other children, followed by feelings of deep confusion and shame. Thus, children with these types of schema disruptions may work hard to stay in control of their impulses to engage in sexual activity with other children. Furthermore, when self-control disturbances accommodate symptoms of posttraumatic stress, children may believe they are "going crazy" as a result of their flashbacks, nightmares, or intrusive imagery.

Children with high self-control disruptions may strongly resist the emotional exploration common within a trauma-focused treatment framework, and have an intense need to control one's actions and emotions. Instead of using trauma-focused therapy, Pearlman (2003) suggests using behavioral techniques with these children to help them manage their panic attacks, flashbacks, and dissociations. Since the agency in this study utilizes trauma-focus therapy frameworks, it is possible that these children were referred to other services, such as a behavioral analyst, to better meet their needs.

**Scales Not Related to Service Usage.** Three scales, self-safety, self-esteem, and other-control, were not related to either the number of sessions attended nor sessions missed. The professional manual of the TABS indicates that children with a high score on the self-safety scale often have experiences of violation of one's body, home, property, or loved ones (Pearlman, 2003). These disruptions coincide with the belief that there is no safe place, that one is uniquely predestined for harm, and that future harm cannot be avoided. Furthermore, states



Pearlman, trauma survivors often struggle to regulate their affect (Allen, 2001; Courtois, 2000, Saakvitne et al., 2000), survivors may become overwhelmed with strong feelings of rage, terror, anxiety, and/or grief. Children with elevated self-safety scores might be struggling with issues of their own safety, and may worry that they will be victimized by another person or by themselves. Connors (2000), and Dieter, Nicholls, and Pearlman (2000) found that self-safety concerns are common who have suffered at the hands of others.

Disturbances in self-esteem are common among survivors of sexual abuse and/or family violence as well. Unfortunately, many children falsely assume that their abuse was their fault or that they deserved it. In concurrent family violence, children may feel responsible for their siblings or parent's safety and wellbeing due to a maladaptive belief that (a) they did not do enough to stop family violence despite their helplessness, or (b) they somehow cause the offender to physically or sexually abuse other family members through their words, beliefs, actions, or inaction. These are similar to the beliefs of children with elevated other-control scores. Moreover, children with low self-esteem generally lack empowerment in the therapeutic setting, potentially placing them at increased risk for failing to meet their therapeutic goals.

Cognitive schema disturbances in the area of control are often linked to traumatic experiences where they were unable to rescue another suffering person (i.e., witnessing the physical abuse of a sibling or parent). Hence, control is a salient theme in a population of sexually abused children who are often unable to stop their abusers, or sexually abused children unable to prevent the abuse of family members. Children with elevated scores in control schemas commonly present with depression, irritability, or rage over limited freedom, and report feeling trapped by others needs, desires, or choices of other people (Pearlman, 2003).

It is not uncommon for children with control distortions to compensate for the inability to make decisions without restrictions by engaging in high-risk behaviors and aggressive attacks on others. According to the assessment manual, children with elevated other-control scores typically feel uneasy when they are not in charge of others, and frequently seek to control people in relationships. Because these children withdraw or become triggered with anger when they are unable to control others, therapists report finding this type of client challenging. The therapeutic relationship, which is characterized by mutual respect and autonomy, is often tested early. Therefore, therapists must simultaneously demonstrate willingness to negotiate while also drawing appropriate boundaries regarding therapy rules, settings, and activities. However, states Pearlman (2003), after engaging in frequent consultation, many therapists choose to refer these types of clients to other therapists if they feel the child is too resistant or challenging to work with.

One possible interpretation for the non-significance of these scales could be that these children attended and/or missed the same number of sessions as those CSA victims who scored in the lower ranges of self-safety, self-esteem, and other-control. Furthermore, it is possible that these children terminated early in the therapeutic process, as between 57% and 61% of children with these disturbances prematurely terminated. Additionally, it is important to remember that CSA victims often have disturbances in several trauma-related cognitive schemas simultaneously, and that the overall findings of this research question could be reflecting scores from the same group of children. Therefore, more research should be done to explore the cognitive schemas of abused children at risk for dropping out of treatment.

