

Sexual Offender, Sexual Abuse Victim, and Generalist Population Therapists'
Perceptions of Permissive Parent-Child Sexual Boundaries and Altered Perceptions of
Self, Others, and Adaptation to the World as a Result of Vicarious Trauma

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Self, Others, and Adaptation to the World as a Result of Vicarious Trauma

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Abstract

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The purpose of this study was to determine if therapist levels (therapists who treat sexual offenders, sexual abuse victims, and general population clients) differ in terms of therapists' overall perceptions of permissive parent-child sexual boundaries and therapists' altered perceptions of self, others, and adaptation to the world as a result of vicarious trauma. Participants in this study consisted of graduate level therapists holding membership in one of three professional organizations: (a) Association for Treatment of Sexual Abusers (ATSA), (b) American Professional Society on the Abuse of Children (APSAC), (c) American Mental Health Counselors Association (AMHCA). Data were collected using four instruments: (a) Trauma and Attachment Belief Scale (TABS; Pearlman, 2003), (b) Secondary Traumatic Stress Scale (STSS; Bride, 1999), and (c) Permissiveness of Parent- Child Sexual Boundary Scale (PPCSBS), and (d) demographic questionnaire. The multivariate analysis of variance (MANOVA) was used to analyze the data.

Significant differences in the levels of therapists were found based upon professional organization membership. However, examination of the effect size (.05) found the differences between the therapist levels to be quite small and unimpressive. ATSA members reported significant differences in increased disrupted cognitive schemas (as

measured by TABS) compared to APSAC members and AMHCA members. ATSA members scored significantly higher on the TABS subscales for Other-Safety, Other-Trust, and Other-Esteem. AMHCA members reported significant differences in permissive parent-child sexual boundaries behaviors (as measured by PPCSBS) compared to APSAC and ATSA members. AMHCA members reported sexual boundary behaviors to be appropriate for only younger age children, while the APSAC and ATSA members reported sexual boundary behaviors to be appropriate for both younger age and slightly older age children.

No significant differences in the levels of therapists were found based upon the number of hours per week treating sexual offender and sexual abuse victim clients together. However, supplemental analyses found increased TABS subscale scores of Other-Safety, Other-Trust, and Other-Esteem for therapists treating sexual offender clients 20 or more hours per week. No significant differences in the levels of therapists were found based upon the number of years of clinical experience.

Lastly, examination of the PPCSBS instrument found the scale to be unrelated to the TABS and STSS. The TABS and STSS were found to be highly correlated instruments of vicarious trauma. Thus it appears that therapists' perceptions of permissive parent-child sexual boundaries are unrelated to symptoms of vicarious trauma.

Approved: _____

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*I dedicate this work to the memory of my grandparents, Mary Geneva Robinson
and Walter Earl Jones. Both have been an inspiration in my life.*

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Chapter One

Introduction

Inappropriate sexual boundaries between parent and child may be as potent as overt sexual abuse in creating sexual confusion, anxiety, and disturbed sexual behaviors in young children (Johnson & Hooper, 2003). Covert sexual abuse, a sexualized climate of verbally or nonverbally communicated attitudes toward sexuality, may arise in families with inappropriate sexual boundaries (Gil, 1993). Family sexual boundary violations are behaviors that fall along a continuum ranging from overt blatant sexual acts, which all agree constitute abuse, to covert sexual acts that many find inappropriate but few label abusive (Cohen, 1995). Boundary violations that increase the child's exposure to sexual situations may be over stimulating, traumatic, not fully understood, or integrated resulting in an increase in the child's interest and knowledge of sexuality (Gil, 1993).

Frequently sexualized children are referred for evaluation and treatment to therapists in private or public agency settings (Gil & Johnson, 1993). The term "sexualized children" refers to children who engage in sexual behaviors that seem problematic and elicit adult concern (Gil, 1993). Therapists who receive referrals for sexualized children have several tasks. One task is to evaluate if the sexualized child's behavior is safe, age-appropriate, or requires treatment intervention other than parental education (Gil & Johnson, 1993). Another task is to identify family dynamics that may contribute to the sexualized child's behaviors (Gil, 1993). The therapists must also determine what behaviors violate appropriate family sexual boundaries. Gil defines appropriate family sexual boundaries as not overstepping the boundaries of propriety.

There is confusion among professionals regarding the definition of child sexual

abuse, particularly behaviors that violate family sexual boundaries. Due to this confusion it is difficult to estimate the exact number of children who have been victims of child sexual abuse (Goldman & Padayachi, 2000). A study by Freyd, Putnam, Becker-Blease, Cheit, and Siegel (2005) found mean prevalence rates for child sexual abuse to be 20% for women and 5% to 10% for men worldwide. There appears to be an upward trend in the prevalence of child sexual abuse. This may be due to the increase in public awareness and reduction in stigmatization associated with reporting rather than the number of actual new cases (Goldman & Padayachi, 2000). Evolving public perceptions of what constitutes child sexual abuse, in particular behaviors that violate family sexual boundaries, may contribute to an increase in mean prevalence rates of child sexual abuse. Although child sexual abuse may occur in many forms, of particular concern in this study is the definition of appropriate parent-child sexual boundaries.

Much ambiguity exists regarding appropriate parent-child sexual boundaries (Johnson & Hooper, 2003). Despite research on the effects of parent-child sexual boundary violations to the child, there are no empirically derived norms on appropriate touch among family members (Rosenfield, Bailey, Siegel, & Bailey, 1986). Definitions of child sexual abuse, in particular parent-child sexual boundary violations, may vary based upon values of the culture and individual (Atterberry-Bennett, 1987; Carsten, 2001).

Several researchers (Atterberry-Bennet, 1987; Cohen, 1995; Disimone-Weiss, 1999; Johnson & Hooper, 2003) attempted to reach consensus regarding appropriate child sexual boundaries by studying various professional groups. However their research indicated a lack of consensus among professionals in defining behaviors considered

covert sexual abuse between parent and child (Atterberry-Bennet, 1987; Cohen, 1995; DiSimone-Weiss, 1999; Johnson & Hooper, 2003). Researchers discovered that professionals' perceptions regarding appropriate sexual boundaries for specific parent-child behaviors varied across all professions and within professional groups (Atterberry-Bennet, 1987; Cohen, 1995; DiSimone-Weiss, 1999; Johnson & Hooper, 2003). Despite the lack of consensus regarding specific parent-child behavior, there was agreement regarding the following: sexual boundaries were more permissive when (a) the parent's gender was the same as the child, (b) the child was a younger age, or (c) the identified parent was the mother (DiSimone-Weiss, 1999; Johnson & Hooper, 2003). The boundaries between fathers and daughters were more restrictive with sexual boundary violations occurring in daughters at younger ages than other comparison parent-child pairs (Johnson & Hooper, 2003). Although professionals tend to favor mothers and lessen boundaries for younger age children, there remains confusion and inconsistency among professionals regarding permissive parent-child sexual boundaries (Atterberry-Bennet, 1987; Cohen, 1995; DiSimone-Weiss, 1999; Johnson & Hooper, 2003).

While research supports the lack of consensus among professionals, researchers have examined factors related to professionals' perceptions of permissive parent-child sexual boundaries (Atterberry-Bennet, 1987; Cohen, 1995; DiSimone-Weiss, 1999; Johnson & Hooper, 2003). These factors are age, professional affiliation, geographical regions, race, ethnicity, gender, and personal trauma history. However, the influence of vicarious trauma, an accumulation of disruptive and painful psychological symptoms resulting from exposure to clients' traumatic memories, has not been examined in relationship to therapists' perceptions of appropriate parent-child sexual boundaries. Can

vicarious trauma influence therapists, exposed to client stories of sexual trauma, to perceive in a more sinister way parent-child sexual boundary behaviors as sexually abusive?

Therapists who are exposed to client stories of trauma and abuse are at risk for developing vicarious trauma. Sex offender and sexual abuse therapists are particularly vulnerable to vicarious trauma because of their exposure to client trauma stories of violence upon another human being. Frequently therapists at risk for developing vicarious trauma report changing their behavior around children as a result of their work experiences with sexual offenders (Jackson, Holzman, & Barnard, 1997). Therapists have attributed their work with sexual offenders to changes in thinking about sexual violence and the impact of sexual abuse upon victims (Jackson et al., 1997). Research suggests that vicarious trauma may affect therapists' perceptions of appropriate sexual boundaries with children (Edmunds, 1997; Ellerby, Gutkin, Smith, & Atkinson, 1993; Freeman-Longo, 1997; Jackson et al., 1997; Scheela, 2001). This research provides a foundation for the present study on differences among therapist levels (therapist who treat sexual offenders, sexual abuse victims, and the general population) in relationship to therapists' perceptions overall of appropriate parent-child sexual boundaries and personal experiences of vicarious trauma.

Parent-Child Sexual Boundaries

The research is inconclusive on the impact of permissive parent-child sexual boundaries upon the child. Some research supports the theory that permissive parent-child sexual boundaries cause harm to the child (Friedrich, Fisher, Broughton, Houston, & Shafran, 1998; Gil, 1993; Johnson, 1999), other research takes a neutral stance

(Okami, 1995), or suggests positive outcomes for the child (Finch, 1982; Lewis & Janda, 1988).

Researchers who have found evidence of harm to the child by sexual boundary violations note primarily increased sexualized behavior problems in the child (Friedrich et al., 1998; Gil, 1993; Johnson, 1999). These sexualized behavior problems may include acts of molestation against other children (Gil, 1993). Higher levels of sexual behavior in 2- to 12-year-old children have been reported by parents who presented signs of permissive sexual boundaries such as co-sleeping, co-bathing, family nudity, exposure to adult movies or magazines, and witnessing intercourse (Friedrich et al., 1998). Friedrich et al. (1998) discovered that a more relaxed approach to “family sexuality” including co-sleeping, co-bathing, family nudity, opportunities to see adult movies, and witnessing sexual intercourse was related to an increased variety of sexual behavior in children. Johnson (1999) reports boundary confusion in children’s homes (e.g. co-sleeping, co-bathing, etc.) may be as potent as physical sexual abuse in creating sexual confusion, anxiety, and disturbed sexual behaviors in young children. However, Johnson provides no empirical evidence to support her position.

Friedrich et al. (1998) and Gil’s (1993) presume negative child sexualized behavior is a result of permissive parent-child sexual boundary violations. On the other hand, Okami (1995) believes the presumption of negative child sexualized behavior is an overreaction to family practices such as co-sleeping, co-bathing, kissing children on the lips, or being nude in front of children. Examining anthropological and ethnographic data provides evidence that childhood exposure to parental nudity and parent-child co-sleeping is common cross culturally (Thevenin, 1977). A recent study of surveyed mental health

professionals confirmed that some family practices given the context of the child's ethnic background, such as co-bathing and co-sleeping, are not considered sexually abusive (Carsten, 2001).

Some research into childhood exposure to parental or adult nudity has suggested positive outcomes, including the belief children develop more positive feelings of sexuality and affection (Finch, 1982; Lewis & Janda, 1988). Lewis and Janda (1988) in a study of college age subjects discovered that males exposed to parental nudity in early childhood reported increased comfort levels with regard to physical contact and affection.

There is confusion in the definition of parent-child sexual boundary violations. The lack of agreement on the impact of permissive parent-child sexual boundaries upon the child contributes to the inability to define appropriate sexual boundaries in the family. In addition to the various opinions posited in the literature, the phenomenon of therapist vicarious trauma may contribute to the confusion in therapists' perceptions of appropriate sexual boundaries in the family.

Vicarious Trauma

Vicarious trauma is a term first used by McCann and Pearlman (1990). It describes pervasive changes that occur within the clinician over time as a result of working with clients who have experienced sexual trauma. It is not uncommon for the therapist to develop vicarious trauma, a trauma reaction secondary to exposure to clients' traumatic experiences (Trippany, White Kress, & Wilcoxon, 2004).

Vicarious trauma may affect the therapist by creating many of the same symptoms as post traumatic stress disorder such as sleep disturbances, intrusive thoughts, and images. Unlike post traumatic stress disorder, vicarious trauma may result in a disruption

in cognitive schemas and belief systems resulting from empathetic engagement with clients' trauma experiences (McCann & Pearlman, 1990). Vicarious trauma impacts perceptions of self and others leading to alterations in adaptation to the world (Rich, 1997).

The exact number of therapists experiencing vicarious trauma is unknown. Research suggests that a higher level of exposure to traumatized clients significantly increases the risk factor for therapists to develop vicarious trauma (Pearlman & Mac Ian, 1995; Schauben & Frazier, 1995). In addition, some research implies that certain characteristics of the therapist, such as personal trauma history, gender, and personal stress, may interact with exposure to trauma material to contribute to symptoms of vicarious trauma (Pearlman & Mac Ian, 1995). McLean, Wade, and Encel (2003) recommend researchers study prior direct and recent traumatic stress in the lives of therapists as a measure of anchoring and non-anchoring events in the development of vicarious trauma. Creamer and Liddle (2005) note research on vicarious trauma has both supported and disputed therapist links to caseload number, level of education, years of professional experience, and type of trauma with human-induced trauma (i.e. sexual abuse) versus natural occurring trauma (i.e. cancer).

Research on vicarious trauma suggests therapists who treat clients with human induced trauma (i.e. sexual abuse) may experience increased fear that certain family practices are sexually motivated and a prelude to sexual offending behavior (Edmunds, 1997; Freeman-Longo, 1997; Scheela, 2001). Therapists with vicarious trauma may even fear their own behavior as a violation of appropriate sexual boundaries, thus leading to accusations of being a sexual offender (Benis, 1997). However, to date there is no

empirical evidence to support this position.

Vicarious Trauma, Burnout, and Countertransference

In the past, therapists' reactions to client trauma were referred to as burnout or countertransference. Although vicarious trauma may share similar characteristics with burnout and countertransference, there are several very distinct elements to the experience of vicarious trauma. Burnout is a result of the psychological stress from working with difficult clients (Figley, 1999). Burnout has a gradual progression while vicarious trauma has an abrupt onset directly related to the traumatic experience of the client (Trippany et al., 2004).

Vicarious trauma is also distinct from countertransference. Countertransference refers to the therapist's emotional reaction to the client as a result of the therapist's unique life experience (Figley, 1995). Countertransference is specific to the therapist's experience during the counseling session. Elements of countertransference may be found in vicarious trauma. However, in vicarious trauma the therapist's reaction to the client transcends beyond the session to impinge on the therapists' private life. Presently the terms burnout and countertransference are rarely used in reference to vicarious trauma.

Vicarious Trauma, Secondary Traumatic Stress Disorder, and Compassion Fatigue

Vicarious trauma and secondary traumatic stress disorder are trauma-related constructs which stem from contact with trauma survivors and both include a similar component of residual like symptoms of post traumatic stress disorder (Jenkins & Baird, 2002). Jenkins and Baird, after distinguishing characteristics of vicarious trauma and secondary traumatic stress, concluded that as a practical matter both terms refer to a single phenomenon. According to Jenkins and Baird, secondary traumatic stress disorder

focuses on observable reactions to symptoms of post traumatic stress disorder (PTSD) described in the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR;* American Psychiatric Association, 2000), while vicarious trauma focuses more on covert changes in thinking. Vicarious trauma focuses on meaning and adaptation and is based on the constructivist self-development theory (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). The focal point of secondary trauma stress is the set of observable PTSD like symptoms of intrusion, avoidance, and arousal (Bride, 2004). While vicarious trauma and secondary traumatic stress both contain observable reactions to PTSD like symptoms, only vicarious trauma includes covert changes in thinking.

Compassion fatigue, like vicarious trauma and secondary traumatic stress, is also a reaction from indirect exposure to traumatic events (Ting, Jacobson, Sanders, Bride, & Harrington, 2005). Compassion fatigue, a term first coined by Figley (1995), refers to the process of experiencing empathy for the client. In both compassion fatigue and vicarious trauma therapists may accurately identify and vicariously experience the client's emotions and responses as if encountering the events and feelings first hand (Moulden & Firestone, 2007). According to Figley (1995) empathizing with clients makes therapists vulnerable to being traumatized as well. While vicarious trauma and compassion fatigue both involve therapists' accurately identifying and vicariously experiencing client emotions and responses as if encountering the events and feelings first hand, only vicarious trauma takes into account therapists' covert changes in thinking. For the purpose of this study, the term vicarious trauma will encompass literary references to secondary traumatic stress and compassion fatigue.

Constructivist Self-Development Theory of Vicarious Trauma

Vicarious trauma has been conceptualized as a residual like symptom of post traumatic stress disorder resulting in covert changes in thinking (Jenkins & Baird, 2002). The Constructivist Self-Development Theory (CSDT) of vicarious trauma is based on the premise that individuals construct their realities through the development of cognitive schemas or perceptions which facilitate their understanding of surrounding life experiences (Trippany et al., 2004). The interaction of client stories and therapists' personal characteristics promotes change within therapists' cognitive schemas or perceived realities (Saakvitne & Pearlman, 1996). CSDT emphasizes the individual nature of trauma including the idea that individuals construct the meaning that a particular trauma has on them. The CSDT suggests irrational therapist perceptions develop as self-protection against hearing stories of emotionally traumatic client experiences (Trippany et al., 2004). Vicarious trauma is pervasive (i.e. has the potential to effect every area of the counselor's life) and cumulative (i.e. potentially permanent because each traumatized client the counselor encounters reinforces these changes in cognitive schemas) (McCann & Pearlman, 1990).

CSDT is based upon the belief that there are five components of the self and the self and one's perception of reality are developed and affected by trauma. The five components of self are: (a) frame of reference, (b) self-capabilities, (c) ego resources, (d) psychological needs; (e) cognitive schemas, memory, and perception (Pearlman & Saakvitne, 1995).

Trippany et al. (2004) provide a basis for understanding frame of reference in this theory. Frame of reference refers to changes in understanding and viewing the self and

the world. It encompasses one's identity, worldview, and belief system as well as cognitive processes of causality and attribution. Disruptions in frame of reference can create difficulties in the therapeutic relationship resulting in the opportunity for the therapist to blame the victim client.

Another component of CSDT is self-capabilities, which allow individuals to manage emotions, sustain positive feelings about themselves, and maintain relationships with others (Trippany et al., 2004). Pearlman and Saakvitne (1995) note that the self-capabilities are "inner capabilities that allow the individual to maintain a consistent, coherent sense of identity, connection, and positive self-esteem" (p. 64). A disruption of self-capabilities as a result of vicarious trauma may manifest in a loss of identity, difficulty controlling negative emotions, avoiding exposure to media that conveys the suffering of others, and being unable to meet the needs of significant others in your life (Trippany et al., 2004).

Ego Resources, a component of CSDT, includes the ability to conceive consequences, to set boundaries, and to protect the self (Trippany et al., 2004). Pearlman and Saakvitne (1995) describe ego resources as the individual's ability to meet psychological needs and relate to others interpersonally. A disruption in ego resources may result in perfectionism and overextension at work, and an inability to be empathetic with clients.

The final components of CSDT are psychological needs and related cognitive schemas. Basic psychological needs include safety, trust, esteem, intimacy, and control. Pearlman and Saakvitne (1995) believe cognitive schemas about self and others are created from the combination of basic psychological needs and the individual's ability to

process information related to these needs.

For the purpose of this study, psychological needs and related cognitive schemas will be discussed in greater depth for their pertinence in understanding issues related to appropriate parent-child sexual boundaries. To review, the five basic psychological needs and related cognitive schemas about self and others are safety, trust, esteem, intimacy, and control.

Safety is a basic psychological need. Therapists experiencing a disruption in cognitive schemas related to safety needs may experience high levels of fearfulness, vulnerability, and concern (Pearlman, 1995). They may become overly cautious concerning the safety of their children, take self-defense courses, install a home alarm system, or carry mace or a rape whistle for protection (Trippany et al., 2004).

The psychological need of trust encompasses the inherent need to have confidence in one's own perceptions and beliefs as well as the ability to trust others to meet one's emotional, psychological, and physical needs (Trippany et al., 2004). Vicarious trauma may disrupt the therapist's cognitive schemas of trust, creating suspicion regarding certain groups of people. The therapist may also experience self-doubt and question his or her ability to judge and intervene effectively with clients (Trippany et al., 2004).

Esteem is a need characterized by value for self and others (Pearlman, 1995). Therapists experiencing vicarious trauma may have distorted cognitive schemas of esteem needs including feelings of inadequacy and questioning their ability to help others (Trippany et al., 2004). Esteem for others may be altered by therapist exposure to stories of violence and cruelty committed by others.

Intimacy is the need to feel connected to self and others (Pearlman & Saakvitne, 1995). The distortion of cognitive schemas surrounding intimacy needs may result in therapists' feelings of emptiness when alone, difficulty enjoying time alone, intense wanting to fill alone time, and withdrawal and avoidance from others (Trippany et al., 2004).

Therapist issues of power and control may result in unreasonable expectations for clients as well as the self (Hesse, 2002). When cognitive schemas are disrupted in the area of control, the result may be therapist feelings of helplessness, giving their clients advice rather than helping them understand their reactions to situations, and therapists' excessive control in other areas of their clients' lives (Heese, 2002; Trippany et al., 2004).

Impact of Vicarious Trauma upon Clinicians

CSDT researchers, Pearlman and Saakvitne (1995), purport the cognitive schemas of safety, trust, esteem, intimacy, and control are most affected by vicarious trauma. Research on therapists treating sexual offenders and sexual abuse victims provides insight into the effects of vicarious trauma on cognitive schemas.

Treating Sexual Offenders

Several researchers have investigated the effects of vicarious trauma upon clinicians who treat sexual offenders (Edmunds, 1997; Ellerby, 1997; Farrenkopf, 1992; Jackson et al., 1997; Shelby, Stoddart, & Taylor, 2001; Steed & Bicknell, 2001). Results suggest that therapists treating sexual offenders experience changes in psychological needs and cognitive schemas that are unique compared to therapists who treat other types of clients (Way, VanDuessen, Martin, Brooks, & Jandle, 2004). This may be due to the

unique nature of therapists' work with sex offenders.

There have been several reported changes in psychological needs and related cognitive schemas in sexual offender clinicians including a decreased sense of personal safety and safety of significant others, hypervigilance around strangers, avoidance symptoms, and disruptions in sexuality (Bengis, 1997, Jackson et al., 1997; Rich, 1997). Therapists working with sexual offenders report a discomfort in caring for or touching their own children (Edmunds, 1997; Freeman-Longo, 1997; Scheela, 2001). Edmunds (1997) and Freeman-Longo (1997) suggest the fear of sexual abuse allegations may create therapists' discomfort in caring for or touching children. Clinicians may be more suspicious of the behaviors of others and view the intent of such behavior to be grooming for perpetration (Bengis, 1997). Jackson et al. (1997) report 59% of therapists working with sexual offenders experience heightened anxiety regarding the safety of their children and grandchildren. Sexual offender clinicians may experience changes in sexuality in response to the stories of the sex offenders' deviant sexual behavior (Bengis, 1997; Ellerby, 1997). These changes may include: (a) disturbing images of sexual offenses that filter into the clinician's mind influencing sexual arousal, (b) decreased interest in sex, or (c) increased sexual thoughts, fantasies, and feelings, sometimes even toward the offender.

Treating Sexual Abuse Victims

The vicarious trauma research indicates similarities between therapists treating sexual offenders and therapists treating sexual abuse victims (Jackson et al., 1997; Rich, 1997; Way et al., 2004). The similarities in symptoms of vicarious trauma include: (a) decreased sense of personal safety and safety of significant others (Way et al., 2004), (b)

hypervigilance around strangers (Meyers & Cornille, 2002; Way et al., 2004), (c) disrupted cognitions about intimacy with others (VanDeusen & Way, 2006), (d) avoidance symptoms (Way et al., 2004), (e) disruptions in sexuality (Way et al., 2004), and (f) intrusive dreams, imagery, and thoughts (Meyers & Cornille, 2002; Steed & Downing, 1998).

Statement of the Problem

There are no empirically derived norms on touch among family members, thus much ambiguity exists regarding how to differentiate appropriate parent-child sexual boundaries from signs of covert sexual abuse (Rosenfield et al., 1986). Some researchers believe covert sexual abuse occurs when adult sexual satisfaction is gained from the child's participation in certain family practice behaviors including the following: nudity, co-bathing, co-sleeping, exposure to adult sexual acts, and various forms of unwanted sexual attention toward the child (Gil, 1993; Weiner & Thompson, 1997; Whealin, Davies, Shaffer, Jackson, & Love, 2002). Friedrich et al. (1998) believe permissive parent-child sexual boundary violations contribute to increased age inappropriate sexual behaviors in the child. Those opposing the negative outcome opinion believe that parent-child sexual boundary violations are not harmful and may result in neutral or positive outcomes for the child (Finch, 1982; Lewis & Janda, 1988; Okami, 1995).

In an effort to understand the differences of opinion among mental health professionals regarding appropriate parent-child sexual boundaries, existing research has examined variables such as subject age, professional affiliation, geographical region, race, ethnicity, and personal trauma history. One variable which has not been examined is vicarious trauma. Vicarious trauma alters perceptions of self, others, and adaptation to the

world (Rich, 1997). The impact of vicarious trauma upon therapists can create ethical concerns. Vicarious trauma increases the potential for clinical error; increases anger toward clients for not completing an idealized response to therapy; and increases the risk of compromising therapeutic boundaries such as forgotten appointments, unreturned phone calls, inappropriate client contact, and abandonment of clients (Trippany et al., 2004). The therapist with vicarious trauma may give the client directives that are inappropriate or may establish unreasonable or rigid boundaries (Hesse, 2002). There is a lack of empirical research to examine clinical error arising from therapist subjective distress and changes in cognitive schema impacting ethical decision making regarding parent-child sexual boundary violations.

Research on therapists with vicarious trauma, have found the following: increasing anxiety for the safety of children from sexual abuse, surmising that innocuous behaviors of adults toward children are sexually motivated and offending (Bengis, 1997; Rich, 1997), and increasing hypersensitivity to the slightest hint of sexual arousal or inappropriate touch leading to therapist fears of violating appropriate sexual boundaries (Bengis, 1997). The extent to which vicarious trauma is related to therapists' perceptions of appropriate parent-child sexual boundaries has not been investigated. This creates the basis for this inquiry: Do therapists levels (therapists who treat sexual offender, sexual abuse victim, and general population clients) differ overall on their perceptions of parent-child sexual boundaries and vicarious trauma symptoms of altered perceptions of self, others, and adaptations to the world?

Significance of the Study

Results from this study may contribute to a growing understanding of the

relationship between therapists' perceptions of permissive parent-child sexual boundaries and therapists' vicarious trauma symptoms of altered perceptions of self, others, and adaptation to the world. To date much of the literature available on vicarious trauma and safety of children from sexual abuse has been based on conjecture with a paucity of empirical research for validation. This research study asks the question: Do therapist levels (therapists treating sexual offenders, sexual abuse victims, or general population clients) differ in relationship to overall perceptions of parent-child sexual boundaries and vicarious trauma symptoms of altered perceptions of self, others, and adaptation to the world? Altered perceptions of self, others, and adaptation to the world are evident in changes in cognitive schemas and secondary traumatic stress symptoms.

This study may also contribute to the existing body of research seeking to reach consistency and consensus among professionals in determining which behaviors are considered covert sexual abuse between parent and child. As mandated reporters of child sexual abuse, therapists are required to report suspected child abuse to professionals in child protection. Results from this study may contribute to the knowledge base of therapists regarding client population influencing therapists' conceptualization of appropriate parent-child sexual boundaries. This study will examine the question of whether therapists treating sexual offenders and sexual abuse victims perceive permissive parent-child sexual boundaries in a more sinister or threatening way than therapists treating the general population. Increasing the knowledge base of all influencing factors, including vicarious trauma, may reduce the current ambiguity that exists and support a greater understanding of appropriate parent-child sexual boundaries and child sexual abuse in general.

Lastly, this study may contribute to the knowledge base of vicarious trauma and its affect on therapists treating diverse client populations. Current research provides empirical evidence that therapists with greater trauma client caseloads experience higher risks for developing vicarious trauma. The results of this study examined differences between levels of therapist vicarious trauma and therapists who treat sexual offenders, sexual abuse victims, or general population clients.

Research Question

The primary purpose of this research is to determine if therapist levels (therapists who treat sexual offenders, sexual abuse victims, and general population clients) differ in terms of therapists' overall perceptions of parent-child sexual boundaries and therapists' altered perceptions of self, others, and adaptation to the world associated as a result of vicarious trauma. Vicarious trauma alters therapists' perceptions of self, others, and adaptations to the world (Rich, 1997). Altered therapists' perceptions of self, others, and adaptations to the world are manifested in changes in cognitive schemas (self and others) and observable secondary traumatic stress symptoms (maladaptation to the world). In addition to vicarious trauma symptoms, research suggests that therapists exposed to client stories of sexual trauma experience altered perceptions of permissible parent-child sexual boundaries (Edmunds, 1997; Freeman-Longo, 1997; Scheela, 2001). Compared to therapists who treat general population clients, therapists who treat sexual offenders and sexual abuse victims are at greater risk for experiencing altered perceptions regarding parent-child sexual boundaries. Therefore the following research question was studied: Do therapist levels (therapists treating sexual offenders, sexual abuse victims, or general population clients) differ on overall therapists' perceptions of parent-child sexual

boundaries and therapists' altered perceptions of self, others, and adaptations to the world (changes in cognitive schemas, secondary traumatic stress symptoms) as a result of vicarious trauma?

Independent Variable

There is one independent variable in this study, participant status, which has three levels: therapists for sexual offenders, therapists for sexual abuse victims, and generalist therapists. All participants hold a graduate degree in the field of mental health and identify their primary role as a clinician.

Participant Status

1. Therapists for sexual offenders: consists of study participants who are members of the Association for the Treatment of Sexual Abusers (ATSA).

2. Therapists for sexual abuse victims: consists of study participants who are members of the American Professional Society on the Abuse of Children (APSAC).

3. Generalist population therapists: consists of study participants who are members of the American Mental Health Counselors Association (AMHCA).

Dependent Variables

This study has three dependent variables: (a) permissive parent-child sexual boundaries, (b) secondary traumatic stress symptoms, and (c) changes in cognitive schemas.

Permissive parent-child sexual boundaries are participants' perceptions regarding behaviors between a parent and a child which violate boundaries of appropriate behavior and constitute sexually inappropriate behavior of an abusive nature. Permissive parent-child sexual boundaries are measured by the Permissive Parent-Child Sexual Boundary

Scale (PPCBS) created by the author for the purpose of this study. Several behavioral items on the questionnaire are based upon The Family Practices Questionnaire (Johnson, 1998).

Secondary traumatic stress symptoms are an indicator of vicarious trauma measuring therapists' secondary traumatic stress symptoms in observable reactions to PTSD like symptoms. These symptoms will be measured by the Secondary Traumatic Stress Scale (STSS: Bride, 1999). The STSS measures trauma symptoms in mental health professionals as a result of secondary exposure to client stories of direct trauma (Bride, Robinson, Yegidis, & Figley, 2003). The STSS parallels the *DSM-IV-TR* (American Psychiatric Association, 2000) criteria for post traumatic stress disorder by measuring intrusion, avoidance, and hyperarousal symptoms.

Changes in cognitive schemas are an indicator of vicarious trauma measuring changes in beliefs about self and others in five areas: safety, intimacy, trust, control, and esteem. The Trauma and Attachment Belief Scale (TABS: Pearlman, 2003) measures changes in cognitive schemas and will be used in this study. The TABS assesses the long-lasting psychological impact of traumatic events in trauma survivors and individuals who experience negative effects as a result of working with trauma survivors.

Delimitations and Limitations of the Study

The delimitations for this study included the boundaries of studying graduate-level therapists who are members in one of three distinct mental health organizations. The three mental health organizations include: (a) Association for the Treatment of Sexual Abusers, (b) American Professional Society on the Abuse of Children, and (c) American Mental Health Counselors Association. Study participants were selected from a random

sample of the three organizations' membership lists.

The limitations of this study include sampling, methodology, and culture. The study is dependent on the self-reporting of participants. Study participants self-report: (a) area of specialization, (b) number of hours spent providing therapy each week, and (c) percentage of current and past caseloads comprising sexual offender and sexual abuse victim clients. Further, all participants are volunteers from professional mental health organizations. Tuckman (1999) acknowledged the inherent limitation of self-reporting to include reliance upon cooperation of participants.

The Parent-Child Sexual Boundary Scale has a methodology limitation due to the case scenario example of father-daughter incest. This scenario was chosen because stepfather-daughter or father-daughter incest is the most frequently reported and discussed incest configuration (Huber, 1993). Results of the Parent-child Sexual Boundary Scale cannot be generalized beyond the father-daughter dyad.

