

2-2018

## Adult-Child Sexual Contact: Examining Mental Health Trainees' Perception of the Impact on Adult Psychological-Emotional Status

Robbie J. Steward Ph.D.

*Stephen F. Austin State University, stewardrj@sfasu.edu*

Shavonne J. Moore Ph.D.

*Massachusetts Mental Health Center; Harvard Medical School, shavonne.moore@state.ma.us*

Lisa P. Petersen M.A., L.P.C.

*lisapetersen85@hotmail.com*


Sharea Ayers M.A.

*Detroit International Academy, shareayers@yahoo.com*

Kristin A. Hinze M.A., L.P.C.

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*Dutty Director of School for Academic Affairs, zupekri@gmail.com*

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### Recommended Citation

Steward, Robbie J. Ph.D.; Moore, Shavonne J. Ph.D.; Petersen, Lisa P. M.A., L.P.C.; Ayers, Sharea M.A.; and Hinze, Kristin A. M.A., L.P.C. (2018) "Adult-Child Sexual Contact: Examining Mental Health Trainees' Perception of the Impact on Adult Psychological-Emotional Status," *Journal of Human Services: Training, Research, and Practice*: Vol. 3 : Iss. 1 , Article 3.

Available at: <https://scholarworks.sfasu.edu/jhstrp/vol3/iss1/3>

Adult-Child Sexual Contact: Examining Mental Health Trainees' Perception of the  
Impact on Adult Psychological-Emotional Status

**Abstract**

Novice mental health trainees' beliefs about the affect of adult-child sexual contact on a female child's future psychological-emotional status were examined. Thirty-eight graduate-level students currently enrolled in academic programs associated with mental health, (i.e., social work, counseling, clinical psychology, rehabilitation counseling, and counseling psychology), completed the Brief Symptom Inventory (BSI) to indicate their expected impact of adult-child sexual contact on the psychological status of a young adult woman from a stable, supportive family environment and a young adult woman from an unstable, un-supportive family environment. BSI subscale scores were significantly higher for both cases than the BSI general population's mean scores for women. For the higher family functioning scenario, practitioners' parent education, family of origin climate, prior childhood sexual contact with an adult, or education were not found to contribute significantly to the variance in their prediction of the client's overall psychological distress (BSI indices). Practitioners' childhood experience with adult sexual contact, education level, and professional experience contributed to 40% of the variance in their prediction of the client's PST scores within the lower functional family case scenario. Results of qualitative analyses are presented, and implications for training and service delivery are discussed.

## Adult-Child Sexual Contact: Examining Mental Health

### Trainees' Perception of the Impact on Adult Psychological-Emotional Status

#### Adult-child Sexual Contact and Psychological Distress

Adult-child sexual contact is a world-wide phenomenon. In a study of 17, 337 adults within a USA sample, Dube, Anda, Whitfield, Brown, Felitti, Dong, and Giles (2005) found that 16% of males and 25% of females reported having sexual contact with adults during childhood. Although prevalent within the boundaries of the USA, consensus in defining adult-child sexual abuse does not exist. Nevertheless, in spite of the differences represented in general society, the prevailing central characteristic of sexual abuse is the dominant position of an adult, who forces or coerces a child into sexual activity (APAonline, 2008).

There is a plethora of empirical research that supports the notion of a significant link between adult-child sexual contact and children's unhealthy psychological-emotional-social development into adulthood. In comparison with individuals who did not have the experience, early sexual contact with an adult has been found to be significantly linked with higher levels of depression (Durbin, Klein, & Schwartz, 2000; McNally, Perlman, Ristuccia, & Clancy, 2006; Thomas, DiLillo, Walsh, & Polusny, 2011); higher levels of anxiety (McNally, Perlman, Ristuccia, & Clancy, 2006); dissociation (Perlman, Ristuccia, & Clancy, 2006); feelings of being less romantic and passionate (negative sexual affect) (Meston, Rellini, & Heiman, 2006); attributional style for negative events (Gold, 1986; Meston & Heiman, 2000); preoccupation with sex, younger at first voluntary intercourse; teen pregnancy (McNally, Clancy, & Schacter, 2001; Noll, Trickett, & Putnam, 2003); politeness in situations wherein politeness is not anticipated or warranted (Bonanno, Keltner, Noll, Frank, Trickett, LeJeune, & Anderson, 2002); repression and memory lapses (Goodman, Bottoms, Rudy, Davis, & Schwartz-Kenney, 2001; Loftus, Garry, &

Feldman, 1994; McNally, Clancy, & Schacter, 2001; Melchert, 1996; Williams, 1994); absorption or fantasy proneness and dissociation (McNally, Clancy, Schacter, & Pitman, 2000); adult victimization (Kessler & Bieschke, 1999); social maladjustment, self-blame, and post-traumatic stress responses (Morgan & Cummings, 1999); poor overall psychological functioning (Schreiber & Lyddon, 1998); disengagement or avoidant coping styles (Coffey, Leitenberg, Henning, Turner, & Bennett, 1996); feelings of shame (Talbot, 1996); elevated scores on the Brief Symptom Inventory Global Severity Index and higher scores on the Millon Clinical Multiaxial Inventory than a clinical population that did not report the abuse (Braver, Bumberry, Green & Rawson, 1992); maladaptive interpersonal patterns and interpersonal hypersensitivity (Elliott, 1994); substance abuse disorders (Burnam, Stein, Golding, Siegel, Sorenson, Forsythe, & Telles, 1988); lower self-esteem (Gold, 1986); suicidality (Briere & Runtz, 1986); and, adolescent behavioral problems (van Gijsegem & Gauthier, 1994). In Figure 1, Lazarus' BASIC-ID Model is used to categorize the symptomology identified in the literature for clients whose early life experience as a child included sexual contact with an adult.

**Figure 1. Lazarus' BASIC-ID Model**

<b>Presentation of the Client</b>	
<b>Behavior</b>	<ul style="list-style-type: none"> <li>▪ Avoidance/Withdrawal (Kallstrom, et al., 2004)</li> <li>▪ Re-enactment of traumatic event through play behaviors. (Green, 2008)</li> <li>▪ Hyper-arousal (Green, 2008)</li> </ul>
<b>Affect</b>	<ul style="list-style-type: none"> <li>▪ Vulnerability (Kallstrom, et al., 2004)</li> <li>▪ Depression &amp; Anxiety (Kallstrom, et al., 2004)</li> <li>▪ Denial (Green, 2008)</li> <li>▪ Shame (Green, 2008)</li> </ul>
<b>Imagery</b>	<ul style="list-style-type: none"> <li>▪ Self-Concept &amp; World View (Kallstrom, et. al, 2004)</li> <li>▪ Dissociation (Kallstrom, et. al, 2004)</li> </ul>
<b>Cognition</b>	<ul style="list-style-type: none"> <li>▪ Powerlessness (Kallstrom, et al., 2004)</li> <li>▪ Stigmatization (Kallstrom, et al., 2004)</li> </ul>
<b>Interpersonal</b>	<ul style="list-style-type: none"> <li>▪ Dependency &amp; Attachment (Mason, et al., 2009)</li> <li>▪ Social Support (Mason, et. Al, 2009)</li> <li>▪ Powerlessness, Denial, &amp; Betrayal (Kallstrom, et. al., 2004)</li> <li>▪ Secrecy &amp; Isolation (Wolak, Finklehor, Mitchell, &amp; Ybrarra, 2008)</li> </ul>
<b>Drug</b>	<ul style="list-style-type: none"> <li>▪ Pain Symptomology (Campbell, R., Greeson, M.R., Bybee, D., &amp; Raja, S., 2008)</li> </ul>

These studies and reports noted in Figure 1, based on quantitative, qualitative, and anecdotal-based research, collectively provide a guide for conceptualizing the impact of early sexual contact with an adult as one possible explanation of current life psychological-emotional and relationships problems. The organization of current symptoms using Lazarus' BASIC-ID model, provides a potential template for identifying the etiology of reports of this early life experience.