### **Research Question Three**

The third research question examined relationships between reason for discharge, posttraumatic stress, and disturbances in cognitive self-development for CSA victims receiving mental health services. The answer to this question revealed whether factors associated with disturbances in child cognitive schemas and trauma symptomology could predict whether a CSA victim graduated or prematurely terminated from treatment. A Logistic Regression examined the dichotomous dependent variable of reason for discharge (i.e., graduation vs. premature termination), and seven independent predictor variables (i.e., posttraumatic stress score of the TSCC and the self-safety, self-trust, self-intimacy, self-esteem, and self-control subscale scores of TABS) (Hair, Black, Babin, & Anderson, 2010). The full model was not statistically significant, indicating that there was no relationship between trauma scores and whether or not a child graduated or prematurely terminated.

As is evident by Table 8 in Chapter Three, the trauma scores of those who graduated were statistically similar to those who prematurely terminated. When reflecting on the findings from the previous research question, it would seem that if trauma scores predict the number of session attended and/or missed, they would also predict whether or not a child graduates or prematurely terminates. However, while those who graduated have a mean of ten additional sessions attended ( $M = 17.7$ ) over those who terminated ( $M = 7.25$ ), no relationship exists between trauma and reason for discharge. This seems to indicate that child trauma-related internal states do not play a role in whether they graduate or prematurely terminate. These findings are particularly interesting when compared to the findings in research question five, which report a relationship between caregiver IPV and reason for discharge. Moreover, the

results echo those of Koverla et al., (2007) who reported that (a) child trauma scores were statistically equivalent among those who completed treatment and those who left early and (b) caregiver distress was related to level of treatment engagement. The authors concluded, “This may reflect that children in this sample do not have a strong voice in determining whether they engage in or complete treatment, but rather they will be involved in treatment at the discretion of their caregivers.”

#### **Research Question Four**

Research question four examined whether a relationship existed between service usage (number of sessions attended and number of sessions missed) and caregiver IPV. The answer to this question revealed whether a caregiver’s IPV status predicted the number of sessions attended and/or missed by a CSA victim. Poisson Regression was chosen because the values of the dependent variable (i.e., number of sessions attended or missed) are count data, which are positively skewed by design and would violate the assumption of normality in a normal linear regression. The first null hypothesis for this research question (4A) was rejected after the model revealed that confirmed past or current IPV predicted the number of sessions attended. Specifically, Compared to caregivers who denied IPV, the expected log count for number of sessions attended for caregivers who confirmed IPV decreases by .16. Furthermore, the results indicate that the incident rate for children with caregivers who confirmed IPV is .86 times the incidence rate for children of caregivers who denied IPV, holding all other variables at constant. However, for the second null hypothesis (4B) examining the relationship between caregiver IPV status and sessions missed, the model was not statistically significant, suggesting that caregiver IPV was not a predictor for the number of sessions missed.

Again, at face value, it may seem that these findings contradict one another. However, due to the session attendance patterns of this population, one cannot assume that if the presence of IPV reduces sessions attended, it will also increase sessions missed. Similarly, one cannot assume that if the presence of IPV reduces sessions attended, that the absence of IPV will also decrease the number of sessions attended.

To further clarify this, I will discuss the different reasons for premature termination. Agency policy states that a child should be administratively discharge if (a) he or she cancels and/or no-shows sessions intermittently and “excessively,” (b) he or she cancels or no-shows sessions two or three times in a row, or (c) he or she is inactive for 30 days or more. While it is tempting to assume that those clients with the highest number of sessions missed are also premature terminators, it is possible that a child was removed from treatment after missing zero sessions (i.e., 30-day inactivity), or after missing two or three sessions in a row. It is also possible, as discussed in research question one, that a child misses more sessions the longer they are in treatment. Therefore, a child could realistically graduate after having missed a total of 15 sessions, while another child prematurely terminates after having missed zero sessions. The reverse is also true: one child could prematurely terminate after missing 15 sessions, while another child graduated after missing zero sessions.

Post hoc analysis revealed that, out of 107 children sampled for this question, 54 (50%) attended less than five sessions total, of which, 46 children also missed less than five sessions. Thus, because it is difficult to tell if this pattern of attendance is associated with graduation or premature termination, one cannot presume that IPV is associated with reason for discharge solely based on its association with the number sessions attended. However, the next research question gives additional information about the relationship between IPV and reason for

discharge within this population. Specifically, it supports the finding in this research question that the presence of IPV is related to decreased session attendance.

