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The Relationship Between Episodes of Dissociative Amnesia, Symptomology of Post-Traumatic Stress Disorder, and Childhood Sexual Abuse

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ABSTRACT

THE RELATIONSHIP BETWEEN EPISODES OF DISSOCIATIVE AMNESIA, SYMPTOMOLOGY OF POST-TRAUMATIC STRESS DISORDER, AND CHILDHOOD SEXUAL ABUSE

by

Jennifer E. Perkins

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ABSTRACT OF GRADUATE STUDENT RESEARCH

Dissertation

Andrews University

School of Education

Title: THE RELATIONSHIP BETWEEN EPISODES OF DISSOCIATIVE AMNESIA, SYMPTOMOLOGY OF POST-TRAUMATIC STRESS DISORDER, AND CHILDHOOD SEXUAL ABUSE

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Problem

Identifying the possibility of a significant relationship between childhood sexual abuse, symptoms of Post-Traumatic Stress Disorder (PTSD), and episodes of dissociative amnesia is both relevant and useful in the therapeutic setting. Identifying indicative factors for a history of childhood sexual abuse and including them in a standardized therapeutic assessment will assist therapists in planning future treatment. This study used secondary data to examine the relationship between childhood sexual abuse, symptomology of PTSD, episodes of dissociative amnesia, and selected demographic characteristics.

Method

This quantitative study used a therapist-completed data collection tool which compiled brief client demographics, episodes of dissociative amnesia, symptomology

indicative of PTSD, reported childhood sexual abuse, and a data specifier available on the client's risk assessment form. Results were compiled through the use of logistic regression, utilizing a convenience sample of 350 adults previously referred to Bethany Christian Services by the State of Michigan Child Protective Services (N=149; response rate, 43%).

Results

A binary logistic regression analysis was conducted to examine the relationship between childhood sexual abuse, symptomology of PTSD, episodes of dissociative amnesia, and selected demographic characteristics. Findings indicated that women are more likely than men to have experienced childhood sexual abuse (p <0.039). Additional findings indicated that the relationship between PTSD and childhood sexual abuse was statistically significant ("least" PTSD $p < 0.001$; "greatest" PTSD p <0.001). Also, the relationship between episodes of dissociative amnesia and PTSD was statistically significant ("least" PTSD $p < 0.001$; "greatest" PTSD p <0.01). Childhood sexual abuse and dissociative amnesia are moderately correlated (0.43).

Conclusions

The data interpretation suggests that there are certain PTSD symptoms that predict childhood sexual abuse. Subjects who were sexually abused are more likely to have experienced traumatic events, more likely to avoid activities, places, or people who remind them of these traumatic events, more likely to feel detached or estranged from other people, and more likely to exhibit irritability and outbursts of anger. The data additionally suggest that certain PTSD symptoms predict dissociative amnesia. Subjects

who experienced episodes of dissociative amnesia are more likely to have experienced traumatic events, more likely to experience recurrent distressing dreams, more likely to exhibit irritability and/or outbursts of anger, and more likely to have difficulty concentrating. The results of research indicate a need for clinicians to be trauma-informed in providing services to individuals. Recommendations include addition of standardized trauma screening tools such as the PC-PTSD to therapist intake assessments, as well as further study.

Andrews University

School of Education

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A Dissertation

Presented in Partial Fulfillment

of the Requirements for the Degree

Doctor of Philosophy

by

Jennifer E. Perkins

July 2015

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TABLE OF CONTENTS

Appendix

LIST OF TABLES

ACKNOWLEDGMENTS

The author of the Proverbs states “Without a vision, the people perish” (Prov 29:18, KJV). This dissertation was long in coming, and once the vision was finally established, it grew exponentially. It is important, however, to acknowledge the individuals who gave of themselves in allowing me the time and space necessary to bring this dissertation to completion. The support of my husband, Joe, as well as the efforts of Shannon Maddox, MSW, and the dedicated therapists at Bethany Christian Services have truly been essential to this research study. Additional thanks should be extended to my professors James Tucker, Elsie Jackson, and Jimmy Kijai, for their tireless effort, belief, and compassion.

Above all, I wish to thank my Creator, the Author of all things, in whom I live and move and have my being. Without You, I am nothing.

CHAPTER ONE

INTRODUCTION

This study originated as the result of the experience of a very dear friend of mine, whom I'll call "John." John, on two separate occasions, in the course of everyday working and living, experienced periods of severe dissociative amnesia to the point where he did not remember his name, his wife, where he lived, what he did for a living, and so forth. The first episode was fairly brief, lasting a matter of days. The second episode, prior to entering counseling, lasted for approximately 3 weeks, and ended as the result of John incidentally viewing an object that triggered his memory.

When looking at John's history, it became apparent that he had been experiencing symptoms of Post-Traumatic Stress Disorder (PTSD) for years, which had been untreated. John routinely experienced nightmares, hypervigilance to the point of not sleeping, and exaggerated startle reflex; he struggled with the ability to attend to a task at hand, reported feeling detached from others (especially his relationship with his spouse), and was extremely irritable at times, which occasionally led to angry outbursts. In addition, John had no recollection of much of his childhood, but immediately prior to the dissociative episodes he had begun to experience flashbacks regarding severe physical and sexual abuse by his mother throughout his childhood. In seeking to provide appropriate assistance to John and his wife during the dissociative episodes, it began to occur to me that this would have been easier to prevent than to treat after-the-fact. As

such, I began to look at the possibility of establishing a simple therapeutically oriented checklist that would help clinicians recognize symptomology associated with a history of childhood sexual abuse. This would have the ultimate goal of identifying victims prior to any severe episodes of dissociative amnesia. Such a tool could serve as a starting point for the treatment process by helping the client identify and deal with a history of trauma.

In the years of my work with victims of trauma (having a diagnosis of PTSD), I have repeatedly noticed a link between a client's lack of childhood memories and the reality of childhood sexual abuse. As a result, I set out to discover if, in fact, a statistically significant relationship existed between these two variables. If so, I also wanted to know if that relationship was supported by other professionals as well as the professional literature available on PTSD, dissociative amnesia, and childhood sexual abuse.

Background of the Study

Through personal experience, anecdotal reference, and review of professional literature, it is theorized that there appears to be a direct relationship between PTSD and dissociative amnesia (Briere, 1989; Burgess, 1995; Dryden-Edwards, 2007; Flannery, 1995; Linehan, 1993; Parkinson, 2000; Tomb, 1994; Tull, 2008). When a person has been through a traumatic event, unless immediate intervention is utilized, there is a high likelihood that the individual will develop PTSD (Briere, 1989; Burgess, 1995; Walker, 1994). At some point, the companion to PTSD (dissociative amnesia) will develop in one form or another (whether event-related or encompassing the entire person). By dissociating all memory of the event or of one's entire life, the brain allows itself a buffer zone in which to process the information it is receiving or recalling (Weber & Reynolds,

2004). Often, dissociative amnesia will result from recurring flashbacks to the traumatic event or from glimpses of suppressed memories of the traumatic event. Thus there exists the high potential for victims of childhood sexual abuse to experience an amnestic episode at some point in their lives (Yoe, Russell, Ryder, Perez, & Boustead, 2005). "In recent years in the United States, there has been an increase in reported cases of dissociative amnesia that involves previously forgotten early childhood traumas" (American Psychiatric Association, 2000, p. 521).

Rationale

Identifying the possibility of a significant relationship between childhood sexual abuse, symptoms of PTSD, and episodes of dissociative amnesia is both relevant and useful in the therapeutic setting (Kezelman, 2011). Therapists frequently offer inappropriate therapeutic interventions based upon inaccurate and incomplete client information (Hanson, Hesselbrock, & Tworkowski, 2002; Kezelman, 2011). It is common practice for therapists to gather historical data from clients and determine diagnoses based upon that information (Cooper, Masi, Dababnah, Aratani, & Knitzer, 2007). Unless a therapist is providing assessment for documentation purposes (such as for court or a paid evaluation), therapists typically do not use standardized instruments to assess client symptomology. Identifying indicative factors for a history of childhood sexual abuse and including them in a standardized therapeutic assessment will assist therapists by alerting them to this possibility at the beginning of the therapeutic relationship as opposed to several months into therapy. Ko et al. (2008) state that "effective trauma screening and assessment protocols are needed at every level" (p. 398). In addition, Taylor, Wilson, & Igelman (2006) emphasize that service providers in child

welfare systems need to have expertise in trauma treatment services that are research-based.

Setting of the Problem

For over 25 years Bethany Christian Services has provided home-based counseling services through the Early Impact Program under continuously renewed contracts with child protective services. Referrals are received from child protective services for children who have been found to have been abused and/or neglected, and Master's-level therapists provide weekly counseling, parental education and support, clinical intervention, and case management services that specifically address family problems and issues that put children at risk for future or continued instances of child abuse and/or neglect. Thirty percent of cases require court involvement and 60% of families struggle with a substance abuse problem (Bethany Christian Services, 2003). Counseling services are provided once a week, for an average of 4 to 6 months, and are intended to prevent the removal of children from their homes by strengthening families and reducing the ongoing risk of child endangerment. The long-term goal of the program is to reduce the risk that abuse or neglect will continue to occur by breaking the generational cycle of child abuse and neglect (Bethany Christian Services, 2003).

At the time of the study, Bethany's Early Impact Program was serving approximately 350 families per year. Of these families, 35-40% represented families of minority color and culture, 60% demonstrated difficulties related to substance abuse, 30% were challenged by undiagnosed or untreated mental health issues, 45% struggled with physical and mental health challenges, and up to 60% of adults reported child abuse and/or neglect within their own childhood histories (Bethany Christian Services, 2003).

In other words, childhood trauma appeared to account for up to 60% of the families that are referred after abusing and/or neglecting children.

Statement of the Problem

Due to inaccurate and incomplete client information, therapists may be unaware of the likelihood of childhood traumas (including childhood sexual abuse), thereby providing inappropriate treatment recommendations (Hanson et al., 2002; Kezelman, 2011). Unreported childhood sexual abuse is a hindering factor to client progress in therapy (Briere, 1989; Linehan, 1993; Walker, 1994; Weber & Reynolds, 2004). Childhood sexual abuse is pervasive, and is one of the most intimate crimes against a person (Briere, 1989; Burgess, 1995; Kezelman, 2011; Linehan, 1993; Walker, 1994). My prior work experience with child protective services has provided information that childhood sexual abuse often occurs in generational cycles. Without acknowledgment of past abuse, there is little hope of complete recovery, and thus a risk of abuse continues to exist for the children of the victim (Bethany Christian Services, 2003; Briere, 1989; Burgess, 1995; Linehan, 1993; Walker, 1994). Through recovery, it is hoped that the generational cycle of abuse can be broken, creating a safer home environment for children.

Purpose of the Study

This study used secondary data to examine the relationship between childhood sexual abuse, symptomology of post-traumatic stress disorder, episodes of dissociative amnesia, and selected demographic characteristics.

Research Questions

The core questions of this study were:

1. What is the incidence of childhood sexual abuse in the study sample?

2. What is the incidence of episodes of dissociative amnesia in the study sample?

3. What is the incidence of PTSD symptoms in the study sample?

4. What is the relationship between childhood sexual abuse and the demographic characteristics of gender, ethnicity, age, educational level, and handedness?

5. What is the relationship between childhood sexual abuse, symptoms of PTSD, and episodes of dissociative amnesia?

Conceptual Framework

This study utilized the conceptual framework of the trauma-informed care model for mental health in that helping professionals need to be able to identify and understand an individual's history of trauma before appropriate intervention can be provided (Kezelman, 2011). The trauma-informed care model focuses on the importance of understanding both the trauma itself, and how the experience of trauma shapes an individual's experience of the world. It is "an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives" (SAMHSA, 2012, para. 4). The trauma-informed care model advocates for the education and awareness of organizations in providing care to traumatized individuals "so that . . . services and programs can be more supportive and avoid re-traumatization" (SAMHSA, 2013, Trauma-Informed Care section, para. 2). Kezelman (2011) emphasizes the importance of the trauma-informed care model by pointing out that

> systems . . . need to integrate awareness and understanding around trauma and traumatic stress in their work and approach people from a trauma informed perspective–that is, to consider the possibility of unaddressed childhood trauma at the root of presentations. . . . Being cogniscent of the possibility can make an enormous difference to the way a survivor reacts, copes going forward and recovers. (para. 34)

The trauma-informed care model includes five main components: "appropriate screening and assessments, effective interventions and supports, culturally and linguistically competent strategies, family and youth engagement, and strong organizational capacity (including outcomes monitoring)" (Cooper et al., 2007, p. 2). Of particular note in relation to this study is the focus on utilizing screening tools and assessments that are designed to identify a history or likelihood of trauma. Such screening tools need to be evidence-based and standardized (Cooper et al., 2007).

Significance of the Study

As recently as 2011, Kezelman stated that “few service systems or workers have the insight and awareness needed to appropriately acknowledge and support [a] survivor's fundamental needs” (para. 4). Kezelman (2011) also emphasized that “frequently the possibility of underlying trauma is not on a health professional's radar at all or if known about, is not viewed as pivotal. Agencies should routinely consider the possibility of trauma even when it hasn't been disclosed” (para. 15). A history of trauma is important in determining type and length of treatment (Briere, 1989; Burgess, 1995; Chu, 2011; Lanktree & Briere, 2011; Linehan, 1993; Walker, 1994). Conducting research into ways to help mental health providers assess and identify a client's trauma history early on in treatment is a best practice method, which is currently highlighted as a need by the trauma-informed care agencies and literature (Kezelman, 2011; Ko et al., 2008;

SAMHSA, 2012, 2013). As such, the goal of this study is to demonstrate that there is a relationship between childhood sexual abuse, symptoms of PTSD, and episodes of dissociative amnesia, and because of that relationship it is important that clinicians work with clients from a trauma-informed care perspective.

Limitations and Delimitations

This study deals with the relationship between three major variables involved in trauma, as reported by Master's-level therapists. It is limited to families with open child-protective-services cases in Kent County, Michigan, because that was the convenience sample group utilized. It is limited to pre-existing client data already maintained in agency files, and as such the pre-existing data were not gathered for the purpose of this research. Thus, the therapists were not specifically looking for nor asking for data with regard to episodes of dissociative amnesia, gaps in historical memory, or exploring the possibility of childhood sexual abuse without client statements to the contrary. Also, an additional limitation may be the therapist uncertainty in recognizing symptomology of PTSD. Although the therapists providing the data are Master's-level therapists, they did not specifically receive specialized training in recognizing PTSD. This study is limited to reports from generalist Master's-level therapists because they will ultimately be the beneficiaries of the research, and the research needs to be understandable and useful to them in everyday practice. Lastly, a limitation may be the generalizability of this study, due to the utilization of both a convenience sample and the low number of subjects disclosing episodes of dissociative amnesia.

Definition of Terms

Before one can begin a discussion of **PTSD** and the correlation with childhood sexual abuse and dissociative amnesia, these things must be defined in such a way as to be clear to the reader. According to the *DSM-IV-TR,* PTSD can be defined as follows:

1. The person has been exposed to a traumatic event in which both of the following were present:
    a. The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.
    b. The person's response involved intense fear, helplessness, or horror.
2. The traumatic event is persistently reexperienced in one (or more) of the following ways:
    a. Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions
    b. Recurrent distressing dreams of the event
    c. Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated)
    d. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
    e. Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
3. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:
    a. Efforts to avoid thoughts, feelings, or conversations associated with the trauma
    b. Efforts to avoid activities, places, or people that arouse recollections of the trauma
    c. Inability to recall an important aspect of the trauma
    d. Markedly diminished interest or participation in significant activities
    e. Feeling of detachment or estrangement from others
    f. Restricted range of affect (e.g., unable to have loving feelings)
    g. Sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span).
4. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two or more of the following:
    a. Difficulty falling or staying asleep
    b. Irritability or outbursts of anger
    c. Difficulty concentrating
    d. Hypervigilance
    e. Exaggerated startle response.

> 5. Duration of the disturbance is more than 1 month.
> [In addition] The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. (American Psychiatric Association, 2000, pp. 467-468)

With regard to **dissociative amnesia**, it is important to understand there are different types of amnesia. *Webster's New Universal Unabridged Dictionary* (1983) defines *dissociation* as "in psychology, the process in which a group of mental activities breaks away from the main stream of consciousness and functions as a separate unit: an intensified dissociation can lead to multiple personality" (p. 532). *Webster's* (1983) also defines *amnesia* as "partial or total loss of memory caused by brain injury, or by shock, repression" (p. 59). This study focused on the *DSM-IV-TR* definition of dissociative amnesia:

> an inability to recall important personal information, usually of a traumatic or stressful nature, that is too extensive to be explained by normal forgetfulness. This disorder involves a reversible memory impairment in which memories of personal experience cannot be retrieved in a verbal form (or, if temporarily retrieved, cannot be wholly retained in consciousness). (American Psychiatric Association, 2000, p. 520)

Having experienced one amnestic episode is not an absolute indicator that subsequent amnestic episodes will result. However, "individuals who have had one episode of dissociative amnesia may be predisposed to develop amnesia for subsequent traumatic circumstances" (American Psychiatric Association, 2000, p. 521).

For the purpose of this study, **childhood sexual abuse** was defined according to the State of Michigan, Department of Human Services (2009):

> Sexual abuse means:
> 1. Sexual contact which includes but is not limited to the intentional touching of the victim's or alleged perpetrator's intimate parts or the intentional touching of the clothing covering the immediate area of the victim's or alleged perpetrator's intimate parts, if that touching can be reasonably construed as being for the purposes of sexual arousal, gratification, or any other improper purpose.

2. Sexual penetration which includes sexual intercourse, cunnilingus, fellatio, anal intercourse, or any other intrusion, however slight, of any part of a person's body or of any object into the genital or anal openings of another person's body. (Emission of semen is not required.)
3. Accosting, soliciting or enticing a minor child to commit, or attempt to commit, an act of sexual contact or penetration, including prostitution.
4. Knowingly exposing a minor child to any of the above acts. (p. 4)

General Method

As the purpose of this study is to examine the relationship between variables, the major methodology applied was binary logistic regression analysis. According to StatSoft, Inc. (2010), "In general, . . . regression allows the researcher to ask (and hopefully answer) the general question 'what is the best predictor of . . .'" (General Purpose section, para. 4). Logistic regression also allows for modeling the likelihood of a "yes" response when comparing the dependent variable to items such as demographics and independent variables. Additionally, binary logistic regression is used when the dependent variable is dichotomous (i.e., the only possible responses are either "yes" or "no"). It is important to clarify that regression analysis does not determine *causality*, but only indicates relationship between variables. For the purposes of this study, the independent variables of dissociative amnesia and PTSD were compared to the dependent variable of childhood sexual abuse.

A convenience sample for this study was utilized, which included 350 individual adults from a population of 350 families, all of whom were referred for therapeutic intervention to Bethany Christian Services by the State of Michigan Child Protective Services. A convenience sample was utilized due to the availability and likelihood of relevant data for this study. As the referred individuals were referred to Bethany

Christian Services on a mandatory basis, the 350 individuals represented the entire referral population for the year and thus was representative of the general population of active child protective services families in Kent County, Michigan. Given the generational cycle of child abuse (Bethany Christian Services, 2003), it was highly likely that the convenience sample would contain individuals with prior childhood sexual abuse history. According to Ko et al. (2008), "perhaps no other child-serving system encounters a higher percentage . . . with a trauma history than the child welfare system" (p. 397).

Data were collected by Master's-level therapists for each child-protective-services-referred adult client within the past year. Data were collected via a data-collection tool from pre-existing client data already maintained in agency files and not collected for this researcher. Data-collection tools were submitted anonymously to a general agency mailbox and were not able to be linked back to either the therapist completing the tools or to any specific client file maintained in agency records. As this researcher was an agency administrator, the data was subsequently reviewed by epidemiologists and clinicians outside of the agency in order to avoid researcher bias.

Relevance to Leadership

As a clinician and program manager, this study demonstrates the application of leadership through job-embedded innovation and advocacy. The development and use of a PTSD screening tool, as well as emphasis on the importance of therapist education in recognizing a client's past traumas, provide an ethical framework to ensure that clients are provided appropriate services. In my current leadership capacity, creating an

environment for clinicians to assess and treat clients according to the trauma-informed care model is a daily aspiration and one made possible through this study.

Organization of the Study

Chapter 1 discussed the purpose and rationale for the study, the conceptual framework for the study, and hypothesized a relationship between the variables of childhood sexual abuse, symptoms of PTSD, and episodes of dissociative amnesia. Chapter 2 contains a review of the literature outlining the three major research variables individually, as well as presents indicators of diagnosis and treatment options. Chapter 3 describes the methodology and the data-collection tool itself. Chapter 4 reports the results of this quantitative study through the use of binary logistic regression analysis. Lastly, Chapter 5 summarizes and interprets the study, as well as suggesting continuing research endeavors.

CHAPTER TWO

THE THREE MAJOR RESEARCH VARIABLES IN THE CONTEXT OF HISTORICAL LITERATURE

Introduction

Chapter 1 presented the problem of determining whether trauma, in fact, does have three distinctive characteristics, and as such, hypothesized whether it is possible through this research study to determine the likelihood of childhood sexual abuse by episodes of dissociative amnesia and symptomology of PTSD. Chapter 1 also briefly discussed the study rationale and conceptual framework, as well as the core research questions, sampling, and methodology. This chapter presents a review of the literature outlining the three major research variables individually and jointly. It also presents research dealing with present indicators of diagnosis, and treatment methods.

Childhood Sexual Abuse

Characteristics

Characteristics of childhood sexual abuse have been identified by Briere (1989) and should be well ingrained in the mind of the therapist when treating a client. Briere's (1989) characteristics are as follows:

1. Intrusive memories of flashbacks to and nightmares of the abuse
2. Abuse-related dissociation, derealization, depersonalization, out-of-body experiences, and cognitive disengagement or 'spacing out'

3. General posttraumatic stress symptoms, such as sleep problems, concentration problems, impaired memory, and restimulation of early abuse memories and emotions by immediate events and interactions
4. Guilt, shame, negative self-evaluation, and self-invalidation related to the abuse
5. Helplessness and hopelessness
6. Distrust of others
7. Anxiety attacks, phobias, hypervigilance, and somatization
8. Sexual problems
9. Long-standing depression
10. Disturbed interpersonal relatedness, including idealization and disappointment, overdramatic behavioral style, compulsive sexuality, adversariality, and manipulation
11. 'Acting out' and 'acting in,' including parasuicidal acts and substance abuse
12. Withdrawal
13. Other-directedness
14. Chronic perception of danger
15. Self-hatred
16. Negative specialness -- that is, an almost magical sense of power
17. Impaired reality testing
18. A heightened ability to avoid, deny, and repress. (p. 10)

Diagnosis

As stated previously in Chapter 1, for the purposes of this study, childhood sexual abuse can be diagnosed according to the definition provided by the State of Michigan, Department of Human Services (2009):

> Sexual abuse means:
> 1. Sexual contact which includes but is not limited to the intentional touching of the victim's or alleged perpetrator's intimate parts or the intentional touching of the clothing covering the immediate area of the victim's or alleged perpetrator's intimate parts, if that touching can be reasonably construed as being for the purposes of sexual arousal, gratification, or any other improper purpose.
> 2. Sexual penetration which includes sexual intercourse, cunnilingus, fellatio, anal intercourse, or any other intrusion, however slight, of any part of a person's body or of any object into the genital or anal openings of another person's body. (Emission of semen is not required.)
> 3. Accosting, soliciting or enticing a minor child to commit, or attempt to commit, an act of sexual contact or penetration, including prostitution.
> 4. Knowingly exposing a minor child to any of the above acts. (p. 4)

As many as 50% of the children in the child-welfare system have experienced trauma, including childhood sexual abuse (Yoe et al., 2005). Of an estimated 794,000 U.S. children who were determined to be victims of abuse or neglect, 7.6% children experienced childhood sexual abuse (U.S. Department of Health and Human Services, 2007). Of the estimated 794,000 child victims of abuse or neglect, 51.5% were girls and 48.2% were boys (U.S. Department of Health and Human Services, 2007). Additionally, 46.1% of victims were White, 21.7% were African-American, and 20.8% were Hispanic (U.S. Department of Health and Human Services, 2007). Many of these children, however, have either not reported the abuse or do not remember the abuse. Williams (1994) reported that in 68% of cases, individuals with documented histories of childhood sexual abuse did not report the abuse. "The closer the relationship to the perpetrator and the younger the child at the time, the greater the likelihood an incident was (apparently) not remembered" (Hopper, 2006, p. 17). Widom and Shepard (1996) reported "substantial underreporting by . . . abused respondents" (p. 412). In other words, "approximately 40% of individuals with documented histories of . . . abuse did not report" (Widom & Shepard, 1996, p. 419).

Treatment

Bethany Christian Services' Early Impact Program works to provide therapeutic intervention at the time trauma occurs and is centered around a theoretical model of solution-focused, strengths-based, cognitive-behavioral therapy. It has been well-documented that a cognitive-behavioral model is highly beneficial in working with victims of trauma (Allen, 2005; Chard, 2005; Foa, Rothbaum, Riggs, & Murdock, 1991;

Litz, Engel, Bryant, & Papa, 2007; McDonagh et al., 2005; Rothbaum et al., 2006; Shalev, Bonne, & Eth, 1996; Tarrier et al., 1999). Research has additionally supported a cognitive-behavioral model in reducing the incidence of child abuse and/or neglect, as well as family violence (Fraser, Pecora, & Haapala, 1991; Veerman, de Kemp, and Brink, 1997). Altering a client's perception of the event is as important as altering the course of events themselves. Brewin (1989) outlines that "cognitive-behavioral therapy is based on the premise that symptoms develop and are maintained, at least in part, by conditioned and learned behavioral responses as well as maladaptive cognitions" (p. 379). In other words, the intensity of the trauma may not be as important as an individual's perception of the trauma. According to Bush (2003), cognitive-behavioral therapy combines two major types of therapy: behavior therapy and cognitive therapy. Behavior therapy "helps [one] weaken the connections between troublesome situations and [one's] habitual reactions to them. It also teaches [one] how to calm [one's] mind and body" (Bush, 2003, para. 4) to aid in clarity of thought, more positive affect, and improved decision-making. Cognitive therapy "teaches [one] how certain thinking patterns are causing [one's] symptoms – by giving [one] a distorted picture of what's going on in [one's] life" (para. 5). Important components of cognitive-behavioral therapy include a comprehensive assessment, as well as being highly structured and focused (Beck, 1983; Brewin, 1996; Clark, Beck, & Alford, 1999; Harvey, Watkins, Mansell, & Shafran, 2004; Roth & Fonagy, 2005). It is additionally necessary that any treatment plan involve the active participation of the client (Linehan, 1993; Walker, 1994).

PTSD

Characteristics

As described in Chapter 1, characteristics of PTSD include the following:

1. The person has been exposed to a traumatic event in which both of the following were present:
    a. The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.
    b. The person's response involved intense fear, helplessness, or horror.
2. The traumatic event is persistently reexperienced in one (or more) of the following ways:
    a. Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions
    b. Recurrent distressing dreams of the event
    c. Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated)
    d. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
    e. Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
3. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:
    a. Efforts to avoid thoughts, feelings, or conversations associated with the trauma
    b. Efforts to avoid activities, places, or people that arouse recollections of the trauma
    c. Inability to recall an important aspect of the trauma
    d. Markedly diminished interest or participation in significant activities
    e. Feeling of detachment or estrangement from others
    f. Restricted range of affect (e.g., unable to have loving feelings)
    g. Sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span).
4. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two or more of the following:
    a. Difficulty falling or staying asleep
    b. Irritability or outbursts of anger
    c. Difficulty concentrating
    d. Hypervigilance
    e. Exaggerated startle response.
5. Duration of the disturbance is more than 1 month.