To better identify the distinctive effect of adult-child sexual contact, some researchers have designed studies that compare the psychological status of those with this background with those who have experienced other forms of abuse during childhood. In a study of male inmates convicted of sexual offenses, Graham, Kimonis, Wasserman, Kline (2012) found that childhood sexual abuse was associated with higher psychopathy, grandiosity, manipulative interpersonal style, impulsive-irresponsible lifestyles and antisocial behavior than those who had experienced other forms of abuse such as neglect, physical, or emotional, in early childhood. In a study of university counseling center clientele (Braver, Bumberry, Green, Rawson, 1992), the psychological-emotional status of individuals reporting physical, sexual, emotional abuse and those reporting no report of abuse were compared. Multivariate analysis of variance results indicated significant differences between the two samples; however, no significant differences on any of the variables examined were found in comparisons across all forms of abuse. Some studies distinguish early sexual contact from other forms of trauma experiences, while some studies do not. These mixed results in the literature may be the crux of the tension that exists around the topic in discussions about the impact of adult-child sexual contact.

#### Effects of Adult-Child Sexual Contact and Family Functioning

Addressing this topic among mental health practitioners is somewhat controversial.

There is the presence of an opposing viewpoint within the field, which purports that early adult-

child sexual contact alone has little to no effect on psychological development. In a meta-analysis, Rind, Tromovitch, and Bauserman (1998), the pinnacle study around much of this perspective, revealed that university students with adult-child sexual contact in their backgrounds, on average, were only slightly less well adjusted than students in the control group; and that the poorer adjustment could not be attributed to the experience. Family environment explained considerably more adjustment variance than the early sexual life experience. In summary, prior beliefs about childhood sexual abuse were not supported.

Strong negative reactions to these findings occurred. Editors, who supported the publication of the findings (Sher & Eisenberg, 2002), were targeted; authors' writing were purported to be unbalanced and somewhat inflammatory (Sternberg, 2002); flaws in the research design and misuse of statistical procedures selected were highlighted (Briere, 1992), and questions were raised about the authors' coding of data (Dallam, Gleaves, Cepeda, Silberg, Kraemer, & Spiegel, 2001; Ondersma, Chaffin, Berliner, Cordon, & Goodman, 2001). Nevertheless, it is apparent that professionals exist who continue to assert confidence in the controversial study's design, results, and the importance of reporting these findings (Lilienfeld, 2002; Rind, Tromovitch & Bauserman, 2001).

Instead of specifically targeting adult-child sexual contact as the primary cause of heightened psychological-emotional-social distress in adulthood, dysfunctional family dynamics, lower socio-economic status, unhealthy parenting, and other forms of abuse (i.e., neglect, physical abuse) are deemed most important by some professionals. Durbin, Klein, & Schwartz (2000) found that the best predictors of dysthymic disorder included an interaction among a number of variables: history of sexual abuse, quality of the patient's relationship with both parents, and higher familial loadings for drug abuse and personality disorders. Melchert (2000)

found that the largest amount of variance in college students' psychological distress was explained by parental substance abuse, and other factors explaining additional, but smaller amounts of variance in distress. In a study comparing patterns of adult psychopathology among abused and non-abused women, Nash, Hulsey, Sexon, & Harralson (1993) found that greater non-specific impairment may be a consequence of pathogenic family structure rather than sexual abuse. This body of research leads to an opposing conclusion that adult-child sexual contact may only exacerbate the effects of pre-existing, unhealthy family dynamics, but independently may not pose a major problem when there are no additional life stressors (APAonline, 2008) or when the adult-child relationship is consensual (Riley, 2001).

Additional support for this contrasting perspective is found in a number of studies that highlight the critical mediating influence of healthy family functioning. Thomas, DiLillo, Walsh & Polusny (2011) found a direct relationship between childhood sexual abuse and depression, but also found that less positive socialization practices by both parents fully mediate the relationship between the experience and alexithymia (difficulties identifying and describing feelings). Schreiber & Lyddon (1998) found that although female survivors of childhood sexual abuse were associated with significantly poorer psychological adjustment than those without the experience in their backgrounds, positive relationships with fathers was significantly associated with better psychological functioning. In an attempt to test the degree to which effects of childhood sexual abuse are independent of other pathogenic qualities in a family system, Feldman-Summers & Pope (1994) found greater nonspecific impairment among abused women may be a consequence, at least in part, to pathogenic family structure rather than sexual abuse. Although many have intuitively linked prior early childhood sexual experience with pathology in

adulthood, research findings and critical reviews of the literature have highlighted the existence of non-traumatic pathways to severe disorders (Graybar & Boutilier, 2002).

### Adult-child Sexual Contact Among Practitioners

Regardless of perspective, the study of the prevalence of both perspectives within the profession is even more imperative given the persisting documentation in the literature of adult-child sexual contact in the early life experience of mental health professionals. No matter what attitudes are held by prospective trainees or among professionals within the field, professionals overall have seemingly concluded that in combination with extremely negative family environments and in the absence of emotional support, the impact of adult-child sexual contact in early life can be severe, including symptoms of depression, anxiety, guilt, fear, sexual dysfunction, withdrawal, post-traumatic stress symptomology, and re-victimization in adulthood (APAonline, 2008; Arata, 2002; Barbo, 2004; Dube, et al, 2005; Messman-Moore & Long, 2003; Ullman & Brecklin, 2003). These phenomena together may significantly affect the entire profession given the persisting documentation of prevalence among professionals within mental health disciplines. In a national sample of psychologists, Feldman-Summers and Pope (1994) found that 22.7% of the women and 16.5% of the men reported sexual abuse in their backgrounds, and documented the phenomenon of periods of ‘forgetting’ among professionals for both genders. In a subsequent study of mental health professionals, approximately 30% of mental health professionals with this past experience was noted in the sample (Follett, Polusny, & Milibeck, 1994). In a survey of 501 clinicians, Little & Hamby (1996) found that 32% reported childhood sexual abuse histories, and were more likely to report counter-transference issues, especially boundary issues than non-abused therapists.