### **Research Question Five**

The final research question explored the relationship between caregiver IPV and whether or not a CSA victim graduated or prematurely terminated. The Chi-square test for independence reveals a statistically significant relationship, and the odds ratio shows that CSA victims with confirmed caregiver IPV were 2.5 times more likely to prematurely terminate than to graduate. Among the sample of 107 CSA victims, exactly 50% of caregivers who denied past or present IPV graduated while the other 50% prematurely terminated. This indicates that the CSA victims without caregiver violence have an equal probability of finishing treatment as they do terminating early. However, out of those children with caregivers who reported past or current IPV, 71% left treatment before meeting their therapeutic goals, while only 29% graduated.

As stated earlier in this dissertation, the purpose of this study was to examine both child and caregiver factors simultaneously to learn more about how these factors are related to treatment attrition for CSA victims. The findings in both research question three and research question five seem to indicate that child factors, specifically traumatization and schema distortions, do not place children at increased risk for premature termination, while parent factors, specifically past or present IPV, places children at significant risk for early termination. This supports the notion that CSA treatment attrition is a function of caregiver distress, especially if the caregiver is the victim of abuse herself. These findings are echoed in previous research from other fields that determined parent factors, such as single motherhood, low

socioeconomic status, and high maternal stress, predicted child attrition (Armbruster & Fallon 1994; Kazdin et al. 2005; McCabe 2002; Peters et al. 2005; Prinz & Miller 1994).

### **Synthesis**

The five research questions in this study investigate the relationships between posttraumatic stress, child cognitive self-development, IPV, and attrition variables. Disturbances in posttraumatic stress and child cognitive self-development among CSA victims with confirmed caregiver IPV were statistically similar to those with CSA alone. These findings are supported by previous literature stating the difficulty of discerning the source of traumatization in multiply traumatized individuals. Thus, while specific types of abuse severity may be related to symptom severity, huge variances in coping skills, protective factors, and risk factors across victims make it difficult (if not impossible) to conclude that a particular combination of traumatic event exposures will result in higher levels of traumatization. McCann and Pearlman's (1990) statement, "One person's trauma may be another person's difficult experience," rings especially true in light of these findings. Therefore, therapists should avoid making assumptions on child traumatization based on abuse type and the presence of concurrent family violence. Because no relationship exists between trauma scores with and without caregiver IPV, therapists should approach treatment without preconceived notions pertaining to the child's exposure to several forms of family violence, and instead, shape treatment based on the specific needs of each child.

Furthermore, posttraumatic stress and cognitive schema disturbance were not related to reason for discharge for this population, but were related to service usage. Specifically, these findings seem to suggest that CSA victims with elevated levels posttraumatic stress attended treatment for longer periods of time, resulting in more sessions attended and more sessions

missed. However, there are no differences in posttraumatic stress between those who graduated and prematurely terminated. Additionally, elevated scores in self-trust, self-control, and other-intimacy were related to increases in missed sessions, with self-trust also statistically related to number of sessions attended. Thus, it is possible that CSA victims with elevated scores in self-trust attend treatment for shorter periods of time. Therefore, assessment scores are not reliable indicators of attrition patterns among CSA victims with and without caregiver IPV, and therapists should avoid relying on trauma scores as benchmarks for threats to retention. Furthermore, while number of sessions missed may inform decisions on administrative discharge, the findings of this study illuminate the notion that these variables are not informative indicators of whether or on a child completes treatment or prematurely terminates.

Finally, caregiver IPV was related to both service usage and reason for discharge. Specifically, children of caregivers who confirmed IPV had fewer sessions attended, and were 2.5 times more likely to prematurely terminate from treatment than those with caregivers who denied IPV. These findings are particularly interesting because they support the notion that caregiver factors influence attrition more than child factors. Therefore, therapists should attend more closely to the specific needs of caretakers, especially if past or current IPV exists in the family, as these findings support the notion that caretaker violence is related to premature termination.

