The Association of Five Therapist Characteristics with Therapists' Suspicion of Childhood Sexual Abuse in Adult Client Cases

Sherri I. Terrell

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THE ASSOCIATION OF FIVE THERAPIST CHARACTERISTICS WITH THERAPISTS' SUSPICION OF CHILDHOOD SEXUAL ABUSE IN ADULT CLIENT CASES

by
Sherri I. Terrell

A Dissertation
Submitted to the
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requirements for the
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and Counseling Psychology

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THE ASSOCIATION OF FIVE THERAPISTS CHARACTERISTICS WITH THERAPISTS' SUSPICION OF CHILDHOOD SEXUAL ABUSE IN ADULT CLIENT CASES

Sherri I. Terrell, Ed.D.
Western Michigan University, 1996

One hundred and twenty-five doctoral level psychologists interning at university counseling centers throughout North America were surveyed to explore the association of therapists' suspicion of childhood sexual abuse (CSA) in adult client cases with five therapist characteristics: (a) gender; (b) having or not having had personal therapy; (c) having or not having professional experience with three or more clients who are survivors of CSA; (d) having or not having a close friend, family member, or significant other who is a survivor of CSA; and (e) being or not being a survivor of CSA.

Information was collected on interns' demographics and their five therapist characteristics using a questionnaire, the Therapist's Data Sheet. The Sensitivity Test of Clinical Issues (STOCI) was used to collect information on interns' suspicion of CSA in clinical vignettes. This instrument, created specifically for the current research, consists of ten clinical vignettes. A list of 12 clinical issues follows each vignette from which participants circle the issues they suspect are most important to conceptualizing the case presented in the vignette. Five of the vignettes are designed
to suggest, but not openly state, CSA. Five of the vignettes are designed not to suggest CSA.

The STOCI went through a process of development which included: a pre-pilot, an assessment by expert raters, and a pilot test. At the end of this process, the STOCI was deemed to have face and content validity and sufficient reliability for the current research; however, when used in the survey the STOCI had less reliability.

In the analyses of the STOCI scores across the five therapist characteristics, only gender was associated with a statistically significant difference. That is, female interns were more accurate in their suspicion of CSA while males tended to miss the suggested CSA more often. There was no evidence that male or female participants inaccurately suspect CSA in cases with no history of CSA. Finally, the similarity in the STOCI scores of interns who were and were not survivors of CSA support Follette, Polusny and Milbeck's (1994) findings that having a history of CSA is not associated with professionals' clinical behaviors.
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DEDICATION

I dedicate this dissertation in loving memory to Thomas S. Barlow, Jr., my brother. Cancer halted Tom's doctoral program in medicine and I promised to finish my doctorate in Counseling Psychology for both of us. Tom died on October 6, 1994. I have kept my promise. This one is for you Tom. I love you wherever you are.
ACKNOWLEDGMENT

I would like to acknowledge many people for their participation and support during my dissertation process. I thank my chair, Dr. James Croteau for his patience and perseverance through many rewrites. I also thank my committee members, Dr. Robert Betz and Dr. Robert Wait for their support and positive input. Dr. Ken Waldman was my internship supervisor and staunch advocate. He also facilitated my data collection by writing a letter of introduction to training directors. Thank you for all of your encouragement and support. Doctors Carol Lee and Felix Famoye were statistical consultants whose expertise was greatly appreciated. Thank you.

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Sherri I. Terrell

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CHAPTER I

OVERVIEW AND INTRODUCTION

Overview of Dissertation

This dissertation addresses five therapists characteristics in relationship to therapists' suspicion of childhood sexual abuse as an important therapeutic issue in adult client cases. It is written in five chapters. At the beginning of each chapter the reader will find an introduction outlining the contents of the material contained within the chapter. Chapter I is designed to give the reader an abbreviated understanding of all aspects of the research. Chapter I contains parts of subsequent chapters and presents the material in the same order as Chapters II through V. Chapters II, III, IV, and V expand upon the material presented in Chapter I and provides further detail. Chapter II contains a review of the literature to familiarize the reader with relevant information and insight into the rationale for this study. Chapter III describes the methods used in this research in sufficient detail for the reader to understand and duplicate the study if desired. Chapter IV presents the research results. Chapter V discusses the results, implications, and limitations of this study, and closes with an invitation to improve and expand upon the current empirical research in this area.
Overview of Chapter I

The false memory versus delayed memory debate stimulated the current research. The major focus of this study is the exploration of five therapist characteristics and their association with therapists' suspicion of childhood sexual abuse (CSA) in adult client cases. The five therapist characteristics are therapist's gender, and whether or not a therapist has had (a) personal therapy or counseling; (b) professional experience with three or more clients who are survivors of CSA; (c) a close friend, family member, or significant other who is a survivor; and (d) personal experience as a survivor of CSA. To give the reader a context for this study, the reminder of Chapter I begins with a review of the CSA literature used for the current study. The historical, clinical, and empirical literature is synthesized and leads to information about the current study, giving the reader an understanding of the purpose and research questions of the study. Following the information, the connection between therapists' suspicion, sensitivity, and ability regarding the assessment of the presence or absence of CSA in adult clients is explained.

The research method used in the present study is presented next. This section on methods has two basic tiers. The first tier discusses the development of a research tool for this study, the Sensitivity Test of Clinical Issues (STOCI) (see Appendix A). The second tier presents the methods employed in the study of the association of five therapist characteristics with therapists' suspicion of CSA in adult client cases, using the Therapists' Data Sheet (see Appendix B) and the STOCI.
The next section of Chapter I contains the results of the study. This includes reliability statistics on the STOCI with the primary results of responses to the STOCI across the five therapist characteristics. The final section of this chapter is a discussion of the results, their limitations and their implications for further research.

Review of Literature Leading to Current Study

Western society has a long history of CSA (Henderson, 1972; Herman & Hirschman, 1981; Meiselman, 1990; Rush, 1980; Russell, 1986). Literature, including the media, organized religion, and professionals in the fields of psychology and mental health have all contributed to the secrecy, shame, and denial that shroud CSA (Herman & Hirschman, 1981; Rush, 1980; Russell, 1986; Tower, 1989). The 1970s appear to be a watershed for growing changes in these practices. The feminist movement and researchers in family violence advocated for support of survivors and social change regarding attitudes about CSA (Herman & Hirschman, 1981; Mayer, 1983; Courtois; 1988; Finkelhore 1982; Russell, 1986). These two forces, more than any other, are credited with being the catalysts for the growing awareness and concern for survivors of CSA.

Currently, we know much more about the family dynamics of incestuous families and the sequelae of CSA than was known twenty years ago (Courtois, 1988; Finney, 1990; Gentry, 1978; MacFarlane, & Korbin, 1983; Russell, 1986; Tower, 1989). Clinicians are beginning to identify survivors with increasing frequency and as
a rule, are more aware of the survivors' mental health difficulties (Bryer, Nelson, Miller, & Krol, 1987; Courtois, 1992; Elliott & Briere, 1992; Goodwin, Cheeves, & Connell, 1990; Rencken, 1989; Williams, 1994a). There has been some improvement in professionals' attitudes regarding CSA over professionals' attitudes of the 1970s. It appears, however, that there may be a significant number of therapists working with survivors who still overestimate the number of false accusations children make due to fantasies, devalue the harm sexual abuse causes victims, and reject the current predicted frequency of CSA (Armsworth, 1989; Attias & Goodwin, 1985; Kirschner, 1993; Reece, 1994). Even so, there are legitimate concerns that some clients may have inaccurate memories of their abuses that are then reinforced to the detriment of the client, the accused, and their families (Loftus, 1993; Loftus, Garry & Feldman, 1994; Yapko, 1994).

Not surprisingly these attitudes and concerns are reflected in the current false-memory versus delayed-memory debate. Supporters from the delayed-memory side of the debate are afraid that the memories of survivors are being discounted (Olio, 1994; Olio & Cornell, 1994; Williams, 1994b). Additionally, these supporters are worried that the harmful effects of CSA are being minimized and devalued in deference to the concerns that adults are being falsely accused of perpetrating sexual abuse and that these false accusations are debilitating the lives of the accused and their families.
For the supporters of the delayed-memory side of the debate, this situation is reminiscent of the socio-political environment of Freud's time when he abandoned his Seduction Theory, which for all practical purposes meant the abandonment of survivors. However, today women are in a much more powerful position within society (Elvik, 1994). This power is being exercised in the legal system and women are beginning to seek financial damages from their perpetrators for emotional and physical damage and the costs of related therapies (Olio & Cornell, 1994). The legal actions of women believed to be survivors appear to have stimulated the supporters of the false-memory side of the debate into challenging survivors' memories of CSA and accusing survivors' therapists of creating false memories in their clients. People from both sides of the debate express concerns that therapists' CSA biases are affecting therapists' ability to assess the presence or absence of CSA in adult clients correctly (Olio & Cornell, 1994; Lofittus, 1993; Ofshe & Watters, 1993; Sifford, 1992; Stayton, 1994; Yapko, 1994).

The literature shows little empirical knowledge from which to argue that therapists' biases and attitudes regarding CSA are affecting therapists' ability to assess CSA in adult clients. Most of the information related to therapist characteristics that might affect therapists' assessment of CSA is derived from clinical experience (Shapiro & Dominiak, 1992). Unfortunately, clinicians do not seem immune to the cultural biases and attitudes from which they have come (Courtois, 1988; Gentry, 1978; Herman & Hirschman, 1977; Kraemer, 1988).
There have been some attempts to research therapist characteristics as they pertain to therapists' attitudes (Adams & Bets, 1993; Attias & Goodwin, 1985; Ciccone, 1981/1982; Follette, Polusny & Milbeck, 1994; Fowler & Wagner, 1993; Grannis, 1985; LaBarbera, Martin & Dozier, 1980; Polusny & Follette, 1996; Sheeny & Meiselman, 1981). Of these studies, gender was the only characteristic that consistently showed a relationship to certain attitudes and behaviors. That is, male therapists tended to be less believing and less supportive of CSA survivors than did females (Adams & Betz, 1993; Attias & Goodwin, 1985; Grannis, 1985; Polusny & Follette, 1996). Males tended to view the effects of CSA as less harmful to survivors than females. In contrast, females tended to be more hopeful for the survivor's recovery from the harmful effects of CSA. However, in light of the false-memory versus delayed-memory debate, it should be noted that Polusny and Follette (1996) did not find any gender differences in therapists' beliefs about the prevalence of repressed memories or the likelihood that therapists or support groups would falsely convince adult clients that they were survivors of CSA.

None of the gender studies attempted to examine the relationship of therapists' gender to therapists' ability or sensitivity in assessing CSA in adult clients. The information gained from examining the effect of therapists' gender on therapists' ability and sensitivity to assess CSA could provide useful information and help to elucidate the delayed-memory versus false-memory debate. Therefore, the current research explores this relationship. Because the research literature shows that female therapists
tend to be more believing of survivors than male therapists (Attias & Goodman, 1985; Grannis, 1985; Herman & Hirschman, 1981), it is expected that the current research will find female therapists to be more sensitive and accurate in their assessment of CSA in adult clients than male therapists.

The clinical literature suggests that characteristics that are effective for working with survivors are the same as those for working with clients overall. What many speculate to be problematic of survivor work are the emotional aspects and unconscious beliefs associated with CSA which affect therapy (Briere, 1989; Courtois & Watts, 1982; Emerson, 1988; Rencken, 1989; Saakvitine, 1990; Zimpfer, 1987). This problem, as expressed in the clinical literature, has led authors to repeatedly advise therapists to deal with their own issues regarding CSA. Not to do so could cause personal difficulty for the therapist and be harmful for the therapeutic relationship with survivors. Therefore, exploring whether or not therapists of CSA survivors routinely invest in their own therapy seems reasonable for this research. Further, given the concerns expressed in the false-memory versus delayed-memory debate about unconscious beliefs motivating therapists and the assumption that therapy helps therapists better understand their own issues, it may be helpful to investigate if therapists' having or not having personal therapy shows any correlation with therapists' accurate assessment of CSA in adult clients. Therefore, this research will examine the relationship of therapists who have had therapy versus therapists who have not had therapy with therapists' sensitivity and ability in assessing CSA in adult clients.
The question of therapists' therapy recalls the evidence that therapists may be survivors of CSA. In Ciccone's (1981/1982) research, more than 5% of the health professionals reported having been involved in incest on a personal level. In a more recent study, 32% of the participating psychologists reported that they had been sexually abused as children (Polusny & Follette, 1996). However, few differences were found (i.e., in the percentage of clients on whom an assessment for CSA was done, referred to survivors' groups, or encouraged to prosecute their perpetrators) between therapists who are and are not survivors of CSA in their clinical practices (Follette et al., 1949; Polusny & Follette, 1996). Further, having a history of CSA did not appear to affect therapists' capability to provide services to CSA survivors negatively.

Nevertheless, no research was conducted on the implications of being a survivor of CSA for therapists' sensitivity and ability in assessing CSA in adult clients. Information about this relationship could provide valuable information for clinicians. The information could also enlighten the false-memory versus delayed-memory debate. That is, the information could provide empirical evidence to either support or negate accusation that the personal issues of some therapists are affecting their belief or disbelief in the veracity of delayed memories of CSA. Therefore, this study will explore the association of therapists' sensitivity and ability in assessing CSA with therapists who are, or who are not, survivors of CSA.
Likewise, very little information is available on the effects of therapists' experience working with survivors. This information could be equally important. The clinical literature suggests that prolonged work with survivors of CSA can have draining and negative psychological effects on therapists (Briere, 1989; Courtois & Watts, 1982). One study suggests that as therapists' clinical experience increases, therapists predict less damaging effect from incest (LaBarbera et al., 1980). Another study suggests that clinicians with fewer years of experience more frequently assess clients for CSA and rate adults' memories of CSA as more accurate than clinicians with more experience (Polusny and Follette, 1996). Suspecting that professional experience with CSA would educate therapists about the dynamics of CSA, thereby improving their ability and sensitivity in assessing CSA seems reasonable. Yet, no research has been conducted to support or deny this notion. Therefore, with the expectation that professional experience with CSA survivors will improve therapists' ability and sensitivity, therapists' professional experience with survivors will be examined as it relates to therapists' sensitivity and ability in assessing the absence or presence of CSA in adult client histories.

This researcher wondered if having a close friend, family member, or significant other would affect therapists' sensitivity and ability in assessing CSA. She speculated that having such a relationship with a survivor could make the existence of CSA real for therapists and yet provides some personal distance from the immediate effects of incest. This potentially less threatening awareness of CSA might sensitize
therapists to CSA and improve their ability to accurately assess CSA in their adult clients. This is pure speculation as no research has been conducted regarding this therapist characteristic. However, all things being equal, if true, having had a close friend, family member, or significant other who is a survivor of CSA might be predictive of a therapists' sensitivity and ability in assessing CSA in their adult clients. Consequently, this research will address whether having a close friend, family member, or significant other who is a survivor, has a positive impact on therapists' ability and sensitivity in assessing CSA.

Finally, this researcher wonders if a combination of the above five therapists' characteristics could essentially be predictive of therapists' ability and sensitivity regarding CSA assessment. Therefore, depending on the feasibility of a two by two factor analyses (i.e., the number of respondents who have the therapist characteristic in question), the current research will examine the possible interaction effects of therapist characteristics. For example, if females turn out to be much more accurate and sensitive in assessing CSA than males, will being a survivor of CSA cause female therapists to over identify CSA in her clients? This is to say, will she suspect CSA in client cases where the client has no history of CSA? If males do tend to deny CSA and be less sensitive and accurate in assessing CSA, will being a survivor of CSA heighten their awareness and override gender difference making men as sensitive and accurate as women in their assessment of CSA in adult clients? Further, does professional experience with CSA survivors mediate gender differences and improve
therapists' sensitivity and ability in assessing CSA? By observing the interaction of therapist characteristics that show a statistically significant relationship to therapists' sensitivity and ability in assessing CSA, this research may provide valuable and entirely new information to the literature.

Naturally there are an unlimited number of therapists' characteristics one could research in relationship to CSA. However, the above questions are particularly interesting to this researcher because they indirectly address countertransference and could provide a base from which more direct investigation of therapists' countertransference issues could be conducted. As used in the current study, countertransference has a broad definition. Countertransference are the reactions, thought and behaviors therapists have to CSA issues that influence their clinical and professional work.

The concept of countertransference has been around since Freud (Herman & Hirschman, 1981; Towers, 1989), and the current literature continually suggests that countertransference could be a major concern for therapists working with survivors (Briere, 1989; Courtois & Watts, 1982; Emerson, 1988). Therefore, it seems particularly relevant that research is done on therapists characteristics that may be associated with countertransference issues in CSA work. Moreover, as mentioned earlier, therapists are being called upon to examine their impact on their client's memories of CSA. As the false-memory versus delayed-memory debate becomes more heated, allegations that therapists are creating trauma in their clients by leading
them to believe falsely they were sexually abused during their childhood are becoming more common. Knowing the characteristics that affect therapists' suspicion of CSA may alert professionals to possible countertransference issues that predispose them to find sexual abuse where it does not exist or miss it where it does exist. Therefore, empirical research that leads to identifying the therapists characteristics which are associated with therapists' sensitivity and ability in assessing CSA could be immensely valuable. To this end a new method was developed and the current research was conducted.

The Connection Between Suspicion, Sensitivity, and Ability

The reader will note in the writing of this dissertation that therapists' sensitivity and ability to accurately assess the presence or absence of childhood sexual abuse in adult clients is associated with therapists' suspicion of CSA. Therefore, before continuing with Chapter II and presenting the research methods, it may be helpful to articulate the basic assumptions that connect suspicion, sensitivity and ability in the present research.

Ability and sensitivity are separate but interrelated constructs that are extrapolated from participants' reported suspicion of CSA. "Ability" is a static measure of how accurate one is in his or her suspicion of CSA in adult client cases. As such, ability is a discrete right or wrong measurement. "Sensitivity" is a multidimensional measure of CSA suspicion. Sensitivity takes into account, not only
whether or not there is an error, but also the type of errors therapists make in their suspicions about the presence or absence of CSA. That is, sensitivity reflects therapists' tendency to miss CSA in cases whether or not it is part of a client's history. Sensitivity also reflects the tendency to suspect CSA whether or not it is part of a client's history.

Therapists who have an appropriate amount of sensitivity will tend to be accurate in their suspicions of CSA in adult client cases. Therapists who are overly sensitive to CSA, hypersensitive, will tend to suspect CSA as an important issue when conceptualizing adult client cases, even when clients have no history of CSA. On the other hand, therapists who are under sensitive to CSA, hyposensitive, will tend not to suspect CSA as an important issue when conceptualizing adult client cases, even when the clients have issues related to being survivors of CSA. Therefore, when reading this dissertation, one can consider sensitivity and ability interrelated constructs, the measure of which, can be derived from participants' suspicions of CSA in response to clinical vignettes presented in an instrument designed for the current study. A description of the instrument is provided in the methods section that follows.

Methods

The methods of the current research are explained in two tiers. The first tier presents the development of the STOCI. The second tier describes the method used in the survey of interning doctoral level psychologists for the research on the relationship
of therapist characteristics to ability and sensitivity in assessing CSA in adult clients.

A compendium of the methods are presented here in Chapter I, for more detail the reader is referred to Chapter III.

First Tier of the Methods

Lacking an appropriate instrument for measuring therapists' ability and sensitivity to assess CSA in adult client cases, the STOCI was created. The STOCI is a paper and pencil test of forced choice responses to 10 vignettes portraying female clients. It measures the respondents' sensitivity and ability to accurately suspect the presence or absence of CSA by asking about therapists' suspicion of CSA in the cases presented in the vignettes. Five of the vignettes are designed to suggest, but not openly state that CSA may be an important therapeutic issue in conceptualizing the case. Five of the vignettes are designed to portray clients who do not have a history of CSA. A list of issues follows each vignette. The list contains 12 issues, one of which is CSA. From this list, participants are instructed to indicate the issues that they suspect are most important in conceptualizing the cases presented in the vignettes. The response options were formatted in this manner to avoid leading a respondent to consider CSA as an issue when he or she may not have otherwise thought of CSA.

The STOCI was created in five phases. Since the development of the STOCI was preliminary to the main study of therapist characteristics, only a summary of the development is presented here. A more thorough discussion appears in Chapter III.
The prepilot version of the STOCI was written in the first phase. In the second phase the STOCI was administered to 20 mental health clinicians for a general check of the STOCI's variability and readability, and to determine if the STOCI's vignettes could stimulate the desired responses. In addition, this prepilot was run to check the length of time required to complete the STOCI. The results of the prepilot indicated that changes needed to be made in one vignette to increase its ability to suggest CSA. Therefore, more client information was added to the vignette. Minor editing changes were made to improve readability, and the length of time required to complete the STOCI was deemed acceptable at an average of 21 minutes. It was also observed that participants may not have been very discriminating in their responses. Some participants reported that they suspected as many as 75% of the issues in response to a vignette. Therefore, changes in the STOCI's directions were made before continuing to the third phase of the STOCI's development. In addition to requesting participants to circle the issues they suspected were the most important in conceptualizing the cases presented in the vignettes, participants were instructed to circle their three top choice responses to each of the vignettes.

In the third phase of development, the amended STOCI was examined by expert raters. Experts were in 100% agreement that the five vignettes designed to suggest CSA as an important issue did so, and that the five vignettes designed to not suggest CSA as an important issue did not. Further, the experts agreed that the 10
vignettes of the STOCI represented the different types of client issues that the experts would expect to see in a college or university counseling center.

In the fourth phase of development, a pilot test was run on the STOCI. One reason for conducting the pilot test was to examine the effects of the changes made to the prepilot directions and one of the prepilot vignettes. With the change in directions, there was a reduction in the number of issues the participants circled in response to the vignettes. This reduction was believed to indicate more discriminating responses by the participants which, in turn, improved the STOCI's discriminative ability. The results of the pilot also indicated that the information added to the vignette strengthened the vignette's suggestion of CSA as an important issue in conceptualizing the case presented, thereby improving the STOCI's reliability.

A second reason for the pilot was to examine the reliability of the STOCI. The results suggested that given the number of participants and the pioneering nature of the current research, the STOCI had sufficient reliability to be used in the intended survey of interns. In addition, the reliability studies indicated that there was not a significant difference in the STOCI's reliability based on the results obtained using only the top three choices participants circled in responses to each vignette versus all of the issues participants chose to circle in response to the vignettes. Consequently, no changes were made in the pilot version of the STOCI for use in the second tier of this research.
In Phase V, the process of developing a method for scoring the STOCI which addressed the type of sensitivity (i.e., appropriate sensitivity, hypersensitivity, and hyposensitivity) was undertaken. In addition to Correct Scores which were used in the reliability studies on the STOCI's pilot-test, Directional Scores were created. Correct Score reflected the total number of times a participant indicated a suspicion of CSA to the vignettes in which the clients had a history of CSA plus the total number of times the participant did not indicate a suspicion of CSA to the vignettes designed to not suggest a history of CSA.

In contrast to Correct Scores, Directional Score indicate the direction in which a respondent makes errors. In other words, a Directional Score indicated if a respondent suspects CSA where it is not suggested more often than (s)he does not suspect CSA when it is suggested (a positive direction), or if a respondent tends to not suspect CSA when it is suggested more often than (s)he tends to suspect CSA in vignettes where it is not suggested (negative direction). Therefore, the responses of any given participant can be scored to see how often they are correct in their suspicion of CSA and, if they make errors, which type of error they make most often. The Correct Score indicate participants' "ability" to correctly suspect the presence or absence of CSA. Correct Score in conjunction with Directional Score indicate the relative amount and type of "sensitivity" (appropriate, hyper, or hypo) a respondent has in assessing CSA in adult client cases.
The process of attaining these scores is rather involved. Therefore, the reader is reminded that a detailed description of how to score the STOCI as well as the other four phases of the STOCI's development can be found in Chapter III.

In all, the STOCI was checked for its readability, reliability, and validity and was found acceptable for the pioneering research for which it was created. Therefore, it was decided the STOCI would be used in the second tier of the current research.

Second Tier of Methods

The second tier of the methods focuses on the current research, a survey designed to explore the possible relationships between interning psychologists' suspicion of the presence or absence of CSA in adult client cases and five therapist characteristics.

Participants

The participants in this survey were volunteers from doctoral internships in psychology at university counseling centers in the United States and Canada. Specifically, interns were from university counseling centers listed in the Association of Psychology Postdoctoral and Internship Centers' 1993-94 directory (APPCI) and represented in the 1993 membership of the Association of Counseling Center Training Agents (ACCTA).
Survey Instruments: Independent and Dependent Variables

The interns were mailed two instruments, the STOCI (see Appendix A) and the Therapist’s Data Sheet (see Appendix B). The Therapist’s Data Sheet was designed to collect demographic and professional information on the research participants. Thus, interns were asked to report their gender, race, age, degree program, and specific training in clinical specialty areas on the data sheets. The data sheets also collected information specific to the five therapist characteristics, the independent variables of this study. In addition to the therapists’ gender, these therapist characteristics included whether or not participants (a) had received counseling or therapy for psychological or interpersonal issues; (b) had professional experience with three or more survivors of CSA; (c) had a close friend, relative, or significant other who was a survivor of CSA; and (d) had personally experienced CSA.

The dependent variables of the current research were the scores that participants obtained on the STOCI. The STOCI was the second instrument given to participants (see Appendix A). This instrument has been described previously, but a note on the scoring is warranted at this point. The responses on the pilot of the STOCI suggested that respondents were not likely to make errors suspecting CSA in the vignettes designed to not suggest CSA. The results of the current survey bore this out. All participants were correct in assessing the absence of CSA. Therefore, there was only one direction in the responses participants made and for all practical purposes, the Correct Scores and Directional Scores became synonymous with STOCI.
scores. The scores indicated the participants relative sensitivity and ability to correctly suspect the presence or absence of CSA. The higher the participants scored (from 5 to 10), the better they were at correctly suspecting the presence of CSA or the more appropriate they were in their sensitivity to CSA. Conversely, the lower the participants scored, the more hyposensitive they were to CSA or the poorer they were at correctly suspecting the presence of CSA.

Survey Procedures

Training directors who were listed as members of Association of Counseling Center Training Agents (ACCTA) in 1993 and whose respective sites were listed in Association of Psychology Postdoctoral and Internship Centers’ directory (APPIC, 1993094) were mailed letters from Dr. Waldman, a member of ACCTA, to introduce this researcher and request the training directors’ support in the current research (see Appendix C). Letters containing basic information on this study and a request for the training directors’ assistance in distributing the included research packets to interns (see Appendix D) were sent along with letters of introduction. The 1993-94 APPIC was used to identify the number of internship positions at each site. Hence, a packet for each intern at a site was included in this mailing.

The interns’ research packets contained a letter soliciting the interns’ participation and information about the study (see Appendix E), the STOCI (see
Appendix A), the Therapist's Data Sheet, (see Appendix B) and a stamped return envelope.

To conduct a second mailing to nonresponders, each packet and it's contents were numbered according to the site's zip code number. When the surveys (completed or blank) were returned and prior to examining the data, the zip code numbers were cut off. The zip codes were only used to determine the number of non-respondents at each site so that the correct number of follow-up packets could be sent to each site in the second mailing. Cutting the numbers off the returned surveys rendered all data anonymous. None of the responses could be tied to a particular individual or site.

Approximately one month later, if the number of zip codes from each site did not match the number of interns expected to be at each site, the respective site's training director was sent a follow up letter (see Appendix F) with additional research packets and follow up letters for interns (see Appendix G). The letter to the training directors reminded them of this study and requested that the accompanying intern letters be given to each of their interns. In addition, the training directors were asked to put the accompanying research packets in a central location so that the interns who wanted to participate in the survey, but had misplaced their original packets, could pick up a second packet anonymously. The intern letters reminded interns of the request for their participation, encouraged a timely response, and informed the interns of the available research packets.
Results of the Current Study

Participant Information

In the current research, 125 interns out of a possible 268 interns returned a completed surveys, yielding a usable return rate of 47%. Of the interns identifying their gender, 30% \((n = 3)\) were male and 70% \((n = 87)\) were female. The interns ranged in age from 25 to 60 with their mean age being 33. One hundred and twenty-three interns reported the racial or ethnic group with which they identified: Asians, 3.3% \((n = 4)\); African-American, 4.9% \((n = 6)\); Caucasian, 81.3% \((n = 100)\); Hispanic, 4.9% \((n = 6)\); Native-American, 2.4% \((n = 3)\); and Other, 3.3% \((n = 4)\). Two (1.6%) of the interns chose not to report the group with which the identified. The reported programs from which the participating interns expected their degrees were: Clinical Psychology, 37.1% \((n = 46)\); Counseling Psychology, 58.9% \((n = 73)\); Educational Psychology, 1.6% \((n = 2)\); and Other, 2.4% \((n = 3)\).

Reliability Studies

The STOCI's reliability was measured using two tests of internal consistency, Cronbach Alpha and Kuder Richardson 20 (K-R20). These tests were run on two sets of data compiled from the research participants' STOCI scores. The first set was based on all of the issues circled as suspected in the STOCI's vignettes. The second set was based on only the top three issues suspected on each vignette of the STOCI.
The Cronbach Alpha tests produced a reliability coefficient of .48614 on the first data set and a reliability coefficient of .459807 on the second data set. The K-R20 produced a reliability coefficient of .49359 on the first data set and a .45980 on the second data set. To determine if there was a significant statistical difference between the results of the reliability test on the two different data sets, the Fisher Z Transformation was run on the KR-20 reliability coefficients. With an alpha level of .05, the Fisher Z did not indicate a statistically significant difference in the reliability coefficient of the first and second data sets, Z(R1 0.4598, R2 0.49359) = .34160, p = .73265.

**STOCI Scores Across Therapist Characteristics**

To examine the association of the five therapists' characteristics with the therapists' suspicion of CSA in adult client cases, ANOVAs were performed on the STOCI scores across each of the five therapist characteristics explored in this study. An alpha level of .05 for statistical significance was used in all ANOVAs. There was no statistically significant difference in the reliability of data sets. Thus, only the results of the ANOVAs on the STOCI scores of the first data set are reported here. For information of both data sets, the reader is referred to Chapter IV.

Interns' gender was the only therapist characteristic in which the STOCI scores demonstrate a statistically significant difference, F (1, 122) = 4.24, p = .04.
Males tended to be more hyposensitive and less accurate ($M = 7.1$, $SD = 1.30$) than females ($M = 7.7$, $SD = 1.14$) in their suspicion of CSA in adult client cases.

Only 8.1% of the interns participating in the study reported that they had not had therapy or counseling. The large difference between the number of interns who did and did not report having had personal therapy or counseling makes the statistical analysis complicated. The complexity of this unbalanced ANOVA and the size of the difference between cells may have affected the test for significance. The results indicated the mean STOCI scores between those having ($M = 7.5$, $SD = 1.38$) or not having personal therapy or counseling ($M = 7.2$, $SD = 1.69$) was not statistically significant, $F(1, 122) = .50$, $p = .48$.

The same was true for professional experience. The difference in interns' STOCI scores did not reflect a statistically significant difference, $F(1, 123) = 3.52$, $p = .06$, between interns with professional experience working with three or more clients who had CSA histories ($M = 7.6$, $SD = 1.37$) and interns who did not have the professional experience ($M = 6.9$, $SD = 1.47$). Again there was a large difference between the number of interns who did and did not have the therapist characteristic analyzed. Only 14.4% of the participating interns reported that they did not have professional experience working with three or more clients who have CSA histories.

The number of interns reporting that they did or did not have a close friend, family member, or significant other who was a survivor was more balanced, $n = 54$ and $n = 71$ respectively. However, the results of the ANOVA on the STOCI score of
interns who did (M = 7.7, SD = 1.32) and did not (M = 7.3, SD = 1.44) have a close friend, family member, or significant other who was a survivor of CSA indicated that there was no statistically significant difference, F (1, 123) = 2.57, p = .1.

The final therapist characteristic explored in this study was whether or not the interns were survivors of CSA. The majority of interns reported that they were not survivors, 82.4%. Only 17.6% of the interns indicated that they were survivors. The difference in STOCI scores between interns who were survivors (M = 7.5, SD = 1.14) and who were not survivors (M = 7.5, SD = 1.14) was not statistically significant, F (1, 123) = .00, p = .96. The similarity in STOCI scores of survivor and non survivors suggests that there is no difference associated with their ability and sensitivity to suspect the presence or absence of CSA in adult client cases accurately.

This researcher wondered if the statistically significant difference in STOCI scores of male and female interns would be affected by the other therapist characteristics. However, the unequal and small cell sizes of gender by the other four therapist characteristics precluded performing the intended 2X2 ANOVAs. The only exception was gender by having a close friend, family member, or significant other who was a survivor. In an analysis of these two characteristics, cell sizes ranged from n = 53 to n = 19. Overall, the results of the test were not significant at F (3, 120) = 2.60, p = .055, and the interaction of gender by close CSA survivor was clearly not statistically significant, F (3, 120) = 0.38, p = .54. This is to say that the addition of
having or not having a close friend, family member, or significant other did not coincide with statistically significant changes in the male and female STOCI scores.

Discussion and Recommendations

The current study was a first attempt to investigate a previously undocumented area of empirical research on the association of therapist characteristics with therapists' suspicion of the presence or absence of CSA in adult client cases. The results of this study tend to support recent empirical studies and the opinions of clinicians who have speculated that male and female therapists may react differently to possible CSA in adult clients. On average, the female interns of this study were more appropriately sensitive and accurate in their suspicions about the presence or absence of CSA in adult client cases than were the male interns. The males tended to be more hyposensitive and less accurate in their suspicions. That is, males tended not to suspect CSA in cases where clients had a history of CSA more often than did women. However, it should be noted that over all both males and females generally make only one type of error. They erred by not suspecting CSA in cases that were designed to stimulate a suspicion of CSA.

The results regarding the association of therapists having received therapy with therapists' suspicion of the presence or absence of CSA in adult client cases were not statistically significant, F(1,122) = .50. In other words, therapists receiving therapy did not appear to have an association with therapists' sensitivity and ability to
accurately suspect CSA in adult client cases. As there was no other research found in
the literature about this association, there was no empirical frame from which to
speculate on the possible reasons for and the meaning of the non-significant results.

One could observe that the analysis of STOCI score of therapists who did (n = 114) and did not (n = 10) report having had personal therapy was unbalanced which may have contributed to the statistical nonsignificance. Another reason for the lack of statistically significant results may have been that participants were very inclusive in their report of having had therapy (i.e., therapy as an experiential component of training versus therapy sought for interpersonal or relationship difficulties). Another reason may have been that there was considerable difference in the quality of the therapy or counseling that therapists received. Further research will be required to learn if and in what ways therapists’ therapy is associated with therapists’ suspicions regarding the presence or absence of CSA in adult client cases.

