

NATIONAL TRAININGHOUSE ON CHILD  
ABUSE AND NEGLECT INFORMATION

# **Project Family**

## **Final Evaluation Report**

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**Charles G. Thomas, Psy.D.**  
**Director of Clinical Services**  
**Project Family Director**

**Robert J. Illback, Psy.D.**  
**Evaluation Consultant**

**Daniel Sanders, Ph.D.**  
**Statistical Consultant**

**The Family Place: A Child Abuse Treatment Agency, Inc.**  
**982 Eastern Parkway**  
**Louisville, KY 40217**

**Voice: 502-636-2801**  
**Fax: 502-636-2857**

**Email: [cthomas@familyplaceky.org](mailto:cthomas@familyplaceky.org)**  
**Web page: [www.familyplaceky.org](http://www.familyplaceky.org)**

# **Project Family Executive Summary**

## ***General Overview of Program***

The Family Place: A Child Abuse Treatment Agency is a non-profit outpatient treatment center serving families confronted by incest. Family Place is distinguished by its comprehensive, integrated family systems approach to the treatment of intrafamilial child sexual abuse. In contrast to the prevailing approach to the treatment of child sexual abuse, which differentiates little in methodology between incest treatment and the treatment of sexual abuse by a non-family member, the Family Place approach acknowledges the unique circumstances of incest, and responds to these differences with a specially tailored array of services designed for each family's needs.

Family Place's treatment program is unique and innovative in its family systems orientation to incest and its inclusive approach to treatment that, in most cases in which families are seeking continued contact or reunification, integrates the adult responsible for the abuse into family therapy. Incest is a particularly complex and potentially devastating form of child abuse. Powerful attachment bonds and trust relationships are exploited by a parent or other family member in service of his or her own needs, often with profound implications for the abused child's self-image and future relationships. Protecting the child from further harm and healing the damage caused by the abuse are the foremost considerations in treatment.

Despite the history of abuse within the families served by Family Place, in many cases the most appropriate healing resources are the parents themselves. Many families possess the motivation and ability to work together to confront the causes of the past abuse, to understand their family's risk for future abuse, and to overcome the harm to all members caused by the experience of abuse within the family. Family therapy offers parents, including the parent who sexually offended, the opportunity to confront their individual risk factors and limitations, and to realize their potential to nurture health and wholeness in their children. The natural role of parents as the protectors and healers in the family is respected and restored whenever possible; children have the opportunity to be healed by the family members who have hurt them. The incest experience will always be a part of the family's history, and the risk of further abuse will always be a part of their present, but their identification as a family in which abuse has occurred does not have to devastate the family's future.

Family therapy is the primary treatment modality used at Family Place. Treatment begins with no contact between the person responsible for the abuse and the child who was abused. Family sessions typically originally involve the non-offending parent and the children in the household. The child who was abused and the non-offending parent also receive adjunctive individual and group therapy, and the non-abused siblings are included in family therapy sessions and receive individual therapy as needed. Individual, couples (when appropriate), and group therapy are initiated immediately with the offending parent. These treatment services are provided in combinations unique to each family based upon the family's goal concerning continued contact or reunification, the degree of

harm resulting from the abuse and the needs of the individuals within the family, the family's acknowledgement of the abuse and its harmfulness to all members, and their ability to hold the person who offended completely responsible for his or her actions. The assignment of a single therapist to the entire family provides the most comprehensive understanding of family dynamics possible and reduces the opportunities for splitting by factions within the family.

The Children's Bureau of the Department of Health and Human Services provided a grant to Family Place to conduct an evaluation of this specialized incest treatment program. In general, research and evaluation strategies serve various purposes. Traditional research paradigms are primarily concerned with generating scholarly knowledge regarding the effects of a specified intervention on one or more dependent variables. Unfortunately, such approaches rely on a degree of experimental control often not available in natural settings or service delivery programs. Another common purpose of research and evaluation is to inform policy-makers and funders (e.g., Administration for Children and Families) of program effectiveness. Finally, evaluative research is concerned with informing program managers about important programmatic processes and outcomes.

The second and third goals, informing policy makers/funders, and informing program managers, received the greatest emphasis in the Project Family evaluation plan. In this context, program evaluation was seen as a set of rigorous methods that could enable program managers to have available technically adequate and socially valid (i.e., relevant) information about program processes and outcomes. The ongoing availability of such information leads to sounder decision-making at multiple levels of the program as it evolves. Thus, program evaluation contributes to continuous development and improvement of the program, in addition to helping reach formative and summative judgments (over time) about the effectiveness of the program relative to its goals.

A primary purpose of the proposed evaluation plan was therefore to enable professionals responsible for the implementation of the Family Place incest treatment program to gather, analyze, and interpret data to assess the program's overall implementation and effectiveness relative to the stated outcomes. Information generated by the evaluation system was to provide funders, community members, program managers, and others with timely and relevant information about the extent to which the stated family systems approach was being faithfully implemented (treatment fidelity) and the degree to which these services provided facilitated client attainment of the program's stated outcomes.

"Project Family" was a validation study designed to assess the degree to which the program's stated outcomes are achieved through utilization of Family Place's innovative systemically oriented treatment approach. These outcomes are as follows:

- Creation of a safe environment and a decrease in perceived vulnerability to further abuse
- Increased acceptance of personal responsibility and awareness of risk factors for child sexual abuse
- Decreased symptoms/psychopathology in family members

- Improved parenting skill development
- Increased adaptive family interaction and responses

Family Place contracted with an independent evaluator, REACH of Louisville, Inc., to conduct the Project Family evaluation. Data were to be collected from approximately 200 families (50 families over each of the four years covered in the proposed grant period) using standardized assessment instruments at various points in treatment (See Appendix B). Research assistants working for REACH administered these instruments, which measured various behaviors, attitudes, perceptions, and symptoms related to the aforementioned outcomes. In addition to these standardized instruments, an agency-created instrument, the Treatment Review Questionnaire (TRQ), which is administered by the therapist as part of the ongoing treatment and assessment process, was to be included in the data collection. The TRQ contains client self-ratings and therapist ratings of client progress on outcome indicators.

Project Family was terminated prematurely due to low enrollment. Several factors within the community negatively affected the rate of referrals to the agency, consequently limiting the pool of possible participants. Due to a shift in procedures, the local Cabinet for Families and Children (CFC), which had been a major source of referrals, began utilizing the local child victim's advocacy center as the initial point of entry for treatment services for sexually abused children rather than making referrals directly to service providers. The victim's advocacy center would conduct the forensic interview and a mental health needs assessment. After providing brief, crisis management services, the center would refer the child and family for appropriate services.

Shortly after this change in procedure, the advocacy center underwent a major reorganization during which time it merged with another entity and experienced the turnover of several key staff members. The period of challenges leading up to the decision to merge, the actual process of merger, and the subsequent staff turnover all resulted in an extended period of decreased referrals from this agency, which had now become the major vehicle by which CFC was securing services for sexually abused children. These changes resulted in a decrease in the number of possible participants below the anticipated level. In time, it became obvious that efforts to increase the rate of referrals would not result in sufficient gains to warrant continuation of the evaluation project, and the decision was made to relinquish the grant. Family Place was given approval to use remaining funds for the fiscal year to complete a re-analysis of the Treatment Review Questionnaire and to prepare the final report on the Project.

### ***Results and Lessons Learned***

Despite the inability to successfully complete the Project as planned, very valuable lessons were learned that will prepare this agency for securing future funding for research through the competitive, peer-review process. Issues related to sample size and enrollment, payment of stipends, scheduling and attendance, instrumentation; and data storage, encoding, and interpretation were confronted at various points throughout the course of the Project.

