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What's Hope Got to do with it? The Role of Hope in Sexual Abuse Treatment

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We the undersigned committee, having examined the submitted doctoral research project, "What's Hope Got to do with it? The Role of Hope in Sexual Abuse Treatment" by Marian Amundsen, M.S. hereby indicate its unanimous approval.

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Abstract

What's Hope Got to do with it? The Role of Hope in Sexual Abuse Treatment

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Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is an evidence-based treatment approach for children suffering from trauma-related symptoms (; Cohen et al., 2018 Cohen et al., 2022; de Arellano et al., 2014; Slalom et al., 2022). Throughout treatment, the primary focus is to reduce the negative symptoms after experiencing a traumatic life event (Child Welfare Information Gateway, 2012). The role of hope in the aftermath of trauma survivors has been supported as a strength contributing to the well-being of the individual (Munoz et al., 2020). However, research has not yet examined the role of hope as a predictor of completing trauma-focused treatment. This study aimed to examine the role that hope plays throughout treatment and establish the relationship between hope levels throughout treatment (at the onset, after six months, upon completion) and treatment outcomes. Using longitudinal data collected from survivors of child sexual abuse and their non-offending family members, this study examined participants' levels of hope throughout treatment and used correlational analyses to establish the relationship of hope to posttraumatic symptoms. Analyses showed that hope did not have a significant predictive value of treatment outcome or posttraumatic symptoms. Potential explanations for these results and implications for future research are discussed.

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Chapter 1: Introduction

The United States, in the year 2020, had an estimated 65,750 minors for whom had experienced sexual abuse (United States Department of Health and Human Services, Administration for Children and Families, 2021). Approximately 22.6% of children in the United States have experienced at least two adverse childhood events (Bethell et al., 2014). Upon reaching adulthood, research has shown that individuals who have experienced more adverse events in early life show decreased levels of hope compared to those adults who have not (Baxter et al., 2017). High levels of hope are predictive of improved well-being, including increased school performance in adolescents (Day et al., 2010). In considering this correlation, a cycle is noted that adverse childhood experiences may result in lower hope levels, often connected with negative outcomes. This could exacerbate feelings of hopelessness, worthlessness, and other damaging views of self. Gorey and colleagues (2001) sought to establish the impact of group treatment among women with histories of childhood sexual abuse (CSA). They found that those who completed group therapy demonstrated higher levels of hope at the end of treatment than those who did not complete treatment. In considering these findings, it is essential to note the need for research to examine how initial hope levels may be used to benefit the survivor from the beginning of treatment rather than only measuring hope levels at the end.

There is no established body of literature that follows clients throughout their treatment process to monitor varying levels of hope and the correlation with other posttraumatic symptoms. In considering the impact that parents have on a child's development and success, it is also vital to examine the correlations between parental hope and stress levels and the child's levels of hope and treatment outcomes (Hoy et al., 2013). Suppose research can uncover the relationship between parent hope and stress levels with child hope and sexual abuse treatment success. In that case,

practitioners may use these factors to better address the client's needs from the onset of treatment to promote more successful treatment outcomes in a shorter period. This additionally has implications for incorporating a family-focused model of treatment which includes non-offending caregivers to participate with the child survivor (Davies & Bennett, 2021).

Chapter 2: Literature Review

Childhood Sexual Abuse

Childhood sexual abuse is defined as "unwanted sexual activity, with perpetrators using force, making threats, or taking advantage of victims not able to give consent" (American Psychological Association, n.d.). In a 2014 study examining the prevalence of sexual assault in the United States, it was found that approximately 26.6% of 17-year-old females had experienced sexual abuse or sexual assault at some point in their lives, while an estimated 5.1% of same-aged males had experienced sexual abuse/assault (Finkelhor et al., 2014). Confidence intervals within this study suggested that the actual percentage of sexual assault/abuse among all 17-year-olds in the United States is between 19.8% and 33.5% of females and 2.6% and 7.6% for males (Finkelhor et al., 2014).

Individuals who have experienced CSA are 48% more likely to meet the criteria for a PTSD diagnosis than children who have not experienced CSA (Briere & Elliot, 1994). In considering the importance of learning in childhood as it pertains to shaping life direction and personal characteristics, one must consider CSA's impact on an individual. Experiencing the safety violation of sexual abuse is likely to teach a child that the world is not safe, that something is wrong with them, that there is little-to-no control over our boundaries, and that they are not worthy of proper security. Moral injury—defined here as "injuries of the soul" (Richardson et al., 2022, p. 10)—may play a role in the healing process of a child survivor of CSA. Richardson et al., (2022)

found themes within individuals who have experienced moral injury include betrayal, lack of reconciliation, moral ambivalence, and soul wounds (which include guilt, demoralization, and isolation). Griffin et al. (2019), poses that soul wounds and demoralization are highly correlated with hopelessness in an individual who has experienced a potentially morally injurious event. In considering these associations and the literature's establishment that moral injury often stems from betrayal of an authority figure and/or betrayal of self from the self, we might find greater correlations with the aftermath of CSA, hope, and trauma symptoms (Griffin et al., 2019; Richardson et al., 2022). CSA in such a critical learning period may create significant cognitive distortions that the child can carry throughout their entire lives if not suitably addressed or challenged (Briere & Elliot, 1994). Such a world- and the self-view is bound to contribute to hopelessness.

Browne and Finkelhor (1984) provided foundational work in childhood sexual abuse. They found that, "depression is the symptom most commonly reported among adults molested as children" (Browne & Finkelhor, 1984, p. 152). Women who experienced CSA are more likely to experience depression in adulthood, experience depressive symptoms at an earlier age, develop a panic disorder, and have a history of suicide attempts (Gladstone et al., 2004). Women who have experienced CSA are more likely to experience revictimization—or more than one experience of sexual assault (Gladstone et al., 2004). Some studies have found that the severity of sexual abuse has no direct relationship to the development of posttraumatic symptoms over time (Guerra et al., 2018). The greatest correlate to decreased negative impacts following CSA was the perception of family support (Guerra et al., 2018). Women for whom have experienced physical abuse in childhood (inclusive of sexual assault but not limited to) were lower ratings of life satisfaction and social support and higher indicators of a depressed mood and problematic alcohol consumption

(Griffin & Amodeo, 2010). Childhood trauma is also strongly correlated with long-term depression and insecure attachment in future relationships (Negele et al., 2015).

More recent research has examined the impact of child sexual abuse on non-offending caregivers. Researchers have found negative emotional, cognitive, and family outcomes for non-offending caregivers, often identified as "secondary victims", and have emphasized the importance of reducing barriers to treatment and including non-offending caregivers within child sexual abuse treatment (Davies & Bennett, 2021; Fuller, 2016; Theimer et al., 2020; and Vilvens et al., 2021).