Elliott & Guy (1993) found that among female mental health practitioners in comparison to women in other professions reported higher rates of physical abuse, sexual molestation, parental alcoholism, psychiatric hospitalization of a parent, death of a family member, and greater family dysfunction in their families of origin than did other professionals. Little & Hamby (1999) found that female clinicians, who had experienced sexual abuse in early childhood, reported more problems with self-esteem in relationships, trust, sex, and work than males.

Given this representation and that females make up the majority of practitioners within mental health professions, the implications of the limited information that we do know, and the dearth of research that specifically examines the phenomenon in the profession, critical blind-spots in training and service delivery may exist that negatively impact outcomes in both. Just as practitioners' attitudes about race/ethnicity, socioeconomic status, and gender might influence how they conceptualize presenting problems, diagnoses, and responses to clients, attitudes about the impact of adult-child sexual contact on psychological-emotional development may do so as well.

#### Clients' Adult-Child Sexual Contact and Duty to Report

In addition, another critical point to consider is related to a commitment to insure ethical and law-affirming practice. Mental health professionals are mandated by law to report both the physical and non-physical indicators of adult-child sexual contact (Guerrina, 2001); however, trainees and even more senior practitioners, may or may not choose to question or report this issue due to personal attitudes about the impact. In addition, training programs may choose not to consistently reinforce the necessity to report, assuming that all students hold attitudes congruent with legal and professional ethical standards, when this may not be the case. Trainees

who do not believe that the impact of adult-child sexual contact is not serious under positive and affirming family situations may choose not to report suspicions in supervision for discussion or problem-solving to avoid the mandate to report; some may hesitate reporting to authorities as required by law even with the mandate. Residual anxiety or uneasiness about the topic due to direct personal experience of adult-child contact or with that of a family member or significant other, may result in: failure to inquire about or attend to clients' subtle reports of adult-child sexual experience; minimization or maximization of the effect of reported adult-child experiences; and diagnostic and treatment errors. In addition, because of individuals' under-reporting, the stigma often associated with the experience (Finkelhor & Browne, 1985), and mixed beliefs among professionals about the impact of the experience on psychological-emotional development (Riley, 2001), it would seem imperative that researchers would more carefully examine practitioners' beliefs about the phenomenon of adult-child sexual contact to increase the probability of optimal treatment outcomes. Findings from such a study will assist educators in mental health graduate programs in identifying clinical 'holes' in trainees' assessment and diagnostic skills and facilitate skill development in trainees' more accurate conceptualization of etiology for this clientele. Understanding if and to what degree mental health practitioners' background, personal experiences, and attitudes about adult-child sexual contact would seem to be imperative and vital, however attention to this specific topic in the literature is limited.

This exploratory pilot empirically examines trainees' attitudes about adult-child sexual contact and their perceptions of the impact of this life experience on psychological-emotional status. The primary objectives of this university-approved study are to examine: the variance of attitudes about adult-child sexual contact that exists among trainees; and, the impact of

practitioners' attitudes and life experiences on their perceptions of the impact of adult-child sexual contact on individuals' psychological-emotional status in young adulthood. Three research questions will be addressed: Do practitioners believe that young adults, who as a child experienced sexual contact with an adult, will have a significantly different psycho-socio-emotional status as young adults than adults in a non-client, general population? Do practitioners believe that the health status of the family of origin results in significant differences in the psycho-socio-emotional status among young adults who have experienced adult-child sexual contact during childhood? Do practitioners' early-life experiences and demographics influence perceptions of individuals who have experienced sexual contact with an adult in early development? Findings of this exploratory study will increase understanding of the implications of practitioners' beliefs about the influence of adult-child sexual contact on adult development.

### **Methods**

#### *Participants*

Participants were master's and doctoral-level graduate students from academic programs in helping professions : Clinical Psychology (doctoral-level) (n = 2 ; 5.3%), Counseling (masters-level) (n = 22; 57.9%), Counseling Education (doctoral) (n = 1; 2.6%), Counseling Psychology (doctoral) (n = 1; 2.6%), Family Ecology (n = 2 ; 5.3%), Kinesiology/Sport Psychology (master's and doctoral-level) (n = 3; 7.9%), Rehabilitation Counseling (doctoral-level) (n = 1; 2.6%), School Psychology (doctoral-level) (n = 3; 7.9 %), Social Work (masters-level) (n = 1; 2.6%), no response (n = 2; 5.3%). There were 38 total participants: *two* (5.3 %) were male and 36 (94.7%) were female; 23 (60.5%) were Caucasian American, 7 (18.4%) African American, 4 (10.5%) Asian (international), 2 (5.3%) Mexican/Hispanic American, 1 (2.6%) Turkish, and 1

(2.6%) African. The mean age was 26.6 years (range 21-53). Four of the participants (10.5%) reported previously experiencing adult-child sexual contact during childhood.

Practitioners' family of origin climate was found to be positively and significantly related to childhood sexual contact experience ( $r=.43$ ;  $p<.01$ ). Those practitioners who reported early experiences with adult-child sexual contact also tended to report an actively discouraging family of origin climate. Practitioners' number of years of professional experience was found to be significantly and positively related to practitioners' years of education ( $r=.38$ ;  $p<.05$ ). Those practitioners with more professional experience were found to be those with more years of education.

### *Research Measures*

**Informed Consent Form.** The informed consent form approved by the university human subjects' committee was distributed and collected.

**Demographic Information Questionnaire.** A researcher-developed demographic survey included items that requested participants personal and professional information related to: discipline of study, parental education level, sex, age, race/ethnicity, city or origin, number of years experience as practitioner, perception of family of origin climate, and past adult-child sexual contact.

**Case Descriptions.** One case described a girl from a supportive and stable family system; and, the second case described a girl from a negligent, unstable family system. The order in presentation of the cases was varied to identify potential case affect on participants' responses. The adult-child sexual contact experience, the characteristics of the perpetrator, and the place of the adult-child contact (school setting), were the same for both cases. Female, as the child, and male, as the adult, were specifically chosen to reflect the sex-role specific prevalence noted

throughout the literature that identified female as the most reported ‘victim’ and male as the most reported perpetrator (APAOnline, 2008). The scenarios are presented in the following section.

From this point forward Scenario 1, describing the client from the healthy family of origin, will be referred to HF; and Scenario 2, describing the client from the unhealthy family of origin, will be referred to LF.

### *Scenario 1*

Jane Doe is a bright, articulate, second-grader (7 years old), who comes from a financially stable, emotionally supportive family system (only child). The parents are well-known professionals in the community, consistently engaged in positive parenting, and have always been actively engaged in Jane’s friendships and school life. School (the same school as the one indicated in Scenario #1) has been a positive place for Jane, who enjoys learning, her friends, and her teachers. Jane went to play for recess after lunch. During recess, as she has done before, she asked a teacher to escort her to the bathroom. School policy required students to be escorted at all times. Jane approached the only teacher available, Mr. Smith, who is always friendly to all of the children, has a positive reputation within the school as a good teacher. After Jane used the restroom, Mr. Smith guided her back to his classroom where he locked the door behind them. When Jane turned around to see what was happening, Mr. Smith picked her up, covered her mouth, and carried her to the far corner of the room. He put her on top of a desk and repeatedly massaged her vulva as he masturbated. Minutes before the bell rang to end recess, Mr. Smith told Jane to sit down at her desk and wait for the other students to come into the room. He also told her not to tell anyone about what happened, or she would be in trouble. He told her that her parents would no longer love her and no one would like them if they tried to cause trouble for a teacher who was so well-liked. Mr. Smith then left to greet the rest of the children at the door

while Jane sat at her desk. This occurred sporadically for the rest of the month, which ended the academic year.