Another limitation in this study is the omission of the influence of culture. Although culture plays a very important role in defining child sexual abuse, for the purpose of this study culture will not be included as a variable to be studied.

Definition of Terms

Cognitive schemas: the cognitive structures used by individuals to organize experiences and information to function effectively in a complex, changing world (Bowlby, 1969; Epstein, 1991). Individuals develop cognitive schemas about self and others on the basis of five areas of psychological needs: safety, trust, esteem, control, and intimacy (Cunningham, 2003).

Trauma: an exposure to a situation in which a person is confronted with an event that

involves actual or threatened death or serious injury, or a threat to self or other's physical well-being (American Psychiatric Association, 2000).

Vicarious trauma: the disruptive and painful psychological symptoms that results from exposure to clients' traumatic memories although the therapist has not experienced the trauma directly (McCann & Pearlman, 1990). These painful psychological symptoms, comparable to post-trauma symptoms, can include sleep disturbances, intrusive images, and disruptions to cognitive schemas about safety, trust, intimacy, and control (McLean et al., 2003). For therapists, the perceived anchoring event for development of symptoms of vicarious trauma is directly related to exposure to one or more client stories of trauma.

It is important to note that the terms "child sexual abuse" and "permissive parent-child sexual boundaries" cannot be defined due to the ambiguity in their meaning. It is the very nature of this ambiguity which has prompted the investigation of this research study.

Conclusion

There is no consensus regarding sexual boundary violations between parent and child. Various factors such as therapists' age, professional affiliation, geographic region, race, ethnicity, gender, and personal trauma history have been examined in an attempt to understand the diversity in perceptions of permissive parent-child sexual boundary violations. To date the influence of vicarious trauma on therapists' perceptions of appropriate parent-child sexual boundaries has not been examined. Vicarious trauma alters perceptions of self, others, and adaptation to the world (Rich, 1997). This introductory chapter provides a background for the current research study on differences in therapists exposed to client stories of sexual trauma from therapists not exposed to

client stories of sexual trauma in terms of altered perceptions of parent-child sexual boundaries and altered perceptions of self, others, and adaptation to the world as a result of vicarious trauma.

Vicarious trauma may alter therapists' perceptions of permissive parent-child sexual boundaries as evidenced by therapist reported fears of sexual abuse allegations and behavioral changes toward caring for and touching children. Empirical evidence suggests that therapists working with trauma clients frequently report changes in their own behavior around children as a result of their work (Jackson et al., 1997). This study poses the question: do therapist levels (therapists treating sexual offenders, sexual abuse victims, or general population clients) differ on therapists' perceptions of parent-child sexual boundaries and therapists' altered perceptions of self, others, and adaptation to the world (changes in cognitive schemas, secondary traumatic stress symptoms) as a result of vicarious trauma?

The significance of this study includes the potential for the results to assist therapists toward greater self-awareness into the relationship of vicarious trauma on perceptions of appropriate parent-child sexual boundaries. This study will also increase the knowledge base on identifying therapists grouped by type of client for increased risk to develop vicarious trauma. Differences in measures of permissive parent-child sexual boundaries will be examined by the type of client treated by three therapist groups.

This study is a multivariate design with three levels of one independent variable: (a) therapists for sexual offenders, (b) therapist for sexual abuse victims, and (c) therapists for the general population. The dependent variables of the study include measurements of (a) permissive parent-child sexual boundaries (b) secondary traumatic

stress symptoms, and (c) changes in cognitive schema.

Chapter Two

Review of the Literature

Parent-child sexual boundaries are a concern for counselors because inappropriate sexual boundaries may be as potent as overt sexual abuse in creating sexual confusion, anxiety, and disturbed sexual behaviors in young children (Johnson, 1999). Appropriate parent-child sexual boundaries are difficult to determine due to the lack of a universal definition of child sexual abuse (Johnson & Hooper, 2003). Parent-child sexual boundary violations range from overt signs of sexual abuse to covert signs of sexual abuse. Most therapists agree upon the overt signs of sexual abuse between a parent and a child (Atteberry-Bennett, 1987). However, covert signs are more difficult to detect (Gil, 1993).

There is a lack of consensus among professionals in determining which behaviors are considered covert sexual abuse between parent and child (Atteberry-Bennett, 1987; Cohen, 1995; DiSimone-Weiss, 1999; Johnson & Hooper, 2003). Due to this lack of consensus, researchers have attempted to identify factors related to therapists' perceptions of parent-child sexual boundary violations. Factors of therapists' age, professional affiliation, geographical regions, race, ethnicity, gender, and personal trauma history have been studied, although results of therapist factors have contributed little to the understanding of professionals' perceptions of parent-child sexual boundaries.

Despite the extensive lists of factors contributing to professionals' perceptions of parent-child sexual boundaries, the phenomenon of vicarious trauma remains one factor yet to be studied. Vicarious trauma is an accumulation of disruptive and painful psychological symptoms resulting from empathetic engagement with clients' trauma material (Pearlman & Saakvitne, 1995). Vicarious trauma alters perceptions of self,

others, and adaptation to the world (Rich, 1997). Vicarious trauma may alter therapists' cognitive schemas (perceptions of self and others) and secondary traumatic stress symptoms (maladaptation to the world). The cognitive schemas and secondary traumatic stress symptoms most affected by vicarious trauma may depend upon therapists' client population.

Research on therapists who treat sexual offenders suggests perceptions of parent-child sexual boundaries are associated with vicarious trauma symptoms (Edmunds, 1997; Freeman-Longo, 1997). Therapists who treat sexual offenders may interpret the intention of others caring for or touching children to be sexually motivated grooming behavior (Bengis, 1997). Therapists who treat sexual offenders and sexual abuse victims may have fears of accusations of sexual boundary violations with children resulting in more discomfort in caring for or touching children (Edmunds, 1997; Freeman-Longo, 1997).

This research study compared therapists who work with different client populations (referred to in this study as therapist levels) for group differences in relationship to therapists' perceptions of parent-child sexual boundaries and altered perceptions of self, others, and adaptation to the world as a result of vicarious trauma. The premise of this research study is that a relationship exists between therapists' perceptions of parent-child sexual boundaries and therapists' altered perceptions of self, others, and adaptation to the world as a result of vicarious trauma symptoms. Vicarious trauma symptoms include changes in cognitive schemas and secondary traumatic stress symptoms. Thus, this research study examined the relationship of perceptions of permissive parent-child sexual boundaries, cognitive schemas, and secondary traumatic stress symptoms to differences among therapists levels. No prior research studies on

vicarious trauma or parent-child sexual boundaries have explored differences among therapists treating sexual offenders, sexual abuse victims, or general population clients.

In summary, this literature review examines differences among therapist levels (sexual offender, sexual abuse victim, and general population) in terms of therapists' perceptions of permissive parent-child sexual boundaries and altered perceptions of self, others, and adaptations to the world (changes in cognitive schemas and secondary traumatic stress symptoms) as a result of vicarious trauma. Covered in this literature review are the following variables: (a) permissiveness of parent-child sexual boundaries, (b) vicarious trauma, and (c) levels of therapists. A keyword search of each variable was conducted using Google Scholar, PsychLit, ProQuest, and Education Resources Information Center (Eric).

Permissiveness of Parent-Child Sexual Boundaries

Much ambiguity exists regarding appropriate parent-child sexual boundaries (Johnson & Hooper, 2003). Despite research on the effects of parent-child sexual boundary violations to the child, there are no empirically derived norms on appropriate touch among family members (Rosenfield et al., 1986). The lack of universal norms on appropriate touch among family members has prompted several researchers to study factors contributing to professionals' perceptions of appropriate parent-child sexual boundaries (Atteberry-Bennett, 1987; Cohen, 1995; Disimone-Weiss, 1999). Factors studied include professionals' age, professional affiliation, geographic regions, race, ethnicity, gender, and personal trauma history. Overall, the study of these factors in rating parent-child sexual boundary violations has resulted in significant findings for: (a) age, with younger professionals compared to older professionals giving higher age cut-offs for

children, (Cohen, 1995; Disimone-Weiss, 1999), (b) profession, with more disagreement between mental health professionals and legal professionals (Atteberry-Bennett, 1987; Cohen, 1995), and (c) practice region, with western states giving higher age cut-offs for nudity-related behaviors than northeastern or southern states (Disimone-Weiss, 1999). Factors studied which have resulted in no significant findings include race and ethnicity of the respondent (Johnson & Hooper, 2003). Factors studied which have resulted in mixed results include (a) gender, with Cohen (1995) finding significance and Disimone-Weiss (1999) not finding significance, and (b) personal trauma history, with Disimone-Weiss (1999) finding significance and Johnson and Hooper (2003) not finding significance. Despite all these studied factors, one factor which has not been explored is the relationship of vicarious trauma to perceptions of permissive parent-child sexual boundaries.

In addition to studying factors related to professionals' perceptions of permissive parent-child sexual boundaries, researchers have studied various professional groups, parents, college students, and the general public regarding their views on the impact of permissive parent-child sexual boundaries to the child (Friedrich et al., 1998; Gil, 1993; Johnson, 1999; Lewis & Janda, 1988; Okami et al., 1995; Olenick, Bahn, Eisenberg, & Lillenfield, 1966; Story, 1979). The results of their studies have provided mixed results.

Some researchers believe that permissive parent-child sexual boundaries cause harm to the child (Friedrich et al., 1998; Gil, 1993; Johnson, 1999). While other researchers believe that permissive parent-child sexual boundaries may have a neutral or positive affect upon the child (Lewis & Janda, 1988; Okami et al., 1995; Olenick, et al., 1966; Story, 1979). Higher levels of sexual behavior in 2- to 12-year-old children have

been reported by parents who presented signs of permissive sexual boundaries such as co-sleeping, co-bathing, family nudity, exposure to adult movies or magazines, and witnessing intercourse (Friedrich et al., 1998). Friedrich et al. discovered that a more relaxed approach to family sexuality was related to an increased variety of sexual behavior in children. Friedrich et al. identified the following behaviors as an example of a relaxed approach to family sexuality: (a) co-sleeping, (b) co-bathing, (c) family nudity, (d) opportunities to see adult movies, and (e) witnessing sexual intercourse. Research into childhood exposure to parental nudity, parental sexuality, and parent-child co-sleeping, and other related family sexuality behaviors will be examined.

Childhood Exposure to Parental Nudity

Lewis and Janda (1988), Olenick et al. (1966), and Story (1979) are the only known researchers to use an empirical perspective to study child outcomes resulting from parental or other family nudity. In general, research on the influence of parental nudity upon the child has been found to be mixed with a combination of neutral, positive, and negative effects reported.

Olenick et al. (1966) reported a neutral effect on childhood exposure to parental nudity. Olenick et al. compared 160 psychiatric outpatient children with a matched control group of nonpsychiatric inpatient children. The purpose of the study was to determine if the two groups differed in early socialization experiences. One of the early socialization experiences studied was exposure to nudity in the home. Olenick et al. found no significant differences between the two groups on the variable exposure to nudity.

Story (1979) reported a positive effect on childhood exposure to parental nudity.

Story examined the relationship in preschool children between positive body self-concept and early exposure to nudity. Story reported that children drawn from a sample of social nudists had a more positive body self-concept than children from social non-nudists. It is important to note that more than one third of the children in the study were intentionally drawn from a sample of social nudists. Thus the high representation of social nudists in the study did not represent a national stratified sample of social nudists. Therefore, results of the study cannot be generalized to all children in the United States (Okami et al., 1995).

Lewis and Janda (1988) reported positive and negative effects on childhood exposure to parental nudity. Lewis and Janda examined the relationship between adult sexual adjustment and the variables of childhood exposure to nudity and parent-child co-sleeping. A total of 210 undergraduate men and women were surveyed regarding their memories of childhood exposure to nudity and parent-child co-sleeping. Those men exposed to parental nudity between birth and age five reported less current discomfort with physical contact and affection, while women in the same age group reported an increased frequency of sexual activity relative to women not exposed to parental nudity during those years. For men and women, exposure to parental nudity in the age group of six through ten years was associated with increased self-reports of casual sexual behavior relative to those students of the same age not exposed.

Childhood Exposure to Scenes of Parental Sexuality

There is limited empirical research available on the childhood impact of exposure to scenes of parental sexuality (Hoyt, 1978, 1979; Rosenfeld, Bailey, Siegel, & Bailey, 1986). In general, research on exposure to scenes of parental sexuality upon the child has

yielded mixed results. According to parent reports, younger children, between ages four and six, have a neutral reaction to exposure to parental sexuality (Rosenfeld et al., 1980), while college student reports, based on memories between ages 10 and 11, indicate a more negative affect response of disgust and revulsion to exposure to scenes of parental sexuality (Hoyt, 1978, 1979). Hoyt (1978, 1979) further reports college students exposed to scenes of parental sexuality as children do not differ from students not exposed to primal scenes in regard to current happiness, satisfaction, and frequency of current sexual relations.

In summary, the limited amount of research on exposure to parental sexuality upon the child has yielded mixed results using parent and college student subjects. Parents report neutral effects of exposure to parental sexuality upon the child (Rosenfield et al., 1986), while college students report negative affect responses to childhood memories of exposure to parental nudity (Hoyt, 1978, 1979). Research on college students reveals the impact of childhood exposure to scenes of parental nudity has a neutral effect (Hoyt, 1978, 1979).

Childhood Exposure to Parent-Child Co-Sleeping

Literature available on the effects of parent-child co-sleeping upon the child suggests mixed results (Forbes, Weiss, & Folen, 1992; Madansky & Edelbrock, 1990; Sperling, 1971; Thevinin, 1976). Advocates for parent-child co-sleeping frequently refer to Thevinin's (1976) book entitled *The Family Bed* in support of the practice. Those opposed to parent-child co-sleeping claim that the intimate contact involved in co-sleeping could overstimulate aggressive and sexual impulses in preschool age children (Sperling, 1971).

Mandasky and Edelbrock (1990) report a neutral effect upon the child to childhood exposure to parent-child co-sleeping. In a study of 303 parents of preschool age children, Madansky and Edelbrock (1990) reported that co-sleeping was not related to standard behavior problems as evidenced by scores on the Child Behavior Checklist for two and three year olds.

Forbes et al. (1992) report positive effects upon the child for childhood exposure to parent-child co-sleeping. In a study of 86 parents of military children between the ages of two and thirteen years, Forbes et al. discovered that co-sleeping with a parent was associated with less likelihood of having been in psychiatric treatment and a greater likelihood of higher parental ratings of adaptive functioning. Further, a significant increase in co-sleeping with mother occurred when father was absent and co-sleeping occurred less frequently with children in the psychiatric treatment.

In summary, literature suggests mixed effects upon the child on childhood exposure to parent-child co-sleeping (Forbes et al., 1992; Madansky & Edelbrock, 1990; Sperling, 1971; Thevinin, 1976). Mandansky and Edelbrock (1990) report neutral effects, while Forbes et al. (1992) report positive effects upon the child for childhood exposure to parent-child co-sleeping.

Other Parent-Child Sexual Boundary Behaviors

A review of the literature indicates Disimone-Weiss (1999) and Johnson and Hooper (2003) are the only researchers known to study the appropriateness of the following parent-child behaviors: (a) parent-child kissing on the mouth, (b) hugging, (c) giving the child back rubs, and (d) putting medication on the child's private areas. With the exception of kissing on the mouth, behaviors involving a parent and child of the same

gender were found to be inappropriate at later ages than those same behaviors between a parent and child of different genders (Disimone-Weiss, 1999; Johnson & Hooper, 2003).

In summary, there is a paucity of research available on the appropriateness of parent-child sexual boundaries. Disimone-Weiss (1999) and Johnson and Hooper (2003) both report increasing inappropriateness of behaviors as children become older.

Instruments to Measure Permissiveness of Parent-Child Sexual Boundaries

There are a number of scales that are used to measure parent-child sexual boundaries. The following instruments will be discussed: (a) Atteberry-Bennett Scale (Atteberry-Bennett, 1987), (b) Perceptions of Sexual Abuse Scale (Cohen, 1995), (c) Study Questionnaire-Versions 1 & 2 (Disimone-Weiss, 1999), (d) Family Practices Questionnaire (Johnson, 1998), and (e) Permissiveness of Parent-Child Sexual Boundaries Scale. The Permissiveness of Parent-Child Sexual Boundaries Scale was created by the author in response to a paucity of scales suitable for the purposes of this research study. In this section each scale will be evaluated for its utility in the study, thus providing support for the author's decision to develop an alternative scale to measure permissive parent-child sexual boundaries.

Atteberry-Bennett Scale.

Atteberry-Bennett (1987) is the first known researcher to investigate professionals' responses to possible instances of parent-child sexual abuse (Haugaard & Reppuci, 1988). Atteberry-Bennett (1987) studied parents, mental health professionals, parole officers, protective service workers, and legal professionals in an attempt to define sexually abusive behaviors between parents and children. Participants were asked to rate behaviors on a five-point scale from "definitely sexual abuse" to "definitely not sexual

abuse”. A total of 255 participants responded to a series of forty-eight vignettes that varied from the age of the child, sex of the parent-child dyad, and the act involved. Across all groups of participants, behaviors involving fathers and daughters were rated as more abusive than the same behaviors involving mothers and sons. All behaviors increased in ratings of sexual abusiveness with an increase in the age of the child, with the exception of sexual intercourse. Sexual intercourse was perceived by participants as equally abusive to the child at all ages. When compared to all professional groups of participants, mental health professionals and legal professionals varied the most on their definitions of sexually abusive parent-child behaviors. Mental health professionals rated parental nudity as significantly more abusive than legal professionals. In addition, mental health professionals rated parent-child co-sleeping as significantly more abusive than any other professional group. Legal professionals rated parent touching child’s genitals as significantly less abusive than any other group.

Participants in the Atteberry-Bennett (1987) study also were asked to rate possible intervention strategies for vignettes in which they felt an intervention was necessary. Eight possible interventions were rated on a five-point rating scale from “definitely would recommend” to “definitely would not recommend”. The eight possible interventions were the following: (a) educational counseling, (b) family therapy, (c) therapy for the child, (d) therapy for the adult, (e) investigation by a child protective service agency, (f) removal of the child from the home, (g) removal of the adult from the home, and (h) prosecution of the adult in court. There was complete agreement among all professional groups that some intervention was needed when the parent-child behavior involved sexual intercourse. A high level of agreement among professional groups

occurred when the behavior involved photographing a naked child or parent-child genital touching. With the exception of sexual intercourse, parental nudity, and photography of a nude child, the decision to recommend intervention for all other parent-child behaviors was based upon the age of the child and parent-child dyad. Almost all of the participants recommended no intervention for a parent kissing a 5 year old child; however, intervention was recommended by almost half of the respondents for a parent kissing a ten year old child. Similarly, only 25% of participants recommended intervention for a mother entering the bathroom of a five year old boy, whereas 52% of participants recommended intervention when a father enters the bathroom on a five year old daughter.

Although the Atteberry-Bennett scale was designed to investigate professionals' responses to possible instances of parent-child sexual abuse, for the purpose of this research study the forty-eight vignette scale is too lengthy to use in combination with other scales. In addition to the Atteberry-Bennett scale, this research study used two other scales to measure vicarious trauma. Further, the Atteberry-Bennett scale lacks a total scale score needed for the MANOVA research design of this study.

The Perceptions of Incestuous Sexual Abuse Scale.

Cohen (1995) studied the responses of professionals who work with children for possible instances of parent-child sexual abuse. Cohen (1995) studied psychologists, psychiatrists, social workers, judges, and lawyers in an attempt to define sexually abusive behaviors between parents and children. Study participants were asked to rate behaviors on a five-point scale from "clearly not sexual abuse" to "clearly sexual abuse". A total of 186 participants responded to a series of 226 items that varied from the age of the child, same or opposite gender parent-child dyad, and type of behavior involved. Unlike

Atteberry-Bennett (1987), who studied the gender of the parent in each vignette, Cohen identified the gender of parent in only 3 of the 226 items. Thus Cohen's research provides no insight into Atteberry-Bennett's (1987) earlier findings that behaviors involving fathers are rated more abusive than the same behaviors involving mothers. Like Atteberry-Bennett (1987), the developmental age of the child was a determining factor regarding which behaviors were considered abusive. Across all groups of participants, behaviors between a parent and post-pubescent child were rated as more abusive than the same behaviors involving a younger age child. Sexual intercourse, oral sex, and genital to genital contact were perceived by participants as equally abusive to children of all ages. When compared to all professional groups of participants, psychologists and psychiatrists as a group rated significantly more behaviors sexually abusive than lawyers or judges as a group. Psychiatrists perceived more interactions between parent and child as sexually abusive. Lawyers perceived the least number of interactions as sexually abusive. A consensus of opinion on sexually abusive acts was not found for either the total sample or within occupational groups.

The Perceptions of Incestuous Sexual Abuse Scale (PISAS) is not appropriate for use in this research study due to the fact it lacks a total outcome score. The PISAS provides 226 outcome scores on study participants' perceptions of which overt and/or covert behaviors may be considered sexual abuse between a parent and a child. The length of the 226 item scale is simply too long for use in this research involving two other instruments.

Study Questionnaire- Versions 1 & 2.

DiSimone-Weiss (1999) investigated professionals' opinions regarding possible

parent-child sexual abuse. DiSimone-Weiss studied child psychologists, child psychiatrists, and pediatricians in an attempt to define sexually abusive behaviors between parents and children. Participants were asked to rate items for the inappropriateness of certain behaviors occurring on a regular basis between parent and child. Participants were able to choose from the following response set for each item: (a) not appropriate at any age, (b) a specific age from 1-18 years, (c) appropriate at all ages. A total of 667 participants responded to a series of 15 vignettes that varied from the sex of the parent-child dyad to the behavioral act involved. Two versions of the Study Questionnaire were developed in order to obtain needed information with minimal response bias and to limit the length of the questionnaire. Versions 1 and 2 of the Study Questionnaire are identical with the only difference being gender for the parent-child dyad in each vignette. The following behaviors are included in vignettes for versions 1 and 2 of the Study Questionnaire: (a) co-sleeping in child's bed, (b) co-sleeping in parent's bed, (c) parent kissing child on the lips, (d) co-bathing, (e) parental nudity in front of child, and (f) child nudity in front of parent.

Results from the both versions 1 and 2 of the Study Questionnaire indicate that 67% of professionals believe the selected behaviors become inappropriate at some point during early childhood ranging from 2 – 7 years. In all case examples, with the exception of kissing, behaviors involving the same sex parent and child were found to be inappropriate at later ages. Behaviors involving opposite sex parent and child were found to be inappropriate at earlier ages when compared to same sex parent and child. Kissing behavior is the only exception for which the opposite sex parent-child dyad was found to be inappropriate at later ages than the same sex parent-child dyad. In same sex and

opposite sex dyads, the gender of the parent is unknown. Thus, it is impossible to determine from the information gathered if mothers are allowed older age cut-offs for appropriateness of behavior compared to fathers. When compared to all professional groups of participants, pediatricians rated behaviors to be abusive at older ages for the child than psychologists or psychiatrists. It is important to note that the pediatrician sample was the youngest of the professions sampled. Younger professionals rated behaviors inappropriate at significantly older age cut-offs than did older professions.

In addition to study participants' age, Disimone-Weiss discovered participants with personal experience rate the age of the child, for which parent-child behaviors are no longer appropriate, to be older than those participants without personal experience. A limitation in the Disimone-Weiss study is the failure to specify the meaning of the term "personal experience". Personal experience may be interpreted as being the victim of abuse or witnessing the abuse of another. Therefore it cannot be concluded that all study participants who indicate "personal experience" are victims of abuse themselves.

The Study Questionnaire versions 1 and 2 were not appropriate for use in this research study due to the instrument lacking a total outcome score. In addition the length of the 15 item vignette Study Questionnaire was too long for this research study which included two other research scales.

Family Practices Questionnaire-Versions 5 & 6.

Johnson (1998) created the Family Practices Questionnaire to investigate professionals' responses to possible instances of parent-child sexual abuse. Johnson and Hooper (2003) studied mental health and child welfare professionals attending trainings provided by Johnson from 1999 to 2000 on the subject of children with sexual behavior

problems. Versions five and six of the Family Practices Questionnaire were administered to participants before the trainings started. Participants were asked to rate behaviors ranging from “no age”, “some ages”, to “all ages”. In addition, for items rated “some ages” participants were asked to specify the oldest age for the child in the following four parent-child dyads: (a) single mother and son, (b) single father and son, (c) single mother and daughter, (d) single father and daughter. A total of 717 participants responded to a series of 13 items analyzed in the three following categories of intimate behavior: (a) hygiene, (b) affection, and (c) privacy. Factor analysis was not used in identifying the three categories of intimate behavior. The hygiene category included questions on the following behaviors: (a) taking baths, (b) taking showers, (c) washing children in the bath, (d) cleaning after toilet use, and (e) placing medicine on the children's private parts. The affection category included questions on the following behaviors: (a) parents kissing children on the mouth, (b) giving back and neck rubs, and (c) hugs with body contact. The privacy category included questions on the following behaviors: (a) parents naked with children, (b) children seeing their parents on the toilet, (c) parents and children changing clothes, and (d) parents engaging in sex while children are sleeping in the same room. Results of the study indicated behaviors involving fathers were rated as more abusive than the same behaviors involving mothers (Johnson & Hooper, 2003). Johnson and Hooper report "the mean age differences between mother/son, mother/daughter, father/son, and father/daughter pairs were fairly small, although generally significantly different" (p. 122). Johnson and Hooper reported overall group means for all parent/child pairs. Johnson and Hooper reported the following mean ages for the three categories of intimate behavior:

1. Hygiene Behaviors: parents and children bathing and showering together until 3.3 years, 4.7 years for washing children's bodies, 4.0 for parents wiping children after they toilet, and 6.1 years for applying medicine to their private parts.

2. Affection behavior: parents kissing children on the mouth until 5 years of age, giving back and neck rubs until 8 years of age, giving hugs until 8.6 years of age.

3. Privacy Behaviors: adults naked with child until 4.6 years, children seeing parents use the toilet until 4.8 years, parents and children changing together including underwear until 5.6 years of age, sexual interaction with child in the same room until child is 2.3 years old, and children sleeping with a single parent until 5.4 years of age (p. 122-123).

Although participants were not divided into professional groups, results of the Johnson and Hooper study reveal wide variation among participants regarding the permissiveness of specific parent-child behaviors and the child's age in which specific behaviors are permissible. Examples of variation among participations include the following: (a) 40.3% of participants believed it acceptable at all ages for parents and children to kiss on the mouth, (b) 40.1% of participants believed it only acceptable at certain ages for parents and children to kiss on the mouth, and (c) 19.6% of participants believed it not acceptable at any age. Regarding variation among study participants, Johnson and Hooper (2003) report "these great differences may account for some of the significant variability in practice when cases are evaluated and decisions regarding possible abuse are made" (p. 119).

One limitation of the Johnson and Hooper study is that all participants were attendees of trainings on the topic of children with sexual behavior problems. Previous

researchers (Atteberry-Bennett, 1987; Cohen, 1995; DiSimone-Weiss, 1999) studying parent-child sexual boundaries have not drawn study participants from those attending trainings on the topic of sexual abuse, but rather mailed surveys to unknown professionals. It is important to note that in the Johnson and Hooper study professional experience of the study participants as child protective workers and mental health professionals may have affected participants' judgment regarding certain family practices. Also, demographic information concerning study participants' client population was not reported. Johnson and Hooper did study participants' history of abuse and found no significant difference in respondents reporting childhood emotional, physical, and sexual abuse or neglect compared to those respondents not reporting.

The Family Practices Questionnaire-Versions 5 & 6 were not appropriate for use in this study due to the instrument's lacking a total outcome score. In addition, the length of the Family Practices Questionnaire, containing 4 parent-child dyads for each of the 13 behavioral items, was too long for this research study which included two other research scales.

Summary of parent-child sexual boundary instruments.

Several researchers (Atteberry-Bennett, 1987; Cohen, 1995; Disimone-Weiss, 1999; Johnson & Hooper, 1999) have developed scales to study various professionals' opinions on appropriate parent-child sexual boundary behaviors (Atteberry-Bennett, 1987; Cohen, 1995). When compared to all professional groups, clinicians as a group rated significantly more parent and child behaviors as sexually abusive compared to groups of lawyers, judges, or pediatricians (Atteberry-Bennett, 1987; Cohen, 1995; Disimone-Weiss, 1999). Although not studied by researchers (Atteberry-Bennett, 1987;

Cohen, 1995; DiSimone-Weiss, 1999), increased exposure to clients sharing their stories of sexual trauma may account for clinicians as a group rating parent-child sexual boundary behaviors as more abusive than other professional groups. Exposure to clients sharing their stories of sexual trauma is a risk factor in the development of vicarious trauma (MacCann & Pearlman, 1990).

There are only four known scales (Atteberry-Bennett, 1987; Cohen, 1995; DiSimone-Weiss, 1999; Johnson & Hooper, 2003) which have been used in studying professionals' opinions on appropriate parent-child sexual boundary behaviors. None of the scales (Atteberry-Bennett, 1987; Cohen, 1995; DiSimone-Weiss, 1999; Johnson & Hooper, 2003) were appropriate for this study. For statistical purposes a total outcome score for the dependent variable, perceptions of permissiveness of parent-child sexual boundaries, was required to run MANOVA procedures.

Permissiveness of Parent-Child Sexual Boundaries Scale.

The Permissiveness of Parent-child Sexual Boundaries Scale (PPCSBS) was created for this study due to problems in the length and scoring of the other instruments. The PPCSBS measures therapists' beliefs regarding the age of the child in which certain behaviors between a parent and child are no longer permissible but rather deemed inappropriate covert sexual acts. To date the PPCSBS has been used only in the pilot study for this research. The results of this pilot study are described in Chapter 3 and Appendix A. The content of the 13 items in the PPCSBS is based upon content of items from the Family Practices Questionnaire (Johnson, 1998). Designed in parallel construction to the Family Practices Questionnaire (Johnson & Hooper, 2003), the PPCSBS contains 13 items in the three categories of intimate behavior. The three

categories of intimate behavior include the following: (a) hygiene, (b) affection, and (c) privacy. The hygiene category contains items on the following behaviors: (a) taking baths, (b) taking showers, (c) washing children in the bath, (d) cleaning after toilet use, and (e) placing medicine on the children's private parts. The affection category contains items on the following behaviors: (a) parents kissing children on the mouth, (b) giving back and neck rubs, and (c) hugs with body contact. The privacy category contains items on the following behaviors: (a) parents naked with children, (b) children seeing their parents on the toilet, (c) parents and children changing clothes, and (d) parents engaging in sex while children are sleeping in the same room.

Although similar to the Family Practices Question (Johnson, 1998) in item content, the PPCSBS differs in item scoring and item construction. Unlike the Family Practices Questionnaire, which does not calculate a total score for all items, the PPCSBS was designed to calculate a total outcome score indicating permissiveness of parent-child sexual boundaries for all item behaviors. For statistical purposes a total outcome score on the PPCSBS, as a dependent variable, is required to run the MANOVA procedure.

In addition to scoring, the PPCSBS differs from the Family Practices Questionnaire (Johnson, 1998) in rating scale construction. In the Family Practices Questionnaire (Johnson, 1998) participants are asked to rate behaviors ranging from “no age”, “some ages”, to “all ages”. In addition, for items rated “some ages” participants were asked to specify the oldest age for the child in the following four parent-child dyads: (a) single mother and son, (b) single father and son, (c) single mother and daughter, (d) single father and daughter. However, in the PPCSBS, participants are provided age ranges to rate the age of the child in which behaviors between a father and

daughter are permissible. The participants are provided three age groups for the child: three, five, and nine years. Participants may select more than one permissible child age for each item behavior. The three age groups for the child in the PPCBSBS are based upon outcome results from a study by Johnson and Hooper (2003) using the Family Practices Questionnaire (Johnson, 1998). Results of the Johnson and Hooper study reveal a range of 3 to 9 years for the mean age of the child in which certain parent-child behaviors are no longer permissible. Thus the mean child age of three to nine years was selected for the age range in the PPCSBS.

Construction of items in the PPCSBS for parent-child dyads was limited from four possible parent-child dyads (mother-son, mother-daughter, father-son, and father-daughter) to only one parent-child dyad (father-daughter). The PPCSBS was designed to provide a total scale score reflective of the level of permissiveness regarding family sexual boundaries between fathers and daughters. The configuration of father-daughter was chosen because father-daughter and step-father-daughter incest is the most frequently reported and discussed incest configuration (Huber, 1993). To include other parent-child dyads in the PPCSBS would have made the scale too long for this research which contained two other scales.