Adverse Childhood Experiences

Adverse Childhood Experiences are defined as traumatic life events that an individual experiences prior to turning 18 years of age (Burke Harris & Renschler, 2015). Felitti established the foundation for viewing adversity in childhood through a lens of assessment, labeling these experiences as "ACEs" when creating the Adverse Childhood Experiences Questionnaire (Felitti et al., 1998). The questionnaire has three variations: one for adults, one for teens, and one for children. These questionnaires allow individuals to endorse the adversity they faced in childhood, and research has established the long-term implications of different ACE scores. The identified 'adverse childhood experiences' consist of lack of met needs (clothing, food, protection), parental abandonment, residing with persons with mental illness or addiction, domestic household violence, imprisonment of someone in the home, physical or sexual abuse, neglect, and lack of proper emotional nurturance (Felitti et al., 1998). In the 'ACE Study,' individuals who received an ACE score of 4 or higher were at increased (4- to 12-fold) risk for depression, history of suicide attempts, alcoholism, and drug abuse. Researchers also found that those individuals were at higher risk (2- to 4- fold) for smoking cigarettes, poorly self-rated health levels, more significant risk-taking behaviors in sexual relations (more than 50 sexual partners and STIs), as well as increased risk

(1.4- to 1.6-fold) for obesity or a sedentary lifestyle. These increased risk factors also put a person at greater risk for liver, lung, cardiac disease, bone fractures, and cancer (Felitti et al., 1998). These initial findings laid the foundational framework for the importance of considering ACE scores when working with clients working for recovery after traumatic childhood experiences and have continued to be supported in the correlational factors with supporting literature over time (Giano et al., 2020; Pilkington et al., 2021).

Individuals with an ACE score of 5 or higher are at 8.32 times greater risk for experiencing sexual victimization in adulthood (Ports et al., 2016). Someone who has an ACE score of 1, which is below the overall clinical cutoff for increased risk, was still shown to be at 1.77 times greater risk for sexual victimization in adulthood (Ports et al., 2016). What is lacking in this research are the long-term impacts and other contributing factors that might be present for these individuals. Through examining the hope levels in correlation with both child and parent ACE scores, we may find clinical interventions that can be utilized to decrease the likelihood of sexual victimization following the presence of even one adverse childhood experience.

Nationwide, 22.6% of children have experienced at least two ACEs. Children with existing chronic conditions were more likely to have had adverse experiences. Children with ACEs were less likely to demonstrate resilience (defined in the NSCH survey as "staying calm and in control when faced with a challenge") (National Survey of Children's Health, 2013; as cited in Bethel et al., 2014, p. 2106), live in a protective home environment, and have healthy mothers and parents that were not aggravated with them than children without an ACE history (Bethel et al., 2014).

Children with greater than 2 ACEs were 2.67 times more likely to be retained in grades in school. However, out of this group, children rated as resilient were 1.55 times more likely to be

engaged in school and half as likely to have been retained than those with ACE histories but not rated as resilient (Bethel et al., 2014).

More recent research examining the rates of adverse childhood experiences has found that an estimated 57.8% of individuals in U.S. territories (the United States, District of Colombia, Puerto Rico, Guam, and the Virgin Islands) had experienced at least one ACE and 21.5% had experienced at least 3 (Giano et al., 2020). Risk factors for higher ACE scores include identifying with a minority racial group, falling in the ages of 25-34 (between the years 2011 and 2017), lower SES, and being a member of a sexual minority (e.g., homosexual, bisexual) (Giano et al., 2020).

Hope

Hope is an essential factor in adaptive coping after experiencing adversity in childhood (Munoz et al., 2020). Hope and resilience are often used interchangeably in the literature (Duggal et al., 2016; Munoz et al., 2020), which is why it is important to discuss each of these variables in their importance to the current study. In his initial hope theory, Snyder (1995) defined *hope* as, "the process of thinking about one's goals, along with the motivation to move toward (agency) and the ways to achieve (pathways) those goals" (p. 355). Prior to this defining moment for hope, most professionals in the field of positive clinical psychology declared hope as being too abstract a concept to break down into concrete, measurable terms. By focusing on the goal-directed nature of humans, Snyder (1995) was able to establish a measure—The Adult Hope Scale—the following year and the Children's version another year after, which are still used today to measure an individual's levels of hope through self-report. Initial standardization of the Children's Hope Scale and subsequent research have confirmed the internal consistency, temporal stability, and predictive validity of this instrument (Dixson, 2017; Snyder, et al., 1997).

Snyder (1995) discusses the need for both agency and pathways for goals to produce high enough hope to impact the individual's well-being. The difference between a highly hopeful and non-hopeful individual, according to Snyder's original theory, would be the emotional state when approaching a goal, a sense of enthusiasm versus apathy, and success versus failure focus. Although he did not explicitly label it as such, the primary way to dictate one's hope levels per Snyder (1995) would be to establish goals that are "S.M.A.R.T.." Doran's creation of S.M.A.R.T. goals emphasizes the importance of goals being specific, measurable, achievable, realistic, and timely (1981). Snyder (1995) explains this concept throughout his hope theory, indicating that an individual must be able to establish goals that they can genuinely aim towards progress in, believe they have the capabilities to accomplish them, and establish a sort of concreteness in terms of when they have been achieved (e.g., not creating goals such as "I will do better"). Through establishing goals through this S.M.A.R.T. lens, if a person believes they have the power to accomplish them, their hope levels will rise through goal achievement (Snyder, 1995).

The simplest definition of *hope* is "an expectation that a goal will be achieved" (Herth, 1992; as cited in Smith et al., 2017, p. 108). Other factors that support an individual's ability to achieve high hope are receptivity to positive experiences, future focus, and desire for interconnectedness (Smith et al., 2017). In addition to improved psychological well-being (as rated through a lack of psychopathology), high levels of hope are also associated with decreased suicidal ideation (Hirsch et al., 2012). The link between hope and psychological well-being is especially vital in populations with trauma histories (Hirsch et al., 2012; Smith et al., 2017).

Baxter et al. (2017) found that parents with personal histories of adverse childhood experiences have less hope for their current situation (significant negative correlation) than those Non-Offending Caregivers (NOCs) who had not experienced adverse events in their childhood.

Parents who specifically had histories of physical or sexual abuse had significantly lower hope scores. Parents with personal histories of abuse have also been shown to be more likely to have low hope levels when facing potential abuse of their children (Baxter et al., 2017). Some literature has found that "hope consistently correlates with well-being among populations facing adversity" (Munoz et al., 2020, p. 178). Hope is a more prominent contributor to long-term health and wellness than resilience (Munoz et al., 2020). Some interesting findings, however, show that reduction of posttraumatic symptoms is not necessarily correlated with increased hope (Saint Arnault & Sinko, 2019). Further research is needed on this topic, but one reason for this may be due to lack of a sense of coherence. In considering sense of coherence consists of comprehensibility, manageability, and meaningfulness, we hope to find that inclusion of a family-treatment model may assist in raising a client's sense of coherence through additional social support (Saint Arnault & Sinko, 2019). These findings suggest that other factors, in addition to hope, may moderate reduction in posttraumatic stress symptoms.