The difference in the STOCI scores between the interns who reported they had professional experience with three or more survivors of CSA and the interns who reported they did not was not statistically significant. The statistical nonsignificance may have been affected by the unequal proportion of interns who did and did not have professional experience (85.6% and 14.4% respectively). It was speculated that this discrepancy may have been reduced had the criterion for “professional experience” been more stringent (i.e., working with a greater number of CSA survivors). A more stringent criterion may have also revealed more notable difference that could only be
detected with greater difference in the experience levels of participants. It follows that interns are not the best choice of research participants to explore the association of professional experience with therapists' sensitivity and ability to assess CSA in adult cases.

Nevertheless, the results approached significance, $F(1, 122) = 3.52, p = .06$ and were in the predicted direction. Interns who reported they had less professional experience with CSA survivors tended to score lower ($M = 6.9, SD = 1.47$) than interns who reported having more professional experience ($M = 7.6, SD = 1.37$). The certainty that the scores are due to real differences rather than chance are lower than required for statistical significance. However, the results are in the direction predicted and merit further investigation. Further, the fact that 85.6% of participants reported that they had professional experience with CSA survivors highlights the need for research on therapist characteristics as they relate to therapists' sensitivity and ability to suspect the presence or absence of CSA in adult client cases correctly.

The difference in the STOCI scores of participants who did and did not have a close friend, family member, or significant other who was a survivor of CSA was not statistically significant. Like therapists' therapy, there was no other research found in the literature on the association of having a close relationship with a survivor and therapists' work with CSA clients. Therefore, there is no empirical data from which to consider the meaning of the results found in the current study regarding therapists' having or not having a close friend, family member, or significant other who is a
survivor of CSA. It is likely however that clustering a close friend, family member and significant other under the cognate of close relationship ignored the differences in the possible relationships. Ignoring these differences confounded the attempt to explore the association of therapists having a close personal relationship with a survivor and therapists’ suspicions about the presence or absence of CSA in adult client cases. Further study that attempts to assess the effects of personal relationships with CSA survivors should take heed and be more circumspect in defining specific relationships to be studied.

The frequency that participants reported being a survivor of CSA lent support to the growing body of evidence that therapists are frequently survivors of CSA. However, the percentage of participants who reported being survivors was considerably lower in the current study than in other recent research. This difference is surprising. As females typically report a higher frequency of CSA than do males, the male-female ratio of the current study cannot explain the lower frequency of CSA survivors (male \( n = 37 \), female \( n = 87 \)). In fact the current study had a greater proportion of female participants than research reporting a much higher frequency of survivors. Likewise, the difference could not be explained by differences in the type of professionals participating in the studies. The greatest differences in reported survivor rates of research participants was between this study's interns' (who were overwhelmingly clinical and counseling psychologist) and another study's practicing clinical and counseling psychologists.
The anonymity of participants was protected in all of the research so confidentiality concerns of participants should not have contributed to the differences. Yet, this researcher wonders if the differences in the percentage of participants who reported being CSA survivors were somehow affected by a combination of two things: (1) the current false-memory controversy and the associated contentions that therapists are letting their personal issues with CSA affect their professional work, and (2) the security of one’s professional identity as a product of the length of time one has had their professional reputation. In other words, therapists who have well-established professional reputations may not feel as vulnerable to accusations that therapists allow their personal histories regarding CSA to affect their clinical judgments and behaviors. Consequently, established professionals may feel more comfortable reporting that they are a survivor than do interns and relatively new professionals. This is pure speculation as there is no research to support or deny this possibility. Further research may provide a more definitive answer why there are differences between studies in the frequency that participants report being survivors of CSA.

Despite frequency differences, the current study’s findings regarding the association of therapists’ histories of CSA with therapists’ professional behaviors are congruent with other empirical research. There were no statistically significant differences found in the STOCI scores of participants who did and did not report being survivors of CSA. These results support the findings of other current research that
suggests there is no association between whether or not a therapist has a history of CSA and therapists' clinical behaviors.

Finally, this researcher was interested in the interactions effects of the five therapist characteristics addressed in the current study. Unfortunately, the unequal and small cell sizes associated with the interactions precluded all but one two-way ANOVA. This exception was gender by close friend, family member, or significant others. The results of this ANOVA were not statistically significant. That is, the differences in male and female participants of this study did not appear to be affected by whether or not the participants had a close friend, family member, or significant other who was a survivor. As mentioned previously, clustering the different types of personal relationships may have clouded the results. Further research will be necessary to establish if any particular relationship with survivors of CSA is associated with male and female therapists’ suspicions regarding the presence or absence of CSA in adult client cases.

In addition to these problems associated with therapist characteristics, there are at least two other problems with the independent variables of this study. First, this study depended on participants’ ability to recall accurately and report their experience with CSA. With the possibility of false and delayed CSA memories still in question, researchers will have to cautiously interpret results that include therapists’ self-report of CSA. Secondly, this researcher did not know what constituted CSA in the minds of the participants. Some participants may believe that CSA refers to sexual penetration
of a child. Whereas, other participants may have a broader definition including such behaviors as fondling, explicit sexual acts between adults in the presence of children, lewd and lascivious remarks to children, etc. Therefore, participants' definitions of what constitutes CSA may have influenced whether or not they reported being a survivor of CSA.

However, the most significant limitation of this study is related to the novelty of the study and measurement of the dependent variable. There were no instruments found in the literature to measure the sensitivity and ability of therapists to assess CSA in adult client cases. Therefore, developing a new instrument was necessary, the STOCI. Expert raters were in 100% agreement that the STOCI had content and face validity and a pilot study suggested that it had good reliability. However, when it was used in the survey on interns, the reliability fell to below acceptable limits, $\alpha = .49$.

This was a disconcerting situation. There was no way of knowing how much the results of the survey were affected by random errors in measurement, so the validity of the results was in question. Therefore, the results of the current research could not be generalized to other groups of interns. Furthermore, the reliability of the STOCI had been expected to improve with the increase of the participant pool from 47 to 125 participants. The obvious question was why had the reliability dropped? Was there a significant difference between the graduate students of the pilot study and the interns surveyed in the way they conceptualized client cases with possible CSA
histories? Did the manner in which the STOCI was administered to participants affect the reliability of the STOCI? Further study will be needed to answer these questions.

Another limitation due to the dependent measure is the possibility that the STOCI is not sensitive enough to identify participants who may be hypersensitivity to CSA. This possibility is because almost everyone who completed the STOCI correctly responded to the five vignettes (i.e., did not suspect CSA) designed not to stimulate a suspicion of CSA. This lack of variation negatively affected the STOCI’s reliability. Likewise, the homogeneity of responses may have hindered the STOCI’s ability to detect participants who may have been prone to over identify CSA when presented with complex clinical cases.

Before attempting to use the STOCI in future research on therapist characteristics, the STOCI needs to be improved. It is hoped that the professionals who are currently involved in the false memory versus delayed memory debate will further develop the STOCI or create a similar instrument. Their energy, commitment, and combined efforts could help to develop a well-balanced instrument capable of detecting the full spectrum of sensitivity from hyposensitive to hypersensitive. With such an instrument it may be possible to detect if therapist characteristics are predictive of therapists’ sensitivity and ability to suspect the presence or absence of CSA accurately. Further it may be possible to determine if therapists who are hypersensitive to CSA influence their clients to create false memories of CSA and if
therapists who are hyposensitive to CSA falsely support their client’s denial of remembered CSA.

Research that can help therapists identify their part in the false or delayed memories of their clients is critical. As a beginning, the current research provides collaborative data for recent findings on therapist characteristics (i.e., there are gender differences, significant numbers of therapists are CSA survivors, a clear majority of therapists report that they have professional experience with CSA, and the clinical behaviors of therapists who work with possible CSA survivors do not appear to be associated with whether or not therapists are survivors of CSA). Further, this research suggests that gender and professional experience with CSA survivors, as opposed to the personal experiences addressed in the current research (i.e., being a survivor or knowing a survivor) are the most predictive of participants' accuracy in suspecting CSA. This finding suggests the possibility that cognitive components of participants' information processing, rather than their underlying emotional CSA issues, are essential factors in participants' ability to correctly suspect CSA.

Women are likely to be better informed and more knowledgeable about CSA than are men. Women are more often the victims of CSA than men and women are the traditional nurtures and caretakers of children. In addition, women appear to be more communicative and sharing with each other about personal issues and vulnerabilities than are men. The idea that women are more informed than men in combination with the results that demonstrate that professional experience with CSA
survivors (that can contribute to the knowledge base of professionals) rather than personal experience (that may have more emotional meaning) point to knowledge as the prime ingredient to accuracy in identifying the presence or absence of CSA in adult client cases. Certainly, more research is needed to test the theory that information processing rather than underlying emotional factors is responsible for the differences in therapists' ability to correctly identify CSA when it is important clinical issues in client cases.

The current research contributes substantial ground work in the development of a new method for exploring the aforementioned assertion and the association of therapist characteristics with therapists' suspicion of the presence or absence of CSA in adult client cases.
CHAPTER II

REVIEW OF THE LITERATURE

Introduction and Overview

The present research was stimulated by the delayed memory - false memory controversy occurring in the field of CSA treatment. On the surface this controversy is a straightforward, albeit passionate, debate between the therapists and advocates of clients who report being falsely accused of perpetrating child sexual abuse and the therapist and advocates of clients who believe themselves to be survivors of CSA. Examples of the current debate can be found in the Journal of Child Sexual Abuse (Geffner, 1994) and in the Comment section of the American Psychologist (Fowler, 1994). At times, the delayed versus false memory debate have disintegrated into personal attacks and accusations.

The discussion in the Journal of Child Sexual Abuse (Geffner, 1994) which appears to be spurred by the Ofshe and Watters (1993) articles is an example. In this article, Ofshe and Watters challenge the reality of the concept that some CSA survivors have repressed memories of their abuse. Their argument is presented in a castigating manner accusing therapists of tricking clients into believing that they remember events that never happened (p. 5). Further, Ofshe and Watters (1993)
intimate that therapists who support the concept of repressed memories are self-proclaimed psychological geniuses, opportunists, zealots and simpleminded (p. 14). Olio and Cornell (1994) take issue with Ofshe and Watters position and accuse Ofshe and Watters of weaving together "facts, distortions, unsubstantiated assertions, and innuendo" in their challenge of "the veracity of delayed recall of childhood abuse" (p. 78). In addition, Olio and Cornell accuse Ofshe and Watters of having an oversimplified and distorted view of memory (p. 88).

The related and somewhat overlapping debate in the American Psychologist appears to be less inflammatory than the debate in the Journal of Child Sexual Abuse. The debate centers around Loftus's (1993) article that discusses some literature on repressed memories and the legal ramifications of purporting repressed memories. In the article, Loftus questions the reality of repressed memories. Like Ofshe and Watters (1993), Loftus suggests that recall of repressed memories may be affected or induced by the therapist's beliefs regarding repressed memories. In this debate, the proponents of the reality of repressed memories discredit Loftus citing inaccuracies in Loftus's depiction of the Paul Ingram court case, a litigation regarding CSA from which Loftus draws conclusions in support of her position (Gleaves, 1994; Olio & Cornell, 1994; Peterson, 1994).

Despite claims of supportive research, the debates appear to be based more on the speaker's allegiance to their clients than on actual empirical data. Stayton (1994),
a lawyer who reportedly has tried many CSA cases, succinctly described the ongoing controversy:

Where a controversy is relatively recent, as with delayed vs. false memory, debate is often focused on the use of nonscientific, anecdotal evidence. Each side can present individual case histories to validate its position. Moreover, the results of genuinely scientific evidence that does exist can often be reconstituted and recharacterized to support the particular viewpoint being espoused (p. 128).

Because of this controversy, the claims of supportive research, and the accusations that call into question the motives of therapists, this researcher began to wonder what, if any, research had been conducted regarding therapists, who work with CSA survivors. Further, she wondered if there were any empirical studies on therapist characteristics that might affect therapists' assessment of the clinical significance of CSA in adult client cases. In other words, were some therapists predisposed to suspect CSA, or not suspect CSA from their own experiences and biases rather than as an accurate assessment of the clients' clinical issues? To explore the possible answers to these questions a literature review was conducted.

The remainder of this chapter presents the findings of the literature review. It begins with several factors that affect the identifying of CSA. Next, this chapter briefly discusses the historical background of CSA to provide a context for the following discussion on the current state of the literature. The current state of the literature is divided into three main sections for ease of reading: therapist characteristics suggested in the literature regarding CSA clients and their treatment, research instruments designed for investigating therapist's attitudes regarding CSA,
and the empirical research on characteristics of therapists who work with survivors.

Following the discussion on the current state of the literature, the chapter will conclude with a summary and research questions pursuant to the current study.

Identifying Childhood Sexual Abuse

Several factors affect the process of identifying CSA discussed in the literature and presented in this section of Chapter II. The first is defining CSA. The second is identifying CSA via the common effects of CSA observed in adult clients. The third is the possibility of therapists' subjective reactions that may affect therapists' ability to identify CSA. A poignant example of therapists' reactions to CSA that directly influences the delayed memory versus false memory debate is included.

Definition of CSA

The literature review for this research accessed the literature on childhood sexual abuse in general and childhood sexual abuse that resulted specifically from incest. Incest occurs when there is sexual abuse by a family member or by a known, trusted caretaker such as a stepfather, stepmother, or live-in friend of a parent (Courtois, 1988). The reason for including the literature specific to incest in this review is that incest is thought to be the most common type of CSA (Blume, 1990; Courtois, 1988). In Tower's (1989) text on child abuse and neglect, he posits that extra-familial abuse represents 40% of reported abuse. More recently, Finney (1990)
stated that according to survey research, 80% of abuse is committed by a family member or someone known by the victim (p. 29). It follows that with such a large portion of CSA survivors believed to be survivors of incest, much of the available literature on CSA is about incest.

One problem associated with defining and identifying CSA is that not all researchers or clinicians have used the same definitions of CSA. The resulting variations in the definition of CSA have been credited for some differences found in research results (Herman, & Hirschman, 1981). For example, Williams (1994a) observed that the reported frequency of CSA ranged from one fifth to one third of all women. This lack of a universal definition can make it difficult to compare research results and, as discussed later, can be a point of contention between mental health practitioners. However, there appears to be a core definition with which most people can agree. A good example is the legal definition found in the 1984 United State's Amendment to the Child Abuse Prevention and Treatment Act. The act declares that sexual abuse includes:

...(I) the employment, use, persuasion, inducement, enticement, or coercion of any child to engage in any sexually explicit conduct (or any simulation of such conduct) for the purpose of producing any visual depiction of such conduct, or (ii) the rape, molestation, prostitution, or other form of sexual exploitation of children, or incest with children, under circumstances which indicate the child's health or welfare is harmed or threatened thereby... (Tower, 1989, p. 105).

In her classic book on adult survivors in therapy, Courtois (1988) includes the use of a non-consenting child for sexual gratification by an older child (five or more
years older) in her definition of CSA. This researcher abides by both the legal
definition and Courtois's definition. The reader can assume that when used by this
researcher the term "childhood sexual abuse" or CSA indicates sexual contact that
harms or threatens a child's health or welfare. The perpetrator of the abuse can be
either an adult or a child who is at least five years older than the victim. The reader
can also assume that the sexual contact was not mutually and freely agreed upon by
the victim. It is believed that most mental health professionals would agree with this
general definition. However, agreeing on a general definition of CSA does not
necessarily mean there will be agreement in the identification of an adult client as
either a survivor or not a survivor of CSA. Part of the problem can be attributed to
the process of identifying CSA as a possible etiology for clients' symptoms when one
only has an incomplete or ambiguous client history.

Identifying CSA Via Its Long-term Effects

There have been many long-term effects commonly identified in the adult
survivors of CSA who seek mental health services. Because these long-term effects,
also called sequelae, are so commonly seen in survivors, some mental health
practitioners have suggested that the sequelae be used to alert clinicians to the
possibility of CSA in clients who may not have presented with, or expressed memories
of CSA (Courtois, 1992; Elliott & Briere, 1992). In other words, these sequelae could
be viewed as possible symptoms of CSA. Briere and Runtz (1988) reported that
depression, guilt, low self-esteem, interpersonal problems, law breaking, substance
abuse, suicidality, sexual problems, and an increased likelihood of being revictimized in
the future could all be found in association with CSA histories in adults (p. 51). They
state that dissociation and somatization were the symptoms most predictive of CSA in
the undergraduate female students he studied.

In a later study of 2,963 professional women who reported histories of CSA,
Elliott and Briere (1992) sought to establish the usefulness of the Trauma Symptoms
Checklist - 40 (TSC-40) as a research tool in the study and prediction of CSA in adult
clients. During this process they found that "women who had been molested as
children reported more anxiety, depression, dissociation, sexual problems, sleep
disturbance, and post-traumatic symptoms than did their nonabused peers . . . " (p.
395). It should be noted that Elliott and Briere clearly state that their TSC-40 is not
intended to be used as a "litmus test" for CSA in adult clients or as a clinical
instrument. However, this acknowledgment was footnoted with a notice that Briere
had developed a longer, more detailed version of the TSC-40 that with "successful
validation, may be appropriate for general clinical use in the assessment of trauma
victims" (pg. 397).

Such an instrument to identify CSA survivors would be helpful because many
sequelae associated with CSA are also associated with clients who are not CSA
survivors. In addition to the aforementioned sequelae, a lack of trust in others, a sense
of powerlessness, a fear of abandonment, and a lack of trust in one's own sense of
reality is regularly observed by clinicians who work with adult survivors of CSA (Courtois, 1988; Finney, 1990; Mudry, 1986; Ratican, 1992; Woitits, 1989). Thoughts of suicide sometimes resulting in death, self-destructive behaviors such as cutting or burning oneself, and drug and alcohol addictions are also common symptoms of survivors. A tool that could help determine when such sequelae, or group of sequelae indicates CSA would be helpful in research and in developing treatment plans for survivors.

Unfortunately, it is doubtful that such a tool can serve as a litmus test for identifying CSA because the sequelae identified above are often present without CSA, or manifest as symptoms of other psychological difficulties. Bushnell, Wells, and Oakley-Browne's (1992) research demonstrated that symptoms associated with CSA do not necessarily indicate a history of CSA in an adult client. They interviewed 301 women from the general population in Christchurch, New Zealand. Their research found that childhood incest was "associated with increased depression and bulimic symptoms, as expected, and with more manic, generalized anxiety, somatization and conduct disorder symptoms" (p. 140). However, they also found that "the effects of sexual abuse appear to be widespread and not very specific" (p. 141). Almost 20% of the women with depression, bulimia or substance disorder reported sexual abuse within the family. Conversely, about 80% of the women who had these psychological difficulties did not report CSA in their families. When Bushnell et al. analyzed their survey results they found that the sexual abuse was only one factor associated with an
increase of symptoms in these disorders. They concluded that their study could not identify the extent to which CSA, rather than the family context within which sexual abuse occurs, was responsible for the difficulties reported by their research participants.

In another study exploring the comorbidity of psychiatric disorders and childhood abuse, Bryer, Nelson, Miller, and Krol (1987) found that women hospitalized with psychiatric illness who had a history of abuse differed from similar but nonabused women. Forty-four percent of the women reported being sexually abused before they reached the age of 16. These women were more frequently diagnosed with borderline personality disorder and had a higher frequency of suicidal symptoms. Women who reported both CSA and physical abuse had more severe psychotic or acute psychotic-like symptoms and were given pharmacological treatment more often. As with Bushnell et al. (1992), Elliott and Briere (1992), and Briere and Runtz (1988), the research of Bryer et al. (1987) demonstrated that women with emotional and psychiatric difficulties have a high rate of CSA histories. However, they were not able to identify CSA as the primary etiology of the women's mental health problems.

Goodwin, Cheeves, and Connell (1990) have also investigated women who had psychiatric hospitalizations and found frequent and severe symptoms in adult survivors of incestuous abuse. These symptoms include borderline personality disorder, affective disorder, dissociative symptoms, post traumatic stress disorder, eating
disorders, antisocial actions, and reenactments such as rape victimization and battering. Consequently, there may be good reason for a therapist or a client to suspect a history of CSA when the client demonstrates these psychiatric difficulties and, or, has a constellation of the sequelae frequently seen in survivors of CSA. Nevertheless, without actual knowledge, physical evidence or other corroboration (multiple survivors, witnesses or confession), one may never be able to establish the veracity of such suspicions.

Like the "symptom" of dissociation, there are coping mechanisms identified as common to, or pervasive with adult survivors of CSA. They include denial, emotional suppression, and repression (Blume, 1990; Courtois, 1992; Gentry, 1978; Leitenberg, Greenwald, & Coda, 1992). As with the other sequelae associated with CSA, these coping mechanisms are seen in association with traumas and mental health issues in clients with no CSA history. Accordingly, correctly identifying when CSA is or is not a clinical issue for a particular adult client may be more difficult than initially suspected. Yet, many clinicians warn that when CSA is the etiology of such symptoms and coping mechanisms, special skills, knowledge, and patience are needed to facilitate recovery (Courtois, 1988; Bass & Davis, 1988; Finney, 1990; Woititz, 1989). In addition, if therapists intend to work with survivors, they need to be informed about issues specific to CSA, and they should be emotionally prepared, and professionally trained to work with clients who have serious mental health problems as a result of CSA. According to clinical opinion, therapists who do not understand the far-reaching
implications of sexual abuse are likely to develop inappropriate types of treatment and make inaccurate diagnoses (Worititz, 1989).

**Therapist's Reactions to CSA and Delayed Memories**

Added to the already difficult task of assessing the clinical relevance of CSA in an adult client case are the therapist's own emotions and reactions to the issues of CSA. Kraemer (1988) reminds us that effective clinicians are not only a product of their training, personal experience, and cultural heritage, they are empathic people who can identify with people in distress. Consequently, he says, it should not be surprising if therapists employ mental mechanisms that are similar to their clients when coping with CSA, e.g., denial, emotional suppression, and repression. Likewise, Courtois (1988), Herman (1992), and Herman and Hirschman (1977) posit in their books that therapists may avoid, minimize, or deny a client's history or concerns about CSA because of their own difficulties dealing with CSA. Conversely, proponents of the false memory concept believe that, because of therapists' own issues regarding CSA, some therapists may create false memories of CSA in their clients (Loftus, 1993; Ofshe & Watters, 1993; Yapko, 1994).

The professionals who believe that some delayed memories of CSA are really false memories, question the wisdom of directly asking clients about possible CSA histories. These professionals are concerned that asking such questions may lead "already suggestible" clients into falsely believing themselves to be survivors of CSA.
However, this literature review did not uncover any empirical studies that supported their fears, and many professionals explicitly disagree with avoiding questions about possible CSA.

Bryer et al. (1987), Courtois (1992), Gomes-Schwartz, and Horowitz (1984), Goodwin, Sheeves, and Connell (1990), Jacobson and Richards, (1987), and Josephson and Fong-Beyette (1987) are but a few who recommend that clients be directly, and routinely, asked about CSA. They based their position on clinical experience and empirical studies with people who were hospitalized psychiatric patients. For example, Bryer et al. (1987) studied the frequency of physical abuse and CSA in women admitted to a private psychiatric hospital. These women were free of organic dysfunction and toxic reactions to drugs and alcohol. Bryer et al. found that 34% of these women reported histories of sexual abuse occurring before age 16. Based upon this research, Bryer et al. concluded that patients be asked specifically about abuse at their initial interviews. Equally important is the creation of a knowledgeable and receptive climate because patients often have repressed or suppressed memories of abuse. The memories emerge only after a period of contact with sensitive clinicians. However, many clinicians are uncomfortable about discussing this topic. Most have not received training for it, especially for dealing with the difficult subjective reactions it evokes in the professional (p. 1430).

Likewise, Williams (1994a) research suggests that therapists' may need special training to work with clients who have repressed or suppressed memories of CSA. Williams interviewed 136 female survivors of CSA who, approximately 17 years earlier, had been taken to a city hospital emergency room for treatment. Medical and
forensic evidence documented the women's abuse. Four women whose initial report did not involve actual sexual contact and three women who indicated that the initial report of sexual abuse had been fabricated were dropped from the study. Of the remaining 129 women, 38% did not report their documented abuse during the research interview. Further questioning of the women revealed that while some women may have decided not to tell the interviewers about the abuse, most of the women who did not report the abuse actually did not remember the abuse (Williams, 1994a, p. 1170).

Another study both supported the possibility of therapists having their own subjective reaction to CSA and affirmed the possibility of CSA survivors forgetting their abuse. Feldman-Summer and Pope (1994) studied a national sample of psychologists from Divisions 12, 17, 29, 37, 3, 42, and 43 of the American Psychological Association. They reported a return rate of 66%. Of the psychologists responding to the mailed survey, 21.8% reported they had been sexually abused before their 18th birthday. Of these survivors, 40.5% reported having had a period where they forgot some or all of the abuse. These results support the possibility of forgetting CSA. In addition, the results draw attention to the fact that therapists can have their own subjective reactions to CSA. These reactions may cause one to wonder whether, or how therapists' subjective reactions may affect therapists' clinical decision making. For certain, the problem of identifying when CSA is the etiology of, or contributing factor in a client's difficulties is an essential component of the delayed memory versus false memory controversy. This controversy is rooted in the Judeo-Christian heritage
which directly affects the attitudes and beliefs of western psychology and mainstream American culture. The following section on the relevant historical background provides a context for the current study.

**Historical Background**

Historically, children were not protected from sexual assault in the Judeo-Christian culture. Disbelief, incredulity, and blaming of the victim have been a part of western society since the Inquisition. Rush (1980), does an excellent job in her book of describing how early Jewish civil and religious law and the early Christian religion, not only ignored, but allowed the use of children as sexual objects. For example, according to Rush, in the Talmud a female child of "three years and one day" could be claimed as a bride by sexual intercourse provided the groom had her father's permission. Further more, Rush says that the early Roman church colluded with child sexual abusers making it possible for clergymen to molest women and children without a penalty. During the witch hunts, woman and children accused of culpability in their own victimization were forced to admit to copulating with the devil and were then burned to death (Rush, 1980).

The accounts of sexual abuse of children and the church's position, though viewed as unconscionable by some, is dismissed by others as ancient history. However, as late as the twentieth century, Reverend Montague Summers interpreted the complaints of sexual assault by young nuns (seventeen and eighteen years old) as
diversions from their own lascivious behavior (Rush, 1980). As recently as 1976, the United States federal government published materials stating that there was not sufficient evidence of harm or enough optimism for treatment to justify legal intervention in intra familial sexual abuse (Summit & Kryso, 1978, p. 249). A year later, a Supreme court ruling still permitted individual judges to translate child sexual use as liberating and educational (Rush, 1980). Finally, as recently as 1982, Finkelhor (1982) observed a rapid escalation in child pornography. In some pornography stores, 25 to 33% of book titles contained references to incestuous sex or sex with underage children (Finkelhor, 1982). Consequently, society's blind eye to CSA has produced a long history of tolerance that continues today.

The field of psychology has a concomitant history of disbelief and victim blaming. Part of the reason given for this history is Freud's "influence on our current denial of, or reluctance to recognize the symptoms of sexual abuse in children" (Tower, 1989, p. 6). The women with whom Freud first worked suffered hysterical symptoms and most of them disclosed that they had been seduced by their fathers. Originally Freud believed their stories. He drew a causal connection between hysteria and sexual assault leading to his Seduction Theory presented in 1896. In his letters to Fliess, a trusted friend and colleague, Freud identified seduction by fathers as the "essential point" in hysteria (Rush 1980). Later he recanted this theory, not because of new evidence, but because believing that his hysterical female clients fantasized perverted acts by their fathers was easier for him than it was to believe that so often
fathers perpetrate sexual acts against their daughters (Herman & Hirschman, 1981).

Unfortunately, this new theory also redirected the onus of incest away from the adult and to the child victim's fantasy (Mayer, 1983). Regardless of Freud's revised position, he must have been aware that CSA did indeed occur. For as Masson (cited in Meiselman, 1990) revealed, Freud was a student of Jean-Martin Charcot when they attended autopsies on child victims of sexual abuse at the Paris morgue in the 1880s. For whatever reasons (i.e., because of his own incest issues, not to offend his benefactors, or to placate his medical colleagues), Freud chose to discredit his seduction theory, thereby participating in society's secrecy and denial of CSA.

Hurley (1991) posits that society's taboo of talking about incest (as opposed to an incest taboo) and Freud's legacy of silence had a strong negative impact on the research, treatment, identification and diagnosis of incest survivors. For example, in the famous Kinsey (1948, 1953) reports other previously taboo topics such as the prevalence of masturbation, homosexual experiences, premarital and extramarital sex, and sexual contact with animals was openly discussed. However, during the Kinsey studies attempts were made to negate the severity and frequency of CSA by minimizing and discounting reported experiences (Herman & Hirschman, 1981; Russell, 1986).

Fortunately, this impact has begun to fade. Beginning in the 1970s, the feminist movement, which challenged the Judeo-Christian legacy of male dominance and ownership of women and children, has worked toward increasing society's
awareness of sexual abuse and has championed survivors of child sexual abuse (Mayer, 1983). Concurrently, researchers studying other types of family violence, such as physical child and spouse abuse, have uncovered CSA. As a result, knowledge and support is replacing personal and societal denial about child sexual abuse (Courtois, 1988; Finkelhor, 1982). However, the invalidating stance of the false memory proponents has been gaining public attention and creating much legal and professional debate. The stance is reminiscent of the past reactions to Freud's Seduction Theory. The current position of the false memory proponents is creating some fear that genuine CSA survivors will again be disbelieved and that this disbelief will lead to inappropriate therapeutic strategies that revictimize clients and further perpetuate Freud's legacy.

In the past 100 years CSA has surfaced in the professional literature as an important clinical issue only to be suppressed. However, today there should be little question that CSA is a serious mental health problem. Finkelhor (1978, 1979, 1982, 1986) and Russell (1983, 1986) have investigated the frequency, associated demographics and effects of CSA, establishing the reality of CSA in the United States. Finkelhor (1978) surveyed 2,000 college students and revealed CSA to be more common than had previously been thought in the United States. Of the females who responded, 19.2% said they had been sexually abused by an adult, and 17% acknowledged they had been abused before puberty. Of the males who responded, 8.6% indicated they had been sexually abused by an adult. Further, in combination
with other contemporary survey research, Finkelhor's survey indicated that 16,000 new cases of incestuous CSA were likely to occur each year (Herman and Hirschman, 1981). In his address to the Third International Congress of Child Abuse and Neglect in Amsterdam, Finkelhor reported that research with non-clinical populations indicated large numbers of adults had been sexual abused as children. As many as 15 to 34% of the women in the U. S. and 3 to 9% of the men had experienced such assaults (Finkelhor, 1982, p. 96). As such, CSA constituted a major mental health problem that had been under-detected by the professionals concerned with child sexual abuse (Finkelhor, 1982).

Russell's (1983) research corroborated Finkelhor's assertion that CSA is a major mental health issue. Russell conducted the largest random study investigating adult-female survivors of CSA to date. The Field Research Corporation was hired to randomly select research participants from the San Francisco area. Trained female interviewers conducted detailed interviews of the 930 women, 18 years or older, in this study. The interviewers asked about any sexual abuse experience the women might have had in their lives. Using a broad definition of CSA that included nongenital touch (i.e., being disturbed by someone exposing their genitals, or experiencing unwanted kisses and hugs), 54% reported being sexually abused one or more times before they were 18 years old. Forty-eight percent reported being sexual abused one or more times before they were 14 years old. Using the more stringent definition of incestuous CSA (unwanted, exploitive sexual-contact occurring between relatives who
are five or more years apart in age), 16% of the women indicated that they had at least one CSA experience before the age of 17, and 12% said they had one or more experiences before the age of 13. Thirty-two percent of the women who reported incestuous abuse said their perpetrator had also abused other family members. However, most of the abuse went unreported to the police. Only 2% of the incestuous CSA and 6% of the extrafamilial CSA was ever reported (Russell, 1983, p.142).

There were several differences between Russell's (1983) and Finkelhor's (1978) research that may have been responsible for their particular results and their different frequencies of CSA rates. These included methodological differences such as Russell's face-to-face interviewing versus Finkelhor's more anonymous questionnaire format and Russell's random community-based participants versus Finkelhor's college students. In addition, Russell used open-ended questions that gave her qualitative data unavailable to Finkelhor. There were also noted differences in their definitions of sexual abuse. However, both researchers alerted health professionals and the public to the fact that CSA and incest occurred more frequently than anyone would want to believe, and that it occurred within all the social-economical strata in the United States. Both researchers acknowledged that due to repressed memories or lack of comfort in disclosing sexual abuse histories, the actual number of survivors may have been under-represented. Both researchers broke the pattern of denial found in psychology and society. Both laid the ground work for a critical look at CSA, its effect on survivors, families and perpetrators, and the process of recovery.
Current State of the Literature Related to Therapist Characteristics

Despite the increased interest and growing literature regarding the phenomena of CSA, its sequelae for adult survivors, and associated treatment issues, there has been very little research into therapists' characteristics that affect therapists' work with adult survivors of child sexual abuse (Adams, & Betz, 1993; Eisenberg, Owens, & Dewey, 1987; Johnson, Owens, & Dewey, Eisenberg, 1990). Given the depth of secrecy, shame, and denial that are a common reality for survivors of child sexual abuse (Blume, 1990; Courtois, 1988; MacFarlane & Korbin, 1983; Woititz, 1989), therapists helping this population require specific characteristics to be effective (Alpert, 1991; Courtois, 1992; Josephson, & Fong-Beyette, 1987; Shapiro & Dominiak, 1992). (As used in the current research "characteristics" refers to distinguishing traits, qualities or skills.) Further, as therapists frequently encounter CSA and because CSA can be a very emotionally charged issue (Attias & Goodwin, 1985; Courtois, 1988; Gomes-Schwartz & Horowitz, 1984; Kraemer, 1988; Saakvitne, 1990), research into effective characteristics for therapists who work with survivors of CSA seems strikingly absent. Indeed, this absence may reflect continued discomfort and a disowning of the issues within the field of psychology. Yet, in the wake of growing criticism and accusations of therapists leading clients into false memories of childhood sexual abuse, therapists are being called upon to examine what precipitates their suspicion of CSA in a client's history. For example, Sifford (1992)
questions if therapists' suspicions of CSA are motivated by ignorance, opportunism, therapist's parent-child relationship, or personal sexual abuse, rather than an a client's actual history of CSA.