### **Limitations**

The purpose of this study was to examine the relationships between both child and parent factors and treatment attrition variables in order to learn more about how these factors work together toward influencing attrition behaviors in families with (and without) multiple types of



abuse. Overall findings suggest that both child and parent factors predict the number of sessions attended and missed for CSA victims in treatment, but that parent factors alone predict whether a CSA victim stays in treatment. Prior to applying these findings to the research, practice, and counselor education fields, it is important to discuss study challenges and limitations.

Firstly, when compared to more complex studies on child abuse, it is clear that this study only “scratches the bivariate surface” (Saunders, 2003, p. 369). Furthermore, with every question answered by this investigation, more than twice as many emerged. In his article on the challenges of researching overlapping family violence, Saunders (2003) reveals that most child victims of violence are victims of more than one type of violence. In fact, he states, children who report a single exposure to violence are in the minority, with most child victims of abuse being exposed to several types of violence on multiple occasions. Out of previous studies that reached the same conclusion (Finkelhor & Dzuiba-Leatherman, 1994; Green et al., 2000; Kilpatrick & Saunders, 1999) a series of National Survey of Adolescents (NSA) studies stands out from the rest (Acierno et al., 2000; Crouch, Hanson, Saunders, Kilpatrick, & Resnick, 2000; Kilpatrick et al., 2000, 2002; Kilpatrick & Saunders, 1999). In a telephone survey on the abuse and violence exposure of randomly sampled adolescents ( $N = 4,032$ ) from 12 to 17-years-old, researchers found that nearly 50% of the sample reported experiencing at least one out of four types of violence. Forty percent of these children (20% of the total sample) reported experiencing at least two types of violence. Moreover, of those children who either witnessed community violence or survived physically or sexually abuse by a parent, 50% admitted exposure to domestic violence. Additionally, of those children reporting caregiver domestic violence, between 40% and 80% stated they were victims of one of the other types of violence also. Therefore, concludes

Saunders, it's possible that researchers of different subtypes of abuse are studying the same group of children from different angles. He explains:

This overlap of childhood violence presents considerable challenges to researchers (as well as clinicians). When the sexual abuse researcher evaluates sexually abused children, and the physical abuse researcher studies physically abused children, and the school violence researcher investigates victims of school crime, and the gang violence researcher examines child victims of gang violence, and the dating violence researcher assesses adolescents assaulted in dating relationships, and the domestic violence researcher studies children who have witnessed domestic violence, and the street crime researcher evaluates child victims of street crime, and the community violence researcher examines children who have witnessed violence in the community, for the most part, they are all studying many of the same children. They are simply catching them at different times of the children's lives and categorizing them according to the singular research protocol. When different forms of violence are not assessed in a comprehensive manner, discerning interactions, cumulative effects, and complex pathways to specific outcomes becomes very difficult. Most important, the risk for misunderstanding the full phenomenon of childhood violence and misattributing outcomes to one type or episode of violence is great (p. 362).

Therefore, research on the link between violence exposure and outcomes are often confounded by the child's and/or caretaker's exposure to other types of trauma. Considering most child abuse researchers examine either (a) one subtype of abuse or (b) all subtypes of abuse in a single sample, the current study selected children with a specific combination of family violence (e.g., CSA and IPV) because of the unique cognitive schema distortions particular to

sexual abuse (versus physical abuse or neglect). However, this does not constitute as a comprehensive method of evaluation.

## **Research Design and Methods**

Within correlational analyses, etiological conclusions cannot be made about the observed relationships between caregiver IPV, service usage, reason for discharge, posttraumatic stress, and child cognitive self-development. Furthermore, while archival data offers a wealth of knowledge on clinical samples, it has several limitations. Firstly, data generated from NCA Trak is not immediately prepared for statistical analysis, nor is it gathered with research in mind. For a large dataset such as this one, many weeks were spent coding each variable into an Excel spreadsheet before it was entered into SPSS. Researchers working with archival data are not able to monitor the accuracy of (a) the information written in the files by the therapists, (b) therapists scoring assessments, or (c) therapists entering data into the NCA Trak database. The researcher's inability to implement a monitored procedure for collecting data threatens the study's internal validity, and hence, calls the findings into question.