Current theories of hope are derived from the same concept of optimism, which made its debut in the world of literature in the 1980s, defined as "the stable tendency to believe that good rather than bad things will happen" (Carver, 1985, p. 219; as cited in Snyder et al., 2001, p. 102). In 2001, Snyder and colleagues differentiated hope from optimism, as the two were previously thought of as sister components—having one was an indication of having the other. They explain that optimism and hope are derived within an expectancy-value framework, and both contribute to and stem from motivation. However, the difference between optimism and hope involved the individual's goal-directed behaviors in hope which we separate within the agency and pathways components. We might say that optimism is a state of mind more closely related to an emotional experience through this mindset. At the same time, hope is more closely related to the behaviors

or "active pursuits" in which the individual engages (Snyder et al., 2001). According to Snyder's original research, there are assumptions within positive psychology that hope has direct benefits for long-term health, achievement, problem-solving, and psychological adjustment/well-being (Snyder et al., 2001). As such, it is essential not to confuse hope with "unrealistic optimism," otherwise known as "Pollyanna Optimism" (Hand, 2008). The difference between these concepts is the thought process behind setting an attainable goal for ourselves and holding the belief that we can achieve this goal and possess the resources and ability to take appropriate steps towards obtaining those goals (Hand, 2008).

Another important aspect of hope is the mindset that individuals possessing high hope have towards their future life direction. Individuals who have a greater internal locus of control rather than an external locus of control are more likely to possess hope towards their goals and feel they are worthwhile to attempt to achieve (Glantz & Johnson, 1999; as cited in Hand, 2008). This relates to the contribution referenced above of "harm-reduction" resilience, as it depends on the mindset of the individual—if the individual can view things as within their control rather than possessing a mindset of powerlessness, they will be more likely to obtain high enough hope levels to pull themselves into a self- and life-direction that is more fulfilling for them (Davydov et al., 2010; Hand, 2008).

Snyder also discusses dispositional hope versus state hope (1996). The theory of these classifications of hope is not measured through the hope scales (Child and Adult) that we will use for this study. However, they are worth considering due to their nature and the insight they provide into the individual being assessed. Dispositional hope provides a sense of 'floor' and 'ceiling' regarding the individual in question's hope-possessing capabilities. In contrast, the individual's state hope will fall within their dispositional hope range and greatly vary based on current life

situation and present-moment engagement. These comparisons were not made in the current study due to a lack of consistency in the measure of dispositional hope measures (Snyder et al., 1996).

Higher scores on agency and pathways hope scores were significantly and positively related to academic performance (better grades) two years following participant performance (Day et al., 2010). Pathways hope was a more distinct predictor of positive academic performance than agencies, even when controlling for other factors. These findings indicate that hope can be a positive predictor of later academic achievement, indicating that the role of hope may be more significant than what is currently established in the literature. When children are aware of available options, they tend to have higher hope scores (Westburg & Martin, 2003). There are no significant findings that parent and child hope scores correlate (Westburg & Martin, 2003). When asked to predict their child's hope scores, parents' guesses were typically closely related to the children's actual Agency score. However, they were not good at accurately estimating their child's Pathways and, by association, overall hope scores (Westburg & Martin, 2003). A different kind of hope measure, the Hunter Opinions and Personal Expectations Scale (HOPES-20), assesses levels of hope through positive versus negative expectations of the individual. Research has found that lower levels of hope, as measured by the HOPES-20, were significantly negatively correlated with higher levels of depression, as measured by either the Children Depression Inventory (CDI) or Beck Depression Inventory (BDI) (Swanston et al., 1999).

Resilience

Resilience is a controversial term among health and social sciences (Davydov et al., 2010; Kaye-Tzadok & Davidson-Arad, 2017; Traub & Boynton-Jarrett, 2017). Some argue that resilience is an effect of the coping resources available within the environment. In contrast, others would argue that resilience is based solely on the compilation of traits within the individual

(Davydov et al., 2010). One definition of *resilience* is "reduced vulnerability" within the individual. This includes one's ability to adapt to adverse situations or to cope after adversity presents adaptively. (Davydov et al., 2010; Traub & Boynton-Jarrett, 2017). This definition is somewhat problematic due to the level of subjectivity it allows when someone is healthily coping after a difficult life situation and whether the vulnerability is indeed a negative trait at the individual level.

Other researchers consider resilience to simply be a personality trait that one may or may not develop after experiencing a traumatic life event (Herrman et al., 2011). There are uncountable definitions of resilience. However, a significant theme across studies is that resilience is dynamic, rather than static. An individual may be resilient through one kind of adversity but not through another form of adversity. Experts in the field typically agree that multiple dynamics play a role in the resilience of an individual (systematic factors, individual factors, and circumstantial factors). However, the presence of resilience cannot be established until adversity is experienced (Herrman et al., 2011; Traub & Boynton-Jarrett, 2017; Kaye-Tzadok & Davidson-Arad, 2017). Potential contributors of resilience include high levels of openness, extraversion, agreeableness, and factors such as internal locus of control, optimism, and positive self-esteem (Herrman et al., 2011).

Many professionals in the field consider resilience to be the "absence of psychopathology, psychological well-being, self-esteem, and social functioning" (Afifi & MacMillan, 2011). There are thought to be three levels of protective factors that contribute to the resilience of children: individual, family, and community. The community-level resilience factors include all extrafamilial relationships and a sense of belonging within religious identity. Intrafamilial protective factors include the support among family relationships, stability, and overall family cohesiveness. Individual-level protective factors appear to be the most subjective in terms of

measurement, including intellectual ability, personality characteristics, coping capabilities, perception of mistreatment, and overall life satisfaction. These vary so greatly from person to person that their direct correlation in terms of contribution to resilience is still primarily theoretical (Afifi & MacMillan, 2011; Kaye-Tzadok & Davidson-Arad, 2017). Afifi and MacMillan (2011) conducted a literature review examining these different levels of protective factors and found that across 27 different studies, the level most closely related to resilience after experiencing adverse events was the familial level, even for non-traditional family structures. The most salient theme in these studies appeared to be the child's perception of familial support (Afifi & MacMillan, 2011). Regarding the community level, the most salient theme was higher resilience levels in children who perceived their teacher relations to be more supportive and positive (Herrenkohl et al., 1994, as cited in Afifi & MacMillan, 2011; Wright et al., 2019). At the individual level, the factors most closely tied to resilience included positive self-concept, daily independent living skills, and easy child temperament (Shultz et al., 2009).

There are thought to be three approaches to resilience within the mental health realm: harm-reduction, protection, and promotion. In the harm-reduction approach, the assumption is that resilience is measured in an individual's ability to bounce back after the initial hardship and relies mainly on the individual's mindset (Davydov et al., 2010). For example, an individual who experiences CSA and views it as something that will forever ruin their ability to feel "normal" again would be less likely to fit the label of 'resilient.' In contrast, someone who views it as a terrible occurrence that will serve as a setback rather than as a haunting of their future endeavors would be more congruent with the concept of resiliency. Under this harm-reduction approach, it was also found that the presence of high perceived social support was more strongly correlated with resilience—an estimated 40 to 60% increase in middle-aged women (Nutuveli et al., 2008; as

cited in Davydov et al., 2010). The protection approach to resilience weighs out the factors that would support or restrict their ability to recover after an adverse life event. Here, different factors such as emotional burden or other interference would be considered in the individual's ability to recover at a different rate, rather than only considering the individual's traits or outlooks. Finally, the promotion approach also considers harm-reduction and protection factors in resilience but focuses on the individual's perspective and availability to engage with mental health processes. This does not directly link to availability to seek mental health services but instead is viewed as the person's trends of experiencing positive versus negative emotions. The underlying concept involves that more frequent experiences of "positive emotions" (positive here being considered emotions such as excitement, happiness, gratitude, interest) serve as a reducer of stress and therefore more strongly contribute to higher rates of resilience (Davydov et al., 2010).