The therapist-centered research necessary to address such concerns would represent a significant shift away from the more predominate client and service oriented research. Notwithstanding, the literature does provide many useful constructs about therapeutic work with adult survivors of CSA in individual and group situations. Most of these theoretical and instructional writings appear to be born out of clinical field experience rather than empirical research (Shapiro & Dominiak, 1992). With the empirical studies that are available, this field-based literature offers some insights into the dynamics of working with survivors of child sexual assault, and suggests some necessary therapist characteristics for effective work with survivors. Therefore, the remainder of this section addresses the relevant clinical literature, the client focused literature, instrument for researching therapists attitudes regarding CSA, and the research on specific characteristics of therapists who work with CSA survivors.

Clinical Literature

Gentry (1978) was a social worker and director of a child and family service center when he advocated for nonaccusatory but firm interventions to help with incestuous families' recovery and adjustment. He believed that society's punitive reactions to incestuous abuse of children was a barrier to prevention and treatment.
Noting that repugnance, guilt, anger, uneasy fascination, and most of all denial were frequent societal responses to incest, Gentry cautioned treatment personnel to consider the predispositions of society and the incestuous family members. He asserted that insensitive interrogation of victims and the sudden dissolving of the family could cause more psychological damage than the incest. Interventions based on what was known about the causes of incest, not impulses, were required (Gentry, 1978, p. 358).

Helping professionals needed to know and like their jobs. Survivors needed adults who were non-judgmental, understanding, and well-trained to discuss their feelings with and to help them talk with their families (Gentry, 1978).

Herman and Hirshman (1977), two feminist therapists, wrote that little was known about how to help child incest survivors and their families. Like Gentry, they noted those common social interventions to child incest (i.e., removing the child from the home or jailing the perpetrator) terrified children and encouraged them not to disclose their abuse. The majority of victims reached adulthood without disclosing their incest experiences. Once in therapy, the question remained how to attend to the survivor's needs best.

Herman and Hirschman (1977) believed that male therapists may have serious difficulty empathizing with survivors and validating survivors' experiences because, at some level, male therapists identified with the aggressor. They based this suspicion on the nature of our patriarchal society that was, as demonstrated earlier, supported by our history. Women and children were seen as possessions and the incest taboo as
merely an agreement among men regarding sexual access. Herman and Hirschman posited that this power imbalance coupled with socially sanctioned attitudes of competition and sexual aggression was likely internalized by therapists.

Accordingly, female therapists may readily identify with the survivor and have difficulty responding appropriately to survivors. As an example, Herman and Hirschman (1977) recalled a round table discussion on therapists' experiences with incest survivors. Most of the participating therapists disclosed that they had "shied away from a full and detailed exploration of the incestuous relationship. In some cases the therapist blatantly avoided the issues" (p. 754). Herman and Hirschman believed that such avoidance suggested to clients that the clients' incest experiences were too terrible to share and reinforced a client's sense of isolation and shame.

Herman and Hirshman (1977) gave two possible explanations for female therapists' avoidance. The first was countertransference from a traditional psychoanalytic point of view. Incestuous wishes and fantasies that were too threatening for the therapist to acknowledge prevented the female therapist from dealing with the client's issues. The second was countertransference from a feminist point of view. In working with the client's issues the therapist re-experienced her fear of her own father and realized how easily she too could have been a victim. In either case, dealing with CSA and incest forced the female therapist to confront her own issues. Further, Herman and Hirschman (1977) suggested a second trap for female therapists. Some therapists who managed to get past the avoidance, became angry for
their client and this was a notoriously unsuccessful intervention. Finally, because of their commitment to building solidarity among women, feminist therapists had another potential trap. Dealing with the mother-daughter estrangement and rage (related to feelings of abandonment, powerlessness, guilt, and competition as a result of father-daughter incest) may be particularly difficult for feminist therapists.

Research has supported Herman and Hirschman's observations. Despite the frequent association of CSA with several mental health issues, rarely did therapists ask their clients whether they had been sexually assaulted, and rarely did clients with histories of abuse disclose it to therapists (Bryer, Nelson, Miller, & Krol, 1987; Jacobson & Richardson, 1987). Therapists needed to ask clients about their sexual abuse history routinely, because treating adult survivors of CSA was difficult and not being forewarned only worsened the situation (Bernstein, 1990). However, the amount and type of exploration into abuse history is still a critically debated subject by clinicians and remains a critical issue in the delayed memory - false memory controversy.

Gentry (1978) and Herman and Hirschman (1977) recommended attitudes and behaviors for therapists working with survivors that were in keeping with Roger's (1957) concepts of empathy, genuineness, and unconditional positive regard. However, they suggested at least two additional characteristics that were particularly important for therapists working with survivors. The first was knowledge specific to CSA, including its sociological and familial aspects. These authors viewed CSA and
its sequelae as more than intrapsychic phenomena. CSA and its effects were inextricably connected to the society in which they occur. The second characteristic that therapists of survivors needed was an awareness of their own issues and how working with their clients affected them. While this may have been good advice for therapists dealing with any population, it appeared particularly important for therapists of survivors because of the multifaceted sociological and psychological dynamics of CSA.

The need for therapists of survivors to be aware of their own attitudes and responses to CSA and survivors was repeated throughout the literature (Courtois and Watts, 1982; Rencken, 1989; Saakvitne, 1990; Zimpfer, 1987). Courtois and Watts (1982) posited that mental health practitioners were not impervious to the denial, myths, and effects of CSA. They recommended that counselors examine their own attitudes towards sexual assault and "vent or work through their feelings away from the client." (p. 277).

Saakvitne (1990) suggested that because of possible responses to (a) the taboo against incest, (b) therapist's parent and parenting issues, (c) the need to protect oneself, (d) sexual voyeurism, and, or (e) gender issues, therapists have brought several countertransference reactions to the therapeutic relationship with survivors. Such countertransference has manifested as "horror, outrage, anxiety, protectiveness, guilt, identification, disgust, blame, denial, arousal, retaliatory wishes, powerlessness, and grief" (p. 3). These reactions were modified or intensified by:
therapist factors such as gender, years of psychotherapy experience, particular experience working with incest survivors, awareness of and knowledge about incest, personal experiences of sexual abuse, assault or incest, training, work in a personal psychotherapy, as well as level of comfort with intensive therapy and painful affect; and patient factors, such as the specific circumstances of the incest - eg, duration, age at onset and discontinuation, level of brutality, the role of the other caretakers, other children involved, etc. - and the patient's current age, circumstances, symptomatology, and presentation (p. 3-4).

Likewise, Emerson (1988) observed countertransference issues in her students. She said that when survivors enter counselor education programs their unresolved issues quickly surfaced. Some signs that her counseling students had been abused included: (a) perfectionism and a discounting of positive feedback from others, (b) an unwillingness to discuss sexual issues, (c) lack of trust demonstrated by excessive anxiety about role-playing clients or sharing of their emotions, and (d) feeling guilty for situations even if they "know" they are not responsible (p. 18, 19).

Briere (1989) acknowledged that the prevalence of CSA in our culture made it quite possible that some therapists have their own history of abuse or assault through which they needed to work. In addition, Briere pointed out that despite the rewards of doing needed, meaningful work, the experience of working with survivors could have its own adverse effects on therapists. Briere suggested that work with survivors required personal characteristics of strength and tolerance for isolation and pain. First, the violence and betrayal common for survivors was difficult to hear. Therapists' difficulty expressing their responses to CSA accounts and concern with confidentiality may lead therapists to feel isolated. Secondly, repeatedly empathizing with survivors...
makes therapists vulnerable to internalizing survivors' trauma. Lastly, societal attitudes impact therapists just like everyone else. Instead of being therapeutic, to some degree, unprepared therapists may unwittingly play out victim or perpetrator roles with clients. Kraemer (1988) expressed a similar level of concern when he said "professionalism acquires a new meaning at this level of work, more to do with courage than with propriety" (p. 255). He cautioned therapists that because of the personal difficulties inherent in work with survivors, therapists must faithfully adhere to professional guidelines and boundaries.

Briere (1989) recommended therapists invest in their own therapy to deal with countertransference and to process personal issues stimulated by ongoing work with survivors. Additionally, he recommended that therapists, who work with abused clients, consult with one another and attend conventions on CSA. These actions would help therapists share the emotional load and decrease their sense of isolation. However, he suggested that survivors' therapists also find social outlets removed from abuse issues and take time to experience diverse interests and physical exercise to maintain a balanced, healthy life. Caseloads should be balanced to include clients with issues other than abuse.

This section on the clinical literature will be summarized and synthesized with the client focused literature at the end of that section that follows.
Client Focused Literature

Implications for effective therapist characteristics can be derived from the client focused literature. As mentioned earlier, many clinicians have described the effects of CSA on adult survivors (Courtois, 1988; Finney, 1990; Mudry, 1986; Ratican, 1992; Woititz, 1989). One of the most important considerations, when working with survivors is perceived therapist trustworthiness. Sexual abuse erodes the core of one's ability to trust (Rencken, 1989). CSA not only disrupts the development of trust, it teaches that trust increases vulnerability and hurts. In addition, survivors learn to interpret their world through their parents, trusted caretakers, and authority figures. Therefore, the denial and secrecy that shrouds CSA can have a profound effect on the survivors' self-trust. Denial and secrecy portray a very different reality than the child victim experiences and can result in confusion and mistrust of the survivor's own perceptions (Bass & Davis, 1988; Courtois, 1988).

Consequently, for survivors, developing trust with a therapist can be a monumental and frightening experience that is revisited throughout treatment (Altman, 1992).

Survivors frequently do not know how to trust; they see trust as an "all or nothing" proposition (Bass & Davis, 1988). They need to learn degrees of trust and be supported when testing the trustworthiness of their therapist. This process is likely to be slow and, at times, frustrating or even angering for the therapist. However, patience and respect for the security needs of the survivor are an absolute necessity.
Therapists need to believe in the survivor's ability to recover and reinforce survivor's demonstrated courage, strength, and limit setting.

Especially in the early stages of recovery, the therapist's gender may be particularly important to the survivor (Bass & Davis, 1988; Courtois & Watts, 1982; Finney, 1990). If the sex of the therapist is the same as the abuser, developing trust can be even more difficult. However, if the survivor is far enough into his or her recovery, learning to trust such a therapist can be tremendously healing (Finney, 1990).

Another characteristic which therapists who work with survivors need is special training in suicide interventions. Therapists working with survivors are more likely to encounter clients with both suicidal ideations and a history of past attempts (Courtois, 1988). Suicide can have many different meanings for survivors. It may be a response to excessive guilt, shame, self-hate, a desperate act of control, or an escape from abuse or painful memories. Alternately, it may be a "cry for help" (Courtois, 1988; Shapiro & Dominiak, 1992). If a client does commit suicide, the therapist should seek immediate support to deal with their own feelings of anger, loss, grief, guilt and, or feelings of responsibility and inadequacy.

Together the CSA clinical and client focused literature suggests characteristics that are common to effective therapists in general. This literature suggests that therapists whose primary work is with survivors need an extra measure of psychological strength and self-nurturing to effectively empathize with, yet not
internalize, survivors' trauma. Therapists who work with CSA survivors require special training and knowledge in CSA and suicide interventions, and perhaps, a new understanding of resistance. They need to be prepared to view resistance as healthy boundary setting and self-care. The therapists also need to be prepared to initiate discussions about sexual abuse. In relationship to the survivor's stage of recovery and the gender of his or her abuser, the therapist's gender may be an important characteristic to consider. However, perhaps the most striking aspect about therapist characteristics for those who work with survivors is how much patience and integrity therapists require. Countertransference appears to be an inevitable challenge for therapists who do ongoing work with survivors. Repeatedly throughout the literature, therapists who work with child victims and adult survivors are admonished to be aware or their own sexual abuse issues and to seek therapy and supervision when appropriate.

**Instruments for Assessing CSA Workers' Attitudes**

Despite the frequency at which survivors' therapists are cautioned to be aware of their own issues and attitudes, there has been very little research in this area. Perhaps, the absence of research is an example of countertransference and indicative of clinicians' and researchers' avoidance of CSA. Perhaps the absence is a testimony of the difficulties involved in pursuing research in a burgeoning area of study that has little established methodology and a dearth of reliable research instruments.
For example, Ciccone (1981/1982) acknowledged that the lack of research on therapist characteristics hampered her work exploring therapist attitudes. When a thorough search revealed no existing reliable instrument for assessing health professionals' attitudes toward incest, she attempted to develop one. She developed an instrument with 82 statements to which respondents indicated if they strongly agreed, mildly agreed, mildly disagreed, or strongly disagreed. The questions represented five content areas providing five scales:

1. Definitions of Incest: How one defines incest, including both the persons who are defined as the participants and what behaviors constitute an incestuous act.
2. Beliefs: This addresses the extent to which one's beliefs regarding incest are based upon myths, misinformation, prejudices and stereotypes.
3. Fantasy versus Reality: This issue concerns the tendency to consider incest claims as based upon incestuous fantasies rather than actual events.
4. Dynamics of Incest: How the incest situation is viewed in terms of individual versus family pathology; and whether there are recognizable characteristics of incest participants.
5. Effects: What the nature of the effects of incest is; whether incest is beneficial or harmful (Ciccone, 1981/1982, p. 60).

Unfortunately, Ciccone's instrument did not demonstrate construct validity. Test results showed a lack of practically significant interscale correlations and no relationship between response scores on the Definition scale with any of the other four scales. Ciccone concluded that there was insufficient factual knowledge about incest to develop such an instrument. She contended that different schools of thought argue and define their own positions. Therefore, other researchers may have the same difficulties that she had experienced. Researchers relying on existing theory and
literature may find that the lack of actual empirical evidence impedes their research efforts.

As a case in point Ciccone (1981/1982) referred to the expert judges and the authors of incest literature who participated in her study. She posited that although they were specialists in CSA, their opinions were based upon clinical findings. They were offering only opinions, and beliefs, not empirically supported notions. The specialists found content validity in her instrument. By Ciccone's report, this validity was insufficient and the lack of construct validity placed her instrument in serious doubt. Yet, given the available research, her instrument has merit as a survey questionnaire. This is to say that while her instrument may not have been "psychometrically sound," it did provide a well-structured research tool to collect information on therapist attitudes. This position was held by other researchers as will be demonstrated in the section on the empirical research of therapist characteristics. However, even in her own work, Ciccone focused on instrument construction and not on analyzing new information regarding therapist characteristics.

For example, the participants in Ciccone's (1981/1982) study were in their last year of training or first year of post-degree work in medicine, social work, health education, marriage and family therapy, or applied psychology. Of these people, 42.4% of the males and 25% of the women (one-third of the combined male and female participants) reported having been involved with an incest experience in a professional capacity. Only 2.2% of the males and 4.1 percent of the females (more
than 5% of the combined male and female participants) reported having been involved
with an incest experience at a personal level. Almost 19% of the males and 44.7% of
the females reported having had no experience with incest. Unfortunately, Ciccone did
not use this information in the analysis of the scales to determine if there was any
significant correlation with the participants' experience and how they responded on the
five scales of her instrument. The only demographic information gathered on
participants that she reported analyzing in relationship to the scales indicated no
significant relationship. Specifically, the participants' reported degree of religiosity and
sexual attitudes did not demonstrate a significant relationship to any of the scales.

It would have been interesting to know if there was any relationship between
specific questions on Ciccone's (1981/1982) instrument and the different demographic
information of participants. For example, question 57 asked participants to indicate
how much they agreed or disagreed with the statement, "It is more helpful to the
patient or client initially to believe the incest report to help foster a trusting
relationship" (p. 142). It would have been interesting to know whether the
participants' gender or experience demonstrated a correlation with the participants'
response to this question. Likewise, an analysis of other specific questions could
provide equally interesting information.

Independent of participants' demographic information, analyses between scales
provided some new empirical information. For example, (a) participants who viewed
CSA as a family system problem were likely to view CSA as more harmful than those
who viewed incestuous situations as an individual phenomenon. (b) Participants who reported beliefs about incest that reflected the current information in the literature also indicated that the effects of incest were harmful. (c) And, participants who viewed CSA as involving the family tended to view reports of incest as based on oedipal fantasy (p. 107-109).

Finally, Ciccone found a lack of a correlation between the Definition scale and the other scales on her instrument. Based on this information, Ciccone speculated that "subjects may be able to respond to questions concerning this cognitive aspect of incest; i.e., what is its definition, from a purely cognitive level, keeping the influences of their own emotional/attitudinal biases somewhat more isolated" (p. 110-111).

In addition to Ciccone's instrument, the only instrument with reported reliability studies that was found to investigate therapists' attitudes in relationship to CSA survivors was the Jackson Incest Blame Scale (Jackson and Ferguson, 1983). Jackson and Ferguson wanted to "identify the empirical structure of attitudes relating to attribution of blame in incest to determine how variables such as [research participants'] gender, physically abused status, and sexually abused status influence the [participants'] attribution of blame in incest" (p. 313). Therefore they adapted Ward's Attribution of Rape Blame Scale to create the Jackson Incest Blame Scale (JIBS).

As the current study pertains to CSA, it should be noted that in Jackson and Ferguson's (1983) report of their study, they seemed to view incest within the context of CSA. However, on their instrument there was no indication of whether or not
"incest" referred to sexual interactions between adults or sexual contact involving children. Therefore, people unfamiliar with the frequency of CSA may have assumed that "incest" referred to adult sexual experiences within a family. CSA may never have occurred to the participants taking the JIBS.

Jackson and Ferguson (1983) administered the JIBS to 412 students enrolled in undergraduate psychology classes. They found their instrument to have an acceptable level of internal consistency with a Chronbach's alpha of .71. The results of the study indicated that there was a significant gender difference in that men tended to blame the victim more than did females, ($t = 4.293$, $df = 403$, $p < .0001$). The results also found that "sexually abused subjects tended to attribute more blame to societal values than did the subjects who had not been sexually abused, ($t = 4.623$, $df = 4$, $p < .01$)" (p. 319).

In summary, except for Ciccone's (1981/1982) and Jackson and Ferguson's (1983) work, this researcher was unable to find research instruments with reported reliability for use in assessing mental health professionals' attitudes toward incest or CSA. Additionally, no research addressed therapist characteristics as they related to therapist's sensitivity and, or accuracy in assessing CSA in adult clients. Given the delayed memory - false memory debate, this lack of research tools and absence of empirical research was disconcerting. Nonetheless, some research was found on other aspects of CSA workers such as (a) amount of experience working with survivors, (b) therapists' gender, (c) beliefs about the prognosis for clients recovery and therapists'
avoidance patterns, (d) therapists' blaming patterns, (e) type of professions to which therapists belong, and (f) the type of agencies in which professionals worked.

Therefore, this empirical research will be presented in the following section.

**Empirical Research on Therapist Characteristics**

Eight studies representing the body of empirical research in the literature regarding the therapist characteristics of those who work with adult CSA survivors are presented in this section (see Table 1). For ease of reading each study are presented separately under the subsection Individual Studies: Adams & Betz (1993), Attias & Goodwin (1985), Follette, Polusny, & Milbeck (1994), Fowler & Wagner (1993), Grannis (1985), LaBarbera, Martin, & Dozier (1980), Polusny & Follette (1996), and Sheehy & Meiselman (1981). A brief description of the methods employed in the study and the study's major findings are included. Then, under the subsection Summary of Research by Therapist Characteristic, the results of the studies are drawn together and synthesized around each of five therapist characteristics: gender, clinical experience and training, personal history of CSA, profession, and pre-knowledge of clients' CSA history (i.e., the therapist knowing that a client is a survivor of CSA before they begin working with the client).
Table 1

Empirical Research on Therapist Characteristics of Therapists Who Work With CSA Survivors

<table>
<thead>
<tr>
<th>Study</th>
<th>Source Sample</th>
<th>Therapist Characteristic</th>
<th>Focus of Study</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adams &amp; Betz, 1993</td>
<td>Counselors</td>
<td>Gender and clinical experience</td>
<td>Attitudes toward incest</td>
</tr>
<tr>
<td>Attias &amp; Goodwin, 1985</td>
<td>Health professionals who work with survivors</td>
<td>Profession and gender</td>
<td>Differences in beliefs and practices between professions</td>
</tr>
<tr>
<td>Follette, Polusny, &amp; Milbeck, 1994</td>
<td>Mental health and law professionals</td>
<td>History of childhood trauma and CSA</td>
<td>Effects on secondary traumatization, influence on specializing in survivor work, and effect on professionals’ response to CSA clients</td>
</tr>
<tr>
<td>Fowler &amp; Wagner, 1993</td>
<td>Sexually abused girls</td>
<td>Gender and training</td>
<td>Client’s preference in gender of therapists when therapist have specific training in CSA work</td>
</tr>
<tr>
<td>Grannis, 1985</td>
<td>Mental health professionals</td>
<td>Gender, profession, clinical experience</td>
<td>Blaming practices of mental health professionals</td>
</tr>
<tr>
<td>LaBarbera, Martin &amp; Dozier, 1980</td>
<td>Psychiatrists</td>
<td>Clinical experience</td>
<td>Psychiatrists’ attitudes toward CSA survivors</td>
</tr>
<tr>
<td>Polusny &amp; Follette, 1996</td>
<td>Psychologists</td>
<td>CSA history, gender, clinical experience</td>
<td>Clinical practices with adult survivors</td>
</tr>
<tr>
<td>Sheehy &amp; Meiselman, 1981</td>
<td>Therapists</td>
<td>Pre-knowledge of clients’ CSA history</td>
<td>Therapists’ willingness to work with client and assessment of client’s level of disturbance and prognosis for recovery</td>
</tr>
</tbody>
</table>
Individual Studies

Adams and Betz. Adams and Betz (1993) used Ciccone's (1981/1982) Incest Attitudes Survey (IAS), the Jackson and Ferguson Incest Blame Scale (1983), and Kalin and Tilby's 1978 Sex-Role Ideology Scale (cited in Adams & Betz, 1993) to study the gender differences in counselors' attitudes toward incest. The professional staff and interns at 25 university centers were asked to participate in the study. One hundred and seventy-seven counselors signed up to participate and were then sent research packets containing a set of intake notes with treatment questions and the three aforementioned instruments. One hundred and eleven (63%) of the counselors responded.

An analysis of the counselors' responses indicated that counselors attributed almost no blame to the victims. Additionally, in contrast to normative samples of undergraduates from Adams and Betz (1985) and Jackson and Ferguson's (1983) studies, Adams and Betz (1993) found counselors to be more supportive of victims. They also found that counselors with more counseling experience than their counterparts placed more responsibility on incestuous parents and less responsibility on society (p. 214). Moreover, Adams and Betz found three differences in attitudes that appeared to be related to a counselor's gender. As measured by the IAS, "female counselors had significantly broader definitions of incest (M = 10.13) than did male counselors (M = 9.14) and were less likely in comparison with male counselors to perceive incest claims as fantasy or imagination rather than reality (M = 1.04 vs. M =..."
Female counselors were also more optimistic about survivors overcoming the impact of incest than were male counselors.

**Attias and Goodwin.** Attias and Goodwin (1985) studied the differences in mental health professionals' management strategies with clients who were incest survivors and studied the differences between professionals' knowledge about incest. Using case scenarios with explicit CSA, 255 professionals (psychologists, psychiatrists, pediatricians, and family counselors) were surveyed. Forty-two percent of the practitioners responded. Over half the respondents had treated a child victim or adult survivor within the past year. The gender makeup of each group of professionals was predominately male except counselors (25% males). Eighty-one percent of the psychiatrists and pediatricians were males and 63% of the psychologists were male.

Attias and Goodwin (1985) observed very few differences between professions. One difference was in health providers' beliefs about children falsely disclosing fantasies as actual abuse. According to Attias and Goodwin (1985) the literature suggested that fewer than 5% of the children who disclose sexual abuse are recounting only fantasies. However, in their research, some professionals in each group overestimated the frequency of false reports due to childhood fantasies. Most noticeably, 40% of the psychiatrists estimated that 25% or more of the children's allegations were fantasies. Some of Attias and Goodwin's (1985) other findings indicated that pediatricians stood out from the rest of the professionals in their knowledge regarding screening for venereal disease. Ninety-four percent of the
pediatricians knew that children who alleged fellatio should be screened; only 76% of
the other three groups knew this.

However, gender rather than the profession was the important predictor of the
clinicians' responses. Men, more often than women, underestimated the prevalence of
father-daughter incest. More men than women chose not to report possible CSA to
child protective services when a child recanted their accusations of sexual abuse.
More men than women overestimated the frequency at which children report fantasies
as actual sexual abuse, and men, more than women, underestimated the frequency of
father-daughter incest (p. 530, 351).

Attias and Goodwin's (1985) compared the research results with the results
from studies completed between 1967 and 1983. Attias and Goodwin found changes
in professionals' beliefs from the previous generation. Old stereotypes about incest
(i.e., natural fathers are never involved, parental denials of sexual abuse were to be
taken literally, and children's allegations were fantasies) were professed by less than
20% of the professionals who responded in their study. There also appeared to be a
positive change in professionals' awareness about laws to report CSA and an increase
in professionals' willingness to report. Lastly, 96% of the professionals in Attias and
Goodwin's study reported that they needed more information. Specifically, they
wanted information on (a) identifying and diagnosing incest trauma, (b) treatment
options, (c) public information on school prevention-programs, media and general
awareness programs through education, and (d) research results (Attias and Goodwin, 1985, p. 531).

**Follette, Polusny, and Milbeck.** Follette et al. (1994) surveyed mental health and law enforcement professionals to assess their personal and professional experience with trauma and to explore the effects of this experience on how the professionals responded to sexually abused clients. As the present research is concerned with therapists characteristics, the current discussion is restricted to the study's findings on mental health professionals.

Follette et al. (1994) mailed all 471 licensed psychologists and marriage and family therapists from a western state, survey packets. The packets contained a letter requesting participation; a modified version of Kelly's 1993 (cited in Follette et al., 1994) Therapist Response Questionnaire (TRQ), a 110-item self-report inventory; Briere and Runtz's (1988) Trauma Symptom Checklist-40; and a stamped addressed return envelope. The number of mental health professionals participating in the study was reduced by 21 incomplete survey packets and 20 surveys returned by the postal services. Therefore, Follette, et al. reported a return rate of 52% (225 out of 430) mental health professionals. Forty-seven percent of the responding mental health professionals were male, 53% were female. A notable number of respondents reported having personally experienced child sexual abuse, 10.6% of the males and 19.3% of the females.
When Follette et al. (1994) compared the research participants' responses on the TRQ and the TSC-40 they found a significant difference between nonabused participants and abused participants. Mental health professionals who reported having been physically or sexually abused during childhood also reported higher levels of trauma-specific symptoms than did mental health professionals who reported no CSA histories. However, no significant difference was found on several variables regarding the participants' professional behaviors. There was no significant difference in: "the percentage of their [respondents] current caseload reporting an abuse history, the percentage of their clients actively working on sexual abuse issues, and the number of negative responses to child sexual abuse survivors [i.e., dissociating during therapy sessions]" (p. 279). Further, participants who reported childhood abuse histories "reported using significantly more positive coping behaviors to deal with [their own responses to] sexual abuse cases" (p. 279). In terms of secondary traumatization (traumatization as a result of hearing traumatic client material), respondents' personal history of trauma and the percentage of their sexual abuse caseloads was not significantly predictive of respondents' reported trauma symptoms on the TSC-40.

Other important findings of this study included (a) the majority of therapists report that they routinely ask about possible CSA, (b) professionals have become increasingly aware of the importance of addressing their own trauma experiences for personal and professional reasons, and (c) 59.1% or the mental health professionals participating in the study reported having had personal therapy. Finally, Follette et al.
found that, although there have been increasing efforts within the legal system to involve therapists' abuse histories in determining the professionals' competency, histories of personal trauma do not appear to negatively affect the competency of therapists to provide services to survivors of sexual abuse (p. 280).

Fowler and Wagner. Fowler and Wagner (1993) studied the effect of training therapists to work with female CSA victims. Their research participants were 20 sexually abused girls between the ages of 7 and 15. Ten of the girls were treated by female counselors for six sessions; 10 were treated by male counselors for 10 sessions. Initially all of the girls preferred female counselors. At the end of treatment, all of the girls treated by female counselors still preferred a female counselor. However, 3 of the 10 girls who were treated by male therapists reported a change in preference toward male counselors. Fowler and Wagner suggested that these results offer an empirical challenge to fears that male counselors tended to revictimize their abused clients and to the assumption that child victims will feel more comfortable in the beginning stages of therapy with female counselors.

Based on Fowler and Watner's (1993) reported research methods and results, this researcher was not able to make the same conclusions. Fowler and Wagner's "empirical challenge" to fears that male counselors tend to revictimize their abused clients and assumptions about CSA clients' preference for female counselors appeared purposefully or inadvertently weak. First, the male counselors in this study were told they were in a study designed to assess effectiveness of a treatment program.
Additionally, male counselors were required to follow a 56-page treatment manual that contained recommended responses. This information likely affected their behavior. Secondly, the short duration of treatment in this study may have affected the counselors' behavior. Thirdly, 70% of the girls treated by men did not report a post-treatment preference for men. Finally, one questions Fowler and Wagner's "empirical challenge" based on three subjects. As Fowler and Wagner are men and this position does not support victims' reported preferences, perhaps it exemplifies a gender bias (i.e. use of denial) described elsewhere in the literature.

As viewed by this researcher, Fowler and Wagner's research does suggest that:
(a) Male therapists can be trained to be supportive and effective therapists with female survivors of CSA, and (b) some female survivors can become comfortable with male therapists who are trained to work with CSA survivors. It was encouraging to find that the girls in the study were favorably impressed by their male counselors and expressed comfort with their male counselors. Indeed, larger studies that indicate female survivors' prejudices for female counselors are readily dissolved by supportive male counselors, could have significant and positive implications for recovery work.

Grannis. Grannis (1985) used a mailed questionnaire to investigate the characteristics of mental health professionals as they related to the professionals' blaming patterns in cases of incest. She measured psychologists, social workers, and psychiatrists' attribution of blame using the Jackson and Ferguson Incest Blame Scale. Her findings indicated that mental health professionals found certain causes to be more
important than others in attributing blame. As for whom or what was most important
to blame, offender and situation were first, followed by society and then victims. How
much blame attributed to each aspect was identified. Professionals attributed as much
blame to situational circumstances as they did to offenders and blamed victims least.
Results also indicated that male mental health professionals blamed victims more than
do female health professionals. Female professionals virtually never blamed the victim.
In contrast, no gender difference was found on how therapists viewed the role of the
offender, situational, or societal causes in incest.

Grannis (1985) found that special training in incest did not affect how mental
health professionals attributed blame. However, type of training as defined by a
therapist's profession (i.e., psychologist, psychiatrist, or social worker) did relate to
therapist attribution of blame. Psychiatrists blame the victims of incest more than do
social workers. Psychologists fall somewhere between psychiatrists and social
workers. It was undetermined if inherent qualities in the individuals who make up the
different professional groups were responsible for the differences. For example, the
type of person attracted to the profession, how much training required for the different
professions, or the type of training specific to each profession could have been
responsible for the differences found in victim blaming. Lastly, how much experience
mental health professionals had worked with survivors affected some blaming patterns.
Professionals with clinical incest experience blamed offenders more than professionals
with no clinical incest experience. Yet, experience did not affect professionals' blaming of victims, or societal and situational factors.

LaBarbera, Martin, and Dozier. LaBarbera, Martin, and Dozier (1980) thought that mental health professionals had little empirical data on which to make clinical judgments. Because of the paucity of scholarly literature on father-daughter incest, they thought that professionals' operating hypotheses were derived from clinical experience. LaBarbera et al. knew of no attempt to assess the attitudes of professionals who treated female survivors. Therefore, they mailed a three-page questionnaire to solicit information from 200 psychiatrists on their assessment of the impact of incest on clients. A total of 32% of the questionnaires was returned. Of these, 46% of the respondents were in practice for 10 years or less and 54% had more than 10 years practice. The results of the survey clearly indicated that psychiatrists viewed incest as pathogenic for daughters. However, the amount of actual experience psychiatrists had with survivors influenced the degree of perceived damage. Psychiatrists who had more experience with survivors predicted less damaging effects from incest. Characteristics of the incestuous family make-up were seen as more harmful than the actual sexual behavior and almost all psychiatrists felt that therapeutic interventions were necessary.

Polusny and Follette. Polusny and Follette (1996) surveyed a random sample of 1,000 psychologists from Divisions 12 (Clinical) and 17 (Counseling) of the
American Psychological Association to investigate psychologists' personal and professional experiences, beliefs, and clinical practices in relationship to CSA and clients remembering CSA in therapy. Twenty-two percent (223) of the surveys were returned. Forty-seven percent of respondents were female, 53% were male. Overall, 32% of the respondents reported having a personal history of CSA (42% of the female psychologists and 23% of the male psychologists). Most of the respondents who reported CSA histories indicated that they had continuous recall of their abuse (70% of the males and 61% of the females). However, 33.3% of the female psychologists and 25% of the male psychologists reported having only partial memories of CSA before participating in any therapy. Further, 3% of the female and 5% of the male respondents reported recalling CSA memories during therapy when they had no such memories before entering therapy.

In psychologists' reported CSA caseloads, 82% of the respondents reported having seen at least one adult survivor of CSA in the past year. Seventy-two percent of the psychologists reported that they had not encountered any repressed memory cases in the past year and 36% of the psychologists reported that they assessed all their adult clients for CSA histories (p. 44). Psychologists' belief about the prevalence of repressed memories or their practices of memory retrieval techniques was not significantly associated with the number of clients they reported having seen with repressed memories. Further, more than 75% of the psychologists indicated that they did not believe that there was an identified constellation of symptoms that indicated a
history of CSA. However, the therapists' who did report believing that a constellation of symptoms could indicate sexual abuse were significantly more likely to report having seen a client with repressed memory. "Over 50% of respondents rated clients' memories of CSA as somewhat accurate and 13% of respondents judged clients' memories as inaccurate or very inaccurate (M = 2.77, SD = .88). Approximately 30% of respondents rated such memories as accurate or very accurate" (p. 46).

Polusny and Follette (1996) examined three therapists characteristics (gender, amount of general clinical experience, and having a personal history of CSA) in relationship to psychologists' clinical practices with adult survivors of CSA. Concerning therapist's gender, Polusny and Follette found no differences in therapists' "beliefs about the prevalence of repressed memories, the importance of remembering abuse, and the likelihood of a therapist or support group falsely convincing an adult of CSA" (p. 46). However, female psychologists believed that adults' memories of CSA were more accurate than did male psychologists. Likewise, males were more likely to believe that adult clients could be falsely convinced that they were CSA survivors from exposure to books or media than did female psychologists.