### ***Scenario 2***

Jane Doe is a bright, articulate, second-grader (7 years old) who lives with her mother, a single parent, within an inner-city community with high crime and poverty. Her mother is unemployed and is addicted to crack-cocaine and heroin. The only male figure in her life is her mother's physically abusive boyfriend, who stays with them periodically.

Although the boyfriend is abusive toward Jane's mother, he is not abusive to Jane, but ignores her. School has been a positive place for Jane, who enjoys learning, her friends, and her teachers. Jane went to play for recess after lunch. During recess, as she has done before, she asked a teacher to escort her to the bathroom. It was school policy for students to be escorted at all times. Jane approached the only teacher available, Mr. Smith, who is always friendly to all of the children, has a positive reputation within the school as a good teacher. After Jane used the restroom, Mr. Smith guided her back to his classroom where he locked the door behind them. When Jane turned around to see what was happening, Mr. Smith picked her up, covered her mouth, and carried her to the far corner of the room. He put her on top of a desk and repeatedly massaged her vulva as he masturbated. Minutes before the bell rang to end recess, Mr. Smith told Jane to sit down at her desk and wait for the other students to come into the room. He also told her not to tell anyone about what happened, or she would be in trouble. He told her that her parents would no longer love her and no one would like them if they tried to cause trouble for a teacher who was so well-liked. Mr. Smith then left to greet the rest of the children at the door

while Jane sat at her desk. This occurred sporadically for the rest of the month, which ended the academic year.

Brief Symptom Inventory (BSI). The 53-item BSI (Derogatis, 1977), the short version of the SCL-90-R (Derogatis, 1975), is a screening tool that indicates self-reported psychological distress or disturbance. In this study, it was used as a measure to assess the participants' perceptions of two young adult female clients' psychological-emotional states. General psychological status on the following nine domains is assessed: somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism. Three global indices of distress result: Global Severity Index (GSI), which is a score computed as a combination of the number of endorsed symptoms and their severity. The GSI is a sensitive indicator of respondents' distress level and combines information about the number of symptoms and the intensity of distress. The Positive Symptom Total (PST), which reflects the number of symptoms endorsed in a pathological direction without regard to intensity. The Positive Symptom Distress Index (PSDI), which reflects the severity of symptoms respondents report experiencing, is the sum of the values of the items receiving non-zero responses divided by the PST. The PSDI provides information about the average level of distress the respondent experiences. Internal consistency and reliability for nine dimensions ranges from .71 on Psychoticism to .85 on Depression. Test-retest reliability ranges from .68 (Somatization) to .91 (Phobic Anxiety), and for the three Global Indices from .87 (PSDI) to .90 (GSI). Validity has been found based on correlations between the BSI and the Wiggins content scales (Mohammadkhani, Dobson, Amiri, & Ghafari, 2010). The Tryon (1966) cluster scores from the MMPI ranged from .30 to .72, with the most relevant score correlations averaging above .50. Factor analysis results confirm the a priori construction of the symptom dimensions

and correlations between the BSI and SCL-R-90 were .92 and .99 (Derogatis, 1993). Lower scores indicate lower severity in psychological status and pathology, and higher scores indicate more extensive severity and pathology. Two measures were included in each packet.

Completion time is 8-12 minutes. In both cases, participants were asked to complete a questionnaire that addressed five themes about perceptions of the impact of an early childhood experience that includes sexual contact with an adult: reporting vs. not reporting; impact on psychological/emotional development; presenting problems in counseling as young adult; and imagined race/ethnicity of cases.

### *Procedure*

The purpose of this university-approved study was to investigate trainees', in mental health-related professions, beliefs about the affect of adult-child sexual contact on psycho-socio-emotional development of the child into young adulthood. Novice mental health trainees (i.e., Counseling, Clinical Psychology, Counseling Psychology, Social Work, Marriage and Family Counseling) provided demographic information (i.e., discipline of study, sex, age, race/ethnicity), read two cases describing a young girl's adult-sexual contact experience with a teacher, and completed two BSI measures as they believed the young girls would 10 years later as young women. The order of presentation of the cases in the research packets was varied to identify potential case affect on participants' responses. The adult-child sexual contact experience, the characteristics of the perpetrator, and the place of the adult-child contact (school setting), were the same for both cases. Female, as the child, and male, as the adult, were specifically chosen to reflect the sex-role specific prevalence noted throughout the literature that identified female as the most reported 'victim' and male as the most reported perpetrator (APAOnline, 2008). After completing the BSI for each scenario, participants were prompted to



provide a brief overview about how they believed the client in each case would immediately respond to the critical event, rate on a scale of 1-5 the degree to which adult-child sexual experience would affect the client's psychological-emotional development (1-not at all to 5-significantly), identify the factors which would be more meaningful points of influence in the client's development than this isolated episode of adult-child sexual contact, and to provide a statement about the aspect of each client's life that they believe would be affected by this adult-child sexual contact experience and in what way.

### *Data Analyses*

Quantitative and qualitative analyses were used. T-tests were used to compare mean BSI subscale scores between the two case scenarios. Pearson product correlation coefficients were found to identify the degree of relationships between all variables examined. Multiple regression analyses were used to examine the influence of the independent variables (i.e., parent education, family of origin climate, prior childhood sexual contact, and education) on each of the criterion variables: GSI, PST, and the PSDI BSI scale scores.

### **Results**

Table 1 presents the BSI norm sub-scores for Adult Female Non-patients and participants' BSI sub-scale scores for both high functioning family of origin client (HF) and low functioning family of origin client (LF). Participants' predicted scores for both prospective clients were at least one standard deviation above norm subscale means. The subscale mean scores for the LF client were at least two standard deviations above the norm mean scores across all subscales.

**Table 1. Non-clinical Adult Female population BSI Norm, LF, and HF mean subscale and index scores**

Symptom Dimensions	SOM	O-C	I-S	DEP	ANX	HOS	PHOB	PAR	PSY	GSI	PSDI	PST
BSI Mean	.35	.48	.40	.36	.44	.36	.22	.35	.17	.35	1.32	12.86
SD	.46	.54	.55	.56	.54	.45	.44	.49	.34	.37	.43	9.97
LF Mean	1.41	2.04	2.59	2.70	2.32	2.19	2.43	2.57	2.63	2.29	2.53	46.81
HF Mean	1.21	1.77	2.32	2.21	2.07	1.82	2.16	2.16	2.12	1.95	2.24	43.92

Note. All subscale means for both cases were at least one standard deviation above the norm subscale means.