The analysis of the Treatment Review Questionnaire yielded useful insights, though they must be viewed cautiously due to the small sample size. These preliminary findings suggest good reliability for the instrument (overall coefficient alpha reliability estimate score = .91). A factor analysis indicated a latent factor structure that corresponds to the treatment program's stated outcomes. Results of this factor analysis and a regression analysis of TRQ also provided potentially programmatically useful information concerning differences in client and therapist perceptions of treatment issues and progress.

## **Chapter I Introduction**

### ***A. Background Information***

Since its inception in 1991, cases involving the sexual abuse of a child by a family member in Jefferson County, KY, are often prosecuted in Family Court. The outcome of these Family Court proceedings in incest cases is typically the removal of the adult responsible for the abuse, the establishment of a No Contact Order between the offending parent and the child who was abused, and court mandated treatment for the parent who abused. The adult who committed the offense is typically not incarcerated. Often the victimized child and non-offending parent are also ordered to receive mental health treatment.

With the Family Court prosecution of incest cases, the treatment needs within the community changed, as there arose within the community an increasing need for services to all members of a family in which incest occurred. One result of the Court's emphasis on treatment rather than incarceration has been an increase in the number of individuals who have been found responsible in a court of law for the sexual abuse of a child, but who have not been criminally convicted. As a result there is no probation or parole officer assigned, and the majority of the individuals serve no time in jail or prison. They remain in the community, ordered into treatment, but without the prospect of incarceration as a consequence of violation of the treatment order (though failure to comply with Family Court orders may result in criminal prosecution).

This change in the characteristics of the population of offenders receiving community-based treatment has required concomitant changes in treatment strategies. Treatment providers now face the challenge of successfully engaging clients in sex offender specific treatment who have not been criminally convicted and are not subject to the terms of a probation or parole agreement. Therapists must work with a notoriously challenging and manipulative population without the aid of a collaborative relationship with a probation or parole officer, and consequently without the benefit of the sometimes necessary coercive power of the Court as represented by the probation or parole officer enforcing and monitoring compliance with the conditions of probation or parole.

Yet another change that has resulted from the maintenance of these individuals in treatment within the community has been the opportunity for continued contact with their families. While there is generally a No Contact order issued by the Court relating to

contact with the child who was abused, contact with other children in the family may, at times, be permitted, and contact with the non-offending spouse or partner is seldom prohibited. Even in circumstances where orders prohibit contact with all family members, experience has shown that families frequently maintain some degree of direct or indirect contact in spite of the existing orders. Removal of the person responsible for the abuse from the home is not the equivalent of removing them from the family. As the family organizes around their different living arrangements and the new adaptive roles required of its members, the goal of the family is frequently to re-establish the pre-disclosure homeostasis. There is often an increased emotional investment in the valued family member who has been removed from the home, and a further strengthening and rigidifying of the boundary around the family system in the face of the perceived external threat. As a result many families enter treatment involuntarily, mistrusting the treatment provider, and seeking continued contact, or even possible reunification, with the family member who committed the offense.

The Family Place: A Child Abuse Treatment Agency, located in Louisville, KY, provides intensive long-term treatment to families confronted by incest. Referrals to Family Place typically come from Family Court, Child Protective Services, the local Child Victim Advocacy Center, District or Circuit Court, local treatment providers, and from families themselves. Most clients enter services at Family Place either as involuntary clients ordered to participate by the Court, or through referrals from Child Protective Services as a condition of the child remaining in the home.

In response to the changing treatment needs within the local community, Family Place implemented an innovative approach to treatment. Grounded in family systems theory, this approach prioritizes the safety and recovery needs of the child who was abused and all family members, and does so in a manner that allows exploration of the viability of family reunification for those families seeking to do so. It is not the belief of Family Place staff that all families should maintain contact after the emergence of incest, nor is our belief that none should maintain contact. This goal is established by the family, explored in treatment, and allowed or disallowed by the Court with input from a variety of sources, including Family Place therapists concerning the family's success at recovering from the previous abuse and managing risk factors for further abuse.

### ***B. Program Model***

Family Place offers an array of services to client families. Family therapy is the primary treatment modality utilized with most clients, whether they seek separation from, or continued contact or reunification with, the family member responsible for the sexual abuse of the child within the family. For those families who do not seek continued contact, Family Place provides treatment for victimization that emphasizes the important role of the non-offending parent in helping the abused child and other children in the home recover from the harmful effects of the abuse experience. Individual therapy is provided for the child who was abused, for the non-offending parent, and for other family members as appropriate. Peer group therapy is provided for the child who was abused and for the non-offending parent.

Families exploring the possibility of continued contact or reunification with the member who committed the offense begin with the same services, configured in the combination most appropriate to their needs. In addition, couples therapy is provided to address such issues as accountability, awareness of risk, marital and sexual issues, conflict resolution, and parenting styles and skills. The parent who committed the offense also participates in individual and sex-offender specific group therapy. When he or she has progressed to a point in treatment that he or she accepts full responsibility for his or her abusive actions and their consequences, and when the non-offending parent holds the offending parent completely accountable for the choice to abuse, consideration is given to the possibility of initiating inclusive family therapy sessions. The remaining critical factor in determining the timing of inclusive family sessions is the readiness of the child who was abused for therapeutic contact with the adult who abused him or her.

In addition to the family, individual, and group therapy provided to all members of the family, other services support the treatment process. Each family receives a 90-Day Risk and Treatment Report. The first ninety days of treatment serve as an evaluation period, during which time static and dynamic risk factors within the family system are assessed. Clients are informed of the contents of the assessment and the resulting recommendations. Copies of the report are provided to the state social workers, probation/parole officers, and the Court. In addition to providing written reports to the Court, Family Place staff frequently provide testimony in Family, District, or Circuit Court.

### ***C. Collaborative Efforts***

Collaboration has been an important aspect both in the operation of the Family Place treatment program and in the Project Family program evaluation undertaken with the federal grant. Family Place staff work in close collaboration with the Family, Circuit, and District courts, Child Protective Services, the Cabinet for Families and Children, and Probation and Parole officers, providing court testimony and written reports regarding treatment amenability and progress, and risk management. The safety and welfare of the child is carefully considered in treatment, whether or not the family is seeking continued contact or reunification. The collaboration of multiple professionals representing different agencies and disciplines in the decision-making process provides a safeguard for the child and family. The authority to allow or disallow contact rests with the Courts, and it is the Judge who makes these decisions. Family Place therapists assess the family's treatment needs and resources for managing risk according to our dynamic, systemic understanding of sexual abuse, and we make recommendations to the Court. Recommendations are also made by the child's guardian ad litem (GAL), the prosecuting and defense attorneys, probation and parole officers, and representatives of social services and protective services agencies involved. Taking all recommendations into account, the judge makes a determination regarding amending No Contact orders to prohibit or to allow various degrees of contact depending on the progress made by the family as a whole, and by the individual members.

In conducting the program evaluation, Family Place contracted with REACH of Louisville, Inc. Robert Illback, Psy.D. served as principle evaluator in the project. His duties are briefly outlined in the Overview of Methodology section of Chapter I.

Collaboration with the Children's Bureau staff was essential to the attempted project. Penelope L. Maza, Ph.D. and Sally Flanzer, Ph.D. provided invaluable support and technical assistance in the design and implementation of the evaluation project.