Secondly, a researcher of archival data is limited to the scales of measurement recorded in the original database. For example, one of the biggest limitations of this study is the manner in which information was recorded on caregiver IPV. As is typical in many CAC's (Thackeray, Scribano, & Rhoda, 2010), the child abuse agency does not administer specific IPV assessments to caretakers, and therefore, the records contain little detail about the specific nature of past or current IPV, including the degree IPV exposure experienced by the CSA victim. Instead, the intake therapist records past or current IPV into NCA Trak with a "yes" or a "no." They record "yes" if (a) the caretaker verbally confirms past or current IPV in the home, (b) the caretaker

indicates in writing the occurrence of past or present IPV in the home on intake paperwork, or (c) if a referring agency provides paperwork to the child abuse agency indicating the presence of past or current IPV in the home. Therefore, while this study reveals a statistically significant relationship between caregiver IPV, number of sessions attended, and reason for discharge, it is not possible to account for important details of the violence that might influence the findings of this study. Some examples of missing details are abuse severity (i.e., slap or attempted murder), duration (i.e., overall length of time in days, weeks, or months the violence occurred), frequency (i.e., the number of times a perpetrator of violence attacked his or her partner), caregiver childhood history of violence, and others.

To better illustrate the issue, consider the following example: a caregiver living in a domestic violence shelter with children who witnessed brutal violence regularly may have fewer financial, occupational, social, and psychological resources to enable them to deliver their child to treatment than a caregiver who was forcefully shoved while the children were not in the home. Furthermore, these differences could account for variations in the children's trauma scores. Without more details about the violence, we cannot research how the forms of violence develop in families over time, nor are we able to understand how treatment centers uniquely help the families. Furthermore, because this study examines two different forms of violence, we do not know the ways in which both forms of violence co-occurred during the same violent incidents. Saunders (2003) furthers that without detailed recordkeeping, we cannot study how perpetrators of dual violence differ from perpetrators of single forms of family violence.

Moreover, the definition of abuse in archival research is a function of (a) how victim describes it to the therapist, and (b) how the therapist records it. In a sense, this prevents the researcher from crafting a definition for different types of abuse that is informed by the literature.

Without agreement across studies on the common definitions and measurements of child maltreatment and intimate partner violence, generalizability will be greatly diminished. This can be challenging in CACs because, in some instances, a counselor asking a child or caregiver about intimate partner violence might place them in greater danger, especially if the question is unknowingly asked in front of the perpetrator.

### **Sample**

The current study selected participants based on a number of criteria, including the requirements that they (a) are sexual abuse victims, (b) are no longer in treatment, and (c) completed both the TSCC and TABS assessments at intake. While making informed decisions in sampling can help reduce threats to validity faced by research studies that do not account for differences in abuse experiences, results are likely to be shaped by a number of unknown confounding variables. In some cases, these confounding variables can elevate findings on negative outcomes (i.e., high attrition) within simple bivariate research. While the vast majority of archival child abuse research is correlational, Saunders (2003) states, “If these alternative explanatory factors are not measured, then criterion group equality cannot be assessed, the impact of other risk factors cannot be determined, and important potential confounds cannot be controlled. (p. 358). However, due to the complex and numerous differences in the families’ risk and protective factors, it is nearly impossible to account for every confounding factor.

Although efforts were made to limit threats to internal and external validity within this research study, generalizability is limited and demographic features of the sample obtained from the child abuse agency. Moreover, all data collection instruments contain some measurement of error even with psychometrically sound qualities (e.g. reliability and validity). The use of self-

report measures with children can be problematic because accurate results depend on the child's ability to accurately comprehend and express thoughts and feelings (Michael & Merrell, 1998; Sadowski & Friedrich, 2000). Furthermore, it is exceedingly difficult, and in many cases impossible, to determine if symptoms like depression, anxiety, hyperarousal, or poor behavior arose after the children experienced a traumatic event, or if these difficulties were evident prior to the event. Yet research shows that child self-report instruments are the best measures for depressive or PTSD symptoms, because children more accurately report internalizing symptoms and distress than their caregivers (Moretti, Fine, Haley, & Marriage, 1984; Muris, Meesters, & Spinder, 2002; Wrobel & Lachar, 1998). The following section discusses the implications for research, clinical practice, and counselor education.