Vicarious Trauma

Although differences in professionals' perceptions of parent-child sexual boundaries have been researched in relationship to professional affiliation (Atteberry-Bennett, 1987; Cohen, 1995; DiSimone-Weiss, 1999; Johnson & Hooper, 2003), researchers have yet to investigate differences in professionals' perceptions of parent-child sexual boundaries in relationship to vicarious trauma. This research study will

explore differences in professional's perceptions of parent-child sexual boundaries in relationship to symptoms of vicarious trauma.

Vicarious trauma is a term first used by McCann and Pearlman (1990). It describes pervasive changes that occur within the clinician over time as a result of working with clients who have experienced trauma. Vicarious trauma may create in professionals pervasive changes in perceptions of self, others, and adaptations to the world (Rich, 1997). Two general symptoms of vicarious trauma may occur in trauma professionals: changes in cognitive schemas and secondary traumatic stress symptoms.

Vicarious trauma may affect therapists' cognitive schemas as a result of empathetic engagement with clients' trauma experiences (McCann & Pearlman, 1990). In addition to changes in cognitive schemas, vicarious trauma may create secondary traumatic stress symptoms similar to post traumatic stress disorder such as sleep disturbances, avoidant behavior, and intrusive thoughts and images.

The exact number of therapists experiencing vicarious trauma is unknown. Research suggests that a higher level of exposure to traumatized clients significantly increases the risk factor for therapists to develop vicarious trauma (Pearlman & Mac Ian, 1995; Schauben & Frazier, 1995). In addition, some research implies that certain characteristics of the therapist, such as personal trauma history, gender, and personal stress, may interact with exposure to trauma material to contribute to symptoms of vicarious trauma (Pearlman & Mac Ian, 1995). Creamer and Liddle (2005) note research on vicarious trauma has both supported and disputed therapist links to caseload number, level of education, years of professional experience, and type of trauma (human-induced trauma of sexual abuse versus natural occurring trauma of cancer).

This section will provide a literature review on the two general types of pervasive changes resulting from vicarious trauma: changes in cognitive schemas and secondary traumatic stress symptoms. Also included in this section is a summary of instruments, selected for use in this study to measure changes in cognitive schemas and secondary traumatic stress symptoms. The instruments are the Trauma and Attachment Belief Scale (Pearlman, 2003) and Secondary Traumatic Stress Scale (Bride, 1999).

Cognitive Schemas

Cognitive schemas are core beliefs about self, others, and the world that are deeply rooted in psychological needs (Pearlman, 2003). Cognitive schemas may or may not be conscious beliefs (Pearlman, 2003). The origin of cognitive schemas is rooted in cognitive behavior therapy. Cognitive schemas determine our relationships with others. For example, if a person believes that people are untrustworthy or unworthy of respect, than the person is unlikely to engage in satisfying relationships (Pearlman, 2003).

The concept of cognitive schemas in reference to vicarious trauma comes from the Constructivist Self-Development Theory (CSDT). The CSDT is based upon the premise that individuals construct their own realities through the development of cognitive schemas or perceptions which facilitates their understanding of surrounding life experiences (Trippany et al., 2004). The interaction of client stories and therapists personal characteristics promotes in the therapist changes in cognitive schemas or perceived realities (Saakvitne & Pearlman, 1996). The CSDT emphasizes the individual nature of trauma including the idea that individuals construct the meanings that particular traumas have on them. The CSDT suggests that irrational perceptions develop in the therapist as a form of self-protection from hearing stories of emotionally traumatic client

experiences (Trippany et al., 2004).

CSDT is based upon the belief that there are five components of the self and the self and one's perception of reality are developed and affected by trauma. The five components of the self are the following: (a) frame of reference, (b) self-capabilities, (c) ego resources, (d) psychological needs, and (e) cognitive schemas, memory, and perception (Pearlman & Saakvitne, 1995).

Trippany et al. (2004) gives us a basis for understanding frame of reference in this theory. Frame of reference refers to changes in understanding and viewing the self and the world. It encompasses one's identity, worldview, and belief system as well as cognitive processes of causality and attribution. Disruptions in frame of reference can create difficulties in the therapeutic relationship resulting in the opportunity for the therapist to blame the victim client.

Another component of CSDT is self-capabilities, which allow individuals to manage emotions, sustain positive feelings about themselves, and maintain relationships with others (Trippany et al., 2004). Pearlman and Saakvitne (1995) note that self-capabilities are "inner capabilities that allow the individual to maintain a consistent, coherent sense of identity, connection, and positive self-esteem" (p. 64). A disruption of self-capabilities as a result of vicarious trauma may manifest in a loss of identity, difficulty controlling negative emotions, avoiding exposure to media that conveys the suffering of others, and being unable to meet the needs of significant others in one's life (Trippany et al., 2004).

Ego Resources, a component of CSDT, includes the ability to conceive consequences, to set boundaries, and to protect the self (Trippany et al., 2004). Pearlman

and Saakvitne (1995) describe ego resources as the individual's ability to meet psychological needs and relate to others interpersonally. A disruption in ego resources may result in perfectionism and overextension at work, and an inability to be empathetic with clients (Trippany et al., 2004).

The final components of CSDT are psychological needs and related cognitive schemas. Basic psychological needs include safety, trust, esteem, intimacy, and control. Pearlman and Saakvitne (1995) believe cognitive schemas about self and others are created from the combination of basic psychological needs and the individual's ability to process information related to these needs.

Psychological needs and related cognitive schemas.

Safety is a basic psychological need. Therapists experiencing a disruption in cognitive schemas related to safety needs may experience high levels of fearfulness, vulnerability, and concern (Pearlman, 1995). They may become overly cautious concerning the safety of their children, take self-defense courses, install a home alarm system, or carry mace or a rape whistle for protection (Trippany et al., 2004)..

Trust is a psychological need encompassing the inherent desire to have confidence in one's own perceptions and beliefs as well as the ability to trust others to meet one's emotional, psychological, and physical needs (Trippany et al., 2004). Vicarious trauma may disrupt the therapist's cognitive schemas of trust, creating suspicion regarding certain groups of people. Therapist may also experience self-doubt and question their ability to judge and intervene effectively with clients (Trippany et al., 2004).

Esteem is a psychological need characterized by one's value of self and others

(Pearlman, 1995). Therapists experiencing vicarious trauma may have distorted cognitive schemas of esteem needs including feelings of inadequacy and questioning their ability to help others (Trippany et al., 2004). Esteem for others may be altered by therapist exposure to stories of violence and cruelty committed by others.

Intimacy is the psychological need to feel connected to self and others (Pearlman & Saakvitne, 1995). The distortion of cognitive schemas surrounding intimacy needs may result in therapists' feelings of emptiness when alone, difficulty enjoying time alone, intense wanting to fill alone time, and withdrawal and avoidance from others (Trippany et al., 2004).

Summary of cognitive schemas.

Various researchers (Brady, Poelstra, & Brokaw, 1999; Cunningham, 2003; Pearlman & Mac Ian, 1995; Schauben & Frazier, 1995) have studied levels of therapists, distinguished by professional membership or client population served, for changes in cognitive schemas as a result of vicarious trauma. In the past, researchers have used no more than two therapist levels in researching vicarious trauma and related cognitive schemas. This research study was the first known to use three therapist levels, distinguished by client population served, to research group differences for related changes in cognitive schemas and perceptions of parent-child sexual boundaries as a result of vicarious trauma. This study used the Trauma and Attachment Belief Scale (TABS) to measure differences in cognitive schemas among therapist levels as a result of vicarious trauma.

Trauma and Attachment Belief Scale.

The Trauma and Attachment Belief Scale (TABS) was constructed to measure

changes in cognitive schemas as a result of vicarious trauma. The TABS was created in the context of the psychological theory known as CSDT (Pearlman, 2003). The earliest version of the TABS, the McPearl Belief Scale, was developed in 1988 (Pearlman, 2003). According to Pearlman (2003), the initial TAB items originated from collected statements of trauma survivor clients and reflected the six identified psychological needs from the constructivist self-development theory at that time. The six psychological need areas were safety, trust, independence, power, intimacy, and esteem. A list of one hundred statements was compiled and expert reviewers assigned each item to one of the six area needs. The list was reduced to a set of 76 items covering the six psychological need areas. The item set described beliefs about self and others as well as nine subscales. The nine subscales were Safety, Trust/Dependency, Self-Esteem, Other-Esteem, Self-Intimacy, Other-Intimacy, High-Power, Low-Power, and Independence. The items on the High-Power and Low-Power subscales originated from Vietnam veteran and battered women clients' statements. Eventually the High-Power and Low-Power subscales were discarded and replaced by the Control subscale. A healthy desire for control over one's behavior and environment shifted the conceptualization of the High-Power and Low-Power items to the more suitably descriptive Control subscale. The original Independence subscale evolved into a strong need to resist one's dependency, known as counterdependence. As a result, some of the Independence items were shifted to the Trust and Control subscales.

The TABS has gone through several additional revisions and name changes. With the discarding of the Power and Independence subscales only five psychological needs remained: safety, trust, intimacy, and control. A new name for the scale emerged, the Traumatic Stress Institute (TSI) Belief Scale (Pearlman, Mac Ian, Johnson, & Mas,

1992). In 1994 the five need areas of safety, trust, esteem, intimacy, and control were divided into self-oriented and other-oriented subscales. This structure change resulted in the revision of the name in 1994 from the TSI Belief Scale to the TSI Belief Scale Revision L (Pearlman, 2003).

Another revision occurred in 2003 which resulted in the current scale (Pearlman, 2003). Many items from the TSI Belief Scale Revision L were modified to make them easier to read. For example, qualifiers such as generally and sometimes were omitted to reduce confusion in understanding items. As a result of the item modification, the TABS could be administered to the child population. Item 1 from the TSI Belief Scale Revision L is “I generally feel safe from danger”. TABS modified item 1 to the following: “I believe I am safe”.

Although the TABS was originally designed to measure the impact of trauma upon victims (Pearlman, 2003), some researchers have used the TABS to assess the impact of indirectly experienced trauma (Brady et al., 1999; Cunningham, 2003; Pearlman & Mac Ian, 1995; Schauben & Frazier, 1995; VanDeusen & Way, 2006). Researchers using the TABS or earlier versions of the TABS have discovered disrupted cognitive schemas in the following subject groups: (a) therapists with higher percentages of trauma clients (Schauben & Frazier, 1995), (b) therapists with a personal trauma history (Pearlman & Mac Ian, 1995; VanDeusen & Way, 2006), (c) therapists treating sexual abuse trauma clients compared to cancer afflicted clients (Cunningham, 2003), and (d) therapists with less clinical experience treating sexual offenders and victims compared to therapists with more clinical experience treating sexual offenders and victims (Brady et al., 1999; Pearlman & Mac Ian, 1995; VanDeusen & Way, 2006).

Schauben and Frazier (1995) assessed the effects of vicarious trauma on female sexual violence counselors. Counselors working with higher percentages of trauma survivors reported more disrupted cognitive schemas, particularly about the goodness of other people. Schaben and Frazier's study used several instruments including five subscales of the TSI Belief Scale, an earlier version of the TABS. Unfortunately, outcome results of the five subscales (Safety, Self-Trust, Other-Trust, Other-Esteem, and Other-Intimacy) were not reported.

Pearlman and Mac Ian (1995) examined vicarious trauma in 188 self-identified trauma therapists. They discovered therapists with a personal trauma history had more disrupted cognitive schemas as evidenced by elevated TABS' scores than others in the study without a personal trauma history. Pearlman and Mac Ian concluded from their research findings that the more distressed trauma history therapists may leave the field early or cognitive schemas become less disrupted over time.

Cunningham (2003) compared the TABS scores for social workers working with two types of trauma: (1) human-induced trauma, sexual abuse and (2) naturally caused trauma, cancer. Therapists who worked with clients who were sexually abused reported more disruptions in cognitive schemas (self and other safety) than therapists who worked with clients who had cancer. Therapists working with clients who were sexually abused had more cognitive disruptions in elevated safety, Other-Trust, and Other-Esteem scores.

Brady et al. (1999) examined spirituality and vicarious trauma in 446 female psychotherapists. Therapists with higher levels of exposure to sexual abuse survivors reported higher scores for trauma symptoms compared to therapists with lower levels of exposure as measured by the Impact of Events Scale (Horowitz, Wilner, & Alvarez,

1979). Disruptions in cognitive schema as measured by the TABS were higher, but not in the clinically elevated range for the same group of therapists with higher levels of exposure to sexual abuse victims. Further, spiritual well-being which was previously believed to be damaged by vicarious trauma was found to be higher for the therapists who saw more sexual abuse survivors.

VanDeusen and Way (2006) in a study of the TABS subscales for trust and intimacy discovered more disrupted cognitive schemas in therapists with less clinical experience compared to therapists with more clinical experience. Both therapist groups specialized in the treatment of sexual offender or sexual abuse victim clients. Further, therapists with a maltreatment history of physical, sexual, or emotional abuse were found to have more disrupted cognitive schemas than therapists without a maltreatment history. In contrast, VanDuesen and Way (2006) concluded a reported history alone of child sexual abuse is not predictive of disrupted cognitive schemas, a finding consistent with earlier studies (Benetar, 2000; Follette, Polusny, & Milbeck, 1994; Kassam-Adams, 1999).

In summary, the TABS is the only instrument available to measure changes in cognitive schemas as a result of vicarious trauma. The TABS has 12 subscales to measure changes in cognitive schemas in the six psychological needs areas: safety, trust, independence, power, intimacy, and esteem. In theory, the cognitive schemas that are most salient to clinicians are those most vulnerable to disruption in trauma work (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). Research indicates the cognitive schemas that are most salient to therapists who treat sexual trauma are other intimacy, self safety, and other safety (Cunningham, 2003; VanDeusen & Way (2006).

To date, research using the TABS has not studied three levels of therapists for comparisons on cognitive schemas. Although previous studies (Brady et al., 1999; Cunningham, 2003; McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995; Vandusen & Way, 2006) using the TABS have compared two therapist levels, none have included a third therapist level. This study will use the TABS instrument to study three therapist levels: sexual offender, sexual abuse victim, and general population.

Secondary Traumatic Stress Symptoms

In addition to changes in cognitive schemas, another component of vicarious trauma is secondary traumatic stress symptoms. Therapists with secondary traumatic stress symptoms may experience PTSD symptoms similar to their clients, such as intrusive thoughts, nightmares, disturbed sleep (Adams, Matto, & Harrington, 2001; Gentry, 2002; Hodgkinson & Shepherd, 1994; McCann & Pearlman, 1990; Minnen & Keijsers, 2000); anger, fear, suppression of emotions, alienation, irritability, anxiety, suicidal thoughts (Hodgkinson & Shepherd, 1994) ; flashbacks, feelings of insanity, loss of control, sexual difficulties (Adams et al., 2001), amnesia, derealization, somatoform complaints (Minnen & Keijsers, 2000), as well as changes in their relationships to self, families, friends, and community (Gentry, 2002). Figley termed these PTSD like symptoms secondary traumatic stress (Figley, 1995).

Research on the secondary traumatic stress symptoms of vicarious trauma suggests that therapists may experience hypervigilance and fearfulness for their own as well as their family's personal safety (Bengis, 1997; Farrenkopf, 1992; Jackson et al., 1997; Rich, 1997; Steed & Downing, 1998). As a result, research suggests secondary traumatic stress symptoms of vicarious trauma may alter therapists' perceptions of

permissive parent-child sexual boundaries (Edmunds, 1997; Freeman-Longo, 1997). This research study investigated secondary traumatic stress symptoms differences among therapists treating sexual offenders, sexual abuse victims, and general population clients.

Secondary traumatic stress disorder and compassion fatigue.

Although vicarious trauma includes both changes in cognitive schemas and secondary traumatic stress symptoms, confusion exists among terms commonly used to describe secondary symptoms of traumatic stress. The terms vicarious trauma, secondary traumatic stress disorder, and compassion fatigue refer to a distinct set of secondary traumatic stress symptoms similar to symptoms of post traumatic stress disorder (Figley, 1995; McCann & Pearlman, 1990). However, unlike post traumatic stress disorder, disruptions in cognitive schemas and belief systems may result from empathetic engagement with clients' trauma experiences (McCann & Pearlman, 1990).

While vicarious trauma focuses on disruptions in cognitive schemas and is based on the constructivist self-development theory (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995), secondary traumatic stress disorder focuses on observable reactions to symptoms of post traumatic stress disorder (PTSD) described in the *DSM-IV-TR* (American Psychiatric Association, 2000). The focal point of secondary traumatic stress disorder is the set of observable PTSD like symptoms of intrusion, avoidance, and arousal (Bride, 2004). Compassion fatigue, on the other hand, focuses on the process of empathetic engagement with the client (Figley, 1995). According to Figley (1995) empathizing with traumatized clients places therapists in a vulnerable position to being traumatized as well. Thus, trauma therapists with compassion fatigue may experience secondary traumatic stress symptoms.

In summary, vicarious trauma, secondary traumatic stress, and compassion fatigue share in common a distinct set of secondary traumatic stress symptoms resulting from exposure to client stories of trauma. However, unlike secondary traumatic stress disorder and compassion fatigue, vicarious trauma includes changes in cognitive schemas as well as secondary traumatic stress symptoms. Only vicarious trauma takes into account the specific cognitive changes experienced as a result of secondary trauma (Sabin-Farrell & Turpin, 2003). For the purpose of this research, the term vicarious trauma was used to study the levels of therapists for changes in cognitive schemas and secondary traumatic stress symptoms.

Secondary Traumatic Stress Scale.

The Secondary Traumatic Stress Scale (STSS) was developed to measure the symptoms of secondary traumatic stress (Ting et al., 2005). It was created in response to the paucity of instruments available to measure secondary traumatic stress (Bride et al., 2003). Before the STSS was created, the majority of instruments used in research of vicarious (secondary) trauma were designed to investigate symptomology among survivors of direct exposure to trauma, rather than secondary exposure (Bride et al., 2003). The STSS measures the reactions of therapists who have experienced traumatic stress through their work with clients (Ting et al., 2005).

In the past, secondary traumatic stress symptoms of vicarious trauma were measured by questionnaires which compared vicarious trauma to other concepts such as burnout and post traumatic stress disorder (Sabin-Farrell & Turpin, 2003). The instrument most commonly used to measure burnout is the Maslach Burnout Inventory (MBI) (Maslach & Jackson, 1986). The Compassion Fatigue Self-Test for Practitioners

(CFST) (Figley, 1995), a scale designed to measure vicarious trauma, has two subscales which measure compassion fatigue and burnout.

In addition to using instruments to assess burnout, secondary traumatic stress symptoms of vicarious trauma have also been measured by using instruments to assess PTSD symptoms. According to Sabin-Farrell and Turpin (2003) the most commonly used instruments to measure PTSD symptoms for vicarious trauma are the Impact of Event Scale (IES) (Horowitz et al., 1979) and the Trauma Symptom Checklist-40 (Elliot & Briere, 1992). Additionally Sabin-Farrell and Turpin list other general instruments of symptomatology and well-being, including the Symptom Checklist-90-Revised (SCL-90-R; Derogatis, 1983) and the Brief Symptom Inventory (Derogatis, 1993).

Despite numerous scales used in the past to measure secondary traumatic stress symptoms, the STSS is the most appropriate scale for use in this research study. The STSS has been selected because it is the only scale designed specifically to measure secondary exposure to trauma. Unlike other instruments, such as the IES, used to measure vicarious trauma, the STSS is the only one normed on samples of participants indirectly exposed to trauma (Bride et al., 2003). It is important to note that the IES, which measures PTSD symptoms, has the same item content as the STSS which measures secondary traumatic stress symptoms. The STSS item content is worded to reflect secondary exposure to trauma, while the IES item content reflects primary exposure to trauma.

The 17-item STSS is based upon the diagnosis of Post Traumatic Stress Disorder (PTSD) found in the *DSM-IV-TR* (American Psychiatric Association, 2000). The PTSD symptoms of intrusion, avoidance, and arousal, found respectively in *DSM-IV-TR* Criteria

B, C, and D, correspond to the STSS' symptoms of intrusion, avoidance, and arousal resulting from indirect exposure to traumatic events by means of a professional helping relationship (Bride et al., 2003). The PTSD symptoms of distressing emotions and functional impairment found in the *DSM-IV-TR* were excluded from the STSS item pool due to concerns of corresponding symptom similarity with burnout (Bride et al., 2003). Burnout is a related but conceptually distinct construct from secondary traumatic stress (Bride et al., 2003).

The development of the STSS began with five experts in the area of secondary traumatic stress who reviewed a list of 36 likert-type items for content validity (Bride et al., 2003). The five experts increased the item pool from 36 to 65 items in order to include all possible examples of secondary traumatic stress. The 65-item version was pilot tested on 37 social workers for the purpose of reducing the item pool which was reduced to 50 items. The STSS was then administered to 200 school of social work alumni from the southeastern United States. Pool items were reduced to 17 for each of the individual 17 *DSM-IV-TR* (American Psychiatric Association, 2000) symptoms of PTSD (Bride et al., 2003). The 17 remaining STSS items were included in the current version of the STSS. Research studies have been conducted to investigate the psychometric properties of the STSS instrument.

Bride et al. (2003) studied 287 master level social workers to investigate the psychometric properties of the STSS. Evidence was found for reliability, convergent and discriminate validity, and factorial validity for the STSS in measuring symptoms of secondary traumatic stress (Bride et al., 2003). The psychometric properties of the STSS will be discussed in greater length in chapter three.

Interpretation of STSS scores is based upon provisional recommendations at this time (Bride, in press). Bride's interpretation of STSS scores for participants experiencing PTSD at a diagnostic level due to secondary traumatic stress is based upon the following item endorsements: one item in the intrusion scale, three items in the avoidance scale, and two items in the avoidance subscale. STSS scores can also be interpreted by a cut-off score of 38, also indicating PTSD at a diagnostic level due to secondary traumatic stress.

The body of empirical research available on the STSS is limited to articles written by Bride, author of the STSS. Bride (in press) studied the prevalence of secondary traumatic stress symptoms in 294 master level social workers representing diverse fields of practice using the STSS. His study on secondary traumatic stress symptoms revealed 40% of study participants experience intrusive thoughts regarding their work with traumatized clients (Bride, in press). In addition, 13.8% of study participants experienced hypervigilance and 10.9% of participants reported avoidance of people, places, or things that served as reminders of work with traumatized clients (Bride, in press).

In summary, the STSS (Bride, 1999) was used in this study because it is the only scale available to measure the symptoms of secondary traumatic stress. Before the STSS was developed older scales, designed to measure burnout and post-traumatic stress disorder, were used to measure secondary traumatic stress disorder. The STSS demonstrates psychometric properties supporting the effectiveness of its use in measuring secondary traumatic stress symptoms (Bride et al., 2003). The psychometric properties of the STSS will be discussed in greater detail in chapter 3.

Levels of Therapists

The present literature review on vicarious trauma examines its impact on the

three levels of therapists used in this study: sexual offender, sexual abuse victims, and generalist population therapists. Three levels of therapists, distinguished by diverse specialization in client populations, were examined for similarities and differences regarding the impact of vicarious trauma.

Sexual Offender Therapist

The effects of vicarious trauma upon therapists who treat sexual offenders have been investigated by a number of researchers (Edmunds, 1997; Ennis & Horne: 2003; Farrenkopf, 1992; Jackson et al., 1997; Rich, 1997; Steed & Bicknell, 2001). In addition to research studies, some therapists who treat sexual offenders have written about the impact of their own personal experiences (Bengis, 1997; Etherington, 2000; Freeman-Longo, 1997). Therapists treating sexual offenders experience changes in psychological needs and cognitive schemas that are unique compared to therapists who do not treat sexual offender clients (Way et al., 2004). A summary of research studies on therapists who treat sexual offenders have reported the following symptoms associated with vicarious trauma symptoms: (a) fear for personal safety (Edmunds, 1997; Jackson, 1997, Rich, 1997), (b) fear for safety of children and family (Edmunds, 1997; Farrenkopf, 1992; Jackson et al., 1997; Rich, 1997), (c) hypervigilance around strangers (Jackson et al., 1997; Rich, 1997), (d) disruptions in sexuality (Edmunds, 1997; Jackson et al., 1997; Rich, 1997), (e) avoidance symptoms (Jackson et al., 1997; Rich, 1997), (f) identification with role of the perpetrator (Etherington, 2000; Pearlman & Saakvitne, 1995), (g) experiences of flashbacks, bad dreams, and bad images of clients' traumatic material (Jackson et al., 1997; Rich, 1997), (i) feeling like a personal failure (Rich, 1997), (j) isolated from family and friends (Rich, 1997), and (k) at odds with the world (Rich,

1997).

Farrenkopf (1992) studied 24 experienced Oregon therapists working with sex offenders. He discovered that almost one third of participants interviewed felt more hypervigilant and suspicious of others and more protective of their own or their family's personal safety. Some therapists saw potential abusers everywhere. Female therapists in particular reported more fearfulness and experienced constant concern over their children encountering abusive situations, including in their own home. Female therapists working predominately with males were prone to increased feelings of vulnerability to abuse as well as increased paranoia and vigilance in their daily lives. Farrenkopf discovered male therapists working with sexual offenders experienced increased awareness of the "collective guilt" over male abusive behavior.

In addition to collective guilt, therapists who treat sexual offenders are at risk for identifying with the role of the perpetrator (Etherington, 2000; Pearlman & Saakvitne, 1995). Pearlman and Saakvitne describe behaviors the supervisor may notice if therapists afflicted with vicarious trauma identify with the role of the perpetrator. The therapist may display the following behaviors: (a) disbelief about the client's story as evidenced by minimizing or rationalizing the abuse, (b) revulsion or disgust at the client's behavior, or judgmental when the client does not live up to how a proper victim should be, (c) contempt for client's helplessness or paranoid fear of client's vindictive rage, (d) moments of hate when they wish to get rid of the client, (e) voyeuristic excitement, fascination, or sexual arousal, and (f) survivor guilt (guilt of the unharmed bystander).

At the opposite end of the spectrum from identification with the perpetrator is the fear of accusation of perpetrating behavior. Jackson et al. (1997) surveyed 332 sexual

offender therapists and discovered many reported an increased awareness of the potential for sexual abuse or misunderstanding of innocent behavior. Some therapists reported a tendency to distance themselves from children to protect themselves from the possibility of accusations of inappropriate behavior. Over half of therapists (57%) reported changing their own behavior around children because of their work with sexual offenders (Jackson et al., 1997). Approximately the same number of therapists (59%) reported anxiety regarding the safety of their own children and grandchildren, while 54% of therapists reported a decreased sense of personal safety (Jackson et al., 1997). A higher percentage (67%) of therapists experience visual images of sexual assaults committed by their clients (Jackson, 1997). Therapists identified the following reactions to these images: (a) painful and disturbing (21%), (b) repulsive (19%), or (c) arousing (1%). As a result, disturbing sexual images may contribute to decreased interest in sexual activity as reported by 27% of therapists (Jackson et al., 1997).

Edmunds (1997) also found decreased interest in sexual activity for 31% of 636 therapists who were members of the Association for the Treatment of Sexual Abusers (ATSA). Although the focus of the study was on personal experiences of the ATSA members in relation to risk factors for job burnout, Edmunds provided empirical evidence to support vicarious trauma development as a risk factor for therapists treating sexual offenders. Edmunds discovered therapists reported the following symptoms associated with vicarious trauma: (a) spending private time thinking about work (33%), (b) increased cynicism (33%), (c) sleep disturbance (33%), and (d) depression (25%). Although not reported by statistics, Edmunds implies the fear of sexual abuse allegations may create therapists' discomfort in caring for or touching children, an implication

supported by Freeman-Longo (1997). Edmunds also explored therapist gender differences and discovered more female participants, 25% compared to 13% of male participants, reported experiencing less confidence in personal safety.

Rich (1997) also found higher percentages of therapists with vicarious trauma reported not feeling safe at work and worrying about their families' safety. Rich studied 137 therapist members of the ATSA, 87 of whom treated both sexual offenders and victims, in order to understand the impact of vicarious trauma. Rich divided conference attendees into two distinct groups, those respondents identifying themselves as vicariously traumatized and those not identifying themselves as vicariously traumatized. A total of 67% of therapists identified themselves as vicariously traumatized. A much higher percentage of vicariously traumatized therapist report the following: (a) feeling at odds with the world, (b) feeling depressed, (c) feeling like a personal failure, (d) isolated from family and friends, (e) decreased sexual enjoyment, and (f) experiences of flashbacks, bad dreams, and bad images of clients' traumatic material (Rich, 1997).

Although Rich (1997) reported intrusion symptoms (flashbacks, bad dreams, and bad images of clients' traumatic material), Steed and Bicknell (2001), in an Australian sample of 67 sexual offender therapists, found no statistical significance for the secondary traumatic stress symptoms of intrusion and arousal. However, a U-shaped relationship was discovered between the number of years of experience as a therapist and avoidance as a symptom of secondary traumatic stress. Steed and Bicknell found therapists with the least and most number of years of practice experienced more avoidance symptoms as measured by the Impact of Events Scale-Revised (IES-R)(Weiss & Marmar, 1997). Therapists with the least risk of developing avoidance symptoms are

those with two to four years of clinical experience. Steed and Bicknell provide the following explanations for the failure to reach statistical significance for intrusion and arousal: (a) the study was severely underpowered due to small sample size and (b) the IES-R was altered by asking participants to endorse statements with regard to their experiences in a short time frame of only seven days.

While Steed and Bicknell (2001) used the IES-R to measure symptoms of secondary traumatic stress, Ennis and Horne (2003) used The Los Angeles Symptom Checklist (LASC)(King, King, Leskin, & Foy, 1995) to study 59 sex offender therapists. Ennis and Horne reported the lack of a significant positive correlation between the number of hours devoted to sex offender treatment and the experience of therapist secondary traumatic stress symptoms. Results of the study must be interpreted with caution due to the fact the LASC is not an instrument designed to measure vicarious trauma. Therapists' changes in cognitive schemas were not studied. Further Steed and Bicknell (2001) report the small sample size of 59 is underpowered for a statistical procedure of linear regression with four independent variables. In a self-report measure of post traumatic stress, greater levels of peer support were found to be a significant predictor of lower levels of psychological distress and symptoms of post traumatic stress disorder (Ennis & Horne, 2003).

In summary, therapists treating sexual offenders may experience changes in psychological needs and cognitive schemas that are unique compared to therapists who do not treat sexual offender clients (Way et al., 2004). A summary of research on therapists who treat sexual offenders have reported the following symptoms of vicarious trauma: (a) fear for personal safety (Edmunds, 1997; Jackson, 1997, Rich, 1997), (b) fear

for safety of children and family (Edmunds, 1997; Farrenkopf, 1992; Jackson et al., 1997; Rich, 1997), (c) hypervigilance around strangers (Jackson et al., 1997; Rich, 1997), (d) disruptions in sexuality (Edmunds, 1997; Jackson et al., 1997; Rich, 1997), (e) avoidance symptoms (Jackson et al., 1997; Rich, 1997), (f) identification with role of the perpetrator (Etherington, 2000; Pearlman & Saakvitne, 1996), (g) experiences of flashbacks, bad dreams, and bad images of clients' traumatic material (Jackson et al., 1997; Rich, 1997), (i) feeling like a personal failure (Rich, 1997), (j) isolated from family and friends (Rich, 1997), and (k) at odds with the world (Rich, 1997). In addition research implies that vicarious trauma alters therapists' perceptions of permissible parent-child sexual boundaries (Edmunds, 1997; Freeman-Longo, 1997).

This research study compared therapists who treat sexual offenders with other therapist levels for differences in perceptions of self, others, parent-child sexual boundaries, and altered adaptations to the world. In other words, this research study explored symptoms unique to therapists treating sexual offenders in perceptions of parent-child sexual boundaries, changes in cognitive schemas, and secondary traumatic stress symptoms.

Sexual Abuse Victim Therapist

Therapists treating sexual abuse victims may experience many of the same symptoms of vicarious trauma as therapists for sexual offender clients (Rich, 1997; VanDeusen & Way, 2006; Way et al., 2004). The similarities in symptoms of vicarious trauma include the following: (a) decreased sense of personal safety and safety of significant others (Rich, 1997; Way et al., 2004), (b) hypervigilance (Meyers & Cornille, 2002; Way et al., 2004), (c) disrupted cognitions about intimacy with others (VanDeusen

& Way, 2006), (d) avoidance symptoms (Way et al., 2004), and (e) disruptions in sexuality (Way et al., 2004), and (f) intrusive dreams, imagery, and thoughts (Meyers & Cornille, 2002; Steed & Downing, 1998). Other vicarious trauma symptoms for therapists who treat sexual abuse victims include the following: (a) increased sense of spirituality (Brady et al., 1999), (b) disturbances in affect (Meyers & Cornille, 2002; Steed & Downing, 1998; Wasco & Campbell, 2002), and (c) difficulties with trust (Steed & Downing, 1998).