Polusny and Follette (1996) also found that the amount of overall clinical experience a psychologist had appeared to influence psychologists' clinical practices and beliefs. Psychologists who believed that there was "a constellation of adult symptoms that almost always indicated a history of CSA reported significantly fewer years of clinical experience" (p. 46), M = 14.5 years versus M = 19.13 years. The
frequency at which psychologists assessed adult clients for a history of CSA was also associated with years of clinical experience. Clinicians with fewer years of experience more frequently assessed clients for CSA and rated adults' memories of CSA as more accurate than therapists with more experience. However, given Polusny and Follette's gender findings, one has to wonder how much of their findings regarding years of clinical experiences are affected by (a) the increasing number of female therapists in later years, and (b) the socio-political environment at the time the clinicians took their training.

Finally, Polusny and Follette explored the association of psychologists being survivors of CSA with their clinical practices and beliefs. Few differences were found between therapists who reported CSA histories and those who did not. No significant difference was found between abused and nonabused psychologists in the percentage of clients that they assessed for (a) CSA histories, (b) referred to survivors' groups, (c) encouraged to confront or prosecute their perpetrators, (d) encouraged to gather collaborative evidence for their memories, or (e) in the percentage of clients to whom the therapists suggested that the client may be a survivor of abuse (p. 47). There was also no difference in the number of repressed memory cases or the number of memory retrieval techniques used in the last year by psychologist reporting they did nor did not have histories of CSA. Likewise, based on whether or not a psychologist had a history of CSA, there was no difference in psychologists' beliefs about the percentage
of clients who had repressed memories or about clients' likelihood of being falsely convinced that they were survivors by therapists or support groups.

Differences were found between nonabused and abused psychologists in their belief of the accuracy in adult clients' CSA memories. Psychologists who were survivors tended to believe that adult clients' memories were more accurate than did nonabused psychologists. Psychologists who were survivors also more strongly supported the importance of retrieving memories and working through them to alleviate psychological distress. Lastly, psychologists who were survivors of CSA expressed less concern about the suggestibility of clients and were more likely to assign bibliotherapy to clients before clients recalled or reported CSA histories than did nonabused psychologists.

Sheehy and Meiselman. Sheehy and Meiselman (1981) studied the impact of therapists' awareness that a female client had a history of child incest. They designed a questionnaire that contained analogs of client cases with explicit incest and client cases with no history of CSA. Respondents were asked to rate the hypothetical cases on (a) level of disturbance, (b) prognosis, (c) therapist's willingness to work with the client, and (d) the importance of various background factors in contributing to the client's present disturbance. Sheehy and Meiselman found that knowing a client had an incest history did not prejudice the therapists' perceptions of disturbance or their prognosis for their clients. Yet, there was a significant difference in that therapists were less willing to work with known survivors of incest. When incest was presented, therapists
judged it to be the most crucial cause of the survivor's disturbance. As the typical respondent in this research was a female with her masters in social work, this research lent some support to Herman and Hirshman's (1977) suspicions that females may not feel comfortable and avoid working with incest survivors. However, it is not possible to determine the causes of this response from this study. As Sheehy and Meiselman (1981) allow, further research into avoidance patterns of therapists is required to confirm or discredit any suspicion regarding the meaning of the therapists' lack of willingness to work with known CSA survivors.

**Summary of Research by Therapist Characteristic**

**Gender.** Gender was the most often studied therapist characteristics of mental health professionals who work with CSA survivors (Adams & Betz, 1993; Attias & Goodwin, 1985; Grannis, 1985; Fowler & Wagner, 1993; Polusny & Follette, 1996). The majority of the findings from this empirical research supported clinical suspicions that male and female therapists differ in their beliefs and that males tended to be less supportive of CSA survivors than females (Adams & Betz, 1993; Attias & Goodwin, 1985; Grannis, 1985; Polusny & Follette, 1996). Female therapists tended to be more believing of clients' incest claims than did male therapists who overestimated the frequency at which CSA claims were inaccurate, fantasy, or imagination. Male therapists, more often than female therapists, underestimated the prevalence of father-daughter incest. Males were also more likely than females to believe that
books and the media could cause adult clients inaccurately to believe themselves to be survivors. However, especially germane to the false-memory, delayed-memory debate, Polusny and Follette (1996) did not find any gender differences in therapists' beliefs about the prevalence of repressed memories or the "likelihood" that therapists or a support group would falsely convince adult clients that they were CSA survivors.

**Clinical Experience and Training.** Clinical experience (in general and specific to CSA) or training in CSA work was examined in five of the eight studies researching the therapist characteristics of therapists who work with CSA survivors (Adams & Betz, 1993; Fowler & Wagner, 1993; Grannis, 1995; LaBarbera, Martin, & Dozier, 1989; Polusny & Follette, 1996). Overall, clinical experience appeared to enhance therapists' support of CSA survivors. Therapists with more clinical experience than their counterparts placed more blame on incestuous parents than society. Therapists with experience blamed offenders more than did the therapists with less experience. However, clinical experience did not appear to effect how much blame attributed to victims, society or situational factors. Psychologists with less experience were associated with believing in a constellation of adult symptoms that usually indicated a history of CSA, more frequently assessed for CSA, and rated adult clients' memories of CSA as more accurate than did therapists with more experience. Specific training in CSA work did not appear to effect therapists attribution of blame. In contrast, specific training in working with survivors of CSA did appear to mitigate some gender differences, enhancing male therapists ability to work with female survivors of CSA.
**Therapist's History of CSA.** The percentage of therapists who report being survivors of CSA varies from study to study. Follette et al. (1994) reported that 10.6% of the male and 19.3% of the female mental health professionals (29.8% in total) participating in their study indicated that they were survivors of CSA. Polusny and Follette (1996) reported an even higher rate of CSA histories. Forty-two percent of the female and 23% of the male psychologists who participated in their study reported histories of CSA. However, the results of both studies agree that having a history of CSA does not appear negatively to affect therapists' ability to work with survivors of sexual abuse. Further, therapists who are survivors appear to be more skillful in personally coping with sexual abuse cases. That is, therapists who are survivors report “using significantly more positive coping behaviors to deal with sexual abuse cases.” (Follette et al., 1994, p 279), i.e., consultation with colleagues, educating self, and using humor. Psychologists sexually abused in childhood tended to believe their adult clients' memories were more accurate than did nonabused psychologists. Psychologists who were CSA survivors were also more strongly supportive of the importance of memory work with survivors of CSA and were less concerned about the suggestibility of clients to falsely believe that they were survivors of CSA (Polusny & Follette, 1996).

However, Follette et al. (1994) and Polusny and Follette's (1996) studies indicate that there were more similarities than differences between abused and nonabused therapists in their clinical practices. For example, there was no significant
difference between abused and nonabused therapists in the percentage of their
caseloads that were survivors of CSA, the relative frequency with which the therapists
assessed clients for CSA, suggested clients may have been abused, encouraged clients
to gather collaborative evidence of their abuse memories, encouraged confrontation or
prosecution of perpetrators, and used memory retrieval techniques. In the final
analysis, being a survivor of CSA may increase therapists willingness to believe that
clients are survivors of CSA; however, being a survivor does not appear to affect the
clinical behaviors of therapists or the competency to work with survivors of CSA
significantly.

Therapists' Profession. While there are some studies that investigate different
professionals' (i.e., teachers, social workers, law enforcers and therapists) attitudes and
practices with CSA survivors, few studies explore the differences between therapists
who work with survivors of CSA based on their professional identities (i.e.,
psychologist versus psychiatrists, versus clinical social worker, professional counselor,
etc.). Attias and Goodwin (1985) and Grannis (1985) were the only studies found in
this literature review that addressed such differences and even these studies' findings
were limited. Attias and Goodwin observed that psychiatrists, as compared with
psychologists, pediatricians and family counselors, stood out in their overestimation
that child allegations of sexual abuse were false reports due to fantasies. Attais and
Goodwin reported that in comparison to the estimations of false allegations of CSA by
children in the literature, the psychiatrists in their study overestimated that children falsely disclosed fantasies as actual abuse by 20%.

Grannis (1985) found that therapist's profession related to therapist's attribution of blame in incest cases. In the hierarchy of whom blamed victims more, psychiatrists blamed victims the most followed by psychologists and then social workers. However, Grannis was unable to determine what characteristics of the individuals who made up the professional groups may have been responsible for the difference.

Pre-knowledge of Client's CSA History. Only one study addressed the effects of knowing a client was a survivor of CSA on therapists (Sheehy & Meiselman, 1981). Knowing that a client was a CSA survivor did not prejudice therapists' perceptions of the clients' level of disturbance or prognosis for mental health. However, therapists were significantly less willing to work with known CSA survivors than with clients who did not have known histories of CSA.

Conclusion Concerning Empirical Research as Related to Current Study

In sum, there has been very little empirical investigation into the therapist characteristics of therapists who work with CSA survivors. Gender appears to be the most widely studied characteristic and the most likely to be the cause of differences found in therapists' beliefs and clinical practices in relationship to CSA survivors. However, none of the studies have addressed how, or even if, therapists' gender,
clinical experience, CSA history, or professional affiliation impact therapists' ability and sensitivity in assessing CSA in adult clients. Therefore, the following section will summarize this literature review's findings leading to the current research.

Summary of Literature Leading to Current Study

Western society has a long history of CSA. Literature, including the media, organized religion, and professionals in the fields of psychology and mental health have all contributed to the secrecy, shame, and denial that shroud CSA. The 1970s appear to be a watershed for growing changes in these practices. The feminist movement and researchers in family violence advocated for support of survivors and social change regarding attitudes about CSA. These two forces, more than any other, are credited with being the catalysts for the growing awareness and concern for survivors of CSA.

Currently, much more is known about the family dynamics of incestuous families and the sequelae of CSA than was known twenty years ago. Clinicians are beginning to identify survivors with increasing frequency and as a rule, are more aware of the survivor's mental health difficulties. While there has been some improvement in professionals' attitudes regarding CSA over professionals' attitude of the 1970s, it appears that most therapists who work with survivors still overestimate the number of false accusations children make due to fantasies, devalue the harm sexual abuse causes victims, and reject the current predicted frequency of CSA. Even so, there are
legitimate concerns that some clients may have inaccurate memories of their abuses that are then reinforced to the detriment of the client, the accused, and their families.

Not surprisingly, these attitudes and concerns are reflected in the current false-memory versus delayed-memory debate. Supporters from the delayed-memory side of the debate are afraid that the memories of survivors are being discounted. Additionally, these supporters are worried that the harmful effects of CSA are being minimized and devalued in deference to the concerns that adults are being falsely accused of perpetrating sexual abuse and that these false accusations are debilitating the lives of the accused and their families.

For the supporters of the delayed-memory side of the debate, this situation is reminiscent of the socio-political environment of Freud's time when he abandoned his Seduction Theory, which for all practical purposes meant the abandonment of survivors. However, today women are in a much more powerful position within society. This power is being exercised in the legal system and women are beginning to seek financial damages from their perpetrators for emotional and physical damage and the costs of related therapies. The legal actions of women believed to be survivors appear to have stimulated the supporters of the false-memory side of the debate into challenging survivors memories of CSA and accusing survivors' therapists of creating false memories in their clients. Both sides of the debate express concerns that therapists' CSA biases are affecting therapists' ability correctly to assess the presence or absence of CSA in adult clients.
As this literature review demonstrates, there is little empirical knowledge from which to argue that therapists' biases and attitudes regarding CSA are affecting therapists' ability to assess CSA in adult clients. Most of the information related to therapist characteristics that might affect therapists' assessment of CSA is derived from clinical experience. Unfortunately, clinicians do not appear to be immune to the cultural biases and attitudes from which they have come.

There have been some attempts to research therapist characteristics as they pertain to therapists' attitudes. Of these studies, gender was the only characteristic that consistently demonstrated a correlation to certain attitudes. That is, male therapists tended to be less believing and less supportive of CSA survivors than did females. Males tended to view the effects of CSA as less harmful to survivors than females. However, females tended to be more hopeful for the survivor's recovery from the harmful effects of CSA.

None of the gender studies attempted to examine the relationship of therapists' gender to therapists' ability or sensitivity in suspecting the presence or absence of CSA in adult clients. The information gained from examining the effect of therapists' gender on therapists' ability and sensitivity to assess CSA could provide useful information and help to elucidate the delayed-memory versus false-memory debate. Therefore, the current research explores this relationship. Because the research literature indicates that female therapists tend to be more believing of survivors than male therapists, it is
expected that the current research will find female therapists to be more sensitive and accurate in their assessment of CSA in adult clients than male therapists.

The clinical literature suggests that characteristics that are effective for working with survivors are basically the same as those for working with clients in general. What many speculate to be problematically of survivor work are the emotional aspects and unconscious beliefs associated with CSA which affect therapy. This problem, as expressed in the clinical literature, has led authors repeatedly to advise therapists to deal with their own issues regarding CSA. Not to do so could cause personal difficulty for the therapist and be harmful for the therapeutic relationship with survivors. Therefore, exploring whether or not therapists of CSA survivors routinely invest in their own therapy seems reasonable for this research. Further, given the concerns expressed in the false-memory versus delayed-memory debate about unconscious beliefs motivating therapists and the assumption that therapy helps therapists better understand their own issues, it may be helpful to investigate if therapists having personal therapy shows any correlation with therapists’ accurate assessment of CSA in adult clients. Therefore, this research will examine the relationship of therapists who have had therapy versus therapists who have not had therapy with therapists’ sensitivity and ability in suspecting CSA in adult clients.

The question of therapists’ therapy recalls the evidence that therapists may well be survivors of CSA. The reader is reminded that in Ciccone’s research (1981/1982), more than 5% of the health professionals reported having been involved in incest on a
personal level. In a more recent study, 32% percent of the participating psychologists reported that they had been sexually abused as children (Polusny & Follette, 1996). Polusny and Follette did not find significant differences in the clinical behaviors of therapists who were and were not survivors of CSA. However, they did not investigate therapists’ suspicions about the presence or absence of CSA. In fact, no research was found in the literature on the implications of being a survivor of CSA for therapists' sensitivity and ability in suspecting the presence or absence of CSA in adult clients. As information about this relationship could provide valuable information for clinicians and could enlighten the false-memory versus delayed-memory debate, the current study will explore the relationship between therapists' sensitivity and ability in suspecting the presence or absence of CSA and therapists who are, or who are not, survivors of CSA.

Likewise, very little information is available on the effects of therapists' experience working with survivors and this information could be equally important. The clinical literature suggests that prolonged work with survivors of CSA can have draining and negative psychological effects on therapists (Briere, 1989; Courtois & Watts, 1982). The empirical literature suggests that as therapists’ experience working with survivors increases, therapists view the effects of incest to be less damaging (LaBarbera, et al., 1980). While suspecting that professional experience with CSA would educate therapists about the dynamics of CSA seems reasonable, and by that improve their ability and sensitivity in suspecting the presence or absence of CSA, no
research has been conducted to support or deny this suspicion. Therefore, with the expectation that professional experience with CSA survivors will improve therapists' ability and sensitivity, therapists' professional experience with survivors will be examined as it relates to therapists' sensitivity and ability in suspecting the absence or presence of CSA in adult client histories.

This researcher wondered if having a close friend, family member, or significant other would affect therapists' sensitivity and ability to suspect the presence or absence of CSA in adult client cases. This research speculated that having such a relationship with a survivor could make the existence of CSA real for therapists and yet provided some personal distance from the immediate effects of incest. This potentially less threatening awareness of CSA might sensitize therapists to CSA and improve their ability accurately to assess CSA in their adult clients. This is pure speculation as no research has been conducted regarding this therapist characteristic. However, all things being equal, if true, having had a close friend, family member, or significant other who is a survivor of CSA might be predictive of a therapists' sensitivity and ability in suspecting CSA in their adult clients. Therefore, this research will address whether having a close friend, family member, or significant who is a survivor, has a positive impact on therapists' ability and sensitivity in suspecting the presence or absence of CSA.

Finally, this researcher wonders if a combination of the above five therapists' characteristics would be essentially predictive of therapists' ability and sensitivity
regarding CSA suspicions. Therefore, depending on the feasibility of a two by two analyses of variance (i.e., the number of respondents who have the therapist characteristic in question), the current research will examine the possible interaction effects of statistically significant therapists characteristics. For example, if females turn out to be significantly more accurate and sensitive in suspecting the presence or absence of CSA than males, will being a survivor of CSA cause female therapists to over identify CSA in her clients? This is to say, will she suspect CSA in client cases where the client has no history of CSA? If males do tend to deny CSA and be less sensitive and accurate in suspecting the presence or absence of CSA, will being a survivor of CSA heighten their awareness and override gender difference making men as sensitive and accurate as women in their assessment of CSA in adult clients? Likewise, does professional experience with CSA survivors mediate gender differences and improve therapists' sensitivity and ability in suspecting the presence or absence of CSA? By observing the interaction of therapist characteristics that show a statistically significant relationship to therapists' sensitivity and ability to suspect the presence or absence CSA, this research may provide valuable and entirely new information to the literature.

Naturally there are an unlimited number of therapists' characteristics one could research in relationship to CSA. However, the above questions are particularly interesting to this researcher because they indirectly address countertransference and could provide the basis for more directly investigating therapists' countertransference
issues. The concept of countertransference has been around since Freud, and the literature continually suggests that countertransference could be a major concern for therapists working with survivors. Therefore, it seems particularly relevant that research is done on therapists characteristics that may be associated with countertransference issues in CSA work. Moreover, as mentioned earlier, therapists are being called upon to examine their impact on their client's memories of CSA. As the false-memory versus delayed-memory debate becomes more heated, allegations that therapists are creating trauma in their clients by leading them to believe falsely they were sexually abused during their childhood are becoming more common. Knowing the characteristics that affect therapists' suspicion of CSA may alert professionals to possible countertransference issues that predispose them to find sexual abuse where it does not exist or miss it where it does exist. Therefore, empirical research that leads to identifying the therapists characteristics associated with sensitivity and ability to suspect the presence or absence of CSA could be immensely valuable.
CHAPTER III

METHODS

Introduction

This is a descriptive study using a written closed-ended questionnaire and an instrument composed of clinical vignettes that serve as stimulus for assessing participants suspicions of childhood sexual abuse (CSA). The purpose is to examine the relationship of five therapist characteristics and therapist's accuracy and sensitivity in suspecting a possible history of childhood sexual abuse (CSA) in adult client cases. This is pioneering work and no instrument was found in the literature to assist in investigating therapist's sensitivity and accuracy in suspecting CSA. Therefore, developing a new instrument for this research was necessary. Consequently, this chapter, which presents the current study's research methods, is two-tiered. The first tier details the development of an instrument. The second tier explains the methods used to collect data on the association of five therapists characteristics with therapists' suspicion of CSA.

The first tier describes the steps taken to develop the instrument needed for this study, the Sensitivity Test of Clinical Issues (STOCI). This tier is divided into three sections. The first section presents the general format of the STOCI. The second section describes the five phases of the STOCI's development: (1) the creation
of the vignettes and the list of possible responses to the vignettes, (2) a prepiilot of the 
STOCI, (3) evaluation of the STOCI by expert raters, (4) a pilot of the STOCI, and 
(5) scoring of the STOCI, and ends with a summary of the STOCI's development. 
Where appropriate, information is included regarding the people who participated in 
the development of the STOCI and the rationale behind the particular steps taken in 
the development of the STOCI. The third, and final section of the first tier, 
summarizes the STOCI's development. 

The development of the STOCI is a major component of this research and is 
expected to make its own contribution to the literature on CSA. Development of this 
instrument is preliminary to the objective of this dissertation to explore the association 
of five therapist characteristics with therapist's suspicion of the presence or absence of 
CSA. Using the STOCI, the second tier of this chapter presents the methods 
employed to complete this objective. As such, the second tier is organized into five 
major areas: (1) description of the variables, (2) description of the Therapist's Data 
Sheet, (3) report on the participants and their selection, (4) discussion of the data 
collection, and (5) presentation of the research hypotheses with a discussion of the 
statistical analysis used in this research.
First Tier of Methods

General Format of STOCI

The STOCI is an instrument designed to assess therapists' sensitivity to childhood sexual abuse in adult clients (see Appendix A). It is a paper and pencil test of forced-choice responses to 10 vignettes portraying female clients that one might see in college or university counseling centers. It measures a therapist's sensitivity and ability to assess CSA as a function of the therapist's suspicion of CSA in the cases presented in the vignettes. Five of the 10 vignettes are designed to suggest, but not openly state, CSA as an important clinical issue. The other five vignettes are designed to portray cases where CSA is not indicated. Following each vignette, there is the same list of the 12 issues, one of which is CSA. From this list the research participants are instructed to circle the issues that they suspect are most important to the conceptualization of the cases presented in the vignettes. Additionally, if the participant circles more than three issues, (s)he is instructed to asterisk his or her three top choices.

The response options were formatted in this manner to avoid leading a person to consider CSA as an important issue when the person may not have otherwise thought of CSA. A more direct questioning (e.g., Is CSA a central issue in the vignette?) would highlight CSA, singling it out as an issue to be considered. Embedding CSA in a list of 12 possible responses was expected to minimize the
possibility of the question's wording, as opposed to the vignette's content, affecting the respondents' suspicion of CSA. Limiting the number of choices to 12 was expected to reduce the possible anxiety that such decision making could evoke in participants. Limiting the number of choices was also expected to facilitate the STOCI's reliability and its timely completion. The particular 12 responses selected to include in the list were chosen for their diversity and because of the author's perception that they are frequent issues for which clients seek professional help.

The vignette format was chosen to use in the STOCI for several reasons. First, vignettes created a low-risk environment that provided a cost-efficient and time-efficient means of gathering information (Black, 1990). Take the current research as an example. The STOCI was sent to 273 interns nationally. Interviewing these interns and their clients to determine the interns' accuracy or sensitivity in assessing when CSA is a significant issue in their client cases would not have been economically feasible. Further, interviewing clients would be plagued with ethical concerns such as the maintenance of client confidentiality and other therapeutic concerns such as the possible negative impact of disrupting the client-therapist relationship or the sequencing of the therapeutic process. Reviewing case notes as an alternative to interviewing clients would pose its own problems. The expense and time that would be required to review a national sampling of case notes would be daunting. Even if clients consented to extend the confidential relationship of therapy to include this research, attaining all their records and signatures for informed consent could be a
nightmare. In addition, the question of how the client's consent would effect their therapy would still need to be addressed. Using written vignettes to assess interns' sensitivity to CSA in adult clients was eminently more "doable".

A second reason for using a vignette format was that it is preferable to other paper and pencil formats, such as multiple-choice knowledge questions, for two reasons. First, vignettes can be used to question respondents directly as to their suspicions, beliefs or opinions, and they could do so without revealing the test's intent. For example, STOCI respondents were asked to indicate what they "suspect" in response to the situation portrayed in the vignettes; however, never were the respondents made aware that the STOCI was being used to assess sensitivity to CSA specifically. Secondly, vignettes are also able to approximate behavior. Case in point, the STOCI tests the reactions of therapists to clinical situations. In contrast, multiple-choice knowledge questions about symptomatology of CSA, the family dynamics often associated with CSA, laws effecting the reporting of CSA, etc., would test respondents' ability to retain information about CSA.

A third reason for using a vignette format is that vignettes have already demonstrated their usefulness. Vignettes have been successfully used as test stimuli in mental health workers' competency testing (Smith, 1985). Vignettes have also been frequently used to explore the responses of therapists who work with CSA survivors in other areas of related research, such as management and intervention strategies, blaming practices, and clinicians' assessment of the impact of incest (Attias, &
Goodwin, 1985; Gomes-Schwarz, & Horowitz, 1984; Johnson, Owens, & Dewey, 1990; Sheehy, & Meiselman, 1981). Unfortunately, CSA was blatantly or openly discussed in the vignettes used in these studies. Therefore, the vignettes could not be adopted for use in the current research.

**Development of the STOCI**

The STOCI went through five phases in its development. The first phase involved the creation of the original vignettes and a list of possible responses. The second phase involved a prepilot of the STOCI. The third phase of development was an assessment of the STOCI's content and face validity, and readability by expert raters. The fourth phase consisted of a pilot test of the STOCI. The fifth phase was the development of a scoring system.

**Phase I**

The STOCI’s development began by writing a sample of three vignettes to be considered for possible use in the STOCI. Then several colleagues were consulted to evaluate these vignettes and to discuss the content and length of possible vignettes to be included in the STOCI. Possible ways to deal with internal reliability and variability were also discussed. Following these discussions, 10 vignettes were created based on the collective experiences and suggestions of the author and her colleagues. The goal
was to create five vignettes where CSA was suggested as an important issue and five vignettes where CSA was not suggested as an important issue.

Presenting concerns of five clients who had CSA in their histories were used to fabricate the five vignettes suggesting CSA. The intent was for these vignettes to suggest CSA as a significant issue in conceptualizing the vignettes. Therefore, key indicators of CSA (Elliott & Briere, 1992; Courtois 1988) from the client cases were included in the vignettes. In an attempt to avoid using issues presented by clients with possible false memories of CSA, only information from clients who reported external validation of CSA (i.e., the perpetrator went to jail, corroboration via another survivor, or perpetrator's admission of guilt) was used. It was hoped that this measure would improve the validity of the vignettes suggesting CSA. To protect the identity of the clients whose cases where adapted for the vignettes, identifying information was either omitted, changed, or borrowed from other cases. For example, an actual client with a history of CSA may have been a substance abuser. However, the type of substance (i.e., alcohol, cocaine, or food), or a combination of substances identified in the vignette may have been borrowed from another client who had a history of CSA. Therefore, while the vignettes portray actual client issues, no vignette is descriptive of any one client.

After the five vignettes suggesting CSA were written, five other vignettes were fabricated from cases where the clients did not present CSA as a part of their histories. In addition, these clients did not, anytime during their therapy, indicate a concern that
they may have been sexually abused. While actual presenting issues of five clients were used, identifying information was changed, omitted, or made up as explained previously. The clients in the vignettes may have presented one or two symptoms found in survivors of CSA such as depression or anxiety. However, lacking other strong indicators of CSA (Elliott & Briere, 1992; Courtois, 1988), these symptoms would not suggest CSA. Therefore, the vignettes created from this group of client cases were not expected to suggest CSA as an issue in their conceptualization.

Having created the vignettes for the STOCI, attention was turned to creating the vignette's response options. As explained earlier, having CSA embedded in a limited list of possible responses was important. However, the responses options were expected to be feasible responses and relevant to some vignettes. Therefore, it was desirable for each issue to be selected as a response to a vignette on the STOCI. To create the list, the author consulted with colleagues at different university counseling centers and reviewed university intake forms that chronicled presenting issues. Based on this information and clinical experience with issues for which clients frequently sought help, 12 issues were selected as response options. This list of 12 issues was placed at the end of each vignette with instructions. The instructions asked participants to circle the issues that they suspected were the most important in conceptualizing the case presented in the vignette.
Phase II: Prepilot of STOCI

At this juncture, a prepilot on the STOCI was done to determine if the vignettes could stimulate the responses desired. In other words, would be the vignettes designed to suggest CSA evoke a suspicion of CSA in respondents? Conversely, would the vignettes designed not to suggest CSA not evoke a suspicion of CSA? The prepilot was also run to see if each of the 12 issues listed as possible responses were appropriate, based on whether or not each issue was circled at some point on the STOCI. In addition to checking the STOCI's reliability and the appropriateness of possible response options, there were two other questions that the prepilot was expected to answer: (1) On the average, how long would it take respondents to complete the STOCI? and (2) Would the STOCI be able to detect differences in the responses of different groups of therapists?

With these questions in mind, a proposal to execute a prepilot of the STOCI was sent to the Human Subjects Institutional Review Board at Western Michigan University. The board approved the pre-pilot as submitted (see Appendix H). The following details the methods used in the pre-pilot. It begins with a description of the participants and their selection. A description of the data collection follows. Next the results are presented. Finally, there is a discussion of the results.

Participant Selection. There were two primary concerns in selecting the volunteers to participate in the prepilot. The first concern was that the volunteers are
sufficiently sophisticated with clinical issues that they would understand the question of suspecting issues that are important in conceptualizing a case. The second concern was to find a population isolated from future pilot and research populations. It was the intention of this researcher to run a pilot test of the STOCI at her home institution, Western Michigan University, and then to complete the data collection for this research using interning psychologists in 1995 - 96. Therefore, two associates at university counseling centers, Dr. Rebecca Black at Central Michigan University and Dr. Gail Hudson at the University of Houston were recruited to assist in contacting possible prepilot participants who would not be in the intended upcoming research pools. Black and Hudson each agreed to distribute 10 copies of the STOCI to colleagues and current 1994 - 95 doctoral level interns (not necessarily at their respective university).

Data Collection. Black and Hudson were each mailed a letter of instruction and 10 copies each of the prepilot version of the STOCI and the letter of informed consent. Two questions were added to the end of the prepilot STOCI. First, volunteers were asked to identify their gender to discern if the STOCI had the potential to detect differences between the genders in responding to the STOCI. Gender was used for this purpose because it would only divide the small research pool into two groups, and because the literature suggested that male and female therapists may respond differently to CSA (Adams & Betz, 1993; Courtois, 1988; Herman &
Hirschman, 1977). Second, to assess how much time was required to take the STOCI, volunteers were asked how long it took them to complete the instrument.

The letter of instructions for Black and Hudson included a script to use when approaching the prospective participants. The informed consent letter advised prospective participants of the purpose of the prepilot and asked for their voluntary participation. The informed consent letter also explained the anonymous nature of the prepilot and requested that those who chose to participate return their response in the uncoded envelopes provided. All responses were received via the uncoded envelopes provided with the STOCIs. No further contact with volunteers was attempted.

This data collection process was expected to provide the answers to the questions for which the prepilot was run. To recap, those questions were (a) Could the STOCI detect differences in the responses of different groups of therapists such as males and females? (b) Could the vignettes stimulate responses of suspected CSA and no CSA as intended? (c) How long would it take respondents to complete the STOCI? (d) Were each of the 12 issues listed as possible responses circled at some point on the STOCI?

Results. Due to the small sample size, the unequal numbers of men and women, and the considerable variation in the responses, a rigorous statistical analysis was not used on the prepilot data. However, data were obtained that addressed the above four questions.
In total, 17 of the STOCIs were returned. One participant returned a blank STOCI. Another participant did not indicate his or her gender. Thus, there was a usable return rate of 75%. On the usable STOCIs, nine respondents indicated they were female and six indicated they were male. The nine female respondents indicated that they suspected CSA a total of 20 times. The six males indicated that they suspected CSA a total of 10 times. Accordingly, females suspected CSA an average of 2.22 times. Males suspected CSA an average of 1.66 times.

The range in the number of times males suspected CSA was greater than that of females. Male respondents indicated a suspicion of CSA in the STOCI's vignettes between 0 and 4 times. The number of times female respondents indicated a suspicion of CSA range from 1 to 3. The returned STOCI that did not include the participant's gender, did not have CSA as a response to any of the vignettes.

One vignette supposed to suggest CSA was not identified by anyone as evoking a suspicion of CSA. All other vignettes designed to evoke a suspicion of CSA did so. In response to a vignette that was not supposed to suggest CSA, one person indicated that they suspected CSA as one of the most important issues in conceptualizing the case. The other four vignettes designed not to evoke a suspicion of CSA, did not evoke a suspicion in any of the participants.

The number of issues a single respondent circled in response to any one vignette varied from 1 to 8 issues. Fifty-six percent of the respondents circle six or
more issues in response to a vignette. All of the issues listed as possible responses were circled. In total, each issue was circled a minimum of 17 times.

The mean response time for completing the STOCI was just less than 21 minutes. One person took 10 minutes to complete the STOCI and another person took 50 minutes. However, most of the people required between 15 and 25 minutes to complete the STOCI.

Discussion. The results of the prepilot provided data on the prepilot research questions. First, the question of whether or not the STOCI could detect differences in the responses between different groups of therapists was addressed. The results seemed to suggest that the STOCI could probably detect differences. Despite the small sample size, a difference in responses was seen between the men and women who participated in the prepilot. As expected, the differences supported the literature in part. Women tended to suspect CSA about 50% more often than did the men, suggesting that women were more responsive to CSA in their clients than were men. Women also tended to be more consistent in the number of correct answers they made than did the men. In fact, women did not demonstrate a tendency to over identify CSA, as one may have suspected based on the literature (Herman & Hirschman, 1977; Saakvite, 1990). Men had a greater range to the number of times they responded correctly. The only respondent who never indicated a suspicion of CSA was a man. Likewise, a man was the only respondent to accurately suspect CSA four times. Based on these results it would be premature to conclude that the STOCI was
definitely capable of discerning differences between groups of therapists. However, the results were encouraging, suggesting that the STOCI would be useful in discerning differences between groups.

Secondly, the results of the prepilot answered whether or not the vignettes could stimulate the desired responses. Overall, the vignettes designed to suggest CSA did and the vignettes designed not to suggest CSA did not. There seemed to be only one vignette that was problematic. A vignette designed to suggest CSA, but failed to do so, needed to be changed to improve the STOCI's overall performance. Therefore, information regarding the client in this vignette was expanded. The expectation was that the added information would strengthen the suggestion of CSA in the vignette.

Third, the prepilot provided the information on how long it would take to complete the STOCI. Since most of the respondents completed the STOCI within 15 to 25 minutes, no changes were made in the length of the STOCI. A longer test may have produced more reliable information on respondents' accuracy and sensitivity to suspect the presence or absence of CSA in adult clients. However, the STOCI was being designed to be used with a questionnaire that gathered personal information on the respondents. A longer STOCI may have discouraged research volunteers from participating in the research for which it was designed.

The last research question regarded the appropriateness of the vignettes' response options. The prepilot's results showed that none of the response options were superfluous. All the issues listed as possible responses were used. Therefore, no
changes were made in the issues listed as response options. However, it was noted that respondents may not have been very discriminating in their responses. Some participants circled as many as 75% of the issues in response to one vignette. Circling so many issues may have reduced the STOCI's ability to discern differences in the sensitivity and accuracy of different groups of therapists assessing CSA. Therefore, changes in the directions were made before continuing to the third phase of the STOCI's development. Besides circling the issues suspected to be the most central in conceptualizing the cases presented in the vignettes, respondents were asked to indicate their three top choices with an asterisk when they circled more than three responses to any vignette. The changes in the instructions were included to see if reducing the number of choices a participant could make would significantly effect the number of times CSA was indicated as a suspicion by a respondent.

In summary, there were only two major changes made to the STOCI based on the prepilot results. Information was added to one of the vignettes and additional response directions were provided. Minor editing changes were made, but these changes did not change the meaning of the vignettes or directions on the STOCI. With these changes in place, the STOCI moved into its third phase of development.