#### ***D. Special Issues***

As has been stated previously, the implementation of Family Court in Jefferson County, KY, has resulted in changes in the client population within the community. Individuals are found responsible in a court of law for sexual abuse, but there is often no criminal prosecution or criminal conviction. These individuals are typically ordered to participate in and complete a treatment program, but there is no motivating probation or parole agreement. In addition to these changes in the offender population, the treatment needs of the abused child and other family members changed. More families were seeking continued contact or reunification with the family member who committed the offense. It became necessary to adapt the treatment program to acknowledge the reality that many families continue contact after incest in an unregulated, unmonitored, and unsupervised manner. Treatment that explores the possibility of safe reunification reduces the family's need to seek contact in violation of court orders. It provides the opportunity to make initiation of approved contact contingent upon attainment of treatment goals. Family therapy with all members present provides the opportunity for the therapist to observe and intervene in family interactional patterns that contribute to risk for further abuse or maintenance of pathology within the family.

The Family Place approach to treatment is unique in its family-centered orientation and integrated array of services that often include the adult responsible for the offense in the family's recovery. In responding to the needs of a child who has been sexually abused by a family member, it is important to understand the impact of the abuse on the child individually as well as within his or her family and social contexts. The Family Place treatment approach evaluates the very personal imprint of the abuse on the child (and all family members). It explores the consequences of the abuse for the child's relationship with the offending parent, and assesses the consequences for relationships between and among all other family members. Additionally, the impact of the abuse on the social functioning of all family members is examined.

The assumptions concerning the origin, maintenance, treatment, and prevention of dysfunctional behavior in general, and of incest in particular, that underlie the Family Place approach derive from systemic family therapy. Incest, by definition, is committed within a familial relationship. The lives of the adult responsible for the abuse and the child who was abused are entwined inextricably. A child's very survival depends on the formation of strong and durable attachment bonds with the caregivers and other significant people in her or his environment. Whether those individuals are healthy and functional or unhealthy and dysfunctional, attachment is a biological imperative so

important to the survival of the species that brain structures and chemical systems, such as the cingulate gyrus and  $\beta$ -endorphin, vasopressin and oxytocin receptors, have evolved to mediate the attachment process. These same structures mediate the attachment of adults to their children creating reciprocal bonding between parent and child.

Treatment must respect the importance of these relationships, however dysfunctional, to the parties involved and the primacy of these relationships in forming the health and wholeness of the child. If we are to provide effective treatment for incest, we must acknowledge the reality and intensity of these family relationships, and we must utilize an approach to treatment that addresses dysfunction within the family relationships. Incest treatment is a subspecialization within sexual abuse treatment that requires an understanding of the importance of attachment bonds within the family and sensitivity to the subtle and overt family dynamics of abuse, exploitation, and emotional abandonment. A family therapy approach to treatment provides the opportunity to utilize the relationships within the family to promote healing. It is a vehicle for addressing the interactional patterns within the family that contribute to risk for abuse and enhancing these relationships to maximize safety. Perhaps most importantly, family therapy challenges each family member to take responsibility for his or her own actions and the impact of these actions on family members and overall family functioning. The Family Place treatment program is unique in this community in its family-centered approach to incest.

### ***E. Funding Information***

Project Family was funded from 10/1/1999 through 10/31/2002. The total funding for the project was \$117,469.93.

### ***F. Overview of Methodology***

Family Place contracted with REACH of Louisville, Inc. to design and implement the program evaluation. Robert Illback, Psy.D. served as principle evaluator in the project. His responsibilities included:

- designing the logic model
- developing the evaluation strategy
- researching and selecting instrumentation
- hiring two research assistants to collect and enter data
- assisting with various aspects of preparation of the proposal and submission of the quarterly and final reports
- conducting the analysis of the Treatment Review

Project Family was a program evaluation project intended to assess the degree to which clients participating in a family-centered incest treatment program attained the stated outcomes of the program. Data were to be collected from 50 families for each of four years using the following standardized instruments, administered at different points in treatment to different family members by research assistants employed by REACH:

- The Family Adaptability and Cohesion Scale (FACES-II)

- The Symptom Checklist 90-R (SCL-90-R)
- Children's Depression Inventory (CDI)
- Reynolds Child Depression Scale
- Reynolds Children's Manifest Anxiety Scale-Revised
- Sexual Abuse Fear Evaluation (SAFE)
- Children's Attributions and Perceptions Scale (CAPS)
- Parent Perception Inventory (PPI)
- Child Behavior Checklist (CBCL)
- Parenting Scale (PS)
- Parent-Child Conflict Tactics Scale (supplemental sexual maltreatment questions only)
- Child Sexual Behavior Inventory (CSBI)

In addition to these standardized measures, the Treatment Review Questionnaire, a client self-rating and therapist-rating instrument completed quarterly after intake for treatment review purposes was to be included in the data collection.

As described in the proposal, Federal funds were to be used to: (1) design and implement information and evaluation systems that gather information about salient programs, processes, and outcomes, and (2) determine the extent to which the intervention accomplishes its goals. A number of types of data were to be generated by the comprehensive evaluation system. Some of these data would be quantifiable and other data would be qualitative in nature.

The following types of statistical analysis of data were proposed: (1) descriptive statistics were to be used to portray the characteristics of the target population and features of the service delivery program, (2) exploratory cluster analysis was to be used to understand common elements across clients, and as a means to determine whether there are differential outcomes associated with various client clusters, (3) multiple regression was to be used to determine whether certain client or programmatic features are predictive of certain outcomes, (4) within subjects multiple analysis of variance (MANOVA) was to be used to assess the extent to which change occurs for a range of client outcome measures, and, (5) structural equation modeling was to be used to ascertain goodness of fit between the program's theory and various process and outcome variables.

## **Chapter 2      Process Evaluation**

### ***A.      Statement of Implementation Objective***

Project Family was originally planned as a program evaluation that would gather data from client families participating in an outpatient incest treatment program using a variety of established instruments as well as a locally created rating scale. The evaluation was to focus on two elements: (1) the extent to which services offered conformed to the stated mission and philosophy of the agency (treatment fidelity), and (2) the extent to which the program participants attained the agency's stated client outcomes.

The treatment services to be evaluated (long-term family/couples, individual, and group therapy) and adjunctive services (written risk assessments, progress reports, collaboration with other involved professionals, and court reports and testimony, etc.) were to be provided by a multidisciplinary team of up to five full-time Master's or Doctoral level therapists. The target population for the program evaluation was comprised of families participating in a long-term, intensive outpatient treatment program for families impacted by incest. Some of these families would include the adult who committed the offense; others would consist of the non-offending parent, abused child, and non-abused siblings. It was projected that 50 families per year would be enrolled over each of the four years of the proposed life of the grant, for a total of 200 families.

Families in treatment at the initiation of Project Family were invited to participate. They were first informed of the Project by their therapist; if the family expressed an interest in participating, they were contacted by a research assistant who scheduled an appointment to meet with the family and secure informed consent. Eleven families expressed an interest, but only four of these consented after meeting with the research assistant. This process was later streamlined in an attempt to improve participation rates. A research assistant was to be present at the time of the intake appointment and was available to meet immediately with clients to secure informed consent from those clients who expressed an interest in learning more about the Project.

As stated previously, ongoing program operation requires collaboration with court, protective services, and social services agencies. Specifically, Family Place staff work closely with Child Protective Services (CPS), Department for Community Based Services (DCBS), Commonwealth's and County Attorney's Offices, Department of Probation and Parole, Court Appointed Special Advocates (CASA), and the child's Guardian ad litem (GAL). In addition to these ongoing collaborative relationships, Family Place contracted with Robert Illback, Psy.D. of REACH of Louisville, Inc. as the third party evaluator. Two additional research assistants were employed by REACH for the administration of assessment instruments, and a statistical consultant was also provided by REACH.