Exposure to sexual trauma has been found to be a predictive factor for the development of vicarious trauma in therapists treating sexual abuse victims (Kassam-Adams, 1999; Schaben & Frazier, 1995; Simonds, 1997). Kassam-Adams (1999), in a survey of 100 psychotherapists, concluded that exposure to sexual trauma clients was directly related to therapist symptoms of intrusion and avoidance as measured by the IES (Horowitz et al., 1979).

In a study of 118 psychologists and 30 counselors working with sexual violence survivors, Schaben and Frazier (1995) discovered participants with a higher percentage of survivors on their caseload reported more disrupted beliefs, symptoms of post-traumatic stress disorder, and vicarious trauma. Cognitive schemas most likely to be disrupted are those involving beliefs about the goodness of other people. In responding to open-ended questions, some therapists reported changes in their world view such as being more distrustful of men, loss of innocence, and being confronted with evil. Further, therapists with a history of victimization were not more distressed by seeing survivors than were therapists without a history of victimization (Schaben & Frazier, 1995).

In support of Schaben and Frazier (1995), Simonds (1997) also discovered

therapist exposure to sexual trauma to be a predictive factor in the development of vicarious trauma symptoms. Simonds (1997) studied vicarious trauma on therapists treating adult survivors of childhood sexual abuse. He discovered a relationship between therapist exposure to sexual abuse clients and vicarious trauma symptoms, notably in changes of cognitive schemas surrounding increased fears about the safety of children.

Although Schaben and Frazier (1995) and Simonds (1997) reported disrupted cognitive schemas in therapists treating sexual abuse clients, a study by Brady et al. (1999) found no evidence to support this finding. In a study of 1,000 psychotherapists, Brady et al. discovered therapists with greater exposure to sexual abuse clients did not evidence higher levels of disrupted cognitive schemas compared to therapists with lesser exposure. However, therapists with greater exposure to sexual abuse clients were found to have secondary traumatic stress symptoms in the mild clinical range. In addition, spiritual well-being, which was previously thought to be damaged by vicarious trauma, was found to be higher for those who treated the sexual abuse victims. Brady et al. theorized that spirituality functioned as a coping skill in reducing therapist distress symptoms. However, results of the Brady et al. study should be interpreted with caution due to the study's limitation of failing to account for participants' years of clinical experience.

Steed and Downing (1998) provide further support for increased risk for development of vicarious trauma in therapists treating sexual abuse victims. In a thematic-content analysis interview, two-thirds of female therapists working with sexual assault and abuse clients reported secondary traumatic stress symptoms of intrusive imagery, dreams, and thoughts as well as increased vigilance regarding safety of self and

others, and difficulties with trust. All participants reported some negative effects including affective responses (anger, pain, sadness, frustration, shock, and horror) and physical effects on energy, sleep, and somatic complaints (Steed & Downing, 1998).

Like Steed and Downing (1998), Meyers and Cornille (2002) studied secondary traumatic stress symptoms in therapists who treat sexual abuse clients. Meyers and Cornille studied 205 child protective service (CPS) workers for secondary traumatic stress symptoms by administering the Impact of Events Scale- Revised (IES-R) and Brief Symptom Inventory (BSI). Meyers and Cornille discovered participants with longer periods of employment suffered more symptoms of secondary traumatic stress than those with fewer years of experience. Also, participants working more than 40 hours a week reported more anger, irritability, hypervigilance, exaggerated startle response, intrusive thoughts, nightmares, and trouble concentrating than those participants who worked 40 hours a week. Meyers and Cornille concluded family of origin style impacted participants' reaction to secondary traumatic stress. Participants who grew up in more enmeshed family interaction patterns reported more nightmares and intrusive thoughts and images than participants who grew up in families with less enmeshed patterns. Participants who grew up in families with disengaged interaction patterns reported more secondary traumatic stress symptoms of withdrawal, isolation, and schizoid lifestyle. Meyers & Cornille measured family functioning characteristics by using The Structural Family Interaction Scale (SFIS).

While Meyer and Cornille (2002) found affect disturbances in therapists treating sexual abuse victims, Wasco and Campbell (2002) discovered the most common affect responses to be anger and fear. In a qualitative study of rape victim advocates, 15.7%

reported fear for others, in particular their children's safety. One participant stated, "My kids are a real sore spot with me and I'm paranoid, at times of what may happen to them" (p. 126).

Another qualitative study of therapists who treated sexual abuse victims was conducted by Lonergan, O'Halloran, and Crane (2004). In a study of eight trauma therapists, Lonergan et al. suggest cognitive distortions from vicarious trauma may contribute to therapists' overgeneralization of sexual abuse. Lonergan et al. discovered two out of eight therapists, early in their career, overgeneralized the existence of sexual abuse. Lonergan et al. quoted one participant as "It seemed like every situation had abuse involved. Sometimes there is no abuse" (p. 361).

Kadambi and Truscott (2004) explored the relationship between vicarious trauma and burnout among three separate groups of therapists. Kadambi and Truscott studied three groups consisting of sexual violence, cancer, and general practice therapists. They reported no significant differences between the groups on the following instruments: Traumatic Stress Institute Belief Scale Revision M, the Masloch Burnout Inventory (MBI), and the Impact of Events Scale (IES). It was concluded that there was little evidence to support vicarious trauma as an occupational hazard unique to therapists working with trauma survivors.

Way et al. (2004), in a study of two therapist levels, those who treat sexual offenders and those who treat sexual abuse victims, reported the majority of therapists scored within the clinical range for vicarious trauma. Way et al. discovered high levels of avoidance and intrusion as measured by the IES (Horowitz et al., 1979). At greatest risk for symptoms of intrusion were therapists with less tenure treating sexual abuse clients

(Way et al.).

Like Way et al., VanDeusen and Way (2006) studied therapists treating sexual abuse clients and sexual offender clients. VanDeusen and Way discovered that the two therapist levels shared in common disrupted cognitive schemas regarding intimacy with others. When compared to general population therapists, the mean score for disrupted cognitions about intimacy with others was significantly higher for therapist levels treating sexual abuse and sexual offender clients. This finding on disrupted cognitions of intimacy with others provides support for research on the relationship between disrupted cognitive schemas and therapists' perceptions of parent-child sexual boundary violations.

Lastly, Follette et al. (1994) are the only known researchers to study factors contributing to vicarious trauma among therapists who treat child sexual abuse victims and law enforcers in the field of child sexual abuse. In the therapist group, Follette et al. found the use of negative coping skills, personal stress, and negative response to treating sexual abuse cases to be predictive of higher levels of vicarious trauma symptoms. Variables that emerged as predictive of vicarious trauma for therapists were somewhat different for law enforcement professionals. Law enforcement professionals, like mental health professionals, identified negative responses to investigating sexual abuse and level of personal stress as predictive of vicarious trauma symptoms. Personal trauma history was found to be predictive for the law enforcement professionals and not predictive for the therapists. Another factor not predictive of vicarious trauma symptoms for the group of therapists was percentage of caseload containing child sexual abuse victims.

In summary, therapists treating sexual abuse victims may experience many of the same symptoms of vicarious trauma as therapists for sexual offender clients (Rich, 1997;

VanDeusen & Way, 2006; Way et al., 2004). The similarities in symptoms of vicarious trauma include the following: (a) decreased sense of personal safety and safety of significant others (Rich, 1997; Way et al., 2004), (b) hypervigilance (Meyers & Cornille, 2002; Way et al., 2004), (c) disrupted cognitions about intimacy with others (VanDeusen & Way, 2006), (d) avoidance symptoms (Way et al., 2004), (e) disruptions in sexuality (Way et al., 2004), and (f) intrusive dreams, imagery, and thoughts (Meyers & Cornille, 2002; Steed & Downing, 1998). Other vicarious trauma symptoms for therapists who treat sexual abuse victims include the following: (a) increased sense of spirituality (Brady et al., 1999), (b) disturbances in affect (Meyers & Cornille, 2002; Steed & Downing, 1998; Wasco & Campbell, 2002), difficulties with trust (Steed & Downing, 1998).

Generalist Population Therapist

There is a paucity of research on the impact of vicarious trauma on generalist population therapists. There are only three studies on vicarious trauma using generalist population therapists as research subjects (Benatar, 2000; Minnen & Keijsers, 2000; McLean et al., 2003). Studies on general population therapists and vicarious trauma have focused on the following factors: (a) history of childhood sexual abuse (Benatar, 2000), (b) comparison of trauma and non-trauma therapists (Minnen & Keijsers, 2000), and (c) therapists' beliefs about therapy (McLean et al., 2003).

Benatar (2000) studied therapists to determine if the presence of a childhood sexual abuse history increased therapists' vulnerability to vicarious trauma. Her finding of no significant difference between the two groups was consistent with some empirical literature, but contradicted some other studies. Benatar (2000) identified five themes of vicarious trauma from open-ended interviews with trauma therapists. Trauma therapists

felt their work had led them to: (a) a more negative, cynical, and pessimistic world view, (b) concerns about safety, (c) changes in how they felt about their life work, (d) negative changes in relationship with self, and (e) isolation from others.

Minnen and Keijsers (2000) studied 20 trauma therapists and 19 non-trauma therapist from mental health institutions and organizations from an unspecified location. Trauma therapists saw clients for at least 4 hours per week. To measure vicarious trauma, Minnen and Keijsers used a combination of a semi-structured interview and three scales including the following: (a) Traumatic Stress Belief Scale (TSI Belief Scale; Pearlman & Mac Ian, 1995), (b) World Assumption Scale (WAS; Janoff-Bulman, 1989), and (c) Symptom Checklist-90-Revised (SCL-90; Derogatis, 1983). No significance differences were found between trauma and non-trauma therapists on the three scales. However, results of the study should be interpreted with caution. Selection of trauma therapist based upon only four hours per week of trauma therapy is a methodological flaw of this study. Research indicates therapists with higher levels of exposure to traumatized clients have an increase in the risk factor for the development of vicarious trauma (Chrestman, 1995; Kassam-Adams, 1999; Pearlman & Mac Ian, 1995; Schauben & Frazier, 1995). This factor was not considered in the interpretation of the study results by Minnen and Keijsers (2000). It is interesting to note the semi-structured interview found more subjective reports of vicarious trauma in the trauma therapists.

McLean et al. (2003) in a study of 116 Australian therapists examined the relationship between therapist beliefs about therapy and therapist distress. They discovered unhelpful beliefs about therapy were related to an increased risk for vicarious trauma and burnout. Examples of unhealthy therapist beliefs taken from *The Therapist*

Belief Scale include the following: (a) perfectionist attitudes toward performance and treatment outcomes, (b) need for therapeutic control, (c) intolerance for client emotionality, and (d) the need to appear knowledgeable.

In summary, only a few researchers (Benatar, 2000; McLean et al., 2003; Minnen & Keijers, 2000) have studied the impact of vicarious trauma on generalist population therapists. Studies on generalist population therapists and vicarious trauma have discovered the following: (a) history of childhood sexual abuse does not impact levels of vicarious trauma (Benatar, 2000), (b) no group differences between trauma and non-trauma therapists (Minnen & Keijers, 2000), and (c) increased risk for vicarious trauma symptoms in therapists with negative beliefs about therapy (McLean et al., 2003).

Summary on the Levels of Therapists

Vicarious trauma research has found similarities between therapists treating sexual offenders and therapists treating sexual abuse victims (Jackson et al., 1997; Rich, 1997; Way et al., 2004). The similarities in symptoms of vicarious trauma include a decreased sense of personal safety and safety of significant others, hypervigilance around strangers, avoidance symptoms, and disruptions in sexuality (Way et al., 2004). One significant difference in therapists treating sexual abuse victims, compared to other therapists, is the discovery of an increased sense of spiritual well-being as a side effect of vicarious trauma (Brady et al., 1999). Research suggests that female therapists treating clients who are sexual offenders experience more hypervigilance and suspiciousness of others (Farrenkopf, 1992; Steed & Downing, 1998), fearfulness for their own or their family's personal safety (Farrenkopf, 1992; Steed & Downing, 1998), and difficulties with trust. Research suggests that a higher level of exposure to traumatized clients

increases the risk factor for therapists to develop vicarious trauma (Chrestman, 1995; Pearlman & Mac Ian, 1995; Schauben & Frazier, 1995).

Studies examining differences in levels of vicarious trauma for trauma therapists and non-trauma therapists have found varying results. The mixed results may be due to the many different scales used to measure vicarious trauma. Also the definition of trauma therapists may vary based on number of hours per week treating trauma clients and treatment techniques used. Research suggests that a higher level of exposure to traumatized clients significantly increases the risk factor for therapists to develop vicarious trauma (Pearlman & Mac Ian, 1995; Schauben & Frazier, 1995). In addition, some research implies that certain characteristics of the therapist, such as personal trauma history, gender, and personal stress, may interact with exposure to trauma material to contribute to symptoms of vicarious trauma (Pearlman & Mac Ian, 1995). Creamer and Liddle (2005) note research on vicarious trauma has supported and disputed therapist links to caseload number, level of education, years of professional experience, and type of trauma with human-induced trauma (i.e. sexual abuse) versus natural occurring trauma (i.e. cancer).

Summary and Conclusions

A review of the literature finds a lack of consensus in research on therapists' perceptions of permissive parent-child sexual boundaries. Researchers have studied many factors believed to influence therapists' perceptions of permissive parent-child sexual boundaries, while ignoring the factor of therapist vicarious trauma. An increasing amount of literature is available on vicarious trauma and the influence of vicarious trauma on therapist levels. Research suggests vicarious trauma alters therapists' perceptions of self,

others, and adaptation to the world (Rich, 1997). While some literature exists on the influence of vicarious trauma in altering perceptions of self, others, and adaptation to the world in sexual offender therapists and sexual abuse victim therapists, there exists a paucity of research on vicarious trauma in generalist population therapists. In addition, a paucity of research exists on sexual offender, sexual abuse victim, and generalist population therapists' perceptions of permissive parent-child sexual boundaries.

This research examined differences in sexual offender, sexual abuse victim, and generalists populations therapists' perceptions of permissive parent-child sexual boundaries and altered perceptions of self, others, and adaptation to the world as a result of vicarious trauma. The results of this study are important in increasing therapists' awareness of vicarious trauma as a related factor in therapists' perceptions of permissive parent-child sexual boundaries. Further, results of this study contribute to the growing body of literature on the two subtypes of vicarious trauma symptoms (changes in cognitive schemas and secondary traumatic stress symptoms) and manifestation of vicarious trauma symptoms among sexual offender, sexual abuse victims, and generalist population therapists.

Chapter Three

Methodology

This chapter describes the process for conducting the research study. A discussion of the population, sampling plan, instrumentation, pilot study results, research design, data collection, and analysis procedures are included in this chapter.

Identification of Population

Three levels of therapists were used in this study: therapists treating: (a) sexual offenders, (b) sexual abuse victims, and (c) general client population. The accessible population consisted of graduate level therapists who hold membership in one of three professional organizations: (a) Association for Treatment of Sexual Abusers (ATSA), (b) American Professional Society on the Abuse of Children (APSAC), (c) American Mental Health Counselors Association (AMHCA). Participants in this study were selected from the sampling frame by a random selection method.

Sampling Plan

Research on vicarious trauma has identified trauma therapists based upon the following criteria: (a) professional organization membership (Cunningham, 2003; Way et al., 2004), (b) number of hours spent working with trauma clients per week (Minnen & Keijsers, 2000), and (c) therapist self-report as working with traumatized clients (McLean et al., 2003), sexual offender, and sexual abuse victim clients (VanDeusen & Way, 2006). Minnen and Keijser required four hours a week of trauma therapy for identification as trauma therapists as compared to non-trauma therapists. It is important to note that researchers do not appear to separate trauma therapists from non-trauma therapists by percentage of trauma victims on caseloads. However, Cunningham (2003) discovered

therapists with a caseload of 40% or more of sexual abuse clients reported significant disruptions in their world view, an indicator of vicarious trauma. VanDuesen and Way (2006) divided therapists into two groups, sexual offender or sexual abuse victim, based upon therapist caseloads containing in the least one sexual offender. The sexual offender group included therapists who treated any sexual offender, and those who treated sexual offenders and victims. The survivor group included therapists who treated sexual abuse victims, but not sexual offenders.

For this study, professional organizations were carefully selected for the purpose of increasing the probability of equal numbers of participants in the three therapist specialization groups: sexual offender, sexual abuse victim, and generalist population. Therapist assignment to therapist specialization groups was based upon therapist membership in one of three professional organizations: ATSA, APSAC, and AMHCA.

Sampling size was determined by consulting Stevens (2002). According to Stevens, for a three group MANOVA study with three variables, a sample size of 87 (29 per group) is required for a large effect size and power of .80. A sample size of 156 (52 per group) is required for a moderate effect size and power of .80 (p. 626). Thus in the current study a sample size greater than 87 was the minimum required, and a sample size of 156 was preferred.

Questionnaire packets were sent to participants through the mail. Given that low response rate has been one of the major problems of mail surveys, a conservative return rate expectation of 30-50% was anticipated for the mail survey (Dillman, 1991). Using the lower figure of 30% as a guide, a total of 150 questionnaire packets were sent to therapists representing each of the three therapists groups; sexual offender therapists,

sexual abuse therapist, and general population therapists. Respondents without a graduate degree were excluded from statistical analysis of the mail survey. The participant prerequisite of a master or doctoral degree in the mental health field was based upon professional standards for independent licensure in psychology, counseling, social work, and marriage and family therapy.

Instrumentation

Four instruments were used in this study: (a) Trauma and Attachment Belief Scale (TABS; Pearlman, 2003), (b) Secondary Traumatic Stress Scale (STSS; Bride, 1999), and (c) Permissiveness of Parent- Child Sexual Boundary Scale (PPCSBS), and (d) demographic questionnaire.

Trauma and Attachment Belief Scale

The Trauma and Attachment Belief Scale measures the impact of traumatic events on the individual. In addition to measuring the effects of direct traumatization, many researchers have used the TABS to assess the impact of indirectly experienced trauma, known as vicarious trauma (Brady et al., 1999; Cunningham, 2003; Galloucis, 1995; Pearlman & Mac Ian, 1995; Schauben & Frazier, 1995).

The TABS is an 84-item, paper-pencil, self-report instrument. The TABS assesses cognitive schemas related to beliefs about oneself and others in the five need areas that are most sensitive to trauma (Pearlman, 2003). The five need areas are safety, trust, esteem, intimacy, and control. The instrument results include a total score and ten subscale scores. The ten subscale scores are Self-Safety, Other-Safety, Self-Trust, Other-Trust, Self-Esteem, Other-Esteem, Self-Intimacy, Other-Intimacy, Self-Control, and Other-Control.

TABS' respondents rate the extent to which each item matches their beliefs on a 6- point rating scale that ranges from (1) disagree strongly to (6) agree strongly. The items fall into the "Easy" range on the Flesch Reading Easy scale (Flesch, 1979). The items should be easily read by anyone with at least a third grade reading level. An example of a question from this scale includes, "I never think anyone is safe from danger."

The TABS demonstrates reliability in studies by the author Pearlman (2003). Reliability refers to the consistency of instrument data and is measured by using many different approaches (Huck & Cormier, 1996). Pearlman measured the TABS' reliability by using the test-retest reliability method and Cronbach's alpha. The test-retest reliability method measures consistency over time by measuring the same group of subjects with the same instrument twice, with the administrations separated by an interval of time (Huck & Cormier, 1996). Cronbach's alpha, also known as coefficient alpha, is a method of assessing internal consistency: the degree to which items in the instrument measure the same characteristic (Huck & Cormier, 1996). Both methods of reliability, test-rest and Cronbach's alpha, lead to a single numerical index, called the reliability coefficient (Huck & Cormier, 1996). The reliability coefficient assumes a value between 0.00 and +1.00 with the endpoints representing varying levels of consistency (Huck & Cormier, 1996). Instruments with reliability coefficients closer to +1.00 are more reliable. Test-retest correlations of .60 or higher and Cronbach's alpha estimates of .70 or higher are considered to indicate adequate reliability for tests of psychological characteristics (Pearlman, 2003). Pearlman (2003) found reliability coefficients for the total TABS scale score to be acceptable (test-retest .75) (Cronbach's alpha .75). Reliability was acceptable

for TABS subscales (median test-retest value .72) with values ranging from .60 for Other-Intimacy to .79 for Other-Trust.

Internal reliability was high for TABS subscales (median Cronbach's alpha estimate .79) with values ranging from .67 for the Self-Intimacy subscale to .87 for the Other-Intimacy subscale (Pearlman, 2003).

The TABS demonstrates construct validity for the population of survivors of traumatic life experiences. Construct validity refers to the degree to which the TABS instrument actually assesses the underlying theoretical constructs it is supposed to assess (Light, Singer, & Willett, 1990). The TABS demonstrates construct validity as evidenced by its correlation to the Trauma Symptom Inventory (Briere, 1997). The Trauma Symptom Inventory (TSI) measures symptoms associated with the experience of trauma which include the following: (a) anxiety, (b) depression, (c) anger, (d) intrusive thoughts, (e) avoidance, (f) dissociation, (g) sexual concerns, (h) sexual dysfunction, (i) impaired self-reference, and (j) tension reduction behaviors.. The subscale correlations range from .23 for Self-Safety (TABS) with Dysfunctional Sexual Behavior (TSI) to .67 for Self-Control and Self-Trust (TABS) with Impaired Self-Reference (TSI) (Pearlman, 2003).

Briere (1997) demonstrates construct validity for the TABS as a measure of direct exposure to trauma. Construct validity outcomes for TABS on research to assess the impact of indirectly experienced trauma has also produced good results (Cunningham, 2003; Galloucis, 1995; Pearlman & Mac Ian, 1995; Schauben & Frazier, 1995) with the exception of one research study (Brady et al., 1999). Brady et al. is the only known research study on vicarious trauma to demonstrate poor construct validity for measuring vicarious trauma. Brady et al. found the TABS to have poor construct validity as

evidenced by therapists' elevated TABS scores not having a direct relationship to high end scores on the Impact of Events Scales (IES; Horowitz et al., 1979). It is important to note that, like the TABS, the IES was not designed as a measure of indirectly experienced trauma (Horowitz et al., 1979) and thus may not be a valid measure of vicarious trauma.

In contrast to Brady et al. (1999), other researchers (Cunningham, 2003; Pearlman & Mac Ian; Schauben & Frazier, 1995) have found evidence of construct validity through correlation to elevated TABS scores. Pearlman and Mac Ian (1995) report a high level of construct validity in elevated TABS scores for therapists with more extensive exposure to clients' trauma material than those without extensive exposure to trauma material.

Schauben and Frazier (1995) found female sexual violence counselors with higher caseloads of trauma survivors had more disrupted beliefs as evidenced by higher TABS scores. Higher TABS scores on the subscales of safety, Other-Trust, and Other-Esteem were found in therapists treating sexual abuse survivors than in therapists treating cancer patients (Cunningham, 2003).

In addition to construct validity, the TABS has been analyzed for evidence of criterion validity. Criterion validity describes how well the TABS, a measure of convenience, actually assesses the criterion of interest: vicarious trauma (Light, Singer, & Willett, 1990). Each of the 76 TABS items are based upon statements of trauma survivor clients. However, Brady et al. (1999) did not find elevated TABS scores for therapists with greater exposure to client trauma material. Further, the study by Brady et al. (1999) demonstrated poor criterion validity as evidenced by dissimilar TABS and Impact of Events Scale- Revised (Weiss & Marmar, 1997) scores for therapists with high caseloads of trauma clients. However, the IES-R is not a measure designed to assess vicarious

trauma. The Impact of Events Scale- Revised (IES-R) was designed to measure the impact of trauma directly upon individuals. Like the TABS, some researchers have adapted the IES-R to measure the effects of secondary trauma in individuals. Since both scales are believed to measure secondary trauma symptoms the scores for the IES-R and TABS should have been positively correlated. Rather, the participants with a high caseload of trauma clients scored high on the IES-R and low on the TABS. The TABS was chosen for this study because it is the only instrument available to measure changes in cognitive schemas as a result of vicarious trauma.

Secondary Traumatic Stress Scale

The Secondary Traumatic Stress Scale (Bride, 1999) was designed to specifically measure trauma symptoms in mental health professionals (Bride et al., 2003). Prior to the STSS, no other instrument measured vicarious trauma (Bride et al., 2003).

The STSS is a 17-item, paper-pencil, self-report instrument. The STSS respondents rate the extent to which each item is true for them in the past seven days. Scoring is based on a five-choice rating scale ranging from 1 (never) to 5 (very often). The STSS consists of three subscales: Intrusion (items 2, 3, 6, 10, 13), Avoidance (items 1, 5, 7, 9, 12, 14, 17), and Arousal (items 4, 8, 11, 15, 16). The STSS subscales are scored by summing the items assigned for each subscale. The total STSS is calculated by combining the scores from all the subscales. The STSS parallels the *DSM-IV-TR* (American Psychiatric Association, 2000) criteria for post-traumatic stress disorder by measuring intrusion, avoidance, and hyperarousal symptoms. Each of the 17 individual *DSM-IV-TR* symptoms corresponds to one of the 17 items in the STSS (Bride et al., 2003). An example of a question from this scale includes, “I had disturbing dreams about

my work with clients.”

Although the STSS has not been tested in an independent study, the STSS demonstrates acceptable reliability (Bride et al., 2003). Unlike the TABS, reliability of the STSS was not tested using the test-retest reliability method. However, Cronbach’s alpha, also known as alpha co-efficient, is reported in studies of STSS internal reliability. In a study of 287 social workers, Bride et al. (2003) reported the internal reliability for secondary stress to be very high for the total STSS score (Cronbach’s alpha .93), and moderately high for the subscales of Intrusion (Cronbach’s alpha .80), Avoidance (Cronbach’s alpha .87), and Arousal (Cronbach’s alpha .87). In another study of 275 social workers Ting, Jacobson, Sanders, Bride, and Harrington (2005) found the STSS internal consistency reliability to be very high for the total STSS score (Cronbach’s alpha .94) and moderately high for the subscales of Intrusion (Cronbach’s alpha .79), Avoidance (Cronbach’s alpha .85), and Arousal (Cronbach’s alpha .87).

The STSS demonstrates construct validity for the theoretical concept of secondary traumatic stress. Unlike the TABS, which demonstrates construct validity through correlation with the TSI, the STSS is not tested against the TSI or any other instrument. Rather, construct validity for the STSS is measured by examining the related and unrelated variables within the instrument. Three factors in design measure and confirm construct validity for the STSS: convergent, discriminate, and factorial validity. Convergent validity is established when the instrument correlates in the range from moderately to strongly with related variables, whereas discriminate validity is established when the instrument correlates poorly with unrelated variables (Campbell & Fiske, 1959). To determine convergent validity the STSS total and three subscales were

correlated with respondent therapist ratings for the following related variables: (a) the extent to which client population is traumatized, (b) the frequency with which their work with clients addresses traumatic stress, (c) the severity of depression symptoms experienced in the past week, and (d) the severity of anxiety symptoms experienced in the past week (Bride et al., 2003). Significant correlations were obtained between the STSS total and three subscales supporting convergent validity for each of the related variables (Bride et al., 2003). Using the Bonferroni technique the alpha level was set at .000179. Convergent total STSS scores ranged from a low of .232 for frequency of clients addressing traumatic stress to a high of .533 for therapist report of anxiety. The STSS subscales scores are similar to total STSS scores with a range of .211 to .563.

While convergent validity examines related variables, discriminant validity examines variables believed to be unrelated to the development of secondary traumatic stress. The variables believed to be unrelated in the STSS include the following: (a) age, (b) ethnicity, and (c) income (Bride et al., 2003). Total STSS scores for discriminant validity were poorly correlated. Total STSS scores ranged from a low of -.026 for ethnicity to a high of -.093 for age (Bride et al., 2003). For the total STSS score and three subscales, significant correlations were not found for the unrelated variables, thus supporting claims of discriminant validity for the instrument (Bride et al., 2003).

In addition to convergent and discriminate validity, Bride et al. (2003) analyzed the STSS using factorial validity, another form of construct validity using factorial analysis. Factorial validity of the STSS is examined through the use of confirmatory factor analysis using structural equation modeling (SEM) techniques (Bride et al., 2003). The SEM techniques selected for the analysis include the Goodness of Fit Index (GFI),

Comparative Fit Index (CFI), Incremental Fit Index (IFI), and Root Mean Square Error of Approximation (RMSEA) (Bride et al., 2003). Adequate model fit is signified by GFI, CFI, and IFI values larger than .90 (Hoyle & Panter, 1995) and RMSEA values less than .08 (Byrne, 1998). The following values supporting evidence of factorial validity were obtained for the chosen fit indices: GFI = .90, CFI = .94, IFI = .94, and RMSEA = .069 (Bride et al., 2003). Thus the three factors in design (factorial validity, convergent validity, and discriminate validity) all statistically confirm the construct validity of the STSS.

Permissiveness of Parent-Child Sexual Boundaries Scale

The Permissiveness of Parent-Child Sexual Boundaries Scale (PPCSBS) was adapted by this researcher for the purpose of this study. The PPCSBS measures beliefs about behaviors between parent and child and the appropriateness of such behaviors given the age of the child.

The PPCSB is a 13-item pencil-paper, self-report instrument. Items from the PPCSBS are based upon items from The Family Practices Questionnaire versions 5 and 6 (Johnson, 1998). The Family Practices Questionnaire provides a gauge for family practices considered acceptable in the United States between parents and children in relation to their age (Johnson & Hooper, 2003). Scores for the Family Practices Questionnaire are reported in the form of appropriate ages for daughters and sons to be involved with mothers and fathers in the following family practice behaviors: (a) bathing together, (b) showering together, (c) sleeping in the same bed with a single parent, (d) hugging between parents and their children, (e) kissing on the mouth, (f) changing clothing including underwear together, (g) giving back rubs, (h) parents' washing their

gather information regarding the scale's reliability. Construct validity for the PPCSBS was established by discussions with pilot study participants (Light et al., 1990).

In addition to the pilot study, the PPCSB was reviewed for construct validity by two master level counselors specializing in the treatment of sexual offenders and one master level social worker. Each therapist holds over ten years of clinical experience and is employed in a non-profit mental health agency. Therapist comments provided support for the PPCSB and no recommendations were made for change.

Demographic Questionnaire

The demographic questionnaire was constructed for use specifically for this study to assess therapists' characteristics. The demographic questionnaire is a 7-item, paper-pencil, self-report instrument. It gathers information on the therapist's gender, age, number of clients on caseload, percentage of trauma clients on caseload, and percentage of clients with the label sexual offender or sexual abuse victim. Information was also collected on the therapist's years of employment in the mental health field and personal history of sexual or other trauma experiences.

Pilot Study Results

Before beginning the study, the researcher conducted a brief pilot study to determine any revisions that might be needed on the test instrument. The pilot study tested the items and survey format, gathered preliminary data, and established level of power for test instruments. Participants were volunteer master level students from a college of education counseling department program. Participants were asked to complete all the instruments so the researcher could gauge the length of time needed to complete the survey packet. Participants had the opportunity to provide written feedback regarding

any revisions needed to clarify and increase the level of comfort in taking the instruments.

Results of the pilot study suggest that the PPCSBS is a reliable scale. Reliability for the PPCSBS was measured at alpha .81 for all 13 items. Pallant (2001) reports that scale which measure above .70 are considered reliable. PPCSBS items 12 and 13 were poorly correlated with the total score as evidenced by low values on the column marked corrected item-total correlation for the reliability output. Corrected item-total correlation values were .01 for item 12 and .00 for item 13. Pallant (2001) suggests that scale items should be amended or omitted when correlated item-total correlation items values are less than .30. When items 12 and 13 are omitted from the PPCSBS, alpha reliability increases for .81 to .83. For this study, items 12 and 13 were amended, rather than omitted, from the PPCSBS. Before revision, item 12 asked the following question: Is it appropriate for a father and daughter to give each other hugs with body contact? After revision, item 12 asked the following question: Is it appropriate for a father and daughter to give each a prolonged embrace with full body contact? The original version of item 12 was poorly constructed because nearly all participants gave the same response of yes. Before revision, item 13 asked the following question: Is it appropriate for parents to engage in prolonged sexual interaction or sexual intercourse with a daughter asleep in the same room? After revision, item 13 asked the following question: Is it appropriate for parents to engage in any type of sexual interaction with a daughter asleep in the same room? The original version of 13 was poorly constructed because nearly all participants gave the same response of no. The other questions had more variance in participants' responses.