One critique of the literature on resilience is the lack of understanding of mediating relationships between resilience factors. What are the other factors that contribute to the individual's healing experience? While there are infinite potential resilience factors to examine, this study will further contribute to the literature by investigating various factors, including depressive, anxiety and posttraumatic symptoms, familial support, and other caregiver factors that may be connected to the child's resilience and treatment outcomes. Another criticism within the understanding of resilience is that most studies are not longitudinal. Therefore, resilience is typically currently defined as the immediate 'bounce back' from adverse life events and does not consider that there may need to be a healing period to allow the individual to become resilient after adversity (Davydov et al., 2010; Traub & Boynton-Jarrett, 2017). This study examines children at the onset of treatment following CSA and follows them throughout their treatment process, allowing the timeline of resilience to be considered in positive treatment outcomes.

Some more recent literature has examined various factors which contribute to resilience, including optimism, hope, coping, control beliefs, externalization, education, social relationships, self-esteem, and other life factors (Domhardt et al., 2015; Kaye-Tzadok & Davidson-Arad, 2017). The best definition we may use for resilience here would be a lack of psychopathology (Domhardt et al., 2015). For the purposes of this study, we will combine this definition with the treatment outcomes of the family (successful completion and early treatment discharge (client- versus clinician-initiated)).

In considering the role of hope in resilience, some studies have found that resilient adolescent survivors demonstrated higher optimism about their future. Even those who did not currently have the means to accomplish their goals due to factors such as unstable housing demonstrated more hope for obtaining the things they aimed for in the future (Edmond et al., 2006; Kaye-Tzadok & Davidson-Arad, 2017). A meta-analysis examining various findings over time into the buffers for healing after CSA found that parental support served as a significant protective factor (Domhardt et al., 2015). Interestingly, the most significant factors consisted of emotional support from caregivers and support from either both parents or the father (Domhardt et al., 2015; Traub & Boynton-Jarrett, 2017). Another study found that one of the strongest relationships with resilience in 11-year-olds was the mother's self-rating of her parenting abilities at that time, which was also associated with reduced parenting stress, and a stronger view from the child as having a "very caring" parent (Traub & Boynton-Jarrett, 2017, p. 3). Considering these findings and the importance they place on caregiver support; we examined the caregiver(s) involvement in sexual abuse treatment as a potential contributor to successful treatment outcomes. Research has also suggested that caregiver level of education is positively correlated with resilience in minors

following adversity (Williams & Nelson-Gardell, 2012; as cited in Domhardt et al., 2015), another factor that can be examined in the family model of sexual abuse treatment.

In adolescent resilience, it has been found that being white, non-Hispanic, and having a stable living environment in childhood was more strongly correlated with resilience before adulthood (DuMont et al., 2007). However, it was found that growing up in what are "better" or "higher class" neighborhoods was not predictive of resilience factors. Nonetheless, neighborhood and socioeconomic status did have a mediating effect on stability within the household and therefore perceived familial support, which is a strong correlate of resilience in adolescents (DuMont et al., 2007 Kaye-Tzadok & Davidson-Arad, 2017). This suggests a potential indirect effect of neighborhood status on a child's resilience throughout their teen years. While we could not examine this factor in our study due to a lack of data on neighborhood status, we were able to examine the potential financial stressors of the families to look at the role that this may play on the child's healing process.

Some researchers have identified five resilience domains: psychological well-being, physical health, interpersonal relationships, arrests, and economic well-being (Hyman & Williams, 2001). However, these measures are most relevant to adult women after many years have passed since their experience of CSA. Therefore, the definition of resilience for this study needs to be reconsidered to factors that emerge in shorter-term healing processes. The amount of time passed since the CSA will be shorter given the nature of sexual abuse treatment with the current treatment facility. Family stability has been a recurrent theme in the literature regarding resilience correlates for individuals who have faced CSA (Hyman & Williams, 2001). Interestingly, Hyman and Williams (2001) found social support links that contradict the typical assumption about its benefits after an adverse life event. They found that abuse-specific therapy and having an opportunity to

feel special are not correlated with higher levels of resilience, while having one 'particular person' to provide support is strongly associated with improved resilience factors. This contradicts the framework of the current study and should be further examined to determine the potential benefits of abuse-specific therapy following sexual abuse.

Some literature has identified potential predictors of resilience (Hyman & Williams, 2001; Williams & Nelson-Gardell, 2012; Wright et al., 2019). These factors include family stability in childhood, CSA being classified as extrafamilial rather than intrafamilial, no revictimization, absence of physical force associated with the sexual assault, graduating from high school, and absence of a criminal record in adolescence. While it is important to note these potential predictors, they highlight the need to examine further potential predictors of resilience in younger populations, as the population examined for the current study will be examining individuals still in childhood/adolescence and have not yet had the opportunity to experience these positive predictors to their healing process. Caregiver support can positively predict resilience (Williams & Nelson-Gardell, 2012; Wright et al., 2019). Other predictors of resilience in children that have experienced CSA include school engagement, hope, and SES (Williams & Nelson-Gardell, 2012).

Complex versus Simple Trauma

Trauma history can be classified into one of two categories: simple versus complex trauma. The most basic definition of these categorizations would be to consider "simple" as an acute traumatic experience and "complex" as a chronic traumatic experience (Ross et al., 2021). As to not undermine the experience of trauma survivors, it is essential to note that the purpose of these classifications is to understand not the impact that the adversity has had on an individual but rather the nature of the experience. Simple trauma is any traumatic experience that occurred in one incident, encapsulating one type of trauma that does not occur over a prolonged period (Ross et

al., 2021; Wamser-Nanney & Vandenberg, 2013). Complex trauma would encapsulate all other types of traumas. That is any traumatic experience that occurs over a prolonged period and includes more than one form of trauma.

Any traumatic experience is classified as complex if it consists of interpersonal violence (Ross et al., 2021). However, in considering the nature of the population that is examined for this study—all survivors of CSA have experienced interpersonal trauma—we classified simple versus complex trauma based on the first two criteria (prolonged-time period and multiple forms of trauma) to examine the impact that these specific factors may have on treatment outcomes as a mediating effect with the initial hope score. One study did not find a significant difference in posttraumatic stress symptoms among simple versus complex trauma survivors (Ross et al., 2021). They found that youth who reported simple trauma had a 44% rate of meeting PTSD criteria, while those who reported complex trauma had a rate of 46%. These findings raise additional questions about the longer-term impacts of simple versus complex trauma, as there have been equivocal findings (Jonkman et al., 2013; Ross et al., 2021; Wamser-Nanney & Vandenberg, 2013).