### ***B. Research Questions to Assess the Implementation Objective***

The program evaluation implementation objectives were not met. Low enrollment into the project necessitated premature termination when it became apparent that the sample size would be too small to permit meaningful analysis of the data. Primary barriers to enrollment into the program were related to a decreased rate of referrals into the agency during the time of the project. Due to a shift in procedures, the local Cabinet for Families and Children (CFC), which had been a major source of referrals, began utilizing the local child victim's advocacy center (CVAC) as the initial point of entry for treatment services for sexually abused children rather than making referrals directly to service providers.

Shortly after this change in procedure, the CVAC underwent a major reorganization during which time it merged with another entity and experienced the turnover of several key staff members. The period of challenges leading up to the decision to merge, the actual process of merger, and the subsequent staff turnover at the CVAC all resulted in a

protracted period of decreased referrals from this agency, which had now become the major vehicle by which CFC was securing services for sexually abused children. These changes resulted in a decrease in the number of possible participants below the anticipated level. In time, it became obvious that efforts to increase the rate of referrals would not result in sufficient gains to warrant continuation of the evaluation project, and the decision was made to relinquish the grant.

Family Place was given approval to use remaining funds for the fiscal year to complete a re-analysis of the Treatment Review Questionnaire and to prepare the final report on the Project. This analysis of the TRQ was successfully completed. Psychometric characteristics of the TRQ related to reliability (as measured by coefficient alpha) and the factor structure were studied. Additional analyses using cluster analysis and multiple regression analysis provided potentially useful information about variables related to outcome attainment.

The sample size is smaller than had been desired originally due to the extended, temporary low number of referrals into the agency. Due to the small sample size, the results must be viewed as speculative and interpreted cautiously. The results of this analysis of the psychometric properties of the instrument and the data it yielded relative to client and therapist responses provide useful insights for further programming considerations and exploration in research.

After more than twenty years of service delivery experience, and the development of an outcomes reporting process for local grant funders, the agency undertook the current program evaluation research project. The experience gained implementing this, Family Place's initial attempt at a federally funded research project, has left us much better informed and better prepared for approaching future research. We have learned several valuable lessons.

Rather than participating in the competitive bid process, funding was sought through earmarked funds. We have since come to more fully appreciate the advantage of the peer review process in honing and refining grant applications and research designs; the result of this process is a project that is better prepared to anticipate and respond to the challenges inherent in conducting research. In conducting Project Family, issues related to recruitment, instrumentation, and post-treatment follow-up might have been better anticipated through participating in the peer review process.

Another valuable lesson learned from undertaking Project Family relates to the difficulty of conducting scientifically rigorous research in a practice setting. Agencies devoted to direct service delivery typically have limited resources for research, in contrast to academic institutions, which are likely to have personnel and other resources available to conduct research. The challenge of data collection and analysis within a service delivery agency can be significant. Family Place has been committed to the development and implementation of an outcomes data collection and analysis procedure. While the demands of collecting relevant data from instruments and forms developed for use in treatment have been challenging, the collection of additional data for the purposes of the

research project proved much more difficult. The addition of the third party evaluator alleviated the data collection task from the agency staff, but it also introduced another set of collaborative relationships that require time, attention, and energy.

Related to the difficulty of data collection is the challenge of enrollment. Clients often responded very positively to the information provided about Project Family, but many changed their minds simply no showed repeatedly for scheduled assessment appointments. It is, perhaps, not surprising, given the highly personal nature incest, that clients might reconsider their initial willingness to be involved in a project that would have little direct benefit to themselves. The procedures for enrolling clients was modified to make it simpler, but this did not result in a significant increase in participation.

As has been previously stated, instrumentation was a challenge. The Treatment Review Questionnaire has been developed and used by Family Place, its reliability and validity have yet to be established. It was difficult to find established and accepted measurement tools that assess the dynamic, interactive variables of interest to Family Place. By their very nature, most instruments are intended to yield information about relatively stable traits within an individual rather than about a dynamic, changing family system. The Family Adaptability and Cohesion Scale, Second Edition, was found to be a useful research tool that examined family systemic variables. Most other instruments were selected because they were accepted instruments that addressed one or more key components related to the agency's proposed client outcomes.

## **Chapter 3 Outcome Evaluation**

The Project Family program evaluation research project was terminated prematurely due to insufficient enrollment. Remaining allocated funds were permitted to be used to complete an analysis of the Treatment Review Questionnaire (TRQ). REACH, Inc. conducted the analysis of the TRQ. The report provided by Robert Illback, Psy.D., principal investigator, and Daniel Sanders, Ph.D., statistical consultant, constitutes the remainder of this chapter.

### **Program Context**

The Family Place is a community agency in Louisville, Kentucky that specializes in the treatment of child sexual abuse (incest) through an innovative and integrative approach. Grounded in family systems theory, the program emphasizes engaging the entire family system in the treatment process, rather than just treating the person responsible for the abuse separately from the victimized child and the rest of the family. By involving the entire family in treatment, and focusing on all members of the family as being responsible for treatment gains, The Family Place treatment program seeks to promote long-lasting and pervasive change within complex family constellations. Family strengths and resources are mobilized through a range of therapeutic approaches to accomplish this end.

At the time of the grant application, a large number of families in the Louisville/Jefferson County region had been served by this intense program, which typically involves a 12-18 month time commitment. Six clinicians were then employed at the Family Place, each carrying an active caseload of between 12-15 families. The treatment “package” was individually-designed, but commonly included family therapy, individual therapy (about 25% of time and effort), group therapy for family members (about 25%), and related psychoeducational and consultation modalities. On the average, about 30 families were estimated to complete the entire treatment program in a given year, along with a substantial number of “partial completers”.

The Family Place received a federal grant in 1999 to validate the efficacy of the unique treatment approach described above. Federal funds were used to: (1) design and implement information and evaluation systems to gather information about salient programs, processes, and outcomes, and (2) determine the extent to which the intervention accomplished its goals. An evaluation system was developed to review available evaluative literature, develop a program logic model (evaluability analysis), design methods for data collection on program indicators (client and staff treatment review forms), and assess changes associated with program participation. Unfortunately, a number of system and program events conspired to limit the number of entering families, dramatically limiting the ability of the research design to address the questions of concern.

The present evaluation report uses a more limited data set than was originally contemplated to consider, in an exploratory and heuristic fashion. Due to their exploratory status, these findings are not intended to be used to draw definitive conclusions about program processes or outcomes. Rather, they are an attempt to make reasonable use of the available data in the service of promoting discussion, ongoing program development, theory- and hypothesis-building, and preliminary understanding.

#### ***Design for a Limited Analysis of TRQ Data***

Project Family is nearing the end of the funding cycle. Additional funding will not be sought because the project was unable to generate a sufficient sample to justify the kinds of analyses that were originally contemplated. However, the project has been authorized to use available funds to conduct limited analyses of extant data regarding the Treatment Review Questionnaire, a locally developed 20-item measure of treatment progress that is completed each quarter by every family in the Family Place treatment program. This will be done as an exploratory investigation.

There are 47 unique families for whom data are available, although not all evidence complete data sets. Comparative analyses which follow are in some instances based on the 18 families for whom complete 3- and 6-month data are available. In total, there are 144 Treatment Review Questionnaire (TRQ) paired protocols (both client and therapist) available for the time period of calendar year 2000 through mid-2002, including both therapist and client data. Data from this period comprise Version 2 of the TRQ instrument. An earlier 30-item instrument was condensed and revised through an exploratory factor analysis in 1999. TRQ scale data are arrayed along a continuum which

ranges from: 1 – strongly disagree, 2 – disagree, 3- somewhat disagree, 4- somewhat agree, 5 strongly agree, 6 strongly agree, N/A or cannot rate.