> [In addition] The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. (American Psychiatric Association, 2000, pp. 467-468)

Diagnosis

Diagnosing PTSD can be difficult. Individual factors weigh heavily on the development of this disorder, including stress, external factors, and the unique physiological makeup of the person. Elliott and Briere (1995) found that "subjects who had recently recalled aspects of their abuse reported particularly high levels of posttraumatic symptomology and self difficulties" (p. 629). Brewin, Dalgleish, and Joseph (1996) additionally state that "traumas experienced after early childhood give rise to 2 sorts of memory. . . . These different types of memory are used to explain the complex phenomenology of PTSD, including the experiences of reliving the traumatic event and of emotionally processing the trauma" (p. 670). Van der Kolk and Fisler (1995) implicated dissociation as the "central pathogenic mechanism that gives rise to . . . PTSD" (p. 505).

According to Flannery (1995), there may be three factors involved in determining individual risk for the development of PTSD–factors related to the person, the traumatic event, and the individual's environment (see Table 1). Brewin et al. (1996), Brewin, Andrews, & Valentine (2000), Kessler, Sonnega, Bromet, Hughes, & Nelson (1995), Macklin et al. (1998), and Ozer, Best, Lipsey, & Weiss (2003) identify similar risk factors represented throughout the trauma literature. In addition, Harvey and Bryant (1998) reported that PTSD rates are influenced not only by type of trauma, but also gender—more females are diagnosed with PTSD than are males. This gender difference

is supported by Fullerton et al. (2001), Prigerson, Maciejewski, & Rosenheck (2001), and Riggs, Byrne, Weathers, & Litz (1998).

Table 1

Risk Factors for Development of PTSD

Person	Event	Environment
Biological Predisposition	Nature of the Event	Safety and Protection
Age/Stage of Development	Severity of the Event	Community Resources
Dysfunctional Family	Frequency of the Event	Community Values
Past History of Abuse	Duration of the Event	
Relationship to Offender	Alone/With Others	
Pre-Trauma Coping Skills		
Values and Meaning		

Note. From *Post-traumatic stress disorder: The victim's guide to healing and* recovery (p. 71), by R.B. Flannery, 1995, New York, NY: Crossroad.

PTSD is the disorder most frequently either misdiagnosed or missed completely by professionals (Schonfeld et al., 1997). It is estimated that between 12 to 39% of individuals in medical primary care settings meet the criteria for PTSD (Samson, Bensen, Beck, Price, & Nimmer, 1999; Stein, McQuaid, Pedrelli, Lenox, & McCahill, 2000). Inconsistent criterion identification of symptoms of PTSD is consistent with the literature on the relationship of childhood sexual abuse and PTSD (Bremner, Krystal, Southwick, & Charney, 1995; Elliott & Briere, 1995). Van der Kolk (1994) reported that "[PTSD], by definition, is accompanied by memory disturbances consisting of both hypermnesias [inability to forget] and amnesias" (p. 253). Additionally, Burgess (1995) indicates that dissociative amnesia may actually be a significant first indicator of PTSD.

Recent research has determined that the likelihood of PTSD can be indicated by sole endorsement of Criterion 1a, which asks the question, "Has the individual

experienced a traumatic event?" (National Research Council, 2008). McFarlane, Atchison, Rafalowicz, & Papay (1994) and Solomon (1988) identify somatic concerns that may indicate traumatic exposure. The National Research Council (2008) found that the endorsement of the symptom of "irritability" (Criterion 4b) was a positive indicator of the presence of PTSD. Harvey and Bryant (1998) discuss a "partial" PTSD diagnosis where the individual has experienced a traumatic event, but may not endorse all needed criteria for a diagnosis of PTSD. As such, the National Research Council (2008) recommended a multimodal approach toward diagnosing PTSD and reviewed a primary care PTSD screen (PC-PTSD) consisting of an introductory statement (PTSD Criteria 1 a/b) and four questions (PTSD Criteria 2b, 3 a/b, 4 d/e, and 3e) (Prins et al., 2003). The instrument has been determined to have good specificity, where a positive response on two to three questions indicates a likelihood of PTSD (Prins et al., 2003).

Treatment

"PTSD is associated with significant deficits in physical health functioning and quality of life that exceed those of other mental disorders" (Prins et al., 2003, p. 10). The pervasive impacts of PTSD on an individual are also noted by Zayfert, Dums, Ferguson, & Hegel (2002). As such, a concern for the therapist-client relationship lies in treatment options for PTSD (Herman & Harvey, 1997). There are a variety of treatments and treatment plans available; each one must be individually tailored to meet the needs of the client, and sometimes results in combining two or more evidence-based methods to achieve the greatest possible outcome (Bryant, Moulds, Guthrie, Dang, & Nixon, 2003; Cloitre, Koenen, Cohen, & Han, 2002; Foa et al., 2005; Glynn et al., 1999; Rothbaum et al., 2006). "The aim of therapy with traumatized patients is to help them move from

being haunted by the past and interpreting subsequent emotionally arousing stimuli as a return of the trauma, to being fully engaged in the present" (Van der Kolk, 1996, p. 419). Treatments that have demonstrated success include psychotherapy (either individual, group, or family) (Glynn et al., 1999; Litz et al., 2007; Schnurr, 2007; Schnurr et al., 2003), eye-movement desensitization and reprocessing [EMDR] (Cusak & Spates, 1999; Rothbaum, 1997; Rothbaum, Astin, & Marsteller, 2005; Taylor et al., 2003), cognitive behavioral therapy (Allen, 2005; Chard, 2005; Ehlers, Clark, Hackmann, McManus, & Fennell, 2005; Foa et al., 1991; Litz et al., 2007; McDonagh et al., 2005; Rothbaum et al., 2005; Schnurr et al., 2007; Shalev et al., 1996; Tarrier et al., 1999) (including cognitive processing therapy [Monson et al., 2006; Resick, Nishith, Weaver, Astin, & Feuer, 2002; Resick et al., 2008] and prolonged exposure therapy [Bryant et al., 2003; Difede et al., 2007; Foa et al., 1999; Foa et al., 2005; Resick et al., 2002; Rothbaum et al., 2005; Simon et al., 2008; Taylor et al., 2003]), and the usage of selective serotonin reputake inhibitor [SSRI] medication (Brady et al., 2000; Davidson, Rothbaum, Van der Kolk, Sikes, & Farfel, 2001; Friedman & Davidson, 2007; Friedman, Davidson, & Stein, 2009; Marshall, Beebe, Oldham, & Zaninelli, 2001; Rothbaum et al., 2006; Simon et al., 2008; Tucker et al., 2001). The National Center for Complementary and Alternative Medicine (2012) additionally lists resources for the use of natural and alternative treatments such as yoga, meditation, tai chi, acupuncture, ayurveda, and others. A recent research study highlighted the particular effectiveness of acupuncture in treating PTSD (Hollifield, Sinclair-Lian, Warner, & Hammerschlag, 2007). In addition, several new alternative treatment modalities are emerging that are focused on the reduction of hyperarousal and irritability through the use of guided meditation (Root et al., 2001; Strauss, Marx, &

Calhoun, 2009) and heart coherence (Ginsberg, Berry, & Powell, 2010; McCraty, Atkinson, Tomasino, & Bradley, 2009).

Dissociative Amnesia

Characteristics

It is estimated that in the general population there is a 2% to 6% likelihood of the presence of dissociative amnesia (Mulder, Beatrais, Joyce, & Fergusson, 1998; Sar, Akyuz, & Dogan, 2007; Seedat, Stein, & Forde, 2003). Dissociative amnesia is more commonly reported in women (Putnam et al., 1996; Saxe et al., 1993; Widom & Morris, 1997). "Dissociative amnesia most commonly presents as a retrospectively reported gap or series of gaps in recall for aspects of the individual's life history. These gaps are usually related to traumatic or extremely stressful events" (American Psychiatric Association, 2000, p. 520). Researchers have found that individuals who experience dissociative amnesia have also experienced childhood sexual abuse (Coons, 1994; Goff, Brotman, Kindlon, Waites, & Amico, 1991; Hopper, 2006; Modestin, Ebner, Junghan, & Erni, 1996; Saxe et al., 1993) (see Table 2). In cases of childhood sexual abuse, researchers have propounded the idea of dissociation as a protective defense (Middleton, 2004). "Children who are severely physically, sexually, and psychologically abused in early childhood . . . are at high risk to develop a . . . dissociative disorder" (Walker, 1994, p. 100). Walker (1994) also states that "dissociation is a psychological technique used as a defense mechanism, unconsciously protecting the mind from the impact of severe abuse" (p. 100). Additionally, when an individual is unable to recall periods of time, it is most often the time period of the trauma which the individual is unable to recall (Degun-Mather, 2002). "Every known study [on dissociative amnesia] has found

amnesia for childhood sexual abuse in at least a portion of the sampled individuals" (Scheflin & Brown, 1996, pp. 178-179).

Table 2

Selected Studies of Amnesia and Delayed Recall for Experiences of Childhood Sexual Abuse

Author(s) and Date of Study	Number of subjects with abuse or trauma histories	% with a period of possible amnesia
Elliott (1997)	357	17 partial/15 total
Williams (1995)	75	16
Widom & Morris (1997)	96	Females 32/males 58
Elliott & Briere (1995)	116	22 partial/20 total
Loftus, Polonsky, & Fullilove (1994)	52	12 partial/19 total
Feldman-Summers & Pope (1994)	79	40.5
Briere & Conte (1993)	450	59.3
Herman & Schatzow (1987)	53	64

Note. From "Recovered memories of sexual abuse: Scientific research and scholarly resources," by J. Hopper, 2006, Retrieved from http://www.jimhopper.com/abstats/

Flannery (1995) emphasizes that "intense biochemical changes that occur in the victim at the time of the traumatic event may lead to permanent alterations in the victim's nervous system" (p. 45). Burgess (1995) points out that "the importance of trauma is the method by which it affects the brain, in particular the key regulatory processes that control memory, aggression, sexuality, attachment, emotion, sleep, and appetite" (p. 16). Because of the changes in the hormonal systems in the brain,

> alterations occur in memory systems. The individual becomes immobilized and as the level of autonomic arousal increases, the body moves into a numbing state through the release of opiates in the brain. This numbing state accounts for disconnection of the processing and encoding of information. (Burgess, 1995, p. 16)

McEwen and Mendelson (1993) state that trauma can cause significant, permanent changes in the brain systems responsible for memory, information processing, and learning. Based upon this information, there would appear to be a specific link between the biochemistry of trauma and the causative factors of dissociative amnesia. Due to the alteration of portions of the brain through the reduction of chemicals within the brain, dissociative amnesia is a likely candidate. As a result of the differences in brain physiology from altered brain chemistry, there could be a higher prevalence of the development of dissociative amnesia. "While we have tried to look at dissociation as a psychological defense, we find that dissociation, in fact, may be better understood as a first-line biological adaptation to trauma" (Burgess, 1995, p. 21).

It is important to be cognizant of the fantasy model of dissociation, which contends that dissociation is caused by factors such as suggestibility, cognitive difficulties, and imaginative proclivity (Dalenberg et al., 2012; Lynn et al., 2014). Schacter (2001) also references suggestibility, which predicates the likelihood of inaccurate memories due to implanted ideas during clinical interviews, retelling of traumatic events, and other origins. However, in a review of available information regarding encoding of memories during traumatic events, Lynn et al. (2014), Kluemper & Dalenberg (2014), and Dalenberg et al. (2012) support a trauma causation model for dissociative amnesia.

Diagnosis

> Some individuals with dissociative amnesia report depressive symptoms, depersonalization, trance states, analgesia, and spontaneous age regression. . . . Other problems that sometimes accompany this disorder include sexual dysfunction, impairment in work and interpersonal relationships, self-mutilation, aggressive impulses, and suicidal impulses and acts. (American Psychiatric Association, 2000, pp. 520-521)

In one study, 42% of inpatients in a psychiatric hospital met the criteria for dissociative amnesia (Lipsanen et al., 2004).

> For most victims abused by other persons, such human viciousness and cruelty cannot be easily explained away as givens. In cases of sexual abuse, battery, murder and so forth, we do not seem to be facing the randomness of natural catastrophe, but rather the deliberate acts of twisted human beings. In the face of malice, madness, and perversion, the search for meaning becomes more difficult. (Flannery, 1995, p. 187)

It is this difficulty in searching for meaning that may be a precursor to the prevalence of episodes of dissociative amnesia for trauma victims. When circumstances no longer make sense, a person has an increased risk of withdrawing from the situation (a dissociative episode) in order to attempt to control the effects of the traumatic event. "Early trauma is much more likely to produce a pattern of . . . dissociation" (Tomb, 1994, p. 247). "The reports of therapists who specialize in the treatment of sexually abused women have shown that women who were sexually abused often experience periods of time during which they cannot remember the abuse" (Walker, 1994, p. 84). Brewin and Andrews (1998) state that "amnesia may be partial or profound, and individuals can often give accounts of deliberate strategies they use to banish distressing memories from consciousness. Recovered memories may be fragmented, emotion-laden, and similar to intrusive memories of the PTSD patient" (p. 958).

Treatment

Treatment of dissociative amnesia can be complicated, given that some mental health professionals do not believe that the disorder exists (Lalonde, Hudson, Gigante, & Pope, 2001; Pope, Oliva, Hudson, Bodkin, & Gruber, 1999). Some treatments for dissociative amnesia involve hospitalization; other treatments can be conducted safely in

an outpatient setting (Middleton & Higson, 2004). The intent of treatment for dissociative amnesia is to help restore the individual's lost memories as quickly as possible without causing additional trauma. Treatments that have demonstrated success include psychodynamic treatments (Burton & Lane, 2001), hypnotherapy (Degun-Mather, 2001, 2002), eye-movement desensitization and reprocessing [EMDR] (Twombly, 2000), cognitive behavioral therapy (Fine, 1999; Goldstein, Deale, Mitchell-O'Malley, Toone, & Mellers, 2004), and antianxiety and antidepressant medications (Sno & Schalken, 1999; Ballew, Morgan, & Lippmann, 2003).

Research Studies on the Relationship Between Childhood Sexual Abuse, Symptoms of PTSD, and Dissociative Amnesia

"Every known study [on dissociative amnesia] has found amnesia for childhood sexual abuse in at least a portion of the sampled individuals" (Scheflin & Brown, 1996, pp. 178-179). Mulder et al. (1998) found that childhood sexual abuse was two-and-a-half times more likely in individuals who were experiencing dissociative amnesia. Linehan (1993) emphasizes that there is typically an absence of memory for individuals who have been severely traumatized. Horowitz (1986) also points out that in the denial phase of the traumatic event, complete or partial amnesia is often a component. It is important to note that Briere's (1989) symptoms 1-3, 7, and 18 outlined in this chapter overlap with both dissociative amnesia and PTSD. Mulder et al. (1998) found, however, that childhood sexual abuse was only related to dissociative amnesia in the presence of another mental disorder. "Childhood sexual abuse was related to current mental state . . . which was in turn related to dissociation" (Mulder et al., 1998, pp. 808-809).

As stated previously, dissociative amnesia is most often an indicator of childhood sexual abuse (Coons, 1994; Goff et al., 1991; Modestin et al., 1996; Saxe et al., 1993). Linehan (1993) discusses the fact that most of the individuals presenting with PTSD will report at least one incidence of childhood sexual abuse. Burgess (1995) states that "etiologic processes [physical changes in the brain] are the first line of memory disturbance in post-traumatic stress disorder" (p. 21). Additionally, "these alterations may be linked to any of the PTSD symptoms that may appear later on in the victim's life" (Flannery, 1995, p. 45). Briere and Conte (1993) found that the "variables most predictive of abuse-related amnesia were greater current psychological symptoms" (p. 21). Also, the relationship between trauma and ongoing emotional problems is often overlooked and undertreated (Chadwick Center for Children and Families, 2004; Chaffin & Friedrich, 2004).

It appears that the question that must be asked is "which came first?" Does a person have a dissociative experience as a result of a traumatic event, and *then* develop PTSD, or is PTSD the response to the traumatic event, and dissociative amnesia develops in the course of the disorder? PTSD may develop as the response to a traumatic event (Bremner et al., 1995; Briere, 1989; Elliott & Briere, 1995; Linehan, 1993), and it is that response, resulting in the suppression of traumatic memories, that may eventually bring about a dissociative episode, namely, dissociative amnesia (Coons, 1994; Goff et al., 1991; Modestin et al., 1996; Saxe et al., 1993). That is not to say that every person who is diagnosed with PTSD will have a dissociative episode; however, the chances are very good that memories may be suppressed as a coping method (Burgess, 1995). It is this memory suppression that may lead to dissociative amnesia. "Dissociation is a biological

adaptive process arising out of physiological changes associated with the response to the trauma events" (Burgess, 1995, p. 24). "Schemas develop that either avoid internal tension or attempt to contain higher levels of internal tension" (p. 24). It is this "attempt to contain higher levels of internal tension" that may spark a dissociative episode. "PTSD can be considered as an expression of, or to overlap with, dissociation and dissociative disorders" (Tomb, 1994, p. 243). As such, identifying overlapping characteristics can lead to a more timely and effective PTSD diagnosis (Dryden-Edwards, 2007; Parkinson, 2000; Tull, 2008).

Some interventions to prevent PTSD, and as a result, dissociative amnesia, are education, coping skills training, sleep management, self-and-buddy care, social support, and health care provider education and training (Ursano & Norwood, 1996). Of particular importance is accurate assessment and effective treatment recommendations (Perry, 2006). In fact, recent studies indicate that adequate social support by itself can significantly reduce the likelihood of an individual's development of PTSD (Erbes, Polusny, Arbisi, & Koffel, 2012; Kiecolt-Glaser & Greenberg, 1994; Pietrzak, Johnson, Goldstein, Malley, & Southwick, 2009; Prati & Pietrantoni, 2009).

Research Studies of Additional Interest

Toward gathering information on cognitive processing in individuals who have experienced trauma, a demographic category of "handedness" was included in this study. Of additional interest in the relationship between biology and dissociative amnesia may be determining handedness in individuals. According to Broca (1865) and Annett (1970), handedness has been correlated to brain lateralization. In other words, it may be possible to draw correlations between the likelihood of an individual to develop dissociative

amnesia simply according to the individual's dominant hand preference (Annett, 1970; Broca, 1865). Individuals who are predominantly right-handed typically utilize the left side of their brain more heavily (Sommer, Ramsey, Mandl, & Kahn, 2002). The left side of the brain is responsible for "understanding and use of language (listening, reading, speaking and writing), memory for spoken and written messages, detailed analysis of information, and control of the right side of the body" (Centre for Neuro Skills, 2010, p. 2). "Underfunction of the left hemisphere produces different memory traces, and experience is stored and interpreted in a different manner" (Burgess, 1995, p. 19). Thus, any treatment interventions may need to take into account brain lateralization differences as well as how trauma may affect spoken and receptive language (Sommer et al., 2002).

CHAPTER THREE

METHODOLOGY

Introduction

The prior chapter briefly discussed the variables of dissociative amnesia, PTSD, and childhood sexual abuse through a review of the literature. Table 1 outlined risk factors for the development of post-traumatic stress disorder; Table 2 outlined selected studies of dissociative amnesia for experiences of childhood sexual abuse. This chapter describes the sample/population, response rate, the data-collection process, the data-collection tool itself, and the selected methodology used in the study.

Research Design

This quantitative, non-experimental study used a therapist-completed data collection tool. The data collection tool compiled brief client demographics, episodes of dissociative amnesia, symptomology of PTSD, reported childhood sexual abuse, and previously documented abuse obtained from child protective services records. Analysis was conducted through the use of binary logistic regression in order to determine the nature of the relationship between the two independent variables of dissociative amnesia and PTSD and the dependent variable of childhood sexual abuse.

Purpose and Research Questions

This study used secondary data to examine the relationship between childhood sexual abuse, symptomology of post-traumatic stress disorder, episodes of dissociative amnesia, and selected demographic characteristics toward educating clinicians about the importance of working with clients from a trauma-informed care perspective. The core questions of this study were:

1. What is the incidence of childhood sexual abuse in the study sample?
2. What is the incidence of episodes of dissociative amnesia in the study sample?
3. What is the incidence of PTSD symptoms in the study sample?
4. What is the relationship between childhood sexual abuse and the demographic characteristics of gender, ethnicity, age, educational level, and handedness?
5. What is the relationship between childhood sexual abuse, symptoms of PTSD, and episodes of dissociative amnesia?

Sample/Population

The population for this study consists of families that were currently actively involved with the State of Michigan Child Protective Services in Kent County, Michigan. In this county these services are administrated by the Bethany Christian Services' Early Impact Program. Bethany's Early Impact Program is currently serving approximately 350 families per year. Of these families, 35-40% represent families of minority color and culture: 60% demonstrate difficulties related to substance abuse, 30% are challenged by undiagnosed or untreated mental health issues, 45% struggle with physical and mental health challenges, and up to 60% of adults report child abuse and/or neglect within their own childhood histories (Bethany Christian Services, 2003). A convenience sample for

this study was utilized, which included 350 individual adults from a population of 350 families, all of whom were referred for therapeutic intervention through the State of Michigan's Kent County Child Protective Services. A convenience sample was utilized due to the availability and likelihood of relevant data for this study. As the referred individuals were referred to Bethany Christian Services on a mandatory basis, 350 was the entire referral population for the year and thus representative of the general population of active child protective services families in Kent County, Michigan. Given the generational cycle of child abuse (Bethany Christian Services, 2003), it was highly likely that the convenience sample would contain individuals with prior childhood sexual abuse history. According to Ko et al. (2008), "perhaps no other child-serving system encounters a higher percentage . . . with a trauma history than the child welfare system" (p. 397).

Instrumentation

The data-collection tool (see Appendix E) consists of three pages and is a researcher-designed checklist that records general demographic information, episodes of dissociation and/or amnesia, symptoms of PTSD as listed by the *DSM-IV-TR*, a data-specifier from the client's risk assessment form previously completed by the State of Michigan Child Protective Services, and a "yes" or "no" response on whether the client previously disclosed childhood sexual abuse during the therapist's clinical interview. Page 1 of the data-collection tool is a demographic page to record information on the subject's sex, age, handedness, highest degree completed, and racial origin. Page 2 of the data-collection tool requests information of the subject's history of episodes of dissociation/amnesia in the form of a list. Specifically, information is requested

regarding the subject's age at the time of the occurrence and the event itself. No identifying subject information is requested. Continuing on page 2, and concluding on page 3 of the data-collection tool, is a checklist of questions recorded from the *DSM-IV-TR* as the diagnostic criteria for determining whether an individual has PTSD (American Psychiatric Association, 2000). Finally, the conclusion on page 3 gathers information from the subject's risk assessment form completed by the State of Michigan Child Protective Services (history of abuse [as victim]–yes or no) (see Appendix J), and whether the subject disclosed sexual abuse (as victim) during the therapist's clinical interview (yes or no). A categorical breakdown of the data-collection tool is listed in Table 3.

The process of determining usability of the data-collection tool was accomplished through utilizing information from two anonymous initial clinical assessments (Appendices G and I), and requesting that five Master's-level therapists complete a data-collection tool for each case. The number of therapists was selected based upon usability research, which indicates that five individuals are capable of finding 85% of the errors (Dumas & Redish, 1993; Nielsen & Landauer, 1993; Rubin, 1994). The two anonymous initial clinical assessments were selected specifically so that one case contained all three of the research variables, while the other case did not. Upon completion of scoring the therapist-completed data-collection tools for these anonymous assessments using the data-collection-tool scoring-template (see Appendix F), it was determined that all of the therapists had correctly identified and classified both assessments. It is important to note that content validity of the data-collection tool was not required, as the diagnostic items are in common usage via the *DSM-IV-TR*, the primary diagnostic and statistical manual

Table 3

Data-Collection Tool Variable Measures

Item	Response Choices
	Demographics
Subject's sex	Male; female
Subject's age	18-24; 25-34; 35-44; 45-54; 55-64; 65+
Is subject (handedness)	Right-handed; left-handed; dual-handed (ambidextrous)
Highest degree subject completed	High school or equivalent; vocational/technical school (2 year); some college; college graduate (4 year); master's degree (MA, MS, MSW); doctoral degree (PhD); professional degree (MD, JD, etc.); other (please describe: _____)
Subject's racial origin	Caucasian/white; African American; Indigenous or aboriginal; Asian/Pacific Islander; Hispanic; Latino; Multiracial; Other (please describe: _____)
	Dissociative Amnesia
Episodes of Dissociation/amnesia (please list/describe)	(Narrative) Client's age at time of occurrence; event
	PTSD
Has the client (please check as appropriate)	Experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others; response involved intense fear, helplessness, or horror
If either of the above is checked, does the client have any of the following (please check as appropriate)	Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions; recurrent distressing dreams of the event; acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated); intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event; physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

Table 3—*Continued*.

Item	Response Choices
Does the client have any of the following (please check as appropriate)	Efforts to avoid thoughts, feelings, or conversations associated with the trauma; efforts to avoid activities, places, or people that arouse recollections of the trauma; inability to recall an important aspect of the trauma; markedly diminished interest or participation in significant activities; feeling of detachment or estrangement from others; restricted range of affect (e.g., unable to have loving feelings); sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)
Does the client have any of the following (please check as appropriate)	Difficulty falling or staying asleep; irritability or outbursts of anger; difficulty concentrating; hypervigilance; exaggerated startle response
Has this lasted for more than 1 month	Yes; no
Does the above cause clinically significant distress or impairment in social, occupational, or other important areas of functioning	Yes; no
Childhood Sexual Abuse	
Did client's risk assessment form list history of abuse (as victim)	Yes; no
Did client disclose sexual abuse (as victim) during clinical interview	Yes; no

utilized by mental health clinicians (American Psychiatric Association, 2000), and as such have already been validated for diagnostic purposes.

Data-Collection Process

Research utilizing the data-collection tool based on initial assessment data was conducted at Bethany Christian Services in Grand Rapids, Michigan. The data-collection process was conducted via an agency-wide email invitation to therapists

currently providing services to active Child Protective Services clients who were employed in Bethany Christian Services' Early Impact or Advanced Impact programs (see Appendix C). The email invitation included the research letter (see Appendix D) and the data-collection tool (see Appendix E). The research letter emphasized the data-collection process, in that the data were being collected by Master's-level therapists for each child-protective-services-referred adult client within the past year. In addition, the research letter emphasized that data were being collected via a data-collection tool from pre-existing client data already maintained in agency files and not collected for this researcher. Master's-level therapists provided anonymous information via the data-collection tool for each initial assessment completed within a 12-month period prior to the study timeframe, which began in May 2007, and continued through October 2007, thus utilizing secondary data sources. The data-collection tools were placed in a mailbox labeled "Research Study" in the central mailroom of the agency. The data-collection tools were then forwarded to me via US mail at the conclusion of the research time period (approximately December 2007). No identifying information for either the therapist or the subject was included with the data-collection tools, so as to ensure compliance with Institutional Review Board guidelines. Additionally, the data were subsequently reviewed by external epidemiologists and clinicians in order to avoid researcher bias. Response rate for completed data-collection tools was 43% (n=149).