Alşen Güney and colleagues (2020) classified these kinds of traumas as acute and chronic rather than simple versus complex. In their definition, acute child sexual abuse would be any case in which sexual abuse occurred on one occasion, while any cases that consisted of more than one sexual assault would be classified as chronic. It was found that parents of children who experienced "chronic" CSA had higher levels of anxiety on average than those parents whose children had experienced "acute" CSA (Alşen Güney, 2020). Single parents were also more likely to experience higher levels of anxiety after their child's experience of CSA. However, the opposite was true for the children. Children who experienced CSA who lived with a single parent had, on average, lower anxiety levels than children who lived with married parents (Alşen Güney, 2020). Additionally, it

has been found that parental anxiety levels are directly correlated with the development of psychopathology in a child that has experienced adversity (Alşen Güney, 2020; Conner et al., 2012). These findings suggest the importance of considering parenting stress levels and their relationship to parental and child hope and treatment outcomes.

Some researchers consider complex trauma to be equivalent to an 'equation,' in the sense that it considers the nature of the abuse, the duration for which it occurred, and the posttraumatic symptoms that occur following the traumatic experience (Wamser-Nanney & Vandenberg, 2013). Children exposed to complex trauma are rated as having more behavioral problems by their parents, as measured by the Child Behavior Checklist (CBCL) and Trauma Symptom Checklist for Young Children (TSCYC) (Wemster-Nanney & Vandenberg, 2013). Without considering mitigating factors, research supports that adolescents/young adults who experienced CSA were less hopeful overall than individuals who do not have a CSA history (Swanston et al., 1999). In examining adult women who have experienced both CSA and adult unwanted sexual experiences (USE), researchers have found that the differentiating factor in the development of depressive and anxiety symptoms is the classification of their trauma as complex rather than simple (Saint Arnault & Sinko, 2019).

Posttraumatic Symptoms

Symptoms of four different classifications manifest Posttraumatic Stress Disorder (PTSD). These include: (a) arousal/reactivity, (b) avoidance, (c) intrusion, and (d) negative alterations of mood/thoughts (American Psychiatric Association, 2013; Kaye-Tzadok & Davidson-Arad, 2017). An estimated 32% of children who experience CSA develop posttraumatic symptoms (PTS) (Kendall-Tacket et al., 1993; as cited in Kaye-Tzadok & Davidson-Arad, 2017). Research has found that hope has both direct and indirect impacts on resilience after CSA (Kaye-Tzadok &

Davidson-Arad, 2017). Both pathways and agency hope scores have a negative correlation with long-term symptoms of anxiety and depression, indicating that a higher presence of both types of hope may aid individuals in better coping with adversity and decrease the long-term negative impact it has on their mental health (Arnau et al., 2007). This process of healing after the presence of PTS is known as posttraumatic growth (PTG).

One theory that discusses PTG is the 'scarring' model, which states that PTS consists of "painful thoughts, emotions, and experiences that are likely to 'color' the way sufferers interpret external events and their thoughts, images, and internal sensations," (Kaye-Tzadok & Davidson-Arad, 2016, p. 552). Research that has sought to examine the factors that play a role in the PTG process found that the only two factors that had significant correlations were hope (positive correlations) and self-blame (negative correlations). As such, it is indicated that higher levels of hope suggests increased PTG potential; while lesser occurrences of self-blame have the same suggestive value. In considering one of the main goals of trauma-focused interventions as being to reduce trauma reactions both short- and long-term, taking a closer look at the initial hope levels may be a better starting point for practitioners looking to achieve successful treatment completion more efficiently (Kaye-Tzadok & Davidson-Arad, 2016).

We have also seen trends in the literature that have indicated that adult CSA survivors tend to demonstrate higher levels of PTG than women who have experienced USE in adulthood (Saint Arnault & Sinko, 2019). While this could be attributed more so to the recency effect, there are no scientific claims which explain this difference in PTS among women who have experienced sexual trauma at different points in their lives.

Trauma-Focused Cognitive Behavioral Therapy

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is an evidence-based treatment for children and their families after experiencing significant childhood traumas (Cohen et al., 2022; Cohen et al., 2018; Deblinger, 2011; Mannarino et al., 2014). The current study utilizes this approach in its participants to support PTG. TF-CBT is meant to serve as a brief cognitive-behavioral approach to treatment that focuses on building resilience (and therefore, potentially hope) in survivors in less than 25 sessions (Cohen et al., 2018; Deblinger, 2011). TF-CBT uses different components to achieve the goals of healing. These components consist of psychoeducation, parenting skills, relaxation skills, affective skills, cognitive processing, trauma narration, intrinsic processing, safety enhancement, and familial cohesiveness (Cohen et al., 2018; de Arellano, 2014; Deblinger, 2011). TF-CBT is well-established as an effective treatment for sexually abused adolescents by incorporating non-offending family members in the treatment process and therefore providing both familial support and overall coping and processing skills throughout treatment. The effectiveness of this treatment approach includes reduction of PTS, depressive symptoms, behavior problems and sexual difficulties, parental support, and parental stress (Cohen et al., 2022; de Arellano, 2014; Deblinger, 2011).

Not only does the model of TF-CBT have empirical support, but the group-based approach used in the current study does as well: group treatment for individuals with CSA history has a positive correlation and impact on their hope levels and feelings of togetherness (Gorey et al., 2001). Participants who completed group treatment responded in a way that reflected less guilt/self-blame, lower feelings of being unaffiliated or alone, and higher levels of hope/empowerment about their future. Participants who had a history of suicidal ideation

experienced more significant changes in hope levels over the course of treatment than did those without histories of suicide attempts (Gorey et al., 2001).

Some findings have suggested that many women initially cope by denying a sexual assault as rape and later having an outside party label it as such, only then moving forward from their sexual abuse (Kahn et al., 2003). This supports the TF-CBT model in which the clinician labels the CSA as an instance of sexual abuse and provides proper education, coping skills, and emotional identification of the situation to assist the child with their healing process. It brings into question the role of experiential avoidance and the breaking of such a cycle as it pertains to contributions to resiliency long-term.

One study conducted by Marshall et al. (2017) found that the verbiage used to relay the narrative of their sexual assault plays a prominent role in the long-term lingering of PTS. They found that individuals who used fewer insight words to process their trauma cognitively were more likely to score higher on posttraumatic symptoms. In considering the need for goal-directed energy as a measure of hope and the final stage of TF-CBT as a fully processed trauma narrative, these findings suggest that the combination of hope, completion of modules (e.g., cognitive coping, cognitive processing), and successful completion of an appropriately planned trauma narrative might be the right combination to reduce long-term persistence of PTS (Marshall et al., 2017).

Rationale for Current Study

This study offers to add to the existing literature by contributing a unique population that had not yet been primarily considered. Most data considering the role that hope plays in the healing journey of survivors of sexual abuse and assault focuses on data collection in the college population. While these findings are essential to the field and can provide many insights into beneficial treatment approaches for this population, the amount of cognitive distance that the

participants may have from their sexual abuse due to the length of time since its occurrence and potential healing steps which have already taken place limits the magnitude of the findings. In examining these factors for children and families undergoing their healing process through sexual abuse treatment with mental health care providers, researchers can provide insights into the impact of hope and approaches that may reduce the maintenance of negative symptoms (e.g., depression, PTS, anxiety, anger).