Table 1.

Demographic Information of Pilot Study Participants

Variable	N	%
Gender	22	100%
Female	16	72.7%
Male	4	18.2%
Missing	2	9.1%
Race	22	100%
Caucasian	7	31.8%
African-American	1	4.5%
Missing	14	63.6%
Professional Affiliation	22	100%
Counselor	15	68.2%
Psychologist	4	18.2%
Missing	2	9.1%
Other	1	4.5%
Therapy Hours per Week	22	100%
Zero	15	68.2%
Ten	3	13.6%
Twenty	2	9.1%
Missing	2	9.1%

Table 1 (*continued*)

Variable	N	%
Years in Profession	22	100%
Zero	12	54.5%
One	4	18.2%
Five	4	18.2%
Missing	2	9.1%
Percentage of Sexual Offenders	22	100%
Zero	19	86.4%
Fifty Percent	1	4.5%
Missing	2	9.1%
Percentage of Sexual Abuse	22	100%
Zero	16	72.7%
Thirty Percent	2	9.1%
Fifty Percent	1	4.5%
Seventy Percent	1	4.5%
Missing	2	9.1%

Research Question

The primary purpose of this research was to determine if therapists exposed to client stories of sexual trauma differed from therapists not exposed to client stories of sexual trauma in terms of therapists' overall perceptions of parent-child sexual boundaries and therapists' altered perceptions of self, others, and adaptation to the world as a result of vicarious trauma. To determine this, it must be understood if specific levels of therapists, based upon client population (sexual offender, sexual abuse victim, and general population), are at greater risk for altered perceptions. Vicarious trauma alters therapists' perceptions of self, others, and adaptations to the world (Rich, 1997). Altered therapists' perceptions of self, others, and adaptations to the world are manifested in changes in cognitive schemas (self and others) and observable secondary traumatic stress symptoms (maladaptation to the world). In addition to vicarious trauma symptoms, research suggests that therapists exposed to client stories of sexual trauma experience altered perceptions of permissible parent-child sexual boundaries (Edmunds, 1997; Freeman-Longo, 1997; Scheela, 2001). Therefore the following research question was studied: Do therapist levels (therapists treating sexual offenders, sexual abuse victims, or general population clients) differ on overall therapists' perceptions of parent-child sexual boundaries and therapists' altered perceptions of self, others, and adaptations to the world (changes in cognitive schemas, secondary traumatic stress symptoms) as a result of vicarious trauma?

Null Hypothesis

Null Hypothesis: There are no significant differences in therapist levels (sexual offenders, sexual abuse victims, and general population clients) in therapists' perceptions of

permissive parent-child sexual boundaries and therapists' altered perceptions of self, others, and the world (changes in cognitive schemas, secondary traumatic stress symptoms) as a result of vicarious trauma.

Alternative Hypothesis: There are significant differences in therapist levels (sexual offenders, sexual abuse victims, and general population clients) in therapists' perceptions of permissive parent-child sexual boundaries and therapists' altered perceptions of self, others, and the world (changes in cognitive schemas, secondary traumatic stress symptoms) as a result of vicarious trauma.

Research Hypotheses

Research Hypothesis 1: Compared to therapists not exposed to client stories of sexual trauma (therapists specializing in the treatment of the general population clients), therapists exposed to client stories of sexual trauma (therapists specializing in the treatment of sexual offenders or sexual abuse victims clients) will report the following differences in therapists' perceptions in permissive parent-child sexual boundaries and therapists' perceptions of self, others, and adaptation to the world (cognitive schemas, secondary traumatic stress symptoms) as a result of vicarious trauma: (a) less permissive perceptions of parent-child sexual boundaries, (b) increased changes in cognitive schemas, and (c) increased secondary traumatic stress symptoms. Research by VanDeusen and Way (2006) reported therapists who treated sexual abuse clients had increased changes in cognitive schemas (intimacy with others) as opposed to therapists who do not treat sexual abuse clients.

Research Hypothesis 2: Compared to therapists with a lesser number of hours spent per week treating sexual offender and sexual abuse clients, therapists with a greater number

of hours spent per week treating sexual offenders or sexual abuse victims will report the following overall therapists' perceptions in permissive parent-child sexual boundaries and altered perceptions of self, others, and adaptation to the world (cognitive schemas, secondary traumatic stress symptoms) as a result of vicarious trauma: (a) less permissive perceptions of parent-child sexual boundaries, (b) increased changes in cognitive schemas, and (c) increased secondary traumatic stress symptoms. Research indicates that therapists with a higher level of exposure to traumatized clients have a greater risk factor for the development of vicarious trauma, than therapists with lower levels of exposure to traumatized clients (Chrestman, 1995; Kassam-Adams, 1999; Pearlman & Mac Ian, 1995; Schauben & Frazier, 1995).

Research Hypothesis 3: Compared to therapists with more years of clinical experience treating sexual offender and sexual abuse clients, therapists with less years of clinical experience treating sexual offender and sexual abuse clients will report the following overall therapists' perceptions in permissive parent-child sexual boundaries and altered perceptions of self, others, and adaptation to the world (cognitive schemas, secondary traumatic stress symptoms) as a result of vicarious trauma: (a) less permissive perceptions of parent-child sexual boundaries, (b) increased changes in cognitive schemas, and (c) increased secondary traumatic stress symptoms. Research indicates that therapists with less tenure in the field report higher levels of vicarious trauma symptoms (Brady et al., 1999; Chrestmen, 1995; Pearlman & Mac Ian, 1995; Rich, 1997; Steed & Bicknell, 2001; VanDeusen & Way, 2006; Way et al., 2004).

Data Collection Procedures

Data collection began by selecting a random sample of potential participants from

the membership directories of the following three professional organizations: Association for the Treatment of Sexual Abusers, American Professional Society on the Abuse of Children, and American Mental Health Counselors Association. Data collection procedures are based upon Dillman's (2000) five-stage method for collecting data from mail surveys. The first stage began with the prenotice letter. A prenotice letter was mailed to each potential participant four days before the complete research packet was sent. The purpose of the prenotice letter was to build anticipation for the survey and create a positive impression of importance so the potential participant would not immediately discard the research packet when it arrived (Dillman, 2000).

In addition to the use of the prenotice letter to increase participation in the mail survey, Dillman (2000) recommends the use of a goodwill gesture. According to Dillman, goodwill gestures improve response rates more than promised incentives. Goodwill gestures are a token of appreciation in advance that creates a sense of reciprocal obligation in potential respondents (Dillman). For the purpose of this study, the researcher chose to enter survey respondents into a lottery for a MP-3 Player. A total of three MP-3 Players were given away. The lottery of the MP-3 Player was briefly mentioned without going into detail in the prenotice letter.

A few days after mailing the prenotice letters, complete research packets were mailed to the potential participants. The research packet consisted of the following items: (a) cover letter requesting participation in the study, (b) TABS, STSS, PPCSBS, and demographic questionnaire instruments, and (c) information on how to enter the free MP-3 Player lottery.

A thank-you postcard was mailed two weeks after the questionnaire. The thank-

you postcard expressed appreciation for responding and served as a courteous reminder for those who had not returned the research packet (Dillman, 2000).

A second cover letter and replacement questionnaire were mailed to non-respondents four weeks later. Non-respondents were urged to complete the research packet and return it in the pre-addressed postage-paid envelope.

For anonymity purposes, participants were asked to not write their names on the survey or postage-paid return envelope. Each research packet had an individual identification number printed on the postage-paid return envelope. The purpose of the individual identification numbers was to track non-respondents for follow-up mailings of research packets (Dillman, 2000). The principal researcher held the master list of individual identification numbers. A color coding system was used to differentiate the returned survey packets from the three professional membership groups. Respondent members from the Association for the Treatment of Sexual Abusers had a blue sticker dot on the upper right hand corner of their demographic questionnaire. Respondent members from the American Professional Society on the Abuse of Children received similar coding with a yellow sticker dot and respondent members from the American Mental Health Counselors Association were coded with a red sticker dot.

In addition to preserving participants' anonymity, individual identification numbers printed on the returned envelopes were used for entry into the MP-3 Player lottery. By returning the self-addressed stamped envelope with a visible identification number potential participants were entered into the lottery. Completion of the research packet was not a pre-requisite for entry into the MP-3 Player lottery.

Data Analysis Procedures

A multivariate analysis of variance (MANOVA) was conducted on dependent and independent variables. The MANOVA was selected for its ability to compare therapist levels with related dependent variables (Pallant, 2001). The MANOVA design consisted of the independent variable of three therapist levels: (a) therapists treating sexual offenders, (b) therapist treating sexual abuse victims, (c) therapists treating general population clients. The dependent variables consist of three scales measuring the following: (a) therapists' perception of parent-child sexual boundaries as measured by the PPCSBS, (b) changes in cognitive schemas as measured by the TABS, and (c) secondary traumatic stress symptoms as measured by the STSS. In comparison to the univariate test results of the analysis of variance (ANOVA), the multivariate test results of the MANOVA reduce the risks of inflated type I error (Stevens, 2002). Type 1 error is the probability of rejecting the null hypothesis when it is true (Stevens, 2002).

Assumptions for MANOVA

Three assumptions for MANOVA (Stevens, 2002) were examined to determine if conditions had been met. The assumptions are the following:

- (1) The observations are independent
- (2) The observations on the dependent variables follow a multivariate normal distribution with each group
- (3) The population covariance matrices for the dependent variables are equal (homogeneity of variance).

Stevens (2002) states violations of independence are very serious. Independence of observation was maintained by mailing individual surveys to therapists in one of three

professional organizations. The list was cross-referenced to ensure that survey participants were not members of more than one of the professional organizations which would alter the unique characteristics of each therapist group.

Multivariate normality requires that the sampling distribution of means for the various dependent variables in each cell and all linear combinations of them are normally distributed (Tabachnick & Fidell, 1996). Tabachnick & Fidell report MANOVA is robust to modest violations of normality if the violation is created by skewness rather than outliers. The assumption of normality for MANOVA requires an examination of both univariate and multivariate normality. Univariate normality was tested by using the Explore option of the Statistical Package for Social Sciences (SPSS). The Explore option examines univariate normality tested by kurtosis, Kolmogorov-Smirnov Test, histogram, and normal Q-Q plot. Multivariate normality was tested by using the regression option of SPSS. The regression option checks multivariate normality tested by Mahalanobis distances using SPSS. Mahalanobis distances will identify any cases that have a strange pattern of scores across the three dependent variables (Pallant, 2001).

When sample sizes are unequal, Box's Test of Equality of Covariance Matrices (Box's M) is applied to check the assumption of homogeneity of the covariance matrices (Stevens, 2002). Box's M test is a notoriously sensitive test of homogeneity of variance-covariance matrices available through SPSS MANOVA (Tabachnick & Fidell, 1996). According to Pallant (2001) if the sig. value of Box's M test is larger than .001, then the assumption of homogeneity of covariance has not been violated. Random assignment of subjects assists in ensuring equality of covariance.

Chapter Four

Results

The purpose of this research was to determine if there was support for the null hypothesis: There are no significant differences in therapist levels (sexual offenders, sexual abuse victims, and general population clients) in terms of therapists' perceptions of permissive parent child sexual boundaries and therapists' altered perceptions of self, others, and the world (cognitive schemas, secondary traumatic stress symptoms) as a result of vicarious trauma.

In addition to determining support for the null hypothesis, the following three research hypotheses were examined:

Research Hypothesis 1: Compared to therapists not exposed to client stories of sexual trauma (therapists specializing in the treatment of the general population clients), therapists exposed to client stories of sexual trauma (therapists specializing in the treatment of sexual offenders or sexual abuse victims clients) will report the following differences in therapists' perceptions in permissive parent-child sexual boundaries and therapists' perceptions of self, others, and adaptation to the world (cognitive schemas, secondary traumatic stress symptoms) as a result of vicarious trauma: (a) less permissive perceptions of parent-child sexual boundaries, (b) increased changes in cognitive schemas, and (c) increased secondary traumatic stress symptoms.

Research Hypothesis 2: Compared to therapists with a lesser number of hours spent per week treating sexual offender and sexual abuse clients, therapists with a greater number of hours spent per week treating sexual offenders or sexual abuse victims will report the following overall therapists' perceptions in permissive parent-child sexual

boundaries and altered perceptions of self, others, and adaptation to the world (cognitive schemas, secondary traumatic stress symptoms) as a result of vicarious trauma: (a) less permissive perceptions of parent-child sexual boundaries, (b) increased changes in cognitive schemas, and (c) increased secondary traumatic stress symptoms.

Research Hypothesis 3: Compared to therapists with more years of clinical experience treating sexual offender and sexual abuse clients, therapists with less years of clinical experience treating sexual offender and sexual abuse clients will report the following overall therapists' perceptions in permissive parent-child sexual boundaries and altered perceptions of self, others, and adaptation to the world (cognitive schemas, secondary traumatic stress symptoms) as a result of vicarious trauma: (a) less permissive perceptions of parent-child sexual boundaries, (b) increased changes in cognitive schemas, and (c) increased secondary traumatic stress symptoms.

This chapter presents in detail the analyzes depicted in Chapter Three. First, a description of research participants is provided. Then reliability analyses are presented. Correlation analyses on the instrument subscales are reported. Statistical analyses employed to test the research hypotheses are provided. Finally, the results of supplement statistical analyses are presented.

Description of Participants

Participants in this study were master level therapists holding membership in one of three professional organizations: (a) Association for the Treatment of Sexual Abusers (ATSA), (b) American Professional Society on the Abuse of Children (APSAC), and (c) American Mental Health Counselors Association (AMHCA). Each participant was requested to complete a total of four instruments: (a) Trauma and Attachment Belief

Scale (TABS), (b) Secondary Traumatic Stress Scale (STSS), (c) Permissiveness of Parent-Child Sexual Boundaries Scale (PPCSBS), and (d) demographic questionnaire.

A total of 450 questionnaire packets were mailed initially. A total of 196 questionnaire packets were returned (43.55 % of the total sample). Three of the 196 respondents stated they were unable to participate because they were retired or were not employed as therapists. None of the questionnaire packets were returned by the postal service as undeliverable. Thus, responses from a total of 193 questionnaire packets (42.88% of the original sample) formed the basis of statistical analysis in this research study.

Demographics

The demographic questionnaire consisted of questions regarding level of education, gender, age, race, professional affiliation, client specialization, and personal trauma history. Information was also collected on the number of hours spent providing therapy to clients each week, the number of years of professional affiliation experience, and the current and past caseload percentages of sexual offender and sexual abuse clients. The number of hours spent treating sexual offender and sexual abuse victim clients per week was calculated from information gathered in the demographic questionnaire.

Organization Membership

All participants ($N = 193$) were categorized by membership in a professional organization through a color coding system on the demographic questionnaire. Colored dot stickers were placed on each demographic questionnaire. Of the 193 participants, 68 (35.23 %) were APSAC members, 67 (34.72 %) were ATSA members, and 58 (30.05 %) were AMHCA members.

Highest Level of Education

All but one of the participants ($N = 192$) answered the question regarding their highest level of education. Of the 192 participants, 131 (68.23%) were master level therapists, and 61 (31.77%) were doctoral level therapists. Participants' highest level of education was also examined for differences in professional organization membership (see Table 2).

Table 2

Participants' Highest Education Level by Membership

Variable	APSAC	ATSA	AMHCA	Total
Highest Level of Education	68 (35.42 %)	67 (34.90 %)	57 (29.69 %)	192 (100 %)
Associate	0 0%	0%	0%	0%
Bachelor	0 0%	0%	0%	0%
Master	39 (20.31%)	40 (20.83%)	52 (27.08%)	131 (68.23%)
Doctorate	29 (15.10%)	27 (14.06%)	5 (2.60%)	61 (31.77%)

Note. Percentages may not add up to 100% due to rounding.

Professional Affiliation

All but two of the participants ($N = 191$) answered the question regarding their professional affiliation. Of the 191 participants, 72 (37.70%) were counselors, 47 (24.61%) were social workers, 50 (26.18%) were psychologists, and 7 (3.66%) were marriage and family therapists, 6 (3.14%) reported other, and 9 (4.71%) indicated more than one professional affiliation. The six professional affiliations listed as other included: psychotherapist (2), early interventionist (1), sexologist (1), program director (1), and

probation supervisor (1). Of the nine participants who indicated more than one professional affiliation, the following responses were reported: counselor and social worker (2); counselor and marriage and family therapist (3); social worker and marriage and family therapist (1); social worker and psychologist (1); counselor, social worker, and marriage and family therapist (2). Participants' professional affiliation was also examined for differences in professional organization membership (see Table 3).

Table 3

Participants' Professional Affiliation by Membership

Variable	APSAC	ATSA	AMHCA	Total
Professional Affiliation	67 (35.08%)	67 (35.08%)	57 (29.84%)	191 (100%)
Counselor	8 (4.19%)	13 (6.81%)	51 (26.70%)	72 (37.70%)
Social Worker	28 (14.66%)	19 (9.95%)	0 (0%)	47 (24.61%)
Psychologist	23 (12.04%)	27 (14.14%)	0 (0%)	50 (26.18%)
Marriage & Family	3 (1.57%)	3 (1.57%)	1 (.52%)	7 (3.66%)
Other	3 (1.57%)	3 (1.57%)	0 (0%)	6 (3.14%)
More than One	2 (1.05%)	2 (1.05%)	5 (2.62%)	9 (4.71%)

Note. Percentages may not add up to 100% due to rounding.

Gender

All but one participant ($N = 192$) answered the question regarding their gender. Of the 192 participants, 143 (74.48%) were female, and 49 (25.52%) were male.

Participants' gender was also examined for differences among professional organization

membership (see Table 4).

Due to disproportionate gender groups, one-way MANOVA procedures were performed on the independent variable of gender. In addition two-way MANOVA procedures were performed on the independent variables gender and professional organization membership. Both MANOVA procedures yielded non-significant results.

Table 4

Participants' Gender by Membership

Variable	APSAC	ATSA	AMHCA	Total
Gender	68 (35.42 %)	67 (34.90 %)	57 (29.69 %)	192 (100 %)
Female	59 (30.73 %)	38 (19.79 %)	46 (23.96 %)	143 (74.48 %)
Male	9 (4.69 %)	29 (15.10 %)	11 (5.73 %)	49 (25.52 %)

Note. Percentages may not add up to 100% due to rounding.

Age

All but 6 participants ($N = 187$) reported their age. The age range of participants was between 26 years to 82 years. The mean age of study participants was 50.8 years. Participants' age was also examined for differences among professional organization membership (see Table 5).

Table 5

Participants' Age by Membership

Variable	APSAC	ATSA	AMHCA	Total
Age (in years and mos.)	50.6	48.3	54.0	50.8
Standard Deviation	11.2	11.2	12.2	11.6
Participant Number	65	65	57	187

Note. Percentages may not add up to 100% due to rounding.

Race

All participants with the exception of one ($N = 192$) answered the question regarding their race. A total of 180 participants self-identified racially as Caucasian (93.75%). Nine participants self-identified as Hispanic/Latino (4.69%). Only one participant self-identified racially in each of the following categories: American Indian/Alaska Native (.52%), Asian/Pacific Islander (.52%), and "Other" (.52%). Zero participants self-identified racially as African-American. Participants' race was also examined for differences among professional organization membership (see Table 6).

Table 6

Participants' Race by Membership

Variable	APSAC	ATSA	AMHCA	Total
Race	68 (35.42 %)	67 (34.90 %)	57 (29.69 %)	192 (100 %)
African-American	0 (0 %)	0 (0 %)	0 (0 %)	0 (0 %)
American Indian/ Alaska Native	1 (.52 %)	0 (0 %)	0 (0 %)	1 (.52 %)
Asian/Pacific Islander	1 (.52 %)	0 (0 %)	0 (0 %)	1 (.52 %)
Caucasian	64 (33.33 %)	62 (32.29 %)	54 (28.13 %)	180 (93.75 %)
Hispanic/Latino	2 (1.04 %)	4 (2.08 %)	3 (1.56 %)	9 (4.69 %)
Other	0 (0 %)	1 (.52 %)	0 (0 %)	1 (.52 %)

Note. Percentages may not add up to 100% due to rounding.

Professional Area of Client Specialization

All but two participants ($N = 191$) answered the question regarding their professional area of client specialization. Of the 191, 47 (24.61%) participants reported their client specialization to be sexual offender, 42 (21.99%) participants reported their client specialization to be sexual abuse victim, 56 (29.32%) participants reported their client specialization to be generalist population, 45 (23.56%) participants reported more than one professional area of client specialization, and 1 (.52) participant reported “other” specialization. Of those who reported more than one professional area of client specialization, 23 participants reported client specialization with sexual offender and sexual abuse victim clients, 10 participants identified specialization with sexual offender and generalist population clients, and 10 participants identified specialization with sexual

abuse victim and generalist population clients. Two participants reported specialization in all three client specialization domains: sexual offender, sexual abuse victim, and generalist population. Participants' professional area of client specialization was also examined for differences among professional organization membership (see Table 7).

Table 7

Participants' Professional Area of Client Specialization by Membership

Variable	APSAC	ATSA	AMHCA	Total
Client Specialization	68 (35.60%)	67 (35.08%)	56 (29.32%)	191 (100%)
Sexual Offender	1 (.52%)	45 (23.56%)	1 (.52%)	47 (24.61%)
Sexual Abuse Victim	30 (15.71%)	1 (.52%)	11 (5.76%)	42 (21.99%)
Generalist Population	13 (6.81%)	3 (1.57%)	40 (20.94%)	56 (29.32%)
More Than One	23 (12.04%)	18 (9.42%)	4 (2.09%)	45 (23.56)
Other	1 (.52%)	0 (0%)	0 (0%)	1 (.52%)

Note. Percentages may not add up to 100% due to rounding.

Personal Trauma History

All but one participant ($N = 192$) answered the question regarding personal trauma history. Of the 192 participants, 73 (38%) participants reported no prior history of personal trauma, 52 (27.08%) participants reported two or more categories of personal trauma, 17 (8.85%) participants reported child sexual abuse, 9 (4.69%) participants reported sexual assault, 12 (6.25%) participants reported domestic violence, , 3 (1.56%) participants reported natural disaster, 3 (1.56%) participants reported violent crime, 14 (7.29%) participants reported health crisis, and 9 (4.69%) participants identified "other".

Participants who reported “other” personal trauma history listed death of a child, military combat, house fire, car accident, physical abuse. Participants’ personal trauma history was also examined for differences among professional organization membership (see Table 8).

Table 8

Participants' Personal Trauma History by Membership

Variable	APSAC	ATSA	AMHCA	Total
Personal Trauma History	68 (35.42%)	67 (34.90%)	57 (29.69%)	192 (100%)
None	30 (15.63%)	27 (14.06%)	16 (8.33%)	73 (38%)
More Than One	16 (8.33%)	13 (6.77%)	23 (11.98%)	52 (27.08%)
Child Sexual Abuse	7 (3.65%)	7 (3.65%)	3 (1.56%)	17 (8.85%)
Sexual Assault	4 (2.08%)	1 (.52%)	4 (2.08%)	9 (4.69%)
Domestic Violence	1 (.52%)	7 (3.65%)	4 (2.08%)	12 (6.25%)
Natural Disaster	2 (1.04%)	1 (.52 %)	0 (0%)	3 (1.56%)
Violent Crime	1 (.52%)	2 (1.04%)	0 (0 %0	3 (1.56%)
Health Crisis	3 (1.56%)	5 (2.60%)	6 (3.13%)	14 (7.29%)
Other	4 (2.08%)	4 (2.08%)	1 (.52%)	9 (4.69%)

Note. Percentages may not add up to 100% due to rounding.

Therapy Hours Per Week

All but 7 participants ($N = 186$) answered the question regarding the number of hours per week spent providing therapy to clients. The range of therapy hours per week was between 0 to 69 hours. The mean number of hours was 21.94 with a standard deviation of 11.71. Participants' therapy hours per week was also examined for differences among professional organization membership (see Table 9).

To examine differences among professional organization membership, the range of therapy hours was divided into five groups of unequal intervals. The five groups are

the following: 0-4 hours, 5-9 hours, 10-19 hours, 20-29 hours, and 30 hours and above. The decision to divide the range of therapy hours into the above listed groups was based upon prior research findings. Research supports that therapists with higher levels of exposure to traumatized clients are at greater risk for vicarious trauma symptoms than therapists with lower levels of exposure to traumatized clients (Chrestman, 1995; Cunningham, 2003; Kassam-Adams, 1999; Pearlman & Mac Ian, 1995; Schauben & Frazier, 1995). Although the groups are of unequal intervals, the group comprising 0 to 4 hours ($N = 9$) was necessary for the study of therapists with the lowest levels of exposure to traumatized clients.

Table 9

Participants' Therapy Hours per Week by Membership

Variable	APSAC	ATSA	AMHCA	Total
Therapy Hours Per Week	65 (34.95 %)	65 (34.95 %)	56 (30.11 %)	186 (100 %)
0-4 Hours	3 (1.61%)	1 (.54%)	5 (2.69%)	9 (4.84%)
5-9 Hours	9 (4.84%)	7 (3.76%)	2 (1.08%)	18 (9.68%)
10-19 Hours	19 (10.22%)	12 (6.45%)	15 (8.06%)	46 (24.73%)
20-29 Hours	13 (6.99%)	24 (12.90%)	21 (11.29%)	58 (31.18%)
30 Hours & Above	21 (11.29%)	21 (11.29%)	13 (6.99%)	55 (29.57%)

Note. Percentages may not add up to 100% due to rounding.

Years in the Profession

All but two of the participants ($N = 191$) answered the question regarding the numbers of years in spent in their profession. Participants' range of years spent in the profession was between 1 to 47 years. The mean numbers of years was 18.62 with a standard deviation of 9.92. Participants' number of years in the profession was also examined for differences among professional organization membership (see Table 10).

To examine differences among professional organization membership, the range of 1 to 47 years in the professional was divided into 5 groups of unequal intervals. The 5 groups representing years in the profession are the following: 0-4 years, 5-9 years, 10-19 years, 20-29 years, and 30 years and above. The decision to divide the range of years into the above listed groups was based upon prior research findings. Previous research has discovered that therapists with fewer years of clinical experience report higher levels of vicarious trauma symptoms than therapists with more years of clinical experience (Brady et al., 1999; Chrestmen, 1995; Pearlman & Mac Ian, 1995; Rich, 1997; Steed & Bicknell, 2001; VanDeusen & Way, 2006; Way et al., 2004). Previous researchers (Pearlman & Mac Ian, 1995; Steed & Bicknell, 2006) studied trauma therapists with 2 years or less of clinical experience. However, there were too few participants in this study with 2 years or less of clinical experience ($N = 5$) required to perform MANOVA procedures. Therefore the researcher chose to study participants with 4 years or less ($N = 12$) of clinical experience.

Table 10

Participants' Years in the Profession by Membership

Variable	APSAC	ATSA	AMHCA	Total
Years in Profession	67 (35.08%)	67 (35.08%)	57 (29.84%)	191 (100 %)
0-4	3 (1.57%)	5 (2.62%)	4 (2.09%)	12 (6.28%)
5-9	4 (2.09%)	7 (3.66%)	12 (6.28%)	23 (12.04%)
10-19	26 (13.61%)	23 (12.04%)	18 (9.42%)	67 (35.08%)
20-29	25 (13.09%)	15 (7.85%)	15 (7.85%)	55 (28.80%)
30 and Above	9 (4.71%)	17 (8.90%)	8 (4.19%)	34 (17.80%)

Note. Percentages may not add up to 100% due to rounding.

Percentage of Sexual Offenders in Current Caseload

All but six participants ($N = 187$) answered the question regarding the percentage of sexual offender clients on their current caseload. The current caseload percentage range was between 0 to 100 percent. The mean caseload percentage was 23.39 percent with a standard deviation of 34.45. Participants' percentage of sexual offenders in their current caseload was also examined for differences among professional organization membership (see Table 11).

Table 11

Participants' Current Percentage of Sexual Offenders by Membership

Variable	APSAC	ATSA	AMHCA	Total
Percentage of Sexual Offenders	66 (35.29%)	65 (34.76%)	56 (29.95%)	187 (100%)
0 – 5%	50 (26.74%)	6 (3.21%)	48 (25.67%)	104 (55.61%)
6 – 25%	10 (5.35%)	15 (8.02%)	6 (3.21%)	31 (16.58%)
26 – 50%	3 (1.60%)	9 (4.81%)	2 (1.07%)	14 (7.49%)
51 – 75%	1 (.53%)	9 (4.81%)	0 (0%)	10 (5.35%)
76 – 100%	2 (1.07%)	26 (13.90%)	0 (0%)	28 (14.97%)

Note. Percentages may not add up to 100% due to rounding.

Percentage of Sexual Offenders in Past Caseload

All but 6 participants ($N = 187$) answered the question regarding the percentage of sexual offender clients on their past caseload. The past caseload percentage range was between 0 to 100 percent. The mean caseload percentage was 31.66 percent with a standard deviation of 38.24. Participants' percentage of sexual offenders in their past caseload was also examined for differences among professional organization membership (see Table 12).

Table 12

Participants' Past Percentage of Sexual Offenders by Membership

Variable	APSAC	ATSA	AMHCA	Total
Percentage of Sexual Offenders	66 (35.29%)	66 (35.29%)	55 (29.41%)	187 (100%)
0 – 5%	47 (25.13%)	4 (2.14%)	39 (20.86%)	90 (48.13%)
6 – 25%	11 (5.88%)	5 (2.67%)	11 (5.88%)	27 (14.44%)
26 – 50%	2 (1.07%)	13 (6.95%)	2 (1.07%)	17 (9.09%)
51 – 75%	2 (1.07%)	13 (6.95%)	0 (0%)	15 (8.02%)
76 – 100%	4 (2.14%)	31 (16.58%)	3 (1.60%)	38 (20.32%)

Note. Percentages may not add up to 100% due to rounding.

Percentage of Sexual Abuse Victims in Current Caseload

All but 6 participants ($N = 187$) answered the question regarding the percentage of sexual abuse victims on their current caseload. The current caseload percentage range was between 0 to 100 percent. The mean caseload percentage was 31.44 percent with a standard deviation of 31.22. Participants' percentage of sexual abuse victims in their current caseload was also examined for differences among professional organization membership (see Table 13).

Table 13

Participants' Current Percentage of Sexual Abuse Victims by Membership

Variable	APSAC	ATSA	AMHCA	Total
Percentage of Sexual Abuse Victim	66 (35.29%)	65 (34.76%)	56 (29.95%)	187 (100%)
0 – 5%	11 (5.88%)	18 (9.63%)	21 (11.23%)	50 (26.74%)
6 – 25%	17 (9.09%)	20 (10.70%)	20 (10.70%)	57 (30.48%)
26 – 50%	11 (5.88%)	19 (10.16%)	10 (5.35%)	40 (21.39%)
51 – 75%	8 (4.28%)	3 (1.60%)	2 (1.07%)	13 (6.95%)
76 – 100%	19 (10.16%)	5 (2.67%)	3 (1.60%)	27 (14.44%)

Note. Percentages may not add up to 100% due to rounding.

Percentage of Sexual Abuse Victims in Past Caseload

All but 6 participants ($N = 187$) answered the question regarding the percentage of sexual abuse victims on their past caseload. The past caseload percentage range was between 0 to 100 percent. The mean caseload percentage was 39.12 percent with a standard deviation of 31.49. Participants' percentage of sexual abuse victims in their past caseload was also examined for differences among professional organization membership (see Table 14).

Table 14

Participants' Past Percentage of Sexual Abuse Victims by Membership

Variable	APSAC	ATSA	AMHCA	Total
Percentage of Sexual Abuse Victim	66 (35.11%)	66 (35.11%)	55 (29.41%)	187 (100%)
0 – 5%	5 (2.70%)	12 (6.38%)	15 (7.98%)	32 (17.02%)
6 – 25%	14 (7.45%)	19 (10.11%)	20 (10.70%)	53 (28.34%)
26 – 50%	10 (5.32%)	24 (12.77%)	12 (6.38%)	46 (24.47%)
51 – 75%	15 (7.98%)	5 (2.66%)	4 (2.13%)	24 (12.77%)
76 – 100%	22 (11.70%)	6 (3.19%)	4 (2.13%)	32 (17.02%)

Note. Percentages may not add up to 100% due to rounding.

Sexual Offender Client Hours per Week

The number of hours spent per week providing therapy to sexual offender clients was calculated by multiplying the number of hours per week providing therapy to the percentage of sexual offender clients on the therapists' caseload. Sexual offender hours ranged from 0 to 40 hours. The mean number of hours spent treating sexual offender clients was 5.19 hours with a standard deviation of 8.50. Participants' number of sexual offender client hours per week was also examined for differences among professional organization membership (see Table 15).