## **Implications**

### **Research**

The findings and limitations of this research study reveal a number of implications for future researchers of attrition and overlapping family violence. The most obvious implication is the need for a valid and reliable assessment of concurrent family violence for both children and caretakers. Currently, no assessments exist that quantitatively measure detailed experiences of violence, as well as cognitive, emotional, or social disturbances associated with concurrent family violence. Considering that over half of the children who were sexually abused in this sample also had caregivers with past or current IPV, the lack of such an assessment has huge implications for both research and practice. Furthermore, as is mentioned in recent literature (Thackeray, Scribano, & Rhoda, 2010), CACs should regularly administer assessments to caregivers in an effort to learn more about other potential caregiver factors influencing attrition.

However, notes Saunders (2003), "...it is unrealistic to think that evaluation protocols can be constructed to assess every important type of violence and trauma, all possible mediators and moderators, and the many potential outcomes. Such a protocol would simply be too long, too complex, and too taxing on participants, particularly children. Therefore, the idea comprehensive study on child violence may never be done" (p. 369).

Furthermore, Fernandez and Eyberg (2009) caution against the "uniformity assumption" in attrition research, or the idea that predictors of dropout are the same across all ages, treatment programs, treatment modalities, or clinical diagnosis (Armbruster & Kazdin 1994, p. 100). For example, while some studies show that higher problem severity is associated with higher rates of attrition (Kazdin, 1990), other studies demonstrate that lower severity is related to higher attrition (Kendall & Sugarman, 1997). Furthermore, attrition research establishes that predictors of attrition depend largely on the level of client-therapist engagement (McKay & Bannon, 2004), and while nature of attrition prevents researchers from adequately assessing therapeutic factors, CACs might consider tracking the therapeutic relationship with through formal and informal check-ins and periodic documentation.

As mentioned in previous studies on concurrent family violence (Kazdin, 1996; Saunders, 2003), there exists a need for researchers and practitioners from multiple specialties and expertise to share information across disciplines. Considering the estimated overlap of research samples is as high as 50% across studies (Saunders, 2003), researchers of trauma, child abuse, IPV, and attrition should create a comprehensive task force to explore these complex issues together, and not separately.

## **Therapy**

Several implications also relate to how counselors and agencies may better support families with multiple abuse victims. Currently, much of the focus is placed on the child victim of abuse, with the majority of assessments and therapeutic attention directed at the child. However, due to the relationship between caregiver wellbeing and their child's successful completion of treatment, additional efforts should be made to support and encourage caregivers to participate in treatment. Specifically, the results of this study demonstrate a need for a multidisciplinary approach to investigate, manage, treat, and prosecute caregiver IPV in families with CSA. Partnerships and collaborations with local domestic violence shelters should go beyond referrals for services.

Currently, mental health counselors and agencies working with caregivers in violent relationships engage in advocacy for their clients to help connect the family resources such as welfare assistance, free food programs, transportation programs, medical assistance, and family therapy to decrease the burdens faced by the family in order to better protect the child. Similar forms of advocacy should be used to increase the likelihood of treatment completion. For example, many perpetrators of abuse extol power and control tactics in order to dominate victims and discourage them from leaving the relationship. These power and control tactics include controlling finances, isolating the victim from friends and family, confiscating important documents such as drivers licenses, birth certificates, and immigration paperwork, and threatening to harm pets and/or children. A caregiver experiencing this type of control and manipulation will benefit from resources, such as group therapy with other IPV victims, financial advisement, career planning, and safety planning to help the victim relinquish her autonomy.



Moreover, alternative forms of therapeutic attention, potentially in the form of home-based visits, should be offered to the caregiver throughout the child's treatment to help bolster treatment engagement.

Future research should also explore whether a relationships exist between treatment formats and attrition. In previous research, multi-modal treatment with an advocacy component was associated with lower attrition (Koverla et al., 2007). Therefore, researchers should account for caregiver participation in child therapy and determine whether attrition is reduced with increased numbers of family sessions. Moreover, systematic efforts to involve and retain caregivers whose children rank with more severe trauma symptomology may be beneficial. However, in instances where the child is engaging in therapy to reduce trauma symptomology (i.e., EMDR), including the caregiver in treatment may complicate and even hinder progress. These decisions must be thoroughly discussed in weekly staff meetings and carefully examined on a case-by-case basis, as complex family dynamics, such as parental traumatization, depression, reversed parent-child roles, and/or unsupportive parents may damage the child's positive growth and healing in treatment. In these cases, parents should be referred to individual counseling and extensively prepared before joining a therapeutic session with a child with acute traumatization.