This study shows great potential in its contribution by using the advantage of the recency effect in data collection by examining these factors at the beginning of treatment, which often takes place shortly after the abuse has been disclosed. In beginning data collection at this point and completing it at the end of the participants' treatment, we can utilize the recency effect's advantage of more accurate reporting of symptoms rather than relying on memory from an event that may have happened many years prior their reporting of symptoms.

Chapter 3: Hypotheses

H_1: Child and Adolescent Victims will have lower mean baseline Hope scores on the Children's Hope Scale than children and adolescents within normative samples (lower than moderately hopeful range).

H_2: Non-offending Caregivers will have lower mean baseline Hope scores on the Adult Hope Scale than individuals within normative samples (lower than moderately hopeful range).

H_3: Individuals with higher baseline Hope scores will have higher success rates in treatment completion.

H_4: Individuals with lower baseline Hope scores will have lower success rates in treatment completion.

H_5: Parental Hope scores will have a stronger correlation with the victim's Hope scores than sibling hope scores.

H_6: Victim and Caregiver Hope scores will increase throughout treatment and will be higher than baseline Hope scores.

H_7: Hope scores will be negatively associated with posttraumatic symptoms (as measured by the Trauma Symptom Checklist for Children/Young Children and Child Revised Impact of Events Scale-13).

H_8: Parents with higher Hope scores will have lower parenting stress scores (as measured by the Parenting Stress Index-4).

H_9: Parents of children who experienced intrafamilial abuse will have higher parenting stress scores (as measured by the Parenting Stress Index-4) than parents of children who experienced extrafamilial abuse.

H_{10}: Children who experience intrafamilial sexual abuse will have lower Hope scores than children who experience extrafamilial abuse.

Chapter 4: Methods

All participants were clients who have received sexual abuse treatment with the Family Learning Program (FLP). The Family Learning Program is one of only 14 Department of Health-Sponsored Sexual Abuse Treatment Programs (SATP) in Florida. FLP provides a family-focused treatment model by treating child/adolescent CSA survivors between the ages of 3 and 17 and any non-offending family members, including caregivers and siblings, residing with them. Because FLP is entirely grant funded, these services are provided at no cost to the families. FLP primarily provides group therapy using components of TF-CBT in addition to other evidence-based and

evidence-supported interventions. FLP primarily provides group therapy to provide evidence-based treatment for clients with same-aged peers (e.g., young children in a young child group, pre-adolescents in a pre-teen group, adolescents in a teen-group; and non-offending caregivers in an NOC group). FLP also provides individual, family, and couples therapy as clinically indicated to enhance the healing process and social support of the child survivor. Safety planning, treatment planning, and risk-assessment is also provided throughout treatment. During their treatment process, families who engage fully in treatment undergo psychological assessment at multiple points in treatment to examine treatment needs and progress. Data is collected from all consenting participants, including children ages 3 through 17, and their non-offended caregivers and siblings. Before beginning treatment, all clients are asked to voluntarily sign research consent forms documenting their agreement for their data to be used for research. Data from any clients who do not consent to utilizing their data for research was excluded from the study. Upon initiation of treatment, participants complete age-appropriate baseline assessments, including The Adult Trait Hope Scale (Adult Hope), The Children's Hope Scale (Children's Hope), The Child Revised Impact of Events Scale-13 (CRIES-13), The Trauma Symptom Checklist for Children (TSCC), The Trauma Symptom Checklist for Young Children (TSCYC), The Parenting Stress Index-4 (PSI-4), Stress Index for Parents of Adolescents (SIPA) and the Adverse Childhood Events Questionnaire (ACE), as appropriate based on age. Participants whose duration of treatment exceeds six months complete midpoint assessments (Adult Hope, Children's Hope, CRIES-13, TSCC, TSCYC, PSI-4, SIPA) and complete assessments again upon discharge from treatment. These archival data, including client demographics, were used for the completion of this study to examine the baseline predictors of successful treatment outcomes.

Measures

The Hope Scales. The Hope Scales were used to measure participant levels of hope for this study. NOCs were provided with the Adult Trait Hope Scale, a 12-item measure which asks participants to rank statements (e.g., "I can think of many ways to get out of a jam") on a Likert scale from 1 (definitely false) to 8 (definitely true) (Snyder et al., 1991). Pathways scores are taken by adding scores from items 1, 4, 6, and 8 to measure, while Agency scores are taken from adding scores from items 2, 9, 10, and 12. The total hope score is found from adding the Agency and Pathways scores together. Higher scores are associated with higher levels of hope. Scores are classified as Low Hope (score of 39 or less), Hopeful (scores 40-48), Moderately Hopeful (scores 48-56), and High Hope (scores greater than 56). Children ages 8 to 16 were provided with the Children's Hope Scale, a 6-item measure which asks the participants to rank statements (e.g., "I am doing just as well as other kids my age") on a Likert scale from 1 (none of the time) to 6 (all of the time (Snyder et al., 1997). The Agency score is calculated from taking the sum of items 1, 3, and 5, while the Pathways score is calculated from taking the sum of items 2, 4, and 6. The total hope score is derived from adding the Agency and Pathways score and dividing by 6. Scores are classified as Low Hope (score less than 3), Medium Hope (score 3.0-4.67) or High Hope (score greater than 4.67).

The Child Revised Impact of Events Scale-13. The CRIES-13 was used to screen for PTS in child participants 8 and older (Horowitz et al., 1979). When taking this screener, participants are instructed to think about a stressful life event that occurred. The evaluators encouraged the participants to consider the sexual abuse when taking this screener; however, children were allowed to consider other life events if they found them more distressing at the time

of intake. The children were asked to rank the frequency of symptoms they experienced during the last week (e.g., unintentionally thinking about it, sleep impacts, flashbacks) which were then coded for scoring (Not at all= 0, Rarely = 1, Sometimes = 3, Often = 5). Scores from items 1, 4, 8, and 9 were summed to determine the overall score of Intrusion symptoms the child reported. Items 2, 6, 7, and 10 were summed to determine the score of Avoidance symptoms, and items 3, 5, 11, 12, and 13 were summed to establish the overall Arousal symptoms reported by the child. The Intrusion and Avoidance scales were summed to establish the child's Intrusion/Avoidance score, and this number was combined with the Arousal subscale to establish the child's overall score. The cutoff score for indication of PTSD development for the Intrusion/Avoidance score is 17, and the cutoff for the total score is 30.