Version 2 data (the 20-item scale) were gathered and organized anonymously by a code ID#, which was then supplemented with demographic and service delivery data (also anonymously) to facilitate certain analyses. The focus of the project was to explore the salient psychometric properties of the TRQ, employing standard approaches to assessing reliability and validity, such as item analysis, factor analysis, coefficient alpha (reliability), and correlation with other measures of treatment. The potential predictive validity of the scale was considered through multiple regression and cluster analysis, exploring the relative contribution of various demographic and service delivery variables to treatment gains evidenced on the TRQ.

**Given the small size of the sample, conclusions have been stated in terms that make clear they are exploratory, speculative, and heuristic in nature. The primary purpose of this report is solely to generate information that can contribute to further program-level research with a larger sample.**

***Analysis and Findings***

*Available data*

144 TRQ protocols were available in electronic form from the Family Place. These reflected both therapist and client ratings of program in therapy, at intervals of 3 months. Given that the duration of treatment and engagement with the treatment process varies, there were substantially more protocols for the first year of treatment, although some were available through 48 months (see Table 1 below).

<i>Month of Treatment</i>	<i>Frequency</i>	<i>Percent</i>
2	1	.7
3	30	20.8
6	21	14.6
9	20	13.9
12	14	9.7
15	14	9.7

**Table 1 (continued)**

<i>Month of Treatment</i>	<i>Frequency</i>	<i>Percent</i>
18	8	5.6
21	7	4.9
24	4	2.8
27	7	4.9
30	6	4.2
33	3	2.1
36	2	1.4
39	2	1.4
42	2	1.4
45	2	1.4
48	1	.7
<i>Total</i>	<i>144</i>	<i>100.0</i>

**Table 1 – Distribution of TRQs by Timeframe**

Table 2 shows a corresponding measure of progress in treatment, in addition to duration, Phase of Treatment (see Family Place program description for discussion of Phases of Treatment, which is program-assigned).

<b>Phase of Treatment</b>	<b>Frequency</b>	<b>Percent</b>
0	1	.7
Phase I	21	14.6
Phase II	89	61.8
Phase III	24	16.7
Uncoded	9	6.3
Total	144	100.0

**Table 2 – Distribution of TRQs by Phase of Treatment**

***Means, standard deviation, comparability of ratings***

Global means and standard deviations for 18 families are shown below for client ratings in the first six months (3- and 6-month ratings combined).

<b>Item</b>	<b>Mean Client Ratings</b>	<b>Standard Deviations</b>
Know risk factors	4.48	1.53
ID risky changes in family	4.36	1.55
ID changes in relationships and communication	4.43	1.37
Understand effects of moods	4.90	1.32
Take responsibility for behavior	4.88	1.01
Acknowledge how abuse has affected family	4.90	1.30
Supportive network of relationships	4.21	1.44
Aware of when to enact safety plan	5.30	1.03
Committed to role in safety plan	5.10	1.33
Parents work together as team	4.81	1.21
Establish and respect appropriate boundaries	4.91	1.11
Communicate wants, needs, opinions safely	4.72	.94
Support and nurture in healthy ways	4.75	1.24
Comfortable showing affection	5.03	1.21
Use appropriate discipline	4.87	1.15
Developmental expectations	4.27	1.40
Function well day-to-day	4.80	1.16
Experience fewer symptoms	4.39	1.23
Experience decreased depression	4.36	1.31
Experience decrease anxiety	4.34	1.37

**Table 3 – Global means and SDs for client ratings**

Global means and standard deviations are shown below for therapist ratings for the same 18 families.

<b>Item</b>	<b>Mean Therapist Ratings</b>	<b>Standard Deviation</b>
Know risk factors	3.08	1.02
ID risky changes in family	3.13	.92
ID changes in relationships and communication	2.96	.96
Understand effects of moods	2.93	.94
Take responsibility for behavior	3.58	.93
Acknowledge how abuse has affected	3.57	1.19

family		
Supportive network of relationships	3.38	1.06
Aware of when to enact safety plan	3.75	1.60
Committed to role in safety plan	3.80	1.52
Parents work together as team	3.22	1.26
Establish and respect appropriate boundaries	3.22	1.10
Communicate wants, needs, opinions safely	3.16	1.03
Support and nurture in healthy ways	3.52	1.01
Comfortable showing affection	4.12	1.24
Use appropriate discipline	3.45	1.23
Developmental expectations	3.57	1.12
Function well day-to-day	4.07	.88
Experience fewer symptoms	3.79	.88
Experience decreased depression	3.73	1.12
Experience decrease anxiety	3.36	.99

**Table 4 – Global means and SDs for Therapist ratings**

A comparison of mean ratings between clients and therapists is shown below. It appears to show that clients in therapy for sexual abuse tend to rate their progress more highly than do their therapists by an average of about 1.5.

<b>Item</b>	<b>Client Ratings</b>	<b>Therapist Ratings</b>
Know risk factors	4.48	3.08
ID risky changes in family	4.36	3.13
ID changes in relationships and communication	4.43	2.96
Understand effects of moods	4.90	2.93
Take responsibility for behavior	4.88	3.58
Acknowledge how abuse has affected family	4.90	3.57
Supportive network of relationships	4.21	3.38
Aware of when to enact safety plan	5.30	3.75
Committed to role in safety plan	5.10	3.80
Parents work together as team	4.81	3.22
Establish and respect appropriate boundaries	4.91	3.22
Communicate wants, needs, opinions safely	4.72	3.16
Support and nurture in healthy ways	4.75	3.52
Comfortable showing affection	5.03	4.12
Use appropriate discipline	4.87	3.45
Developmental expectations	4.27	3.57
Function well day-to-day	4.80	4.07
Experience fewer symptoms	4.39	3.79
Experience decreased depression	4.36	3.73
Experience decrease anxiety	4.34	3.36

**Table 5 – Comparison of mean client and therapist ratings**

When subjected to a pairwise t-test to determine the relative strength of these differences in estimation of progress, it can be seen that all were significant at high levels of significance, as shown below in Table 6.

Item	t	Df	Sig. (2-tailed)
Know risk factors	5.661	34	.000
ID risky changes in family	5.911	34	.000
ID changes in relationships and communication	7.766	34	.000
Understand effects of moods	8.667	34	.000
Take responsibility for behavior	6.668	34	.000
Acknowledge how abuse has affected family	5.464	34	.000
Supportive network of relationships	4.015	34	.000
Aware of when to enact safety plan	9.672	34	.000
Committed to role in safety plan	9.549	34	.000
Parents work together as team	5.798	34	.000
Establish and respect appropriate boundaries	6.329	34	.000
Communicate wants, needs, opinions safely	8.286	34	.000
Support and nurture in healthy ways	7.093	34	.000
Comfortable showing affection	4.878	34	.004
Use appropriate discipline	5.487	34	.000
Developmental expectations	3.348	34	.000
Function well day-to-day	3.938	34	.000
Experience fewer symptoms	3.041	34	.005
Experience decreased depression	3.388	34	.002
Experience decrease anxiety	4.475	34	.000

**Table 6 – Paired samples t-tests of item comparisons**

It should not be surprising that families and therapists might have substantially different estimations of their progress in treatment, especially under conditions where the presenting problems (alleged or substantiated sexual abuse), the nature of participation (usually involuntary), and the outcome of documented progress (release from court conditions) tend to shape responding. What is interesting is the magnitude of the differences and the relative strength of these differences across items.

### ***Exploratory factor analysis***

A pairwise exploratory analysis of available data for the Treatment Review Questionnaire (TRQ) was accomplished to understand its underlying psychometric features. Two versions of the scale, one for family members and the other for therapists, were assessed. All completed protocols were used for analysis, divided equally between family members and therapists.