### **Counselor Education**

Lastly, counselor educators should focus on training counselors to work effectively with multiple-victim families. Koverla and colleagues (2007, p. 39) suggested that, "...the combination of highly trained clinicians who receive ongoing training in this specialty area with emphasis on cross-cultural competence and vicarious trauma may be critical components in

equipping clinicians who are able to facilitate retention in this population.” Current CACREP accredited Counselor Education programs prepare trainees through basic courses on family systems and individual counseling. Yet, due to the large amount of information that must be addressed in counselor education programs, special topics, such as play therapy, trauma therapy, and trauma assessments for children and families are sparsely covered in the curriculum, aside from brief and/or voluntary seminars or lectures. Given the high incidence rates of child abuse and traumatization in the general population, and the fact that many trainees are placed at internship sites that provide services for abused and traumatized children, counselor educators should place more emphasis on assessment, child abuse treatment, family therapy, and group therapy for these populations. Furthermore, techniques for retaining high-risk children and their caretakers should be discussed in practiced in counseling skills and techniques courses. In sum, many issues related to CSA victim attrition remain to be studied.

### **Conclusion**

Research question one explored the relationship between caregiver IPV, posttraumatic stress, and disturbances in child cognitive-self development. The findings indicated that no relationship exists between concurrent family violence and child disturbance. A closer examination of mean trauma scores shows that CSA victims with concurrent caregiver IPV had similar levels of traumatization and cognitive disturbances when compared those CSA victims without concurrent caregiver IPV. The second research question investigated whether relationships exist between service usage, posttraumatic stress, and child cognitive self-development. The findings indicated that a statistically significant relationship existed between the number of sessions attended and *posttraumatic stress* and *self-trust*. Similarly, a statistically

significant relationship existed between the number of sessions missed and *posttraumatic stress*, *self-trust*, *self-control*, and *other-intimacy*

The third research question examined whether relationships exist between reason for discharge, posttraumatic stress, and child cognitive self-development. The findings suggested no relationship existed between level of traumatization, disturbance of trauma-related cognitive schemas, and whether a CSA victim graduated or prematurely terminated from treatment. The fourth research question investigated whether relationships exist between service usage and caregiver IPV. Findings yielded a statistically significant relationship between number of sessions attended and confirmed caregiver IPV, but found no significant relationship between caregiver IPV status and number of sessions missed. Finally, the fifth research question explored whether a relationship existed between caregiver IPV and reason for discharge. Findings indicate a statistically significant relationship between caregiver IPV and whether a CSA victim graduates or prematurely terminate. Specifically, children with confirmed caregiver IPV were 2.5 times more likely to prematurely terminate from treatment than those without caregiver IPV.

The goal of this study was to illuminate the relationships between caregiver IPV, child traumatization, child cognitive self-development, and treatment attrition. A need exists for more detailed caregiver assessments in CACs, as well as cross-field collaboration in both research and practice. Without these partnerships, the depth and breadth of research is sacrificed. Most importantly, these collaborations will better serve the millions of vulnerable children and families who desperately need healing and help.

## APPENDIX A: CSDT ASPECTS OF THE SELF

## CSDT Aspects of the Self

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- Self capacities (regulate self-esteem)
  - Ability to tolerate strong affect
  - Ability to be alone without being lonely
  - Ability to calm oneself
  - Ability to regulate self loathing
- Ego Resources (regulate interactions with others)
  - Intelligence
  - Willpower
  - Initiative
  - Ability to strive for personal growth
  - Awareness of psychological needs
  - Empathy
  - Ability to foresee consequences
  - Ability to establish mature relations with others
  - Ability to establish boundaries
  - Ability to make self-protective judgments
- Psychological Needs (motivate behavior)
  - Frame of reference
  - Safety
  - Trust/dependency
  - Esteem
  - Independence
  - Power
  - Intimacy
- Cognitive schemas (organize experience of self and world)
  - Beliefs, assumptions, and expectations related to psychological needs