To perform statistical analyses to answer research hypothesis two, the researcher divided the total number of sexual offender client hours per week into five groups of hours. The five groups of hours are the following: 0-1 hours, 2-4 hours, 5-9 hours, 10-19 hours, and 20-40 hours.

Table 15

Participants' Sexual Offender Client Hours per Week by Membership

Variable	APSAC	ATSA	AMHCA	Total
Sexual Offender	66 (35.48%)	64 (34.41%)	56 (30.11%)	186 (100%)
Hours				
0-1	53 (28.49%)	8 (4.30%)	48 (25.81%)	109 (58.60%)
2-4	5 (2.69%)	10 (5.38%)	3 (1.61%)	18 (9.68)
5-9	5 (2.69%)	10 (5.38%)	4 (2.15%)	19 (10.22%)
10-19	3 (1.61%)	18 (9.68%)	1 (.54%)	22 (11.83%)
20-40	0 (0 %)	18 (9.68%)	0 (0%)	18 (9.68%)

Note. Percentages may not add up to 100% due to rounding.

Sexual Abuse Victim Client Hours per Week

The number of hours spent per week providing therapy to sexual abuse victim clients was calculated by multiplying the number of hours per week providing therapy to the percentage of sexual abuse victim clients on the therapists' caseload. Sexual offender hours ranged from 0 to 38 hours. The mean number of hours spent treating sexual abuse clients was 6.35 hours with a standard deviation of 6.97. Participants' number of sexual abuse victim client hours per week was also examined for differences among professional organization membership (see Table 16).

To perform statistical analyses to answer research hypothesis two, the researcher divided the total number of sexual offender client hours per week into five groups of hours. The five groups of hours are the following: 0-1 hours, 2-4 hours, 5 -9 hours, 10-19

hours, and 20- 40 hours.

Table 16

Participants' Sexual Abuse Victim Client Hours per Week by Membership

Variable	APSAC	ATSA	AMHCA	Total
Sexual Offender	66 (35.48%)	64 (34.4%)	56 (30.1%)	186 (100%)
Hours				
0-1	16 (8.60%)	20 (10.75%)	23 (12.37%)	59 (31.72%)
2 -4	11 (5.91%)	13 (6.99%)	14 (7.53%)	38 (20.43%)
5 -9	15 (8.06%)	15 (8.06%)	10 (5.38%)	40 (21.51%)
10-19	18 (9.68%)	13 (6.99%)	6 (3.23%)	37 (19.89%)
20 -40	6 (3.23%)	3 (1.61%)	3 (1.61%)	12 (6.45%)

Note. Percentages may not add up to 100% due to rounding.

Sexual Offender and Sexual Abuse Victim Client Hours

The number of hours spent per week providing therapy to sexual offender and sexual abuse victim clients was calculated by adding the number of hours per week providing therapy to the sexual offender clients and sexual abuse victim clients. Sexual offender and sexual abuse victim client hours ranged from zero to forty hours. The mean number of hours spent treating sexual abuse clients was 11.17 hours with a standard deviation of 10.97. Participants' number of sexual offender and sexual abuse victim client hours per week was also examined for differences among professional organization membership (see table 17).

To perform statistical analyses to answer research hypothesis two, the researcher

divided the total number of sexual offender client hours per week into four groups of hours. The four groups of hours are the following: 0-4 hours, 5-9 hours, 10-19 hours, 20-29 hours, and 30 and above hours.

Table 17

Sexual Offender and Sexual Abuse Victim Client Hours per Week by Membership

Variable	APSAC	ATSA	AMHCA	Total
Sexual Offender	66 (35.48%)	64 (34.41%)	56 (30.11%)	186 (100%)
& Victim Hours				
0-4	25 (13.44%)	4 (2.15%)	36 (19.35%)	65 (34.95%)
5-9	11 (5.91%)	18 (9.68%)	7 (3.76%)	36 (19.35%)
10-19	22 (11.83%)	16 (8.60%)	6 (3.23%)	44 (23.66%)
20-29	5 (2.69%)	11 (5.91%)	7 (3.76%)	23 (12.37%)
30 & Above	3 (1.6%)	15 (8.06%)	0 (0%)	18 (9.68%)

Note. Percentages may not add up to 100% due to rounding.

Summary of Demographics

Demographic information was collected from the demographic questionnaire completed by the participants. A majority of participants completed all of the demographic questions. All participants ($N = 193$) were identified by their professional organization membership. The majority of participants self-identified as female, Caucasian, and experienced with at least 10 years in the profession. Differences among organizational members for each demographic variable were small with the exception of demographic questions related to therapy hours with sexual offender or sexual abuse

victim clients. As expected, the ATSA members reported providing more therapy to sexual offender clients, while the APSAC members reported providing more therapy to sexual abuse victim clients. Further, the overwhelming majority of therapists, who identified their area of client specialization as sexual offender were members of ATSA, whereas the greater number of therapists who identified their area of client specialization as sexual abuse victim were members of APSAC. In addition, more ATSA and APSAC members self-identified as having more than one area of client specialization, than a far lesser number of AMHCA members.

Reliability Analyses on Research Instruments

Reliability analyses were conducted on three research instruments: TABS, STSS, and PPCSBS. Reliability refers to the consistency of instrument data and is measured by many different approaches (Huck & Cormier, 1996). For this research study, reliability of the research instruments was measured by Cronbach's alpha. Cronbach's Alpha is a method of assessing internal consistency, the degree to which items in the instrument measure the same characteristic (Huck & Cormier, 1996). Cronbach's alpha produces a numerical index, called the reliability coefficient. The reliability coefficient assumes a value between 0.00 and +1.00 with the end points representing varying levels of consistency. According to Huck and Cormier, instruments with reliability coefficients closer to +1.00 are more reliable.

Trauma Attachment Belief Scale – TABS

Changes in beliefs about self, others, and world view as a result of vicarious trauma were measured using the TABS. The TABS measures changes in cognitive schemas. The TABS' 10 subscales and total scale were examined for internal consistency. Results

support a high degree of internal consistency (Cronbach's Alpha = .92, $N = 193$) for the total TABS scale score. Internal consistency rates for individual TABS subscales ranged from .58 to .83. Seven of the TABS sub-scales indicated good internal consistency with scores .7 or above. Only three TABS sub-scales were below .7: Other-Safety, Self-Trust, and Self-Intimacy (see Table 18).

Table 18

Cronbach's Alpha Reliability Coefficients, Means, and Standard Deviations for TABS Subscales

Tabs Sub-scales	α	M	SD
Self-Safety	.76 (.83)	24.15 (29.3)	6.66 (7.2)
Other-Safety	.65 (.72)	14.50 (16.3)	5.15 (4.0)
Self-Trust	.69 (.74)	13.85 (16.6)	4.12 (4.3)
Other-Trust	.79 (.84)	15.49 (21.3)	4.99 (5.7)
Self-Esteem	.74 (.83)	14.78 (17.4)	4.63 (6.0)
Other-Esteem	.76 (.82)	16.01 (18.5)	4.89 (4.4)
Self-Intimacy	.58 (.67)	14.30 (17.0)	4.15 (4.3)
Other-Intimacy	.83 (.87)	15.75 (17.3)	6.02 (5.9)
Self-Control	.73 (.73)	19.75 (21.2)	5.61 (5.3)
Other-Control	.72 (.76)	14.35 (17.0)	4.38 (4.7)
Total	.92 (.96)	161.52 (187.2)	39.10 (44.9)

Note. Contained within the parentheses are results from The Trauma and Attachment Belief Scale (Pearlman, 2003) manual.

Secondary Traumatic Stress Scale – STSS

Secondary traumatic stress symptoms as a result of vicarious trauma were measured using the Secondary Traumatic Stress Scale (STSS). The STSS instrument measures secondary traumatic stress symptoms specific to mental health professionals. The STSS' three subscales and total scale were examined for internal consistency. Results support a high degree of internal consistency (Cronbach's Alpha = .92, $N = 187$) for the total STSS scale score. Internal consistency rates for all three of STSS subscales

were good as evidenced by scores above .7 (see Table 19).

Table 19

Cronbach's Alpha Reliability Coefficients, Means, and Standard Deviations for STSS Subscales

STSS Sub-scale	α	M	S.D.
Intrusion Sub-scale	.77 (.80)	9.4 (8.11)	3.07 (3.03)
Avoidance Sub-scale	.83 (.87)	13.23 (12.49)	4.57 (5.00)
Arousal Sub-scale	.83 (.83)	10.03 (8.89)	3.72 (3.57)
Total	.92 (.93)	32.50 (29.49)	10.42 (10.76)

Note. Contained within the parentheses are results from the study by Bride et al. (2003).

Permissiveness of Parent-Child Sexual Boundaries Scale – PPCSBS

Beliefs about the appropriateness of parent and child behaviors as a result of vicarious trauma were measured using the Permissiveness of Parent-Child Sexual Boundaries Scale (PPCSBS). The PPCSBS instrument measures beliefs about behaviors between parent and child and the appropriateness of such behaviors given the age of the child. The PPCSBS was examined for internal consistency. Results for the PPCSBS support a high degree of internal consistency (Cronbach's Alpha = .92, N = 187). There are no sub-scales for the PPCSBS (see Table 20).

Table 20

Cronbach's Alpha Reliability Coefficients, Means, and Standard Deviations for PPCSBS

	α	M	SD
PPCSBS Scale	.92 (.81)	14.99 (18.76)	6.17 (6.78)

Note. Contained within the parentheses are results from the pilot study.

Summary of Reliability Analyses on Research Instruments

Results of reliability analyses found internal consistency rates above .7 for the total score of all three research instruments: TABS, STSS, and PPCSB. Thus all three research instruments are reliable. Only 3 out of 10 subscales of the TABS were below .7, while all three of the STSS subscales were above .7.

Statistical Analyses to Test Research Hypotheses

Statistical analyses were performed using the Statistical Package for Social Sciences (SPSS), version 13.0. The research hypotheses were tested by multivariate analysis of variance (MANOVA).

The research hypotheses have three dependent variables: (a) permissive parent-child sexual boundaries measured by PPCSBS, (b) secondary traumatic stress symptoms measured by STSS, and (c) changes in cognitive schemas measured by TABS. The independent variables vary for each of the three research hypotheses. For research hypothesis one the independent variable is professional organization membership. For research hypothesis two the independent variable is hours per week treating sexual offender and sexual abuse victim clients. Lastly, for hypothesis three the independent variable is years of professional clinical experience.

Testing of the Research Hypotheses

Testing of the research hypotheses was conducted in two parts. First the assumptions of MANOVA were tested using the research data. Then a MANOVA was used to test the research hypotheses.

Assumption Testing For Manova

For this research study, three assumptions of MANOVA were tested. Violations of the assumptions were found and dealt with through the use of Pillai's Trace. While Wilks' Lambda is used for general tests of group differences, Tabachnick and Fidell (1996) recommend the use of Pillai's Trace for small sample sizes and unequal N values. Pillai's Trace is more robust to violations of assumptions involving small sample sizes and unequal N values (Tabachnick & Fidell, 1996). The assumptions are the following:

- (1) The observations are independent
- (2) The observations on the dependent variable follow a multivariate normal distribution with each group
- (3) The population covariance matrices for the dependent variables are equal (homogeneity of variance).

The assumption of independent observations was maintained by mailing individual surveys to therapists in one of three professional organizations. The membership list was cross referenced to ensure that survey participants were not members of more than one of the professional organizations which could alter the unique characteristics of each therapist group.

Modest violations of the assumption of normality were found upon examination of both univariate and multivariate normality. Univariate normality was tested by using

the Explore button of SPSS to calculate Kolmogorov-Smirnov. Non-significant Kolmogorov-Smirnov results (significance value equal or greater than .05) indicate normality (Pallant, 2001). Kolmogorov-Smirnov results for the PPCSBS were non-significant ($p = .07$), indicating univariate normality. However, Kolmogorov-Smirnov results of the TABS were significant ($p = .00$) and STSS were significant ($p = .01$), indicating the lack of univariate normality.

In addition to Kolmogorov-Smirnov, univariate normality can also be examined by studying histograms, mean scores, and outliers. Examination of the TABS, STSS, and PPCSBS histograms (labeled as Normal Q-Q Plots) shows a reasonably straight line. A reasonably straight line suggests a normal distribution (Pallant, 2001). Further, the TABS' mean (1.14) is very close to the TABS' 5% Trimmed Mean (1.15) suggesting univariate normality. The TABS has six outliers, all above the mean score. The TABS' highest mean score (3.83) is within the range of possible TABS scores. The STSS' mean (1.93) is close to the STSS' 5% Trimmed Mean (1.89), the difference in the two means is attributed to three outliers. The three outlier scores (4.44, 4.16, 3.78), although higher than the mean, are within the range of possible STSS scores.

In addition to univariate normality, the assumption of normality was also tested by multivariate normality. Results for Multivariate normality were tested by using the regression option of SPSS to calculate Mahalanobis distance. Mahalanobis distance for the sample totaled 20.69, exceeded the 16.27 critical value of Chi-square for three dependent variables, indicating multivariate outliers. Results from the extreme values box for Mahalanobis distance for the five highest value outliers are 20.70, 17.11, 17.06, 16.43, and 16.28. MANOVA is robust to modest violations of normality if the violation is

created by skewness rather than outliers. When outliers for the four highest values are removed (20.70, 17.11, 17.06, and 16.43), the new calculated Mahalanobis distance of 18.67 still exceeds the critical value of 16.27, providing evidence that violations of normality in this sample are due to skewness rather than outliers. To prevent violations of normality, Tabachnick and Fidell (1996, p.381) recommend sample sizes of at least twenty in each cell to ensure robustness. In this sample, the lowest cell sizes are the following: (a) 58 AMHCA participants for membership, (b) 18 participants with 30 hours or more for therapy per week, and (c) 13 participants with 0-4 years for clinical experience. Although the cell sizes for hours and years are less than the recommended 20 per cell, smaller cell sizes are necessary to support existing literature (Steed & Bicknell, 2001; VanDeusen & Way, 2006; Way et al., 2004) on the risks factors for vicarious trauma.

The assumption of homogeneity of variance-covariance matrices (Box's M) is applied to check the assumption of homogeneity of covariance matrices when the sample sizes are unequal (Stevens, 2002). The Box's M Test evaluates whether the variances and covariance among the dependent variables are the same for all levels of the independent variable (Salkind & Green, 2005). Green and Salkind (2005) advise that the results of the Box's M test should be interpreted cautiously because significant results may be due to violation of the multivariate normality assumption. According to Pallant (2001) significance values smaller than .001 violate the assumption of homogeneity of variance. The Box' M test did not violate the assumption of homogeneity of variance for membership ($p = .19$) and years of professional experience ($p = .09$). However, the Box's M test did violate the assumption of homogeneity of variance for sexual offender and

sexual abuse victim client hours ($p = .001$).

MANOVA Findings for Null Hypothesis

Null Hypothesis: There are no significant differences in therapist levels (sexual offenders, sexual abuse victims, and general population clients) in therapists' perceptions of permissive parent-child sexual boundaries and therapists' altered perceptions of self, others, and the world (changes in cognitive schemas, secondary traumatic stress symptoms) as a result of vicarious trauma?

Findings from MANOVA did not support the null hypothesis. Results of the null hypothesis indicated the following: There were significant differences in therapist levels (sexual offenders, sexual abuse victims, and general population clients) in therapists' perceptions of permissive parent-child sexual boundaries and therapists' altered perceptions of self, others, and the world (changes in cognitive schemas, secondary traumatic stress symptoms) as a result of vicarious trauma. Significant differences in levels of therapists were discovered in examining therapists' organization membership. Statistical analysis for the null hypothesis is presented in research hypothesis one.

MANOVA Findings for Research Hypothesis One

Research Hypothesis 1: Compared to therapists not exposed to client stories of sexual trauma (therapists specializing in the treatment of the general population clients), therapists exposed to client stories of sexual trauma (therapists specializing in the treatment of sexual offenders or sexual abuse victims clients) will report the following differences in therapists' perceptions in permissive parent-child sexual boundaries and therapists' perceptions of self, others, and adaptation to the world (cognitive schemas, secondary traumatic stress symptoms) as a result of vicarious trauma: (a) less permissive

perceptions of parent-child sexual boundaries, (b) increased changes in cognitive schemas, and (c) increased secondary traumatic stress symptoms.

Findings from MANOVA reveal mixed results. Results indicate less permissive perceptions of parent-child sexual boundaries for therapists not exposed to sexual trauma (AMHCA members) and increased changes in cognitive schemas for some therapists exposed to sexual trauma (ATSA members). Hypothesis one had predicted the following for therapists exposed to client stories of sexual trauma: (a) less permissive perceptions of parent-child sexual boundaries (ATSA and APSAC members), (b) increased changes in cognitive schemas (ATSA and APSAC members), and increased secondary traumatic stress symptoms (ATSA and APSAC members). For research hypothesis one, therapist levels were differentiated by membership in professional organizations. Therapists exposed to sexual trauma clients were members of ATSA and APSAC, while therapists not exposed to sexual trauma were members of AMHCA.

Results reveal the Pillai's Trace significance value was .00 indicating that there are differences among therapist groups. The multivariate eta square based on Pillai's Trace was .05 reflecting a low effect size. According to Green and Salkind (2005) the multivariate eta square should be interpreted similar to univariate eta square with ranges in value from 0 to 1. A zero value indicates no relationship between membership and the total dependent variable score, while a value of one indicates the strongest possible relationship (see Table 21).

Tests of between subject effects reveal significant differences among members on TABS ($p = .01$) and PPCSBS ($p = .00$). The multivariate eta square was .05 for TABS and .06 for PPCSBS, reflecting a small effect size. Post Hoc Tests using Tukey found mean

differences for the TABS at the .05 alpha level between APSAC and ATSA. Post Hoc Tests using Tukey found mean differences for the PPCSBS at the .05 alpha level between AMHCA and APSAC/ATSA (see Table 22).

Table 21

Summary of Multivariate Analysis of Variance (MANOVA) for Participant Membership

Effect or Variable	Value: Pillai's Trace	<i>F</i>	Hypo. <i>df</i>	Error <i>df</i>	<i>p</i>	η^2
Membership	.11	3.53**	6.00	376.00	.00	.05

* $p < .05$. ** $p < .01$.

Table 22

Participant Membership Tests of Between-Subjects Effects

Effect or Variable	Type III Sum of Squares	df	Mean Square	F	<i>p</i>	η^2
TABS	1.95	2	.97	4.43*	.01	.05
STSS	1.21	2	.61	1.56	.21	.02
PPCSBS	2.47	2	1.24	5.77**	.00	.06

* $p < .05$. ** $p < .01$.

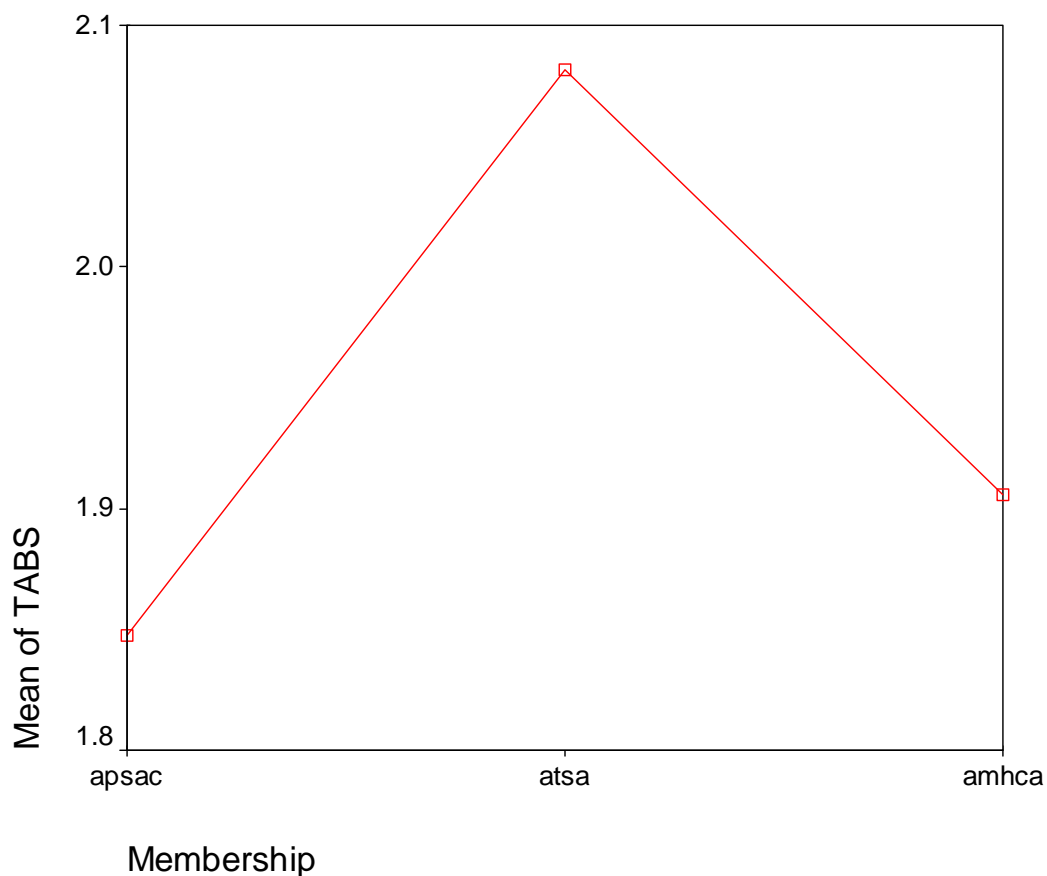


Figure 1. Membership differences for TABS instrument.

MANOVA Post Hoc Tests using Tukey's found mean differences for TABS at the .05 alpha level between APSAC and ATSA members. AMHCA members' TABS scores ($M = 1.91$) were not significantly different from other group members (see Figure 1). The higher average TABS score of ATSA members suggests greater levels of vicarious trauma than the lower average TABS scores of AMHCA and APSAC members (see Figure 1). An inspection of the mean scores indicated that ATSA members reported slightly higher scores for TABS ($M = 2.08$) than APSAC members ($M = 1.84$) and AMHCA members ($M = 1.91$). Despite reaching statistical significance, the actual difference in mean scores between the groups was quite small. The effect size, calculated

using eta squared, was .05 (see Table 22).

TABS subscale scores were examined by dividing the ten subscales into self scales (5) and other scales (5). The five self subscales include Self-Safety, Self-Trust, Self-Esteem, Self-Intimacy, and Self-Control. The five other self subscales include Other-Safety, Other-Trust, Other-Esteem, Other-Intimacy, and Other-Control (see Table 23).

Significant group membership differences were discovered for the total self subscales as evidenced by the Pillai's Trace significance value of .04. In general, therapists who treat sexual offender clients (ATSA) scored higher on every TABS self subscale than therapists who treat sexual abuse victim clients (APSAC members) and therapists who treat general population clients (AMHCA members). However, post hoc tests using Tukey found no significant differences among membership groups based upon individual self subscale scores.

Table 23

Mean TABS "Self" Subscale Scores by Membership

Effect	ATSA	APSAC	AMHCA
Self-Safety	1.97 (.54)	1.79 (.50)	1.91 (.60)
Self-Trust	2.01 (.61)	1.96 (.66)	1.95 (.51)
Self-Intimacy	2.13 (.53)	1.93 (.61)	2.11 (.64)
Self-Esteem	1.73 (.57)	1.55 (.41)	1.65 (.54)
Self-Control	2.28 (.70)	2.19 (.60)	2.04 (.56)

Note. Contained within the parentheses are standard deviation figures.

Significant group membership differences were found for the total other subscales as evidenced by the Pillai's Trace significance value of .02. The sig. value for Levene's Test for Equality of Variance is less than .05 for all other subscales with the exception of Other-Control. Tabachnick and Fidell (1996) suggest adjustment of the alpha level to a more conservative .025 or .01 in cases when the sig. value is less than .05 for Levene's Test for Equality of Variances. For this MANOVA analysis the researcher has selected .025 as the new alpha level. Tests of between - subjects effects found significant group membership differences for the other subscales of safety ($p = .00$), trust ($p = .01$), and esteem ($p = .00$) based upon the conservative alpha level of .025. Post Hoc tests using Tukey reveal significant differences regarding Other-Safety between ATSA ($M = 2.05$) and ASPAC ($M = 1.62$) group members. Further Tukey results identify Other-Trust differences between ATSA ($M = 2.14$) and APSAC ($M = 1.82$)/AMHCA ($M = 1.87$). Lastly Post Hoc tests using Tukey found significant differences for Other-Esteem

between ATSA ($M = 2.24$) and APSAC ($M = 1.85$)/AMHCA ($M = 1.95$) (see Table 24).

Table 24

Mean TABS "Other" Subscale Scores by Membership

Variable	ATSA	APSAC	AMHCA
Other-Safety	2.05 (.74)	1.62 (.50)	1.79 (.62)
Other-Trust	2.14 (.72)	1.82 (.49)	1.87 (.61)
Other-Intimacy	2.16 (.91)	1.85 (.60)	1.89 (.68)
Other-Esteem	2.24 (.78)	1.85 (.49)	1.95 (.51)
Other-Control	2.20 (.68)	1.99 (.53)	1.96 (.65)

Note. Contained within the parentheses are standard deviation figures.

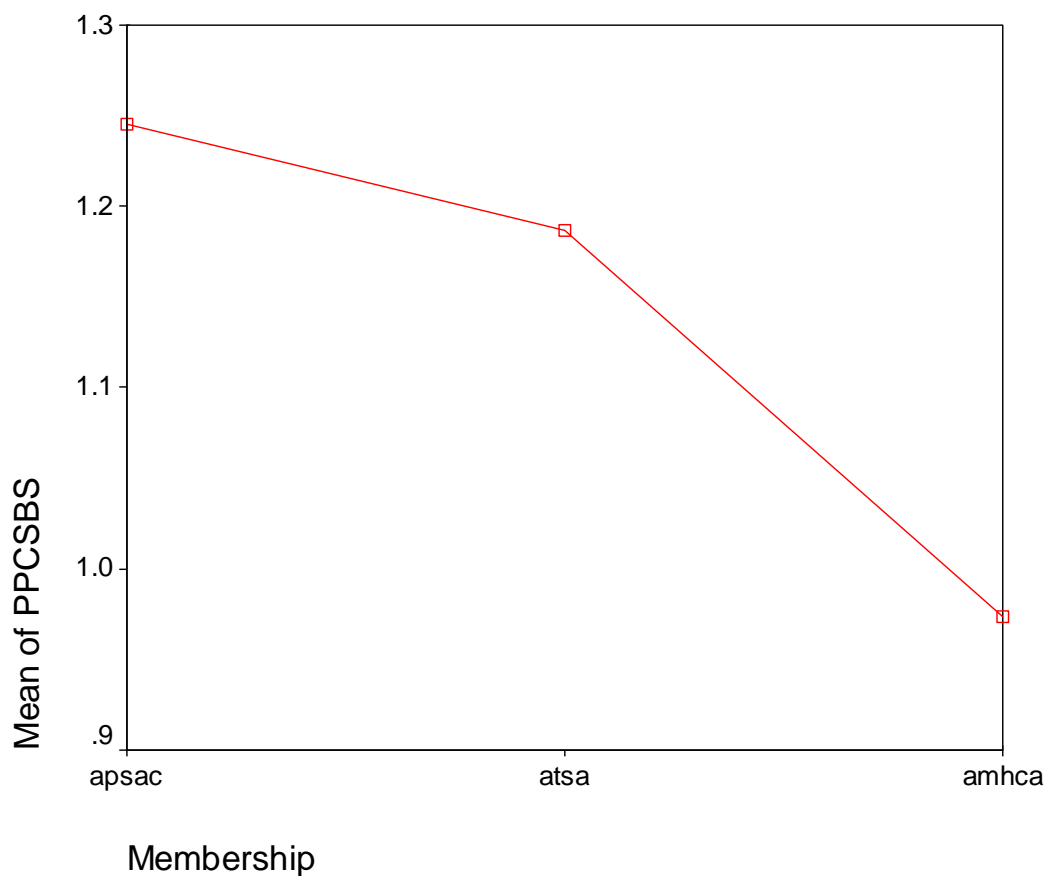


Figure 2. Membership differences for PPCSBS instrument.

MANOVA post hoc tests using Tukey reveal statistically significant mean differences for the PPCSBS comparing AMHCA members to APSAC members and ATSA members. PPCSBS scores reflect the fact that on average, more APSAC and ATSA members rate parent-child sexual boundary behaviors appropriate for older age children than AMHCA members (see Figure 2). An inspection of the mean scores indicated that AMHCA members reported slightly lower scores for PPCSBS ($M = .97$) than APSAC members ($M = 1.25$) and ATSA members ($M = 1.19$). Despite reaching statistical significance, the actual difference in mean scores between the groups was quite

small. The effect size, calculated using eta squared, was .06.

Lastly, no significant differences were found for therapist levels for STSS, the ATSA and APSAC members scored slightly higher than the AMHCA members. The means membership scores for the STSS are the following: ATSA ($M = 2.04$), APSAC ($M = 1.89$), and AMHCA ($M = 1.86$). Although the STSS scores were not significant, the scores did followed a predicted pattern for hypothesis one.

MANOVA Findings for Research Hypothesis Two

Research Hypothesis 2: Compared to therapists with a lesser number of hours spent per week treating sexual offender and sexual abuse clients, therapists with a greater number of hours spent per week treating sexual offenders or sexual abuse victims will report the following overall therapists' perceptions in permissive parent-child sexual boundaries and altered perceptions of self, others, and adaptation to the world (cognitive schemas, secondary traumatic stress symptoms) as a result of vicarious trauma: (a) less permissive perceptions of parent-child sexual boundaries, (b) increased changes in cognitive schemas, and (c) increased secondary traumatic stress symptoms.

Findings from MANOVA are non-significant for research hypothesis two. Results indicate that there were no significant differences in therapists with a lesser number of hours spent per week treating sexual offender and sexual abuse victim clients, compared to therapists with a greater number of hours spent per week treating sexual offenders or sexual abuse victims in therapists' perceptions of permissive parent-child sexual boundaries, changes in cognitive schemas, and secondary traumatic stress symptoms. To calculate the number of hours spent treating sexual offender and sexual abuse victim clients, the number of hours treating sexual offender clients was added to the number of

hours treating sexual abuse victim clients. It is important to note the number of hours spent per week treating sexual offender clients was calculated by multiplying the numbers of hours per week providing therapy to the current caseload percentage of sexual offender clients. Likewise, the number of hours spent per week treating sexual abuse victim clients was calculated in the same manner as the sexual offender client hours.

For this MANOVA procedure the alpha level of .025 was used to determine non-significance. Tabachnick and Fidell (1996) suggest adjustment of the alpha level to a more conservative .025 or .01 in cases when the significance value is less than .05 for Levene's Test for Equality of Variances. Levene's Test for Equality of Variances was less than .05 ($p = .00$) for the dependent variable TABS. If the alpha level was adjusted to .05, the Pillai's trace significance value would indicate significant differences between groups based upon number of hours spent per week treating sexual offender and sexual abuse victim clients. The multivariate test statistic Pillai's trace was used to explore group differences rather than Wilks' Lambda because of the violation of the MANOVA assumption of homogeneity of covariance matrices. Tabachnick and Fidell (1996) recommend Wilks' Lambda for general tests of group differences, while Pillai's trace is more robust to violations of assumptions involving small sample sizes and unequal N values. The Pillai's trace significance value was .04 (see Table 25).

Table 25

Summary of Multivariate Analysis of Variance (MANOVA) for Hours Spent Treating Sexual Offender and Sexual Abuse Victim Clients

Effect or Variable	Value: Pillai's trace	<i>F</i>	Hypo. <i>df</i>	Error <i>df</i>	<i>p</i>	η^2
Sexual Offender & Victim Hours	.12	1.84	12	540.00	.04	.04

MANOVA Findings for Research Hypothesis Three

Research Hypothesis 3: Compared to therapists with more years of clinical experience treating sexual offender and sexual abuse clients, therapists with less years of clinical experience treating sexual offender and sexual abuse clients will report the following overall therapists' perceptions in permissive parent-child sexual boundaries and altered perceptions of self, others, and adaptation to the world (cognitive schemas, secondary traumatic stress symptoms) as a result of vicarious trauma: (a) less permissive perceptions of parent-child sexual boundaries, (b) increased changes in cognitive schemas, and (c) increased secondary traumatic stress symptoms.