The Trauma Symptom Checklists. The trauma symptom checklists were also used to assess for PTS in the child participants. The TSCC was used for child participants aged 8-16 (Briere, 1996). This assessment consists of 54 items, which includes screening for under- and overreporting of symptoms, and 6 clinical scales (Anxiety, Depression, Anger, Posttraumatic Stress, Dissociation, and Sexual Concerns). The child is asked to rank the frequency of symptoms on a scale from 0 (never) to 3 (almost all the time). Based on the scores reported, the children are given scores for each subscale, with an associated T-score based on age and gender. The Posttraumatic Stress clinical scale was used for this study to examine levels of PTS the child reported. The TSCYC was used for child participants aged 3-12 (Briere, 2005). Children ages 8-12 for this study were given the assessment established by the clinician's clinical judgment based on the child's developmental status and reading levels. Children requiring the TSCYC were assessed using the report of their accompanying NOC. This assessment consists of 90 items, which creates 8 clinical scales (Anxiety, Depression, Anger/Aggression, PTS Intrusion, PTS Avoidance,

PTS Arousal, Dissociation, and Sexual Concerns). The PTS scales are combined to create a PTS-Total T-score, which was used in this study to examine levels of PTS the child is experiencing based on their caregiver's report. For both scales, T scores in the 60-65 range are considered subclinical, and scores above a 70 are considered clinically significant.

Parenting Stress. The Parent Stress Scales were used to measure the NOC participants' levels of stress regarding their role as a caregiver for those caregiving for children up to the age of 12. In the latter portion of this study, the PSI-4 was used to assess stress levels (Abidin, 2012). This assessment consists of 120 items, and scores are broken into 3 domains (Child, Parent, and Life Stress). They are also given a total score to assess overall stress. On this assessment, scores are broken down into percentiles, which are classified as Normal stress levels (16^{th}-84^{th} percentile), High stress levels (85^{th}-89^{th} percentile), and Clinically Significant stress levels (90^{th} percentile and higher). For this study, the overall PSI-4 scale was used to measure parenting stress. In the early stages of this study, due to assessment availability, the Parenting Stress Index, Fourth Edition, Short Form (PSI-4-SF) was given to NOCs to assess stress levels regarding their role as a caregiver. This assessment is a 36-item assessment, all derived from the original PSI (Abidin, 2012). This assessment also provides a total stress index with identical classifications of percentile scores. The total stress score for this assessment was used for the study for those caregivers administered the PSI-4-SF instead of the PSI-4. NOCs with children ages 11-19 years were given the SIPA. For children ages 11 and 12, clinical judgment was used to determine whether the PSI-4 or the SIPA would be administered to the NOC. The SIPA is a 112-item measure in which the caregiver rates their levels of stress in 3 domains (Parent, Adolescent, and Adolescent-Parent Relationship) (Sheras et al., 1998). They are also provided with a Life Stress and Total Parenting Stress score. The Total Parenting Stress score was used to measure stress levels for NOCs in this

study. All scores are classified through percentiles as Within Normal Limits (less than 85th percentile), Borderline stress levels (85th – 89th percentile), Clinically Significant stress levels (90th – 94th percentile) and Clinically Severe stress levels (95th-100th percentiles).

The Adverse Childhood Events Questionnaire. All participants were given an Adverse Childhood Experiences Questionnaire at the baseline of treatment. NOCs were given the adult form, which is a 10-item measure in which participants indicate if they have or have not experienced various forms of adversity (e.g., domestic violence in home, abuse, substance abuse in home) during childhood. All items indicated with a "yes" are scored as a 1, all items indicated with "no's" are scored as a 0. The total number summed is the overall ACE score. All teens were given the ACE-Q Teen self-report, which consists of 19 items for the teen to rate as having experienced or not. The total number experienced is the overall ACE score. Children entering treatment were not administered the ACE, rather their caregiver completed the child form on their behalf. The child ACE form consists of 17 items for the caregiver to indicate as having happened or not happened during the child's life. The total number experienced is the overall ACE score.

Participants

Participants included 34 families, for a total of 106 participants (age 3-66, *M*= 23.72, *SD*= 16.69) who participated in treatment at FLP, a sexual abuse treatment program in Florida. Of the 106 participants, 43 (40.6%) were child/adolescent victims, 45 (42.5%) were NOCs, and 18 (17%) were siblings. Out of this sample, 79 (74.5%) were Caucasian, 11 (10.4%) were African America, 1 (.9%) was Asian, 14 (13.2%) were Hispanic, and 1 (.9%) identified as "other." Females comprised of 73.6% (78) of the sample, while 26.4% (28) were male. FLP separates group treatment into age groups: 24 (22.6%) were in the young child group, 14 (13.2%) were in the preteen group, 21 (19.8%) were in the teen group, and 47 (44.3%) were in the adult NOC group.

Regarding abuse type, 16 (15.1%) of participants were in treatment due to simple abuse (for themselves or their family member) and 90 (84.9%) were in treatment due to complex abuse (for themselves or their family member). On the background information forms provided at the onset of treatment, 56 (52.8%) of the participants indicated they did not have financial concerns present, while 50 (47.2%) endorsed having financial concerns. Also provided on the background information forms at the beginning of treatment, 76 (71.7%) of participants indicated they did not have health concerns present, while 30 (28.3%) indicated they did have health concerns. On the ACE Questionnaire provided at the beginning of treatment, 35 (33%) of the participants had an ACE score associated with lower risk, while 51 (48.1%) had an ACE score associated with higher risk; 20 participants (18.9%) did not have an ACE score reported. Of the participants in this sample, 26 (24.5%) did not initiate services after the initial intake and assessment process, 30 (28.3%) initiated treatment but discontinued due to client decision (no longer desire services for various reasons), 21 (19.8%) initiated treatment but discontinued due to clinician decision (exceeding maximum number of absences, trauma-focused treatment not indicated), and 29 (27.4%) of clients successfully completed their treatment via completing treatment goals. A total of 14 participants were omitted; 13 due to lack of any assessments completed at any point of treatment, and 1 due to outlying scores and conditions of treatment.

Chapter 5: Results

Permission was obtained by the researcher from the Department of Health IRB (May 26, 2022) and Florida Institute of Technology IRB (April 28, 2022) to utilize the Family Learning Program's archival data. The study utilized a longitudinal design. Data is entered and stored within a HIPAA-compliant database, and all personal identifying information was de-identified to maintain confidentiality. Descriptive statistics were initially examined to record

means, standard deviations, and frequencies for demographic variables, symptom variables, levels of hope, and treatment outcomes. Levels of hope came directly from the Adult/Child Hope Scale. PTS was assessed through examination of TSCC (posttraumatic stress subscales), TSCYC (intrusion, avoidance, arousal, and dissociation posttraumatic stress subscales), and CRIES-13 (intrusion, avoidance, and arousal subscales) scores, based on the age of the participant. Parent stress levels were assessed using the PSI-4-Short Form (PSI-4-SF), PSI-4, and SIPA, depending on their child's age. Due to a lack of availability of the PSI-4 full form during the initial data collection, the PSI-4-SF was used to gather parental stress levels for the early participants. All other variables were coded based on client intake summaries and demographic information. Data was coded numerically, assigning specific numbers for each variable through categorical coding (i.e., successful treatment completion: 0, patient early termination: 1; clinician early termination: 2). All symptoms were recorded based on the score of the assessments.