Data-Collection Tool Coding

In order to analyze data collected via the data-collection tool, it was necessary to code the data utilizing a binary system (0, 1) and classify each data point for "scale" analysis in the selected statistical reporting software. Data coding conversion resulted in

73 data points, which were coded according to the following classifications: Demographics, Dissociative Amnesia, PTSD, and Childhood Sexual Abuse (see Table 4).

Data Sets for Primary Hypothesis

With regard to data sets for the primary hypothesis (symptomology of PTSD and dissociative amnesia as indicators of childhood sexual abuse), the data points compared were Amnesia 1 = yes, Client 1a = yes, Client 1b = yes, 1 of any of Client 2a, 2b, 2c, 2d, 2e = yes, 3 of any of Client 3a, 3b, 3c, 3d, 3e, 3f, 3g = yes, 2 of any of Client 4a, 4b, 4c, 4d, 4e = yes, Duration = yes, Distress = yes, and History = yes (see Table 5).

Data Analysis

Data were analyzed utilizing SPSS 16.0 for Windows (2008). In order to examine the relationship between variables, I primarily utilized binary logistic regression analysis. According to StatSoft, Inc. (2010), "In general, . . . regression allows the researcher to ask (and hopefully answer) the general question 'what is the best predictor of'" (General Purpose section, para. 4). Logistic regression also allows for modeling the likelihood of a "yes" response when comparing the dependent variable to items such as demographics and independent variables. Additionally, binary logistic regression is used when the dependent variable is dichotomous (i.e., the only possible responses are either "yes" or "no"). It is important to clarify that regression analysis does not determine *causality*, but only indicates relationship between variables. For the purposes of this study, the independent variables of episodes of dissociative amnesia and symptomology of PTSD were compared to the dependent variable of childhood sexual abuse.

Table 4.

Data Coding Conversion

Item	Data Coding Options
	Demographics
Subject's sex	Gender 1 (Male) – No = 0, Yes = 1 Gender 2 (Female) – No = 0, Yes = 1
Subject's age	Age 1 (18-24 Years) – No = 0, Yes = 1 Age 2 (25-34 Years) – No = 0, Yes = 1 Age 3 (35-44 Years) – No = 0, Yes = 1 Age 4 (45-54 Years) – No = 0, Yes = 1 Age 5 (55-64 Years) – No = 0, Yes = 1 Age 6 (65+ Years) – No = 0, Yes = 1
Is subject (handedness)	Hand 1 (right-handed) – No = 0, Yes = 1 Hand 2 (left-handed) – No = 0, Yes = 1 Hand 3 (dual-handed/ambidextrous) – No = 0, Yes = 1
Highest degree subject completed	Degree 1 (High school or equivalent) – No = 0, Yes = 1 Degree 2 (Vocational/technical school/2 year) – No = 0, Yes = 1 Degree 3 (Some college) – No = 0, Yes = 1 Degree 4 (College graduate/4 year) – No = 0, Yes = 1 Degree 5 (Master's degree/MA, MS, MSW) – No = 0, Yes = 1 Degree 6 (Doctoral degree/PhD) – No = 0, Yes =1 Degree 7 (Professional degree/MD, JD, etc.) - No = 0, Yes = 1 Degree 8 (Other/please describe:) - No = 0, Yes = 1
Subject's racial origin	Race 1 (Caucasian/white) – No = 0, Yes = 1 Race 2 (African American) – No = 0, Yes = 1 Race 3 (Indigenous or aboriginal) – No = 0, Yes = 1 Race 4 (Asian/Pacific Islander) – No = 0, Yes = 1 Race 5 (Hispanic) – No = 0, Yes = 1 Race 6 (Latino) – No = 0, Yes = 1 Race 7 (Multiracial) – No = 0, Yes = 1 Race 8 (Other/please describe:) - No = 0, Yes = 1
	Dissociative Amnesia
Episodes of Dissociation/amnesia	Amnesia 1 (Episodes of Dissociation/Amnesia) – No = 0, Yes = 1

Table 4—*Continued.*

Item	Data Coding Options
Client's Age at Time of Occurrence	Amnesia 2a (Age 0-4) – No = 0, Yes = 1 Amnesia 2b (Age 5-9) – No = 0, Yes = 1 Amnesia 2c (Age 10-14) – No = 0, Yes = 1 Amnesia 2d (Age 15-19) – No = 0, Yes = 1 Amnesia 2e (Age 20-24) – No = 0, Yes = 1 Amnesia 2f (Age 25-34) – No = 0, Yes = 1 Amnesia 2g (Age 35-44) – No = 0, Yes = 1 Amnesia 2h (Age 45-54) – No = 0, Yes = 1 Amnesia 2i (Age 55-64) – No = 0, Yes = 1 Amnesia 2j (Age 65+) - No = 0, Yes = 1 Amnesia 2k (Unspecified childhood) – No = 0, Yes = 1 Amnesia 2l (Unspecified adulthood) – No = 0, Yes = 1
Type of amnestic event	Amnesia 3a (Blackouts) – No = 0, Yes = 1 Amnesia 3b (Blanks in memory) – No = 0, Yes = 1 Amnesia 3c (Complete loss of memory) – No = 0, Yes = 1 Ammesia 3d -3j (To be determined) – No = 0, Yes = 1
	PTSD
Client experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others	Client 1a (Experienced) – No = 0, Yes = 1
Client's response involved intense fear, helplessness, or horror	Client 1b (Response involved) – No = 0, Yes = 1
Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions	Client 2a (Recurrent and intrusive) – No = 0, Yes = 1
Recurrent distressing dreams of the event	Client 2b (Recurrent distressing) – No = 0, Yes = 1
Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated)	Client 2c (Acting) – No = 0, Yes = 1

Table 4—*Continued.*

Item	Data Coding Options
Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event	Client 2d (Intense) – No = 0, Yes = 1
Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event	Client 2e (Physiological) – No = 0, Yes = 1
Efforts to avoid thoughts, feelings, or conversations associated with the trauma	Client 3a (Efforts to avoid thoughts) – No = 0, Yes = 1
Efforts to avoid activities, places, or people that arouse recollections of the trauma	Client 3b (Efforts to avoid activities) – No = 0, Yes = 1
Inability to recall an important aspect of the trauma	Client 3c (Inability) – No = 0, Yes = 1
Markedly diminished interest or participation in significant activities	Client 3d (Markedly) – No = 0, Yes = 1
Feeling of detachment or estrangement from others	Client 3e (Feeling of detachment) – No = 0, Yes = 1
Restricted range of affect (e.g., unable to have loving feelings)	Client 3f (Restricted) – No = 0, Yes = 1
Sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)	Client 3g (Sense of a foreshortened) – No = 0, Yes = 1
Difficulty falling or staying asleep	Client 4a (Difficulty falling) – No = 0, Yes = 1
Irritability or outbursts of anger	Client 4b (Irritability) – No = 0, Yes = 1
Difficulty concentrating	Client 4c (Difficulty concentrating) – No = 0, Yes = 1
Hypervigilance	Client 4d (Hypervigilance) – No = 0, Yes = 1
Exaggerated startle response	Client 4e (Exaggerated) – No = 0, Yes = 1
Has this lasted for more than 1 month	Duration (month) – No = 0, Yes = 1

Table 4—*Continued*

Item	Data Coding Options
Childhood Sexual Abuse	
Did client's risk assessment form list history of abuse (as victim)	History (Risk assessment form) – No = 0, Yes = 1
Did client disclose sexual abuse (as victim) during clinical interview	Disclose (Disclose sexual abuse) – No = 0, Yes = 1

As stated previously, research questions were identified that looked at the incidence of childhood sexual abuse, episodes of dissociative amnesia, and symptomology of PTSD in the study sample. The research questions additionally looked at the relationship between childhood sexual abuse and demographic characteristics of the sample including gender, ethnicity, age, educational level, and handedness. Finally, the research questions assisted in examining the relationship between the three variables of childhood sexual abuse, episodes of dissociative amnesia, and symptoms of PTSD.

Table 5.

Variable Data Set Classification

Data Set	Triad Interaction	Sexual Abuse	PTSD	Dissociative Amnesia
Amnesia 1 (episodes of dissociation/amnesia)	= yes			= yes (alone)
Client 1a (experienced, witnessed, or was confronted)	yes		= yes	
Client 1b (response involved intense fear)	= yes		= yes	
Client 2a-2e (recurrent and intrusive recollections, recurrent distressing dreams, acting or feeling as if the traumatic event were recurring, intense psychological distress at exposure, physiological reactivity on exposure)	1 of any = yes		1 of any = yes	
Client 3a-3g (efforts to avoid thoughts, efforts to avoid activities, inability to recall, markedly diminished interest, feeling of detachment, restricted range of affect, sense of a foreshortened future)	3 of any = yes		3 of any = yes	3c = yes (with History = yes and Disclose = no)
Client 4a-4e (difficulty with sleep, irritability, difficulty concentrating, hypervigilance, exaggerated startle)	2 of any = yes		2 of any = yes	
Duration (lasted more than 1 month)	= yes		= yes	
Distress (clinically significant distress)	= yes		= yes	
History (risk assessment form listed history of abuse)	= yes	= yes (either/or)		= yes (with Disclose = no)

Table 5—*Continued.*

Data Set	Triad Interaction	Sexual Abuse	PTSD	Dissociative Amnesia
Disclose (client disclosed history of sexual abuse)		= yes (either/or)		= no (with History = yes)

CHAPTER FOUR

RESULTS

Introduction

The prior chapter described the sample/population, response rate, the data-collection process, the data-collection tool itself, and the selected methodology used in the study. The purpose of this study was to examine (a) the incidences of childhood sexual abuse, episodes of dissociative amnesia, and symptoms of Post-Traumatic Stress Disorder (PTSD) and (b) the extent to which commonality of episodes of dissociative amnesia and symptomology of PTSD are related to childhood sexual abuse in a sample of 149 adult subjects toward educating clinicians about the importance of working with clients from a trauma-informed care perspective. This chapter presents demographic characteristics of subjects and results of the analyses for each of the five research questions.

Demographic Characteristics of the Sample

Table 6 outlines the demographic characteristics of the sample. Demographic characteristics were divided into categories of gender, age group, level of education, racial group, and handedness.

Subjects in this study were predominantly female (90.6%). With regard to age group, those most commonly represented were 18-24 (35.6%), 25-34 (35.6%), and 35-44 (22.8%), with approximately 2/3 of the sample (71.2%) being aged 18-34.

Approximately 40% of the subjects reported their highest level of education as "high school or equivalent." Most subjects (61.1%) indicated that they are "Caucasian/White," although almost one-third of subjects (28.9%) identified themselves as "African American." About 87% of the subjects identified themselves as being predominantly right-handed.

Data Analysis

Research Question 1

Research question 1 asks, "What is the incidence of childhood sexual abuse in the study sample?" In this study, sexual abuse was defined as whether an individual has experienced childhood sexual abuse by either disclosing that experience or a history of childhood sexual abuse that was previously documented by Child Protective Services. The purpose for this definition is that an individual may disclose a history of abuse but Child Protective Services has no historical record of such abuse (Bethany Christian Services, 2003). Also, an individual may have a history of abuse, but not disclose any abuse during the clinical interview (Linehan, 1993; Walker, 1994). This may signify that the individual is experiencing some level of amnesia surrounding the event (Briere, 1989; Horowitz, 1986; Linehan, 1993; Tomb, 1994; Walker, 1994). As such, data regarding an individual's disclosure of sexual abuse were compared with whether the individual had a documented history of sexual abuse. Frequency analysis indicates that 71 subjects (or 47.7% of the sample) experienced childhood sexual abuse. Thus, the incidence of childhood sexual abuse in the study sample is 71 out of 149 subjects. Frequency analysis is delineated in Table 7.

Table 6

Demographic Characteristics of the Sample (n=149)

Characteristics	*n*	%
Gender		
Male	14	9.4
Female	135	90.6
Age Group		
18-24	53	35.6
25-34	53	35.6
35-44	34	22.8
45-54	9	6.0
Level of Education		
High School/Equivalent	59	39.6
Vocational/Technical School	6	4.0
Some college	11	7.4
College Graduate	1	0.7
Master's Degree	3	2.0
Other	1	0.7

Table 6—*Continued.*

Characteristics	*n*	%
Racial Group		
Caucasian/White	91	61.1
African American	43	28.9
Indigenous/Aboriginal	2	1.3
Asian/Pacific Islander	1	0.7
Hispanic	7	4.7
Multiracial	3	2.0
Other	1	0.7
Handedness		
Right-handed	129	86.6
Left-handed	18	12.1
Ambidextrous	1	0.7

Note. Percentages for some categories may not equal 100 due to missing responses.

Research Question 2

Research question 2 asks, "What is the incidence of episodes of dissociative amnesia in the study sample?" In this study, dissociative amnesia was defined as those subjects who identified either a specific amnestic event or who had a documented history of childhood sexual abuse by Child Protective Services but who did not disclose the abuse. Frequency analysis indicates that one subject identified specific amnestic events, and another 20 subjects (or 13% of the sample) (for a total of 21 subjects) possessed a documented child protective services history of abuse but did not either report or indicate memory of childhood abuse. The lack of memory of childhood abuse is measured by

Table 7

Frequency of Childhood Sexual Abuse (n=149)

Variable	*n*	%
No history of childhood sexual abuse	78	52.3
History of childhood sexual abuse	71*	47.7
History of Childhood Sexual Abuse		
Disclosed in intake	52	34.9
By Child Protective Service History	64	43.0

*It is important to note that the sub-items for "History of Childhood Sexual Abuse" ("disclosed in intake" and "by child protective service history") do not equal 71 due to the numbers not being mutually exclusive when measuring "history of childhood sexual abuse" as a data set. Of the 71 individuals who were categorized as having a "history of childhood sexual abuse," 64 of the 71 had a documented child protective service history for abuse, and an additional 7 individuals disclosed sexual abuse but did not have a documented child protective service history for abuse. In other words, individuals identified with a "history of childhood sexual abuse" were categorized by a) a documented child protective service history or b) a disclosure of childhood sexual abuse during therapist intake that was undocumented by Child Protective Services.

symptom "inability to recall important aspect" and as such was included as a criterion for episodes of dissociative amnesia. Thus, the incidence of episodes of dissociative amnesia in the study sample is 21 out of 149 subjects. Frequency analysis is delineated in Table 8.

Research Question 3

Research question 3 asks, "What is the incidence of PTSD symptoms in the study sample?" In this study, individuals were categorized on a continuum from "least" to "greatest" PTSD, which was determined by the number of PTSD symptoms as outlined in the following sections. In addition, there were individuals who presented various combinations of PTSD symptomology but did not meet specific criteria for "greatest"

Table 8

Frequency of Episodes of Dissociative Amnesia (n=149)

Variable	*n*	%
No episodes of dissociative amnesia	128	85.90
Episodes of dissociative amnesia	21	14.10
Episodes of Dissociative Amnesia		
Reported specific amnestic events	1	0.01
Child Protective Service history/ no disclosure	20	13.40

PTSD (see Appendix K). The delineation of "least" to "greatest" PTSD is based upon research by Harvey and Bryant (1998), which reported gradations of PTSD or "partial" PTSD. The National Research Council (2008) found that positive responses on two to three PTSD criteria yielded a strong likelihood of PTSD. The National Research Council (2008) also found that the endorsement of the symptom of "irritability" (Criterion 4b) was a positive indicator of the presence of PTSD.

"Least" PTSD

The data points utilized in determining whether an individual met criteria for "least" PTSD were whether an individual had experienced a traumatic event (data collection tool item Client 1a) and whether the individual's response involved intense fear (data collection tool item Client 1b). Frequency analysis for "least" PTSD indicates that 83 subjects (or 55.7% of the sample) met criteria for "least" PTSD.

“Greatest” PTSD

The data points utilized in determining whether an individual met criteria for “greatest” PTSD were consistent with *DSM-IV-TR* diagnostic criteria, that is, the individual met the criteria for “least” PTSD stated above, in addition to one symptom from PTSD Cluster 2 (recurrent and intrusive recollections [data collection tool item Client 2a], recurrent distressing dreams [data collection tool item Client 2b], acting or feeling as if traumatic event were recurring [data collection tool item Client 2c], intense psychological distress at exposure [data collection tool item Client 2d], physiological reactivity on exposure [data collection tool item Client 2e]), three symptoms from PTSD Cluster 3 (efforts to avoid thoughts [data collection tool item Client 3a], efforts to avoid activities [data collection tool item Client 3b], inability to recall important aspect [data collection tool item Client 3c], markedly diminished interest [data collection tool item Client 3d], feeling of detachment [data collection tool item Client 3e], restricted range of affect [data collection tool item Client 3f], sense of a foreshortened future [data collection tool item Client 3g]), two symptoms from PTSD Cluster 4 (difficulty with sleep [data collection tool item Client 4a], irritability [data collection tool item Client 4b], difficulty concentrating [data collection tool item Client 4c], hypervigilance [data collection tool item Client 4d], exaggerated startle response [data-collection tool item Client 4e]), the symptoms have lasted longer than one month (data-collection tool item Duration), and the symptoms are causing the client clinically significant distress (data collection tool item Distress). Frequency analysis for “greatest” PTSD indicates that 24 subjects (or 16.1% of the sample) met full PTSD diagnostic criteria as listed above.

“One-off” PTSD

In the process of data analysis, it was discovered that 12 subjects (or 8%) were missing only one criterion (“one-off”) from full PTSD diagnostic criteria listed above. The concept of "one-off" PTSD is consistent with Harvey and Bryant (1998). Of the 12 subjects who met the "one-off" standard, no subjects were missing the criterion of Duration (sole criterion). Approximately 41% of subjects (5; *n*=12) were missing 1 criterion from PTSD Cluster 3 (need 3 in this cluster). Twenty-five percent of subjects (3; *n*=12) were missing 1 criterion from PTSD Cluster 2 (need 1 in this cluster), 25% of subjects (3; *n*=12) were missing 1 criterion from PTSD Cluster 4 (need 2 in this cluster), and 8.3% of subjects (1; *n*=12) were missing the criterion of Distress (sole criterion).

“Other Combination” PTSD

Of the 83 subjects who met “least” PTSD criteria, additional frequency analysis indicated that 56 subjects experienced at least one symptom from PTSD Cluster 2, 77 subjects experienced at least one symptom from PTSD Cluster 3, and 71 subjects experienced at least one symptom from PTSD Cluster 4 (see Table 9).

In summary, the incidence of PTSD in the study sample is that there were 83 subjects who met "least" PTSD criteria, 24 subjects who met "greatest" PTSD criteria, and 12 subjects who met "one-off" PTSD criteria.

Research Question 4

Research question 4 asks, “What is the relationship between childhood sexual abuse and the demographic characteristics of gender, ethnicity, age, educational level,

Table 9

Incidence of PTSD (n=149)

Categories	*n*	%
"Least" PTSD	83	55.7
"Greatest" PTSD	24	16.1
"One-off" PTSD	12	8.0
"Other Combination" PTSD		
PTSD Cluster 2	56	37.6
PTSD Cluster 3	77	51.7
PTSD Cluster 4	71	47.7

and handedness?" Listed in Table 10 are the results of frequency analysis for subjects who experienced childhood sexual abuse compared to demographic characteristics. Listed in Table 11 are the results of chi-square analysis for subjects who experienced childhood sexual abuse compared to demographic characteristics. The results of frequency analysis indicate that more females (68 subjects out of 71 subjects) experienced childhood sexual abuse than did males (3 subjects). Additionally, 55 subjects who experienced childhood sexual abuse were aged 18-34, and 58 subjects who experienced childhood sexual abuse were right-handed. Twenty-eight subjects who experienced childhood sexual abuse had at least a high-school education, and 43 subjects who experienced childhood sexual abuse were Caucasian. The results of chi-square analysis indicate that, among females, 50.4% experienced childhood sexual abuse compared to only 21.4% among males. This difference is statistically significant

Table 10

Frequency Relationship Between Demographic Variables and Subjects Who Experienced Childhood Sexual Abuse (n=149)

Variable	*n*	%
Gender		
Female	68	45.6
Male	3	2.0
Age Group		
18-24	25	16.8
25-34	30	20.1
35-44	14	9.4
45-54	2	1.3
Handedness		
Right	58	38.9
Left	11	7.4
Ambidextrous	1	0.7
Level of Education		
High School/equivalent	28	18.8
Vocational/technical school	3	2.0
Some college	5	3.4
College graduate	0	0.0
Master's degree	0	0.0
Other	1	0.7

Table 10—*Continued.*

Variable	*n*	%
	Racial Group	
Caucasian/white	43	28.9
African American	18	12.1
Indigenous/Aboriginal	1	0.7
Asian/Pacific Islander	1	0.7
Hispanic	5	3.4
Multiracial	2	1.3
Other	0	0.0

(*p*=0.039). Childhood sexual abuse was not significantly related to other demographic characteristics such as ethnicity, age, educational level, and handedness.

In summary, the relationship between childhood sexual abuse and the demographic characteristics of gender, ethnicity, age, educational level, and handedness in the study sample is that a significantly larger proportion of females (50.4%) than males (21.4%) had experienced childhood sexual abuse. These findings are consistent with prior research regarding gender (U.S. Department of Health and Human Services, 2007). Childhood sexual abuse was not significantly related to the other demographic characteristics.

Research Question 5

Research question 5 asks, “What is the relationship between symptoms of PTSD, childhood sexual abuse, and episodes of dissociative amnesia?"

Table 11

Childhood Sexual Abuse and Selected Demographic Characteristics (n=149)

		Abuse				
Variables	***n***	**No**	**Yes**	***x²***	***df***	***p***
		Gender				
Female	135	49.6	50.4	4.26*	1	0.039
Male	14	78.6	21.4			
		Ethnicity				
White	91	52.7	47.3	0.34	1	0.558
Black	43	58.1	41.9			
		Age Group				
18-24	53	52.8	47.2	4.61	3	0.202
25-34	53	43.4	56.6			
35-44	34	58.8	41.2			
45-54	9	77.8	22.2			
		Education				
High School/Equivalent	59	52.5	47.5	0.28	1	0.599
Other	22	59.1	40.9			
		Handedness				
Right	129	55.0	45.0	1.65	1	0.198
Left	18	38.9	61.1			

Note. Totals for some characteristics may not equal sample size due to missing responses.
*$p<.05$.

Childhood Sexual Abuse and PTSD

Frequency analysis for PTSD indicates that of the individuals who met criteria for "least" PTSD (*n*=83), 85.5% experienced childhood sexual abuse. Frequency analysis also indicates that of the subjects who qualified for "greatest" PTSD (*n*=24), 100% experienced childhood sexual abuse. Additional frequency analysis indicates that of the subjects who met criteria for "one-off" PTSD (*n*=12), 91.7% experienced childhood sexual abuse. Of particular interest from frequency analysis is that several symptoms of PTSD were present in the majority of individuals who had experienced childhood sexual abuse (see Table 12). Such symptoms include "recurrent and intrusive recollections" (53.5%), "recurrent distressing dreams" (54.9%), "efforts to avoid thoughts" (85.9%), "efforts to avoid activities" (70.4%), "feeling of detachment" (64.8%), and "difficulty with sleep" (62%).

To fully examine the relationships between childhood sexual abuse and PTSD symptoms, hierarchical (sequential) logistic regression analysis was employed. First-stage predictors were the 'least' PTSD symptoms while second-stage predictors were the 'greatest' PTSD symptoms.

In Stage 1, a test of the full model versus a model with intercept only was statistically significant, χ^2 (1, n=149) = 79.21, p<0.001. The model correctly classified 76.9% of those with no history of sexual abuse and 91.5% of those with history of sexual abuse for an overall correct classification of 83.9%. In Stage 2, the full model against a model with intercept only was statistically significant, χ^2 (16, n=149) = 52.51, p<0.001. The model correctly classified 93.6% of those with no history of sexual abuse and 87.3% of those with history of sexual abuse for an overall correct classification of 90.6%.

Table 12

PTSD Symptoms in Subjects Compared to Childhood Sexual Abuse (n=149)

	Childhood Sexual Abuse (*n*=71)		**No Childhood Sexual Abuse (*n*=78)**	
PTSD Symptoms	***n***	**%**	***n***	**%**
Experienced traumatic event	65	91.5	18	23.1
Response involved intense fear	65	91.5	18	23.1
Recurrent and intrusive recollections	38	53.5	5	6.4
Recurrent distressing dreams	39	54.9	4	5.1
Acting or feeling as if traumatic event were recurring	2	2.8	0	0.0
Intense psychological distress at exposure	24	33.8	3	3.8
Physiological reactivity on exposure	8	11.3	1	1.3
Efforts to avoid thoughts	61	85.9	12	15.4
Efforts to avoid activities	50	70.4	3	3.8
Inability to recall important aspect	9	12.7	1	1.3
Markedly diminished interest	3	4.2	0	0.0
Feeling of detachment	46	64.8	2	2.6
Restricted range of affect	2	2.8	0	0.0
Sense of a foreshortened future	0	0.0	0	0.0
Difficulty with sleep	44	62.0	12	15.4
Irritability	29	40.8	4	5.1
Difficulty concentrating	34	47.8	4	5.1
Hypervigilance	15	21.1	2	2.6
Exaggerated startle response	4	5.6	1	1.3
Lasted more than 1 month	60	100.0*	19	24.4**
Causes clinically significant distress	37	60.7	7	9.0***

*11 data collection tools were missing a response to this item.
** 59 data collection tools were missing a response to this item.
***58 data collection tools were missing a response to this item.

Regression coefficients, Wald statistics, *p* value, and Odds-Ratio results of the logistic regression analysis are shown in Table 13.

In Stage 1, the model explained about 55% (Negelkerke R^2=0.55) of the variance in sexual abuse. However, the only significant predictor of childhood sexual abuse was whether or not the subject experienced traumatic event(s). With a negative regression coefficient (-3.59), the inverted Odds-Ratio (*OR*=0.03) indicates that subjects who experienced traumatic events were approximately 33 times more likely to have been sexually abused.

In Stage 2, the model explained about 78% (Negelkerke R^2=0.783) of the variance in childhood sexual abuse. Significant predictors are efforts to avoid activities (*p*=0.007), feeling of detachment (*p*=0.028), and irritability (*p*=0.023). With a negative regression coefficient (-2.85), an inverted Odds-Ratio (*OR*=0.058) for 'efforts to avoid activities' suggests that subjects who avoid activities, places, or people that arouse recollection of the trauma are about 17 times more likely to have been sexually abused. Similarly, an inverted Odds-Ratio (*OR*=0.049) for 'feeling of detachment' shows that subjects who feel detached or estranged from others are about 20 times more likely to have been sexually abused. Finally, an inverted Odds-Ratio (*OR*=0.128) for 'irritability' indicates that subjects who are irritable and/or burst into anger are approximately eight times more likely to have been sexually abused.