Findings from MANOVA are not statistically significant for research hypothesis three. Results indicate that there were no significant differences in therapists with more years of professional clinical experience treating sexual offender and sexual abuse clients compared to therapists with less years of clinical experience treating sexual offender and sexual abuse clients in therapists' perceptions of permissive parent-child sexual boundaries, changes in cognitive schemas, and secondary traumatic stress symptoms.

For this MANOVA procedure the alpha level of .05 was used to determine non-significance. The Pillai's Trace significance value was .08. (see Table 26).

Table 26

Summary of Multivariate Analysis of Variance (MANOVA) for Years of Clinical Experience

Effect or Variable	Value: Pillai's Trace	<i>F</i>	Hypo. <i>df</i>	Error <i>df</i>	<i>p</i>	η^2
Years of Clinical Experience	.10	1.63	12	555.00	.08	.03

Supplemental Analyses

Supplemental analyses were carried out to investigate two-way MANOVA interactions for the independent variables: membership, hours spent treating sexual offender and sexual abuse victim clients, and years of professional experience. In addition, area of client specialization was examined. Sexual offender and sexual abuse victim hours were examined separately using MANOVA procedures. Lastly, correlations were performed to explore the relationship between the dependent variables: TABS, STSS, and PPCSBS.

Two-Way MANOVA

Supplemental analyses were carried out to investigate two-way MANOVA

interactions for the independent variables: membership, hours spent treating sexual offender and sexual abuse victim clients, and years of professional experience. Two-way MANOVA procedures were conducted in the following configurations: (a) membership and hours treating sexual offender and sexual abuse victim clients, (b) membership and years of professional experience, (c) years of professional experience and hours treating sexual offender and sexual abuse victim clients, and (d) hours treating sexual offender and hours treating sexual abuse victim clients. The results of the two-way MANOVA's were all not significant for interaction effects. The Pillia's Trace value (.60) was not significant for the interaction effect of membership hours treating sexual offender and sexual abuse victims. The Pillia's Trace value (.10) was not significant for the interaction effect of membership and years of professional experience. The Pillia's Trace value (.52) was not significant for the interaction effect of years of professional experience and hours treating sexual offender and sexual abuse victim clients. Thus no significant interaction effects were found among the various groups.

Area of Client Specialization

No statistically significant group differences were found when participants' area of client specialization was examined. The Pillia's Trace value (.37) was not significant for any group differences.

However, significant group differences were found for those participants whose client area of specialization matched their professional organization membership. Of the 115 participants who met this criterion, 30 participants were APSAC members with self-identified specialization as sexual abuse victim, 45 participants were ATSA members with self-identified specialization as sexual offender, and 40 participants were AMHCA

members with self-identified specialization as generalist population (see Table 14). The Pillai's Trace value ($p = .03$) was significant for overall group differences. Tests of Between-Subject Effects revealed no significant group differences for the dependent variables TABS (.04), STSS (.34), and PPCSBS (.03) based upon Bonferroni adjustment of the alpha level to .017 (see Table 27). Bonferroni adjustment of the alpha level is recommended for interpretation of the Tests of Between-Subjects Effects results to reduce the chance of Type 1 error (Pallant, 2001).

Table 27

Summary of Multivariate Analysis of Variance (MANOVA) by Matching Participants' Client Area of Specialization with Professional Membership

Effect or Variable	Value: Pillai's trace	<i>F</i>	Hypo. <i>df</i>	Error <i>df</i>	<i>p</i>	η^2
Specialization	.12	2.33	6.00	222.00	.03	.06
By Membership						

Further evaluation of the TABS revealed significant group differences for the following TABS subscales: Other-Safety and Other-Esteem. The subscales Other-Trust, Other-Intimacy, and Other-Control were not significant. The Pillai's Trace value (.01) was significant for group differences at the alpha level .025. The alpha level of .025 was used to determine non-significance due to the fact the significance value for Levene's Test for Equality of Variances was less than .05. Tests of Between Subjects Effects found significant group specialization differences for Other-Safety ($p = .01$) and Other-Esteem ($p = .00$). For the TABS subscale Other-Safety significant differences were discovered

between ATSA members with specialization treating sexual offender clients ($M = 2.1$) and APSAC members with specialization treating sexual abuse victim clients ($M = 1.60$). For the TABS subscale Other-Esteem significant differences were discovered between ATSA members with specialization treating sexual offender clients ($M = 2.3$) and APSAC members with specialization treating sexual abuse victim clients ($M = 1.80$)/AMHCA members with specialization treating general population clients ($M = 1.92$) (see Table 28).

Table 28

Mean TABS Other Subscale Scores by Matching Participants' Client Area of Specialization with Professional Membership

Variable	ATSA	APSAC	AMHCA
Other-Safety	2.10	1.60	1.79
Other-Trust	2.17	1.86	1.87
Other-Intimacy	2.10	1.93	1.89
Other-Esteem	2.30	1.80	1.92
Other-Control	2.19	2.00	1.95

Sexual Offender Hours

No statistically significant group differences were found when sexual offender hours were examined separately from sexual abuse victim hours. The Pillia's Trace value (.15) was not significant for any group differences. Examination of descriptive statistics revealed that mean TABS values increased as offender hours increased for each group, while mean values for the STSS and PPCSBS were random. The number of hours

participants spent per week treating sexual offender clients was divided into five groups (see Table 15).

Further examination of the TABS revealed significant group differences for the following TABS subscales: Other-Safety, Other-Trust, and Other-Esteem. The subscales Other-Intimacy and Other-Control were not significant. The Pillai's trace value (.02) was significant for group differences at the alpha level .025. Pillai's trace was the multivariate test statistic used because Box's M test was significant (.00). In addition for this MANOVA procedure the alpha level of .025 was used to determine non-significance due to the fact the significance value for Levene's Test for Equality of Variances was less than .05. Tests of between - subjects effects found significant group membership differences for Other-Safety ($p = .01$), Other-Trust ($p = .00$), and Other-Esteem ($p = .01$). For the TABS subscales Other-Safety and Other-Esteem significant differences were discovered between 0-1 hour and 20-40 hours treating sexual offenders. For the subscale Other-Trust significant differences were found between 0-1 hour and 10-19 hours, 0-1 hour and 20-40 hours (see Table 29).

Table 29

Summary of Multivariate Analysis of Variance (MANOVA) for Hours Spent Treating Sexual Offender Clients

Effect or Variable	Value: Pillai's trace	F	Hypo. df	Error df	<i>p</i>	η^2
Sexual Offender Hours	.83	1.74	20	587.99	.02	.05

Sexual Abuse Victim Hours

No significant group differences were found when sexual abuse victim hours were examined separately from sexual offender hours. The Pillai's Trace value (.61) was not significant for any group differences. Examination of descriptive statistics revealed that mean values for the TABS, STSS, and PPCSBS were random and did not follow any clear pattern for increasing hours spent treating sexual abuse victims. The number of hours participants spent per week treating sexual abuse victim clients was divided into five groups (see Table 16).

Dependent Variable Correlations

The Pearson product-moment correlation was performed to explore relationships between the dependent variables. The total scale score for each instrument was used for the analyses. Results of the Pearson product-moment correlation reveal that there is a high correlation between TABS and STSS (.53), but no correlation between PPCSBS and TABS (.09) or PPCSBS and STSS (.03). MANOVA is based upon the assumption that dependent variables are correlated. When the PPCSBS is removed as a dependent variable from the one-way MANOVA, significant differences are noted only on research

hypothesis one. Research hypothesis one found overall therapist differences based upon organization membership.

Results of research hypothesis one suggests that there are group membership differences attributed to vicarious trauma as measured by TABS, STSS, and PPCSBS. However, when the dependent variable PPCSBS is removed from the MANOVA procedure, there are no group membership differences based upon total scale scores of the TABS and STSS (see Table 30).

Table 30

Summary of Multivariate Analysis of Variance (MANOVA) for Participant Membership With PPCSBS Removed

Effect or Variable	Value: Wilks' Lambda	<i>F</i>	Hypo. <i>df</i>	Error <i>df</i>	<i>p</i>	η^2
Membership	.95	2.33	4.00	376.00	.06	.02

Summary

Data from 193 responses of therapists treating sexual offender, sexual abuse victim, or general population clients were examined for differences in perceptions of permissive parent child sexual boundaries and therapists' altered perceptions of self, others, and the world (cognitive schemas, secondary traumatic stress symptoms) as a result of vicarious trauma. The research found statistically significant results for therapist group differences based upon membership in ATSA, ASPAC, or AMHCA organizations.

Research hypothesis one revealed group differences based upon professional

organization membership for therapists' perceptions of permissive parent-child sexual boundaries and cognitive schemas. Significant therapist differences were found in the following areas:

1. More ATSA members report statistically significant higher levels of vicarious trauma than AMHCA and APSAC members as evidenced by statistically significant TABS scores measuring changes in cognitive schemas.
2. More ATSA members, compared to ASPAC members, report statistically significantly higher levels of vicarious trauma in the TABS subscales of Other-Safety and Other-Trust.
3. More ATSA members report statistically significant higher levels of vicarious trauma in the TABS subscale of Other-Esteem compared to APSAC and AMHCA members.
4. More APSAC and ATSA members report statistically significant parent-child sexual boundary behaviors appropriate for older age children than AMHCA members as measured by the PPCSBS.

Research hypothesis two found no statistically significant results for group therapist differences based upon therapists' number of hours spent treating sexual offender or sexual abuse victim clients. Likewise research hypothesis three found no statistically significant results for group therapist differences based upon the therapists' number of years spent treating sexual offender and sexual abuse victim clients.

Supplemental analyses revealed increased TABS subscale scores (Other-Safety, Other-Trust, and Other-Esteem) for therapists providing 20 or more hours per week to sexual offender clients. Conclusions of research findings, study limitations, and possible

implications of research results on therapists are discussed in Chapter 5.

Chapter Five

Discussion

The purpose of this study was to determine if therapist levels (therapists who treat sexual offenders, sexual abuse victims, and general population clients) differ in terms of therapists' overall perceptions of parent-child sexual boundaries and therapists' altered perceptions of self, others, and adaptation to the world as a result of vicarious trauma. In this final chapter, the results of the statistical analyses reported in chapter four are discussed. Comprehensive discussions of the overall findings including research hypotheses and supplements analyses are provided. Reliability of the instruments and limitations of the study are identified with their possible impact upon the results. This chapter will conclude with study implications for the therapist levels and recommendations for future research.

Discussion of the Results

This study examined therapists' perceptions of parent-child sexual boundaries and therapists' altered perceptions of self, others, and adaptation to the world as a result of vicarious trauma. Therapists' altered perceptions of self, others, and adaptations to the world were measured as disrupted cognitive schemas and observable secondary traumatic stress symptoms.

In addition to altered perceptions of self, others, and adaptations to the world, research suggests that vicarious trauma symptoms are linked to therapists' perceptions of appropriate sexual boundaries with children (Edmunds, 1997; Ellerby, Gutkin, Smith, & Atkinson, 1993; Freeman-Longo, 1997; Jackson et al., 1997; Scheela, 2001). Therapists working with sexual offenders report a discomfort in caring for or touching their own

children (Edmunds, 1997; Freeman-Longo, 1997; Scheela, 2001). Edmunds (1997) and Freeman-Longo (1997) suggest the fear of sexual abuse allegations may create therapists' discomfort in caring for or touching children. Further, research suggests therapists treating sexual offenders may experience increased fear that certain family practices are sexually motivated and a prelude to sexual offending behavior (Edmunds, 1997; Freeman-Longo, 1997; Scheela, 2001).

While some researchers (Edmunds, 1997; Freeman-Longo, 1997; Scheela, 2001) suggest that therapists who treat sexual offenders experience altered perceptions of permissive parent-child sexual boundaries, other researchers (Jackson et al., 1997; Rich, 1997; Way et al., 2004) have found similarities in vicarious trauma symptoms for therapists treating sexual offenders and therapists treating sexual abuse victims. Research by Way et al. (2004) on therapists treating sexual offenders and therapists treating sexual abuse victims reported a decreased sense of personal safety, safety of significant others, and hypervigilance around strangers. Research also indicates that therapists with higher levels of exposure to traumatized clients are at greater risk for development of vicarious trauma, compared to therapist with lower levels of exposure to traumatized clients (Chrestman, 1995; Kassam-Adams, 1999; Pearlman & Mac Ian, 1995; Schauben & Frazier, 1995). Thus, less permissive perceptions of parent-child sexual behaviors, increased disrupted cognitive schemas, and increased secondary traumatic stress symptoms are predicted for therapists with greater exposure to sexual trauma through client therapy.

Null Hypothesis Results

Null Hypothesis: There are significant differences in therapist levels (sexual offender,

sexual abuse victims, and general population clients) based upon therapists' perceptions of permissive parent-child sexual boundaries and therapists' altered perceptions of self, others, and the world (changes in cognitive schemas and secondary traumatic stress symptoms) as a result of vicarious trauma.

Results of the study found the null hypothesis to be rejected. There were significant differences in therapist levels overall in perceptions of permissive parent-child boundaries (as measured by the TABS), cognitive schemas (as measured by the TABS), and secondary traumatic stress symptoms (as measured by STSS). Therapist levels were differentiated by membership in one of three professional organizations: (a) Association for Treatment of Sexual Abusers (ATSA), (b) American Professional Society on the Abuse of Children (APSAC), (c) American Mental Health Counselors Association (AMHCA).

In addition, supplemental analysis of therapists self-report of specialization found no significant differences in therapist groups. However, therapists self-report of specialization revealed that participants from two organizations, APSAC and AMHCA, responded similarly. To reduce merging the two organizations together, only those participants with specialization matching professional organization (ATSA/sexual offender, APSAC/sexual abuse victim, and AMHCA/general population) were selected for MANOVA analysis. Results support significant group differences for participants with specialization matching professional organization membership.

In summary, the null hypothesis supports overall significant differences in therapist levels. The research hypotheses explored in greater depth differences in therapist levels based upon predicted outcomes of the instruments used. In this study,

there are three research hypotheses.

Research Hypothesis One Results

Research Hypothesis One: Compared to therapists not exposed to client stories of sexual trauma (therapists specializing in the treatment of general population clients), therapists exposed to client stories of sexual trauma (therapist specializing in the treatment of sexual offenders or sexual abuse victim clients) report the following differences in therapists' perceptions in permissive parent-child sexual boundaries and therapists' perceptions of self, others, and adaptation to the world (cognitive schemas and secondary traumatic stress symptoms) as a result of vicarious trauma: (a) less permissive perceptions of parent-child sexual boundaries (as measured by PPCSBS), (b) increased disrupted cognitive schemas (as measured by TABS), and (c) increased secondary traumatic stress symptoms (as measured by STSS).

Results of research hypothesis one found significant differences in therapist levels based upon professional organization membership. However, examination of the effect size (.05) revealed differences in therapist levels to be quite small and unimpressive. Further, results were not significant for all instruments or always in the direction predicted for the therapist levels. Significant differences were found for disrupted cognitive schemas and parent-child sexual boundaries, but not for secondary traumatic stress symptoms. For therapist levels, therapists were grouped according to professional organization membership. Therapists exposed to sexual trauma clients were members of APSAC and ATSA, while therapists not exposed to sexual trauma were members of AMHCA.

Cognitive schemas.

As predicted, therapists exposed to client stories of sexual trauma reported significant differences in increased disrupted cognitive schemas compared to therapists not exposed to sexual trauma. However, post hoc tests revealed that only some of the therapists exposed to sexual trauma (ATSA members) reported significant differences in increased disrupted cognitive schemas as measured by the TABS. Other therapists exposed to sexual trauma (APSAC members) received TABS scores more closely resembling therapists not exposed to sexual trauma (AMHCA members). Research hypothesis one predicted therapists exposed to sexual trauma (ATSA and APSAC members) would report similar disrupted cognitive schemas. Results of research hypothesis one found significant differences in the TABS subscales for ATSA members and APSAC/AMHCA members. ATSA members scored significantly higher on the TABS subscales for Other-Safety, Other-Trust, and Other-Esteem. ATSA members scored significantly higher than APSAC members on Other-Safety, a measure of members' concern about the safety of loved ones. ATSA members scored significantly higher than APSAC and AMHCA members on Other-Trust, a measure of elevated beliefs that members cannot trust or rely upon other people. ATSA members scored significantly higher than APSAC and AMHCA members on Other-Esteem, a measure of members' tendency to view others with disdain and disrespect which may create disrupted countertransference issues in the therapeutic relationship.

One possible explanation for ATSA members scoring significantly higher on the TABS subscales than APSAC members may be due to stereotypical negative characteristics of some sexual offender clients. ATSA members scored significantly

higher on TABS subscales Other-Safety, Other-Trust, and Other-Esteem. Therapists who treat sexual offenders may experience greater client resistance to treatment and cognitive distortions. Sexual offender clients may be more resistant to treatment since they are frequently court ordered to receive treatment rather than seeking treatment voluntarily. In addition to not seeking treatment voluntarily, some sexual offender clients may also exhibit cognitive distortions. Cognitive distortions may include beliefs which justify the behavior of the offender and blame the victim for the sexual offense. It is possible that therapists who are exposed to the stories of sexual offending, from the perspective of the sexual offender experience greater countertransference issues due to client resistance, cognitive distortions, and possible lack of remorse for harm inflicted on victims.

Another possible explanation for ATSA members scoring significantly higher on the TABS subscales than APSAC members may be due to direct contact and lack of anonymity with sexual offender clients. Therapists treating sexual abuse victims are less likely to have contact with their clients' offenders and be less concerned about anonymity from their clients' offenders in their community. However, therapists who treat sexual offender clients may potentially encounter their clients in the community setting. The potential to be recognized by ones' clients in the community may contribute to increased hypervigilance, concern for the safety of family, and decreased trust in others for some therapists treating clients accused of random sexual offenses.

While ATSA members scored significantly higher on TABS subscales than APSAC members, ATSA members also scored significantly higher than AMHCA members on TABS subscales of Other-Trust and Other-Esteem. One possible explanation for the significant differences between ATSA and AMHCA members may be due to the

nature of the therapists' work. It is possible that therapists who treat sexual offender clients, due to their greater exposure to stories of sexual offending, report more disruptions in cognitive schemas including greater suspicious toward others, less trust in others, and greater counter-transference issues of aversion toward sexual offending clients.

Parent-child sexual boundaries.

In addition, to greater disrupted cognitive schemas for therapists exposed to stories of sexual trauma from the perspective of offender clients (ATSA members), results of research hypothesis one indicated therapists exposed to stories of sexual trauma, from the perspective of both offender and victim clients (ATSA and APSAC members), reported significantly more permissive perceptions of parent-child sexual boundaries than therapists not exposed to sexual trauma (AMHCA members). Contrary to research predictions, the AMHCA therapists reported sexual boundary behaviors to be appropriate for only younger age children, while the APSAC and ATSA members reported sexual boundary behaviors to be appropriate for both younger children and children of slightly older age children.

One possible explanation for AMHCA members reporting less permissive views of parent-child sexual boundary behaviors may be due to the PPCSBS not being an accurate instrument to measure vicarious trauma. The PPCSBS measures participants' beliefs about behaviors between parent and child and the appropriateness of such behaviors given the age of the child. Perhaps, the PPCSBS should be modified to survey participants' behaviors with their own children and the age of their children when such behaviors were no longer practiced in the home.

Another possible explanation for AMHCA members' less permissive perceptions of parent-child sexual boundary behaviors may be due to AMHCA members' limited exposure to stories of sexual trauma. Therapists with less exposure to stories of sexual trauma (AMHCA members) may react with more astonishment to their clients' permissive parent-child sexual boundary behaviors than therapist with more exposure to stories of sexual trauma (ATSA and APSAC members).

A final possible explanation for AMHCA members' less permissive perceptions of parent-child sexual boundary behaviors may be due to ATSA and APSAC members' specialized expertise and knowledge. Perhaps, ATSA and APSAC members perceived parent-child sexual boundary behaviors more permissively because they have greater knowledge into the techniques used by sexual offenders to select and prepare their victims for abuse. ATSA and APSAC members may use their expertise to distinguish innocuous permissive parent-child boundary behavior from grooming behaviors which prepare victims to be abused.

Secondary traumatic stress symptoms.

Although significant differences were found for cognitive schemas and permissive parent-child sexual boundaries, significant differences in therapist levels were not found for secondary traumatic stress symptoms in research hypothesis one. There are several possibilities for the lack of significance for secondary traumatic stress symptoms in therapist levels.

One possibility for the lack of significant differences in therapist levels may be attributed to the use of coping skills to alleviate secondary traumatic stress symptoms. Although this study did not explore therapists' use of coping skills, research (McLean et

al., 2003; Minnen & Keijsers, 2000; Pearlman & Mac Ian, 1995) supports that therapists reduce their risk for vicarious trauma by using coping skills to promote wellness.

Another possible explanation for the lack of significant differences in therapist levels may be that those therapists with the highest levels of secondary traumatic stress symptoms did not respond to the survey. Thus some therapists may have used avoidance and not completed the survey due to concerns of triggering symptoms of vicarious trauma.

A final explanation for the lack of significant differences in therapist levels may be attributed to the STSS instrument being an accurate measure of secondary traumatic stress symptoms. It may be possible that therapist levels differ on the degree of disrupted cognitive schemas, but not on the degree of secondary traumatic stress symptoms.

Summary of research hypothesis one.

In summary, research hypothesis one found significant differences in disrupted cognitive schemas for therapists exposed to sexual trauma through sexual offender clients (ATSA members) in the TABS subscales of Other-Safety, Other-Trust, and Other-Esteem. Therapists not exposed to sexual trauma (AMHCA members) rated parent-child sexual behaviors appropriate for only younger age children compared to therapists exposed to sexual trauma (APSAC and ATSA members) who rated parent-child sexual behavior appropriate for younger and slightly older age children.

Research Hypothesis Two Results

Research Hypothesis Two: Compared to therapists with fewer number of hours spent per week treating sexual offender and sexual abuse clients, therapists with more hours spent per week treating sexual offenders or sexual abuse victims will report the following

overall therapists' perceptions in permissive parent-child sexual boundaries and altered perceptions of self, others, and adaptation to the world (cognitive schemas and secondary traumatic stress symptoms) as a result of vicarious trauma: (a) less permissive perceptions of parent-child sexual boundaries, (b) increased changes in cognitive schemas, and (c) increased secondary traumatic stress symptoms.

Research hypothesis two revealed no significant differences in therapist levels based upon the number of hours per week spent treating sexual offender and sexual abuse victim clients. Thus, therapists in this sample did not differ based upon the number of hours spent per week treating sexual offender, sexual abuse victims, and general population clients. Therapist levels were differentiated by number of hours per week spent treating sexual offender and sexual abuse victim clients. Therapists were divided into five groups based upon the combined sexual offender and sexual abuse victim client hours per week. The groups are the following: 0-4 hours, 5-9 hours, 10-19 hours, 20-29 hours, and 30 hours and above. The non-significant findings of research hypothesis two did not support previous research findings. Researchers (VanDeusen & Way, 2006; Way et. al., 2004) discovered that therapists with higher levels of exposure to sexual offender and sexual abuse victim clients are a greater risk factor for development of vicarious trauma, compared to therapists with lower levels exposure to sexual offender and sexual abuse victim clients

One possible explanation for the non-significant findings of research hypothesis two may be the low response rate of therapists reporting 30 hours or more per week of therapy treating sexual offender and sexual abuse victim client hours. Only 18 (9.68%) of 186 participants reported spending 30 hours and above treating sexual offender and

sexual abuse victim clients per week, whereas 65 (34.95%) of 186 participants reported spending 0-4 hours per week treating sexual offender and sexual abuse victim clients.

A second possible explanation for the non-significant findings of research hypothesis two may be that those therapists with the highest levels of vicarious trauma did not respond to the survey. Thus some therapists may have used avoidance and not completed the survey due to concerns of triggering symptoms of vicarious trauma.

A final possible explanation for the non-significant findings of research hypothesis two may be due to the combining of sexual offender hours and sexual abuse victim hours. Research hypothesis one suggests that therapists treating sexual offender clients report greater levels of vicarious trauma than therapists treating sexual abuse victim and general population therapists. As a result of this finding, sexual offender client hours and sexual abuse victim client hours were separated. Supplemental analysis of hours spent treating sexual offender clients yielded significant results for the following TABS subscales: Other-Safety, Other-Trust, and Other-Esteem. Significant differences were discovered between 0-1 hour and 20-40 hours treating sexual offenders on the subscales Other-Safety and Other-Esteem. For the subscale Other-Trust significant differences were found between 0-1 hour and 10-19 hours as well as 0-1 hour and 20-40 hours. There are some possible explanations for significant differences in therapists levels based upon hours spent treating sexual offender clients.

One possible explanation for significant differences in therapist levels based upon hours spent treating sexual offender clients may be due to small sample sizes. Less than 10 percent ($N = 18$) of the sample reported treating sexual offenders 20 or more hours per week, whereas the number of therapists reporting 10 to 19 hours per week treating sexual

offender clients was slightly higher than 10 percent ($N = 22$). It is possible that a larger percentage of therapists, treating sexual offender clients 10 or more hours per week, would have resulted in no significant differences for therapist levels.

Another possible explanation for significant differences in therapist levels may be attributed to the results being an accurate indication of disrupted cognitive schemas in therapists treating sexual offender clients 20 or more hours per week. It is possible that this sample of 18 therapists, treating sexual offender clients 20 or more hours per week, is an accurate reflection of the degree of disrupted cognitive schemas.

Research Hypothesis Three Results

Research Hypothesis 3: Compared to therapists with more years of clinical experience treating sexual offender and sexual abuse clients, therapists with less years of clinical experience treating sexual offender and sexual abuse clients will report the following overall therapists' perceptions in permissive parent-child sexual boundaries and altered perceptions of self, others, and adaptation to the world (cognitive schemas, secondary traumatic stress symptoms) as a result of vicarious trauma: (a) less permissive perceptions of parent-child sexual boundaries, (b) increased changes in cognitive schemas, and (c) increased secondary traumatic stress symptoms.

Research hypothesis three revealed no significant differences in therapist levels based upon the number of years in the profession. Thus, therapists in this sample did not differ based upon the number of years of clinical experience treating sexual offender, sexual abuse victims, and general population clients. Therapist levels were differentiated by number of years of clinical experience treating sexual offender, sexual abuse victim, and general population clients. Therapists were divided into five groups based upon the

number of years in the profession. The groups were the following: 0-4 years, 5-9 years, 10-19 years, 20-29 years, and 30 years and above. The non-significant findings of research hypothesis three did not support previous research findings. Researchers (Steed & Bicknell, 2001) found that therapists with less than two years of clinical experience report higher levels of vicarious trauma symptoms, compared to therapists with two to four years of clinical experience.

One possible explanation for the non-significant findings of research hypothesis three may be that the study is underpowered due to the low response of therapists with two years or less of clinical experience. Only one (.01%) of 191 participants reported 1 year of clinical experience, while four (.02%) participants reported two years of clinical experience.

A second possible explanation for the non-significant findings of research hypothesis three may be that those therapists with the highest levels of vicarious trauma did not respond to the survey. Thus some therapists may have used avoidance and not completed the survey due to concerns of triggering symptoms of vicarious trauma.

A final explanation for the non-significant findings of research hypothesis three may be that those therapists with the highest levels of vicarious trauma self-select and leave the profession. Therapists with more years of clinical experience may represent therapists with the lowest levels of vicarious trauma who consequently have not left the profession. Therapists with the highest levels of vicarious trauma may have not responded to the survey because they have left the profession and thus are no longer members of the professional organizations included in this study.

Response Rate

The return rate of 43.55%, and the final figure of 42.88% useable questionnaires, from a total of 450 mailed surveys, was within Dillman's (1991) anticipated conservative return rate of 30 – 50% for mail surveys. Despite the use of the MP-3 player lottery as a goodwill gesture, response rates remained at a conservative rate, below 50% of all mailed surveys. Possible reasons for non-response included the length of the questionnaire, amount of time required to complete the questionnaire, lack of interest in the topic, beliefs regarding criteria to participate in the survey, or respondents' discomfort with issues of vicarious trauma and parent-child sexual boundaries.

Two respondents who opted not to participate in the survey reported that they were retired. Therefore, they may have assumed their response to the survey would not provide information of value since they were no longer seeing clients. Another respondent reported he was employed by a fund raising agency which did not provide therapy. Thus, it is possible that some non-responses could have resulted from respondents' beliefs that they did not meet criteria to participate in the survey since they were not currently providing therapy to clients.

Reliability Analyses of Instruments

Reliability analyses of research instruments refer to the consistency of instrument data (Huck & Cormier, 1996). Cronbach's alpha is a method of assessing internal consistency, the degree to which items in the instrument measure the same characteristic (Huck & Cormier, 1996). Cronbach alpha estimates of .70 or higher are considered to indicate adequate reliability for tests of psychological characteristics (Pearlman, 2003). Reliability of the research instruments in this study were compared to previous research

studies using Cronbach's alpha.

Trauma and Attachment Belief Scale

The TABS with 10 subscales was examined for internal consistency. Results from this study supported the TABS as an instrument with a high degree of internal consistency (Cronbach's Alpha = .92, $N = 193$). Previous TABS research (Pearlman, 2003) found slightly higher reliability coefficients (Cronbach's Alpha = .96, $N = 260$).

TABS subscales in this study received Cronbach's Alpha scores ranging from .58 to .83. Previous research (Pearlman, 2003) on TABS subscale found slightly higher Cronbach's Alpha scores ranging from .67 to .87. In both Pearlman's study and this study, Self-Intimacy received the lowest TABS subscale score. This finding implies that the items in the Self-Intimacy subscale do not satisfactorily measure the same construct and therefore are not sufficiently homogeneous. In addition to Self-Intimacy, this study's only other subscales below .70 were Other-Safety and Self-Trust. Pearlman's study has no other subscales below .70. In general, items from the TABS subscales of Self-Intimacy, Other-Safety, and Other-Trust, lack reliability and should be interpreted with some degree of caution in this study.

Secondary Traumatic Stress Scale

The STSS with 3 subscales was examined for internal consistency. Results from this study support the STSS as an instrument with a high degree of internal consistency (Cronbach's Alpha = .92, $N = 187$). Previous STSS research by Bride et al. (2003) found slightly higher reliability coefficients (Cronbach's Alpha = .93, $N = 287$), while Ting et al. (2005) reported even higher reliability coefficients (Cronbach's Alpha = .94, $N = 275$).

STSS subscales in this study also supported internal consistency with Cronbach's

Alpha scores ranging from .77 to .83. Previous STSS subscales (Bride et al., 2003; Ting et al., 2005) have similar scores of internal consistency with Cronbach's Alpha scores ranging from .79 to .87. In summary, internal consistency rates were high for the STSS items in this study, as well as previous studies (Bride et al., 2003; Ting et al., 2005).

Permissiveness of Parent-Child Sexual Boundaries Scale

The PPCSBS was examined for internal consistency. Results from this study supported the PPCSBS as an instrument with a high degree of internal consistency (Cronbach's Alpha = .92, $N = 187$). Since the PPCSBS was created for this study, no previous research has been conducted on the reliability of this scale. However, results of the pilot study found slightly lower reliability coefficients (Cronbach's Alpha = .81, $N = 22$). The difference in the PPCSBS' reliability scores between the pilot study and the actual study may be due in part to the modified wording of two items. Pilot study results indicated that items 12 and 13 were poorly correlated to the total score. When items 12 and 13 were omitted from the PPCSBS, Cronbach's Alpha increased from .81 to .83.

Item 12 was modified from "Is it appropriate for a father and daughter to give each other hugs with body contact?" to "Is it appropriate for a father and daughter to give each other a prolonged embrace with full body contact?" The original version of item 12 was poorly constructed because nearly all participants gave the same response of yes. With the modification of item 12, only 121 of 193 participants responded yes, while 72 participants responded no to at least one of the child age groups.

Item 13 was modified from "Is it appropriate for parents to engage in prolonged sexual interaction or sexual intercourse with a daughter asleep in the same room?" to "Is it appropriate for parents to engage in any type of sexual interaction with a daughter

asleep in the same room?” The original version of item 13 was poorly constructed with nearly all participants giving the same response of no. With the modification of item 13, the majority of participants still responded no, while 16 out of 193 participants responding yes to at least one of the child age groups. In summary, results from this study supported the PPCSBS as an instrument with a high degree of internal consistency

Limitations of the Study

The limitations of the study have the potential to influence study results. Therefore, study limitations must be considered among potential reasons for non-significant results. The study limitations included sample characteristics, instrument validity, and violations of MANOVA assumptions.

Sample Characteristics

Several sample characteristics have the potential to influence study results. Those sample characteristics which may present as study limitations include the following: (a) professional organization membership, (b) years of clinical experience, (c) gender, and (d) cultural influence.