Table 2 presents the BSI norm sub-scores for Adult Female Psychiatric Outpatients and participants' BSI sub-scale scores for both high functioning family of origin client (HF) and low functioning family of origin client (LF). Participants' predicted mean scores for LF client were at least one standard deviation above the norm mean scores for the following subscales: Hostility, Phobia, Paranoid Ideation, Psychoticism, Global Severity Index, and Positive Symptom Total. Participants' predicted mean scores for the HF client were less than one standard deviation higher than all norm means.

**Table 2. Adult Psychiatric Outpatient Female population BSI Norm, LF, and HF mean subscale scores**

Symptom Dimensions	SOM	O-C	I-S	DEP	ANX	HOS	PHOB	PAR	PSY	GSI	PSDI	PST
BSI Mean	.94	1.60	1.66	1.90	1.82	1.23	.91	1.21	1.24	1.40	2.22	31.81
SD	.84	1.01	1.04	1.05	1.02	.95	.91	.97	.89	.72	.59	11.35
LF Mean	1.41	2.04	2.59	2.70	2.32	2.19*	2.43*	2.57*	2.63*	2.29*	2.53	46.81*
SD	1.03	1.02	.91	.84	.69	1.07	1.06	.77	1.04	.80	.61	7.73
HF Mean	1.21	1.77	2.32	2.21	2.07	1.82*	2.16*	2.16	2.12	1.95	2.24	43.92*
SD	1.04	1.02	1.13	1.10	1.07	1.14	1.09	.93	1.17	.97	.77	11.49

\* indicates that the subscale mean is at least one standard deviation above norm subscale means.

These findings indicate that trainees tended to believe that both individuals would experience a significantly greater degree of psychological stress than that represented in the general population: the LF client would report an experience of significantly greater psychological distress than non-patient norm on three domains and two indices measured by the BSI; the HF client would report an experience of significantly greater psychological distress on two domains and one index score.

Table 3 presents the differences between the participants' BSI mean subscale scores for the LF and HF client. In comparison to the HF client, the LF client was expected to report a significantly greater degree of depression (DEP – clinical symptoms of depression) ( $F=5.29$ ;  $p=.02$ ), interpersonal sensitivity (I-S – feelings of personal discomfort, inadequacy, and/or inferiority) ( $F=3.71$ ;  $p=.05$ ) and anxiety (ANX – clinical symptoms of anxiety) ( $F=8.80$ ;  $p=.004$ ); and exhibit a greater number of symptoms, Positive Symptom Total (PST – intensity of reported symptoms) ( $F=38.03$ ;  $p=.000$ ), and express a greater degree of distress indicated within each symptom (PSDI – number of symptoms reported) ( $F=5.54$ ;  $p=.02$ )

No significant differences were found between the HF and LF case's anticipated BSI subscale scores on the following dimensions: somatization, obsessive-compulsive, hostility, phobia, paranoid ideation, psychoticism, and the global severity index.

**Table 3. BSI subscale mean raw scores of both case scenarios.**

Symptom Dimensions	SOM	O-C	I-S	DEP	ANX	HOS	PHOB	PAR	PSY	GSI	PSDI	PST
LF Mean	1.41	2.04	2.59	2.70	2.32	2.19	2.43	2.57	2.63	2.29	2.53	46.81
HF Mean	1.21	1.77	2.32	2.21	2.07	1.82	2.16	2.16	2.12	1.95	2.24	43.92
Difference	.20	.27	.27*	.49*	.25*	.37	.27	.41	.51	.34	.29*	2.89*

\* $p < .05$

Table 4 presents the participants' BSI subscale T scores for the LF and HF client based on the Adult Non-Patient Female Norm. All subscale T-scores for each client case meet the criteria established for "caseness" ( $T \geq 63$ ) for this norm. Participants' scores indicate a belief that in both cases the psychological distress would be significantly higher than that typical among adult female non-patients. Table 5 presents the participants' BSI subscale T scores for the LF and HF client based on the Adult Psychiatric Outpatient Female Norm. For the HF client, T-scores were within one standard deviation of the mean for the Adult Psychiatric Female Outpatient norm. For the LF client, T-scores met the criteria established for "caseness" ( $T \geq 63$ ) for two domains, Phobia and Psychoticism, and two indices (PST – intensity of reported symptoms—and PSDI – number of symptoms reported). This finding suggests that participants perceived that the LF client would be even more psychologically distressed than other women who are already considered highly distressed (Adult Psychiatric Outpatient) within the general population.

**Table 4.** BSI subscale T-scores based on Adult Non-Patient Female Norms of both case scenarios.

Symptom Dimensions	SOM	O-C	I-S	DEP	ANX	HOS	PHOB	PAR	PSY	GSI	PSDI	PST
LF Mean	66	70	73	72	70	73	75	75	80+	78	69	78
HF Mean	65	68	70	70	70	72	72	72	78	74	67	76

Note. All subscale T-scores meet the criteria established for "caseness" ( $T \geq 63$ ) for this norm.

**Table 5.** BSI subscale T-scores based on Adult Female Psychiatric Outpatient Norms of both case scenarios

Symptom Dimensions	SOM	O-C	I-S	DEP	ANX	HOS	PHOB	PAR	PSY	GSI	PSDI	PST
LF Mean	57	55	58	56	55	59	65*	62	64*	62	65*	63*
HF Mean	55	52	57	53	53	57	61	59	59	57	61	59

\*Indicates that the subscale T-score meets the criteria established for "caseness" ( $T \geq 63$ ) for this norm.

These findings suggest that participants' attitudes about the impact of socio-economic status and family of origin health may significantly influence case conceptualization and development of a prognosis. These results support the importance of the examination of the relationship between practitioners' biases, past experiences, and background (due to the differences across the data) on practitioners' anticipated BSI scores for each of the cases in the following section.

*Correlational/Multiple Regression Results for*

*Higher Family Functioning Case Scenario*

Participants' reported degree of impact rating of the adult—child sexual contact (noted as a Likert-scale on the survey) was found to be positively and significantly ( $p < .01$ ) correlated to nine BSI subscale scores [Anxiety ( $r = .62$ ), Depression ( $r = .65$ ), Hostility ( $r = .50$ ), Interpersonal-Sensitivity ( $r = .51$ ), Obsessive-Compulsive ( $r = .52$ ), Paranoid ( $r = .59$ ), Phobic Anxiety ( $r = .50$ ), Psychoticism ( $r = .61$ ), and Somatization ( $r = .51$ )] and all three global composite scores [GSI ( $r = .63$ ), PST ( $r = .42$ ), and PSDI ( $r = .67$ )] . In other words, participants' general ratings of the anticipated effect of adult-child sexual contact significantly correlated with anticipated higher BSI subscale scores for the young woman having a higher functioning family of origin.