Thus, taken together, it appears that subjects who were sexually abused are more likely (a) to have experienced traumatic events, and that they are more likely (b) to avoid activities, places, or people that remind them of these traumatic events, (c) to feel

Table 13

Results of Hierarchical Logistic Regression of PTSD Symptoms in Individuals Who Have Experienced Childhood Sexual Abuse (n=71)

	"Least" PTSD				**"Greatest" PTSD**			
PTSD Symptoms	***b***	***Wald***	***p***	***OR***	***b***	***Wald***	***p***	***OR***
			Stage 1					
Experienced traumatic event	-3.587***	50.59	0.000	0.03				
Nagelkerke R^2		0.55						
Chi-Square		79.21						
df		1						
p		.000						
			Stage 2					
Experienced traumatic event					-1.06	1.07	0.30	0.35
Recurrent and intrusive recollections					0.81	0.59	0.44	2.24
Recurrent distressing dreams					-0.29	0.07	0.80	0.75
Acting or feeling as if traumatic event were recurring					-16.63	0.00	1.00	.00
Intense psychological distress at exposure					1.11	0.51	0.48	3.05
Physiological reactivity on exposure					1.39	0.39	0.54	4.01
Efforts to avoid thoughts					-0.64	0.35	0.56	0.53
Efforts to avoid activities					-2.85*	7.33	0.01	0.06
Inability to recall important aspect					-0.40	0.03	0.86	0.67

Table 13—*Continued.*

	"Least" PTSD				"Greatest" PTSD			
PTSD Symptoms	***b***	***Wald***	***p***	***OR***	***b***	***Wald***	***p***	***OR***
Markedly diminished interest					-15.06	0.00	1	.00
Feeling of detachment					-3.02*	4.81	0.03	0.05
Restricted range of affect					-12.20	0.00	1.00	.00
Difficulty with sleep					-0.51	0.45	0.50	0.60
Irritability					-2.06*	5.18	0.02	0.13
Difficulty concentrating					-0.97	0.91	0.34	0.38
Hypervigilance					1.26	0.36	0.55	3.52
Exaggerated startle response					-1.54	0.36	0.55	0.21
Negelkerke R^2		0.78						
Chi-Square		52.51						
df		16						
p		.000						

*$p<.05$. **$p<.01$. ***$p<.001$.

detached or estranged from other people, and (d) exhibit irritability and/or outbursts of anger.

Dissociative Amensia and PTSD

With regard to episodes of dissociative amnesia, frequency analysis for PTSD and dissociative amnesia indicates that of the 83 individuals who met the criteria for "least" PTSD, 19 (22.9%) experienced episodes of dissociative amnesia. Frequency analysis also indicates that of the 24 individuals who met criteria for "greatest" PTSD, six (25%) experienced episodes of dissociative amnesia. Additional frequency analysis for "one-

off" PTSD indicates that 4 out of 12 (33.3%) individuals experienced episodes of dissociative amnesia. It should be noted that several symptoms of PTSD were present in the majority of individuals who experienced dissociative amnesia (see Table 14). Such symptoms include "efforts to avoid thoughts," "efforts to avoid activities," "feeling of detachment," "difficulty with sleep," and "difficulty concentrating."

To fully examine the relationships between episodes of dissociative amnesia and PTSD symptoms, hierarchical (sequential) logistic regression analysis was employed. First-stage predictors were the 'least' PTSD symptoms while second-stage predictors were the 'greatest' PTSD symptoms.

In Stage 1, a test of the full model versus a model with intercept only was statistically significant, χ^2 (1, n=149) = 13.96, p<0.001. The model correctly classified 100% of those with no history of episodes of dissociative amnesia and 0% of those with history of episodes of dissociative amnesia for an overall correct classification of 85.9%. In Stage 2, the full model against a model with intercept only was statistically significant, χ^2 (16, n=149) = 35.48, p<0.01. The model correctly classified 96.1% of those with no history of episodes of dissociative amnesia and 47.6% of those with history of episodes of dissociative amnesia for an overall correct classification of 89.3%. Regression coefficients, Wald statistics, p value, and Odds-Ratio results of the logistic regression analysis are shown in Table 15.

In Stage 1, the model explained about 16% (Negelkerke R^2=0.16) of the variance in episodes of dissociative amnesia. However, the only significant predictor of episodes of dissociative amnesia was whether or not the subject experienced traumatic event(s). With a negative regression coefficient (-2.25), the inverted Odds-Ratio (OR=0.11)

Table 14

PTSD Symptoms in Subjects Compared to Dissociative Amnesia (n=149)

	Dissociative Amnesia (*n*=21)		**No Dissociative Amnesia (*n*=128)**	
PTSD Symptoms	***n***	**%**	***n***	**%**
Experienced traumatic event	19	90.5	64	50.0
Response involved intense fear	19	90.5	64	50.0
Recurrent and intrusive recollections	9	42.9	34	26.6
Recurrent distressing dreams	7	33.3	36	28.1
Acting or feeling as if traumatic event were recurring	2	9.5	0	0.0
Intense psychological distress at exposure	6	28.6	21	16.4
Physiological reactivity on exposure	2	9.5	7	5.5
Efforts to avoid thoughts	16	76.2	57	44.5
Efforts to avoid activities	15	71.4	38	30.0
Inability to recall important aspect	1	4.8	9	7.0
Markedly diminished interest	1	4.8	2	1.6
Feeling of detachment	12	57.1	36	28.1
Restricted range of affect	2	9.5	0	0.0
Sense of a foreshortened future	0	0.0	0	0.0
Difficulty with sleep	11	52.4	45	35.2
Irritability	9	42.9	24	18.8
Difficulty concentrating	11	52.4	27	21.1
Hypervigilance	3	14.3	14	10.9
Exaggerated startle response	2	9.5	3	2.3
Lasted more than 1 month	17	81.0	62	48.4
Causes clinically significant distress	13	61.9	31	24.2

indicates that subjects who experienced traumatic events were approximately nine times more likely to have experienced episodes of dissociative amnesia.

In Stage 2, the model explained about 51% (Negelkerke R^2=0.507) of the variance in experienced episodes of dissociative amnesia. Significant predictors are experienced traumatic event (p=0.037), recurrent distressing dreams (p=0.025), irritability (p=0.023), and difficulty concentrating (p=0.037). With a negative regression coefficient (-2.42), an inverted Odds-Ratio (OR=0.09) for 'experienced traumatic event' suggests that subjects who have experienced a traumatic event are about 11 times more likely to have experienced episodes of dissociative amnesia. Similarly, an Odds-Ratio (OR=19.04) for 'recurrent distressing dreams' shows that subjects who experience dreams that recur and are distressing are about 19 times more likely to have experienced episodes of dissociative amnesia. Additionally, an inverted Odds-Ratio (OR=0.14) for 'irritability' shows that subjects who are irritable and/or burst into anger are approximately seven times more likely to have experienced episodes of dissociative amnesia. Finally, an inverted Odds-Ratio (OR=0.12) for 'difficulty concentrating' indicates that subjects who have difficulty concentrating are approximately eight times more likely to have experienced episodes of dissociative amnesia. Thus, taken together, it appears that subjects who have experienced episodes of dissociative amnesia are more likely (a) to have experienced traumatic events, and that they are more likely (b) to experience recurrent distressing dreams, (c) to exhibit irritability and/or outbursts of anger, and (d) have difficulty concentrating.

Childhood Sexual Abuse and Dissociative Amnesia

The relationship between childhood sexual abuse and dissociative amnesia is

Table 15

Results of Hierarchical Logistic Regression of PTSD Symptoms in Individuals Who Have Experienced Episodes of Dissociative Amnesia (n=19)

	"Least" PTSD				**"Greatest" PTSD**			
PTSD Symptoms	***b***	***Wald***	***p***	***OR***	***b***	***Wald***	***p***	***OR***
				Stage 1				
Experienced traumatic event	-2.25**	8.68	0.003	0.11				
Nagelkerke R^2		0.16						
Chi-Square		13.96						
df		1						
p		.000						
				Stage 2				
Experienced traumatic event					-2.42*	4.33	0.04	0.09
Recurrent and intrusive recollections					1.38	1.69	0.19	3.96
Recurrent distressing dreams					2.95*	5.00	0.03	19.04
Acting or feeling as if traumatic event were recurring					-21.32	0.00	1.00	0.00
Intense psychological distress at exposure					-1.06	0.73	0.39	0.35
Physiological reactivity on exposure					1.46	0.94	0.33	4.29
Efforts to avoid thoughts					0.71	0.47	0.49	2.03
Efforts to avoid activities					-1.39	2.30	0.13	0.25
Inability to recall important aspect					2.42	3.13	0.08	11.24
Markedly diminished interest					21.08	0.00	1.00	1.43

Table 15—*Continued.*

	"Least" PTSD				"Greatest" PTSD			
PTSD Symptoms	***b***	***Wald***	***p***	***OR***	***b***	***Wald***	***p***	***OR***
Feeling of detachment					-1.27	2.03	0.16	0.28
Restricted range of affect					-24.06	0.00	1.00	0.00
Difficulty with sleep					1.05	2.00	0.16	2.87
Irritability					-1.97*	5.19	0.02	0.14
Difficulty concentrating					-2.09*	4.37	0.04	0.12
Hypervigilance					1.90	1.73	0.19	6.66
Exaggerated startle response					-3.37	2.63	0.11	0.03
Negelkerke R^2	0.51							
Chi-Square	35.48							
df	16							
p	.003							

*p<.05. **p<.01. ***p<.001.

shown in Table 16. No subjects who were not sexually abused experienced dissociative amnesia. However, 21 of the 71 subjects who were sexually abused were also diagnosed with dissociative amnesia. This relationship between childhood sexual abuse and dissociative amnesia is statistically significant (χ^2=26.86, df=1, p<0.001, Cramer's V=0.43). The magnitude of this relationship is moderate at 0.43.

The table also indicates that all 21 subjects who were diagnosed with dissociative amnesia were sexually abused. Additionally, of those 21 subjects, 6 (28.6%) met "greatest" PTSD criteria; 19 (90.5%) met "least" PTSD criteria. In other words, 90.5%

Table 16

Relationship Between Childhood Sexual Abuse and Dissociative Amnesia (n=149)

		Dissociative Amnesia				
Group		**No**	**Yes**	χ^2	***p***	***V***
Sexual Abuse	No	78 (100.0)	0 (0.0)	26.9	0	0.4
	Yes	50 (70.4)	21 (29.6)			

Note. *df*=1.

of the subjects who experienced dissociative amnesia and childhood sexual abuse also experienced "least" PTSD symptoms (see Table 17).

In summary, the relationship between symptoms of PTSD, childhood sexual abuse, and episodes of dissociative amnesia is that childhood sexual abuse and dissociative amnesia are moderately correlated at 0.43. Additionally, 78% of the variation in childhood sexual abuse can be explained by variation in PTSD symptoms. Subjects who experienced childhood sexual abuse were (a) more likely to have experienced traumatic events, (b) more likely to avoid activities, places, or people that remind them of these traumatic events, (c) more likely to feel detached or estranged from other people, and (d) more likely to exhibit irritability and/or outbursts of anger. Approximately 51% of the variation in dissociative amnesia can be explained by variation in PTSD symptoms. Subjects who have experienced episodes of dissociative amnesia are (a) more likely to have experienced traumatic events, (b) more likely to experience recurrent distressing dreams, (c) more likely to exhibit irritability and/or outbursts of anger, and (d) more likely to have difficulty concentrating.

Table 17

PTSD Symptoms Related to Childhood Sexual Abuse for Subjects Who Experienced Episodes of Dissociative Amnesia (n=21)

PTSD Symptoms	*n*	%
Experienced traumatic event	19	90.5
Response involved intense fear	19	90.5
Recurrent and intrusive recollections	9	42.9
Recurrent distressing dreams	7	33.3
Acting or feeling as if traumatic event were recurring	2	9.5
Intense psychological distress at exposure	6	28.6
Physiological reactivity on exposure	2	9.5
Efforts to avoid thoughts	16	76.2
Efforts to avoid activities	15	71.4
Inability to recall important aspect	1	4.8
Markedly diminished interest	1	4.8
Feeling of detachment	12	57.1
Restricted range of affect	2	9.5
Sense of a foreshortened future	0	0.0
Difficulty with sleep	11	52.4
Irritability	9	42.9
Difficulty concentrating	11	52.4
Hypervigilance	3	14.3
Exaggerated startle response	2	9.5
Lasted more than 1 month	17	81.0
Causes clinically significant distress	13	61.9

Summary of Major Findings

This chapter has discussed the results of the data analyses with regard to the major research questions. Subjects in this study were predominantly: female (90.6%), aged 18-44, Caucasian, and right-handed. Approximately 40% of the subjects reported a high-school diploma or equivalent level of education. The incidence of childhood sexual abuse among subjects was 47.7%. The incidence of episodes of dissociative amnesia among subjects was 14.1%. The incidence of PTSD symptoms among subjects was 56% for "least" PTSD, and 16.1% for "greatest" PTSD. Eight percent of subjects were missing only one criterion for a full PTSD diagnosis. A significantly larger proportion of females (50.4%) than males (21.4%) in the study sample experienced childhood sexual abuse.

With regard to the relationship between symptoms of PTSD, childhood sexual abuse, and episodes of dissociative amnesia, childhood sexual abuse and dissociative amnesia are moderately correlated at 0.43. There are certain PTSD symptoms that predict childhood sexual abuse. Of the subjects who met criteria for "least" PTSD, 85.5% had experienced childhood sexual abuse. Of the subjects who met criteria for "greatest" PTSD, 100% experienced childhood sexual abuse. Of the subjects who met criteria for "one-off" PTSD, 91.7% experienced childhood sexual abuse. Subjects who were sexually abused are more likely to have experienced traumatic events, more likely to avoid activities, places, or people that remind them of these traumatic events, more likely to feel detached or estranged from other people, and more likely to exhibit irritability and/or outbursts of anger.

Additionally, certain PTSD symptoms predict dissociative amnesia. Of the subjects who met criteria for "least" PTSD, 22.9% had experienced episodes of dissociative amnesia. Of the subjects who met criteria for "greatest" PTSD, 25% had experienced episodes of dissociative amnesia. Of the subjects who met criteria for "one-off" PTSD, 33.3% had experienced episodes of dissociative amnesia. Subjects who experienced episodes of dissociative amnesia are more likely to have experienced traumatic events, more likely to experience recurrent distressing dreams, more likely to exhibit irritability and/or outbursts of anger, and more likely to have difficulty concentrating.

CHAPTER FIVE

SUMMARY, DISCUSSION, RECOMMENDATIONS, AND CONCLUSIONS

Summary

Purpose

This study used secondary data to examine the relationship between childhood sexual abuse, symptomology of post-traumatic stress disorder, episodes of dissociative amnesia, and selected demographic characteristics.

Research Questions

The core questions of this study were:

1. What is the incidence of childhood sexual abuse in the study sample?
2. What is the incidence of episodes of dissociative amnesia in the study sample?
3. What is the incidence of PTSD symptoms in the study sample?
4. What is the relationship between childhood sexual abuse and the demographic characteristics of gender, ethnicity, age, educational level, and handedness?
5. What is the relationship between childhood sexual abuse, symptoms of PTSD, and episodes of dissociative amnesia?

In this study, childhood sexual abuse was defined as whether an individual had experienced such abuse by either disclosing that experience or a history of childhood sexual abuse was previously documented by Child Protective Services. Additionally, an

individual may have a history of abuse, but not disclose any abuse during the clinical interview (Linehan, 1993; Walker, 1994). This lack of disclosure may signify that the individual is experiencing some level of amnesia surrounding the event (Briere, 1989; Horowitz, 1986; Linehan, 1993; Tomb, 1994; Walker, 1994). As such, data regarding an individual's disclosure of sexual abuse was compared with whether the individual had a documented history of sexual abuse. This comparison was included in the category of "dissociative amnesia," as all subjects in the study who experienced episodes of dissociative amnesia also experienced childhood sexual abuse due to the above classification.

Literature Review

Unreported childhood sexual abuse is a hindering factor to client progress in therapy (Briere, 1989; Linehan, 1993; Walker, 1994). Childhood sexual abuse is pervasive, and is one of the most intimate crimes against a person (Briere, 1989; Burgess, 1995; Kezelman, 2011; Linehan, 1993; Walker, 1994). My prior work experience with Child Protective Services provided information that abuse often occurs in generational cycles. Without acknowledgment of past abuse, there is little hope of complete recovery, and thus a risk of abuse continues to exist for the children of the victim (Bethany Christian Services, 2003; Briere, 1989; Burgess, 1995; Linehan, 1993; Walker, 1994). Through recovery, it is hoped that the generational cycle of abuse can be broken, creating a safer home environment for children.

It is estimated that in the general population there is a 2 to 6% likelihood of the presence of dissociative amnesia (Mulder et al., 1998; Sar et al., 2007; Seedat et al., 2003). Dissociative amnesia is more commonly reported in women (Putnam et al., 1996;

Saxe et al., 1993; Widom & Morris, 1997). "Dissociative amnesia most commonly presents as a retrospectively reported gap or series of gaps in recall for aspects of the individual's life history. These gaps are usually related to traumatic or extremely stressful events" (American Psychiatric Association, 2000, p. 520). Researchers have also found that individuals who experience dissociative amnesia have also experienced childhood sexual abuse (Coons, 1994; Goff et al., 1991; Hopper, 2006; Modestin et al., 1996; Saxe et al., 1993). In fact, Linehan (1993) emphasizes that there is typically an absence of memory for individuals who have been severely traumatized. In cases of childhood sexual abuse, researchers have propounded the idea of dissociation as a protective defense (Middleton, 2004). "Children who are severely physically, sexually, and psychologically abused in early childhood . . . are at high risk to develop a . . . dissociative disorder" (Walker, 1994, p. 100). Additionally, when an individual is unable to recall a period of time, that time period is most often the time period of the trauma (Degun-Mather, 2002). "Every known study [on dissociative amnesia] has found amnesia for childhood sexual abuse in at least a portion of the sampled individuals" (Scheflin & Brown, 1996, pp. 178-179). Horowitz (1986) points out that in the denial phase of the traumatic event, complete or partial amnesia is often a component. Difficulty in the search for meaning related to a traumatic event may be a precursor to the prevalence of episodes of dissociative amnesia for trauma victims. When circumstances no longer make sense, a person has an increased risk of withdrawing from the situation (a dissociative episode) in order to attempt to control the effects of the traumatic event. The ultimate method of withdrawal is dissociative amnesia, in that the person can create an

entirely new identity, apart from the one who experienced the traumatic event (Tomb, 1994; Walker, 1994).

PTSD results from an individual's experience of a traumatic event and the lack of the individual's ability to appropriately synthesize that information. The key component for the initiation of PTSD assessment is whether or not an individual experienced a traumatic event that caused the individual to experience intense feelings of fear, helplessness, or horror (American Psychiatric Association, 2000). Additionally, Burgess (1995) indicates that dissociative amnesia may actually be a significant first indicator of PTSD. PTSD is the disorder most frequently either misdiagnosed or missed completely by professionals (Schonfeld et al., 1997). It is estimated that between 12 to 39% of individuals in medical primary care settings meet the criteria for PTSD (Samson et al., 1999; Stein et al., 2000). Inconsistent criterion identification of symptoms of PTSD is consistent with the literature on the relationship of childhood sexual abuse and PTSD (Bremner et al., 1995; Elliott & Briere, 1995). Van der Kolk (1994) reported that "[PTSD], by definition, is accompanied by memory disturbances consisting of both hypermnesias [inability to forget] and amnesias" (p. 253).

Identifying the possibility of a significant relationship between childhood sexual abuse, symptoms of PTSD, and episodes of dissociative amnesia is both relevant and useful in the therapeutic setting (Kezelman, 2011). Therapists frequently offer inappropriate therapeutic interventions based upon inaccurate and incomplete client information (Hanson et al., 2002; Kezelman, 2011). It is common practice for therapists to gather historical data from clients and determine diagnoses based upon that information (Cooper et al., 2007). Unless a therapist is providing assessment for

documentation purposes (such as for court or a paid evaluation), therapists typically do not use standardized instruments to assess client symptomology. Identifying indicative factors for a history of childhood sexual abuse and including them in a standardized therapeutic assessment will assist therapists by alerting them to this possibility at the beginning of the therapeutic relationship as opposed to several months into therapy. Ko et al. (2008) state that "effective trauma screening and assessment protocols are needed at every level" (p. 398). In addition, Taylor et al. (2006) emphasize that service providers in child welfare systems need to have expertise in trauma treatment services that are research-based. As recently as 2011, Kezelman stated that "few service systems or workers have the insight and awareness needed to appropriately acknowledge and support [a] survivor's fundamental needs" (para. 4). Kezelman (2011) also emphasized that "frequently the possibility of underlying trauma is not on a health professional's radar at all or if known about, is not viewed as pivotal. Agencies should routinely consider the possibility of trauma even when it hasn't been disclosed" (para. 15). A history of trauma is important in determining type and length of treatment (Briere, 1989; Burgess, 1995; Chu, 2011; Lanktree & Briere, 2011; Linehan, 1993; Walker, 1994). Conducting research into ways to help mental health providers assess and identify a client's trauma history early on in treatment is a best-practice method which is currently highlighted as a need by the trauma-informed care agencies and literature (Kezelman, 2011; Ko et al., 2008; SAMHSA, 2012, 2013).

This study used secondary data to examine the relationship between childhood sexual abuse, symptomology of post-traumatic stress disorder, episodes of dissociative amnesia, and selected demographic characteristics. Based on literature review and

secondary data available, it was predicted that childhood sexual abuse would be significantly related to symptomology of PTSD and episodes of dissociative amnesia.

Methods

For more than 25 years Bethany Christian Services has provided home-based counseling services through the Early Impact program under continuously renewed contracts with Child Protective Services. Referrals are received from Child Protective Services for children who have been found to have been abused and/or neglected, and Master's-level therapists provide weekly counseling, parental education and support, clinical intervention, and case management services that specifically address family problems and issues that put children at risk for future or continued instances of child abuse and/or neglect. Of the family services provided, 30% of the cases require court involvement and 60% of families struggle with a substance abuse problem (Bethany Christian Services, 2003). Counseling services are provided once per week, for an average of 4 to 6 months, and are intended to prevent the removal of children from their homes by strengthening families and reducing the ongoing risk of child endangerment. The long-term goal of the program is to reduce the risk that abuse or neglect will continue to occur, by breaking the generational cycle of child abuse and neglect (Bethany Christian Services, 2003).

Data for this study were collected from pre-existing client data already maintained in agency files out of an annual subject pool of 350. A total of 149 data-collection tools were returned (43% response rate). Therapists provided anonymous information via a data-collection tool which compiled brief client demographics, episodes of dissociative amnesia, symptomology indicative of PTSD, reported childhood sexual abuse, and a

data-specifier available on the client's risk assessment form previously completed by Child Protective Services. The data-collection tool is a researcher-designed checklist that recorded general demographic information, episodes of dissociation and/or amnesia, symptoms of post-traumatic stress disorder as listed by the *DSM-IV-TR*, a data-specifier from the client's risk-assessment form previously completed by Child Protective Services, and a "yes or no" response on whether the client previously disclosed childhood sexual abuse during the therapist's clinical interview. The usability of the data-collection tool was assessed with practicing Master's-level Child Protective Services therapists.

Therapists affiliated with Bethany Christian Services' Early Impact Program were requested to participate in the study via research letter. Demographic information for subjects was gathered, but in no way to identify a specific individual. Participation in the research project was entirely voluntary. Therapists did not identify themselves when completing data-collection tools, thus providing additional protection for both participant and therapist confidentiality. There was no reimbursement for therapist participation. Data collection occurred between May 2007, and October 2007, and data were gathered from cases that were initiated with Bethany Christian Services for the 12-month period prior to May 2007. Data were analyzed using frequency distribution, Chi-Square analysis, and binary logistic regression.

Results

Sample Representativeness

At the time of the study, Bethany's Early Impact Program was serving approximately 350 families per year. Of those families, 35-40% represent families of minority color and culture, 60% demonstrate difficulties related to substance abuse, 30%

are challenged by undiagnosed or untreated mental health issues, 45% struggle with physical and mental health challenges, and up to 60% of adults report child abuse and/or neglect within their own childhood histories (Bethany Christian Services, 2003). A convenience sample for this study was utilized, which included 350 individual adults, all of whom were referred for therapeutic intervention through the State of Michigan's Kent County Child Protective Services. A convenience sample was utilized due to the availability and likelihood of relevant data for this study. Since the referred individuals were referred to Bethany Christian Services on a mandatory basis, 350 was the entire referral population for the year and thus representative of the general population of active Child Protective Services families in Kent County, Michigan. Given the generational cycle of child abuse (Bethany Christian Services, 2003), it was highly likely that the convenience sample would contain individuals with prior childhood sexual abuse history. According to Ko et al. (2008), "perhaps no other child-serving system encounters a higher percentage . . . with a trauma history than the child welfare system" (p. 397).

Summary of Results

Subjects in this study were predominantly female (90.6%), right-handed (87%), aged between 18-34 (71.2%), and Caucasian (61.1%). Approximately 40% of subjects reported their highest level of education as "high school or equivalent." The incidence of childhood sexual abuse among subjects was 47.7%. A significantly larger proportion of females (50.4%) than males (21.4%) had experienced childhood sexual abuse (see Table 18). However, according to the data, the only area of significance indicated was that it is more likely individuals who have experienced childhood sexual abuse will be female.

Research findings are consistent with prior research with regard to gender (U.S. Department of Health and Human Services, 2007).

The incidence of PTSD among subjects was 55.7% for “least” PTSD, and 16.1% for “greatest” PTSD. Eight percent of subjects were missing only one criterion for a full PTSD diagnosis ("one-off" PTSD) (see Table 19).

The incidence of episodes of dissociative amnesia among subjects was 14.1% (see Table 20), with one individual reporting specific amnestic events and 20 individuals possessing a Child Protective Services history of abuse.

With regard to the relationship between childhood sexual abuse, symptoms of PTSD, and episodes of dissociative amnesia, childhood sexual abuse and dissociative amnesia are moderately correlated at 0.43. Additionally, 78% of the variation in childhood sexual abuse can be explained by variation in PTSD symptoms. Also, approximately 51% of the variation in dissociative amnesia can be explained by variation in PTSD symptoms. There are certain PTSD symptoms that predict childhood sexual abuse including avoiding activities, places, or people that remind them of traumatic events, feeling detached or estranged from other people, and exhibiting irritability and/or outbursts of anger. There are also certain PTSD symptoms that predict dissociative amnesia including the experience of recurrent distressing dreams, exhibiting irritability and/or outbursts of anger, and difficulty concentrating.

Table 18

Childhood Sexual Abuse and Selected Demographic Characteristics (n=149)

		Abuse				
Variables	***n***	**No**	**Yes**	***x²***	***df***	***p***
		Gender				
Female	135	49.6	50.4	4.26*	1	0.039
Male	14	78.6	21.4			
		Ethnicity				
White	91	52.7	47.3	0.34	1	0.558
Black	43	58.1	41.9			
		Age Group				
18-24	53	52.8	47.2	4.61	3	0.202
25-34	53	43.4	56.6			
35-44	34	58.8	41.2			
45-54	9	77.8	22.2			
		Education				
High School/Equivalent	59	52.5	47.5	0.28	1	0.599
Other	22	59.1	40.9			
		Handedness				
Right	129	55.0	45.0	1.65	1	0.198
Left	18	38.9	61.1			

Note. Totals for some characteristics may not equal sample size due to missing responses.
*$p<.05$.

Discussion

History of Childhood Sexual Abuse

Out of a sample group of 149, 71 subjects (47.7%) reported (or were documented to have) a history of childhood sexual abuse. This was determined by either a self-report of childhood sexual abuse or Child Protective Services records that indicated a history of childhood sexual abuse. Additionally, a significantly larger proportion of females (50.4%) than males (21.4%) had experienced childhood sexual abuse. Such numbers are reinforced through research conducted by the U.S. Department of Health and Human Services (2007), as out of an estimated 794,000 U.S. children who were determined to be victims of abuse or neglect, 7.6% children experienced childhood sexual abuse, of whom 51.5% were girls and 48.2% were boys.