Phase III: Expert Raters

The third phase of the STOCI's development was dedicated to further determining the STOCI's face validity and content validity for evaluating therapists'
suspicions of CSA. In other words, the object of the third phase was to evaluate how adequately the STOCI suggested CSA in the vignettes designed to do so, and how well the STOCI provided contrasting vignettes that did not suggest CSA as an issue. Further, it was hoped that additional information would be acquired that might improve the STOCI's readability. Therefore, as Moser and Kalton (1972) suggested in their book on survey methods, a panel of experts was established to judge the STOCI's validity and provide general feedback. The following sections describe the expert judges, the data collection process, the results, and closes with a discussion of the results.

Experts. Doctors Black, Hudson, and Starks were asked to judge the STOCI's validity. They were chosen to be judges for several reasons. First, the author was personally aware of their reputations within their professional communities. They all had extensive clinical experience treating adult survivors of CSA and they all held the high regard of their colleagues. Secondly, these experts were chosen because they represented three different groups of mental health clinicians: Dr. Black, counseling; Dr. Hudson, clinical social work and communications; and Dr. Starks, clinical psychology. It was expected that mental health professionals with different professional backgrounds and training would collectively provide a more diverse and comprehensive analysis of the STOCI. Lastly, the three judges did not know each other. Therefore, the expert judges could not bias each other's responses and would make their initial responses independent of each other.
Data Collection. Initially, this researcher contacted the three experts by telephone to request their assistance. With the experts' consent, they were each mailed the revised STOCI with instructions to assess the vignettes for their suggestion, or lack of suggestion of CSA, and then to mail their responses to the author. The experts were also encouraged to share any additional thoughts they had that might be useful for improving the STOCI's readability, validity, and variability of responses. After receiving their written responses, this researcher called each expert to discuss their feedback in full.

Results. All three experts mailed their assessment of the STOCI to the author. The expert raters were in 100% agreement regarding the STOCI's face validity and content validity. Each expert rater found CSA to be an issue or not an issue in each vignette as expected. Further, the experts agreed that the vignettes were diverse and representative of the female clients they would expect to encounter in a university counseling center. However, the experts made several suggestions or comments related to the readability, variability, and, or content of the STOCI. These comments can be generally divided into two groups, comments regarding the directions and comments regarding one vignette on the STOCI.

Dr. Black commented on the readability of the STOCI's directions. She said that it was difficult to assign an asterisk her three top choices. She explained that the difficulty was because her top choices would be dependent upon the model from which
she was required to work, i.e., long-term versus short-term. Her "suspicions" of the most important issues for conceptualizing the cases presented in the vignettes included underlying issues. Yet working from a short-term model, she felt compelled to asterisk the presenting issues before the underlying issues. In other words, Dr. Black explained, using a short-term model, presenting issues tended to be obvious, not suspected. Using a long-term model, she felt freer to speculate on the possible underlying or "hidden" issues that may be driving the presented concerns or complaints.

Dr. Black believed that the readability of the directions could be improved to eliminate this conflict. She suggested that either the word "suspect" be changed to "think" or "believe," or that "most important issues" be changed to "most central underlying issues." With the first suggestion, the question would read: "... circle the issues that you think (or believe) are the most important issues for conceptualizing..." With the second suggestion, the question would read "... circle the issues that you suspect would be the most central underlying issues for conceptualizing..."

Dr. Black also suggested contemplating another solution to deal with the ambiguity in the directions which was to consider omitting the instructions to asterisk the three top choices. This omission would free participants to circle as many issues as they needed regardless of the models from which they operated. However, she was concerned that this freedom might adversely effect the variability, and ultimately the reliability of the instrument. If respondents were allowed to circle as many issues as
they suspected, would respondents discriminate sufficiently to provide enough variation in responses for the STOCI to detect differences?

Fortunately, the prepilot had already suggested the number of issues one might expect a given respondent to circle. The high number of responses to the vignettes on the prepilot was discussed. Dr. Black concluded that the number of responses to each vignette on the pilot test could be contrasted with the number of responses to the corresponding vignettes on the prepilot to provide more information on the effects of the added directions. Further, she wondered if the ambiguity of the question might "tease out" differences in therapists' sensitivity to CSA better than a less ambiguous question. She suggested consulting another expert to get another opinion. Ultimately Dr. Black cautioned: When interpreting the results of a survey using the STOCI, one should address the possibilities that responses might, in part, reflect the therapeutic model from which the therapist works.

Following Dr. Black's suggestion, I discussed Dr. Black's concerns regarding the STOCI's directions with Dr. Hudson. Dr. Hudson agreed with Dr. Black that one needed to be cautious when considering the meaning of data collected with the STOCI. However, Dr. Hudson averred that one needed to be cautious about speculating on the meaning of any data. In concert with Dr. Black's comments about the STOCI's directions, Dr. Hudson believed that the instructions to asterisk the three top choices might provide useful information. Before any decisions were made to
change the instructions, she suggested that the results of the proposed pilot test should be considered.

Both Dr. Starks and Dr. Hudson commented on one vignette that was not supposed to suggest CSA. Dr. Starks said that although she would not suspect CSA from the information presented in this vignette, she would not be surprised if CSA surfaced later in therapy. When this observation was shared with Dr. Hudson, she agreed and asked if any of the volunteers participating in the STOCI's prepilot indicated that they had suspected CSA in the vignette. In fact, this particular vignette was circled by a prepilot participant indicating a suspicion of CSA. Dr. Hudson felt that this was a good indication that the STOCI could probably detect therapists that are overly suspicious of CSA in adult clients. Further, Dr. Hudson suggested that the low rate of CSA suspicion on the prepilot might be an accurate representation of therapists' tendency to under identify CSA in adult client cases. She believed that having identified a vignette on the STOCI that stimulated a false-positive suspicion of CSA lent credence to this assertion. In other words, if the STOCI was able to detect overly suspicious therapists and still the respondents overwhelmingly indicated a lack of suspicion to the vignettes, then it was likely that the STOCI accurately reflected a low rate of CSA suspicion in therapists.

Wondering if more false-positive responses would improve the STOCI, I asked Dr. Hudson if she thought that more of the non-CSA vignettes should be changed to stimulate a false-positive suspicion of CSA. Dr. Hudson said "no." She believed the
vignettes represented well the various types of client concerns encountered in a university counseling center. Fabricating unreal vignettes with the purpose of leading respondents to incorrectly suspect CSA would undermine the validity and integrity of the STOCI. A check with the other experts indicated that they were both in agreement with Dr. Hudson.

**Discussion.** As the experts were in total agreement that the STOCI suggested CSA in the vignettes intended to do so and not suggest CSA in the vignettes not intended to do so, the vignettes were not changed. Recommended grammatical changes were made without discussion. No changes were made in the directions on the experts' version of the STOCI. The reader may recall that on the pre pilot version of the STOCI, participants were instructed to circle the issues that they believed were most important to conceptualizing the cases presented in the vignettes. However, on the experts' version the directions were amended to include instructions for the participants to place asterisks by their three top choices when they circled more than three issues in response to a vignette. The experts recommended that the results of a pilot, using the experts' version of the STOCI, be compared with the prepilot results to examine the possible effects of the amended directions. Specifically, did the extended directions appeared to reduce the number of issues participants circled in response to the vignettes, thereby improving the variability of the responses? In addition, the responses on the pilot could be examined to determine if there was a significant difference in the STOCI's reliability based on the asterisked responses versus all the
responses each participant made to the vignettes. Hence, any possible changes to the extended directions were put on hold until a pilot test could be run and the results examined. It was also agreed that caution would be used in drawing any inference from responses due to concerns that participants' responses may be affected by idiosyncratic interpretations of the direction's wording.

Phase IV: Pilot Test of the STOCI

With the approval of the Human Subjects Institutional Review Board (see Appendix I), the STOCI was piloted in the department of Counselor Education and Counseling Psychology at Western Michigan University. There were four basic reasons for piloting the STOCI. The first reason was to see if respondents indicated a suspicion of CSA in response to the vignette changed to better elicit a suspicion of CSA. The reader may recall that on the prepilot version, phase II of the STOCI, one vignette intended to stimulate a response of suspected CSA did not do so. Therefore, information about the client in the vignette was added. The second reason was to see how participants responded to the changed directions: to examine the variability of responses based on all the items circled versus only the top three choices of respondents. The third reason for running a pilot of the STOCI was to check the STOCI's reliability. Finally, the pilot was run to collect data from a larger group of participants for use in the fifth phase of the STOCI's development, scoring the STOCI.
The remainder of Phase IV presents the methods and results of the STOCI's pilot. For ease of reading, the presentation will be formatted in much the same way as the previous section of the prepilot: participant selection, data collection, results, and discussion.

**Participant Selection.** Graduate level students in the department of Counselor Education and Counseling Psychology at Western Michigan University were asked to participate in the pilot test of the STOCI voluntarily. This population was chosen for the pilot test because of their accessibility. Additionally they would, at a minimum, have some graduate level training. This training was expected to have acquainted research participants with conceptualizing clinical cases, by that familiarizing prospective participants with the task required on the STOCI. To access this population the following steps were taken.

**Data Collection.** Initially, instructors and professors of graduate students in the department of Counselor Education and Counseling Psychology at Western Michigan University were contacted. They were asked for permission to approach their students during class time to ask for volunteers to participation in a pilot test of the STOCI. Instructors and professors were informed about the purpose of the pilot test and advised that the pilot test would require approximately 35 minutes of class time. Arrangements were made with instructors and professors who granted permission to run the pilot during class time. Then, letters were sent to the instructors
and professors confirming the time and place when data collection for the pilot was to take place.

At the agreed upon times, the STOCI was administered to the volunteers by either myself or another doctoral student from the department of Counselor Education and Counseling Psychology. Instructions from a script and the letter of informed consent designed for use in this pilot were read to students. Students were advised that their participation was strictly voluntary and that their participation, or lack of participation, would not affect their class grade. All responses were anonymous. The prepiilot instruction to indicate how much time it took to complete the STOCI were dropped because the time required was already established. The instruction for participants to indicate their gender was also dropped in the pilot version of the STOCI. This question was dropped to further insure participants' anonymity in small classes where there may have been only one male or one female student. Regardless of whether students chose to participate, all students were instructed to place their copy of the STOCI in the same box which was provided so that the students decisions regarding their participation could be anonymous.

When all the STOCIs were completed, the responses to the vignettes were scored as correct or incorrect. Responses were considered correct when the participant circled CSA in response to the vignettes intended to stimulate such a suspicion and when participants did not circle CSA in response to the vignettes not intended to stimulate a suspicion of CSA. The opposite was true for incorrect
answers. Responses were considered incorrect when participants did not circle CSA in response to the vignettes intended to stimulate a suspicion of CSA and when participants circled CSA in response to vignettes not intended to stimulate a suspicion of CSA. The correct and incorrect answers of each participant were then entered into a computer program using the Statistical Analysis System (1990).

Two sets of data were compiled. The first set was based on whether or not CSA was circled. This set was called the “full set.” The second set was based on the participant's top three choices. This set was called the "partial set." The frequency of correct and incorrect answers for each vignette and each participant was calculated on each data set. These frequencies were then used to compute internal consistency measures of reliability for the full set and partial set of data. Finally, the reliability coefficient of each set was compared to determine if there was a significant statistical difference between the reliability of the full set and the reliability of the partial set.

**Results.** In total, 57 STOCIs were distributed to students. Ten of the STOCIs were returned blank. This meant that 82.48%, or 47, of the 58 STOCIs were returned completed. The results from the 47 STOCIs are presented in the following order: frequencies, reliability tests of internal consistency, and the test of significance between the reliability scores of the full set and the partial set of data. Tables are included, when appropriate, to succinctly present data and supplement text.

Frequencies of responses were tabulated to identify how often each vignette attained the correct response and how often the vignette attained an incorrect
response. Table 2 contains the frequencies of correct and incorrect responses for each of the 10 vignettes for both the full set and partial set. The left side of the table lists the number of the vignettes on the STOCI. Immediately following the vignette number there is a set of parentheses. "CSA" is in the parentheses behind the vignettes intended to suggest CSA and "NO" is in the parentheses behind the vignettes intended not to suggest CSA. To the right of this is the total number of responses to the vignette followed by the frequency (n) and percentage of correct responses and the frequency (n) and percentage of incorrect responses.

Table 3 presents the frequencies of correct scores. A correct score is the total number of correct responses of a given participant. As indicated on Table 3, in the full set of data eight people responded correctly to five vignettes; whereas, only four people responded correctly to all ten vignettes.

Reliability coefficients were obtained from the SAS statistical program, using the Cronbach (1951) and the Kuder-Richardson 20 (1937). Only the responses to the vignettes suggesting CSA were used to calculate the reliability coefficients for the full set and the partial set. The reason is that the Cronbach and the Kuder-Richardson 20 (K-R20) are measures of internal consistency that calculate reliability from the variance, or difference in responses. As all the participants responded correctly to the vignettes intended not to suggest CSA, there was no variation in the responses to the non CSA vignettes, so they were not used to calculate the reliability coefficients.
Table 2
Frequency of Correct and Incorrect Answers to Vignettes

<table>
<thead>
<tr>
<th>Vignette</th>
<th>Total N</th>
<th>n</th>
<th>% Correct</th>
<th>n</th>
<th>% Incorrect</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Full Set:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 (CSA)</td>
<td>47</td>
<td>19</td>
<td>40.4</td>
<td>28</td>
<td>59.6</td>
</tr>
<tr>
<td>2 (NO)</td>
<td>47</td>
<td>47</td>
<td>100</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>3 (CSA)</td>
<td>47</td>
<td>15</td>
<td>31.9</td>
<td>32</td>
<td>68.1</td>
</tr>
<tr>
<td>4 (CSA)</td>
<td>47</td>
<td>23</td>
<td>48.9</td>
<td>27</td>
<td>57.4</td>
</tr>
<tr>
<td>5 (NO)</td>
<td>47</td>
<td>47</td>
<td>100</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>6 (NO)</td>
<td>47</td>
<td>47</td>
<td>100</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>7 (CSA)</td>
<td>47</td>
<td>12</td>
<td>25.5</td>
<td>35</td>
<td>74.5</td>
</tr>
<tr>
<td>8 (CSA)</td>
<td>47</td>
<td>22</td>
<td>46.8</td>
<td>25</td>
<td>53.2</td>
</tr>
<tr>
<td>9 (NO)</td>
<td>47</td>
<td>47</td>
<td>100</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>10 (NO)</td>
<td>47</td>
<td>47</td>
<td>100</td>
<td>0</td>
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<tr>
<td><strong>Partial Set:</strong></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
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<td>3.8</td>
</tr>
<tr>
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<td>47</td>
<td>100</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>3 (CSA)</td>
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<td>15</td>
<td>31.9</td>
<td>32</td>
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<tr>
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<td>47.4</td>
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<tr>
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<td>47</td>
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<td>0</td>
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<tr>
<td>6 (NO)</td>
<td>47</td>
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<td>0</td>
<td>0</td>
</tr>
<tr>
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<td>11</td>
<td>23.4</td>
<td>36</td>
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<td>0</td>
</tr>
<tr>
<td>10 (NO)</td>
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<td>47</td>
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</table>
Table 3
Frequency of Scores

<table>
<thead>
<tr>
<th>Correct Score</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Set:</td>
<td></td>
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<tr>
<td>5</td>
<td>8</td>
<td>17.0</td>
</tr>
<tr>
<td>6</td>
<td>14</td>
<td>29.8</td>
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<td>21.3</td>
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<td>14.9</td>
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<td>8.5</td>
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<tr>
<td>10</td>
<td>4</td>
<td>8.5</td>
</tr>
<tr>
<td>Partial Set:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
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<td>19.1</td>
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<td>10</td>
<td>4</td>
<td>8.5</td>
</tr>
</tbody>
</table>

Tables 4 and 5 presents the Cronbach Coefficient Alpha for the five vignettes suggesting CSA and the contribution of each vignette to the reliability for the full partial sets respectively. The table indicates how well each vignette correlated with the total score and what the alpha level would have been if a particular CSA vignette was eliminated from the analysis. As demonstrated in Tables 4 and 5, the fourth CSA vignette was the vignette that contributed the most to the reliability of the STOCI in both the full set and the partial set. The first CSA vignette contributed the least.
The K-R20 provided a reliability coefficient of .62066 for the five vignettes intended to suggest CSA in the full set and a reliability coefficient of .59255 for the partial-set.

The K-R20 coefficients for the full-set and the partial-set were compared using the Fisher Z Transformation (in Hays, 1989) to determine if there was a significant statistical difference between the two reliability scores. With an alpha level of .05, there was no statistically significant difference between the full set and the partial set, $Z (R_1 = .62066, R_2 = .59255) = .20868, p = .8347$.

Table 4
Cronbach Reliability Coefficients for Full Set

<table>
<thead>
<tr>
<th>Vignette</th>
<th>Correlation with Total</th>
<th>Alpha if Vignette is Deleted</th>
</tr>
</thead>
<tbody>
<tr>
<td>CSA 1</td>
<td>.162624</td>
<td>.660236</td>
</tr>
<tr>
<td>CSA 2</td>
<td>.399544</td>
<td>.544529</td>
</tr>
<tr>
<td>CSA 3</td>
<td>.292097</td>
<td>.599174</td>
</tr>
<tr>
<td>CSA 4</td>
<td>.561836</td>
<td>.454775</td>
</tr>
<tr>
<td>CSA 5</td>
<td>.459345</td>
<td>.512489</td>
</tr>
</tbody>
</table>

Discussion. The reader will recall that one reason for this pilot test was to see how participants responded to a vignette changed to include more information about the client in the vignette. In fact, the vignette in question was number eight (see Table 2). On the prepilot, no one indicated a suspicion of CSA in response to this vignette.
However, with the added information to the vignette on the pilot version, 46.8% of the respondents indicated a suspicion of CSA in vignette eight. Therefore, it seems that the added information improved the vignette and the dependability of the STOCI to evoke a suspicion of CSA when appropriate.

Table 5
Cronbach Reliability Coefficients for Partial Set

<table>
<thead>
<tr>
<th>Vignette</th>
<th>Correlation with Total</th>
<th>Alpha if Vignette is Deleted</th>
</tr>
</thead>
<tbody>
<tr>
<td>CSA 1</td>
<td>.204864</td>
<td>.605679</td>
</tr>
<tr>
<td>CSA 2</td>
<td>.343130</td>
<td>.533351</td>
</tr>
<tr>
<td>CSA 3</td>
<td>.236040</td>
<td>.589938</td>
</tr>
<tr>
<td>CSA 4</td>
<td>.556986</td>
<td>.408088</td>
</tr>
<tr>
<td>CSA 5</td>
<td>.406207</td>
<td>.497573</td>
</tr>
</tbody>
</table>

One other reason for piloting the STOCI dealt with the changes made in the directions to respondents. On the STOCI's prepilot, 56% of the respondents circled six or more issues in response to some vignettes. Some participants circled as many as 75% of the possible responses to a vignette. With participants circling so many issues, there was a concern that the STOCI could not discern differences in the sensitivity of therapists in detecting CSA. Therefore, the directions were expanded to request participants to asterisk their three top choices when they circled more than three issues in response to a vignette. With the added directions, the participants tended to circle
fewer issues in response to vignettes. In contrast to the prepilot, only 20% of the respondents circled six or more issues to any vignette on the pilot version of the STOCI. So, it appeared that participants were more selective in their responses that ultimately may have improved the STOCI's discriminative ability. Yet, the changes in the directions led to a question of how the directions might affect the STOCI's reliability. Before actually examining this question, learning the general reliability of the STOCI was necessary. In fact, deciding if the STOCI demonstrated enough reliability to warrant its use as a research instrument in the second tier of this study was an important reason for conducting the current pilot study.

To examine the STOCI's reliability two statistical analyses of internal consistency was done, the Cronbach Alpha and the K-R20. Cronbach's alpha is one of the more often used and well-recognized general tests of internal consistency (F. Famoye, personal communications, October 26, 1995) and is frequently discussed in general texts on behavioral research and test construction for the social sciences (Kaplan & Saccuzzo, 1989; Kerlinger, 1986). Besides providing a reliability coefficient for the total test, the Cronbach provides specific data on the contribution of each vignette to the total reliability of the STOCI (Tables 4 and 5). In contrast, the K-R20 is a test of internal consistency specifically designed to calculate the reliability of tests in which the items are scored correct or incorrect. It simultaneously considers all the possible ways the responses on each vignette correlate with the other vignettes and the total number of correct answers to provide one reliability coefficient for the whole
test. Generally speaking with internal consistency measures of reliability, a coefficient alpha of .70 to .80 is considered sufficient for most purposes in basic research (Kaplan and Saccuzzo, 1989, p. 110).

The coefficient alphas obtained on the results of the pilot were lower, Cronbach (Full set = .614780, Partial set = .587836) and K-R20 (Full set = .62066, Partial set = .59255). However, these general reliability coefficients estimate the lowest level of reliability anticipated. As Kaplan and Saccuzzo (1989) pointed out in their text, it is possible for the actual reliability to be higher. In addition, by the nature of the mathematical processes used to analyze internal consistency, the reliability coefficient tends to increase as the number of participants increases and the number of items on the test increases. The reader may recall that only five items (the vignettes to which there was variation in responses) was used in the analyses. As explained earlier, it was decided not to increase the number of vignettes on the STOCI. However, it was expected that there would be many more people participating in the second tier of this research than there were in the pilot study. Therefore, it was reasonable to expect that the STOCI would demonstrate a higher reliability in the second tier of this research than it did on the pilot. Consultation with two statisticians, Doctors Lee and Famoye, supported this assumption. Consequently, it was decided that the STOCI demonstrated sufficient reliability for use in the proposed research on the association of therapist characteristics and therapists sensitivity to CSA.
Returning to the question of how the changes in the directions might affect the STOCI's reliability, the reader is directed to the results of the Fisher Z Transformation. Not to be confused with Z scores, the Fisher Z was the linear regression model used to compare the reliability of the full data set and the reliability of the partial data set. The results indicated that there was not a significant statistical difference between the reliability of the two sets of data. In other words, for all practical purposes, scoring the results of the STOCI using all the responses provided information that was as reliable as using only the participants' top three responses to each vignette. Therefore, it appears that the added directions may have encouraged participants to reduce the total number of issues they circled in response to the vignettes. However, the change in directions did not appear to affect the reliability of the STOCI.

The final reason for running the pilot test on the STOCI was to collect responses from a large enough group of participants to experiment with a scoring system for the STOCI. This objective was met and a method of scoring the STOCI was developed. The resulting method of scoring the STOCI is explained in full detail in the next section.

Phase V: Scoring the STOCI

Reviewing the pilot study's results, two different types of scores, Correct Score and Directional Score, were created. The Correct Score was created to identify the total number of correct responses made by a participant. To identify the type of error
which respondents made, Directional Scores were created. The Directional Score indicates the direction in which a respondent tends to error. In other words, does the respondent more often tend to see CSA where it was not suggested (a positive direction), or does (s)he tend more often to miss CSA when it is suggested in a vignette (a negative direction)? As such, a Directional Score is the total number of times a participant has suspected CSA in vignettes where it was not suggested minus the number of times the participant did not suspect CSA in vignettes where it was suggested (Table 6). Directional Scores are expressed as 0 (no error), or ±1 through ±5 errors. Negative scores indicate a preponderance of errors in which participants tend to miss CSA in vignettes designed to suggest CSA. Positive scores indicate a preponderance of errors in which participants tend to suspect CSA in vignettes that were not intended to suggest CSA.

Directional Scores always have a corresponding Correct Score. Correct scores are a measure of ability. Correct Scores in combination with Directional Scores is a measure of sensitivity. As explained in Chapter I, ability and sensitivity are separate but interrelated constructs. "Ability" is a static measure of how accurately one is in his or her suspicion of CSA in adult client cases. As such ability is a discrete, right or wrong measurement. "Sensitivity" is a multidimensional measure of CSA suspicion. Sensitivity takes into account, not only whether or not there is an error, but also the type of errors therapists make in their suspicions about the presence or absence of CSA. That is, sensitivity reflects therapists’ tendency to suspect CSA when it is or is
not part of a client's history as well as the tendency to not to suspect CSA when it is and is not part of a client's history.

A therapist who is overly sensitive to CSA, hypersensitive, will have a tendency to identify CSA as a central issue in conceptualizing adult client cases even when the clients have no history of CSA. A therapist who is under sensitive to CSA, hyposensitive, will have a tendency not to identify CSA in conceptualizing adult client cases, even when the clients have issues that relate to being a survivor of CSA. In contrast to therapists who are hyper or hyposensitive, therapists who have an appropriate amount of sensitivity will tend to identify CSA in adult client cases correctly. As used in this research, the type and degree of sensitivity a therapist has toward CSA is comparative and identifies the tendency of the therapist to respond in a particular way. Hence, ability is a measure of how often a participant correctly assesses CSA in the vignettes on the STOCI. Sensitivity, on the other hand, is a relative type and degree of response as measured by combining Directional Scores and Correct Scores.

Using Correct Scores between 9 and 6, Table 6 presents an example of the connection between Correct Scores and Directional Scores. If a participant inaccurately suspects CSA in three vignettes, but does not suspect CSA in a vignette where (s)he should have, (s)he would have made a total of four errors. In this situation the participant would have attained +2 Directional Score and a Correct Score of 6. However, if the participant had received a Correct Score of 6 and only made
Table 6

Correct Scores With Corresponding Directional Scores

<table>
<thead>
<tr>
<th>Correct Score</th>
<th>Vignette Group Indicating CSA</th>
<th>Vignette Group NOT Indicating CSA</th>
<th>Directional Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>no errors</td>
<td>one error</td>
<td>+1</td>
</tr>
<tr>
<td>9</td>
<td>one error</td>
<td>no errors</td>
<td>-1</td>
</tr>
<tr>
<td>8</td>
<td>no errors</td>
<td>two errors</td>
<td>+2</td>
</tr>
<tr>
<td>8</td>
<td>two errors</td>
<td>no errors</td>
<td>-2</td>
</tr>
<tr>
<td>8</td>
<td>one error</td>
<td>one error</td>
<td>0</td>
</tr>
<tr>
<td>7</td>
<td>no errors</td>
<td>three errors</td>
<td>+3</td>
</tr>
<tr>
<td>7</td>
<td>one error</td>
<td>two error</td>
<td>+1</td>
</tr>
<tr>
<td>7</td>
<td>two errors</td>
<td>one error</td>
<td>-1</td>
</tr>
<tr>
<td>7</td>
<td>three errors</td>
<td>no errors</td>
<td>-3</td>
</tr>
<tr>
<td>6</td>
<td>no errors</td>
<td>four errors</td>
<td>+4</td>
</tr>
<tr>
<td>6</td>
<td>one error</td>
<td>three errors</td>
<td>+2</td>
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<tr>
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<td>two errors</td>
<td>two errors</td>
<td>0</td>
</tr>
<tr>
<td>6</td>
<td>three errors</td>
<td>one error</td>
<td>-2</td>
</tr>
<tr>
<td>6</td>
<td>four errors</td>
<td>no errors</td>
<td>-4</td>
</tr>
</tbody>
</table>

mistakes of suspecting CSA in vignettes where CSA was not indicated, (s)he would have a Directional Score of +4. The lower the Correct Score the more variation there can be in the possible corresponding Directional Score. Scored thus, participants' scores can be used to identify participants' relative type of sensitivity to CSA in adult clients.
Figure 1 depicts the three vectors of sensitivity displaying the relative position of the three types of sensitivity to CSA, Appropriate, Hyper, and Hypo. For example, when a participant has a high Correct Score, it can be said that the participant tends to have appropriate sensitivity to CSA in adult clients as demonstrated by his or her ability to assess CSA in adult clients’ cases correctly. However, if a participant has a low Correct Score, (s)he can have either a positive or negative Directional Score. If a participant with a low Correct Score has a positive Directional Score, it can be said that the participant tends to be hypersensitive to CSA in adult clients. If, on the other hand, a participant has a low Correct Score and a negative Directional Score, it can be said that the participant tends to be hyposensitive.

Note that in Figure 1, the most appropriately sensitive participants in the pilot of the STOCI had a Correct Score of 10 and a Directional score of 0. The most hyposensitive participants had a Correct Score of 5 and a Directional Score of -5 and none of the participants in the pilot were hypersensitive.

Summary of STOCI’s Development

In total, the STOCl went through five developmental phases. The STOCI was written in the first phase. In the second phase, a prepilot version of the STOCI was administered to 20 mental health clinicians for a general check of the STOCI’s variability, readability, and reliability, and to check the length of time required to complete the STOCI. The results of the prepilot suggested that changes needed to be
made in one vignette to increase its ability to suggest CSA expected to increase the reliability of the STOCI. Therefore, more client information was added to the vignette. Minor editing changes were made to improve readability, and the length of time required to complete the STOCI was deemed acceptable at an average of 21 minutes.

**Correct Scores**

<table>
<thead>
<tr>
<th>10</th>
<th>9</th>
<th>8</th>
<th>7</th>
<th>6</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>0</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>HypoSensitive</td>
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<td></td>
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</tr>
<tr>
<td></td>
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<td>*10</td>
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<td></td>
<td></td>
<td>*8</td>
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<td></td>
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<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

* Number of participants with that particular score in the full data set of the STOCI's pilot.

Figure 1. Sensitivity of Pilot Participants.
In the third phase of development, the STOCI was examined by expert raters. Experts were in 100% agreement that the five vignettes designed to suggest CSA as an important issue did so, and that the five vignettes designed not to suggest CSA as an important issue did not. Further, the experts agreed that the 10 vignettes of the STOCI represented the different types of client issues that the experts would expect to see in a college or university counseling center.

In the fourth phase of development, a pilot test was run on the STOCI to examine the effects of the changes made to the prepilot directions and one prepilot vignette. With the change in directions, there was a reduction in the number of issues the participants circled in response to the vignettes. This reduction was believed to indicate more discriminating responses by the participants that, in turn, improved the STOCI's discriminative ability. The results of the pilot also showed that the information added to the vignette strengthened the vignette's suggestion of CSA as an important issue in conceptualizing the case presented, by that improving the STOCI's reliability.

Reliability studies were conducted on the pilot data. These results suggested that further research using the STOCI may provide valuable information. In addition, the reliability studies indicated that there was not a significant difference in the STOCI's reliability based on the results obtained using only the top three choices participants circled in responses to each vignette versus all the issues participants chose to circle in response to the vignettes. Consequently, no changes were made in
the pilot version of the STOCI for use in the second tier of this research. In the meantime, the results of the pilot were used to develop a scoring system for the STOCI which became the fifth and final phase of the STOCI's development.

In all, the STOCI was checked for its readability, reliability, and validity and was found acceptable for the pioneering research for which it was created. Therefore, it was decided to use the STOCI in the second tier of this research on the association of five therapist characteristics with therapists' sensitivity to CSA.

Second Tier of Methods

Having completed the development of the STOCI, discussion of the methods moves to the second tier. In this tier, the focus is on the current research design which is meant to explore the possible relationship between interns' suspicion of the presence or absence of CSA in adult client cases and five therapist characteristics. This research involved a national survey of doctoral level interns who were mailed two instruments, the STOCI and the Therapist's Data Sheet. The following details the methods employed in the second tier of this study. It will begin with a description of the independent and dependent variables and a description of the Therapist's Data Sheet: To complete the discussion on the methods, the following sections are presented in order: participant selection, data collection, and hypotheses and statistical procedures.
Independent and Dependent Variables

The independent variables of this study are dichotomous variables identified on the Therapist's Data Sheet (see Appendix A). They include five therapist characteristics: (1) male or female; (2) personal therapy or no personal therapy; (3) does or does not have professional experience providing therapy to three or more clients who were survivors of CSA; (4) aware or not aware of a close friend, family member, or significant other who is a survivor of CSA; (5) and a survivor or not a survivor of CSA.

The dependent variable measures for the current research are the scores that participants obtained on the STOCI. The reader is referred to Phase V of the STOCI's development in the First Tier of the Methods for a complete description on how to obtain Correct Scores and Directional Scores. The responses on the STOCI's pilot-test suggested that respondents are not likely to make errors of suspecting CSA in the vignettes designed not to suggest CSA. In this situation there is only one direction in the responses of participants and for all practical purposes, Correct Scores and Directional Scores become synonymous STOCI scores. As it is expected that interns will be similar to pilot participants in the way they respond on the STOCI, the dependent variables will be STOCI scores.
Therapist's Data Sheet

As mentioned earlier, the Therapist's Data Sheet provides data on the independent variables used in the study (see Appendix B). The data sheet was kept purposefully short for efficiency and to maximize participation. To obtain descriptive information regarding this research, participants were asked for demographic and professional information including their gender; race, age, degree program, and specific training in clinical specialty areas. In addition, the data sheet included questions specific to the five therapist characteristics explored in the present study. Participants were asked to indicate whether they (a) had received counseling or therapy for psychological or interpersonal issues; (b) had professional experience with three or more survivors of CSA; (c) had a close friend, relative or significant other who was a survivor of CSA; and (d) had personally experienced CSA. To prevent participants from singling out CSA as a focus of this study (which might have affected the participants' responses) the same precautions were taken on the data sheet as were taken on the STOCI. The questions regarding the participants' experiences with CSA were embedded in the list of 12 clinical issues that was used on the STOCI (e.g., alcohol/drug abuse, depression, emotional/physical abuse, etc.). The clinical issues were listed on the Therapist's Data Sheet below the heading "Problem Areas." To the right of this list were three columns of lines with the headings: Professional Experience with Three or More Clients; a Close Friend, Family Member, or Significant-other, and
Personally Experienced. The participants were instructed to check all the ways in which they had experienced each of the possible problem areas (see Appendix B).

Participant Selection

The people participating in this research were volunteers from doctoral internships in psychology at university counseling centers in the United States and Canada. Specifically, participants were from sites represented by the membership of the 1993 Association of Counseling Center Training Agents (ACCTA) and listed in the Association of Psychology Postdoctoral and Internship Centers' directory (APPIC, 1993-94). This cross-referenced group of sites provided a total of 74 doctoral level internship sites for psychologists and offered a possible research pool of 273 interns.

These interns were deemed appropriate for the present research for several reasons. First, no research was found that addressed if, or in what way, a therapist's gender, personal therapy, personal experience with CSA, and the interaction of these characteristics influenced a therapist's suspicion of childhood sexual abuse when working with adult clients. Using doctoral level psychology interns provided a limited and relatively homogeneous group of mental health professionals. This homogeneity was expected to help reduce the number of nuisance variables that could mask or override the effects of the therapist characteristics being studied. However, the most important reason for using these interns was that their training was current and
because they would be future psychologists who were doctoral level educators, supervisors, consultants, and clinicians in North America.