A principal components factor analysis with varimax rotation was conducted on each version of the scale separately. The client (family) version of the scale yielded a five factor solution that explained 68.1% of the variance within the client variables.

Item	1	2	3	4	5
Know risk factors	.740				
ID risky changes in family	.872				
ID changes in relationships and communication	.822				
Understand effects of moods					
Take responsibility for behavior					
Acknowledge how abuse has affected family	.695				
Supportive network of relationships					
Aware of when to enact safety plan					.791
Committed to role in safety plan					.836
Parents work together as team			.725		
Establish and respect appropriate boundaries					
Communicate wants, needs, opinions safely			.673		
Support and nurture in healthy ways		.629			
Comfortable showing affection		.801			
Use appropriate discipline		.674			
Developmental expectations					
Function well day-to-day					
Experience fewer symptoms					
Experience decreased depression				.747	
Experience decrease anxiety				.832	
Variance explained	19.1 %	13.3 %	12.8 %	12.5 %	10.4 %

**Table 7 – Principal components factor analysis of client ratings**

The above exploratory data suggest an underlying factor structure (latent traits) for the client version of the scale that may be as follows:

- Factor 1 – Acknowledgment of sexual abuse and awareness of risk factors
- Factor 2 – Parent-child interaction and discipline
- Factor 3 – Family cohesion and communication
- Factor 4 – Decreased psychopathology/symptomology
- Factor 5 – Safety plan awareness and commitment

The therapist version of the scale yielded a somewhat different profile, wherein a three factor solution emerged from the factor analysis, accounting for 73.3% of the variance.

Item	1	2	3
Know risk factors	.763		
ID risky changes in family	.789		
ID changes in relationships and communication	.773		
Understand effects of moods	.605		
Take responsibility for behavior	.662		
Acknowledge how abuse has affected family	.610		
Supportive network of relationships			
Aware of when to enact safety plan	.630		
Committed to role in safety plan	.677		
Parents work together as team		.616	
Establish and respect appropriate boundaries			
Communicate wants, needs, opinions safely			
Support and nurture in healthy ways		.679	
Comfortable showing affection		.802	
Use appropriate discipline		.668	
Developmental expectations			
Function well day-to-day			.680
Experience fewer symptoms			.819
Experience decreased depression			.789
Experience decrease anxiety			.821
Variance explained	28.6 %	22.8 %	22.4%

**Table 8 – Principal components factor analysis of therapist ratings**

The above exploratory data suggest an underlying factor structure (latent traits) for the therapist version of the scale that may be as follows:

- Factor 1 – Acknowledgment of sexual abuse, awareness of risk factors, safety planning
- Factor 2 – Family cohesion, communication, parent-child interaction and discipline
- Factor 3 – Decreased psychopathology/symptomology

It is interesting to note that the underlying factor structure of the scales differs to an extent between therapists and clients. This may reflect a paradigmatic difference between their perspectives, and be of some usefulness in terms of stimulating further research. One interesting hypothesis is that therapists tend to view their client's progress within three areas at the Family Place: (1) risk for sexual abuse; (2) family dynamics and interaction; and, (3) effects of psychopathology. In contrast, clients (families) tend to compartmentalize the issue of acknowledgment of sexual abuse and safety planning as

two separate areas, and see parenting as separate from family dynamics. It would be interesting to explore whether the ability to connect risk assessment with safety planning is a meaningful predictor of treatment efficacy, for example.

***Internal consistency (Cronbach’s alpha)***

Using the therapist factors described above as a guide, factor scores were derived for both client and therapist data. A coefficient alpha reliability estimate was obtained to assess the scale’s overall internal consistency, an important psychometric feature that is often used to determine whether a scale has sufficient consistency to be used for decision-making. Findings are shown below:

	Time1 (3 months)	Time 2 (6 months)	Times 1&2
Client factor 1	.7159	.7092	.7410
Client factor 2	.8793	.7774	.8396
Client factor 3	.7097	.7385	.7199
All Client variables	.8832	.8529	.8745
Therapist factor 1	.8393	.9197	.8832
Therapist factor 2	.9218	.8618	.8945
Therapist factor 3	.8733	.8574	.8644
All Therapist variables	.9504	.9345	.9422
All variables	.9109	.8980	.9069

**Table 9 – Internal consistency scale reliability estimates**

Given that these factors were generated using scores from therapists, therapist factors are likely to have higher reliability scores than the client factors by definition. Nonetheless, all are within an acceptable range for the scale as a whole (in the .9 range and above) and for subscale analysis (particularly the therapist factor scores).

***Multiple regression***

Regression analysis can answer questions about what subset of client is helped most by this program. More precisely, it allows us to determine which combinations of indicators at time1 (3 months) are associated with progress between time1 and time2 (6 months). Just determining, and ranking, the top three among 19 predictors for a change variable involves consideration of 2,394 (19x18x17) combinations. Stepwise regression analysis not only can find the best combination, but can find the optimal weighting of each of the three predictors, which involves billions of alternative weightings. It chooses the most highly correlated predictor, enters it, reconsiders all remaining predictors in light of the inclusion of the first predictor, enters a second predictor, reevaluates both the included variables and the remaining variables, and continues to add, and if necessary, remove variables until neither additions nor deletions would improve the then current group of predictors.

Regression analysis was used to consider three different TRQ measures of change between time1 and time2: change in the therapist scores, change in client scores, and total change. The change in therapist scores had the strongest set of predictors. The change in

client scores had the weakest set, but even its relationship was strong compared with the kind of relationships that one usually finds in the evaluation of social programs.

	b	beta	t	Sig.
Total score (time1)	-4.95	-.812	-5.750	.000
Substantiation	18.533	.523	4.051	.002
Duration	5.089	.376	2.654	.024
constant	57.805	-	3.961	.003

Combined r = .913; r square = .834

**Table 10 – Regression findings for change in Therapist Scores (T1 to T2)**

The numbers in the beta column indicate how much of a change (in terms of standard deviations) in the outcome (dependent) variable is caused by a change of standard deviation in the predictor (independent) variable. A higher number (ignoring sign) indicates a stronger influence. The “t” and “Sig.” values both measure the likelihood that the relationship between the predictor variable and outcome variable is statistically significant rather than merely accidental. A high (again ignoring sign) value of “t” has the same meaning as a low value in the “Sig.” column. The coefficients in the “b” column are results of the computer’s computation of the optimal weighting of the predictor variables. One can feed them into an equation to create a composite predictor variable (CPV):

$$CPV = -4.95 * \text{total score} + 18.533 * \text{substantiation} + 5.089 * \text{duration} + 57.805.$$

This correlation between this CPV and the outcome variable is .913.

The “Total score” variable is the sum of the twenty therapist scores and the twenty client scores at time1. Since “b”, “beta”, and “t” are negative, a lower “total score” at time1 is associated with greater improvement between time1 and time2. The “Substantiation” variable has a coding of 1=yes and 2=no. The indicators are positive, so the absence of substantiation is associated with greater improvement. The “Duration” variable has a coding of 1=frequent, 2=episodic, and 3=limited time. The indicators are positive, so infrequent abuse is associated with greater improvement. Thus, greater improvement has been achieved when the initial situation is more severe according to the therapist and client scores, but less severe in terms of substantiation and duration.

	b	beta	t	Sig.
Total score (time1)	-.663	-.701	-4.271	.001
Type of disclosure	29.833	.519	3.167	.009
constant	86.970	-	3.168	.009

Combined r = .840; r square = .706

**Table 11– Regression findings for change in total score (T1 to T2)**

Using change in total score as the outcome variable, the total score at time1 again appears as the strongest predictor, but not as strong a predictor as it is for change in therapist scores. The “type of disclosure” variable has a coding of 1=self, 2=reporter, and it has positive indicators. Thus improvement in combined therapist and client scores has tended to be greatest when the combined scores were particularly low at time1 and when the abuse was reported by someone other than the victim.