Symptomology of PTSD

With regard to the incidence of symptomology PTSD in the study sample, out of a sample group of 149, 24 subjects (16.1%) endorsed enough criteria to qualify for a full diagnosis of PTSD according to the *DSM-IV-TR*. Twelve subjects (8.1%) were missing only one criterion for a full PTSD diagnosis ("one-off" PTSD). As discussed in Chapter 4, the data sets for PTSD were expanded in order to measure PTSD on a continuum from "least" to "greatest" ("greatest" being full DSM-IV-TR PTSD diagnosis). Once the data sets were expanded, 83 subjects (55.7%) qualified for "least" PTSD diagnosis. It is important to note that simply because criteria were not endorsed for PTSD does not mean the individual would not qualify for a diagnosis of PTSD. The intake assessment currently in use by Bethany Christian Services' therapists does not specifically ask for symptomology of PTSD, nor did the subjects or therapists complete a standardized

Table 19

Incidence of PTSD (n=149)

Categories	*n*	%
"Least" PTSD	83	55.7
"Greatest" PTSD	24	16.1
"One-off" PTSD	12	8.0
"Other Combination" PTSD		
PTSD Cluster 2	56	37.6
PTSD Cluster 3	77	51.7
PTSD Cluster 4	71	47.7

PTSD-specific measurement scale. Thus, if symptoms of PTSD were endorsed in the data-collection tool, either the client disclosed symptoms of PTSD unsolicited, or the therapist was familiar enough with PTSD to determine that the client was disclosing symptoms of PTSD. It is additionally important to note that one of the criteria for "greatest" PTSD diagnosis is a positive response to the question, "Does the above cause clinically significant distress or impairment in social, occupational, or other important areas of functioning?" This question may not be positively endorsed by clients if the PTSD symptoms are by history as opposed to currently being experienced.

Episodes of Dissociative Amnesia

Only one subject out of the sample group of 149 reported specific episodes of dissociative amnesia. In order to have increased data available for analysis and to

Table 20

Frequency of Episodes of Dissociative Amnesia (n=149)

Variable	*n*	%
No episodes of dissociative amnesia	128	85.90
Episodes of dissociative amnesia	21	14.10
Episodes of dissociative amnesia		
Reported specific amnestic events	1	0.01
Child Protective Service history/no disclosure	20	13.40

incorporate any outliers, the data sets for the variable of dissociative amnesia were expanded to include those subjects who answered "yes" to data-collection tool item Client 3c ("inability to recall an important aspect of the trauma") and who also had a Child Protective Services documented history of childhood sexual abuse but who did not disclose childhood sexual abuse during the intake assessment. This expanded data set yielded one additional subject. Again, in order to have increased data available for analysis and to incorporate any outliers, the data sets were further expanded to also include subjects who had a Child Protective Services documented history of childhood sexual abuse and who did not disclose childhood sexual abuse during the intake assessment. This yielded an additional 19 subjects, for a total of 21 subjects or 14.1% of the sample. These numbers are consistent with other research findings (Hopper, 2006). Additionally, Williams (1994) reported that in 68% of cases, individuals with documented histories of childhood sexual abuse did not report the abuse. "The closer the

relationship to the perpetrator and the younger the child at the time, the greater the likelihood an incident was (apparently) not remembered" (Hopper, 2006, p. 17). Widom and Shepard (1996) reported "substantial underreporting by . . . abused respondents" (p. 412). In other words, "approximately 40% of individuals with documented histories of . . . abuse did not report" (Widom & Shepard, 1996, p. 419). "Every known study [on dissociative amnesia] has found amnesia for childhood sexual abuse in at least a portion of the sampled individuals" (Scheflin & Brown, 1996, pp. 178-179).

With regard to possible interpretation regarding why only one subject reported specific episodes of dissociative amnesia, it is important to remember that the intake assessment completed by the therapist does not ask specific questions designed to elicit responses regarding episodes of dissociative amnesia. For the purposes of the data-collection tool, the therapist only recorded episodes of dissociative amnesia if the subject disclosed such information unsolicited. The initial data set expansion to include data-collection tool item Client 3c was purposeful in that Client 3c is the component of PTSD that inquires about whether the subject has an inability to recall an important aspect of the trauma (i.e., amnesia). It is important to note, however, that the single subject reporting specific episodes of dissociative amnesia did not endorse data point Client 3c, but did endorse both a Child Protective Services history of childhood sexual abuse and did not disclose childhood sexual abuse during the intake assessment, consistent with Williams (1994) and Widom and Shepard (1996). Because of this, the data set for dissociative amnesia was further expanded to include the final two data points of Child Protective Services history of childhood sexual abuse and no disclosure of childhood sexual abuse during the intake assessment.

Childhood Sexual Abuse and Comparison With Symptomology of PTSD and Episodes of Dissociative Amnesia

With regard to the relationship between childhood sexual abuse and symptoms of PTSD in the study sample, out of a sample group of 149, 83 subjects (55.7%) endorsed criteria for a "least" diagnosis of PTSD. Of those 83 subjects, 85.5% experienced childhood sexual abuse. Of the 24 subjects (16.1%) who qualified for a "greatest" diagnosis of PTSD, 100% experienced childhood sexual abuse. Of the 12 subjects (8.1%) who qualified for a "one-off" diagnosis of PTSD, 91.7% experienced childhood sexual abuse. Frequency analysis indicated that several symptoms of PTSD were present in the majority of subjects who had experienced childhood sexual abuse. Those symptoms include "recurrent and intrusive recollections" (53.5%), "recurrent distressing dreams" (54.9%), "efforts to avoid thoughts" (85.9%), "efforts to avoid activities" (70.4%), "feeling of detachment" (64.8%), and "difficulty with sleep" (62%). Regression analysis indicated that subjects who were sexually abused are more likely to have experienced traumatic events; they are also more likely to avoid activities, places, or people that remind them of these traumatic events, they are more likely to feel detached or estranged from other people, and they are more likely to exhibit irritability and/or outbursts of anger. Thus, the data suggest a prediction can be made that if an individual has experienced childhood sexual abuse, that individual will also meet criteria for a diagnosis of "least" PTSD, as well as will also experience one or more symptoms of PTSD including "efforts to avoid activities" ($p<.01$), "feeling of detachment" ($p<.05$), and "irritability" ($p<.05$). These symptoms of PTSD are consistent with the literature on the relationship of childhood sexual abuse and symptoms of PTSD (Bremner et al., 1995; Elliott & Briere, 1995). In addition, two of the symptoms (PTSD Criteria 3b and 3e) are

consistent with the findings of the National Research Council (2008) which highlighted a primary care PTSD screen (PC-PTSD) consisting of an introductory statement (PTSD Criteria 1 a/b) and four questions (PTSD Criteria 2b, 3 a/b, 4 d/e, and 3e) (Prins et al., 2003). The results are also supported by recent research, which has determined that the likelihood of PTSD can be indicated by sole endorsement of Criterion 1a that asks the question, "Has the individual experienced a traumatic event?" (National Research Council, 2008). Additionally, the National Research Council (2008) found that the endorsement of the symptom of "irritability" (Criterion 4b) was a positive indicator of the presence of PTSD.

With regard to the relationship between symptoms of PTSD and reported episodes of dissociative amnesia in the study sample, out of a sample group of 149, of the 83 subjects who qualified for "least" PTSD, 19 subjects (22.9%) experienced episodes of dissociative amnesia. Of the 24 subjects who qualified for "greatest" PTSD, six subjects (25%) experienced episodes of dissociative amnesia. Of the 12 subjects who were "one-off" from "greatest" PTSD, four subjects (33.3%) experienced episodes of dissociative amnesia. It is important to note that with regard to the one subject who reported specific episodes of dissociative amnesia, that subject qualified for a diagnosis of "least" PTSD. Frequency analysis indicated that several symptoms of PTSD were present in the majority of subjects who had experienced episodes of dissociative amnesia. Those symptoms include "efforts to avoid thoughts," "efforts to avoid activities," "feeling of detachment," "difficulty with sleep," and "difficulty concentrating." Regression analysis indicated that subjects who experienced episodes of dissociative amnesia are more likely to have experienced traumatic events, and they are also more likely to experience

recurrent distressing dreams, more likely to exhibit irritability and/or outbursts of anger, and more likely to have difficulty concentrating. Thus, the data suggest that for those individuals who have experienced episodes of dissociative amnesia, they are more likely to also have the following symptoms of PTSD: "recurrent distressing dreams" ($p<.05$), "irritability" ($p<.05$), and "difficulty concentrating" ($p<.05$). These symptoms of PTSD are also consistent with Van der Kolk's (1994) research which reported that "[PTSD], by definition, is accompanied by memory disturbances consisting of both hypermnesias [inabilities to forget] and amnesias" (p. 253). In addition, Elliott and Briere (1995) found that "subjects who had recently recalled aspects of their abuse reported particularly high levels of posttraumatic symptomology and self difficulties" (p. 629). Brewin and Andrews (1998) stated that "amnesia may be partial or profound, and individuals can often given accounts of deliberate strategies they use to banish distressing memories from consciousness. Recovered memories may be fragmented, emotion-laden, and similar to intrusive memories of the PTSD patient" (p. 958). Brewin et al. (1996) additionally state that "traumas experienced after early childhood give rise to 2 sorts of memory. . . . These different types of memory are used to explain the complex phenomenology of PTSD, including the experiences of reliving the traumatic event and of emotionally processing the trauma" (p. 670). Van der Kolk and Fisler (1995) implicated dissociation as the "central pathogenic mechanism that gives rise to . . . PTSD" (p. 505).

With regard to the nature of the joint relationship between the variables of childhood sexual abuse, symptomology of PTSD, and episodes of dissociative amnesia in the study sample, childhood sexual abuse and dissociative amnesia are moderately correlated at 0.43. Out of a sample group of 149, of the 21 subjects who experienced

dissociative amnesia, 21 (or 100%) also experienced childhood sexual abuse. Also of those 21 subjects, six (28.6%) met "greatest" PTSD criteria; 19 (90.5%) met "least" PTSD criteria. In other words, 90.5% of the subjects who experienced dissociative amnesia and childhood sexual abuse also experienced "least" PTSD symptoms (see Table 21). As such, the data suggest that if an individual has experienced dissociative amnesia, it is likely that individual will meet "least" PTSD criteria, in addition to PTSD symptoms of "recurrent distressing dreams," "irritability," and "difficulty concentrating." Further, the data suggest that if an individual has experienced childhood sexual abuse it is likely that individual will meet "least" PTSD criteria, in addition to PTSD symptoms of "efforts to avoid activities," "feeling of detachment," and "irritability."

Thus, the data support the primary research hypothesis that the combination of symptoms of PTSD and episodes of dissociative amnesia can be indicators of childhood sexual abuse, specifically the overlapping PTSD symptom cluster 1 ("traumatic event" and "response involved intense fear") and the individual PTSD symptom of "irritability." This has important treatment implications in that any symptoms of PTSD and reported episodes of dissociative amnesia should warrant further investigation and the likelihood of treatment for childhood sexual abuse trauma alongside other presenting reasons for treatment.

Research Limitations

With reference to research limitations, one limitation that may be present with regard to data collection is the therapist's uncertainty in recognizing symptomology of PTSD. When the group of Master's-level therapists were field testing the data-

Table 21

PTSD Symptoms Related to Childhood Sexual Abuse for Subjects Who Experienced Episodes of Dissociative Amnesia (n=21)

PTSD Symptoms	***n***	**%**
Experienced traumatic event	19	90.5
Response involved intense fear	19	90.5
Recurrent and intrusive recollections	9	42.9
Recurrent distressing dreams	7	33.3
Acting or feeling as if traumatic event were recurring	2	9.5
Intense psychological distress at exposure	6	28.6
Physiological reactivity on exposure	2	9.5
Efforts to avoid thoughts	16	76.2
Efforts to avoid activities	15	71.4
Inability to recall important aspect	1	4.8
Markedly diminished interest	1	4.8
Feeling of detachment	12	57.1
Restricted range of affect	2	9.5
Sense of a foreshortened future	0	0.0
Difficulty with sleep	11	52.4
Irritability	9	42.9
Difficulty concentrating	11	52.4
Hypervigilance	3	14.3
Exaggerated startle response	2	9.5
Lasted more than 1 month	17	81.0
Causes clinically significant distress	13	61.9

collection tool, they were provided with a test case (see Appendix H) to determine familiarity with symptoms of PTSD. None of the test group was able to correctly classify this test case, despite the diagnosis of PTSD clearly present in the case. The test group was able to identify some of the criteria for PTSD diagnosis, but not all of the criteria. This could be a limiting factor in having the data-collection tool completed on the basis of intake assessment information. The hypothesis for this would be that although the therapist group was comprised of Master's-level therapists, the overall understanding of the therapists with regard to concrete application of PTSD symptoms is not comprehensive, which can thus lead to incorrect identification and treatment of client symptoms.

A second limitation may be that only one subject specifically endorsed episodes of dissociative amnesia, which may affect the generalizability of this study.

A third limitation may be that a convenience sample was utilized, which was limited to families with open Child Protective Services cases in Kent County, Michigan, which may affect the generalizability of this study.

A fourth limitation may be that pre-existing client data already maintained in agency files were utilized; thus, the pre-existing data were not gathered for the purpose of this research. As such, the therapists were not specifically looking for nor asking for data with regard to episodes of dissociative amnesia, gaps in historical memory, or exploring the possibility of childhood sexual abuse without client statements to the contrary.

A fifth limitation may be that the *DSM* was updated in May of 2013 following the conclusion of this research study. The *DSM-IV-TR* (American Psychiatric Association, 2000) was used for this research; the criteria for diagnosing PTSD have subsequently

been altered with the updated *DSM* (*DSM-V*) and as such, the revised criteria may impact on future PTSD diagnosis.

Recommendations

Recommendations for Practice

The trauma-informed care model for mental health "is an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives" (SAMHSA, 2012, para. 4). The trauma-informed care model advocates for the education and awareness of organizations in providing care to traumatized individuals "so that . . . services and programs can be more supportive and avoid re-traumatization" (SAMHSA, 2013, Trauma-Informed Care section, para. 2). The core components of the trauma-informed care model advocate for appropriate screening and assessments and effective interventions and supports (Cooper et al., 2007). Kezelman (2011) emphasizes the importance of the trauma-informed care model by pointing out that:

> systems . . . need to integrate awareness and understanding around trauma and traumatic stress in their work and approach people from a trauma informed perspective–that is, to consider the possibility of unaddressed childhood trauma at the root of presentations. . . . Being cogniscent of the possibility can make an enormous difference to the way a survivor reacts, copes going forward and recovers. (para. 34)

With regard to recommendations for practice, an important component for therapists to implement would be ensuring that any client-intake assessment tool utilized incorporates questions specifically designed to elicit any history of periods of amnesia (such as "Are there periods of time in your life that you do not remember?"), as well as specific questions regarding whether the client has experienced the specific PTSD symptoms of

"recurrent distressing dreams," "efforts to avoid activities," "feeling of detachment," and "irritability." Integration of a standardized tool such as the PC-PTSD screen (Prins et al., 2003) into a standard therapist assessment could be a low-impact and effective way to document a client's PTSD symptoms. Conducting an appropriate and comprehensive client-intake assessment is a key component in the therapist establishing an appropriate treatment plan for the client. If the assessment is missing pieces, then the treatment plan will not be fully applicable, thus hindering the client's progress in therapy. Of additional assistance may be a recently published guide for child welfare administrators, which provides a step-by-step process for building an effective trauma-informed care system for child welfare (The Chadwick Trauma-Informed Systems Project, 2012).

Additionally, the therapists should receive training specific to identifying and classifying symptomology of PTSD. Training specific to PTSD is not highlighted in graduate school programs, and because of this, Master's-level therapists may not be qualified to accurately diagnose symptomology of PTSD without further training. Also, data indicating handedness can be important in a treatment setting. For each of the primary variables, it is more likely that clients will be right-handed, which typically means that those clients will more heavily utilize the left side of their brain (Broca, 1865). The left side of the brain is responsible for "understanding and use of language (listening, reading, speaking and writing), memory for spoken and written messages, detailed analysis of information, and control of the right side of the body" (Centre for Neuro Skills, 2010, p. 2), which may indicate that treatments involving psychoeducation, bibliotherapy, and cognitive-behavioral techniques will be more effective.

Recommendations for Further Study

With regard to recommendations for further study, this study should be replicated on a larger scale, but with three key changes. First, the therapists who will be completing the data-collection tool should receive specific training on symptomology of PTSD. Second, the client-intake assessment completed by the therapists should be expanded to include additional questions specifically to determine the presence of dissociative amnesia. Although the data set for dissociative amnesia was expanded, further study with regard to a larger sample may be warranted in order to verify prediction results. It is also possible that adding some questions to the therapist-intake assessment specifically designed to inquire about dissociative amnesia may be helpful in expanding the subject pool. Third, the client-intake assessment completed by the therapists should be expanded to include additional questions specifically to determine the presence of PTSD, such as the questions contained in the standardized PC-PTSD screen (Prins et al., 2003).

Additional recommendations for further study include investigations into treatment modalities that are specifically designed to reduce symptoms of PTSD, particularly symptoms of hyperarousal and irritability, which may be evidenced by client responses to the data-collection tool items of Client 4b ("irritability") and Client 4c ("difficulty concentrating"). Herman and Harvey (1997) stressed that "future clinical research is needed in order systematically to document treatment outcome and establish preferred modalities of psychotherapy for patients with histories of childhood trauma" (p. 569). Several new treatment modalities are emerging that are focused on the reduction of hyperarousal and irritability through the use of guided meditation (Root et al., 2001; Strauss et al., 2009) and heart coherence (Ginsberg et al., 2010; McCraty et al., 2009).

These new treatment modalities are promising in that they are self-directed, inexpensive, and appear to be as effective or more so than current traditional interventions.

Conclusions

This study used secondary data to examine the relationship between childhood sexual abuse, symptomology of post-traumatic stress disorder, episodes of dissociative amnesia, and selected demographic characteristics. The core questions of this study were:

1. What is the incidence of childhood sexual abuse in the study sample?

2. What is the incidence of episodes of dissociative amnesia in the study sample?

3. What is the incidence of PTSD symptoms in the study sample?

4. What is the relationship between childhood sexual abuse and the demographic characteristics of gender, ethnicity, age, educational level, and handedness?

5. What is the relationship between childhood sexual abuse, symptoms of PTSD, and episodes of dissociative amnesia?

Subjects in this study were predominantly: female (90.6%), aged 18-34, Caucasian, and right-handed. Approximately 40% of the subjects reported a high-school diploma or equivalent level of education. The incidence of childhood sexual abuse among subjects was 47.7%. The incidence of episodes of dissociative amnesia among subjects was 14.1%. The incidence of PTSD among subjects was 55.7% for "least" PTSD, and 16.1% for "greatest" PTSD. Eight percent of subjects were missing only one criterion for a full PTSD diagnosis. A significantly larger proportion of females (50.4%) than males (21.4%) experienced childhood sexual abuse.

With regard to the relationship between symptoms of PTSD, childhood sexual abuse, and episodes of dissociative amnesia, childhood sexual abuse and dissociative amnesia are moderately correlated at 0.43. There are certain PTSD symptoms that predict childhood sexual abuse. Of the subjects who met criteria for "least" PTSD, 85.5% had experienced childhood sexual abuse. Of the subjects who met criteria for "greatest" PTSD, 100% experienced childhood sexual abuse. Of the subjects who met criteria for "one-off" PTSD, 91.7% experienced childhood sexual abuse. Subjects who were sexually abused are more likely to have experienced traumatic events, more likely to avoid activities, places, or people that remind them of these traumatic events, more likely to feel detached or estranged from other people, and more likely to exhibit irritability and/or outbursts of anger.

Additionally, certain PTSD symptoms predict dissociative amnesia. Of the subjects who met criteria for "least" PTSD, 22.9% had experienced episodes of dissociative amnesia. Of the subjects who met criteria for "greatest" PTSD, 25% had experienced episodes of dissociative amnesia. Of the subjects who met criteria for "one-off" PTSD, 33.3% had experienced episodes of dissociative amnesia. Subjects who had experienced episodes of dissociative amnesia are more likely to have experienced traumatic events, more likely to experience recurrent distressing dreams, more likely to exhibit irritability and/or outbursts of anger, and more likely to have difficulty concentrating.

Recommendations for further practice include the addition of questions to client-intake assessment forms that are specifically designed to elicit any history of periods of amnesia (such as "Are there periods of time in your life that you do not remember?"), as

well as specific questions regarding whether the client has experienced the specific PTSD symptoms of “recurrent distressing dreams,” “efforts to avoid activities,” “feeling of detachment,” “irritability,” and "difficulty concentrating," such as through the integration of the PC-PTSD screen (Prins et al., 2003) into a therapist's standard assessment. Additionally, the therapists should receive training specific to identifying and classifying symptomology of PTSD. Training specific to PTSD is not highlighted in graduate school programs, and because of this Master’s-level therapists may not be qualified to accurately diagnose symptomology of PTSD without further training. Also, data regarding handedness can be important in a treatment setting as it may indicate that treatments involving psychoeducation, bibliotherapy, and cognitive-behavioral techniques will be more effective.

Recommendations regarding further study include the need for replication on a larger scale, but with three key changes: (a) therapist-specific training on symptomology of PTSD, (b) the expansion of the client-intake assessment form to include additional questions specifically designed to determine the presence of dissociative amnesia, and (c) the expansion of the client-intake assessment form to include additional questions specifically designed to determine the presence of PTSD, such as through the integration of the PC-PTSD screen (Prins et al., 2003). Additional recommendations include investigations into treatment modalities that are specifically designed to reduce symptoms of PTSD, particularly symptoms of hyperarousal and irritability. Several new treatment modalities are emerging that are focused on the reduction of hyperarousal and irritability. These new treatment modalities are promising in that they are self-directed, inexpensive, and appear to be as effective or more so than current traditional interventions.

APPENDIX

APPENDIX A

AGENCY RESEARCH PROPOSAL

ABSTRACT OF GRADUATE STUDENT RESEARCH

Dissertation

Andrews University

School of Education

Title: DOES TRAUMA HAVE THREE FACES? A STUDY TO DETERMINE WHETHER CHILDHOOD SEXUAL ABUSE CAN BE PREDICTED BY COMMONALITY OF A HISTORY OF DISSOCIATIVE AMNESIA AND SYMPTOMOLOGY OF POST-TRAUMATIC STRESS DISORDER

Name and address of researcher: Jennifer E. VanDerTuuk-Perkins
301 Crescent NE
Grand Rapids, MI 49503

Name, degree, and telephone number of faculty chair: Elsie P. Jackson, Ph.D.
(269) 471-3200

Category of Human Subjects Review Board (HSRB): Exempt from Full HSRB Review (Code of Federal Regulations for the protection of human subjects from research risk) due to this research being a project involving the collection or study of existing data, documents, and/or records which information is recorded by the researcher in such a way that the subjects CANNOT be identified directly or through identifiers linked to the subjects.

Summary of Project: To predict the likelihood of childhood sexual abuse through evidence of commonality of dissociative amnesia and symptomology of post-traumatic stress disorder (PTSD). Families will be identified by therapists contracted by child protective services in Kent County, Michigan. Once identified, the family's therapist will complete a family assessment including a family risk assessment and diagnostic checklist (CSAP-TR). A simple quantitative comparison will be made between reported historical childhood sexual abuse, identified history of dissociative amnesia, and symptomology of PTSD (diagnosable using DSM-IV criteria).

Problem

Unreported childhood sexual abuse is a major hindering factor to client progress in therapy during child protective services involvement. When a person has been through

a traumatic event, unless immediate intervention is utilized, there is a high likelihood that the individual will develop post-traumatic stress disorder (PTSD). At some point, the companion to PTSD (dissociative amnesia) will develop in one form or another (whether event-related or encompassing the entire person). By dissociating all memory of the event or of one's entire life, the brain allows itself a buffer zone in which to process the information it is receiving or recalling. Often dissociative amnesia will result from recurring flashbacks to the traumatic event or from glimpses of suppressed memories of the traumatic event. Thus, there exists the high potential for victims of childhood sexual abuse to experience an amnestic episode at some point in their lives. The American Psychiatric Association (1994) notes that there are increasing reports of episodes of dissociative amnesia involving previously forgotten childhood memories.

Childhood sexual abuse is pervasive, and is one of the most intimate crimes against person. During current work with child protective services, the generational cycle of abuse is overwhelmingly apparent. Without acknowledgement of past abuse, there is little hope of complete recovery, and thus a risk of abuse continues to exist for the children of the victim. Through recovery, it is hoped that the generational cycle of abuse can be broken, creating a safer home environment for children.

Characteristics of Childhood Sexual Abuse

As stated previously, dissociative amnesia is most often an indicator of childhood sexual abuse. Marsha Linehan (1993) discusses the fact that most of the clients [presenting with PTSD] will report at least one incidence of childhood sexual abuse. "Information about the facts of previous sexual, physical, or emotional trauma and/or physical or emotional neglect should be obtained on a continuing and as-needed basis as therapy progresses" (Linehan, 1993). Characteristics of childhood sexual abuse have been identified by Briere (1989) and should be well ingrained in the mind of the therapist when treating a client who presents with PTSD. Briere's (1989) characteristics are as follows:

1. Intrusive memories of flashbacks to and nightmares of the abuse.
2. Abuse-related dissociation, derealization, depersonalization, out-of-body experiences, and cognitive disengagement or 'spacing out.'
3. General posttraumatic stress symptoms, such as sleep problems, concentration problems, impaired memory, and restimulation of early abuse memories and emotions by immediate events and interactions.
4. Guilt, shame, negative self-evaluation, and self-invalidation related to the abuse.
5. Helplessness and hopelessness.
6. Distrust of others.
7. Anxiety attacks, phobias, hypervigilance, and somatization.
8. Sexual problems.
9. Long-standing depression.
10. Disturbed interpersonal relatedness, including idealization and disappointment, overdramatic behavioral style, compulsive sexuality, adversariality, and manipulation.
11. 'Acting out' and 'acting in,' including parasuicidal acts and substance abuse.
12. Withdrawal.
13. Other-directedness.
14. Chronic perception of danger.
15. Self-hatred.
16. Negative specialness -- that is, an almost magical sense of power.
17. Impaired reality testing.
18. A heightened ability to avoid, deny, and repress.

"Individuals who have been severely traumatized often have little memory of the experience" (Linehan, 1993). Horowitz (1986) also points out that in the denial phase of the traumatic event, complete or partial amnesia is often a component. "In individual ...

sessions, when cues associated with the trauma are brought up, the individual may become mute and stare blankly into space" (Linehan, 1993).

Trauma Causation Model of Dissociation

There is a tendency for each person, having experienced a traumatic event, to ask "why me?" "For most victims abused by other persons, such human viciousness and cruelty cannot be easily explained away as givens. In cases of sexual abuse, battery, murder and so forth, we do not seem to be facing the randomness of natural catastrophe, but rather the deliberate acts of twisted human beings. In the face of malice, madness, and perversion, the search for meaning becomes more difficult" (Flannery, 1995, p. 187). It is this difficulty in searching for meaning that may be a precursor to the prevalence of episodes of dissociative amnesia for trauma victims. When circumstances no longer make sense, a person has an increased risk of withdrawing from the situation (a dissociative episode) in order to attempt to control the effects of the traumatic event. The ultimate method of withdrawal is dissociative amnesia, in that the person can create an entirely new identity, apart from the one that experienced the traumatic event. "Early trauma is much more likely to produce a pattern of ... dissociation ..." (Tomb, 1994, p. 247). "The reports of therapists who specialize in the treatment of sexually abused women have shown that women who were sexually abused often experience periods of time during which they cannot remember the abuse" (Walker, 1995, p. 84). "[w]hile experiencing trauma children may dissociate, and this will interfere with the perception of and attention paid to the ongoing abuse. It is suggested that memories that arise from a

dissociative state are perceived subcortically through visual and kinesthetic somatization rather than through cognitive attention" (Walker, 1995, p. 95).