ACCTA's interns were chosen for the research population because they represented a geographically diverse population of doctoral level therapists. Cross-referencing the list with sites found in APPIC reduced the number of sites in the research pool, thereby improving the manageability of this research. Cross-referencing the list with sites found in the APPIC also improved the possibility of interns being doctoral level psychology as opposed to other professionally trained therapists such as counselors and clinical social workers. Additionally, APPIC identified the number of doctoral level interning psychologists at each ACCTA site.

Data Collection

Before any data collection, a proposal to conduct the following research was submitted to the Human Subjects Institutional Review Board at Western Michigan University. With the Board's approval (see Appendix J), the following data collection was undertaken to study the association of five therapist characteristics with therapists' suspicion of CSA in adult clients.

Training directors who were listed as members of ACCTA in 1993 whose respective sites were listed in APPIC were mailed a letter of introduction from an ACCTA member, Ken Waldman, Ph.D. (see Appendix C) with a cover letter (see Appendix D) containing basic information on this study and a request for the training
directors' assistance in distributing research packets to interns. Included with this material was a sticker saying "I support dissertation research" and a research packet for each internship position at the site. The 1993-94 APPIC was used to identify the number of internship positions and to determine the number of research packets needed for each site.

Each research packet to be distributed to interns contained a letter soliciting the interns' participation and a statement providing information about the study. The statement explained what the participation involved (see Appendix E). The packet also included the STOCI (see Appendix A), the Therapist's Data Sheet (see Appendix B), a stamped return envelope, and a sticker saying "I support dissertation research."

All participants were informed that completing and returning the research packet indicated their consent to participate in the current study. Interns who did not want to participate in this study were asked to return their blank copies of the survey.

Each packet and its contents were numbered according to the site's zip code number. The number identified the location of the site. The research numbers provided a means of tracking return rates. When the surveys (completed or blank) were returned to the researcher and before examining the data, the research numbers were cut off and kept separate for the tracking of response rates and follow-up mailings. Thus, the data was anonymous. None of the responses could be tied to a particular individual or site. Later, using the tracking numbers, the number of returned surveys was compared with the number of interns listed at each site. If the number of
returned surveys did not correspond to the number of intern positions for each site, the respective site's training director was sent a follow-up letter (see Appendix F) with additional research packets and follow up letters for interns (see Appendix G). This material was mailed approximately one month after the original request for participation.

The letter to the training directors reminded the directors of this study and the need for a timely response from the prospective participants. The training director's letter also requested the training director to distribute the accompanying intern letters to each of their interns and to put the additional research packets in a central location so that any intern who had misplaced his or her original packet could pick up a second packet anonymously. The intern letter reminded interns of the request for their participation, encouraged a timely response, and informed the interns of the available research packets.

**Hypotheses and Statistical Procedures**

As mentioned previously, based on the pilot results, it was expected that participants would only make errors in the direction of missing CSA in the STOCI vignettes designed to suggest CSA. That is, participants were not expected to suspect CSA in the vignettes designed not to suggest CSA. Responses were expected to be scored as continuous STOCI scores from hyposensitivity to appropriate-sensitivity. The higher the participants' STOCI scores (from 5 to 10), the better they would be at
correctly suspecting the presence of CSA and the more appropriate they would be in their sensitivity to CSA. The lower the participant’s STOCI score, the more hyposensitive they are to CSA and the poorer they are at correctly suspecting the presence of CSA. The following hypotheses and statistical procedures are written with the expectation that participants will score on a continuum from hyposensitivity to appropriate-sensitivity.

This descriptive study was conducted to investigate the possible relationship between five therapist characteristics and therapists' suspicion of the presence or absence of CSA in adult client cases. It was hypothesized that a therapist's gender and experiences would affect his or her ability and sensitivity in suspecting when CSA is an important clinical issue in adult client cases. In other word, the STOCI scores of participants would vary across participants' gender and experience. The particular experiences included (a) whether or not therapists had received counseling or therapy for psychological or interpersonal issues; (b) whether or not therapists have had professional experience with three or more survivors of CSA; (c) whether or not therapists have had a close friend, family member, or significant other who was a survivor of CSA; and (d) whether or not therapists are a survivor of CSA (i.e., personally experienced CSA).

To facilitate this investigation an analyses of variance (ANOVA) were used to examine the statistical significance of the relationship of each therapist characteristic to the STOCI scores. With an interest in the possible interaction effects of the therapist
characteristics and assuming that the STOCI scores will be continuous scores (from hyposensitivity to appropriate-sensitivity), the ANOVA was deemed appropriate for this study. The ANOVA, as opposed to at T-tests, would provide statistical continuity across the test concerning therapist characteristics and allow for an analysis of interaction effects between therapist characteristics. The following discussion details the specific questions addressed by this research and their accompanying null hypotheses. The section closes by describing the processes used to check the STOCI's reliability.

The first characteristic investigated was gender as it related to the ability and sensitivity of therapists to suspect the presence or absence of CSA in the adult clients cases depicted on the STOCI. This characteristic was studied because the literature suggested that male and female therapists may react differently to CSA issues, females tending to identify with survivors, males tending to deny CSA. This difference may affect therapists' suspicions about CSA in adult clients. Therefore, the basic question that this research sought to answer was, whether there is a significant difference between males and females in their sensitivity to possible CSA in adult client cases. That is, are there statistically significant differences between the STOCI scores of male and female therapists?

To address this question, the frequency and distribution of the STOCI scores of male and female participants were tabulated and noted for comparison to test the
null hypothesis: There will be no statistically significant difference between the STOCI scores of female versus male participants.

It was anticipated that the null hypothesis would be rejected. In keeping with the pilot results (which did not indicate any hyper sensitive respondents) and the literature (which suggests that males may tend to deny CSA), it was anticipated that females would be significantly more appropriate in their suspicions than males who would tend to be more hyposensitive.

The second characteristic investigated was the possible relationship between therapists' STOCI scores and whether or not therapists had undergone counseling or therapy for psychological or interpersonal issues. It was reasoned that therapy would enhance therapists' self-knowledge and ability to identify their own issues, thereby affecting therapists' suspicions of the presence or absence of CSA in adult client cases. Therefore, this researcher wondered: Is there a statistically significant difference between the STOCI scores of therapists who have had counseling or therapy and those who have not?

To address this questions, the frequency and distribution of the STOCI scores of participants who had therapy along with the scores of participants who had not had therapy were analyzed to test the null hypothesis: There will be no statistically significant difference in the STOCI scores of the participants who have had therapy versus the participants who have not had therapy.
Assuming therapy does positively affect therapists’ sensitivity and ability to suspect the presence or absence of CSA, it was anticipated that the null hypothesis would be rejected.

The third therapist characteristic investigated was the possible relationship between whether or not therapists had professional experience with three or more clients who were survivors of CSA and the therapists’ STOCI scores. It was expected that therapists’ suspicions regarding CSA in adult client cases would be more accurate if therapists had some experience working with CSA survivors than if they were inexperienced with this group of clients. Therefore, this researcher investigated whether there was a significant difference in the suspicions of therapists regarding the presence or absence of CSA in adult client cases, in relation to whether or not the therapists had professional experience with three or more survivors of CSA. In other words, was there a statistically significant difference in the STOCI scores of participants who had professional experience with three or more clients and participants who did not?

To address this question, the STOCI scores of participants who did or did not have professional experience with three or more clients were analyses to test the null hypothesis: There will be no statistically significant difference in the STOCI scores of the participants who have had professional experience with three or more survivors of CSA and the STOCI scores of participants who have not had professional experience with three or more survivors of CSA.
As professional experience is expected to improve therapists’ sensitivity and ability in suspecting the presence or absence of CSA, it was anticipated that the null hypothesis would be rejected.

The fourth therapist characteristic explored in this research was the relationship between therapists having or not having a close friend, family member, or significant other who was a survivor of CSA and therapists’ STOCI scores. This researcher speculated that having such a relationship with a survivor could heighten one’s awareness of CSA, while providing some personal distance from the emotional impact of CSA. From this perspective, therapists who have a relationship with a survivor may be better able to suspect the presence or absence of CSA in adult client cases. Therefore, this researcher asked, is there a statistically significant difference between the STOCI scores of therapists who do or do not have a close friend, family member, or significant other who is a survivor of CSA?

To address this question, the frequency and distribution of the STOCI scores of participants who did and did not have a close friend, family member, or significant other who was a survivor of CSA were analyzed to test the null hypothesis: There will be no statistically significant difference in the STOCI scores of the participants who have a close friend, family member, or significant other who is a survivor of CSA and the participants who do not.
It is anticipated that a therapist who had a close friend, family member, or significant other would score higher on the STOCI than those therapists who did not. Therefore, it is anticipated that the null hypothesis will be rejected.

The fifth therapist characteristic that this study explores in relationship to therapists' sensitivity and ability to suspect the presence or absence of CSA in adult client cases is whether or not therapists are themselves survivors of CSA. One may think that being a survivor of CSA would make a therapist hypersensitive to CSA in adult clients. However, the results of the pilot-test did not detect any hypersensitive in its participants. Therefore, this researcher wonders if being a survivor of CSA would improve a therapist's ability to correctly suspect CSA? That is to say, would there be a statistically significant difference between the STOCI scores of therapists who are CSA survivors and therapists who are not?

To address this questions, the STOCI scores of participants who reported being survivors of CSA and participants who did not report being survivors of CSA were analyzed to test the null hypothesis: There will be no statistically significant difference in the STOCI scores of the participants who are survivors of CSA and the STOCI scores of participants who are not survivors of CSA.

As mentioned previously, it is expected that survivors will score higher on the STOCI than participants who are not survivors. Therefore, the null hypothesis is expected to be rejected.
A second level of questions was developed to address the possibility of the therapist characteristics interacting with each other and affecting therapists' sensitivity and ability to suspect the presence or absence of CSA in adult client cases. It was anticipated that, all things being equal, therapists' gender would be the most significant predictor of differences in therapists' ability and sensitivity. However, this researcher suspected that professional experience working with survivors of CSA would reduce the gender differences in therapists' sensitivity to CSA. This suspicion led to the development of a research question: Is there a statistically significant interaction between gender and professional experience with CSA in relationship to STOCI scores?

A null hypothesis was extrapolated from this question. There will be no statistically significant interaction between therapists' gender and professional experience as these variables relate to STOCI scores.

The statistical procedure selected to test this null hypothesis was a two-factor ANOVA. This test evaluated the mean differences between the STOCI scores of males versus females, professional experience versus no professional experience, and the interaction of professional experience by gender on STOCI scores. As mentioned previously, it was expected that there would be interaction between gender and professional experience. Therefore, it is expected that the null hypothesis will be rejected.
Similarly, this researcher wondered if there was an interaction between therapists' gender and whether or not therapists were survivors of CSA. For example, if males tend to be less accurate than females in their suspicions about CSA, and if males tend to use denial to cope with CSA as some feminist therapists suspect (Herman & Hirschman, 1981), would male survivors be significantly less able to suspect the presence of CSA when it was an issue in an adult client case than females or males who were not survivors? Put in more operational terms: Is there a statistically significant difference in the STOCI scores of males and females who are and are not survivors of CSA? This question leads to the null hypothesis: There will be no statistically significant interaction between therapists' gender and CSA survivors status as these variables relate to STOCI scores.

The statistical procedure selected to test this null hypothesis was also a two-factor ANOVA. This test evaluated the mean differences in STOCI scores of male versus female, and being a survivor of CSA versus not being a survivor of CSA, and the interaction of CSA survivorship by gender on STOCI scores. While there may be some supposition that there could be interaction between therapists' gender and being or not being a survivor, there is no empirical evidence to support this possibility. Therefore, no prediction was made as to whether the null hypothesis would be accepted or rejected.

The third interaction that this research explored was gender by close friend, family member or significant other who was a CSA survivor. There was no literature
found that addressed any aspect of therapists having had a personal relationship with a survivor and it was very unclear whether there would be a significant interaction between gender and having a close relationship with a survivor of CSA. Consequently, this researcher wondered if there would be a statistically significant difference in the STOCI scores of male and female participants in conjunction with whether or not they did or did not have a close friend, family member, or significant other who was a CSA survivor? This question lead to the following null hypothesis. There will be no statistically significant interaction between therapists' gender and having a close friend, family member, or significant other who is a CSA survivor, as these variables relate to STOCI scores.

A two-factor ANOVA was run on the participants' STOCI scores to test the interaction effects of participants' gender and whether or not participants had a close friend, family member, or significant other who was a CSA survivor. It was reasoned that having a close friend, family member, or close friend who was a survivor would improve male and female participants' ability to correctly suspect the present or absence of CSA. Therefore, it is anticipated that the null hypothesis will be rejected.

The Statistical Analyses System (1990) was selected to compute the analyses. A conventional alpha level of .05 (Isaac & Michael, 1989) was selected as the level of significance.

Additional statistical analyses were performed to check the STOCI's reliability and to compare the participants' scores based on all of their responses to the STOCI
vignettes versus the participants' scores based only on their top three responses to each
vignette on the STOCI. The analyses of the STOCI's reliability used the same
procedure used to check the reliability and responses of the STOCI's pilot data.

Two sets of data were compiled (all of participants' responses versus the three
top choices of participants to each STOCI vignette) to examine the STOCI's reliability. Reliability coefficients were computed on each data set with the SAS statistical
program using the Cronbach Coefficient Alpha and the Kuder-Richardson 20. The
reliability of each data set was then compared using the Fisher Z Transformation to
learn if there was a statistically significant difference in the calculated reliability of the
STOCI based on all of the participants' responses to each vignette versus only the
participants' top three responses to each of the vignettes.
CHAPTER IV

RESULTS

Overview of the Chapter

The results of this research testing the association of therapist characteristics with ability to assess CSA among doctoral level interning psychologists are presented in five sections. The first section presents descriptive data on the participants of this research. The remaining three sections address the statistical analyses performed. For these analyses two sets of data were compiled. The first set is based on all of the interns' responses to each vignette on the STOCI. From now on this data set is called "Full - I." The second set of data (hereafter known as the "Partial - I") is based on the interns' top three choice responses to each vignette on the STOCI.

The second section of this chapter presents the results of the reliability tests on both sets of data and a comparative analysis of these results. The third section presents the ANOVAs performed to determine if there are a statistically significant differences on the STOCI scores relative to interns' gender and whether or not interns: (a) have had therapy; (b) have professional experience with three or more survivors of CSA; (c) have a close friend, family member, or significant other who is a survivor of CSA; and (d) are a survivor of CSA. The fourth section addresses possible interaction affects.

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Descriptive Data on Interns

The interns of this research were 1995-96 doctoral level interns at sites represented by the membership of the 1993 Association of Counseling Center Training Agents and were listed in the 1993-94 directory of the Association of Psychology Postdoctoral and Internship Centers. One site was dropped from the research because its director returned the research packets and reported that the site did not have doctoral interns at the time of this research. Therefore, the study surveyed 73 sites that provided a possible pool of 273 participants. Of these interns, 149 interns responded. However, due to clerical errors or postal problems five of the completed surveys were received too late to be included in the analyses and had to be dropped. Nineteen surveys were returned without completed STOCIs. The remaining useable 125 surveys yielded a return rate of 47%, more than the average return rate of the other empirical research on therapist characteristics discussed in Chapter II (Adams & Betz, 1993; Attias & Goodwin, 1985; Follette, et.al., 1994; LaBarbera et al., 1980; Poluny & Follette, 1996).

Of the interns identifying their gender, 30% (n = 37) were male and 70% (n = 87) were female. The interns ranged in age from 25 to 60. The mean age of the interns was 33. One hundred and twenty-three interns reported the racial or ethnic group with which they identified: Asian, 3.3% (n = 4); African-American, 4.9% (n = 6); Caucasian, 81.3% (n = 100); Hispanic, 4.9% (n = 6); Native-American, 2.4% (n = 3); and Other, 3.3% (n = 4). Two (1.6%) of the interns chose not to report the group
with which they identified. The reported programs from which the participating interns expected their degrees were: Clinical Psychology, 37.1% (n = 46); Counseling Psychology, 58.9% (n = 73); Educational Psychology, 1.6% (n = 2); and Other, 2.4% (n = 3).

Test of Reliability

The procedure and tests of internal consistency that were used to analyze the STOCI's reliability parallel those used for the pilot study. For a detailed description of the analyses and procedure see the results section of the pilot which are discussed in the first tier of the methods section in Chapter III.

As mentioned earlier, two sets of data were compiled for analysis based on the two different scoring methods of the STOCI (all answers, and top three choice answers to each vignette). The frequency of the correct and incorrect answers to each vignette for the Full-1 and Partial -1 data sets were calculated and are presented in Table 7 and Table 8 respectively. The frequency of the STOCI scores (the total of correctly suspected CSA cases) were also calculated and are presented in Table 9 for the Full -1 and Table 10 for the Partial-1 data sets. These frequencies were then used to calculated the STOCI's reliability with the interns of this research. As with the pilot tests, the analyses performed were the Coefficient Cronbach and the K-R20. The reader is reminded that due to the lack of variability in responses to the vignettes depicting no CSA, only the five vignettes containing a suggestion of CSA were used.
for these analyses. The results of the Cronbach are presented in Table 11 for the Full-I and Table 12 for the Partial-I data sets.

The K-R20 provided a reliability coefficient of .49359 for the Full-I and a reliability coefficient of .45980 for the Partial-I. These coefficients were compared using the Fisher Z Transformation to determine if there was a significant statistical difference between the two reliability scores. With an alpha level of .05, the Fisher Z did not indicate a statistically significant difference in the reliability between the Full-I and the Partial-I, $Z(R_1 = .4598, R_2 = .49359) = .34160, p = .73265$.

Table 7
Frequency of Interns' Correct and Incorrect Answers to Vignettes for Full-I

<table>
<thead>
<tr>
<th>Vignettes</th>
<th>Total N</th>
<th>n</th>
<th>% Correct</th>
<th>n</th>
<th>% Incorrect</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (CSA)</td>
<td>125</td>
<td>75</td>
<td>60.9</td>
<td>50</td>
<td>40.0</td>
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<tr>
<td>2 (NO)</td>
<td>125</td>
<td>125</td>
<td>100</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>3 (CSA)</td>
<td>125</td>
<td>52</td>
<td>41.6</td>
<td>73</td>
<td>58.4</td>
</tr>
<tr>
<td>4 (CSA)</td>
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<td>76</td>
<td>60.8</td>
<td>49</td>
<td>39.2</td>
</tr>
<tr>
<td>5 (NO)</td>
<td>125</td>
<td>125</td>
<td>100</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>6 (NO)</td>
<td>125</td>
<td>124</td>
<td>99.2</td>
<td>1</td>
<td>.8</td>
</tr>
<tr>
<td>7 (CSA)</td>
<td>125</td>
<td>54</td>
<td>43.2</td>
<td>71</td>
<td>56.8</td>
</tr>
<tr>
<td>8 (CSA)</td>
<td>125</td>
<td>59</td>
<td>47.2</td>
<td>66</td>
<td>52.8</td>
</tr>
<tr>
<td>9 (NO)</td>
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<td>124</td>
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<td>1</td>
<td>.8</td>
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<tr>
<td>10 (NO)</td>
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<td>125</td>
<td>100</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
Table 8
Frequency of Interns’ Correct and Incorrect Answers to Vignettes for Partial-1

<table>
<thead>
<tr>
<th>Vignettes</th>
<th>Total N</th>
<th>n</th>
<th>% Correct</th>
<th>n</th>
<th>% Incorrect</th>
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<tr>
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<td>125</td>
<td>125</td>
<td>100</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>3 (CSA)</td>
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<td>44</td>
<td>35.2</td>
<td>81</td>
<td>64.8</td>
</tr>
<tr>
<td>4 (CSA)</td>
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<td>67</td>
<td>53.6</td>
<td>58</td>
<td>46.4</td>
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<tr>
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<td>100</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>6 (NO)</td>
<td>125</td>
<td>124</td>
<td>99.2</td>
<td>1</td>
<td>.8</td>
</tr>
<tr>
<td>7 (CSA)</td>
<td>125</td>
<td>44</td>
<td>35.2</td>
<td>81</td>
<td>64.8</td>
</tr>
<tr>
<td>8 (CSA)</td>
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<td>50</td>
<td>40.0</td>
<td>75</td>
<td>60.0</td>
</tr>
<tr>
<td>9 (NO)</td>
<td>125</td>
<td>124</td>
<td>99.2</td>
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<td>10 (NO)</td>
<td>125</td>
<td>125</td>
<td>100</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Table 9
Frequency of Interns’ STOCI Scores for Full-1

<table>
<thead>
<tr>
<th>STOCI score</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
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<tr>
<td>5</td>
<td>7</td>
<td>5.6</td>
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<td>6</td>
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<td>21.6</td>
</tr>
<tr>
<td>7</td>
<td>31</td>
<td>24.8</td>
</tr>
<tr>
<td>8</td>
<td>28</td>
<td>22.4</td>
</tr>
<tr>
<td>9</td>
<td>19</td>
<td>15.2</td>
</tr>
<tr>
<td>10</td>
<td>13</td>
<td>10.4</td>
</tr>
</tbody>
</table>
Table 10

Frequency of Interns' STOCI Scores for Partial-1

<table>
<thead>
<tr>
<th>STOCI score</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
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<td>9.6</td>
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<tr>
<td>6</td>
<td>32</td>
<td>25.6</td>
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<tr>
<td>7</td>
<td>35</td>
<td>28.0</td>
</tr>
<tr>
<td>8</td>
<td>27</td>
<td>21.6</td>
</tr>
<tr>
<td>9</td>
<td>8</td>
<td>6.4</td>
</tr>
<tr>
<td>10</td>
<td>11</td>
<td>8.8</td>
</tr>
</tbody>
</table>

Table 11

Cronbach Test of Reliability for Full-1

<table>
<thead>
<tr>
<th>Vignette</th>
<th>Correlation with Total</th>
<th>Alpha if Vignette is Deleted</th>
</tr>
</thead>
<tbody>
<tr>
<td>CSA 1</td>
<td>.232824</td>
<td>.450030</td>
</tr>
<tr>
<td>CSA 2</td>
<td>.244201</td>
<td>.442528</td>
</tr>
<tr>
<td>CSA 3</td>
<td>.130480</td>
<td>.514836</td>
</tr>
<tr>
<td>CSA 4</td>
<td>.328039</td>
<td>.385350</td>
</tr>
<tr>
<td>CSA 5</td>
<td>.388629</td>
<td>.341897</td>
</tr>
</tbody>
</table>
Table 12

Chronbach Test of Reliability for Partial-1

<table>
<thead>
<tr>
<th>Vignette</th>
<th>Correlation with Total</th>
<th>Alpha if Vignette is Deleted</th>
</tr>
</thead>
<tbody>
<tr>
<td>CSA 1</td>
<td>.177513</td>
<td>.443073</td>
</tr>
<tr>
<td>CSA 2</td>
<td>.208485</td>
<td>.421826</td>
</tr>
<tr>
<td>CSA 3</td>
<td>.149135</td>
<td>.462121</td>
</tr>
<tr>
<td>CSA 4</td>
<td>.270877</td>
<td>.377537</td>
</tr>
<tr>
<td>CSA 5</td>
<td>.406451</td>
<td>.274200</td>
</tr>
</tbody>
</table>

Results of ANOVAs

In this section, the results of the ANOVAs performed on the STOCI scores (dependent variables) for each of the five therapists characteristics (independent variables) are presented separately by therapist characteristic: (1) gender, (2) therapists' personal therapy; (3) professional experience; (4) close friend, family member, or significant other; and (5) survivor of CSA. Each therapist characteristic is introduced along with its associated null hypothesis. A table presenting the distribution of the STOCI scores for the Full-1 and Partial-1 data sets for the characteristic follow. Then an ANOVA table delineating the results from the Full-1 data set and an ANOVA table delineating the results from the Partial-1 data sets are presented. The section on each characteristic concludes with the decision to either accept or reject the null hypothesis.
The reader is advised that a probability level of .05 was selected as the level of significance for the ANOVAs. The reader is also reminded (see Tables 7 and 8) that except two isolated responses, all of the errors made on the STOCI were mistakes of not suspecting CSA in the vignettes designed to stimulate a suspicion of CSA. Therefore, the mean scores of interns depict the accuracy of the interns in identifying CSA and the relative degree of hyposensitivity to appropriate sensitivity of the interns (the higher the score the more appropriate the sensitivity, the lower the score the more hypo the sensitivity). Therefore, only the Correct Scores (hereafter known as STOCI score) are used in the analyses regarding therapists characteristics.

**Gender**

ANOVAs on the STOCI scores were performed to determine if there was a statistically significant difference between male and female interns' sensitivity and accuracy in suspecting CSA in adult clients. The null hypothesis was: There will be no significant difference between the STOCI scores of female and male subjects. The results of these analyses are presented in Table 13 and Table 14 (showing the distribution the STOCI scores of the male and female interns for the Full-1 and Partial-1 data sets respectively), Table 15 (Gender ANOVA: Full-1), and Table 16 (Gender ANOVA: Partial-1).

The null hypothesis was rejected for both the Full-1 and Partial-1 data sets on the gender ANOVAs. That is, that there was a statistically significant difference between male and female interns in their sensitivity and accuracy in assessing the
presence or absence of CSA in adult client case. Women had higher scores than men, i.e., women were more accurate and less hyposensitive than were men.

Table 13

<table>
<thead>
<tr>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>STOCI score</td>
<td>Number</td>
</tr>
<tr>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>9</td>
<td>5</td>
</tr>
<tr>
<td>10</td>
<td>1</td>
</tr>
</tbody>
</table>

Note: Male mean = 7.1, median = 7.0, mode = 6.0, and SD = 1.30
Female mean = 7.7, median = 8.0, mode = 7.0, SD = 1.41

Table 14

<table>
<thead>
<tr>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>STOCI score</td>
<td>Number</td>
</tr>
<tr>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>8</td>
<td>11</td>
</tr>
<tr>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td>10</td>
<td>0</td>
</tr>
</tbody>
</table>

Note: Male mean = 6.8, median = 7.0, mode = 6.0, and SD = 1.21
Female mean = 7.3, median = 7.0, mode = 7.0, SD = 1.41
Table 15
Gender ANOVA: Full-1

<table>
<thead>
<tr>
<th>Degrees of Freedom</th>
<th>Sum of Squares</th>
<th>Mean Square</th>
<th>F Value</th>
<th>Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>1</td>
<td>8.1</td>
<td>8.1</td>
<td>4.24</td>
</tr>
<tr>
<td>Error</td>
<td>122</td>
<td>232.9</td>
<td>1.9</td>
<td>4.24</td>
</tr>
</tbody>
</table>

Note: N = 124; Male n = 37, mean = 7.1; Female n = 8, mean = 7.7

Table 16
Gender ANOVA: Partial-1

<table>
<thead>
<tr>
<th>Degrees of Freedom</th>
<th>Sum of Squares</th>
<th>Mean Square</th>
<th>F Value</th>
<th>Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>1</td>
<td>8.0</td>
<td>8.0</td>
<td>4.34</td>
</tr>
<tr>
<td>Error</td>
<td>122</td>
<td>223.4</td>
<td>1.8</td>
<td></td>
</tr>
</tbody>
</table>

Note: N = 124; Male n = 37; mean = 6.8; Female n = 87, mean = 7.3

Therapy

ANOVA on the STOCI scores were performed to determine if there was a statistically significant difference between interns who have and interns who have not had personal therapy versus interns who had not had personal therapy in their sensitivity and accuracy in suspecting CSA in adult client cases. The null hypothesis was: There will be no statistically significant difference in the STOCI scores of interns who have had therapy and the interns who have not had therapy. The results of these analyses are presented in Tables 17 and 18 (showing the distribution of the STOCI scores of interns who have had therapy and interns who have not had therapy for the
Full-1 and Partial-1 data sets), Table 19 (Therapy ANOVA: Full-1), and Table 20 (Therapy ANOVA: Partial-1).

### Table 17

Distribution of STOCI Scores by Therapy for Full-1

<table>
<thead>
<tr>
<th>STOCI score</th>
<th>Therapy</th>
<th>Number</th>
<th>% of N</th>
<th>No Therapy</th>
<th>Number</th>
<th>% of N</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>6</td>
<td>10.0</td>
<td>1</td>
<td>10.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>23</td>
<td>20.2</td>
<td>4</td>
<td>40.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>30</td>
<td>26.3</td>
<td>1</td>
<td>10.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>27</td>
<td>23.7</td>
<td>1</td>
<td>10.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>16</td>
<td>14.0</td>
<td>2</td>
<td>20.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>12</td>
<td>10.5</td>
<td>1</td>
<td>10.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Therapy mean = 7.5, median = 7.0, mode = 7.0, SD = 1.38
No Therapy mean = 7.2, median = 6.5, mode = 6.0, SD = 1.69

### Table 18

Distribution of STOCI Scores by Therapy for Partial-1

<table>
<thead>
<tr>
<th>STOCI score</th>
<th>Therapy</th>
<th>Number</th>
<th>% of N</th>
<th>No Therapy</th>
<th>Number</th>
<th>% of N</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>10</td>
<td>8.8</td>
<td>2</td>
<td>20.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>29</td>
<td>25.4</td>
<td>3</td>
<td>30.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>34</td>
<td>29.8</td>
<td>1</td>
<td>10.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>25</td>
<td>21.9</td>
<td>2</td>
<td>20.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>6</td>
<td>5.3</td>
<td>1</td>
<td>10.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>10</td>
<td>8.8</td>
<td>1</td>
<td>10.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Therapy mean = 7.2, median = 7.0, mode = 7.0, SD = 1.35
No Therapy mean = 7.0, median = 6.5, mode = 6.0, SD = 1.70

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Table 19

Therapy ANOVA: Full-1

<table>
<thead>
<tr>
<th>Degrees of Freedom</th>
<th>Sum of Squares</th>
<th>Mean Square</th>
<th>F Value</th>
<th>Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>1</td>
<td>0.98</td>
<td>0.98</td>
<td>0.50</td>
</tr>
<tr>
<td>Error</td>
<td>122</td>
<td>240.02</td>
<td>1.97</td>
<td></td>
</tr>
</tbody>
</table>

Note: \( N = 124; \) Therapy \( n = 114, \text{mean} = 7.5; \) No Therapy \( n = 10, \text{mean} = 7.2 \)

Table 20

Therapy ANOVA: Partial-1

<table>
<thead>
<tr>
<th>Degrees of Freedom</th>
<th>Sum of Squares</th>
<th>Mean Square</th>
<th>F Value</th>
<th>Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>1</td>
<td>0.23</td>
<td>0.23</td>
<td>0.12</td>
</tr>
<tr>
<td>Error</td>
<td>122</td>
<td>231.16</td>
<td>1.89</td>
<td></td>
</tr>
</tbody>
</table>

Note: \( N = 124; \) Therapy \( n = 114, \text{mean} = 7.16; \) No Therapy \( n = 10, \text{mean} = 7.0 \)

The null hypothesis could not be rejected for either the Full-1 or Partial-1 data sets on the therapy ANOVAs. This is to say, there was no statistically significant difference between interns who have had therapy and interns who have not had therapy in their sensitivity and accuracy in suspecting the presence or absence of CSA in adult client case.

**Professional Experience**

ANOVA\(^s\) on the STOCI scores were performed to determine if there was a statistically significant difference in the accuracy and sensitivity of interns who have professional experience with CSA survivors versus those interns who do not have
professional experience with CSA survivors in their suspicion of the presence or absence of CSA in adult client cases. The null hypothesis was: There will be no statistically significant difference in the STOCI scores of interns who have professional experience with three or more survivors of CSA and interns who do not have professional experience with three or more survivors of CSA. The results of these analyses are presented in Tables 21 and 22 (showing the distribution of the STOCI scores of interns who have and who do not have professional experience for the Full-I and Partial-I data sets), Table 23 (Professional Experience ANOVA: Full-I), and Table 24 (Professional Experience: Partial-I).