Participants' number of years of professional experience was found to be significantly ( $p < .05$ ) and positively related with three assigned BSI domain subscale scores [Anxiety ( $r = .37$ ), Hostility ( $r = .35$ ), Psychotism ( $r = .53$ )], two BSI global indices [GSI ( $r = .35$ ), PSDI ( $r = .38$ )], and practitioners' education ( $r = .38$ ). More experienced practitioners were found to anticipate a larger number of symptoms, a greater degree of stress experienced in symptomology, and higher

subscale scores in BSI anxiety, psychotism, and hostility in clients with this early childhood experience who also were from higher functioning families.

Results of the multiple regression analyses indicated that the model did not significantly predict either of the criterion variables. Neither participants' parent education, family of origin climate, prior childhood sexual contact, or level of education significantly predicted the anticipated client's GSI (R square = .20, Adjusted R squared = .06;  $F(5, 31) = 1.45, p = .24$ ), PST [R square = .10, Adjusted R squared = .06;  $F(5, 29) = .65, p = .67$ ], PSDI (R square = .23, Adjusted R squared = .10);  $F(5, 29) = 1.73, p = .16$ .) or and participants' rating of anticipated degree of impact of the general impact on client's future functioning [R square = .18, Adjusted R squared = .04;  $F(4, 32) = 1.33, p = .28$ ]. Regression analyses indicate that a practitioners' background has no significant effect on their anticipation of this client's psycho-socio-emotional status or psychological distress.

#### *Correlational/Multiple Regression Results for*

##### *Lower Family Functioning Case Scenario*

Practitioners' assigned rating of the impact of adult-child sexual experience was found to be positively and significantly ( $p < .01$ ) related to eight BSI subscale scores [Anxiety ( $r = .50$ ), Depression ( $r = .46$ ), Interpersonal-Sensitivity ( $r = .39$ ), Obsessive-Compulsive ( $r = .41$ ), Paranoid ( $r = .59$ ), Phobic Anxiety ( $r = .44$ ), Psychoticism ( $r = .34$ ), and Somatization ( $r = .46$ )] and two global indices [GSI ( $r = .47$ ), PSDI ( $r = .45$ )]. This means that the higher trainees rated the degree of impact of adult-child sexual contact on psycho-socio--emotional status into young adulthood, the higher they also tended to rate anticipated symptomology of anxiety, depression, interpersonal sensitivity, obsessive-compulsive, paranoia, phobic anxiety, psychoticism, somatization, and general distress. However, in contrast, PST subscale scores were found to

significantly and negatively correlate with this variable ( $r = -.36$ ). Thus, while practitioners' perceptions of the degree of impact on the young adult increased, the anticipated number of reported symptoms tended to be fewer. It appears that in the case of LF, the greater trainees believed the impact of adult-child sexual contact would be greater, they would also tend to believe that the impact would be more focused in a smaller number of symptom types such as those assessed by the BSI domains.

Practitioners' parent education, family of origin climate, prior childhood sexual contact, and years of education did not significantly predict the LF client's anticipated GSI [R square = .13, Adjusted R squared = .01;  $F(5, 31) = .94, p = .47$ ], or the client's PSDI [R square = .13, Adjusted R squared = .01;  $F(5, 31) = .92, p = .48$ ]. This model also did not predict practitioners' anticipated rating of degree of impact of adult-child contact on the client's future functioning [R square = .17, Adjusted R squared = .04;  $F(5, 31) = 1.30, p = .29$ ]. However, in contrast to the findings associated with the HF client, the multiple regression model examining the influence of practitioners' background on BSI general scores was statistically significant at least in the case of one BSI global index. The model was found to account for 40.2% of the total variance in the average level of distress experienced (PST); [R square = 40.2, Adjusted R square = 30.2,  $F(5,30) = 4.04, p = .006$ ]. Table 6 presents the results of the hierarchical multiple regression analysis. Practitioners' childhood experience with adult sexual contact, education level, and counseling experience contributed to 40 percent of the variance in PST scores with the LF client case, but not with the HF client case. Practitioners, who reported experiencing early childhood sexual contact with an adult, had more years of education, and more years of professional experience, tended to anticipate a larger of number of symptoms endorsed in the case of LF than

those practitioners who did not. Family of origin climate and parents' education were not found to be significant variables in the model.

Table 6. Summary of Hierarchical Regression Analysis for Variables Predicting Participants' reported PST with the Lower Family Functioning Case Scenario.

Variable	R Square	F	Significance
Parent Education	.004	.14	.71
Family of Origin Climate	.005	.08	.93
Adult-Child Experience	.336	5.40	.004
Education Level	.399	5.16	.003
Counseling Experience	.402	4.04	.006

**Note.** R square = 40.2, Adjusted R square = 30.2), F(5,30) = 4.04, p = .006

#### *Summary of Quantitative Analyses*

Questions that might be considered in future research is the discrepancy in the strength of the correlations found across each of the case scenarios. Explanation of the stronger relationships between variables associated with the higher functioning family scenario than within the lower functioning family scenario is not addressed in this study. Does this reflect a greater degree of certainty about the impact of adult-child sexual contact in the case of clients from higher functioning families than from lower functioning scenario? Why does practitioner experience significantly correlate with BSI ratings in the case of the higher functioning family scenario, but not in the lower functioning scenario? Why does the model significantly predict practitioners' anticipated PST in the case of the LF client and not in the case of the HF? Why does the model not predict the variance in the other global indices within the lower family



functioning case scenario and only the PST index? Future research examining these outcomes is certainly warranted.

### *Qualitative Data Analysis*

Participants were asked follow-up questions eliciting their response to each of the scenarios. Several themes emerged as a result of these inquiries.

#### *Theme 1: Reporting vs. Not Reporting.*

##### ***Briefly state what you believe Jane did in response to this adult-child sexual contact***

***experience?*** When responding to the LF client case, 2.6% (n = 1) of the participants stated that Jane would report the sexual contact; 92.1% (n = 35) stated she would not report; and, 5.3% (n = 2) did not respond to this item. Reasons for not reporting included lack of family support and fear. Self-blame/guilt and losing school as a safe place were also included in responses; however, they were not as frequently noted.

In the HF client case, 52.6% (n = 20) of participants specifically stated that she would report; 44.7% (n = 17) stated she would not report; and 2.6% (n = 1) did not respond to this item. The reasons listed for not reporting were fear and self-blame/guilt. Thirty percent (n = 6) of the participants responding that HF would report the event, indicated that there would be a delay in response (i.e. later in life, after a while, somewhat older, eventually, within a few months of the experience). Responses for HF also indicated who she would tell about the contact. Eighty percent (n = 16) reported that she would tell her parents, with approximately 10% (n = 2) of those stating she would specifically tell her mother. No one noted that she would specifically tell her father. This finding is similar to previous research by Paine and Hansen (2000), who found that self-disclosure may be delayed for months or years, and when disclosure did occur, they found that it was most often directed toward the mother. The remaining participants indicated that the

client in the HF case would tell a friend, teacher, or trusted adult. Twenty-five percent (n = 5) of the responses indicated that HF's parents would notice a change in her behavior as a result of the sexual contact, and that this acknowledgement would prompt her telling them. No one reported that LF's parents would notice a behavior change.