"Children who are severely physically, sexually, and psychologically abused in early childhood ... are at high risk to develop a ... dissociative disorder. Unable to integrate the pain and both 'good' and 'bad' images of themselves, they develop fragmented personalities. Their feelings are separated from the reality of what is happening to them. Dissociation is a psychological technique used as a defense mechanism, unconsciously protecting the mind from the impact of severe abuse" (Walker, 1995, p. 100).

Method

The core questions of this study are:

1. Is there a correlation between common diagnoses of dissociative amnesia and PTSD and the likelihood of childhood sexual abuse?
2. Can a simple checklist serve as measurement of predictors of childhood sexual abuse?
3. If a correlation exists between the three major variables, what is the percentage of correlation, and is this statistically significant?

This quantitative study will utilize a therapist-completed checklist regarding a client's history of dissociative amnesia, childhood sexual abuse, and symptomology that would support a diagnosis of PTSD (according to DSM-IV criteria), as well as compiling a data specifier available on the client's risk assessment form completed by child protective services. Therapists affiliated with Bethany Christian Services' Early Impact Program will be requested to participate in the study, as Bethany's Early Impact Program is currently serving approximately 300 families per year referred from child protective services. Of these families, 35-40% represent families of minority color and culture, 60%

demonstrate difficulties related to substance abuse, 30% are challenged by undiagnosed or untreated mental health issues, 45% struggle with physical and mental health challenges, and up to 60% of adults report child abuse and/or neglect within their own childhood histories (Bethany Christian Services, 2003). In other words, childhood trauma appears to account for up to 60% of the families that are referred after abusing and/or neglecting their children. This is a serious generational problem that must be stopped through the treatment of childhood traumas at the time of occurrence.

No identifying client information is requested, other than whether the client is male or female. Participation in this research project is entirely voluntary. There is no reimbursement for the therapist's participation. Information is requested from each participating therapist for each referred adult client (approximately 150 during the term of the research study) for whom the therapist gathers intake information between September 15, 2003 and February 15, 2004.

The therapists will be asked via research letter (see attached Appendix 1) to complete a diagnostic checklist (CSAP-TR) (see attached Appendix 2). The CSAP-TR is an original checklist that was validated among practicing Master's-level child protective services therapists. The CSAP-TR simply gathers anonymous client information with regard to history of dissociation, symptoms of PTSD, whether the client's risk assessment form indicates a history of abuse, and whether the client disclosed childhood sexual abuse during the clinical interview. A simple quantitative comparison will be made between reported historical childhood sexual abuse, identified history of dissociative amnesia, and symptomology of PTSD (diagnosable using DSM-IV criteria).

Delimitations

This study deals with the correlation between three major variables involved in trauma, as reported by Master's-level therapists. It is limited to families with open child protective services cases in Kent County, Michigan because that is the focus of the research benefit. It is limited to reports from Master's-level therapists because they will ultimately be the beneficiaries of the research and the research needs to be understandable and useful to them in everyday practice. In addition, these therapists bring combined years of experience in working with victims of trauma and have not only the expertise needed for the study, but the heart commitment as well.

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APPENDIX B

AGENCY RESEARCH APPROVAL

Bethany
CHRISTIAN SERVICES

901 Eastern Avenue NE
PO Box 294
Grand Rapids, MI 49501-0294

To Whom It May Concern:

The Grand Rapids Branch Directors have examined the research proposal that has been submitted by Dr. Jennifer Perkins for her Andrews University Doctoral Study entitled Predictors of Childhood Sexual Abuse and believe that the project as proposed is a worthy endeavor that will produce data and analysis that will benefit the clients that this organization provides service to, as well as provide pertinent data for the field of Child Welfare. It has long been Bethany's position to support research efforts that are conducted on behalf of our profession as it adds to the body of knowledge and understanding from which best practice treatment protocols can be developed and implemented. As an organization, we have supported the use of staff time and specified branch resources to support these types of research efforts and look forward to the implementation and research conclusions that will result from this project.
It is our understanding that this research will be conducted by way of information collected by participating therapists and submitted on the data collection form. The data collection process will begin in approximately January of 2004 and continue until the Summer of 2004. Bethany looks forward to receiving a copy of the research findings when published.

Sincerely,

Deb Peters

Debra Peters
Director of Kent County Program Operations
Bethany Christian Services

APPENDIX C

AGENCY MEMO RE: AGENCY RESEARCH PROTOCOL

MEMO TO: Jennifer VanDerTuuk-Perkins
FROM: Grand Rapids Branch Director, Debra Peters
RE: Trauma Research Proposal

Protocol for research:

1. Dr. Jennifer Perkins will send out an invitation (in the form of a letter) to participate in the research project to Bethany-Grand Rapids Master's-level therapists that may provide counseling services to adult parents that have become involved with the Child Welfare system following substantiation of Child Abuse/Neglect by Children's Protective Services. As such, an invitation to participate in this research project will be sent to therapists currently employed in the Early Impact and Advanced Impact programs.

2. The informational packet will contain information on the research project, the data collection tool and the following:

    - The assurance and confirmation that any and all participation in this research project is and will be throughout the course of the project totally and completely voluntary. Any and all participation in the research project will be completely anonymous and confidential allowing there to be no means of identifying those who chose to participate or decline participation in the research project to either Dr. Perkins, or anyone else within the Bethany system. Further, there will be no knowledge of what level or intensity of involvement that any given therapist will have had in the collection of data for this project.

    - There will be no identifying information of any type requested on or within the research tool used to collect research information. As such there will be no way to relate or connect a specific research response to a specific client. Nor will there be any way to connect a specific research response to an individual therapist.

    - Ms. Peters will establish a secure location within the mailbox area of the Early Impact Program that is easily accessible to staff where completed and collected research responses (i.e. checklists) can be deposited. Participating therapists can deposit completed checklists to this location directly or through interoffice mail at any time during regular business hours. The mailroom staff will be made aware that there will be a new mail slot labeled "Trauma Research" and that any envelope addressed as such should be deposited there. Early Impact Training Supervisor Shannon Maddox will be assigned the responsibility to gather any forms that collect in this location and forward them on to Dr. Perkins via US Mail.

3. It will be noted that the research will be continuing from approximately May, 2007 through November, 2007, and that the therapists can complete as many or as few checklists as they so desire. This affords the therapist full control over level of participation in the event that he or she becomes too busy to continue participation at a given time period during the study period. Thus, the therapists have the flexibility and complete decision-making control to limit, discontinue or renew their participation within the study at any time throughout the study.

4. Completed checklists will be gathered by Early Impact Training Supervisor Shannon Maddox periodically as the mailbox fills. Ms. Maddox will then immediately send them to Dr. Perkins. Dr. Perkins will have no other contact with therapists regarding this research during the research process with the exception of being available to answer any technical questions regarding the checklist as initiated by the therapists.

5. A copy of the published research results and conclusions as prepared by Dr. Perkins will be provided to Bethany Christian Services by Dr. Perkins and made available to any interested employee within the above-named programs.

APPENDIX D

RESEARCH CONSENT

Jennifer VanDerTuuk-Perkins, Ph.D. candidate
7853 Grasmere Dr., Land O'Lakes, FL 34637/(616) 633.6771

Date

Contract CPS Therapist
Bethany Christian Services
Kent County, Michigan

Re: Andrews University Doctoral Study on Predictors of Childhood Sexual Abuse

Dear Therapist:

I am a Ph.D. candidate in Educational Leadership at Andrews University in Berrien Springs, Michigan. The purpose of my research is to determine whether a significant relationship exists between episodes of dissociative amnesia, symptomology of post-traumatic stress disorder, and historical childhood sexual abuse, and whether that relationship can be used to predict historical childhood sexual abuse in the absence of one of the other variables. My research will compile pre-existing client data, as well as the professional clinical opinions of CPS contract therapists at Bethany Christian Services, who will ultimately be the beneficiaries of the research.

Attached to this letter is a therapist checklist to record demographic information, episodes of dissociative amnesia and symptomology of post-traumatic stress disorder, as well as to record an abuse specifier from the Family Risk Assessment form and any history of childhood sexual abuse disclosed during the clinical interview. Basic demographic information is requested, but nothing that will identify any client specifically.

As a participant in this research project, it is important to understand that participation in this research study is completely voluntary, and refusal to participate or withdrawal from the study will have no impact on each individual therapist's relationship with Bethany Christian Services. There is no reimbursement for your participation.

It is my policy to ensure your anonymity and confidentiality during the research project and thereafter with respect to any identifying information and privacy in all phases of research conducted. As such, completed checklists will not be numbered or labeled so as to identify the completing therapist, and will be deposited into a designated mail slot in the Early Impact department at Bethany Christian Services.

If you wish to participate in this research, I would ask that you complete the attached checklist for each child protective services referred adult client for whom you have gathered intake information for the past year, and return the checklists to the assigned mailbox in the Early Impact Center at Bethany Christian Services before November 15, 2007. If you do not wish to participate, simply do nothing.

Should you have any questions or concerns that you would like to discuss, please do not hesitate to contact me at the above telephone number, or send me an email at: perkinsjen@yahoo.com. You are also welcome to contact my committee chairperson, Dr. James Tucker, at (423) 425-5261.

Thank you in advance for your time and for assisting with this research.

Sincerely,

Jennifer VanDerTuuk-Perkins

Att.

APPENDIX E

THERAPIST CHECKLIST

Subject's sex: □ Male □ Female

Subject's age: □ 18-24 years
□ 25-34 years
□ 35-44 years
□ 45-54 years
□ 55-64 years
□ 65+ years

Is subject: □ right-handed
□ left-handed
□ dual-handed (ambidextrous)

Highest degree subject completed?
□ High School or equivalent
□ Vocational/Technical School (2 year)
□ Some College
□ College Graduate (4 year)
□ Master's Degree (MA, MS, MSW)
□ Doctoral Degree (Ph.D.)
□ Professional Degree (MD, JD, etc.)
□ Other (please describe:_____)

Subject's racial origin:
□ Caucasian/White
□ African American
□ Indigenous or Aboriginal
□ Asian/Pacific Islander
□ Hispanic
□ Latino
□ Multiracial
□ Other (please describe: _____)

Episodes of Dissociation/Amnesia (please list/describe):

Client's Age at Time of Occurrence	Event

Has the client (please check as appropriate):

☐ experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others

☐ response involved intense fear, helplessness, or horror

If either of the above is checked, does the client have any of the following (please check as appropriate):

☐ recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions

☐ recurrent distressing dreams of the event

☐ acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated)

☐ intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

☐ physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

Does the client have any of the following (please check as appropriate):

☐ efforts to avoid thoughts, feelings, or conversations associated with the trauma

☐ efforts to avoid activities, places, or people that arouse recollections of the trauma

☐ inability to recall an important aspect of the trauma

☐ markedly diminished interest or participation in significant activities

☐ feeling of detachment or estrangement from others

☐ restricted range of affect (e.g., unable to have loving feelings)

☐ sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

Does the client have any of the following (please check as appropriate):

☐ difficulty falling or staying asleep

☐ irritability or outbursts of anger

☐ difficulty concentrating

☐ hypervigilance

☐ exaggerated startle response

Has this lasted for more than 1 month: ☐ Yes ☐ No

Does the above cause clinically significant distress or impairment in social, occupational, or other important areas of functioning:

☐ Yes ☐ No

Did Client's Risk Assessment Form list history of abuse (as victim)?
[Located in Abuse column, number A5: "Caretaker(s) Abused as Child(ren)"]

☐ Yes ☐ No

Did Client disclose sexual abuse (as victim) during clinical interview?

☐ Yes ☐ No

APPENDIX F

THERAPIST CHECKLIST (SCORING TEMPLATE)

Subject's sex: □ Male □ Female

Subject's age: □ 18-24 years
□ 25-34 years
□ 35-44 years
□ 45-54 years
□ 55-64 years
□ 65+ years

Is subject: □ right-handed
□ left-handed
□ dual-handed (ambidextrous)

Highest degree subject completed?
□ High School or equivalent
□ Vocational/Technical School (2 year)
□ Some College
□ College Graduate (4 year)
□ Master's Degree (MA, MS, MSW)
□ Doctoral Degree (Ph.D.)
□ Professional Degree (MD, JD, etc.)
□ Other (please describe:_____)

Subject's racial origin:
□ Caucasian/White
□ African American
□ Indigenous or Aboriginal
□ Asian/Pacific Islander
□ Hispanic
□ Latino
□ Multiracial
□ Other (please describe: _____)

Episodes of Dissociation/Amnesia (please list/describe):

Client's Age at Time of Occurrence	Event

Score = _____ (Proceed if =1)

Symptomology of Post-Traumatic Stress Disorder:

Has the client (please check as appropriate):
[Has the person been exposed to a traumatic event in which BOTH of the following were present:]

☐ experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others

☐ response involved intense fear, helplessness, or horror

Score = _____ (Proceed if =2)

If either of the above is checked, does the client have any of the following (please check as appropriate):
[The traumatic event is persistently reexperienced in ONE (or more) of the following ways:]

☐ recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions

☐ recurrent distressing dreams of the event

☐ acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated)

☐ intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

☐ physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

Score = _____ (Proceed if =/<1)

Does the client have any of the following (please check as appropriate):
[Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by THREE (or more) of the following:]

☐ efforts to avoid thoughts, feelings, or conversations associated with the trauma

☐ efforts to avoid activities, places, or people that arouse recollections of the trauma

☐ inability to recall an important aspect of the trauma

☐ markedly diminished interest or participation in significant activities

☐ feeling of detachment or estrangement from others

☐ restricted range of affect (e.g., unable to have loving feelings)

☐ sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

Score = _____ (Proceed if =/<3)

Does the client have any of the following (please check as appropriate):
[Persistent symptoms of increased arousal (not present before the trauma), as indicated by TWO or more of the following:]

☐ difficulty falling or staying asleep

☐ irritability or outbursts of anger

☐ difficulty concentrating

☐ hypervigilance

☐ exaggerated startle response

Score = _____ (Proceed if =/<2)

Has this lasted for more than 1 month: ☐ Yes ☐ No

Score = _____ (Proceed if =Yes)

Does the above cause clinically significant distress or impairment in social, occupational, or other important areas of functioning:

☐ Yes ☐ No

Score = _____ (Proceed if =Yes)

Diagnosis: 309.81 Post-Traumatic Stress Disorder

Did Client's Risk Assessment Form list history of abuse (as victim)?
[Located in Abuse column, number A5: "Caretaker(s) Abused as Child(ren)"]

☐ Yes ☐ No

Did Client disclose sexual abuse (as victim) during clinical interview?

☐ Yes ☐ No

APPENDIX G

SAMPLE VALIDATION CASE–A

FOR PROFESSIONAL USE ONLY
DO NOT COPY OR FORWARD

PSYCHOLOGICAL EVALUATION

Client's Name: Jane Doe
Birth Date: 02/28/78
Date of Evaluation: 12/05/01
Date of Report: 01/07/02

REASON FOR REFERRAL.

Jane Doe is a 23-year-old Hispanic female, who was referred for a psychological evaluation by her case manager, I.M. CP3, from Children's Protective Services (CPS). The purpose of the psychological evaluation is to help provide greater insight into Jane's current level of psychological functioning, assess her parenting abilities, and assist in providing appropriate recommendations regarding treatment interventions.

BACKGROUND INFORMATION:

Children's Protective Services became involved with the family in September of 2000. Reportedly a telephone call was made to Children's Protective Services stating that the mother, Jane Doe, is currently staying in a shelter. According to the referent, the mother left James Doe alone two times unsupervised yesterday. The referent states that James is a very active child. He is crawling around pretty well. The referent has expressed concerns to mother and has advised her not to leave her son alone. The referent states that James was found in the living room area by another client who brought him to the office. The referent states that James was in the office with them for at least 20 minutes before the mother came looking for him. The referent states that they did not know how long James was left alone prior to that time. The referent states that the mother told them that she was on the telephone. The referent states that you have to walk down a hall and up some stairs in order to get to the telephone from the living room. The referent confronted the mother. The mother informed the referent that the reporting person does not know how to raise a child. The referent states that if the mother continues to violate the rules, it could put her placement in jeopardy. The referent states that she does not think the mother asked anyone to ask James at the time.

Jane Doe states that she was never married and that she has one child who turned 2 on December 5th, 2001. The child's name is James Doe. Jane reports that she lives at 12345 Main Street, Apt. 1, Anytown, Michigan 49000. Jane states that it is her own apartment and that she has lived there for a couple of months.

Jane reports that she completed 10th grade in high school. Jane states that school was "too hard" for her. Jane reports that she went to counseling while she was in school. She additionally stated that the school wanted to put her in special education classes and told her that she had ADD.

Jane reports that she currently works at Fazoli's restaurant and that she enjoys it. She reports that she has been working there for a few weeks. Previously, Jane had a telemarketing job which she reports didn't "go too well" because she could not make sales. She has previously worked at Meijer's. She is currently supporting herself using her income from Fazoli's and supplementing that with food stamps. She also is receiving Section 8 for her housing. Jane reports that there was a period of time when she was unable to work or go to school from about the age of 12 and continuing. She reports that it was difficult to go to school. She was in numerous foster homes and was also going to individual counseling at that time.

Jane reports that she has previously received treatment from Community Agency 1 but has not attended for several months. She reports that she is currently receiving individual counseling through Community Agency 2. Her therapist's name is Ms. Therapist. Jane states that she began seeing Ms. Therapist in either January or February of 2001. Jane states that she is subjecting herself to a psychological evaluation by a court order.

Jane states that she contacted Children's Protective Services because she was homeless. She states that she broke up with her boyfriend because her boyfriend was doing drugs. Jane reports that she wanted help at the time with homelessness and with parenting. She states that this began when she was in shelter approximately 1 to 1½ years ago. Jane states she feels nervous much of the time. At the time she became homeless, Jane states that her boyfriend was doing drugs. She states that he had cirrhosis of the liver and she tried to help him. Jane states additionally that he sprayed pepper spray in her face when she was pregnant. Jane also reports that her boyfriend went to jail for theft and for drugs and that he locked her in the house. Jane additionally states that she did not consider this incident to be abusive.

Jane states that she is familiar with Community Agency 2. She was adopted through Community Agency 2 when she was approximately age 4. Subsequent to that, she was in Community Agency 3, in the local psychiatric hospital for several months, in Community Agency 4, and at the local dual-diagnosis program approximately 1 – 1½ years ago. Jane states that she has been a patient at the previously mentioned psychiatric hospitals. She reports that she was sexually abused by her adopted father.

Jane states that her older sister was also sexually abused by the adopted father. Jane additionally reports that her adoptive mother beat her older sister when she found out that Jane was being sexually abused. Jane reports that there was abuse in her home and Jane additionally reports that there was some concern with stealing. Jane reports that when was she was 16, she left home and became a prostitute. She states that she was beaten and had stitches more than 5 times. Jane states that she has not prostituted since she was 18.

Jane states that her mood lately has been tired. She works either the 9-5 shift or the 11-7 shift and reports that her older sister cares for her son while she is working. Jane reports that her physical health has been good. Jane reports that she is currently taking medication: she was taking Prozac which was prescribed at the dual-diagnosis program, however, this medication made her shake. She was then placed on Celexa which she reports did not work, so the doctor did not prescribe it again for her. Jane reports that she is not taking any vitamins. Jane reports that she does not drink and she has never done drugs. Jane reports that she does not have much free time. She reports that she goes to sleep when she gets home from work. Jane additionally states that when she starts to think about things or remember incidents from the past, she reports that she wants to "sleep and not deal with it."

Jane reports that she feels depressed when she begins to think about things from the past and she gets scared when she is by herself. She reports that she is constantly anxious and depressed. Jane reports that she is not interested in this point in pleasurable things. Jane additionally reports that she eats more when she is starting to "feel things." Jane reports that she has trouble falling asleep because thoughts race through her head and won't stop. Jane reports that she is tired all the time. Jane reports that she feels guilty about prostitution in the past and about "being dumb" about things. Jane reports that she has difficulty thinking or making decisions and that this happens every day. Jane reports that she does not have any suicidal ideation because she is "too afraid of death," but states that she does think about death as a concept.

Jane additionally believes that people are "looking at her." Jane also believes that people in the past, such as pimps, Protective Services, or foster families have been prejudiced against her because of her race. Jane additionally reports that after she was a patient at the local psychiatric hospital, she received a vision in prayer. Jane additionally reports that she has troubling following trains of thought and following directions from others. Jane additionally demonstrated flattened affect during the entire interview.

Jane reports the following traumatic events: Jane reports that she was subject to physical abuse prior to the age of 4 and reports that her twin sister died in infancy. Jane additionally reports that she was subjected to physical abuse in her adoptive family from the ages of 4 to 13. Jane also reports that she was sexually abused by her adopted father from the ages of 4 to 6 which ceased with the death of her adopted father when Jane was approximately age 6. Jane reports that she did not tell anyone about the

abuse until she was 10 to 12 years old but Jane is unclear as to the exact age. Jane also reports that she would often crawl into her bedroom to withdrawl from the events in her home situation. Jane also reports that she was a bed-wetter and reports that her adopted mother made her sleep in a wet bed as a child. Jane reports that she has recollections of these events on numerous occasions and did have dreams of these traumatic events when she was growing up. Jane reports that she does make an effort to avoid thoughts, feelings, or conversations which have to do with this past trauma and reports that she makes an attempt to avoid activities, places, or people that arouse recollections of this trauma. Jane additionally reports that she does not remember much from the age of 4 until early adulthood. Jane reports that she used to love art and used to love to draw and paint but that desire has lessened significantly in recent years. Jane reports that she feels detached or estranged from others. Jane additionally reports that she has difficulty falling or staying asleep, difficulty concentrating and is experiencing hypervigilance. Jane states that this has lasted for several years. Jane additionally reported that she experiences quite a bit of anxiety accompanied by these symptoms and others.

CURRENT TESTS ADMINISTERED:

Clinical Interview
Consultation with Ms. Therapist, Community Agency 2
Review of Children's Protective Services records
The Millon Clinical Multiaxial Inventory-III
Parenting Stress Index
Wechsler Adult Intelligence Scale
House-Tree-Person

BEHAVIORAL AND TESTING OBSERVATIONS:

Jane is a Hispanic female of medium to heavy build. She was clean and appropriately dressed. She appeared tired and had somewhat guarded behavior. She was cooperative during the testing process. Her affect was both flat and depressed during the testing session. She demonstrated scattered cognition and some difficulty with short-term memory recall.

EVALUATION FINDINGS:

On the *Millon Clinical Multiaxial Inventory – III (MCMI-III)*, Jane's response style indicates a tendency to magnify illness, an inclination to complain, or feelings of extreme vulnerability associated with a current episode of acute turmoil. On the basis of the test data, it may assumed that the client is experiencing a severe mental disorder. This client tends to be self-deprecating and unpredictable. Although she is overly self denying and dysphoric, there is an underlying irritability and discontent that should be handled by drawing upon her strong desire to please others and act in a deferential

manner. Positive gains may be achieved by using either cognitive or interpersonal therapy of a short-termed and focused nature.

There is reason to believe that at least a moderate level of pathology characterizes the overall personality organization of this woman. Defective psychic structure suggests a failure to develop adequate internal cohesion and a less than satisfactory hierarchy of coping strategies. This woman's foundation for effective interpsychic regulation and socially acceptable interpersonal conduct appears deficient or incompetent. She is subjected to the own flux of her own enigmatic attitudes and contradictory behavior and her sense of psychic coherence is often precarious. Although she is usually able to function on a satisfactory basis, she may experience periods of marked emotional, cognitive, or behavioral dysfunction. The profile of this woman suggests that she is often melancholy and blue, fearful, socially shy, and self-pitying. Expressing feelings of self-reproach and inappropriate guilt, she has learned to lean on others for security, and she assumes the role of a submissive, cheerless, self-sacrificing partner in close relationships. Exceedingly insecure and vulnerable if separated from those who provide support, she may willingly place herself in inferior or demeaning positions, permitting others to be inconsiderate, if not exploitive. She probably feels considerable resentment toward those who fail to appreciate her intense needs for affection and nuturance. Although emotionally irritable and overly angry at times, because her security is threatened when she expresses her resentment, she is loath to discharge any negative feelings and most typically does so in a passive-aggressive manner. She would rather withdrawl from painful social relationships or try to convince herself that being isolated and sad is a worthy state. It is likely that her depression, loneliness, and isolation are getting worse. Her underlying tension and emotional dysphoria appear to be present in disturbing mixtures of anxiety, sadness, and guilt. Insecurity and fear of abandonment may account for her mournful, sorrowful and dispirited attitude. Aside from her periodic outbursts and expressions of resentment, she is likely to be conciliatory, placating, and even ingratiating. By acting dejected and weak by expressing self-derogation, by being self-depriving, communicating a need for assurance and direction, and displaying a willingness to submit and comply, she hopes to evoke nuturance and protection. By submerging her individuality, voicing thoughts of death or suicide, focusing on her worst features and lowly status, subordinating her personal desires, and submitting at times to abuse and intimidations, she hopes to avoid total abandonment.

Her preoccupation with and complaint of inadequacy, fatigability, and illness, probably reflect her underlying mood of depression. Simple responsibilities may demand more energy then she can muster. Life may be referred to by her to as empty with constant feelings of weariness and apathy. By withdrawing, being dependent and self-abnegating, or restricting her social involvement to those few situations in which she is not exploited or rejected, she precludes the possibility of new, potentially favorable experiencing redirecting her life.

Interwoven with this woman's fretful and melancholic feelings are clear signs of a major depression overlying a characterologic mix of dysthemic features. Notable among these

features are a diminished capacity for pleasure, preoccupation with lessened energy and adequacy, pessimism and suicidal ideation, a loss of confidence, feelings of worthlessness, resentment, and fears that she may vent her anger and thereby lose the little security she possesses. This woman's thinking includes a number of delusional facets, for example transient ideas of reference, mixed jealousy, and persecutory beliefs (that interweave with other features to constitute a mini paranoid episode.) These facets were most likely precipitated by her feeling mistreated by those from whom she had hoped to gain support and she now believes that these people have betrayed or forsaken her. Previously repressed resentments have slipped through her once adequate controls, rising to the surface as irrational, brief, expressions of anger and suspicion. Tensions are likely to accumulate, however, leading her to be quite touchy and irritable.

This woman appears to have been confronted with an event or events in which she was exposed to a severe threat to her life, a traumatic experience which precipitated intense, fear, or horror on her part, as previously outlined above in the background information for this client.

Consistent with her pervasive discontent and sadness, this insecure and troubled woman reports suffering from a variety of symptoms that constitute an anxiety disorder. In addition to palpitations, distractibility, jittery feelings, and restlessness at one moment, and exhaustion the next, she may experience presentiments of tragic outcomes as well as period panic attacks and agoraphobia. Expecting the worst to happen, she not only looks for confirmation but may also precipitate events that generate self-defeating stressors that further intensify her anxieties.