Table 21
Distribution of STOCI Scores by Professional Experience for Full-I

<table>
<thead>
<tr>
<th>STOCI Score</th>
<th>Professional Experience</th>
<th>% of N</th>
<th>No Professional Experience</th>
<th>% of N</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>4</td>
<td>3.7</td>
<td>3</td>
<td>16.7</td>
</tr>
<tr>
<td>6</td>
<td>22</td>
<td>20.6</td>
<td>5</td>
<td>27.8</td>
</tr>
<tr>
<td>7</td>
<td>27</td>
<td>25.2</td>
<td>4</td>
<td>22.2</td>
</tr>
<tr>
<td>8</td>
<td>25</td>
<td>23.4</td>
<td>3</td>
<td>16.7</td>
</tr>
<tr>
<td>9</td>
<td>17</td>
<td>15.9</td>
<td>2</td>
<td>11.1</td>
</tr>
<tr>
<td>10</td>
<td>12</td>
<td>11.2</td>
<td>1</td>
<td>5.6</td>
</tr>
</tbody>
</table>

Note: Professional Experience mean = 7.6, median = 8.0, mode = 7.0, SD = 1.37
   No Professional Experience mean = 6.9, median = 7.0, mode = 6.0, SD = 1.47
Table 22

Distribution of STOCI Scores by Professional Experience for Partial-1

<table>
<thead>
<tr>
<th>STOCI score</th>
<th>Number</th>
<th>% of N</th>
<th>Number</th>
<th>% of N</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>8</td>
<td>7.5</td>
<td>4</td>
<td>22.2</td>
</tr>
<tr>
<td>6</td>
<td>27</td>
<td>25.2</td>
<td>5</td>
<td>27.8</td>
</tr>
<tr>
<td>7</td>
<td>30</td>
<td>28.5</td>
<td>5</td>
<td>27.8</td>
</tr>
<tr>
<td>8</td>
<td>24</td>
<td>22.4</td>
<td>3</td>
<td>16.7</td>
</tr>
<tr>
<td>9</td>
<td>8</td>
<td>7.5</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>10</td>
<td>10</td>
<td>9.3</td>
<td>1</td>
<td>5.6</td>
</tr>
</tbody>
</table>

Note: Professional Experience mean = 7.3, median = 7.0, mode = 7.0, SD = 1.37
     No Professional Experience mean = 6.6, median = 6.5, mode = 6.0, SD = 1.34

Table 23

Professional Experience ANOVA: Full-1

<table>
<thead>
<tr>
<th>Degrees of Freedom</th>
<th>Sum of Squares</th>
<th>Mean Square</th>
<th>F Value</th>
<th>Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>1</td>
<td>6.77</td>
<td>6.77</td>
<td>3.52</td>
</tr>
<tr>
<td>Error</td>
<td>123</td>
<td>236.46</td>
<td>1.92</td>
<td></td>
</tr>
</tbody>
</table>

Note: N = 125, Professional Experience n = 107, mean = 7.6;
     No Professional Experience n = 18, mean = 6.9

The null hypothesis could not be rejected for either the Full-1 or the Partial-1 sets. This is to say that there was no statistically significant difference between interns who have and interns who do not have professional experience with three or more clients in their accuracy and sensitivity in suspecting the presence or absence of CSA in adult client cases.
Table 24

Professional Experience ANOVA: Partial-1

<table>
<thead>
<tr>
<th></th>
<th>Degrees of Freedom</th>
<th>Sum of Squares</th>
<th>Mean Square</th>
<th>F Value</th>
<th>Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>1</td>
<td>6.34</td>
<td>6.34</td>
<td>3.41</td>
<td>0.07</td>
</tr>
<tr>
<td>Error</td>
<td>123</td>
<td>228.46</td>
<td>1.86</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: N = 125, Professional Experience n = 176, mean = 7.3
No Professional Experience n = 18, mean = 6.6

Close CSA Survivor

ANOVAs on the STOCI scores of the STOCI were performed to determine if there was a statistically significant difference in the accuracy and sensitivity when suspecting CSA between those who have personal experience with CSA survivors and those interns who do not have personal experience with CSA survivors. The null hypothesis was: There will be no statistically significant difference in the STOCI scores of interns who have a close friend, family member, or significant other who is a survivor of CSA and interns who do not have a close friend, family member, or significant other who is a survivor of CSA. The results of these analyses are presented in Tables 25 and 26 (showing the distribution of the STOCI scores of those interns who have and those interns who do not have a close friend, family member, or significant other who is a CSA survivor for the Full-1 and Partial-1 data sets.), Table 27 (Close CSA ANOVA: Full-1), and Table 28 (Close CSA ANOVA: Partial-1).
Table 25

<table>
<thead>
<tr>
<th>STOCI score</th>
<th>Close CSA</th>
<th>% of N</th>
<th>No Close CSA</th>
<th>% of N</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>0</td>
<td>0</td>
<td>7</td>
<td>9.9</td>
</tr>
<tr>
<td>6</td>
<td>12</td>
<td>22.2</td>
<td>15</td>
<td>21.1</td>
</tr>
<tr>
<td>7</td>
<td>12</td>
<td>22.2</td>
<td>19</td>
<td>26.8</td>
</tr>
<tr>
<td>8</td>
<td>15</td>
<td>27.8</td>
<td>13</td>
<td>18.3</td>
</tr>
<tr>
<td>9</td>
<td>8</td>
<td>14.8</td>
<td>11</td>
<td>15.5</td>
</tr>
<tr>
<td>10</td>
<td>7</td>
<td>13.0</td>
<td>6</td>
<td>8.5</td>
</tr>
</tbody>
</table>

Note: Close CSA mean = 7.7, median = 8.0, mode = 8.0, SD = 1.32
No Close CSA mean = 7.3, median = 7.0, mode = 7.0, SD = 1.44

Table 26

<table>
<thead>
<tr>
<th>STOCI score</th>
<th>Close CSA</th>
<th>% of N</th>
<th>No Close CSA</th>
<th>% of N</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>2</td>
<td>3.7</td>
<td>10</td>
<td>14.1</td>
</tr>
<tr>
<td>6</td>
<td>15</td>
<td>27.8</td>
<td>17</td>
<td>23.9</td>
</tr>
<tr>
<td>7</td>
<td>13</td>
<td>24.1</td>
<td>22</td>
<td>31.0</td>
</tr>
<tr>
<td>8</td>
<td>15</td>
<td>27.8</td>
<td>12</td>
<td>16.9</td>
</tr>
<tr>
<td>9</td>
<td>3</td>
<td>5.6</td>
<td>5</td>
<td>7.0</td>
</tr>
<tr>
<td>10</td>
<td>6</td>
<td>11.1</td>
<td>5</td>
<td>7.0</td>
</tr>
</tbody>
</table>

Note: Close CSA mean = 7.4, median = 7.0, mode = 6.0, SD = 1.35
No Close CSA mean = 7.0, median = 7.0, mode = 7.0, SD = 1.38
The null hypothesis could not be rejected for either the Full-1 or Partial-1 data sets. This is to say that there was no statistically significant difference in the sensitivity and accuracy of interns who have a close friend, family member, or significant other and the interns who do not in the interns' suspicion of the presence or absence of CSA in adult client cases.

Survivor

ANOVARs on the STOCI Scores were performed to determine if there was a statistically significant difference in the accuracy and sensitivity in suspecting CSA between interns who are survivors of CSA and interns who do not have a history of
The null hypothesis was: There will be no statistically significant difference in the STOCI scores of the interns who are survivors of CSA and interns who are not survivors of CSA. The results of these analyses are presented in Tables 29 and 30 (showing the distribution of the STOCI scores of interns who are survivors of CSA and interns who do not have a history of CSA for Full-1 and Partial-1 data sets), Table 31 (Survivor ANOVA: Full-1), and Table 32 (Survivor ANOVA: Partial-1).

Table 29
Distribution of STOCI Scores by Survivor for Full-1

<table>
<thead>
<tr>
<th>STOCI score</th>
<th>Number</th>
<th>% of N</th>
<th>Number</th>
<th>% of N</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>1</td>
<td>4.5</td>
<td>6</td>
<td>5.8</td>
</tr>
<tr>
<td>6</td>
<td>5</td>
<td>22.7</td>
<td>22</td>
<td>21.4</td>
</tr>
<tr>
<td>7</td>
<td>5</td>
<td>22.7</td>
<td>26</td>
<td>25.2</td>
</tr>
<tr>
<td>8</td>
<td>7</td>
<td>31.8</td>
<td>21</td>
<td>20.4</td>
</tr>
<tr>
<td>9</td>
<td>1</td>
<td>4.5</td>
<td>18</td>
<td>17.5</td>
</tr>
<tr>
<td>10</td>
<td>3</td>
<td>13.6</td>
<td>10</td>
<td>9.7</td>
</tr>
</tbody>
</table>

Note: Survivor mean = 7.5, median = 7.5; mode = 8.0, SD = 1.41
      Not Survivor mean = 7.5, median = 7.0; mode = 7.0, SD = 1.41

The null hypothesis could not be rejected for either the Full-1 or Partial-1 data sets. This is to say that there was no statistically significant difference in the sensitivity and accuracy of interns who were survivors of CSA and the interns who did not have a history of CSA in the interns' suspicion of the presence or absence of CSA in adult client cases.
Table 30

Distribution of STOCI Scores by Survivor for Partial-1

<table>
<thead>
<tr>
<th>STOCI score</th>
<th>Survivor</th>
<th>Not Survivor</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>% of N</td>
</tr>
<tr>
<td>5</td>
<td>1</td>
<td>4.5</td>
</tr>
<tr>
<td>6</td>
<td>8</td>
<td>36.4</td>
</tr>
<tr>
<td>7</td>
<td>6</td>
<td>27.3</td>
</tr>
<tr>
<td>8</td>
<td>4</td>
<td>18.2</td>
</tr>
<tr>
<td>9</td>
<td>1</td>
<td>4.5</td>
</tr>
<tr>
<td>10</td>
<td>2</td>
<td>9.1</td>
</tr>
</tbody>
</table>

Note: Survivor mean = 7.1, median = 7.0, mode = 6.0, \( SD = 1.34 \)
Not Survivor mean = 7.2, median = 7.0, mode = 7.0, \( SD = 1.39 \)

Table 31

Survivor ANOVA: Full-1

<table>
<thead>
<tr>
<th>Degrees of Freedom</th>
<th>Sum of Squares</th>
<th>Mean Square</th>
<th>F Value</th>
<th>Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>1</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Error</td>
<td>123</td>
<td>243.23</td>
<td>1.98</td>
<td></td>
</tr>
</tbody>
</table>

Note: \( N = 125 \), Survivor \( n = 22 \) means = 7.5; Non Survivor \( n = 103 \), means = 7.5

Table 32

Survivor ANOVA: Partial-1

<table>
<thead>
<tr>
<th>Degrees of Freedom</th>
<th>Sum of Squares</th>
<th>Mean Square</th>
<th>F Value</th>
<th>Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>1</td>
<td>0.13</td>
<td>0.13</td>
<td>0.07</td>
</tr>
<tr>
<td>Error</td>
<td>123</td>
<td>234.67</td>
<td>1.91</td>
<td></td>
</tr>
</tbody>
</table>

Note: \( N = 125 \), Survivor \( n = 22 \), means = 7.1; Not survivor \( n = 10 \), means = 7.2 3
Possible Interaction Effects of Therapist Characteristics

To learn if there was any statistically significant interaction between gender and the other four therapist characteristics under study, the data was prepared for two by two ANOVAs. Cross tabulations of interns; (1) gender by therapy; (2) gender by professional experience; (3) gender by close friend, family member, or significant other; and (4) gender by survivor was completed. Table 33 depicts the cell sizes of interns' gender with each of the other four therapist characteristics addressed in the current research. The results of the cross tabulations indicated that ANOVAs on these interactions would be very unbalanced creating a dramatic difference between cell sizes with some cells being very small. Small cell size can indicate large within cell variance as a result of having few within cell differences and may not be a true measure of the variance. Hence, the small cell size and unequal populations precluded the viability of doing a two by two ANOVAs on all but gender by close friend family member or significant other (see Table 33). Therefore, the only two-way ANOVAs performed were on gender by close friend, family member, or significant other. The results of these analyses follow Table 33.

Gender by Close Friend, Family Member, or Significant Other

Two by two ANOVAs on the STOCI scores of participants were performed to determine if the interaction of therapists’ gender and having or not having a close friend, family member or significant other who was a survivor would demonstrate a
Table 33
Distribution of Males and Females by Remaining Therapist Characteristics

<table>
<thead>
<tr>
<th>Gender by Therapy</th>
<th>No Therapy</th>
<th>Therapy</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n</td>
<td>7</td>
<td>80</td>
<td>n = 87</td>
</tr>
<tr>
<td>%</td>
<td>5.7%</td>
<td>64.5%</td>
<td>70.2%</td>
</tr>
<tr>
<td>Male</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n</td>
<td>3</td>
<td>34</td>
<td>n = 37</td>
</tr>
<tr>
<td>%</td>
<td>2.4%</td>
<td>27.4%</td>
<td>29.8%</td>
</tr>
<tr>
<td>Column</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n</td>
<td>10</td>
<td>114</td>
<td>N = 124</td>
</tr>
<tr>
<td>%</td>
<td>8.1%</td>
<td>91.9%</td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender by Professional Experience</th>
<th>No Pro. Experience</th>
<th>Pro. Experience</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n</td>
<td>11</td>
<td>76</td>
<td>n = 87</td>
</tr>
<tr>
<td>%</td>
<td>8.9%</td>
<td>61.3%</td>
<td>70.2%</td>
</tr>
<tr>
<td>Male</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n</td>
<td>7</td>
<td>30</td>
<td>n = 37</td>
</tr>
<tr>
<td>%</td>
<td>5.6%</td>
<td>24.2%</td>
<td>29.8%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender by professional Experience</th>
<th>No Pro. Experience</th>
<th>Pro. Experience</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male cont.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n</td>
<td>18</td>
<td>106</td>
<td>N = 124</td>
</tr>
<tr>
<td>%</td>
<td>14.5%</td>
<td>85.5%</td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender by Close CSA</th>
<th>No Close CSA</th>
<th>Close CSA</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n</td>
<td>53</td>
<td>34</td>
<td>n = 87</td>
</tr>
<tr>
<td>%</td>
<td>42.8%</td>
<td>27.4%</td>
<td>70.2%</td>
</tr>
<tr>
<td>Male</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n</td>
<td>18</td>
<td>19</td>
<td>n = 37</td>
</tr>
<tr>
<td>%</td>
<td>14.5%</td>
<td>15.3%</td>
<td>29.8%</td>
</tr>
</tbody>
</table>
Table 33—Continued

<table>
<thead>
<tr>
<th>Column</th>
<th>Not Survivor</th>
<th>Survivor</th>
<th>N = 124</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>57.3%</td>
<td>42.7%</td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender by Survivor</th>
<th>Not Survivor</th>
<th>Survivor</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>68</td>
<td>19</td>
<td>n = 87</td>
</tr>
<tr>
<td></td>
<td>54.9%</td>
<td>15.3%</td>
<td>70.2%</td>
</tr>
<tr>
<td>Male</td>
<td>34</td>
<td>3</td>
<td>n = 37</td>
</tr>
<tr>
<td></td>
<td>27.4%</td>
<td>2.4%</td>
<td>29.8%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column</th>
<th>102</th>
<th>22</th>
<th>N = 124</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>82.3%</td>
<td>17.7%</td>
<td>100%</td>
</tr>
</tbody>
</table>

statistical significance. The null hypothesis was: There will be no statistically significant interaction on STOCI scores associated with therapists' gender and having or not having a close friend, family member, or significant other who is a survivor or CSA. The results of these analyses are presented in Table 34 (Gender by Close CSA: Full-1), and Table 35 (Gender by Close CSA: Partial-1).

The null hypothesis could not be rejected for either the Full-1 or Partial-1 sets. This is to say that as measured by the STOCI scores, interaction of gender and close friend, family member, or significant other who was a survivor, was not statistically significant. In other words, the difference between men and women’s STOCI scores was not associated with whether or not the men and women had a close friend, family member, or significant other who was a survivor of CSA.
### Table 34

Gender by Close CSA: Full-1

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>SS</th>
<th>MS</th>
<th>E-Value</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model</td>
<td>3</td>
<td>14.71</td>
<td>4.90</td>
<td>2.06</td>
<td>0.06</td>
</tr>
<tr>
<td>Error</td>
<td>120</td>
<td>226.29</td>
<td>1.87</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>1</td>
<td>9.86</td>
<td>9.86</td>
<td>5.23</td>
<td>0.02</td>
</tr>
<tr>
<td>Close CSA</td>
<td>1</td>
<td>3.67</td>
<td>3.67</td>
<td>1.95</td>
<td>0.17</td>
</tr>
<tr>
<td>Gender by Close CSA</td>
<td>1</td>
<td>0.72</td>
<td>0.72</td>
<td>0.38</td>
<td>0.54</td>
</tr>
</tbody>
</table>

**Note:** Female $M = 7.726$, SEM = 0.15; Male $M = 7.105$, SEM = 0.226; Close CSA $M = 7.605$, SEM = 0.197; No Close CSA $M = 7.226$, SEM = 0.187

### Table 35

Gender by Close CSA: Partial-1

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>SS</th>
<th>MS</th>
<th>E-Value</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model</td>
<td>3</td>
<td>13.00</td>
<td>4.34</td>
<td>2.38</td>
<td>0.07</td>
</tr>
<tr>
<td>Error</td>
<td>120</td>
<td>218.38</td>
<td>1.82</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>1</td>
<td>9.42</td>
<td>9.43</td>
<td>5.18</td>
<td>0.03</td>
</tr>
<tr>
<td>Close CSA</td>
<td>1</td>
<td>3.50</td>
<td>3.50</td>
<td>1.92</td>
<td>0.17</td>
</tr>
<tr>
<td>Gender by Close CSA</td>
<td>1</td>
<td>0.19</td>
<td>0.19</td>
<td>0.10</td>
<td>0.75</td>
</tr>
</tbody>
</table>

**Note:** Female $M = 7.360$, SEM = 0.15; Male $M = 6.753$, SEM = 0.222; Close CSA $M = 7.241$, SEM = 0.193; No Close CSA $M = 6.872$, SEM = 0.184
CHAPTER V

DISCUSSION OF RESULTS AND RECOMMENDATIONS
FOR FURTHER STUDY

Introduction and Overview

This study makes several contributions to the current literature on therapist characteristics in association with therapists' suspicion of CSA histories in adult client cases. These contributions are discussed in this chapter and are organized around a summary of the survey results and a summary of the development of the Sensitivity Test of Clinical Issues (STOCI). First, the discussion addresses the results concerning the relationship of five therapist characteristics to therapists' suspicion of CSA in adult client cases. Then the discussion moves to the descriptive statistics obtained on the interning psychologists' therapist characteristics. A discussion of results on the possible interaction effects completes this section on the survey results. The limitations of the current research with suggestions for further research follow and segues into a discussion of the STOCI. The section of the STOCI has two sub-sections, summary of STOCI's development, and possible areas for improvement to the STOCI. The chapter concludes with a summary of this study's findings and their significance.
Summary of Results

The reader will observe that caution is taken in the following discussion not to generalize the results of this study except as they support the existing literature. This caution is taken because of the poor internal consistency of the STOCI with survey participants. A discussion of the STOCI’s reliability is presented in the section on the STOCI which follows the summary of the results. The low reliability is mentioned here only to provide the reader with an explanation for the tentative tone in the discussion of results.

Gender

The current study contributes to the literature in several ways, one of which concerns the association of therapists’ gender with therapists’ sensitivity and ability to accurately suspect CSA in adult client cases. Clinicians’ have suggested that male and female mental health providers may react differently to clients who are survivors of CSA (Courtois, 1988; Courtois & Watts, 1982; Herman & Hirschman, 1981, 1987). The current study supports this belief. The results of this study indicate that females are more appropriately sensitive and accurate in their suspicion of CSA in adult client cases than are males. Whereas, males tend to be more hyposensitive. That is, men tend not to suspect CSA in cases where clients have a history of CSA more often than do women.
Based on this study alone, it would not be appropriate to infer that in general female clinicians are more sensitive and accurate in their suspicions of CSA than male clinicians. However, in conjunction with other recent empirical studies which suggest that females tend to be more believing of clients' incest claims than do male therapists (Adams & Bets, 1993; Attias & Goodwin, 1985; and Polusny & Follette, 1996), the results of the current study become more cogent. Clearly, the finding on therapists' gender is a significant contribution to a growing body of evidence that indicates therapists' gender has a significant role in therapists' perceptions of CSA in their clients and that females appear to be more open to possible CSA histories in their adult clients than are males.

While this information seems to have implications for the false-memory versus delayed- debate, just what the implications are is difficult to say. From the current research there is no way of knowing how a therapist's suspicions of CSA would impact the therapist's approach in providing therapy. Further, therapist who do not suspect CSA initially, may suspect it later in the therapeutic relationship. Therefore, while the gender findings of this study make an important contribution to the literature, much more research is need to determine if therapists' sensitivity and ability to accurately suspect CSA affect therapists' services to clients and ultimately their clients beliefs and actions regarding the possibility of CSA.

It should also be noted that over-all, both male and female interns tended to make only one type of error. That is, participants erred by not suspecting CSA in
vignettes that were designed to stimulate a suspicion of CSA. There was only one exception. A male intern who answered all of the vignettes suggesting CSA correctly, made an error on a vignette designed not to suggest CSA. This was an isolated situation and was only true when considering all of the issues suspected by this participant and not just his three top suspected issues on the vignette. Therefore, it can be said that neither male nor female participants erred on the side of suspecting CSA where it did not exist on the STOCI. The implication is that participants are not hypersensitive to the presence of CSA in adult clients. However, as will be discussed in the section on the STOCI, the lack of hypersensitivity observed in participants may be due to measurement problems with the STOCI. On the other hand, the majority of participants did tend to be somewhat hyposensitive which in its self suggests that hypersensitivity to CSA may not be as common an occurrence as some might fear. Further research will be needed to determine if the current research results are typical of clinicians and to explore the possibility of therapists being hypersensitivity or hyper-vigilant to possible CSA in adult clients.

Professional Experience

No statistically significant difference was found in the STOCI scores of interns who had professional experience and interns who did not have professional experience with three or more survivors of CSA. The statistical non-significance may have been affected by the unequal proportion of interns who did and did not have professional
experience (85.6% and 14.4% respectively). Perhaps the proportion of interns with and without professional experience could have been more balanced if the criterion for "professional experience" had been more stringent (i.e., working with a greater number of CSA survivors).

Likewise, a more stringent criterion for professional experience may have produced a more notable differences in the suspicions of those who did or did not have professional experience. For example, Polusny and Follette (1996) examined the influence of general clinical experience on psychologists' clinical beliefs and practices around possible CSA. They found statistically significant differences (discussed shortly). However, they were talking about observable differences in terms of "years" of experience as opposed to the number of clients therapists had work with who were dealing with CSA issues. With interns who are early in their professional development, one would not expect to find large differences in the amount of their general clinical experience or specific experience with CSA survivors. It follows that interns are not the best choice of research participants to explore the effect of professional experience with CSA survivors on therapists' sensitivity and ability to assess CSA in adult clients.

Nevertheless, the results from the current study did provide impetus for further study. Although the results of the statistical analyses indicated that the difference in STOCI scores between interns with and without professional experience with CSA survivors only approached statistical significance, $\bar{E}(1, 123) = 3.52, p = .06$, the
difference was in the predicted direction. Interns who reported no professional experience with CSA survivors tended to score lower on the STOCI (less accurate in their suspicions and more hyposensitive) than their counterpart. This difference can be observed in the predicted direction of the mean, mode, and median STOCI scores of interns. Interns with professional experience ($M = 7.6$, $SD = 1.37$, mode = 7.0, $Mdn = 8.0$) scored higher than interns without professional experience, ($M = 6.9$, $SD = 1.47$, mode = 6.0, $Mdn = 7.0$) on the STOCI. Therefore, although the degree of certainty that the scores are due to real differences rather than chance are lower than required for statistical significance, the substantial and consistent directional differences are in the direction predicted and warrant further investigation. The need for research in this area was appreciated by Polusny and Follette. The reader is reminded that Polusny and Follette (1996) studied psychologists’ personal and professional experiences, beliefs, and clinical practices in relationship to CSA and clients remembering CSA in therapy. Forty-seven percent of respondents were female, 53% were male. Polusny and Follette found that psychologists who believed that a constellation of adult symptoms almost always indicated a history of CSA, had significantly fewer years of experience than psychologists who did not profess this belief. Further, clinicians with fewer years of experience more frequently did assessments on clients for CSA and rated adults’ memories of CSA as more accurate than therapists with more experience. However, it is yet to be determined if these beliefs and practices are accurate and therapeutically sound.
Intervening variables may have affected the results obtained on clinical experience in both Polusny and Follette's (1996) study and the current study. For example, the historical period in which the participating psychologists took their training may have influenced their exposure to CSA issues and their training regarding therapeutic approaches to working with survivors of CSA. One also wonders what effect the current false-memory controversy may have had on the responses of research participants. Undoubtedly, the empirical research thus far is only a small step towards understanding the possible association of therapists' professional experience with their suspicion of CSA in adult client cases. Further research is needed.

Survivor

There was no statistically significant difference in the STOCI scores of participants who were and were not survivors of CSA. In fact, the similarity between the STOCI scores of participants was striking. For all intended purposes, the average score and standard deviation of both groups were the same, survivors (Full-1, $M = 7.5$, $SD = 1.14$; Partial-1, $M = 7.1$, $SD = 1.34$) and non survivors (Full-1 $M = 7.5$, $SD = 1.14$; Partial-1 $M = 7.2$, $SD = 1.39$). Therefore, in the current study there was no real differences between survivors and non-survivors in their sensitivity and ability to correctly suspect CSA on the STOCI.

Based solely on the results of this study, it is not prudent to make inferences or generalize the findings to other groups of mental health professionals. However, the
findings of this study are consistent with Polusny and Follette's (1996) findings that mental health professionals who report a history of CSA are not significantly different in their clinical behaviors than mental health professionals who do not report a history of CSA. Such consistency in findings lends support to Follette et al. (1994) research results and their subsequent conclusion that histories of personal trauma [including CSA] do not appear to negatively affect the competency of therapists to provide services to survivors of CSA (p. 280).

As no empirical evidence was found to contradict the above findings, participants of the false-memory versus delayed-memory debate do not appear to have empirical support for their contention that therapists' professional behaviors are negatively affected by therapists' personal history of CSA. However, in this researcher's opinion, the dearth of research in this area also makes it difficult to state with certainty that being a survivor does not impact the clinical work of therapists. Therefore, much more research is needed to clarify if therapists' suspicions about the presence or absence of CSA in adult client cases are being affected by the therapist's history of being or not being a survivor of CSA.

**Therapy**

The differences in the STOCI scores of participants who reported having had personal therapy or counseling and participants who reported did not report having had therapy or counseling were not statistically significant. While clinicians have
suggested that therapists who work with survivors should invest in their own therapy (Briere, 1989; Courtois, 1988), no research was found in the literature which addressed the effects of therapists' therapy on therapists' beliefs and therapists' own work with clients who are possible CSA survivors. Therefore, there is not an empirical frame of reference from which to speculate on the possible reasons for, and meanings of the non-significant results regarding therapists' therapy. Perhaps therapy does not have an effect on therapists' suspicions regarding the presence or absence of CSA in adult client cases. On the other hand, the lack of statistical significance may have been due to other reasons.

One reason may have been that participants' were very inclusive in their report of personal therapy or counseling. For example, they may have included personal therapy that they had received as part of an experiential component in their training program as opposed to personal therapy directed at working with severe trauma, intrapersonal difficulties, relationship difficulties, etc. A second reason might have been that there were drastic differences in the quality of the therapy interns had received. Finally, the fact that only 8.1% of the participants reported that they did not have therapy created a very unbalanced analysis. The extreme difference in the cell sizes may have contributed to the lack of statistical significance on the analysis of the STOCI scores of participants who did and did not have personal therapy. As the current study is the only known study on the topic and the results are far from unequivocal, more research is need to establish if therapists's therapy is or is not
associated with therapists' suspicion of the presence or absence of CSA in adult client cases.

**Close Friend, Family Member, or Significant Other Who Is a Survivor**

The results of this study did not find a statistically significant relationship between whether or not a therapist had a close friend, family member, or significant other who was a survivor of CSA and therapists' suspicion of the presence or absence of CSA in adult client cases. Like therapists' therapy, there was no research on the association of having a close relationship with a survivor and therapists' work with CSA clients. Originally, this researcher had speculated that having such a relationship with a survivor could make therapists more aware of CSA yet provide some emotional distance from the impact of CSA. This type of relationship could heighten the therapists awareness of CSA in a non-threatening manner. If this were the case, it seemed logical to speculate that such an awareness would improve therapists' ability to correct suspect CSA in adult client cases.

However, this line of thinking could be entirely incorrect or possibly only partly flawed. For example, clustering close friend, family member, and significant other under the rubus of close relationship ignores the great diversity of relationship and range of significance that these relationships could have for the therapist. The therapist may have been the mother of the survivor who was assaulted by the therapist's husband. This therapist's "emotional distance" might be quite different
from the therapists who had a close relationship with an aunt who had been sexually abused by a neighbor twenty years ago. Therefore, while some relationships with survivors might provide therapists personal awareness that is emotionally distant, other close relationships might be very emotionally charged for therapists. Therefore, if the effects of close relationships with survivors of CSA are to be researched in the future, this research suggest that they be more specifically defined.

Descriptive Statistics on Therapist Characteristics

In light of the paucity of information on the characteristics of therapists who work with survivors of CSA, the following information provides a look at a national group of doctoral interns near the end of their graduate program. The percentage of participants who reported being survivors in this study was lower than that of other current research. Overall, 17.6% of the participants of this current study reported being survivors (9% of the males and 27% of the females) whereas 32% of the psychologists in Polusny and Follette’s (1996) study reported being survivors (23% of the males and 42% of the females). Follette et al. (1994) reported that in their study 10.2% of the male mental health professionals and 19.3% of the female mental health professionals reported that they had personally experienced CSA. Lastly, in Feldman-Summer and Pope’s (1994) survey, 21.8% of the psychologists reported being sexually abused before they were 18 years old.
The relatively lower percentage of clinicians reporting CSA in the current study is a puzzle. This researcher wonders if the current false memory controversy is affecting clinicians’ ease with self-disclosure of past CSA, if this group of participants are unique in the amount of CSA that has been experienced, or if there was less CSA occurring during the time participants were children than during other times in history. It would be nice to think that although there is an increase in the awareness of the frequency of CSA, the actual frequency of CSA is declining. However, there is no empirical evidence to support this notion. Given what is known currently, it is not possible to determine what is responsible for the lower percentage of participants who report being survivors of CSA in the current study. Obtaining the age of individual participants relative to their disclosure of CSA in each of the above mentioned three studies and in the current study may provide some insight into the differences or similarities between the studies. That is, perhaps the participants of all four studies who report being survivors are similar in age. If this is true, then it may be possible to examine the socio-political environment at the time of their CSA. In a more general way, it may be possible to expand this line of study to explore how or if the socio-political environment is associated with specific therapist characteristics and or therapeutic issues regarding CSA.

Another interesting piece of information is the frequency at which participants of the current study reported having experience with CSA. It was observed that more than 88% of the participants reported that they had professional and, or personal
experience with CSA (i.e. 85% reported professional experience, 43.2% reported having a personally close survivor, and 17% reported being a survivor of CSA). Over all, only 11.2% of the participants indicated that they had no contact or experience whatsoever with survivors.

The impressive portion of participants who reported they had some form of experience with survivors of CSA highlights the importance of conducting research on the therapist-client dynamics where CSA may be a therapeutic issue. If these results are truly representative of therapists in general, than surely the majority of therapists will be dealing with CSA issues. Therefore, it seems striking that there has not been more research exploring the relationship of therapists’ history of CSA with therapists’ suspicions and perceptions about possible CSA in their adult clients. Certainly, more research is needed on the association of therapist characteristics with therapists’ suspicions about CSA in adult clients. Information from this type of research could be very useful in developing training programs for therapists who work with possible adult survivors of CSA.

Possible Interaction Effects

Unfortunately, due to the unequal distribution of experiences within the interns (some cells were empty or very small), it was not possible to perform a two-way ANOVA to determine if various combinations of professional and personal experiences showed a relationship to the way in which interns responded to the
vignettes on the STOCI. Likewise, the unequal distribution of male and female
STOCI scores across therapy, professional experience, and being a survivor precluded
doing a two-way ANOVA to test for gender by experiences interaction effects.

Gender by close friend, family member, or significant other who was a
survivor, was the only two-way ANOVA performed in this research and it rendered
statistically non-significant results. Therefore, it can be said that in the current study,
differences in male and female's suspicion of CSA where not related to whether or not
they have a close friend, family member, or significant other who is a survivor of CSA.
As mentioned earlier, the clustering of relationships may have confounded the results.
Isolating and clearly defining specific types of close relationships is required to
investigate their interactions with therapists' gender on therapists' sensitivity and
ability to accurately suspect CSA in adult client cases.

Limitation of Research on Interns and Further Suggestion for Research

Although the current research provided important empirical data on aspects of
the association of therapists characteristics to therapists' suspicion, or lack of suspicion
of CSA in adult clients, there were several limitations to this study. First, there were
limitations in the ways the independent variables were measured and defined. For
example, this study depended on participants' ability to accurately recall and report
their experience with CSA. With the possibility of false and delayed CSA memories
still in question, researchers will have to cautiously interpret results that include
therapists' self-report of CSA. This researcher had no way of knowing who, or if any of the participating interns had false or delayed memories of CSA at the time of the research. Likewise, she did not know what constituted CSA in the minds of the participants. For example, one participant may interpret frequent inappropriate sexual remarks to very young children as CSA. Other participant may interpret CSA as sexual penetration of a child. Hence, participants reports as to whether or not they are survivors are affected by their definitions of CSA.

A similar problem was discussed earlier regarding therapists' therapy. The current research did not assess the quality or even what criterion the participants used in reporting whether or not they had received counseling or therapy for psychological or interpersonal issues. Lack of such information is a limitation of the current study.

Another limitation of the current research was that it surveyed interns as opposed to practicing clinicians. The reader is reminded that this research was stimulated by the false-memory versus delayed-memory debate and the accompanying contention that therapists' personal issues and needs are causing therapists to influence clients' "memories" of CSA. While the current research is only a first step in the process of unraveling how or if therapists' CSA issues impact clients, the use of therapists as research participants may have brought the present research a step closer to understanding the association of therapist characteristics and therapists' assessment of possible CSA in adult cases. As such, the use of interns as research participants is a limitation of this study. Just as the graduate students in the STOCT's pilot test
responded differently to the clinical vignettes than did the doctoral interns in this study, practicing therapists may respond differently than interns. Therefore, surveying a national random sample of therapists currently working in the field may provide data more immediately relevant to the false memory versus delayed memory debate.

As mentioned earlier, the use of interns as research participants confounded the results regarding professional experience in the current study. Interns simply can not be expected to have large differences in the amount of clinical experience they have either in general or with CSA survivors. Small differences may not appropriately measure the effects of clinical experience on therapists' suspicions regarding the presence or absence of CSA in adult client cases.

The most significant limitation of this research is a product of the pioneering nature of the study and has to do with the measurement of the dependent variable. There were no instruments found in the literature to measure the research participants' sensitivity and ability to assess CSA in adult client cases. Therefore, it was necessary to develop a new instrument, the STOCI. While expert raters established the content and face validity, due to the novelty of the STOCI, it was not possible to establish concurrent validity. As measured by tests of internal consistency, a pilot-test indicated that the STOCI had adequate reliability. However, when used in the current survey, the STOCI had a low level or reliability. That meant there was no way of telling if the results were affected by random errors of measurement or if the results were an accurate representation of interns' sensitivity and ability to assess CSA in adult clients.
"Because the alpha coefficient [level of internal consistency] only marks the lower bound for the reliability, the actual reliability may still be high...it [alpha level] can be used to confirm that a test has substantial reliability. However, it cannot tell us that a test is unreliable" (Kaplan & Saccuzzo, 1989, p. 98). Therefore, this researcher submits the STOCI as a first step in developing a new method for researching therapists' suspicion of CSA and recommends further development and refinement of the STOCI to study possible relationships between therapist characteristics and therapists' assessment of CSA in adult client cases.

The STOCI

The STOCI was developed for research on therapists characteristics as they pertain to therapists' assessment of CSA in adult clients. Specifically, the STOCI was created to assess clinicians' sensitivity and ability to appropriately suspect the presence or absence of CSA as an important clinical issue in adult client cases. Although there is room for improvement, the STOCI provides the ground work for a much needed research tool. The reader is reminded that the STOCI consisted of ten written vignettes (five intended to stimulate a suspicion of CSA and five intended not to stimulate a suspicion of CSA), and a list of 12 clinical issues which follows each of the vignettes. Participants were asked to circle the issues that they suspect are most important in conceptualizing the cases presented in the vignette. Participants were also instructed to asterisk their three top choices when they circle more than three
issues in response to any one vignette. The responses are then examined for accuracy and type of error (not suspecting CSA in the vignettes where it is suggested and suspecting CSA in vignettes that are not designed to suggest CSA).