## APPENDIX B: MAJOR ASSUMPTIONS OF CSDT

## Major Assumptions of CSDT

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- Constructivism
  - Individuals construct their own realities
- The self
  - The self is the seat of the individual's identity and inner life
  - The self develops over the lifespan through internalization and assimilation/ accommodation
- The self comprises four interrelated aspects:
  - Self capacities allow for the development and maintenance of positive self-esteem
  - Ego resources regulate interaction with others and the environment
  - Psychological needs motivates behavior
  - Cognitive schemas are the cognitive manifestation of psychological needs
- Traumatic memories
  - Traumatic experiences are encoded in the verbal and imagery systems of memory
- Adaptation to trauma
  - Trauma can disrupt any or all parts of the self, including capacities, resources, needs, and schemas
  - Adaptation to trauma reflects an interaction between life experiences and the self

APPENDIX C: IRB APPROVAL FORM





University of Central Florida Institutional Review Board  
Office of Research & Commercialization  
12201 Research Parkway, Suite 501  
Orlando, Florida 32826-3246  
Telephone: 407-823-2901, 407-882-2012 or 407-882-2276  
[www.research.ucf.edu/compliance/irb.html](http://www.research.ucf.edu/compliance/irb.html)

## NOT HUMAN RESEARCH DETERMINATION

From : UCF Institutional Review Board #1  
FWA00000351, IRB00001138  
To : Andrew Daire and Leigh deArmas  
Date : May 03, 2011

Dear Researcher:

On 5/3/2011 the IRB determined that the following proposed activity is not human research as defined by DHHS regulations at 45 CFR 46 or FDA regulations at 21 CFR 50/56:

Type of Review: UCF Initial Review Submission Form  
Project Title: The research and evaluation of children exposed to abuse and family violence project.  
Investigator: Andrew P Daire  
IRB ID: SBE-11-07644

University of Central Florida IRB review and approval is not required. This determination applies only to the activities described in the IRB submission and does not apply should any changes be made. If changes are to be made and there are questions about whether these activities are research involving human subjects, please contact the IRB office to discuss the proposed changes.

On behalf of Kendra Dimond Campbell, MA, JD, UCF IRB Interim Chair, this letter is signed by:

Signature applied by Janice Turchin on 05/03/2011 09:41:03 AM EDT

A handwritten signature in cursive script that reads "Janice Turchin".

IRB Coordinator

APPENDIX D: DEMOGRAPHICS BY RETENTION/ATTRITION STATUS

*Demographics By Retention/Attrition Status*

<b>Child</b>	Graduated (N = 53) N (%)	Prematurely Terminated N (%)
<b>Gender</b>		
Male	10 (19%)	14 (18%)
Female	43 (81%)	65 (82%)
<b>Race</b>		
White	32 (60%)	43 (54%)
Black	5 (9%)	19 (24%)
Hispanic	12 (23%)	12 (15%)
Multi-Heritage	3 (6%)	4 (5%)
Asian	1 (2%)	0 (0%)
<b>Education</b>		
Elementary	15 (28%)	12 (15%)
Middle	23 (43%)	35 (44%)
High School	13 (25%)	31 (39%)
<hr/>		
<b>Caretaker</b>	N (%)	N (%)
<b>Gender</b>		
Male	15 (30%)	36 (46%)
Female	37 (70%)	46 (58%)
<b>Race</b>		
White	32 (60%)	38 (48%)
Black	5 (9%)	24 (30%)
Hispanic	15 (28%)	17 (22%)
Asian	1 (2%)	
<b>Income</b>		
≤. \$15,000	14 (26%)	22 (28%)
\$15,001 - \$30,000	11 (21%)	15 (14%)
\$31,001 - \$50,000	13 (25%)	7 (9%)
+\$50,000	6 (11%)	18 (23%)
Unknown	9 (17%)	17 (22%)
<b>Marital Status</b>		
Single	19 (36%)	34 (43%)
Married	16 (30 %)	24 (30%)
Divorced	10 (19%)	12 (15%)
Separated	6 (11 %)	5 (6%)
<b>Past/Current IPV</b>		
Yes	18 (34%)	45 (57%)
No	22 (42%)	22 (28%)
Unknown	13 (25%)	12 (15%)

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