	B	Beta	t	Sig.
Duration of sexual abuse	-5.947	-.486	-2.530	.024
Family history of chemical abuse / dependency	10.756	.438	2.281	.039
Constant	-.844	-	-.092	.928

Combined  $r = .705$ ;  $r\text{ square} = .497$

**Table 12 – Regression findings for change in client scores (T1 to T2)**

The combined  $r$  and  $r\text{ square}$  are lower here.

The duration variable here has a negative coefficient, and since 1=frequent, Client scores tend to increase more when duration had been more frequent. The “family history of chemical abuse/dependency” variable has positive coefficients and a coding 1=yes and 2=no, so improvement in client scores tended to be higher when the family did not have a history of chemical abuse.

### ***Cluster analysis***

Using the three factor solution resulting from the pairwise factor analysis described earlier, which involved the therapist variables and all cases, the variables were grouped and summed, creating three client factor variables and three therapist factor variables. A new change variable ( $t_2 - t_1$ ) for each of the six factor variables was then computed. Using these six change variables, cases (families) were categorized into three groups (clear improvement, clear worsening, & little change). Those cases classified as showing clear change usually had all six change variables showing change in the same direction. (The case classified as showing clear change with the smallest net change had scores of .7, .1, -1.5, -8.7, -.7, & -3.0. The case classified as not showing clear change with the highest net change had a more inconsistent set of scores: 3.8, -1.8, -3.5, 4.8, 2.8, & 4.0.)

A new total score variable was computed, summing all scores, and a derivative variable was computed showing the change in the total score variable in the 3 months from time1 to time2. Families with lower initial scores tended to improve more. The correlation between the total score at time1 and the total change between time1 and time2 was a negative .661, which was highly significant ( $p=.004$ ) despite the small number of cases.

Cluster analysis of time 1 data produced results consistent with the correlations:

Three cluster solution	Clear Improvement	Little Change	Clear Worsening
Big group (15 cases)	4	7	4
2 small groups (3 cases)	3	0	0

**Table 13 – Cluster categorization of cases into three groups**

Four cluster solution	Clear Improvement	Little Change	Clear Worsening
Big group (11 cases)	2	5	4
3 small groups (7 cases)	5	2	0

**Table 14 – Cluster categorization of cases into four groups**

For the purposes of cluster analysis, it should be noted that these are the most speculative of the exploratory findings, and perhaps the most subject to problems of a small sample. At best, this may serve as a model for data analysis in future investigations with larger samples.

### **Summary**

It should again be emphasized that this is an exploratory investigation into data available for a small group of families that received treatment at the Family Place between CY2000-2002. The primary focus of the research is to validate the Treatment Review Questionnaire and to understand its relationship to other variables of concern.

There appears to be preliminary evidence to support the fundamental reliability of the measure. Moreover, exploratory factor analysis reveals at least three relatively stable underlying factors that may have promising clinical and programmatic utility. There is clear evidence that clients appear to view progress in treatment in fundamentally different ways than do therapists, but this is not surprising given the nature of the treatment program.

Regression analysis reveals that for this very small sample, therapist estimations of progress over time are correlated with the severity of their initial problems/needs, the duration of abuse, and whether the abuse was substantiated. For clients, predictive multiple correlations look somewhat different, influenced most heavily by the duration of abuse and family chemical dependency. When these two estimations are combined, a different pattern emerges, in which the nature of the disclosure may play a role. Given the small sample, and some of the assumptions that underlie this analysis, great caution should be taken in interpretation, but this may serve as a model for further hypothesis testing with a larger sample. Finally, cluster analysis was accomplished but the sample size was too small to make profitable use of the results.

## **Chapter 4      Use of Program Implementation Data to Understand Outcomes**

The premature termination of the program evaluation research project precludes drawing conclusions about the relationship between program implementation and participant outcome evaluation results.

Regarding the evaluation of the Treatment Review Questionnaire, program implementation procedures did adversely affect the data analysis. Early difficulty with tracking the due dates for, and completion of, required paperwork resulted in incomplete data sets for many families. This, coupled with the limited number of new clients entering the program, resulted in a smaller number of records included in the calculations of global T-scores discussed in Chapter 3.

## **Chapter 5      Recommendations for Future Policies, Programs, and Evaluations**

1. Families impacted by incest must deal with the incredible emotional devastation caused by the sexual abuse of a child by a family member. In addition to the harm caused directly by the incest, everyone in the family is impacted by the dysfunctional family dynamics that often precede the actual sexual acting out by the offending family member. Comorbid problems of child physical abuse, domestic violence, and substance abuse often contribute to the further isolation of the family from external supports. Additionally families often respond either by fusing in enmeshed relationships, or fragmenting into factions and coalitions. These responses often lead to a confusing and complicated mixture of feelings of anger and rage, intense dependency, fear, and disgust. Non-offending parents are frequently blamed by their extended families and ostracized because of their continued feelings of love or dependency that characterize one side of their ambivalence toward their partner or family member. Most families report intense feelings of shame and embarrassment that are reinforced by the reactions of others in their community. Families that had isolated themselves behind rigid boundaries experience the involvement of the child protective services system as intrusive, and the interactions with the legal system as adversarial.

Many of the families ordered into treatment approach the process with the awareness that the therapist is, in many ways, acting as an extension of these systems. They are mistrusting of the therapist, fearful of the change required by active and successful participation in therapy, and resentful of the potential power of the therapist's recommendations.

These attitudes and perceptions appeared to have a direct impact on client willingness to participate in the project. When extant clients were presented with the opportunity to enroll in the project at its inception, there was a higher rate of positive responses,

and a greater frequency of appointments kept with fewer reschedules as compared to clients newly entering the treatment who were offered the opportunity to participate at intake. While these new clients often indicated an initial willingness to participate in the project, many of them changed their minds before the first appointment, and the rate of no-shows and reschedules for assessment was greater. This would suggest that clients who have clarified the respective roles of therapist, protective services worker, and court personnel, and who have established more of a therapeutic alliance are more likely to commit to a similar project. Additionally, these clients may have been experiencing less chaos and crisis in their lives, as the time since disclosure was longer and initial court dispositions had typically been made, in comparison to clients newly entering treatment when disclosure is recent and court dispositions remain uncertain. It is recommended that researchers weigh the potential benefits of enrolling participants in a similar project at a later date, and perhaps gaining greater commitment to the project, against the needs to gain pre-treatment baseline information as early as possible.

2. In light of the enrollment difficulties faced by this project, other programs seeking to undertake a research project might do well to attempt to inform referral sources of the any upcoming research. Paying special attention to maintaining existing relationships and cultivating new referral sources may help assure a steadier rate of referrals. Notifying existing referral sources of the purpose, nature, and duration of research being undertaken by the agency and offering to provide a written summary of the results may increase the interest of these referral sources in contributing to the body of knowledge concerning treatment outcomes relative to their client populations.
3. Conducting research with a court-ordered population brings several important considerations for researchers. Informed consent is a matter of particular importance, as clients must understand there is no compulsion to participate in the project, and their choice to do so or not to do so will in no way affect their treatment or their standing with the court system. For this reason, a single blind design is advised, with treatment providers being unaware of who is or is not participating in the research.