Summary of STOCI's Development

The STOCI played a key role in collecting data for the current research. Therefore, serious consideration was given to the STOCI's readability, validity, and reliability. The process of developing the STOCI included a prepilot with therapists from two different counseling centers, an assessment by expert raters, and a pilot study with graduate students in counseling and counseling psychology (see tier I of Chapter III). At the end of this process, expert raters were in 100% agreement that the STOCI had face validity and that it was a fair representation of the different types of client issues one could expect to see in a college or university counseling center. In addition, the feedback from the participants and experts, and the results of the tests of internal consistency from pilot data indicated that the STOCI had acceptable readability and was generally understood.

The reliability studies on the STOCI's pilot indicated that the STOCI had reasonably good reliability (Cronbach Alpha = .62) given the size of the pilot pool (n = 47) and the preliminary nature of this research. However, several problems became evident subsequent to the STOCI's use in the survey of interning doctoral level psychologists. When the STOCI was used in the survey of interning psychologists, the
reliability fell to below acceptable limits (Cronbach Alpha = .49) instead of improving with the larger research population (n = 125) as expected. This drop in reliability meant that the STOCI did not have internal consistency. Therefore, the results of this survey should not be generalized to other groups of clinicians.

The drop in reliability created some interesting questions. Why was the STOCI less reliable when used in the current study than it was during the pilot study? Is there a significant difference between graduate students and interns in the way in which they conceptualize client cases with possible CSA histories? The graduate students were asked to complete the STOCI in a classroom setting whereas interns were free to respond to the STOCI in an environment of their choice and at their own convenience. Did the way in which the STOCI was administered affect the reliability of the STOCI? Further study will be needed in order to answer these questions. However, before attempting further research with the STOCI, some improvements in the STOCI are recommended.

Possible Areas for Improvement to the STOCI

One area for improvement is in the five vignettes that were designed not to stimulate a suspicion of CSA. Almost everyone who completed the STOCI correctly responded to these five vignettes (i.e., did not suspect CSA). The lack of variation in these responses negatively affected the STOCI's reliability by limiting the number of items. In addition, this homogeneity of responses leaves open the possibility that the
STOCI was not sensitive enough to discriminate between participants who may be appropriately-sensitive and hypersensitive to CSA. The reader is reminded that the respondents’ STOCI scores only indicated varying degrees of sensitivity from hypo sensitive to appropriately sensitive. In other words, respondents only made errors of not suspecting CSA in the vignettes designed to stimulate a suspicion of CSA. One wonders if the non CSA vignettes depicted cases in which the clients had more severe difficulties, would some of the respondents be more likely to indicate a suspicion of CSA even if CSA was not part of the client’s history? While this is an interesting research question in itself, the question also raises some interesting questions for test construction and requires further investigation.

Given the purpose of the STOCI, perhaps it would be helpful if a large random sample of client cases from university counseling centers could be evaluated for severity of problems and history of CSA. The distribution of problem severity and CSA in the sample could then be reflected in the vignettes on the STOCI. Unfortunately, this type of research was beyond the scope and financial means of this research. However, future researchers may want to direct their resources to such research and improve upon the STOCI.

The STOCI’s instructions may be another area that could be changed to improve the STOCI’s usefulness in future research. As cautioned by the expert raters, the STOCI participants may have made idiosyncratic interpretations of the instructions. In fact, two interns commented on some vignettes that they would have
liked to have "ruled out" CSA; however, the interns did not circle CSA as an important issue that they would "suspect" when conceptualizing the vignettes. This researcher found it interesting that the participants chose to mention ruling out CSA as opposed to any of the other 11 issues listed as possible choices. One wonders if other respondents had similar reactions to the instructions. If so, what do the reactions mean in terms of the readability of the STOCI and the wording of instructions? Further, what do the reactions mean in terms of the participants' comfort with "suspecting" CSA and does the current climate of the false memory versus delayed memory debate affect the participants' responses?

Changing the response options on the STOCI might improve the STOCI's usability in future research. Instead of circling issues in response to the cases presented in the vignettes, the participants could be asked to indicate, on a scale of 1 to 5, the degree to which each of the issues are significant in the case conceptualization. The number of issues following each vignette could be reduced to manage the amount of time required to complete the STOCI. While this response format would force the participants to consider CSA, it may provide valuable information about participants' tendency to accept or reject CSA as a significant issue in adult client cases. Such a format may also have the added advantage of providing more gradients in participants' responses and provide a better means of comparison between respondents than does the current format.
Summary of Findings and Their Significance

In conclusion, the current research was a first attempt to investigate a previously undocumented area of empirical research on the association of therapist characteristics with therapists' sensitivity and ability to accurately suspect the presence or absence of CSA in adult client cases. It contributes to the literature in several ways. First, a method that was not based solely upon therapists' self-report was developed. The current research is the first research on the relationship between the therapist characteristics of clinicians who work with CSA survivors and their clinical behaviors that does not rely on therapist's self report of their behaviors. The method was accomplished by creating an instrument to assess therapists' suspicion of CSA that did not alert the participants to the fact that their suspicion to possible CSA was being examined. In the process of developing this method a new instrument was produced, the STOCI. With improvement, the STOCI may be a useful tool in future research.

Another way in which this research contributes to the literature is in the descriptive statistics it provides on intern ing psychologists and their possible personal and professional experiences with childhood sexual abuse. The results of the current study clearly indicate that the majority of clinicians can expect to encounter clients who are survivors CSA. Many of these clinicians will themselves be survivors of CSA. The current research indicates that there is no association of therapists' sensitivity and ability to correctly suspect CSA in adult client cases with therapists' history regarding
Therefore, it appears that having a personal history of CSA neither enhances nor impairs therapists' ability to correctly suspect CSA in their adult client cases.

The results of the current research provides empirical data that supports clinicians' suspicions that male therapists and female therapists react differently to possible CSA in their adult clients. The responses of the female interns in this study indicate that females are more appropriately sensitive and are more accurate in their suspicions of CSA in adult cases than are males. More research will be needed to determine the ramifications of this difference.

However, the findings regarding gender differences in conjunction with other findings in the current research suggest an interesting possibility. Perhaps the amount of information and the way in which women process and share information are responsible for the differences in therapists' ability to correctly suspect the presence of CSA in adult client cases. Because women are more often victims of CSA and because women are the tradition nurturers of children, it is likely that women are more aware of the need to be well informed about CSA than are men. In addition, women appear to be more communicative and sharing with each other about personal issues and vulnerabilities than are men. Combined with the findings that professional experience with CSA is more predictive of participants' accuracy in suspecting CSA survivors than is personal experience (i.e., being a survivor or knowing a survivor) gender differences suggest that knowledge, not emotional and unresolved personal
issues, is the prime factor in determining therapists' ability to correctly suspect CSA in adult client cases.

Perhaps with further research, new studies will be able to determine if, or what therapist's characteristics are predictive of therapists' suspicions regarding the presence or absence of CSA in their cases. It could be very helpful to consumers as well as educators and clinicians to know if there are therapist characteristics that are associated with hypersensitivity, hyposensitivity, or appropriate sensitivity to possible CSA. Further, it may be possible to determine if therapists who are hypersensitive to CSA influence their clients to create false memories of CSA and if therapists who are hyposensitive to CSA falsely support their clients' denial of remembered CSA. At the present, accusations that therapists are influencing their clients' memories, or lack there of, as a result of their own issues are not substantiated by empirical evidence.

Research that can help therapists to identify their part in the false or delayed memories of their clients is critical. It is hoped that many of the professionals who are currently involved in the false memory versus delayed memory debate will take up this line of research. Perhaps the debaters can examine the current research and make improvements to better understand the relationship of therapist characteristics and therapists' assessment of the presence or absence of CSA in adult client cases. Such research can use the debaters' commitment and energy because no one research project will be able to clarify the therapist-client dynamics related to the recovery work of clients who come to believe they are survivors of CSA. By way of a beginning, the
current research provides data which are consistent with recent findings on therapist characteristics (i.e. there are gender differences, significant numbers of therapist are CSA survivors, a clear majority of therapists report they have professional experience with CSA, and the clinical behaviors of therapists who work with possible CSA survivors do not appear to be associated with whether or not therapists are survivors of CSA). Finally, the current research contributes substantial ground work in the development of a new method to explore the association of therapists characteristics with therapists' sensitivity and ability to accurately suspect the presence or absence of CSA in adult client cases.
Appendix A

Sensitivity Test of Clinical Issues
SENSITIVITY TEST OF CLINICAL ISSUES

The following are ten vignettes depicting female client cases that you might expect to see at a college or university counseling center. After each vignette you will find a list of 12 possible clinical issues. Please read each vignette and circle the issues that you suspect would be the most important issues for conceptualizing the case presented in the vignette. Circle only the most important issues. Work as quickly as you can. If you need to circle more than three issues, please indicate your three top choices by marking them with an asterisk (*). Do not read ahead or return to previously answered vignettes. Please do not consult with anyone regarding your answers.

Question # 1:

The client is a 19 year old single college sophomore. She is 5'6" and weighs 200 pounds. While living on campus, she was referred for psychotherapy by the university MD. The doctor had first treated her one year ago (October) for lacerations to her right hand and wrist. In December, the client was treated for accidentally burning her forearm on a hot oven rack. The following January, she "accidentally" burned her right inner thigh while ironing her clothes on her bed. This burn subsequently became infected and was treated in February. The doctor became suspicious while treating the client's burn when he observed two smaller burns (possible cigarette burns) on her left thigh. The client says, "I'm just clumsy, I guess" and claims her doctor "likes to make a big thing out of nothing."

The client states that her mother is really terrific, but that, "She's never home because she works all the time to support my damn father." The client has two younger brothers (ages 15 and 16). She has been concerned about them since she left for college because she is not home to look after them. The client says she wishes she could kill her father and that her father has been "a no good drunk" for as long as she can remember. She became teary eyed when she stated, "I hate him."

Based on the above vignette, please circle only the most important issues that you would suspect when conceptualizing this case. Work as quickly as you can. If you need to circle more than three issues, please indicate your three top choices by marking them with an asterisk (*).

1) Alcohol/Drug Abuse  5) Emotional/Physical Abuse  9) Sleep Problems
2) Childhood Sexual Abuse  6) Family/Romantic Relationships  10) Suicidal Thoughts
3) Depression  7) Self-esteem  11) Stress
4) Eating Problems  8) Sexual Identity/Orientation  12) Vocational

Sensitivity Test of Clinical Issues continued
Question # 2:

The client is 20 years old. She is in her senior year of college and has just completed her student teaching requirement for a secondary education certification. She has reported to the counseling center "in crisis" because she "hates teaching," wants to change her major but doesn't know to what, and is afraid she is going to disappoint her parents. Both of her parents are teachers and they had hoped that she would follow in their footsteps. She is supposed to go home this weekend and interview for a summer job tutoring students in a reading resource lab at the community college where her mother works. The client wants to take a summer job in the town where her boyfriend lives. Her mother and father don't even know that she has a boyfriend. The client says that she has never challenged her parents' plans for her. She is so upset about confronting them now that she cannot sleep and has been throwing up for the past week.

Based on the above vignette, please circle only the most important issues that you would suspect when conceptualizing this case. Work as quickly as you can. If you need to circle more than three issues, please indicate your three top choices by marking them with an asterisk (*).

1) Alcohol/Drug Abuse 5) Emotional/Physical Abuse 9) Sleep Problems
2) Childhood Sexual Abuse 6) Family/Romantic Relationships 10) Suicidal Thoughts
3) Depression 7) Self-esteem 11) Stress
4) Eating Problems 8) Sexual Identity/Orientation 12) Vocational

Sensitivity Test of Clinical Issues continued
Question # 3:

The client is a 38 year old married mother of three children (girl 17, girl 15, and boy 13) with 15 years experience as an elementary school teacher. She was an only child and "had to take care of" her mother who was "emotionally unbalanced" and remote. The client was "extremely close" to her father and was "sad" when he died. She reports that her relationship with her mother has improved "some" since her father's death. Presently, the client is requesting therapy for help in deciding whether or not she should get a divorce. She reports having a lot of unexplained shame and that she has been considering divorcing her husband ever since her father died five ago. Currently, she is "tired all the time" and is having "nightmares where I dream I kill myself." She says "The dreams show how desperately I want out of this marriage." The client states that her "husband doesn't drink or do drugs. He is just demanding and our sex life is terrible." She also says, "I know it sounds awful, but the only reason I married him was to get away from my parents."

Based on the above vignette, please circle only the most important issues that you would suspect when conceptualizing this case. Work as quickly as you can. If you need to circle more than three issues, please indicate your three top choices by marking them with an asterisk (*).

1) Alcohol/Drug Abuse  5) Emotional/Physical Abuse  9) Sleep Problems
2) Childhood Sexual Abuse  6) Family/Romantic Relationships  10) Suicidal Thoughts
3) Depression  7) Self-esteem  11) Stress
4) Eating Problems  8) Sexual Identity/Orientation  12) Vocational

Sensitivity Test of Clinical Issues continued
Question # 4:

The client is a 19 year old, single college freshman. She requested therapy because of her growing concerns that she "may have an alcohol problem" and because of "body image problems." She reports that she drinks between 6 and 8 beers nightly. In addition, the client says that she "had to give up an athletic scholarship" because she "got into a fight" with her coach when the client was "under the influence." She states that sports were the only way in which she and her father ever connected. She says that she is very depressed because "now that mom and dad are divorced, and I don't play sports anymore, dad hardly even talks to me."

The client says that her body image problems are compounded by the fact that she "knew too much about sex too early." She reports that her parents were very progressive and supportive. They wanted her to "feel good about my sexuality" and therefore talked very openly with her. She says that ever since she can remember, her parents allowed her to "watch pornographic movies" and that "they left porn magazines laying around the house." She says her parents always encouraged her to ask any questions she might have, but that she never really had to ask anything. She states that she wishes she didn't know so much about sex. She also said that she wished she didn't feel like she had to have sex with her boyfriends in order to have a relationship with them.

Based on the above vignette, please circle only the most important issues that you would suspect when conceptualizing this case. Work as quickly as you can. If you need to circle more than three issues, please indicate your three top choices by marking them with an asterisk (*).

1) Alcohol/Drug Abuse 5) Emotional/Physical Abuse 9) Sleep Problems
2) Childhood Sexual Abuse 6) Family/Romantic Relationships 10) Suicidal Thoughts
3) Depression 7) Self-esteem 11) Stress
4) Eating Problems 8) Sexual Identity/Orientation 12) Vocational

Sensitivity Test of Clinical Issues continued
Question # 5:
The client is a 45 year old woman who is returning to college after 25 years. She reports that all five of her children have grown and that her husband died unexpectedly a year ago from a heart attack. She started a bachelor degree in home economics 27 years ago. However, she dropped out of school after two years to get married and have a family. She states that her husband was a very successful businessman and that she did not need to work. She used her education raising her family and doing a lot of entertaining for her husband’s business colleagues. She reports being very proud of her ability to "put on a good business party." She says that originally she thought she could support herself by starting a catering business, but now she is not so sure and is wondering if there is anything she could take in college that could help her get a career launched. She says that she does not want to be going to school when she turns 50. However, she would be willing to "start all over in another career" if she could graduate with a marketable career in four years. She says that she doesn’t mind hard work and that a difficult academic program would help her take her mind off her husband.

Based on the above vignette, please circle only the most important issues that you would suspect when conceptualizing this case. Work as quickly as you can. If you need to circle more than three issues, please indicate your three top choices by marking them with an asterisk (*).

1) Alcohol/Drug Abuse
2) Childhood Sexual Abuse Thoughts
3) Depression
4) Eating Problems
5) Emotional/Physical Abuse
6) Family/Romantic Relationships Thoughts
7) Self-esteem
8) Sexual Identity/orientation
9) Sleep Problems
10) Suicidal
11) Stress
12) Vocational

Sensitivity Test of Clinical Issues continued
Question #6:

The client is a 21 year old college senior. She appears tall, thin and tired. She is about to graduate with a bachelor of science in architecture. She states that she has been working so hard for so long that she has forgotten how to sleep. She says that she is excited about graduating and already has a good job lined up. She is planning a June wedding and couldn't be happier.

When asked what brought her to counseling, she said her family thought she should come. She explained that when she was a junior she started gaining weight because she was too busy with her studies to exercise. She had gotten a prescription from her doctor, which helped her lose a little weight. About four months after she started taking her medicine she started dating her fiancé. He was in the pharmacy program and is also graduating in the spring. She says she stopped seeing her doctor because her fiancé could get her pills for her, but that he always lectured her about needing to see her doctor. Her fiancé said that if she wasn't going to see a doctor she should get some counseling.

The client said that she was shocked that he would suggest such a thing. She said that she discussed the situation with her mother and that her mother didn't think there was any problem. However, the client's mother talked with the client's father. The client said that at first her father "exploded and threatened to have my fiancé's career crushed". She said that after he calmed down and talked with her fiancé, her father said that she should come in for counseling. The client says she has not taken any pills in the past two days just to prove to herself that she can stop taking her medicine without any problems. She reports that she feels a little tired but that she is fine. She says that she will just take her pills when she has a big final project. However, she would like to come in for counseling until she graduates to "explore how to manage her career and a life as a wife at the same time."

Based on the above vignette, please circle only the most important issues that you would suspect when conceptualizing this case. Work as quickly as you can. If you need to circle more than three issues, please indicate your three top choices by marking them with an asterisk (*).

1) Alcohol/Drug Abuse
2) Childhood Sexual Abuse
3) Depression
4) Eating Problems
5) Emotional/Physical Abuse
6) Family/Romantic Relationships
7) Self-esteem
8) Sexual Identity/Orientation
9) Sleep Problems
10) Suicidal Thoughts
11) Stress
12) Vocational

Sensitivity Test of Clinical Issues continued
Question #7:

The client is a 40 year old mother of two. She is returning to college after three unsuccessful marriages. She says that her first husband was "hateful" and used to make "rude comments about my weight when we made love." She says that he used to make her "take speed to stay thin." The client reports that after 14 years of marriage he left her for a younger woman. She said that she remarried three months later to a drunk that used to like to spank her during sex. She said that he was really crazy so she left him after two years.

The client reports that she was alone for about three years following her second marriage. During that time she states that she was in and out of the hospital and ended up seeing a male psychiatrist that diagnosed her as schizophrenic. She says that she used to see things that weren't there and had terrible nightmares. The nightmares are usually of "a silhouette of a giant leering at me. He never moves, but I'm terrified and wake up trembling." She reports that her doctor put her on medication, but she had never told him she was taking speed. Consequently, she says she had a bad reaction and went to the hospital. Her doctor became furious with her and referred her to someone else. The client says that she never went to the suggested therapist, but that she did quit taking speed while in treatment at the hospital. She reports that she has not taken speed or any medication since.

When she was thirty-eight she remarried for the third time. She reports that this marriage only lasted for about six months. She said that she "knew real fast that he was an alcoholic. When he got drunk one night and threatened to kill me, I left. The next morning I filed for divorce." She states that: "Basically life has been going along fine since, but just recently my dreams have come back. I don't want to be crazy again, and honest I'm not taking any speed, so it can't be that. I just want to keep my life together and finish up school so that I can have a decent job."

Based on the above vignette, please circle only the most important issues that you would suspect when conceptualizing this case. Work as quickly as you can. If you need to circle more than three issues, please indicate your three top choices by marking them with an asterisk (*).

1) Alcohol/Drug Abuse  5) Emotional/Physical Abuse  9) Sleep Problems
2) Childhood Sexual Abuse  6) Family/Romantic Relationships  10) Suicidal Thoughts
3) Depression  7) Self-esteem  11) Stress
4) Eating Problems  8) Sexual Identity/Orientation  12) Vocational

Sensitivity Test of Clinical Issues continued
Question #8:

The client is a 19 year old freshman who reported to the college counseling center because she was "so depressed I didn't know what else to do." She states that two years ago she was "successfully treated with an antidepressant by my father" but doesn't want to take them again because "they made me sleepy and gave me bad dreams". She says that her bad dreams are "too sick to talk about". Client reports that her father is a urologist and that he is the only doctor she has ever seen.

She reports that she has not been able to sleep or eat since her boyfriend, Bill, and she broke up a week ago. She says that she has never loved anyone as much as Bill and can't imagine living without him. She says that "everyone says that he wasn't good enough for me, and I should be glad that he's screwing up someone else's life up. I just don't feel that way." She says that "he has always gone out on me and sometimes he would hit me, but I didn't think he would ever dump me". She reports that her grades are suffering because she can't think about anything else and she is wondering if there is anything she could do to make him come back to her. She suggested that maybe if she lost weight or learned to be happier he would love her again. The client is 5'6" and 125 pounds.

The client says that one of the problems they had was that she didn't drink or smoke and that he liked to "party down". She says that whenever they went out, Bill would end up in a fight with a guy who was looking at her. She also reports that Bill was no longer happy with petting and oral sex and he wanted to have intercourse. However, she says that she is Catholic and doesn't believe in having intercourse before marriage. In addition, it made her "sick" when he touched her "down there". She says that she is the only one she knows that hasn't had intercourse and that maybe she is wrong. "Maybe if I'd have sex with him he would come back." She would like to know what to do.

Based on the above vignette, please circle only the most important issues that you would suspect when conceptualizing this case. Work as quickly as you can. If you need to circle more than three issues, please indicate your three top choices by marking them with an asterisk (*).

1) Alcohol/Drug Abuse 5) Emotional/Physical Abuse
2) Childhood Sexual Abuse 6) Family/Romantic Relationships
3) Depression 7) Self-esteem
4) Eating Problems 8) Sexual Identity/Orientation
9) Sleep Problems 10) Suicidal Thoughts
11) Stress
12) Vocational

Sensitivity Test of Clinical Issues continued
Question # 9

The client is a 38 year old mother of two teen age girls. She has requested therapy to know how to deal with telling her children that she is a lesbian. She reports that she "divorced the girl's father ten years ago because he was an alcoholic who refused help." She had never considered any thing but a "straight life" until about two years ago. She says that one night she went out to a new bar with some friends. She got drunk and ended up in bed with a woman. She reports that it was the best sex in her life and it's only gotten better since. She explained that "sex with a woman is more loving and caring... More than sex, a relationship with a woman is intimate companionship." However, she doesn't think her girls will understand. She states that identity is confusing enough when you are a teenager without hearing your mother is a lesbian. She says that she and her daughters are very close and that, "We know practically everything about each other." The client says that she doesn't know how she has been able to keep her sexual preference from them. She says that her lover is over to the house all the time and that her girls really like her, but that "the girls wouldn't suspect we're lovers". The client says that she would like to have her lover move in, but doesn't know what to tell her daughters.

Based on the above vignette, please circle only the most important issues that you would suspect when conceptualizing this case. Work as quickly as you can. If you need to circle more than three issues, please indicate your three top choices by marking them with an asterisk (*).

1) Alcohol/Drug Abuse  5) Emotional/Physical Abuse  9) Sleep Problems
2) Childhood Sexual Abuse  6) Family/Romantic Relationships  10) Suicidal Thoughts
3) Depression  7) Self-esteem  11) Stress
4) Eating Problems  8) Sexual Identity/Orientation  12) Vocational

Sensitivity Test of Clinical issues continued
The client is a 20 year old international student from India. She is a straight A student in her Junior year of pre-med. studies. She is seeking counseling because of "mental confusion" and "feeling panicky". She reports that she has not been able to concentrate lately and is concerned that her grades may be effected. She looks gaunt and fatigued with a blunted affect. She reports that she is living with a large extended family while she attends school in the US. She states that there are two young women with children where she is living and that they keep her awake at night with their noise. She also reports that she has been too busy to eat much lately. She says that she is a vegetarian and, if she had more time to prepare food, she would eat better. However, she says that "it is probably just as well that I fast as I am already a burden on my family and friends. You see, I have very little money and my family must support me." The client says that she works as much as she can tutoring students, but that she is not supposed to work off campus because of her student status. When asked what she does for relaxation or entertainment, she said, "I study and go to school. After I become a doctor I can relax."

Based on the above vignette, please circle only the most important issues that you would suspect when conceptualizing this case. Work as quickly as you can. If you need to circle more than three issues, please indicate your three top choices by marking them with an asterisk (*).

1) Alcohol/Drug Abuse  5) Emotional/Physical Abuse  9) Sleep Problems
2) Childhood Sexual Abuse  6) Family/Romantic Relationships  10) Suicidal Thoughts
3) Depression  7) Self-esteem  11) Stress
4) Eating Problems  8) Sexual Identity/Orientation  12) Vocational

You have reached the end of the Sensitivity Test of Clinical Issues. Do not return to the STOCI or make any changes at this time. Please complete the following two paged Therapist's Data Sheet.
Appendix B

Therapists' Data Sheet
Therapist's Data Sheet

Please answer all of the following questions as they best describe you. Do not look back at your previous responses. Remember that all of your responses are anonymous.

Circle the answer that best describes you.

1) Indicate your sex. 
   Male □ Female □

2) Have you ever received counseling or therapy for psychological or interpersonal issues?
   Yes □ No □

3) What is your age? ______

4) What is your racial group?
   Asian □ Asian-Pacific □
   African-American □ Caucasian □
   Hispanic □ Native American □
   Other □

5) What program will you receive your degree from?
   Clinical Psychology □ Counseling Psychology □
   Educational Psychology □
   Other □

6) Do you have training in a clinical specialty area(s) i.e., Family and Marriage, Holistic Health, Substance Abuse, etc... If so, indicate. 

__________________________________________________________
Therapist's Data Sheet Continued

Please note the list below of possible problem areas for which a client might seek professional help. To the right of this list are three columns of lines with headings indicating three ways in which one might have experience with the areas: Professional experience with 3 or more clients; A close friend, family member, or significant other; and Personally experienced. Please check the ways in which you have had experience with each of the possible problem area. For example, you may have had professional experience working with three or more clients who have an alcohol or drug abuse problem. You may have also abused drugs or alcohol yourself. In this case, you would check the first and third lines to the right of "Alcohol/Drug Abuse".

Please read the following list of possible problem areas and check all the ways you have experienced each area. If you have never had any experience with a problem area, leave the lines to the right of that area blank.

<table>
<thead>
<tr>
<th>Problem Areas</th>
<th>Professional Experience with 3 or More Clients</th>
<th>A Close Friend, Family Member, or Significant Other</th>
<th>Personally Experienced</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol / Drug Abuse</td>
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<td></td>
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<tr>
<td>Childhood Sexual Abuse</td>
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<td>Depression</td>
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<td>Eating Problem</td>
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<td>Emotional / Physical Abuse</td>
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<td>Sexual Identity</td>
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<td>Sleep Problem</td>
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<td>Suicidal Thoughts</td>
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<td>Stress</td>
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<tr>
<td>Vocational</td>
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</tbody>
</table>

You have reached the end of this survey. Please return the completed survey in the return envelope provided. If you have lost your envelope, send the survey to:

Sherri Terrell, Department of Counselor Education and Counseling Psychology, Western Michigan University, Kalamazoo MI 49008-5195.

Thank you for participating in my dissertation research. Good luck on your internship.
Appendix C

Letter of Introduction
Dear

Sherri Terrell is a doctoral candidate at Western Michigan University and an intern from our Counseling and Testing Service. She is looking for doctoral interns in psychology to participate in her dissertation research and is mailing sets of questionnaires to all the training directors who are members of ACCTA. She could use our support and assistance in delivering these questionnaires to our respective interns.

Enclosed you will find a research packet for each of the intern positions you have at your site. Please distribute the packets to your interns. A return envelope is included for convenience. Thank you for your help.

Sincerely,

Ken Waldman, Ph. D.
Director, Psychological Services and Training
Counseling and Testing Service
Appendix D

Cover Letter
September, 1995

Dear Training Director:

Please allow me to introduce myself. I am a doctoral candidate in Counseling Psychology at Western Michigan University. I am currently working on my dissertation and would appreciate your assistance. Enclosed you will find research packets for surveying interns and their assessment of clinical issues. To standardize the recruitment process, please distribute the packets to your interns without comment. A copy of the letter of information is attached for your reference. This letter, which is in the research packets, invites interns to participate in my dissertation research and provides information about the study.

This research is designed to be anonymous. Interns choosing not to participate are requested to return their unanswered research instruments. Interns choosing to participated are instructed to return their completed research instruments. Therefore, each packet contains its own reply envelope and does not require further involvement on your part. However, if all the interns do not return their research instruments, approximately one month from now I will send you a follow-up request for participation. At that time, I would appreciate it if you would distribute the follow-up letter to your interns. If you have any questions about this research please feel free to contact me or my chair, Dr. James Croteau at:

Department of Counselor Education and Counseling Psychology
Western Michigan University
Kalamazoo, Michigan 49008-5195

If you prefer to call, I can be reached at (517) 588-4010. Dr. Croteau can be reached at (616) 387-5111. You may also contact the Chair of Human Subjects Institutional Review Board or the Vice President for Research at (616) 387-6293 with any concerns you may have.

Thank you for your assistance. Please accept the sticker enclosed as my way of saying thank you for your time and consideration.

Sincerely,

Sherri I. Terrell
Appendix E

Request for Interns' Participation
September, 1995

Dear Intern,

I would like to ask your assistance in collecting the necessary data to complete my dissertation. This study is designed to collect information about interns' assessment of clinical issues in response to provided vignettes.

If you agree to participate in this study, you will need to complete the enclosed survey. The survey will ask you to select key clinical issues in ten client vignettes. You will also be asked for personal information related to your experience with clinical issues. It should take about 30 minutes to answer all the questions. If you choose not to participate, please return the unanswered survey in the envelope provided. Any response on your part is entirely voluntary and you can choose not to respond without prejudice or penalty.

The surveys have research numbers on them that identify your internship site and not individuals. (All interns at any one site will have the same number.) These numbers will only be used for tracking purposes. When surveys are received, the numbers will be cut off and put into an envelope for tracking purposes. Thus your responses are anonymous. In one month, if all the interns at your site have not returned either blank or completed surveys, a follow-up letter inquiring about participation will be sent to all the interns at your site.

As in all research, there may be unforeseen risk to the participant. If an accidental injury occurs no compensation or treatment will be made available to the subject except as otherwise stated in this letter. Please know that no risk is expected, and that the information collected on interns' assessment of clinical issues may be useful in future training and research. It may also benefit practitioners by providing information on their expected sensitivity to clinical issues.

Your completion of the survey will indicate that you have read, understood, and voluntarily agreed to participate. If you have any questions about this research please feel free to contact me or my dissertation chair, Dr. James Croteau at:

Department of Counselor Education and Counseling Psychology
Western Michigan University
Kalamazoo, Michigan 49008-5195

If you prefer to call, I can be reached at (517) 588-4010. Dr. Croteau can be reached at (616) 387-5111. You may also contact the Chair of Human Subjects Institutional Review Board or the Vice President for Research at (616) 387-8293 with any concerns you may have.

Please keep the enclosed sticker as my thanks for your time and consideration.

Sincerely,

Sherri I. Terrell
Appendix F

Training Directors' Follow-up Letter
October 24, 1995

Dear Training Director:

Thank you for reviewing the material I previously sent to your interns in care of you. You may recall that I requested your assistance in distributing research packets to survey your interns and their assessment of clinical issues.

In order to facilitate my research, I would appreciate it if you would also distribute the enclosed follow-up letters. It is important that neither you or I know who has, or has not, chosen to participate my research. Therefore, please give the follow-up letters to all of your interns. An extra copy of the interns' follow-up letter has been enclosed for your information. The letter asks interns who have decided to participate in my dissertation research, but who have not yet responded, to please do so as soon as possible. Anticipating that some of your interns may have misplaced their packets, I have enclosed additional packets. Please make the research packets available in a central location where they can be picked up anonymously by interns.

If you have any questions about this research please feel free to contact me or my dissertation chair, Dr. James Croteau at:

Department of Counselor Education and Counseling Psychology
Western Michigan University
Kalamazoo, Michigan 49008-5195

If you prefer to call, I can be reached at (517) 588-4010. Dr. Croteau can be reached at (616) 387-5111. You may also contact the Chair of Human Subjects Institutional Review Board or the Vice President for Research at (616) 387-8293 with any concerns you may have.

Thank you for your assistance.

Sincerely,

Sherri L. Terrell
Appendix G

Interns' Follow-up Letter
October 24, 1995

Dear Intern:

As you may recall, I previously requested your participation in my dissertation research on therapists' assessment of clinical issues. Since the responses were anonymous, I have no way of knowing whether or not you have responded or wish to respond. Therefore, I am sending this follow-up reminder to all the interns at your site. If you have returned a survey, thank you. You do not need to do anything more. If you have not returned a survey and do not want to participate in this research, please return an unanswered survey at this time. If you are considering participation in the research and have not as yet returned the completed survey, please read the letter of information attached to the survey. Then, complete the survey and return it as soon as possible. In the event that your letter of information and, or, survey have been misplaced, please know that additional copies are available. I have sent additional research packets to your director with the request that they be placed in a central location where you can pick them up anonymously. Return envelopes are included in the packets.

Again, thank you for your time and assistance. Please accept the attached sticker as my thanks for your time and consideration.

Sincerely,

Sherri I. Terrell
Appendix H

Prepilot Permission Letter From HSIRB
Date: April 17, 1995
To: Terrell, Sherr
From: Richard Wright, Interim Chair
Re: HSIRB Project Number 95-04-14

This letter will serve as confirmation that your research project entitled "Pre-pilot of the sensitivity test of clinical issues to assess sensitivity to childhood sexual abuse" has been approved under the exempt category of review by the Human Subjects Institutional Review Board. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note that you must seek specific approval for any changes in this design. You must also seek reapproval if the project extends beyond the termination date. In addition if there are any unanticipated adverse or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: Apr. 17, 1996

xc: Croteau, James, CECP
Appendix I

Pilot Permission Letter From HSIRB
Date: June 5, 1995
To: Terrell, Sherri
From: Richard Wright, Interim Chair
Re: HSIRB Project Number 95-05-24

This letter will serve as confirmation that your research project entitled "Pilot of the sensitivity test of clinical issues to assess sensitivity to childhood sexual abuse" has been approved under the exempt category of review by the Human Subjects Institutional Review Board. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note that you must seek specific approval for any changes in this design. You must also seek reapproval if the project extends beyond the termination date. In addition if there are any unanticipated adverse or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: June 1, 1996

xc: Croteau, James, CECP
Appendix J

Survey Permission Letter From HSIRB
Date: September 10, 1995
To: Sherri Terrell
From: Richard Wright, Chair
Re: HSIRB Project Number 95-09-01

This letter will serve as confirmation that your research project entitled "The association of five therapist characteristics with therapist's sensitivity to childhood sexual abuse" has been approved under the exempt category of review by the Human Subjects Institutional Review Board. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note that you must seek specific approval for any changes in this design. You must also seek reapproval if the project extends beyond the termination date. In addition if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: September 10, 1996

xc: James Croteau, CECI
BIBLIOGRAPHY


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