On the *Parenting Stress Index*, Jane scored with a total stress in the concern area. The *Parenting Stress Index* was designed to be an instrument in which the primary value would be to identify parent-child systems that were under stress and at risk for the development of dysfunctional parenting behaviors or behavior problems in the child involved. Jane's overall score on the child domain falls within the average range overall, however, on the Demandingness subscale with regard to her child, she received a fairly high score. She is at the 85th percentile. High scores in this area are produced when the parent experiences the child as placing many demands on him or her. In the parent domain, Jane's overall stress was high which suggests that the sources of stress and potential dysfunction of the parent-child system may be related to dimensions of the parent's functioning. Two areas especially that were of concern were with regard to Competence and Spouse. High scores on the Competence subscale may often suggest parents who are lacking in practical child development knowledge or who possess a limited range of child management skills. Additionally, high scores will be found among parents who do not find the role of parent as reinforcing as they had expected. These parents are often overwhelmed by the feeling that "this child is more than I bargained for" and "I am not sure if I would have children if I had to do it over again." A high score on this scale is also associated with a lack of acceptance of criticism from the child's other parent. It would be expected with an elevated competence score that the Spouse

subscale would also be elevated, which it is in this case. High scores on the Spouse subscale are indicative of parents who are lacking the emotional and active support of the other parent in the area of child management. As Jane's child does not appear to be a special needs child at this point, it is most likely that Jane's scores with regard to her child are fairly accurate with exception of the Demandingness subscale. Jane's perceives her child's expression of developmentally appropriate needs as inappropriate.

The *Wechsler Adult Intelligence Scale* was administered to estimate Jane's intellectual ability. Jane scored at the Below Average level of intellectual ability however, her score falls within one standard deviation from average intelligence. There is a non-significant difference between Jane's verbal score and her performance score which indicates that she performed about the same in the ability to deal with words and solve problems closely related to schooling, when compared to the ability to think non-verbally and solve "new" problems, the kind that are not taught in school.

On the *House-Tree-Person*, the results were indicative of an insecure, withdrawn, fearful individual who feels that her domestic difficulties are overwhelming, who has difficulty in socialization, who struggles with repression of past events viewed as unacceptable, and has inappropriately optimistic expectations for the future. In addition, the results indicate low self-concept, anxiety, and some what hostile feelings toward male figures. Also, there is some concern with regard to serious psychological disturbance.

DIAGNOSTIC IMPRESSIONS (DSM-IV):

Axis I	296.64	Bipolar I Disorder, Mixed with Psychotic Features
	309.81	Posttraumatic Stress Disorder
Axis II	301.90	Depressive Personality Disorder
	301.82	Avoidant Personality Disorder with Dependent personality traits and Paranoid personality features
Axis III	No concerns	
Axis IV	Psycho-social stressors:	
	Job difficulties	
	Fatigue	
	problems related to the legal system (child)	
	inadequate education	
Axis V	Current GAF: 41	

RECOMMENDATIONS:

The evaluation findings support the following recommendations:

1) It is likely that this client's difficulties can be managed with extended therapeutic methods. Continued therapy sessions are recommended to

utilize a variety of techniques in order to reduce depressive symptoms, to reduce anxiety, and to continue to develop parenting skills.

2) With appropriate consultation, targeted psychopharmacologic medications would be recommended. Attention should be given to the possibility of anti-depressant medications as a useful instrument to moderate Jane's persistent dejection and pessimism.

3) A major initial goal employing short-term therapy with Jane is to illustrate that the goals of treatment are fully achievable and that they should motivate her rather than seem impossible and futile. Disconsolate clients such as she fear that therapy may reawaken what she views as false hope; that is, it may remind her of the disillusionment she experienced when she aspired in the past and was rejected. Now that she may have found a modest level of comfort by distancing herself from desires and withdrawing from others, it is important therapeutically not to let matters remain at the levels of depressive-anxious adjustment to which she has become accustomed. At the cognitive-behavioral level, therapeutic attention may be usefully directed to Jane's depressive assumptions, anxious demeanor, self-deprecating attitudes, and behavior that may have evoked unhappiness, self-contempt, and denigration in the past. Short term and focused techniques such as those developed by Beck and Meichenbaum should help reduce her sensitivity to rebuff, her unassertive style, and her outlooks and fears that only reinforce her inversive and depressive inclination.

4) Short-term techniques may also focus attention on Jane's depressive tendencies to demean her self-worth and subject herself to the mistreatment of others. All supportive measures should be used to counteract her hesitation about sustaining a consistent therapeutic relationship. Maneuvers designed to test the sincerity of the therapist may be evident. A warm and accepting attitude is needed because this client fears facing her feelings of unworthiness and because she sets this her coping defenses are weak. With skillful supportive approaches, it will be possible to prevent her tendency to withdraw from treatment before any real gains are made. Cognitive methods will be especially useful in exploring the contradictions in her feelings and attitudes. Genuine short term gains will be achieved, but only with the building of trust and enhancing her shaky sense of self-worth, both of which lend themselves well to brief cognitive procedures. Effective focused cognitive techniques can be directed to reduce her vigilant and self-demeaning appraisals and hence diminish rather than intensify her anguish.

5) To diminish or even prevent relapse, more focused procedures can be useful in re-instructing the erroneous beliefs and interpersonal

problems. As Jane has demonstrated an interest in art, artistic intervention such as art therapy would be highly recommended to assist client in dealing with past traumatic events and in learning new behavior. The Sexual Abuse Treatment Program is an excellent example of available art therapy in the community.

6) Jane's personality has interfered with her parenting ability. Jane has been receiving services from Community Agency 2 over the past several months but states she has difficulty with consistency and recall of the information learned. Jane's intelligence evaluation shows that Jane is cognitively able to understand the information presented, however Jane would best benefit from concrete examples of information to be learned, including the use of pictures to aid in retention of the information.

7) It is my recommendation additionally that Jane does have the capacity to be an appropriate parent, however, it is imperative that she receive very highly structured intervention in parenting techniques, in developmental stages of children, and that her interactions with her child be highly supervised in a therapeutic setting due to Jane's numerous psychological difficulties.

If there are any questions concerning this report or its contents, please do not hesitate to contact me.

Sincerely,

Jennifer VanDerTuuk-Perkins, LLP

APPENDIX H

ALTERNATE TEST CASE

J. VanDerLinde Perkins, LLP
Andrews University
Dissertation Project
Validation for Checklist
Chair: Elsie Jackson, Ph.D.

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PSYCHOLOGICAL EVALUATION

Client's Name:	Jane Doe
Birth Date:	01/17/83
Date of Evaluation:	10/23/02
Date of Report:	11/22/02

REASON FOR REFERRAL:

Jane Doe is a 19-year-old Caucasian female who was referred for a psychological evaluation by her case manager, Ms. Carealot, from Children's Protective Services. The purpose of the psychological evaluation is to help provide greater insight into Jane's current level of psychological functioning and assist in providing appropriate recommendations regarding treatment interventions.

BACKGROUND INFORMATION:

Children's Protective Services became involved with the family in July of 2002. Reportedly, the allegations were for physical abuse, neglect, and domestic violence.

Ms. Doe reports that her home address is 111 Smith St. Apt. 1, Grand Rapids, MI 49504. She lives here with her fiance, Jesse James, age 36, and her son, John Doe. Ms. Doe reports that she has never been married, but has been engaged on three separate occasions: once at age 17, once at age 18, and her current relationship. She has one son, previously mentioned, John Doe, DOB 3/06/02, age 6 months. Ms. Doe reports that Jesse James is the father of John. Ms. Doe additionally states that she has "always had a thing for older guys."

Ms. Doe reports that she has completed 10th grade, but has a GED. She additionally reports no history of special education, and no family history of learning disabilities. Ms. Doe states that she did take Jr. ROTC, but dropped out after 10th grade. She reports that she got written up five times at school (in one day), and she states that her boyfriend at the time broke up with her via email. Ms. Doe states that she does not know why she got written up 5 times in one day. She

additionally reports that the school suspended her, and she decided that she "didn't need school." Ms. Doe states that she got kicked out of her house at about the same time, quite her job, and was also having emotional problems.

Ms. Doe reports that she is currently unemployed, and states she receives SSI Disability for Bipolar Disorder at a rate of $343.00 per month. She reports that she only sees $70 because the rest goes toward her rent. In addition, Ms. Doe states that she also receives cash assistance, as well as Medicaid and food stamps.

Family history includes Ms. Doe being placed with adoptive parents at approximately age 11. She feels she had to work for more things than the biological children in the family. With regard to her biological parents, Ms. Doe reports that her dad threw "something" at her, and she reports that she had a closed head injury as a result. She additionally reports that her biological father hit her repeatedly in the face for a long time and also sexually abused her, even on parenting visits while she was in foster care. She states that she has a scar on her face where her face had to be stitched. Ms. Doe states that she doesn't remember much prior to age 2, and also states that her biological brother was also physically and sexually abused by her biological father. She reports as well that her biological mother was physically abused by her father. Ms. Doe states that she has been told that she has more than 2 brothers and sisters, and reports that she has met 2 of her brothers: one was adopted elsewhere and one remained in foster care. Ms. Doe states that parental rights were terminated on her biological parents, and she reports that she was adopted by a divorced single parent who also adopted 1 other child, in addition to her 2 biological children. Ms. Doe reports that her adoptive mom "smacked" her in the face and "took her anger out on her." Ms. Doe states that her adoptive mom attempted to use time-outs, removal of privileges, etc., but these things did not work with Ms. Doe. She reports that her adoptive mother always "yelled" at her. Ms. Doe does state that there may possibly be some psychiatric/psychological history in her family-of-origin, but she is not certain. She does state that she believes her biological dad is "crazy," and states that her older brother (Jimmy) does not currently speak with her because he doesn't like her fiance (Jesse James). Ms. Doe believes that her brother Joe, who was adopted, has a "mental problem." She reports that the last time she saw him he started writing like a "kindergartener." She thinks he had "ADD because he had the attention span of a gnat."

Current psychiatric/psychological treatment consists of outpatient therapy with therapists Sue Smart, MSW, and Delight Tomeetu, MSW. Ms. Doe's previous psychiatric history is quite extensive, beginning at age 3, when she first visited a counselor. She states that she thinks she saw a counselor from the time she was 3 to approximately age 11. She reports that she didn't trust the counselor then because she didn't know who the person was. She then states that she saw another counselor until age 13, and then after her inpatient stay at age 15, at Grand Rapids Psychiatric Hospital, she began seeing another counselor. Ms. Doe reports that she was "betrayed" by her counselor when she was ages 9 to 11. With regard to this, she states that 18 families wanted to adopt her and she reports that her counselor lied to these families and told them she was a "bad kid." Ms. Doe additionally states that her adoptive mother got the counselor fired. She reports that she has a large problem with trust.

Psychiatric hospitalization began at age 7, when she was hospitalized at Detroit Psychiatric Hospital in Detroit, Michigan. At that time, Ms. Doe reports that she had a "nervous breakdown" and tried to hurt someone while she was in foster care. She states that she didn't understand what was happening to her. She additionally reports that she was not prescribed any medications, and does not recall how long she was inpatient in the children's wing. Ms. Doe does state that she met her current fiance at that time (when she was 7) because her fiance's son (who later died due to heart failure) was inpatient alongside her. She reports that she recognized her fiance when they first met.

Second and third hospitalizations occurred at approximately age 15. Ms. Doe reports that these were situational, and that each hospitalization resulted in a week of inpatient treatment, with a diagnosis of Bipolar disorder, manic phase. At that time, Ms. Doe was prescribed meds which included Dexedrine, Seroquel, Risperdal, Prozac, Wellbutrin, and Depakote. She reports that she stopped taking the Depakote at approximately age 17. The events leading up to the hospitalizations included blackouts and intent to self-harm. In addition, Ms. Doe states that she "went off" on her family and supposedly tried to kill herself. She reports that her sister was angry and swearing, and her mother said "something awful" to Ms. Doe (she called her a "slut"). Ms. Doe said "oh, it's okay when your own daughter acts like a bitch, but not when I do." She states that her mother slammed a baked potato into her back. She reports that the situation escalated from that point, and she punched her mother. In addition, Ms. Doe states that she repeatedly broke curfew just sitting and talking to her boyfriend. She also reports that her adoptive mother's nephew tried to kill her because she stuck up for her cousin. Ms. Doe states that he knocked her over while he was hitting his sister. He slammed Ms. Doe against the wall and held a pool cue against her neck. She reports that she blacked out and she ended up throwing him across the room.

At approximately age 16, Ms. Doe reports that she went through "relapse," and states that she was not taking her medication. She reports that she began getting depressed. This led to hospitalization at Walker Psychiatric Hospital at age 17 which Ms. Doe states was the "best week of her life." She reports that she was inpatient for approximately 1½ weeks, and stopped taking Depakote because it was making her angry. Ms. Doe states that her adoptive mother took her to Walker Psychiatric Hospital after Ms. Doe left home. Ms. Doe reports that she was in a downward spiral, and states that her fiance at the time threw her down the stairs. She reports that she left home and went to the Adolescent Home, where she lived for approximately a week. After that, she had nowhere to go so her adoptive mother placed her at Walker Psychiatric Hospital in the children's wing. Ms. Doe states that she did not want to go. She reports that she was not taking her medication regularly, but had been taking it regularly at the Adolescent Home. Ms. Doe states that while she was at Walker Psychiatric Hospital she got angry at the staff because one of the children broke their arm and she thought the staff did it.

Ms. Doe reports that she is an "insomniac" or a "night owl." She states that she sleeps a lot during the day, and reports that she has been afraid of the dark throughout her entire life. In fact, she states that she slept with a nightlight until age 16. Ms. Doe states that she had seizures when she was smaller, and reports that she will start shaking prior to a seizure. She states this is the result of her closed head injury.

Ms. Doe reports that her physical health is adequate, but states that she is getting x-rays for her knees, and reports that she might be anemic. In addition, she states that her medical doctor is checking for thyroid disease currently because she is having trouble losing weight. She is not now taking any medication or vitamins. Ms. Doe reports a history of both anorexia and bulimia. She states that at age 15-16 she was anorexic because she went from a size 22 to a size 14 in 3 months and reports that she was barely eating. She states she was constantly working out, and would only eat "a bag of Doritos and a Diet Coke, and occasionally Taco Bell." She reports this was largely due to her brother calling her a cow, for example, he said "Moo ..., Get up!" (in the morning). Ms. Doe states that at age 13 she was bulimic because she "thought she was fat." She reports that everyone at her school was skinny and one of her friends told her that she wasn't fat, just overdeveloped. Ms. Doe states that she was bulimic for approximately 2 months. She reports that she realized she was not happy with herself that skinny. In addition, Ms. Doe states that during all of her hospitalizations, she continued to work out, including weightlifting her bed at Grand Rapids Psychiatric Hospital.

Use of substances includes previous use of alcohol on 2 reported occasions. Ms. Doe reports that she had a wine cooler at approximately age 18, and had a "screwdriver" at age 17, from which she promptly threw up. She states that she does not now smoke, but did smoke for approximately 1 month when she was 15 because she thought it made her look "cool." Ms. Doe reports that she did smoke marijuana last year, which she tried on one occasion, and which helped her go to sleep easily. (I will note here that Ms. Doe asked me if marijuana was a drug; when I asked Ms. Doe if she had ever used any drugs, she initially said "no.") Ms. Doe stated that she smoked marijuana like a cigarette and reports that she was told it was a just a cigarette. She states she was "manipulated." Ms. Doe additionally states that "drugs are bad anyway ... they just get you into trouble and cost money."

Ms. Doe does not report any history of prostitution or sexual addiction.

Legal history includes Child Protective Service involvement, where Ms. Doe reports that her fiance hit her. She states she was told she called the police and her fiance was arrested. With regard to her son, she states that a friend called CPS because her son had a bruise on his head from crawling around, and her friend thought the bruise was from Ms. Doe's fiance hitting Ms. Doe's son. Ms. Doe reports that her case would have been closed by now, and states that she was offered P21! services from another agency, but states that she was told it was completely voluntary and she did not want to sign anything that day. In addition, Ms. Doe states that she thought she was pregnant, and went to the hospital because she was having pain. She reports that the hospital told her she wasn't pregnant, she was just having pain. She states that "maybe she was dealing with losing a baby."

When CPS became involved, the police officer who responded to the domestic violence call told Ms. Doe that Jesse James had a bench warrant for child support and for "hindering an officer." In addition, it was reported that Mr. James had a ticket for "public consumption of alcohol." Ms. Doe states that she did not believe the police officer. Ms. Doe also reports that she was asked to take a breathalyzer, but there were no legal charges.

Ms. Doe reports that Jesse James has hit her on a previous occasion, but she states it was just a "joke." She reports that she lived at Homeless Inn and states she and Jesse were arguing loudly. Ms. Doe reports that the police were called because they thought "they were beating each other up." Currently, Mr. James has a no-contact order with Ms. Doe, and they are to have no contact.

Further legal difficulties arose when Ms. Doe was a teenager prior to her hospitalization at Grand Rapids Psychiatric Hospital at age 15. She reports that she broke into someone's home to use the telephone. In addition, Ms. Doe states that she ran away from home, and reports that she used to have trouble with stealing things. She states that she stole from a home where she was babysitting.

Ms. Doe reports that she has not attended any parenting classes, but states that she has covered some parenting topics with therapist Sue Smart, MSW. She reports that she plans to use time-outs with her son, and states that she has smacked her son's hand once because he reached for the space heater. In addition, Ms. Doe reports that she started attending an agency for domestic violence counseling approximately one month ago, but has only been to one session, which she states "didn't help." Ms. Doe does not report any specific sexual abuse counseling, and states that she is not bothered about the sexual abuse. She states that no-one has ever told her that it could lead to some of her current behaviors. She reports that she "never let it bother her."

Ms. Doe appears to move in and out of relationships quickly, as evidenced by her repeated engagements, for example, she was engaged at age 17 for approximately 1 day, but reports that her fiance died the next day. Then she was engaged approximately 20 days later to another man.

Current medication includes nothing at the moment. Past usage as of February, 2001, included Wellbutrin, Dexedrine, Risperdal, and Seroquel. Ms. Doe reports that the Risperdal would calm her down. She states that she has not taken these medications due to a lack of health insurance. Ms. Doe reports that she is seeing her medical doctor November 20, 2002 and would like to have her prescriptions renewed at that time.

History of hallucinations includes the possibility of a visual perception of a "ghost" on one occasion. No other history of either visual or auditory hallucinations is reported, however, there is some evidence of delusional thoughts and/or ideation.

CURRENT TESTS ADMINISTERED:

Clinical Interview
Consultation with Sue Smart, MSW
Review of Children's Protective Service records
Mini-Mental State Examination (MMSE)
Millon Clinical Multiaxial Inventory-III (MCMI-III)
Kaufman Brief Intelligence Test (K-BIT)
Parenting Stress Index
Human Figure Drawing

BEHAVIORAL AND TESTING OBSERVATIONS:

Jane Doe is a 19 year old Caucasian female. She demonstrates a right-handed preference. Her appearance was within normal limits. Her behavior was cooperative, but demonstrated pressured speech and at times she was highly agitated, including exaggerated startle reflex. She demonstrated almost euphoric affect at times, such as that consistent with a manic phase. She was extremely difficult to keep "on task," and in addition she demonstrated poor eye contact, and often exaggerated actions and/or activities in her personal history. She demonstrated somewhat illogical cognitions and was grandiose in her approach. Ms. Doe appeared to periodically confuse the lines between reality and imagination. She did report some history of depression, and also a history of sexual abuse and domestic violence. In addition, there appears to be a lack of realization of how Ms. Doe's decisions and actions affect her son, in particular.

EVALUATION FINDINGS:

On the *Mini-Mental State Examination (MMSE)*, Ms. Doe attained a total score of 30, which demonstrates normal cognitive functioning. The MMSE is a brief and objective screening test for cognitive impairment. It is an effective and widely used method for detecting and quantitatively estimating the severity of cognitive impairment and for documenting cognitive changes over time. Ms. Doe did not miss any questions, and was alert and responsive during this test.

On the *Millon Clinical Multiaxial Inventory III (MCMI III)*, testing indicates a need for social approval or naivete about psychological matters. On the basis of test data, it may be assumed that Ms. Doe is experiencing a severe mental disorder; further professional observation and inpatient care may be appropriate. At times charming, but often moody and erratic, Ms. Doe is disposed to vent upsetting feelings and to overreact to conflicts and difficulties. There is reason to believe that at least a moderate level of pathology characterizes Ms. Doe's overall personality structure. Her foundation for personality regulation appears to be either deficient or incompetent. Although she is usually able to function on a satisfactory basis, she may experience periods of marked emotional, cognitive, or behavioral dysfunction. Ms. Doe's testing profile suggests a veneer of friendliness and sociability that cloaks an abrasive hypersensitivity to criticism and a marked tendency to project blame onto others. Although she is able to make a good impression on casual acquaintances, her apparently characteristic unpredictability, impulsiveness, resentment, and moodiness may be seen frequently by family members and close associates. Testing indicates that Ms. Doe is likely to seek attention and excitement, and often engages in self-dramatizing behavior. Relationships may be shallow and fleeting, and they may frequently be characterized by manipulative deceptions and disrupted by caustic comments and hostile outbursts. She may often act on impulses with insufficient deliberation and poor judgment. She may also be seen as irresponsible and undependable by others, and may exhibit short-lived enthusiasm followed by disillusionment and resentment. Antisocial tendencies may at times be acted out. When challenged, subjected to minor pressure, or faced with potential embarrassment, she may be provoked to vindictive anger. Temper outbursts may reach intense proportions and sudden, unanticipated violence may be expressed.

On the *Kaufman Brief Intelligence Test (K-BIT)*, Ms. Doe obtained a Vocabulary Scale IQ of 101 (53rd percentile) and a Matrices Scale IQ of 108 (70th percentile). These scores result in a Full Scale IQ score of 105, which places her overall level of intelligence in the average range of functioning. The present findings appear to be a valid indicator of her current level of intelligence. There was not a significant difference in the test scores on the two main areas measured by this instrument. Ms. Doe performed about the same in the ability to deal with words and solve problems closely related to schooling, when compared to the ability to think non-verbally and solve "new" problems, the kind that are not taught in school.

On the *Parenting Stress Index*, Ms. Doe scored with total stress in the average range. Ms. Doe responded to this instrument with regard to her son, John, DOB 03/06/02. She did not respond to this instrument in a defensive manner, and appears to perceive herself as a capable parent. The *Parenting Stress Index* was designed to be an instrument in which the primary value would be to identify parent-child systems that are under stress and at risk for the development of dysfunctional parenting behaviors, or behavior problems in the child involved. Ms. Doe did, however, achieve high scores in the areas of Demandingness (child domain) and Health (parent domain). In addition, Ms. Doe scored extremely low on the scale of Attachment (parent domain). High scores in the Child Domain may be associated with children who display qualities that make it difficult for parents to fulfill their parenting roles. High scores in the parent domain suggest that the sources of stress and potential dysfunction of the parent child system may be related to dimensions of the parent's functioning. High scores on the scale of Demandingness are produced when the parent experiences the child as placing many demands upon her. High scores on the Health scale are suggestive of deterioration in parental health that may be the result of either parenting stress or an additional independent stress in the parent-child system. A low score on the scale of Attachment could suggest that Ms. Doe is reporting that she is extremely attached to her child, which may indicate a discrepancy between Ms. Doe's perception of her feelings and her actual behavior.

The *Human Figure Drawing* projective test was administered to attempt to determine the presence of a configurational pattern of personality traits. Wide agreement exists that human figure drawings are primarily a manifestation of the subject's perception of self or the self one wishes to be. Ms. Doe's drawing had the following emotional indicators: feelings of weakness; feelings of inadequacy; possible organicity; aggressive, dominant tendencies; strong drive level; compensatory strivings for feelings of weakness; suspicion, perhaps paranoid tendencies; anxiety; overly sensitive to social opinion; overly sensitive about appearance; compensatory defenses of aggression and social dominance due to felt inadequacies, grandiose, ego-expansive tendencies; paranoia and narcissism; overevaluation placed upon intelligence or high intellectual aspirations; fantasy is basic source of satisfaction; oral eroticism or verbal aggressiveness associated with dependence; regressive personality; schizoid tendencies; hysteria in neurotic individuals; feelings of body weakness and inferiority; phallic preoccupation; sexual inadequacy with compensatory feelings; possible homosexual tendencies; possible acting-out tendencies spawned by defiance of authority and/or insecurity; heightened awareness of unsatisfied motives or drives; and sexual conflict.

DIAGNOSTIC IMPRESSIONS:

1. Bipolar disorder (manic, severe), possibility of schizoaffective disorder (rule out thyroid problems)
2. Post traumatic stress disorder
3. Paranoid personality disorder, narcissistic personality disorder with depressive personality traits, and negativistic (passive-aggressive) personality traits

SUMMARY AND RECOMMENDATIONS:

Individuals who experience mania may not complain about their symptoms (and may resist treatment) because initially, euphoria may be the predominant feeling. Family or friends may first notice that the individual is behaving abnormally. Some individuals, especially those with psychotic features, may become physically assaultive or suicidal. Mood may shift rapidly to anger or depression. Frequently, manic episodes occur following psychosocial stressors. There is some evidence that changes in sleep-wake schedule may precipitate a manic episode. Approximately 70%-90% of patients with bipolar disorder continue to display mood lability and interpersonal or occupational difficulties.

In addition, individuals with paranoid personality disorder (delusional disorder) may appear tense, anxious, unsure, irritable, or angry. They may present themselves as very businesslike but have an underlying expectation of harm or trickery by the clinician. There may be preoccupation with justice and rules.

Concern exists surrounding this patient's reported past history of blackouts, and I would recommend continued observation in this regard. In addition, sexual abuse counseling would be extremely beneficial, as this patient's history may be contributing to her mental health issues at this point.

Additional concern exists due to Ms. Doe's dependency and narcissism which puts her son at risk of neglect and/or abuse.

A first step following this evaluation would be to refer Ms. Doe for a psychiatric appointment to evaluate Ms. Doe's need for psychotropic medication. Secondly, the treating therapist should help Ms. Doe understand, using concrete, behavioral intervention methods, how her past experiences have impacted on her current behaviors, and how those behaviors are affecting the well-being of her son. A cognitively-oriented approach might assist Ms. Doe in becoming more sensitive and aware of objective reality; this may prove especially helpful after taking steps to strengthen her capacity to confront her weaknesses and deficiencies. When she can deal with herself on a more realistic and insightful basis than before, she will be less likely to develop illusory attitudes and dysfunctional behavior. A starting goal for therapy should be to aid the patient in reducing her intense ambivalence and growing resentment of others. The clinician should avoid acting omnipotent, but should maintain a firm, consistent, and understanding

attitude. Short-term approaches may be best, at least initially. Ms. Doe will not be inclined to face her ambivalence, but this must be a major focus of treatment.

It is advisable that the therapist not set goals too high because Ms. Doe may not be able to tolerate demands or expectations well. Brief therapeutic methods should be directed to build this patient's trust, to focus on positive traits, and to enhance her confidence and self-esteem.

It is also recommended that Ms. Doe receive parenting education with regard to developmental stages of children, age-appropriate expectations, and education with regard to protective parenting.

If there are any questions concerning this report or its contents, please do not hesitate to contact me.

Sincerely,

Jennifer VanDerTuuk-Perkins, LLP

APPENDIX I

SAMPLE VALIDATION CASE–B

J. VanDerPool-Perkins, Ph.D.
Andrews University
Dissertation Project
Validation for Checklist
Chair: Elsie Jackson, Ph.D.