*Theme 2: Impact on Psychological/Emotional Development*

***On a scale from 1-5, rate the degree to which you believe that this adult-child sexual experience will affect Jane's psychological-emotional development (1 = not at all to 5 = significantly in every aspect).*** All participants indicated some degree of impact on development for both LF and HF. Researchers categorized responses as little to no impact with participants' ratings of 3 and below. Approximately sixteen percent (15.8%, n = 6) of the participants indicated little to no impact for the client in the LF case, and 34.1% (n = 13) indicated the same for the client in the HF case. Those reporting in this area listed their reasons as environmental factors (i.e. LF - neighborhood context, drug using mom, abusive step father; HF - supportive family systems, and misunderstanding of appropriate sexual behavior). Approximately sixty-one percent (60.5%, n = 23) of participants reported that the adult-child sexual contact would impact LSJ significantly in every aspect; while 42.1% (n = 16) indicated that same for HSJ.

***Theme 3: Affected Aspects of Jane's Life***

***Concisely state in the space below the aspect of Jane's life that will be affected by this experience and how.*** Responses were placed into two categories: Mental Health and Interpersonal Relationships. These two categories were defined using previous research (Mullen, Martin, Anderson, Romans, & Herbison, 1996; Silberg, 2004). When participants stated that Jane's life would be affected through Depression, Anxiety, Suicide, Eating Disorder, Dissociation, or PTSD, they were categorized as Mental Health (Mullen, et al, 1996; Silberg,

2004). Responses including Poor Self-Esteem, Stigmatization, Trust, and Guilt were categorized under Interpersonal Relationships (Kallstrom-Fuqua, Weston, & Marshall, 2004; Feiring, Taska, & Lewis, 1996). Two other categories emerged, Sexuality/Promiscuity Issues and School, which were not based on previous literature. Responses such as promiscuous behavior, hyper-sexuality, using her body to get what she wants, and sexual development were categorized under Sexuality/Promiscuity Issues. Responses with any indication of failing grades, lack of enjoyment in school, and behavior problems in school were categorized under School. In retrospect, the researchers questioned if the theme of ‘school’ was a result of the scenarios’ setting, and if the theme would exist if there had been a change in scenario description.

Table 7 presents the number and percentages of participants’ responses in each category of *Theme 3*. These items represent the participant’s perception (as practitioners) of how they believe the sexual contact will affect both LF and HF in the short-term. The most frequently anticipated affected aspects of development reported in both cases was in the area of Interpersonal Relationships (LF = 89.5%; HF = 86.8%). Trust was found to be the most frequently reported interpersonal issue for both LF and HF within the Interpersonal Relationship category. The least frequently anticipated affected area was School in both cases (13.2%).

**Table 7. Frequency of Trainees’ Anticipated Affected Aspects of Development**

	<b>Mental Health</b>	<b>Interpersonal Relationship</b>	<b>Sexuality/Promiscuity</b>	<b>School</b>
<b>LF</b>	N=4 (10.5%)	N=34 (89.5%)	N=7 (18.4%)	N=5 (13.2%)
<b>HF</b>	N=8 (21.1%)	N=33 (86.8%)	N=8 (21.1%)	N=5 (13.2%)

Note. Trust was found to be the most frequently reported interpersonal issue for both LF and HF. The percentages add larger than 100% as there is an overlap in possible aspects listed by the participants, meaning the case is affected in more than one way.

Theme four is reflected in the next related prompt that requested participants to: *Imagine*

*Jane at 20 and the question: Where is she and what might be a presenting problem for her if*

*she came in for counseling?* Table 8 consists of the number of participant responses, as well as the percentages, in each category. These items represent the participant's perceptions (as practitioners) of how the adult-child sexual contact will affect both LF and HF into young adulthood, and consider what might be possible presenting concerns for her if she were to seek counseling. Two additional categories emerged, Domestic Violence and Drugs. Responses predicted that Jane would be in an abusive relationship and/or abusing substances. The most frequently reported presenting problem was associated with Interpersonal Relationship issues (42.1%) and the second were issues related to mental health (34.2%). The least anticipated presenting problem reported fell within the Drug category (2.6%).

**Table 8. Participants' responses to:** *What might be a presenting problem or problem(s) for this individual if she came in for counseling as a young adult?*

<b>Mental Health</b>	<b>Interpersonal Relationship</b>	<b>Sexuality/Promiscuity</b>	<b>School</b>	<b>Domestic Violence</b>	<b>Drugs</b>
N=13 (34.2%)	N=16 (42.1%)	N=5 (13.2%)	N=5(13.2%)	N=2 (5.3%)	N=1 (2.6%)

*Theme five, Race/Ethnicity, is indicated in the prompt that requested participants to respond to the following question: If you imagined race/ethnicity with Jane #1 and Jane #2, what race(s)/ethnicity(ies) did you perceive them to be, respectively?* Approximately 84% (84.2%; n = 32) reported that they did imagine a race/ethnicity while reading the scenarios, and 15.8% (n = 6) reported that they did not. Of those thirty-two participants, who imagined a race/ethnicity, 60.5% (n = 23) of them did not distinguish race/ethnicity between LF and HF.

Approximately forty percent (39.5%, n = 15) of the responses did distinguish a racial difference between HF and LF; 100% of them identifying HF as White/Caucasian or Asian American and LF as Black/African, Hispanic, or Native American. (One participant indicated

HF was White/Black and LF as Black/Hispanic; one participant indicated HF was White/Asian and one indicated LF as Black or Hispanic or Native American.)

Sixty-three percent ( $n = 24$ ) of the participants explained that prior knowledge of the client's race/ethnicity would not have influenced their previous responses, while 28.9% ( $n = 11$ ) stated that race would have influenced their responses to the client cases in a manner that would have increased the symptomology and distress. Approximately 7% ( $n = 3$ ) did not acknowledge a response of influence.

### **Discussion**

The objective of this study was to examine future mental health professionals' attitudes about the impact of adult-child sexual contact on female psychological-emotional development. The researchers believe that there were three primary and critical overarching findings. First, the mean BSI subscale scores across both cases indicated that future practitioners believe that adult-child sexual contact will significantly and negatively impact the psychological-emotional development of young girls. All BSI subscale means scores met the criteria for 'caseness' or diagnosis ( $T > 63$ ), which means that participants overall tended to predict that serious issues requiring intervention would be the outcome of this critical event in early childhood. These findings support that of research that found significant relationships between the experience of adult-child sexual contact with greater psychological distress and symptoms associated with psychopathology in adulthood (Braver, Bumberry, Green, Rawson, 1992; Graham, Kimonis, Wasserman, & Kline, 2012).