This study drew on a sample of master and doctoral level therapists across the country holding membership in one of three professional organizations: Association for the Treatment of Sexual Abusers (ATSA), American Professional Society on the Abuse of Children (APSAC), and American Mental Health Counselors Association (AMHCA). It is not possible to generalize these study findings to therapists who are living outside the United States or therapists living within the United States who are not members of one of the three professional organizations. Further, study findings cannot be generalized to associate or bachelor level mental health professionals.

One potential limitation of this study is the lack of demographic information available on professional membership organizations: ATSA, APSAC, and ATSA. This researcher contacted each professional membership organizations and was informed that demographic information was not available on members' age, race, years of clinical experience, and gender. It is not known whether this sample is characteristic overall of the membership from each professional organization. However, demographic information was gathered from the existing literature to compare ATSA and APSAC participants with participants from this study.

Another potential limitation to this study is the number of years of clinical experience. In this sample of 191 participants, only 12 (6.28%) participants reported less than 5 years of clinical experience, while 23 (12.04%) participants reported 5 to 9 years, and 156 (82.68%) participants reported 10 years or more. This sample was not expected to have such an experienced group of participants. In a similar study of ATSA and APSAC members, Way et al. (2004) reported sample characteristics of less professional experience. For the Way et al. sample consisting of 347 participants, 22% reported less than 5 years of professional experience, 22% reported 5 to 10 years, and 56% reported greater than 10 years. A sample of therapists with more experience may have biased the results of this study. Pearlman and Mac Ian (1995) theorize that therapists suffering from the highest levels of vicarious trauma self-select and leave the profession in their early years of clinical experience. Thus, only those therapists with the greatest coping skills to avoid vicarious trauma may remain in the profession for an extended length of time.

In addition to the years of clinical experience, another potential limitation to this study is the gender of participants. In this study, 143 (74.48%) participants were female

and 49 (25.52%) were male. An explanation for the higher percentage of women in this sample could be that more women than men are members holding membership in the three professional organizations studied. The Way et al. (2004) study of ATSA and APSAC members had a slightly higher percentage of females (60%) to males (40%). However, in study involving only ATSA members, Engle, McFalls, and Gallagher (2007) found a higher percentage of males to females, with two-thirds of participants identifying as male and one-third identifying as female. A sample of therapists with more women than men has the potential to bias the results of this study, particularly in the area of disrupted cognitive schemas and secondary traumatic stress symptoms. Research by Steed and Downing (1998) found female therapists treating clients who are sexual offenders experience more hypervigilance and suspiciousness of others, fearfulness for their own and their family's personal safety, and difficulties with trust.

A final limitation in this study is the lack of data on the influence of culture. In this study 180 (93.75%) participants self-identified their race as Caucasian, followed by a much smaller number of 9 (4.69%) participants self-identified as Hispanic/Latino, and only one response each for American Indian/Alaska Native (.52%), Asian/Pacific Islander (.52%), and other ethnicity (.52%). There were no participants who self-identified as African-American. The reason that African-American therapists were not represented in this study is unknown. However, the ethnicity of this sample closely resembled another study of ATSA and APSAC members by Way et al. (2004). The study by Way et al. found 94% of respondents to be Caucasian, while the remaining 6% of respondents were somewhat evenly divided among African-American, Latino, and other ethnicity. A sample without African-American therapists could have biased the results of

this study. The degree to which racial diversity may have biased study results is unknown since research on racial diversity in vicarious trauma was not included in this study.

Instrument Validity

Concerns of instrument validity have the potential to influence study results. Those instrument validity concerns in this study which may present as limitations included the following: (a) self-report bias, (b) calculation of hours per week providing therapy to sexual offender and sexual abuse victim clients, and (c) father-daughter dyad in the Permissiveness of Parent-Child Sexual Boundaries Scale.

One potential limitation of this study concerning instrument validity is the self-reporting of participants. All instruments used in this study were self-report instruments. Self-report can be a highly unreliable source of data due to the following reasons: (a) self-reports are highly context dependent and minor changes in wording, format, or order can profoundly affect the obtained results and (b) participants may decide to edit their answers for reasons of social desirability and self-presentation (Schwarz & Oyerman, 2001). For example, those participants suffering from disrupted cognitive schemas may have underreported secondary traumatic stress symptoms.

Another potential study limitation is the calculation of hours per week providing therapy to sexual offender and sexual abuse victim clients. In the demographic questionnaire, therapists were asked to report the percentage of their caseload comprising sexual offender clients and the percentage of their caseload comprising sexual abuse victim clients. The researcher calculated the combined number of hours per week providing therapy to sexual offender and sexual abuse victim clients by multiplying the combined percentage of sexual offender and sexual abuse victim clients with the number

of hours of therapy per week. It appears that when reporting the percentage of sexual abuse victims in their caseload, some therapists may have included sexual offender clients as victims of sexual abuse. As a result, the total number of hours providing therapy to sexual offender and sexual abuse victim clients was larger than the number of hours of therapy per week in a few cases. However, when these few cases were excluded from the sample, the results had no influence on the significance of the research hypothesis.

Lastly, another potential study limitation to this study is the Permissiveness of Parent-Child Sexual Boundary Scale (PPCSBS). The PPCSBS has a methodology limitation due to the case scenario example of father-daughter incest. Results from the Parent-Child Sexual Boundary scale cannot be generalized beyond the father-daughter dyad.

Violations of MANOVA Assumptions

The MANOVA assumptions of normality and homogeneity of variance-covariance were not met for this sample. In this sample normality was violated due to skewness. MANOVA is robust to modest violations of normality if the violation is created by skewness rather than outliers (Pallant, 2001), whereas violations of homogeneity of variance-covariance can influence power (Holloway & Dunn, 1967). Holloway and Dunn found that small heterogeneity lowered power, even for equal group sizes. A decrease in power may increase Type II error resulting in failure to recognize group differences. Type I error is the rejection of the null hypothesis when it is true, whereas Type II error is the failure to reject the null hypothesis when it is false (Stevens, 1996). To control for the violation of homogeneity of variance-covariance, the researcher

used the multivariate test statistic Pillai's trace. Tabachnick and Fidell (1996) recommend using Pillai's trace because it is more robust to violations of assumptions involving small sample sizes and unequal N values. Stevens (1996) found Wilks' lambda and Pillai's trace to be equal in terms of robustness with respect to Type I error for the homogeneity of covariance matrices. Power differences in terms of Type II error are quite small, although the Pillai's trace tends to have a slight power advantage over Wilks' lambda (Stevens, 1996).

Implications of the Study

The results have implications for therapists treating sexual offender, sexual abuse victim, and general population clients. The results of this study may validate previous research that therapists treating sexual offenders are at increased risk for vicarious trauma as evidenced by disrupted cognitive schemas. Evidence for increased risk of vicarious trauma symptoms was not found for therapists treating sexual abuse victims or general population clients. Further, there was little evidence to support that therapist treating sexual offender or sexual abuse clients experience altered perceptions of permissive parent-child sexual boundaries as a result of vicarious trauma.

Implications for Therapists Treating Sexual Offender Clients

Results of this study suggest that therapists who treat sexual offender clients are at some risk to experience altered perceptions of others (cognitive schemas) as a result of vicarious trauma. Specifically, therapists treating sexual offenders may experience some altered perceptions of Other- Safety, Other-Trust, and Other-Esteem as measured by the TABS subscales. Results from this study suggest therapists treating sexual offenders more than 20 hours a week may be at greater risk of worrying about the safety of loved

ones (Other-Safety) and encountering more countertransference issues in therapy (Other-Esteem). Further, therapists treating sexual offender clients more than 10 hours a week may experience elevated beliefs regarding not being able to trust people and being more suspicious of others' motives (Other-Trust). It is important to note the small effect size for each statistically reliable difference, lessening the magnitude of these implications for therapists treating sexual offender clients.

Lastly, results of this study found weak evidence to support that therapists treating sexual offender clients experience altered perceptions of permissive parent-child sexual boundaries as a result of vicarious trauma. Previous research suggests that therapists working with sexual offender clients experience altered perceptions of permissible parent-child sexual boundaries (Edmunds, 1997; Freeman-Longo, 1997; Scheela, 2001). Despite their increased risk for vicarious trauma, this study found that therapists treating sexual offender clients, reported more permissive perceptions of parent-child sexual boundary behavior than therapists treating general population clients. Therefore, therapists treating sexual offender clients, as mandated reporters of abuse, do not appear to have altered perceptions of permissive parent-child sexual boundary behavior, resulting in unnecessary reports of child sexual abuse.

Implications for Therapists Treating Sexual Abuse Victim Clients

Results of this study suggest that therapists treating sexual abuse victims report symptoms of vicarious trauma at the same level as therapists treating general population clients. Previous studies (Brady et al., 1999; Cunningham, 1997; VanDeussen and Way, 2006) report disrupted cognitive schemas for therapists treating sexual abuse victim clients as measured by the TABS subscales. Therapists treating sexual abuse victim

clients appear to be more resilient to vicarious trauma symptoms than therapists treating sexual offender clients.

Lastly, results of this study found weak evidence to support that therapists treating sexual abuse victim clients experience altered perceptions of permissive parent-child sexual boundaries as a result of vicarious trauma. Study results suggests that therapists treating sexual abuse clients are not at greater risk to perceive permissive parent-child sexual boundaries in a more sinister or threatening way than therapists treating sexual offender or general population clients. Therefore, therapists treating sexual abuse victim clients, as mandated reporters of abuse, do not appear to have altered perceptions of permissive parent-child sexual boundary behavior, resulting in unnecessary reports of child sexual abuse.

Implications for Therapists Treating General Population Therapists

Results of research hypothesis one suggest that therapists who treat general population clients have less permissive perceptions of parent-child sexual boundaries than therapists who treat sexual offenders and sexual abuse victims, as measured by the PPCSBS. However, results of research hypothesis two do not indicate therapists with fewer hours treating sexual offender and sexual abuse victim clients have less permissive parent-child sexual boundaries than therapists who spend more hours treating sexual offender and sexual abuse victim clients. In addition, no previous research exists on therapist perceptions of parent-child sexual boundaries based upon therapists' professional membership or hours spent treating sexual trauma clients. Therefore, it is unclear whether therapists who treat general population clients perceive parent-child sexual boundary behaviors less permissively in younger age children than other therapist

groups.

Future Research

Although results of this study found therapists who treat sexual offenders are at greater risk for disrupted cognitive schemas, more research is needed to explore the risk to therapists who treat sexual offenders 30 hours or more per week. Statistical analysis of this sample suggests therapists who treat sexual offenders 30 hours or more per week report higher levels of disrupted cognitive schemas than therapists treating sexual offenders less than 30 hours a week as measured by the total TABS score (see Table 31). However, supplemental analyses of therapists who treat sexual offenders more than 30 hours a week violated MANOVA assumptions of sample size. While 15 participants were needed for the cell size, only 4 participants reported 30 hours or more per week treating sexual offenders for this sample. To meet MANOVA assumptions of sample size, the sample size was increased to 18 through the inclusion of therapists treating sexual offenders 20 hours or more per week. The reduction of therapist hours from 30 to 20 hours per week resulted in non-significant findings for the total TABS score measuring disrupted cognitive schemas. Therefore, more research is needed to explore disrupted cognitive schemas in therapists treating sexual offenders more than 30 hours per week.

Table 31

Mean TABS Scores for Therapists Treating Sexual Offenders

Variable	<i>N</i>	<i>M</i>	<i>SD</i>
Hours			
0-4	126	1.87	.40
5-9	19	2.10	.50
10-19	22	2.09	.54
20-29	14	1.91	.40
30 & Above	4	2.90	.96
Total	186	1.95	.47

In addition to studying therapist hours for sexual offender treatment, more research is needed to understand disrupted cognitive schemas in therapists with 2 years or less and 10 years or more of clinical experience. Statistical analysis of this sample suggests therapists with less than two years of clinical experience report statistically significant higher levels of disrupted cognitive schemas than therapists with 10 years or more of clinical experience as measured by the TABS. However, supplemental analyses of therapists with two years or less of clinical experience violated MANOVA assumptions of sample size. While 15 participants were needed for the cell size, only 5 participants reported 2 years or less of clinical experience for this sample. As a result, the sample size was increased to 13 participants through the inclusion of therapists with 4 or less years of clinical experience. The increase of therapist years of clinical experience from 2 years or less to 4 years or less resulted in non-significant findings for disrupted

cognitive schemas. Previous research by Steed and Bicknell (2001) found a U-shaped relationship between the number of years of experience as a therapist and vicarious trauma symptoms. Contrary to Steed and Bicknell who reported those most at risk for developing vicarious trauma symptoms were therapists with the least and most number of years of clinical experience, the sample from this study suggests a decrease in disrupted cognitive schemas for therapists with the most number of years of clinical experience. In this sample, those participants with 10 or more years of clinical experience reported significantly lower disrupted cognitive schemas. The results of the Steed and Bicknell study differ from the findings in this study possibly due to the fact that Steed and Bicknell used the IES-R to measure symptoms of vicarious trauma. Nevertheless more research is needed to explore disrupted cognitive schemas in therapists with two years or less and 10 years or more of clinical experience (see Table 32).

Table 32

Mean TABS Scores for Therapists' Years of Clinical Experience

Variable	<i>N</i>	<i>M</i>	<i>SD</i>
Years			
0-2	5	2.56	.34
3-9	30	2.00	.48
10-19	67	1.91	.45
20-29	55	1.94	.56
30 & Above	34	1.90	.34
Total	191	1.95	.48

Conclusion

This study's purpose was to determine if therapist levels (therapists who treat sexual offenders, sexual abuse victims, and general population clients) differ in terms of therapists' overall perceptions of parent-child sexual boundaries and therapists' altered perceptions of self, others, and adaptation to the world as a result of vicarious trauma. Significant differences were found in therapists treating sexual offender clients in altered perceptions of self, others, and adaptation to the world as measured by the TABS. Therapists treating sexual offender clients more than 20 hours a week scored significantly higher on the TABS subscales Other-Safety and Other-Esteem, whereas therapists treating sexual offenders more than 10 hours a higher scored significantly higher on the TABS subscale Other-Trust.

General population therapists belonging to the AMHCA professional organization

were more likely to perceive parent-child sexual boundary behaviors (as measured by the PPCSBS) to be inappropriate in younger age children, compared to therapists belonging to the APSAC and ATSA professional membership organizations. While professional organization membership reveals significant differences in therapists' perceptions of permissive parent-child sexual boundary, support for this finding is not evident in examination of therapy hours spent treating sexual offender and sexual abuse victim clients. Therapists who spend fewer hours treating sexual offender and sexual abuse victim clients, do not significantly differ on perceptions of permissive parent-child sexual boundary behaviors than therapists who spend more hours treating sexual offender and sexual abuse victim clients. Similar results were obtained when hours treating sexual offenders were examined separately from hours treating sexual abuse victims and vice versa.

Lastly, this study does not support therapists' altered perceptions of parent-child sexual boundaries as a symptom of vicarious trauma. Pearson-product moment correlations found no relationship between PPCSBS and the TABS or STSS. The TABS and STSS were found to be highly correlated, supporting that they are both measures of vicarious trauma.

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Appendix A

Cover Letter

Dear Colleague,

We are writing to request your participation in a research study. This study is designed to enhance our understanding of vicarious trauma in therapists exposed to client stories of personal trauma. Participation in this study is voluntary and will require approximately 15 to 20 minutes of your time. If you consent to participate in this study, please complete the enclosed survey packet.

In this survey packet, you will find four survey instruments: (1) Trauma and Attachment Belief Scale, (2) Secondary Traumatic Stress Scale, (3) Permissiveness of Parent-Child Sexual Boundaries Scale, and (4) demographic questionnaire. Your response is requested within 2 weeks of receipt of this survey packet.

You are requested to complete the survey packet and return it to us in the self-addressed stamped envelope enclosed. Please do not put your name on any of the instruments. There are no known potential risks to you as a participant, and all efforts are being made to preserve anonymity of responses. No individual data will be reported in this study. Response envelopes will be coded to facilitate follow-up with non-respondents. As soon as the survey packet is received it will be separated from the envelope so that no link will be maintained between your identity and your responses.

As a token of appreciation for taking the time to complete this survey, you will be entered into a lottery drawing to win one of three free MP-3 Players valued at \$150 each. Four hundred and fifty therapists will be invited to participate in this study. Expected response rates of approximately 30% increase your odds of winning to one in forty-five. The previously mentioned response envelopes with visible codes will serve as lottery entries. To preserve anonymity of survey responses, your response envelope will be placed in a lottery drawing box. Lottery winners' names will not be released due to anonymity of participants.

If you have any questions or would like a copy of research findings e-mailed to you, please send an e-mail request to jodidenell@AOL.com or telephone (740) 385-3196. If you have any questions regarding your rights as a research participant, please contact Rebecca Cale, Associate Director, Office of Research Compliance, Ohio University, at (740) 593-0664. Thank you for your willingness to participate in this research study.

Sincerely,

Jodi Jones, M.Ed.
Doctoral Candidate
Counselor Education Program
Ohio University

Patricia Beamish, Ed.D.
Professor
Counselor Education Program
Ohio University

Appendix B

Trauma and Attachment Belief Scale

Belief Scale**Laurie Anne Pearlman**

This questionnaire is used to learn how individuals view themselves and others. As people differ from one another in many ways, there are no right or wrong answers. Circle the number next to each item which you feel most clearly matches your own beliefs about yourself and your world.

Try to complete each item. Use the following response scale.

1 = Disagree Strongly	2 = Disagree	3 = Disagree Somewhat
4 = Agree Somewhat	5 = Agree	6 = Agree Strongly

1. I believe I am safe.....	1	2	3	4	5	6
2. You can't trust anyone.....	1	2	3	4	5	6
3. I don't feel like I deserve much.....	1	2	3	4	5	6
4. Even when I am with friends and family, I don't feel like I belong.....	1	2	3	4	5	6
5. I can't be myself around people.....	1	2	3	4	5	6
6. I never think anyone is safe from danger	1	2	3	4	5	6
7. I can trust my own judgment.....	1	2	3	4	5	6
8. People are wonderful.....	1	2	3	4	5	6
9. When my feelings are hurt, I can make myself feel better.....	1	2	3	4	5	6
10. I am uncomfortable when someone else is the leader.....	1	2	3	4	5	6
11. I feel like people are hurting me all the time.....	1	2	3	4	5	6
12. If I need them, people will come through for me.....	1	2	3	4	5	6
13. I have bad feelings about myself.....	1	2	3	4	5	6
14. Some of my happiest times are with other people.....	1	2	3	4	5	6
15. I feel like I can't control myself.....	1	2	3	4	5	6
16. I could do serious damage to someone.....	1	2	3	4	5	6
17. When I am alone, I don't feel safe.....	1	2	3	4	5	6
18. Most people ruin what they care about.....	1	2	3	4	5	6
19. I don't trust my instincts.....	1	2	3	4	5	6
20. I feel close to lots of people.....	1	2	3	4	5	6
21. I feel good about myself most days.....	1	2	3	4	5	6
22. My friends don't listen to my opinion.....	1	2	3	4	5	6
23. I feel hollow inside when I am alone.....	1	2	3	4	5	6
24. I can't stop worrying about others' safety.....	1	2	3	4	5	6
25. I wish I didn't have feelings.....	1	2	3	4	5	6
26. Trusting people is not smart.....	1	2	3	4	5	6
27. I would never hurt myself.....	1	2	3	4	5	6
28. I often think the worst of others.....	1	2	3	4	5	6
29. I can control whether I harm others.....	1	2	3	4	5	6
30. I'm not worth much.....	1	2	3	4	5	6
31. I don't believe what people tell me.....	1	2	3	4	5	6
32. The world is dangerous.....	1	2	3	4	5	6
33. I am often in conflicts with other people.....	1	2	3	4	5	6
34. I have a hard time making decisions.....	1	2	3	4	5	6
35. I feel cut off from people.....	1	2	3	4	5	6

36. I feel jealous of people who are always in control.....	1	2	3	4	5	6
37. The important people in my life are in danger.....	1	2	3	4	5	6
38. I can keep myself safe.....	1	2	3	4	5	6
39. People are no good.....	1	2	3	4	5	6
40. I keep busy to avoid my feelings.....	1	2	3	4	5	6
41. People shouldn't trust their friends.....	1	2	3	4	5	6
42. I deserve to have good things happen to me.....	1	2	3	4	5	6
43. I worry about what other people will do to me.....	1	2	3	4	5	6
44. I like people.....	1	2	3	4	5	6
45. I must be in control of myself.....	1	2	3	4	5	6
46. I feel helpless around adults.....	1	2	3	4	5	6
47. Even if I think about hurting myself, I won't do it.....	1	2	3	4	5	6
48. I don't feel much love from anyone.....	1	2	3	4	5	6
49. I have good judgment.....	1	2	3	4	5	6
50. Strong people don't need to ask for help.....	1	2	3	4	5	6
51. I am a good person.....	1	2	3	4	5	6
52. People don't keep their promises.....	1	2	3	4	5	6
53. I hate to be alone.....	1	2	3	4	5	6
54. I feel threatened by others.....	1	2	3	4	5	6
55. When I need people I feel alone.....	1	2	3	4	5	6
56. I have problems with self-control.....	1	2	3	4	5	6
57. The world is full of people with mental problems.....	1	2	3	4	5	6
58. I can make good decisions.....	1	2	3	4	5	6
59. I often feel people are trying to control me.....	1	2	3	4	5	6
60. I am afraid of what I might do to myself.....	1	2	3	4	5	6
61. People who trust others are stupid.....	1	2	3	4	5	6
62. I am my own best friend.....	1	2	3	4	5	6
63. When people I love aren't with me, I believe they are in danger.....	1	2	3	4	5	6
64. Bad things happen to me because I am a bad person.....	1	2	3	4	5	6
65. I feel safe when I am alone.....	1	2	3	4	5	6
66. To feel ok I need to be in charge.....	1	2	3	4	5	6
67. I often doubt myself.....	1	2	3	4	5	6
68. Most people are good at heart.....	1	2	3	4	5	6
69. I feel bad about myself when I need help.....	1	2	3	4	5	6
70. My friends are there when I need them.....	1	2	3	4	5	6
71. I believe that someone is going to hurt me.....	1	2	3	4	5	6
72. I do things that put other people in danger.....	1	2	3	4	5	6
73. There is a evil force inside me.....	1	2	3	4	5	6
74. No one really knows me.....	1	2	3	4	5	6
75. When I am alone, it's as if there is no one, not even me.....	1	2	3	4	5	6
76. I don't respect the people I know best.....	1	2	3	4	5	6
77. I can usually figure out what is going on with people.....	1	2	3	4	5	6
78. I can't do good work unless I am the leader.....	1	2	3	4	5	6
79. I can't relax.....	1	2	3	4	5	6
80. I have physically hurt people.....	1	2	3	4	5	6
81. I am afraid I will harm myself.....	1	2	3	4	5	6
82. I feel left out everywhere.....	1	2	3	4	5	6

83. If people really knew me they wouldn't like me.....	1	2	3	4	5	6
84. I look forward to time I spend alone.....	1	2	3	4	5	6

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Appendix C

Permissiveness of Parent-Child Sexual Boundaries Scale

Permissiveness of Parent-Child Sexual Boundaries Scale

When responding to the questions below think of a daughter in the stated age range without any developmental delays or neurological impairments. The parent is the biological father because the father-daughter scenario is one of the most frequently reported and discussed incest configurations. The frequency of behaviors for each question is one or more times per month. Please fill in the best answer to the question by circling either yes or no.

In general:

1. Is it appropriate for a father and daughter to take baths together-

If the daughter is 3?	Yes or No
If the daughter is 5?	Yes or No
If the daughter is 9?	Yes or No

2. Is it appropriate for a father and daughter to take showers together-

If the daughter is 3?	Yes or No
If the daughter is 5?	Yes or No
If the daughter is 9?	Yes or No

3. Is it appropriate for a father to wash his daughter's body while giving her a bath-

If the daughter is 3?	Yes or No
If the daughter is 5?	Yes or No
If the daughter is 9?	Yes or No

4. Is it appropriate for a father to help clean his daughter after she has used the toilet-

If the daughter is 3?	Yes or No
If the daughter is 5?	Yes or No
If the daughter is 9?	Yes or No

5. Is it appropriate for a father to sleep with his daughter-

If the daughter is 3?	Yes or No
If the daughter is 5?	Yes or No
If the daughter is 9?	Yes or No

6. Is it appropriate for a father to be naked around his daughter-
- | | |
|-----------------------|-----------|
| If the daughter is 3? | Yes or No |
| If the daughter is 5? | Yes or No |
| If the daughter is 9? | Yes or No |
7. Is it appropriate for a father to kiss his daughter on the mouth-
- | | |
|-----------------------|-----------|
| If the daughter is 3? | Yes or No |
| If the daughter is 5? | Yes or No |
| If the daughter is 9? | Yes or No |
8. Is it appropriate for a daughter to be present while her father uses the bathroom-
- | | |
|-----------------------|-----------|
| If the daughter is 3? | Yes or No |
| If the daughter is 5? | Yes or No |
| If the daughter is 9? | Yes or No |
9. Is it appropriate for a father to give his daughter neck, back, or shoulder rubs-
- | | |
|-----------------------|-----------|
| If the daughter is 3? | Yes or No |
| If the daughter is 5? | Yes or No |
| If the daughter is 9? | Yes or No |
10. Is it appropriate for a father to put medicine on his daughter's private parts-
- | | |
|-----------------------|-----------|
| If the daughter is 3? | Yes or No |
| If the daughter is 5? | Yes or No |
| If the daughter is 9? | Yes or No |
11. Is it appropriate for a father and daughter to change clothes (including underwear) in the same room-
- | | |
|-----------------------|-----------|
| If the daughter is 3? | Yes or No |
| If the daughter is 5? | Yes or No |
| If the daughter is 9? | Yes or No |
12. Is it appropriate for a father and daughter to give each a prolonged embrace with full body contact-
- | | |
|-----------------------|-----------|
| If the daughter is 3? | Yes or No |
| If the daughter is 5? | Yes or No |
| If the daughter is 9? | Yes or No |
13. Is it appropriate for parents to engage in any type of sexual interaction with a daughter asleep in the same room-
- | | |
|-----------------------|-----------|
| If the daughter is 3? | Yes or No |
| If the daughter is 5? | Yes or No |
| If the daughter is 9? | Yes or No |

Scoring for the Permissiveness of Parent-Child Sexual Boundaries Scale

Scoring will be based upon the following likart-type scale:

- 1 point Yes response to daughter who is 3.
- 2 points Yes response to daughter who is 5.
- 3 points Yes response to daughter who is 9.

An appropriate response for yes to daughter age 9 will also include yes responses to ages 3 and 5. The total points for all three yes responses will include only the 3 points for the age of 9. An appropriate yes response for age 5 will include a yes response to age 3 and a no response to age 9. The total points for a yes response to age 5 will be 2 points. Responses answering yes for an older age (i.e. 9) and no to a younger age (i.e. 3) will be deemed inappropriate response patterns and removed from use in this study.

Appendix D

Secondary Traumatic Stress Scale

SECONDARY TRAUMATIC STRESS SCALE

The following is a list of statements made by persons who have been impacted by their work with traumatized clients. Read each statement then indicate how frequently the statement was true for you in the past **seven (7) days** by circling the corresponding number next to the statement.

NOTE: "Client" is used to indicate persons with whom you have been engaged in a helping relationship. You may substitute another noun that better represents your work such as consumer, patient, recipient, etc.

	Never	Rarely	Occasionally	Often	Very Often
1. I felt emotionally numb.....	1	2	3	4	5
2. My heart started pounding when I thought about my work with clients.....	1	2	3	4	5
3. It seemed as if I was reliving the trauma(s) experienced by my client(s).....	1	2	3	4	5
4. I had trouble sleeping.....	1	2	3	4	5
5. I felt discouraged about the future.....	1	2	3	4	5
6. Reminders of my work with clients upset me.....	1	2	3	4	5
7. I had little interest in being around others.....	1	2	3	4	5
8. I felt jumpy.....	1	2	3	4	5
9. I was less active than usual.....	1	2	3	4	5
10. I thought about my work with clients when I didn't intend to.....	1	2	3	4	5
11. I had trouble concentrating.....	1	2	3	4	5
12. I avoided people, places, or things that reminded me of my work with clients.....	1	2	3	4	5
13. I had disturbing dreams about my work with clients.....	1	2	3	4	5
14. I wanted to avoid working with some clients.....	1	2	3	4	5
15. I was easily annoyed.....	1	2	3	4	5
16. I expected something bad to happen.....	1	2	3	4	5
17. I noticed gaps in my memory about client sessions.....	1	2	3	4	5

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Appendix E

Demographic Questionnaire

Demographic Questionnaire

For the following questions, please circle the items that best describes you.

1. My highest level of education is-

Associate Bachelor Master Doctorate Other _____

2. My gender is- Male Female

3. My Age is- _____.

4. My Race is- African-American American Indian/Alaska Native
Asian/Pacific Islander Caucasian
Hispanic/Latino Other_____

5. My professional affiliation is- Counselor Social Worker Psychologist
Marriage & Family Therapist Other_____

6. My professional area of client specialization is-

Sexual Offender Sexual Abuse Victim Generalist Population

7. I have experienced personally the following traumas in my own life-

Childhood sexual abuse Sexual Assault Domestic Violence
Natural Disaster Crime Violent Health Crisis
Other_____

For the following questions, please fill in the blank items with the approximate answer that best describes your work experiences.

8. The number of hours spent providing therapy to clients each week is _____.

9. The percentage of sexual offender clients on my current caseload is _____.

10. In the past the percentage of sexual offender clients on my caseload has been _____.

11. The percentage of sexual abuse victim clients on my current caseload is _____.

12. In the past the percentage of sexual abuse clients on my caseload has been _____.
13. The number of years experience in my professional affiliation is _____.

Appendix F

Permission to Use Trauma and Attachment Belief Scale

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October 19, 2006

Jodi Jones, PCC
28361 Ilesboro Road
Logan, OH 43138

Re: Trauma and Attachment Belief Scale (TABS)

Dear Ms. Jones:

This confirms WPS's receipt today of prepaid licensing fees for your authorized use of the above-referenced material in scholarly investigation. Under separate cover by mail you will soon receive a paid-in-full WPS invoice, which will formally serve as your license to use and reproduce copyrighted TABS material, subject to the provisions of my letter to you of August 14 - for sole application in the described study - with no authorization for continued or commercial use, for any purpose without the prior, written approval of WPS.

In keeping with the terms of my August 14 letter, the following is the reprint notice that must appear on each reprint you make of the adapted TABS forms now licensed for use in your project:

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Thank you for your interest in this instrument, and for your consideration of our copyright. Please feel free to contact me if you have any follow-up comments or questions.

Sincerely yours,

Susan Dunn Weinberg
Assistant to the President
WPS Rights and Permissions
e-mail: weinberg@wpspublish.com

SDW:se

Appendix G

Permission to Use Secondary Traumatic Stress Scale

Hi Jody,

Permission granted and no fee is required. Your dissertation sounds interesting. I hope you'll consider sending me an abstract of your findings when it is completed. I am also attaching a couple documents regarding the STSS that may be helpful, including a copy of the scale in Word format.

BTW, what school are you completing your degree at? And in what discipline?

Feel free to contact me with any questions you have regarding the instrument.

Best, Brian

Brian E. Bride, Ph.D., L.C.S.W.
Assistant Professor
University of Georgia
School of Social Work
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(706) 542-3282 fax
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JodiDenell@aol.com wrote:

Dear Mr. Bride,

I am writing for your permission to use the secondary traumatic stress scale in my doctoral dissertation. The topic of my dissertation is the impact of vicarious trauma on the therapist's definition of child sexual abuse. I have three therapist groups (sex offender therapists, sexual abuse victim therapists, and general population therapists).

I would be willing to purchase the scale for use in my dissertation if necessary.

Thank you,
Jodi Jones

Appendix H

Correspondence with Institutional Review Board



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The amendment, detailed below, and submitted for the following research study has been approved by the Institutional Review Board at Ohio University. Approval date of this amendment does not affect the expiration date of the original approval.

Amendment: Title Change

Project: Sexual Offender, Sexual Abuse Victim, and General Population Therapists' Perceptions of Permissive Parent Child Sexual Boundaries and Altered Perceptions of Self, Others, and Adaptation of the World as a Result of Vicarious Trauma

Project Director: Jodi Jones

Advisor: Patricia Beamish
(if applicable)
Department: Counselor Education

A handwritten signature in blue ink that reads "Rebecca G. Cale".

Rebecca G. Cale
Institutional Review Board

6/18/07

Date