PSYCHOLOGICAL EVALUATION

Client's Name: Ms. Jane Doe
Birth Date: 01/01/61
Date of Evaluation: 8/15/02
Date of Report: 8/20/02

REASON FOR REFERRAL:

Ms. Doe is a 41-year-old Caucasian female who was referred for a psychological evaluation by her case manager, I.M. Caring, from Children's Protective Services. The purpose of the psychological evaluation is to help provide greater insight into Jane's current level of psychological functioning and assist in providing appropriate recommendations regarding treatment interventions.

BACKGROUND INFORMATION:

Jane reports that her permanent home address is 12345 Main St., Anytown, Michigan 49999, but states that she is currently residing with her parents at 11570 Front St., Anytown, Michigan 49999. Jane states that this is the result of a divorce action which she recently filed. Jane reports that she currently has physical custody of the children. Jane states that she has three children: Justine, age 12; James, age 9; and Jude, age 5. Jane reports that her spouse is John Doe, age 42, and states that he is currently residing at the family address in Anytown, pending further order of the court.

When asked to describe her children, Jane reports that Justine is depressed and suicidal. Jane states that Justine wishes she were dead and reports that Justine feels that her father ignores her. Jane states that Jude is happy all of the time and states that John plays with Jude all of the time and is greatly involved with him. Jane reports that James is also depressed, and has been diagnosed with Oppositional Defiant Disorder and depression by the local psychiatric hospital and has been taking Concerta. Jane reports that James "calmed down within 2 days of taking Concerta." Jane reports that James would start screaming and attacking others for no reason and

states that he frequently attacks Jude. Jane reports that with regard to discipline she utilizes "1-2-3 Magic," time-outs, uses a reward system, and removes privileges. She also gave a recent example that "the children were naughty at the swimming pool, so they can't go swimming today." Jane reports that she has utilized spanking in the past, including the use of a paddle, but states that she "didn't do it as hard as John." Jane reports extensive medical history on each of the children as follows (Jane does preface this information by stating that a previous doctor had expressed concerns that Jane was making up her childrens' difficulties, but Jane just felt that "something was wrong" with her children):

Justine had the most problems when she was born. Jane reports numerous pregnancy complications including toxemia, preeclampsia, failing kidneys, and almost bleeding to death after the birth. Jane reports that she had a County health nurse come to her home because Justine was very sickly for the 1st year. Jane states that she had to keep going to different doctors to determine Justine's medical problems. Jane reports that Justine was 90% deaf at 18 months and reports Justine was lip reading. Justine had tubes put in her ears by a specialist which aided her hearing. Jane also states that Justine had no feeling in her feet, and Jane reports that she came home from the doctor and prayed with her church. She then states that she returned with Justine to the doctor 2 weeks later and the doctor stated that Justine had 100% feeling in one foot and 85% in the other foot. Jane reports that Justine is also nearsighted and wears glasses. Jane also reports that Justine's teeth were crooked so she took her to an orthodontist who reported that Justine needed to have a "palate expander" because of a constricted nose bone which was not allowing enough oxygen to reach Justine's brain. After the palate expander, Justine then had to have her tonsils and adenoids taken out prior to braces being applied. Jane states that Justine always suffered from low energy, which she believes to be the lack of oxygen to Justine's brain, and reports that she often had to carry Justine up the stairs after school because Justine did not have enough energy to walk. Jane reports that after Justine had the palate expander installed, and her tonsils and adenoids removed, Justine had so much energy that she was able to walk and run without any difficulty. The ENT specialist who recommended that Justine's tonsils and adenoids be removed apparently gave reasoning that these were placing pressure on Justine's eardrum so she couldn't hear sounds. Jane reports that after the tonsils and adenoids were removed, Justine began complaining that sounds were so loud she could hardly tolerate the noise.

James had the same tonsils/adenoids problems as Justine, and these were removed. Jane states that the doctor said James had "larger adenoids than he had ever seen." James also saw the same orthodontist as Justine who told Jane that James also wasn't getting enough oxygen to his brain and recommended a palate expander also. Jane reports that James is also nearsighted and needs glasses, and in addition, has an eye muscle problem and almost went blind as a result of this problem. Jane reports that she diagnosed this eye problem herself, and then took James to the eye specialist who recommended glasses. Jane reports that James hasn't had visual trouble since that time. Jane additionally reports that James was diagnosed as AD/HD, ODD, and depressed by the local psychiatric hospital.

Jude hasn't visited any specialists. Jane reports that Jude doesn't get sick very often. She additionally states that Jude is John's favorite child. (I will note here some concern that Jane may not feel needed by this child, hence the lack of illness?)

When speaking about her relationship with John Doe, Jane states that they have been married for 14 years and reports that John has been verbally and physically abusive toward her. Jane reports that John has been neglectful in replacing household items as they wore out. When questioned about this, Jane reports that the family home is a "damp, musty house" and reports that when they moved into it, they needed to have a new air conditioner because the house was "full of germs." Jane states that no one would come to visit them because they "got sick from the house." Jane additionally reports that there were squirrels in the house.

With regard to educational history, Jane reports that she has completed a bachelor's degree plus one year of additional coursework. She reports that she was valedictorian of her high school class, and was in the band. With regard to family history, Jane reports positive relationships with each of her parents, and reports that her mother was an elementary school teacher and her father was a Methodist minister. She reports that her parents were married, and states that she has one sibling, a brother, Bob Doe, age 42. Jane reports that growing up in her family she thought everyone got along well, but reports that her brother wanted to get away from the family, and identifies him as the "black sheep" of the family. Jane stated that her brother often referred to her as "just like her mother," and reported that she would often tell her mother about her brother's activities. Jane reports that she was spanked up to age 8, but reports that she never rebelled. Jane additionally states that her parents were "wonderful" and states that her parents loved her and states that "you can tell I come from a Christian family because my parents are so wonderful."

Jane recounts several painful instances of difficult adjustment during her school years. She reports that "kids are mean" and reports that she was often picked on as a child. She reports that during childhood she often had nightmares because of the kids at school. She stated that the kids were "monsters" and "didn't like her" and "harassed her." Jane even goes on to state that when she was in girl scouts, the other scouts picked on her. When questioned about how she chose friends in school, Jane reported that she befriended "outcasts" so "each of them had a friend." Jane additionally reported that she didn't fit in with others, learned things early, had no "special" pets, felt distant from others, and sucked her thumb to the age of 5. Jane also states that she had a favorite object, a "Mrs. Beasley" doll, that she still has. Jane reports that the Mrs. Beasley doll was blonde, and states she used to pretend the doll was her daughter because she always wanted a daughter with blonde hair. Jane reports that when Justine and James were little, she used to take out the Mrs. Beasley doll and measure their growth against the Mrs. Beasley doll, and would take their picture with the doll. Jane states that she "always wanted kids" and reports she was thrilled that she had a daughter with blonde hair, just like her Mrs. Beasley doll.

With regard to employment information, Jane reports that she is not currently employed, but has worked as a stay-at-home mother for the past 5 years since the birth of Jude. Prior to that, Jane reports that she worked as a data entry clerk, and has worked in customer service and accounts receivable. Jane reports that she enjoys this type of work and would like to return to it.

Jane's health and psychological history is quite extensive. Jane reports numerous prior visits for psychological/psychiatric treatment, beginning as early as age 3. Jane states that when she was 5, her parents took her to see someone because her parents couldn't understand her. When questioned about this statement, Jane clarified that "she didn't make sense to her parents." This

was not due to a speech/language delay according to Jane, but simply the meaning of the words that she used. Jane reports that she saw a counselor in Jr. High because she didn't make any friends and she needed social skills training. Jane reports suicidal ideation in Jr. High because of kids picking on her. She also reports an "out of body" experience in Jr. High while she was contemplating suicide. She states that she was laying prone with arms and legs spread on the living room floor and left her body and an angel took her to heaven and told her that great things were planned for her. She says she then returned to her body and did not remember that she was contemplating suicide. As recently as February of 2002, Jane was inpatient at the local psychiatric hospital for approximately 10 days. Jane reports that "they thought she was psychotic" because she reported a "near death" experience when she was recounting a car accident that happened 5 years ago. With regard to that accident, Jane states that she and Justine were in the car and the car was totaled. Jane states that she had a bruised chest and was bleeding internally. She reports that the hospital did not keep her overnight, but told her that she had a bruised heart and told her to go home and lay down for a month or two. Jane reports that she had the experience of seeing Jesus and angels and dying and returning to life, and reports that her daughter Justine also had the same experience. Jane reports that they both hit their heads, and states that Justine was 6 or 7 at the time. (I will also note here that Justine was not seriously injured in the accident and did not require hospitalization, according to Jane.) Jane reports that she had a physical exam approximately 1 year ago, but reports that she has had abnormal bleeding recently. Jane reports that she is highly allergic to the sun and has stated that she is prescribed Zyrtec for this. (Again, I will note here that Zyrtec is a medication commonly prescribed for seasonal allergies.) Jane also reports that she has had a skin cancer removed as recently as a week ago, Monday. Jane reports that this was basal cell cancer and states that she had the stitches taken out yesterday. She states that the dermatologist removed the cancer in the doctor's office last Monday, and then Jane had to go to the hospital for plastic surgery last Wednesday. (Jane presented with a small "butterfly" bandage on her face alongside her nose.)

Jane's history of delusions is lengthy. While in college, Jane reports that she frequently "cast out" demons, and often while praying, angels would visit her and talk to her. Jane states that on one occasion when she was praying with her roommate, she could hear the angels singing and talking and states that both she and her roommate could hear this in their heads. Jane reports that she was singing in tongues, and states that the next day 2 girls came to talk to her and said they could hear at least 15 voices coming from Jane's room the night before. Jane states that the 2 girls told her they tried to enter the room, but that a force prevented them from knocking on the door. Jane additionally states that the next morning after this incident, she saw an angel walk through the outside door who said "why are you afraid of my messenger?" Jane states that the angels could read her thoughts and states that she came up to her roommate with an angel on each side of her that the roommate could not see.

On one occasion during college, Jane reports that she cast out demons from a student "who had declared himself to be the devil." She reports that she made a cross with her arms on one side of the student, and states that the room had a cross on the other side of the student. Jane states that God gave her the words to speak and states that God identified her as his "chosen one." Jane reports that she saw Jesus chase the demon and other demons out of the building. Jane states that while casting out these demons, she did not have a herd of swine available (as in the Bible), so she cast several of the demons into 3 squirrels and 2 cats that were running around the campus.

Jane states that she sent the rest of the demons to Hell. Jane goes on to recount that she cast demons from approximately 25 students, and had to leave college because these 25 students had hired a man to harass her and molest her. She reports that this man came to her and told her that "he would come back later to rape her." Jane states that he waited to rape her because she wasn't on birth control and he didn't want her to become pregnant. Jane reports that she had nervous anxiety after this, and was on a heart monitor because she was a "shaky mess." She reports that she ended up having to do correspondence courses. Jane states that when she returned to college after several months to take an examination, a friend of hers in the biology department told her that 3 squirrels and 2 cats had been found on campus with exploded internal organs, and that these animals had to be sent to Lansing because no-one could determine the cause of death. Reportedly, these animals died the night Jane cast out the demons into them.

Jane also recounts another incidence in college when she was attending computer classes at college. She states she went to a nursing home to sing Christmas carols. She reports that there was a demon-possessed old man there who told her "we don't want you here." Jane states that others in the nursing home saw Jesus walking behind her. Jane reports that a woman in a wheelchair was trying to get away from her, and Jane states that she went up toward the woman and said in her mind "In the name of Jesus, you must get out ...." Jane then states that she told the woman verbally that the demon had left and reports that she saw a black inky spot come out of the woman's back. Jane reports that the old woman then stated that her back hurt her. On the same occasion, Jane states that there was another old woman who was blind and who grabbed Jane's arm and told her that she could see Jane. Jane reports that Jesus told her to ask the woman if she would like to see. Jane told this to the woman, then states that the woman said she didn't want to see her surroundings, being in a nursing home, and did not want her sight restored.

With regard to her children, Jane states that she saw an angel visit each child when they were less than 2 years old. She also reports that she saw an angel in her bedroom approximately 10 years ago. She states that she opened the door and saw the angel looking her in the face. Jane reports that when Justine was 13 months old, Jane saw a man in regular clothes in Justine's bedroom talking to her, but when she went to Justine's bedroom, the man was no longer there. Jane states that she left the room and went back into the hallway, and then saw the man again. Jane states that she knew this man was an angel, and the angel talked to her and told her that he was the "Protector of Children" and stated that Jane should not be able to see him because only children could see him. Jane states that James saw an angel when he was 18 months old, and states that James described the angel, but Jane reports that she could not see it. Jane also states that Jude saw an angel when he was 2. Jane says that Jude told her that he saw a ghost in his room. Jane asked him to describe it, and states that Jude reported it had wings and a white robe. Jane reports that Jude says it kept coming back. Jane states that one time she sensed that an angel was coming to the house and she went to Jude's room where she saw it was a "bad angel" and she "cast it out." Jane reports that the angel was trying to hurt Jude, and states that Jude became sick that evening.

Jane reports that she has not seen any angels in her home since the "bad angel" incident, which was approximately 2 years ago. Jane does report hearing God talk to her as recently as February, 2002, when she states that God told her to tell the pastor at church to put the Lord's Prayer back into the service, and that he needed to stop preaching blasphemy from the pulpit. Jane reports

that she used to attend a local large church, but reports that "they thought she was crazy." Jane states that she is extra-sensitive and sees angels frequently in church talking to people.

With regard to present habits, Jane reports that she gets approximately 8-9 hours of sleep per night, but reports that it takes her approximately 1-2 hours to fall asleep. She reports that she awakens at 6 a.m. to use the restroom. She additionally reports that Zyprexa helped her sleep. Jane states that she does not exercise regularly, and reports that her parents currently have her on a weight-loss diet which she states is well-balanced. Jane reports that she does not drink alcoholic beverages. Jane states that she did have a blackout after a car accident in Anothertown, Michigan during her first job after college. She reports that she lost consciousness and had a dislocated back and a head injury. She reports that she went to see a neurologist who reported that she did not have memory recall and told her that her head was "short-circuiting." She reports that the medication she was prescribed did help her at that time. Jane reports that currently she is prescribed Paxil (20 mg.) and Klonopin (5 mg.), and has previously been prescribed Zyprexa (10 mg.), but states that she has not taken Zyprexa recently and is more awake and "upbeat" off this medication. (I will note here that Zyprexa is an anti-psychotic medication that is often used to help manage the symptoms of schizophrenia and other psychotic disorders.) Jane is additionally prescribed Zyrtec, which is, according to Jane, for her allergy to the sun. Jane reports that there is no history of alcohol or other substance abuse problems in her family.

Jane reports that she feels that she is currently in a safe living situation, that her physical needs are being met, and that she is physically healthy. She reports her self-esteem as "high." With regard to future goals, Jane states that she wants to have her kids during the day, wants to get back into her house, and wants to get a day job. She reports that her current financial situation is tight, as she has no income. Jane also states that she is not currently receiving any child support. Jane reports that she does not receive Medicaid, and states that she and the children are covered by John's insurance. For fun, Jane states that she enjoys knitting hats for charity. She reports that she has knitted 18 hats in the last 2 months. She also states that she enjoys hooking rugs and sewing clothing for herself and the children. Jane also reports that she enjoys home-décor sewing. Jane reports that there is nothing about herself that she would like to change, but reports that she is currently on medication and is often critical of others.

CURRENT TESTS ADMINISTERED

Clinical Interview
Consultation with treating therapist
Review of Children's Protective Services records
Mini-Mental State Examination (MMSE)
Parenting Stress Index
Koppitz Human Figure Drawing

BEHAVIORAL AND TESTING OBSERVATIONS:

Jane is a 41-year-old Caucasian female. She demonstrates a left-handed preference, but reports that she is ambidextrous. She presents as very verbal with "happy" affect and an immature humor structure. She made poor eye contact, was continuously off-task, and her perception of events was greatly distorted. She demonstrated hypochondriasis, and was very concrete in her approach to task completion. She did not appear to remember many childhood events and played with her hands repeatedly.

EVALUATION FINDINGS:

On the *Mini-Mental State Examination (MMSE)*, Jane attained a total score of 28, which falls in the normal range of cognitive functioning. The MMSE is a brief and objective screening test for cognitive impairment. It is an effective and widely used method for detecting and quantitatively estimating the severity of cognitive impairment and for documenting cognitive changes over time. Jane missed questions with regard to the date and with regard to immediate recall of a list of objects.

On the *Parenting Stress Index*, Jane scored with a total stress in the high average range. Jane responded to this instrument with regard to her son, James, date of birth 12/12/92. The *Parenting Stress Index* was designed to be an instrument in which the primary value would be to identify parent-child systems that were under stress and at risk for the development of dysfunctional parenting behaviors, or behavior problems in the child involved. Jane's testing profile is consistent with that found in families with hyperactive children and/or children with behavior disorders. High scores were obtained on several subscales of the Child Domain. High scores on the Adaptability subscale is associated with characteristics that make the parenting task more difficult by virtue of the child's inability to adjust to changes in his physical environment. A high score on the Demandingness subscale is often produced when the parent experiences the child as placing many demands upon her. A high score on the Mood subscale is associated with children whose affective functioning shows evidence of dysfunction. Often, it is critical to look at the possibility of impairment in maternal attachment to the child. A high score on the Acceptability subscale is produced when the child possesses physical, intellectual, and emotional characteristics that do not match the expectations the parents had for their child. Poor attachment, rejection, or both may consciously or unconsciously be issues in the parent-child relationship.

Jane additionally scored high on the Spouse subscale of the parent domain. High scores in the parent domain suggest that the sources of stress and potential dysfunction of the parent-child system may be related to dimensions of the parent's functioning. A high score on the Spouse subscale is most consistent with those parents who are lacking the emotional and active support of the other parent in the area of child management. In most instances, the most probable hypothesis is that the relationship between the mother and the child's father is generally negative and the lack of mutual support in the childcare area is one of the symptoms of a dysfunctional relationship. Overall, Jane's total Life Stress score was at or above the 99th percentile and is

extremely concerning. As such, there is some question as to whether Jane is reporting actual events or simply her perception of these events.

The *Human Figure Drawing (Koppitz System)* projective test was administered to attempt to determine the presence of a configurational pattern of personality traits. Wide agreement exists that human figure drawings are primarily a manifestation of the subject's perception of self or the self one wishes to be. Jane's drawing indicated a narcissistic personality; sexual preoccupation; conflict over control and expression of sexual and/or other body drives; suspicion, paranoid tendencies, anxiety, overly sensitive to social opinion, uneasiness over fantasy life; need to compensate for feelings of inadequacy; aggression, hostile tendencies; defensive attitude; heightened awareness of unsatisfied motives or drives; and sexual conflict.

DIAGNOSTIC IMPRESSIONS (DSM-IV):

AXIS I:	295.60 Schizophrenia, Residual type R/O 300.19 Factitious Disorder by proxy (Munchausen) With combined psychological and physical signs and symptoms
AXIS II:	301.6 Dependent Personality Disorder
AXIS III:	Skin Cancer (by verbal history)
AXIS IV:	Child protective service involvement; custody proceedings; housing issues; unemployment; finances; medical issues
AXIS V:	Current GAF: 45

SUMMARY AND RECOMMENDATIONS:

Great concern is present in this case with regard to the history, number, and frequency of Jane's delusions, both auditory and visual. In addition, there is history with regard to a medical concern of Munchausen's Syndrome by proxy (or Factitious Disorder by proxy). It appears that Jane's perception of reality is not "realistic" and that her statements with regard to "emotional and physical abuse" of her husband may not be accurate. When I questioned Jane's statements such as "my husband tried to blow me up," I discovered that Jane's husband did not, in fact, attempt to "blow her up," it was simply that Jane's perception of reality was distorted. Additional concern is noted with regard to Jane's level of inappropriate enmeshment with her children, to the extent that Justine is exhibiting shared delusions with Jane in regard to "out-of-body" and "near death" experiences. It is highly unusual that Jane's parents have not sought out psychiatric care more diligently for Jane, but instead appear to believe her delusions.

Of additional concern is that Jane is no longer taking an anti-psychotic medication. Jane's reported lack of hallucinations of recent is most likely attributable to the anti-psychotic medication, and I fully anticipate that without this medication, Jane will soon be reporting additional hallucinatory observations.

There are only two possibilities in this situation: (1) that Jane is telling the truth and is truly "called of God" to deliver demons and to commune with angels; or (2) that she is and has experienced numerous auditory and visual hallucinations that have caused her to develop paranoid and anxious tendencies and have contributed to her gross medical care of her children, to include unnecessary surgeries and inappropriate diagnoses. Themes such as spirituality and persecutory delusions are common with schizophrenia. I tend to agree with the second conclusion, and as such, have great concern for the safety and well-being of Jane's children.

I would recommend that Jane continue to receive both psychological and psychiatric services to include anti-psychotic medication and psychotherapy to help Jane understand the difference between reality and her perception of reality. In addition, I would also recommend that Jane's interaction with her children be highly supervised and counter-balanced by reality-checking on the part of the observer to help Jane's children understand the difference between reality and perception, as that appears to be undefined within the family. As Jane's parents also appear to be sharing in Jane's delusions, I have additional concern with regard to their continued interaction with the children.

If there are any questions concerning this report or its contents, please do not hesitate to contact me.

Sincerely,

Jennifer VanDerTuuk-Perkins, LLP

APPENDIX J

CHILD PROTECTIVE SERVICES RISK ASSESSMENT FORM

FAMILY RISK ASSESSMENT OF ABUSE/NEGLECT

PS Case Name: [redacted]
Lead Number:

PS Case Number:
Assessment Date: [redacted]

NEGLECT	Score	ABUSE	Score
N1. Current complaint is for neglect		A1. Current Complaint is for Abuse	
a. No 0		a. No 0	
b. Yes 1	1	b. Yes 1	1
N2. Number of Prior Assigned Complaints		A2. Prior Assigned Abuse Complaints	
a. None 0		a. None 0	
b. One 1		b. Abuse complaint(s) 1	
c. Two or More 2	0	c. Sexual abuse complaint(s) 2	
N3. Number of Children in the Home		d. Both b and c 3	0
a. Two or more 0		A3. Prior CPS Service History	
b. Three or more 1	0	a. No 0	
N4. Number of Adults in Home at Time of Complaint		b. Yes 1	0
a. Two or more 0		A4. Number of Children in the Home	
b. One Parent 1	0	a. One 0	
N5. Age of Primary Caretaker		b. Two or more 1	0
a. 30 or Older 0		A5. Caretaker(s) Abused as Child(ren)	
b. 29 or Younger 1	1	a. No 0	
N6. Characteristics of Primary Caretaker(parent A and/or parent B)		b. Yes 1	1
a. Not applicable 0		A6. Secondary Caretaker has a Current Substance Abuse Problem	
b. X Lacks parenting skills 1		a. No, or no secondary caretaker 0	
c. X Lacks self-esteem 1		b. Yes (check all that apply)	
d. ___ Apathetic or hopeless 1	2	X Alcohol abuse problem	
N7. Primary Caretaker Involved in Harmful Relationships		___ Drug abuse problem 1	1
a. No 0		A7. Primary or Secondary Caretaker Employs Excessive and/or Inappropriate Discipline	
b. Yes, but not domestic violence 1		a. No 0	
c. Yes, including domestic violence 2	2	b. Yes 2	0
N8. Primary Caretaker Has a Current Substance Abuse Problem		A8. Caretaker(s) has a History of Domestic Violence	
a. No 0		a. No 0	
b. Alcohol only 1		b. Yes 1	1
c. Other drug(s) (with/without alcohol) 2	0	A9. Caretaker(s) is a Domineering Parent	
N9. HOUSEHOLD is Experiencing Severe Financial Difficulty		a. No 0	
a. No 0		b. Yes 1	1
b. Yes 1	0	A10. Child in the Home has a (developmental Disability or History of Delinquency	
N10. Primary Caretaker's Motivation to Improve Parenting Skills		a. non, or no secondary caretaker 0	
a. Motivated and realistic 0		b. Yes (check all that apply)	
b. Unmotivated 1		___ Dev. disability including emotionally troubled	
c. Motivated but unrealistic 2	1	___ History of delinquency 1	0
N11. Caretaker(s) Response to Investigation		A11. Secondary Caretaker Motivated to Improve Parenting Skills	
a. Viewed situation as seriously as investigator and cooperated 0		a. Yes 0	
b. Viewed situation less seriously than investigator 1		b. No 2	2
c. Failed to cooperate satisfactorily 2		A12. Primary Caretaker Views Incident Less Serious than Agency	
d. Both b and c 3	1	a. No 0	
		b. Yes 1	1
TOTAL NEGLECT RISK SCORE	08	TOTAL ABUSE RISK SCORE	08

RISK LEVEL

Assign the family's risk level based on the highest score on either scale, using the following chart:

Neglect Score	Abuse Score	Risk Level
___ 0 - 4	___ 0 - 2	___ Low
___ 5 - 7	___ 3 - 5	___ Moderate
X 8 - 12	X 6 - 9	X High
___ 13 - 20	___ 10 - 18	___ Intensive

OVERRIDE

Policy Override to Intensive. Check appropriate reason.

___1. Sexual Abuse cases where the perpetrator is likely to have access to the child victim

___2. Cases with non-accidental physical injury to an infant.

___3. Serious non-accidental physical injury requiring hospital or medical treatment.

___4. Death (previous or current) of a sibling as a result of abuse or neglect.

Discretionary:

___5. Reason: _____

OVERRIDE RISK LEVEL ___ LOW ___ MODERATE ___ HIGH ___ INTENSIVE

Supervisor's Review/Approval of Discretionary Override _____ Date ___/___/___

APPENDIX K

PTSD FREQUENCY TABLE

Table 22

Frequency of PTSD (n=149)

Variable	*n*	%
PTSD Symptoms 1 Client 1a: experienced traumatic event Client 1b: response involved intense fear		
2 symptoms - both 1a and 1b	83	55.7
PTSD Symptoms 2 Client 2a: recurrent and intrusive recollections; Client 2b: recurrent distressing dreams; Client 2c: acting or feeling as if traumatic event were recurring; Client 2d: intense psychological distress at exposure; Client 2e: physiological reactivity on exposure		
1 symptom	18	12.1
2 symptoms	17	11.4
3 symptoms	13	8.7
4 symptoms	7	4.7
5 symptoms	1	.7
PTSD Symptoms 3 Client 3a: efforts to avoid thoughts; Client 3b: efforts to avoid activities; Client 3c: inability to recall important aspect; Client 3d: markedly diminished interest; Client 3e: feeling of detachment; Client 3f: restricted range of affect; Client 3g: sense of a foreshortened future		
1 symptom	16	10.7
2 symptoms	21	14.1
3 symptoms	30	20.1
4 symptoms	9	6.0
5 symptoms	1	.7

Table 22—*Continued.*

Variable	*n*	%
PTSD Symptoms 4 Client 4a: difficulty with sleep; Client 4b: irritability; Client 4c: difficulty concentrating; Client 4d: hypervigilance; Client 4e: exaggerated startle response		
1 symptom	24	16.1
2 symptoms	23	15.4
3 symptoms	18	12.1
4 symptoms	5	3.4
5 symptoms	1	.7
PTSD Symptoms 5 Duration: lasted more than 1 month; Distress: causes clinically significant distress		
Duration	79	53.0
Distress	44	29.5

REFERENCE LIST

REFERENCE LIST

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