Second, results indicated that participants considered the level of family functioning as a mediator to the impact on psychological distress into adulthood. Mean BSI subscale scores showed that future practitioners in this study hypothesized that the young girl from the low

functioning family of origin would experience more serious psychological-emotional trauma (higher BSI subscale scores) into adulthood than the young girl from the higher functioning family of origin. These results are consistent with *the* prevailing viewpoint in the literature that anticipates that this early life event will be experienced as a traumatic emotional and psychological event with serious developmental implications; however, that higher family functioning will decrease the impact of the event on development (Durbin, Klein, & Schwartz, 2000; Schreiber & Lyddon, 1998; Thomas, DiLillo, Walsh, & Polusny, 2011).

Third, although mean scores indicated a general conclusion that adult-child sexual contact will have a serious affect on psychological-emotional development, an in-depth review of the findings indicates the existence of a varied response pattern within the sample about the degree of anticipated impact into adulthood. Approximately sixteen percent (15.8%,  $n = 6$ ) of the participants indicated that there would be little to no impact on the psychological-emotional development of the child with origins in the LF (low functioning family), and 34.1% ( $n = 13$ ) indicated the same for the child in the HF (high functioning family). There was the presence of perspective within this sample who had adopted a contrary view of the impact of adult-child sexual contact on development (APAonline, 2008; Riley, 2001).

The results of this qualitative study are quite unusual in that there appears to be evidence that supports each of the competing perspectives within the literature: adult-child sexual contact will have a significant impact on development and psychological-emotional stress into adulthood; adult-child sexual contact that occurs in a lower functioning family will have a more significant negative impact on development and psychology-emotional stress into adulthood than in a higher functioning family; and, that there exists within mental health, professionals who

believe that the impact of the event may have little to no effect on development or psychological distress into early adulthood. The findings are even more startling given the small sample size.

Fourth, not only do professionals' attitudes about adult-child sexual contact seem to be a critical factor in perceptions of impact, but pre-existing racial attitudes were also found to surface as variables that may potentially influence practitioners' diagnoses and prognoses. Findings suggest that trainees may arrive with preconceived beliefs associated with socioeconomic status that without, appropriate inquiry in supervision, will influence perceptions of clients and the counseling process. Reports indicated that for some participants, higher family of origin functioning was automatically associated with Caucasian and Asian families without any prompts. This may mean that practitioners working with clients from these racial groups, with associated presenting problems, may not consider inquiring about an adult-child sexual contact history or about family of origin functioning. Healthy family functioning may automatically be assumed for White or Asian clients from higher socio-economic backgrounds, when this is not the case. While clients from other racial/ethnic groups from lower socio-economic backgrounds may automatically be assumed, in error, to also have origins from low functioning family systems, which may not be the case.

Fifth, the presence of participants that had adult-child sexual contact within their history supports the literature that purports the representation of practitioners with histories of physical abuse, sexual molestation, parent alcoholism, psychiatric hospitalization of a parent, death of a family member, and greater family dysfunction than other professionals (Elliott & Guy, 1993). Although not to the degree found within a larger sample of female clinicians (32%) (Little & Hamby, 1996), even within this small sample, approximately 10% of the sample reported a history of sexual abuse as children. The connection between such histories and issues with

counter-transference in relationships with clients having shared backgrounds, has already been established (Elliott & Guy, 1993; Little & Hamby, 1996). It would seemingly be critical that clinical supervisors consider the backgrounds of trainees in their work with clients. Given that sexual history was found to be a significant contributor to the number of symptoms noted, results of this study suggests that even more careful monitor and process of counter-transfer might be warranted in clinical work with clients from lower functioning families of origin.

An unanswered question persists: Why weren't practitioners' family educational background and family of origin psychological functioning found to be significant predictors of the number of BSI symptoms? It was interesting that counseling experience, education, and sexual history background were significant variables in the regression model related to only one BSI index score in the LF case, but variables associated with socio-economic status (i.e., educational level of parents) and family functioning were not. The absence of any influence of practitioner background information on any of the BSI index scores for the HF case was also noteworthy. Socio-economic status is a critical part of individuals' cultural backgrounds that have been associated with a wide range of varying attitudes and worldviews (Asner-Self & Feyissa, 2002; De Coteau, Anderson, & Hope, 2006; Sladen, 1982), consequently, when no significant impact was found on practitioners' perceptions associated with clients' background experiences, the researchers strong believe that future research is certainly warranted.

Sixth, findings reiterate the importance of clinicians/supervisors: monitoring their own beliefs; facilitating a training environment that examines the impact of supervisees' beliefs and attitudes on practice; and teaching supervisees' how to most effectively monitor their own issues through self-reflection, supervision, and consultation throughout the lifetime of their careers (Bemak & Chung, 2011; DiMino, 2009; Ladany, Constantine, Miller, Erickson, & Muse-Burke,



2000; Schwing, LaFollette, Steinfeldt, & Wong, 2011) . This self- and supervisee-monitoring becomes especially key to increasing the probability of effective and ethical service delivery in attending to a critical life event that has such a varied response within the profession in the face of a law-mandated, required, duty to report to the authorities. In light of the findings of this study, all perspectives regarding adult-child sexual contact that are evident in the literature were supported. Failure to address the existence of the three perspectives and to resolve the tensions toward highest ethical practices will diminish the development of most effective work with all clients. For example, novice and senior practitioners, who do not perceive adult-child sexual contact as serious in work with children, may respond differently to the mandate to report than those who do. With adult clients, prior attitudes may lead some to overlook or dismiss indicators typically found to be associated with this early life experience. On the other hand, those who consider the early life experience as debilitating, may tend to attribute all current symptoms to the event, and fail to explore other contributors. Results suggest that supervisors might consider supervisees' level of education, years of experiences as counselors, and family histories as critical variables in working with clients with this history.

#### *Strengths, Limitations, and Implications for Future Research*

One strength of this study is that each packet was randomly assigned in regards to the varying order of the scenarios. This allowed the participants to respond LF and HF objectively and not be persuaded to compare one case to the other. Language that referred to the experience as traumatic or abusive was intentionally omitted. On the other hand, limitations of the study include the sample size and challenge of developing unbiased and non-leading questioning. Recommendations for future research include the examination of: the direct influence of practitioners' attitudes about adult-child sexual contact on case conceptualization, prognosis,

strategy selection, and treatment; the influence of practitioners' attitudes about adult-child sexual contact on decision-making about duty to report; the influence of adult-child sexual contact on the psychological-emotional development of young boys; the influence of adult-child sexual contact with same gender on psychological-emotional development; and, the impact of assumed consensus between the two parties. We believe that the most cutting-edge research also would be to design a study to identify person, life experience, and family of origin variables that minimize the degree of the impact of adult-child sexual contact on children's psychological-emotional development and future interpersonal relationships.

### **Conclusion**

In conclusion, the purpose of the study was to investigate novice practitioners' beliefs about the affect of adult-child sexual contact on a young woman's overall development. The study demonstrated that differences in practitioners' anticipated effect of adult-child sexual contact occurred based on the client's socioeconomic status. These results increase awareness of the importance of monitoring monitor personal beliefs/views in our work with clients in areas that extend beyond race/ethnicity and culture. Furthermore, findings open the door for future research that will shed some light on the influence of practitioners who believe that adult-child sexual contact is not detrimental to psychological-emotional development.

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