An additional consideration relates to the involvement of multiple systems in the lives of the research participants. Participation in a research project may be affected by the involvement with the legal and child protective systems. Legal system involvement may impact participation in several ways. Clients may agree to participate in the project, only to be advised by their legal counsel not to do so; this was the case with a potential Project Family participant whose attorney advised him not to complete any of the assessment instruments due to concerns over what the responses may indicate and the potential for these to be used to the detriment of his client. Clients may be withdrawn from the project due to probation violations and subsequent incarceration or parole revocation.

The child protective services systems may impact participation in a research project if protection issues require outplacement of the children or a change in visitation or contact agreements.

These factors should be considered in estimating attrition rates and determining necessary sample sizes.

## Appendix A: Technical Appendix

### Program Evaluation

The program evaluation research component of Project Family was terminated prematurely due to low enrollment. At the time funding was sought for the project, Family Place employed six full-time therapists and received a steady stream of referrals from CPS, the Cabinet for Families and Children, and the Family and Criminal Courts. Projections were made for the enrollment of 50 families into the project for each of the four years of the grant. Shortly after receiving funding for the program evaluation, changes in the local community's referral protocol and reorganization by major referral sources resulted in a significant and prolonged decline in referrals to Family Place.

From the time client enrollment began in May 2000 until relinquishment of the grant in August 2001, 18 families had begun participating in the project. This number was far short of the anticipated fifty per year. Realistic projections of best case scenarios of improved referrals led to the conclusion that it would not be possible to achieve a large enough sample size during the life of the grant to allow for meaningful statistical analysis of the data. It was at that point the decision was made to relinquish the grant.

For those 18 families participating in the project prior to its termination, enrollment into the project and data collection sessions were scheduled by and with research assistants working for REACH of Louisville, Inc., the third party evaluator hired to conduct the project. The research assistants met with the clients at intake or contacted them by phone shortly afterward. They secured informed consent and administered the assessment instruments in accordance with the schedule described below (see Appendix B for a timetable of assessment administrations).

- Sexual Abuse Fear Evaluation (SAFE)- administered at intake, 1 year, upon exit, and six months following exit
- Children's Attributions and Perceptions Scale (CAPS)- administered at intake, 1 year, upon exit, and six months following exit
- Parent Perception Inventory (PPI)- administered at intake, 1 year, upon exit, and six months following exit
- Child Behavior Checklist (CBCL)- administered at intake, 1 year, upon exit, and six months following exit
- Parenting Scale- administered at intake, 1 year, upon exit, and six months following exit
- Parent-Child Conflict Tactics Scale (supplemental sexual maltreatment questions only)- administered at intake, 1 year, upon exit, and six months following exit
- Child Sexual Behavior Inventory (CSBI)- administered at intake, 1 year, upon exit, and six months following exit
- Family Adaptability and Cohesion Scale, Second Edition (FACES-II)- administered at intake, upon completion of Phases I and II of treatment, and upon exit.

- Children's Depression Inventory (CDI) - administered at intake, upon completion of Phases I and II of treatment, and upon exit.
- Revised Children's Manifest Anxiety Scale (RCMAS) - administered at intake, upon completion of Phases I and II of treatment, and upon exit.
- Symptom Checklist 90-Revised (SCL-90-R) - administered at intake, upon completion of Phases I and II of treatment, and upon exit.

Due to the long-term nature of the treatment program and the slow rate of referrals, 13 of the 18 families only underwent the first round of testing before the project was terminated; 5 families were administered the second round.

The research assistants submitted a requisition for the \$25.00 stipend directly to the Director of Clinical Services in an attempt to keep the therapists as blind as possible to the participation status of the clients on their caseloads.

In addition to the extant clients with whom the research met directly or whom they contacted by phone to invite to participate, former clients who had participated in at least one year of services and who had exited the program within a year were invited by mail to attend. Of the seventy-three families with whom we attempted to establish contact by mail to invite to participate, no families accepted the invitation; a substantial number of letters were returned because the clients were no longer at that mailing address.

#### Treatment Review Questionnaire Analysis

The Treatment Review Questionnaire was revised in 2000 following a factor analysis and reliability study of the original version of the instrument in 1999. This 2000 revision continues to be the version in use. The current study of the TRQ utilized electronically encoded information from 144 pairs of TRQ's ; with a pair consisting of both the client version and staff version of the TRQ for the same client.

These TRQ's were completed by clients and staff between January 2000 and mid-2002. Results are encoded using a Likert type scale, and are arrayed along a continuum which ranges from: 1 – strongly disagree, 2 – disagree, 3- somewhat disagree, 4- somewhat agree, 5 strongly agree, 6 strongly agree, N/A or cannot rate. These data were organized anonymously by a code ID#. Using this ID#, a research assistant obtained demographic and service delivery information from documentation from the charts of clients included in the data set.

Standard approaches to assessing reliability and validity were utilized, such as item analysis, factor analysis, coefficient alpha (reliability), and correlation with other measures of treatment. The potential predictive validity of the TRQ was considered through multiple regression and cluster analysis, exploring the relative contribution of various demographic and service delivery variables to treatment gains evidenced on the TRQ.

**It bears repeating that, given the small size of the sample, conclusions have been stated in terms that make clear they are exploratory, speculative, and heuristic in nature. The primary purpose of this report is solely to generate information that can contribute to further program-level research with a larger sample.**

## Appendix B: Data Collection Instruments\*

Instrument	Intake	End of Phase I	One Year after Intake	End of Phase II	Completion of Treatment	Six Months After Completion
Sexual Abuse Fear Evaluation (SAFE)						
Children's Attributions and Perceptions Scale (CAPS)						
Parent Perception Inventory (PPI)						
Child Behavior Checklist (CBCL)						
Parenting Scale (PS)						
Parent-Child Conflict Tactics Scale (supplemental sexual maltreatment questions only)						
Child Sexual Behavior Inventory (CSBI)						
Family Adaptability and Cohesion Scale (FACES-II)						
Children's Depression Inventory (CDI)						
Revised Children's Manifest Anxiety Scale (RCMAS)						
Symptom Checklist 90-Revised (SCL 90-R)						
Treatment Review Questionnaire (TRQ)**						

\*Shaded cells represent administration of the instrument

\*\*Administered quarterly after intake







10/31/02

Penelope L. Maza  
Senior Policy Research Analyst  
Children's Bureau  
330 C St., SW, Room 2427  
Washington, D.C. 20447

Dear Dr. Maza:

Please find enclosed the final report for the Project Family grant. I would like to thank you very much for your continued assistance at every point of this venture. From helping us refine the program design to providing feedback on proper reporting, you have provided invaluable support. We have learned a great deal from our first attempt at conducting federally funded outcomes research, and we are much better informed and prepared to seek future funding through the peer review process.

We continue to believe that there is a scarcity of research literature examining family systems treatment of incest, and we are committed to making an appropriate and significant contribution. While Family Place is very well respected within this region as a service provider, we now have a greater awareness of the ways in which the research arena is different. The suggestions provided by you and Dr. Flanzer to prepare Family Place to gain credibility within the research community will certainly prove beneficial to us in the future as we embark on future research projects.

On a more personal note, I have enjoyed the mentoring you have provided. You have always been very responsive to my inquiries, and you have always been open to discussing new ideas to revise or enhance the project. I have learned a great deal from our association, and I thank you for that.

Sincerely,

Charles G. Thomas, Psy.D.  
Licensed Clinical Psychologist  
Director of Clinical Services



The Family Place: A Child Abuse Treatment Agency  
982 Eastern Parkway, Louisville, KY 40217-1567  
(502) 636-2801 Fax: (502) 636-2857  
[www.familyplaceky.org](http://www.familyplaceky.org)