A series of t-tests and correlational analyses examined the differences and correlations of symptom presentation with hope levels, hope levels at the onset of treatment with treatment outcome, and parental hope and stress levels with child hope and treatment outcome. All analyses were considered significant at the $p < .05$ level. Data was analyzed using the Statistical Package for the Social Sciences (SPSS)- version 28.

Hypothesis 1

To test the first hypothesis, descriptive statistics were examined to record the means and standard deviation for victim baseline total hope scores. Table 1 presents the means and standard deviations for child and adolescent participants from the baseline assessments. As shown, the means for victim hope scores were derived from 32 participants. The Child Hope Scale is normed for children and adolescents aged 8 to 16. Therefore, total hope scores were only able to be

collected from participants in this age range (total of 10 not included due to age). Victim participants outside of this age range were still included in the overall sample to allow analyses of impact for accompanying NOC and sibling hope scores on overall treatment. Statistics were also run to view the mean total Hope score at the onset of treatment for non-offending siblings to determine if their baseline scores were aligned with our prediction that participants in this study would have lower mean baseline Hope scores than children and adolescents in normative samples. Due to age of some accompanying siblings in treatment (outside of 8-16 years), five siblings from the overall sample did not have any data for total hope scores. See Table 1 for Means and Standard Deviations of hope scores.

Normative data from the original validation study (Snyder et al., 1997) is not fully provided. However, Snyder et al. (1997) reports a normative mean of 4.32, with the normative sample classifying as falling in the "medium" or "moderately hopeful" range. Therefore, a one-sample T-test was performed to compare the mean levels of total hope between the current sample and the normative sample from the Child Hope Scale (Snyder et al., 1997). Results from 32 victim participants showed that victims at the onset of sexual abuse treatment (M= 4.13, SD = 1.04) did not have significantly different Total Hope scores than the normative sample (M = 4.32), $t(31) = -1.04$, $p > .05$, with the difference to have a 95% CI [-0.52, 0.17]. The difference presents a very large-sized effect, *Cohen's d* = 1.04. Thus, this hypothesis was not supported.

Hypothesis 2

To test hypothesis 2, descriptive statistics were examined to record the means and standard deviation for NOC baseline total hope scores. Table 2 presents the means and standard deviations at pre-treatment NOCs that sought sexual abuse treatment with FLP.

Normative data from the original studies (Snyder et al., 1991; Snyder et al., 1996) were not provided. Rather, they classified the mean score from the normative sample as the "Moderately Hopeful" range, consisting of all total hope scores falling between 48 and 56. The mean total hope scores for all NOCs (M = 51.81), female NOCs (M= 50.75), and male NOCs (M= 54.07) are classified in the "Moderately Hopeful" range, indicating no substantial difference of mean baseline Hope scores on the Adult Hope Scale for NOCs than individuals within normative samples. A one-sample T-test was performed to compare the mean levels of total hope between the current sample and the medium hope score in the "Moderately Hopeful" range (52). Results from 47 NOC participants showed that NOCs at the onset of sexual abuse treatment (M= 51.81, SD= 5.81) did not have significantly different Total Hope scores than the normative sample (assumed M = 52), $t(46) = -0.27$, p> .05, with the difference to have a 95% CI [-0.32, 0.25]. The difference presents a very large-sized effect, *Cohen's d* = 5.81. Thus, this hypothesis was not supported.

An independent-samples t-test was performed to compare the mean levels of total hope between male and female NOCs. Results from 47 participants (15 male, 32 female) showed that males (M= 54.07, SD = 5.76) were not significantly different from females (M = 50.75, SD= 5.61) on their total hope, $t(45) = 1.87$, p >.05, with the difference to have a 95% CI [-0.25, 6.88]. A one-way ANOVA was conducted, and the assumption of homogeneity of variances were met (Levene's statistic = .005, p > .05). ANOVA results showed that there is not an overall significant mean difference between male and female NOCs on baseline total hope scores, $F(46)=3.51$, p>.05.

Hypotheses 3 and 4

A simple linear regression was conducted to examine if baseline Hope scores predicted success rates in treatment completion. This was run for victim, sibling, and NOC participants. For victim participants, initial hope scores (M =4.13, SD = 0.62) did not significantly predict success

rates in treatment completion (M = 1.00; SD = 0.62), b = 0.02, p> .05. Initial hope scores did not explain a significant amount of the variance in treatment outcomes, R^2 = .001, $F(1, 30)$ = .03, p > .05.

For sibling participants, initial hope scores (M= 3.52, SD= 0.86) did not significantly predict success rates in treatment completion (M= 0.92, SD= 0.86), b= -0.04, p> .05). Initial hope scores did not explain a significant amount of the variance in treatment outcomes, R^2 = .004, $F(1,11)$ = .04, p >.05.

NOC initial hope scores (M= 52.21, SD= 5.40) also did not significantly predict success rates in treatment completion (M= 1.09, SD= 5.40), b= -0.02, p >.05. Initial hopes scores did not explain a significant amount of the variance in treatment outcomes R^2= 0.02, $F(1, 43)$ = .65, p >.05.

The results of these analyses show that these hypotheses were not supported.

Hypothesis 5

Baseline Total Hope scores were utilized to test this hypothesis. Victim Total Hope scores (M=4.12, SD= 1.04), were significantly positively correlated with the NOC Total Hope scores (M= 51.71, SD= 5.29), r= .34, p < .05. Victim Total Hope scores were also significantly positively correlated with the sibling Total Hope scores (M= 3.74, SD= 1.08), r = .54, p < .05. These findings suggest that both sibling and NOC Total Hope scores have a significant correlation with the associated victim hope scores; however, sibling scores had a higher degree of relationship (.54) than NOC scores (.34). Thus, this hypothesis was not supported.

Hypothesis 6

A paired-samples t-test was conducted to examine the effect of treatment on Total Hope scores. It was predicted that hope scores would increase throughout treatment and would be higher

than baseline Hope scores. Assumption testing suggests that the difference of scores from before to after treatment have no outliers and are normally distributed. As not all participants took endpoint assessments (either due to not initiating treatment or terminating treatment early and not returning for assessments), this data was not collected for all participants. Results from 9 victims showed that participant's Total Hope score at the end of treatment (M= 4.74, SD= 1.24) was not significantly different from before they attended treatment (M= 4.37, SD= .87), $t(8) = -0.90$ $p > .05$ (two-tailed). The mean difference was -.37 (SD= 1.28), with a 95% CI [-1.36, .61], and reflect a very large effect size with Cohen's d = .28. The hypothesis was not supported.

A paired-samples t-test was run to examine the difference of scores from before treatment to the 6-month point of treatment. As not all participants attended treatment for 6-months, this data was not collected for all participants. Assumption testing suggests that the difference of scores from before to the 6-month mark of treatment have no outliers and are normally distributed. Results from 7 victims showed that participant's Total Hope score at the 6-month point of treatment (M= 3.85, SD= .91), while somewhat lower, was not significantly different from before they attended treatment (M= 4.17, SD= .77), $t(6) = .90$, $p > .05$ (two-tailed). The mean difference was .32 (SD=.93) with a 95% CI [-0.55, 1.18], and reflect a small effect size with Cohen's d= .34. The hypothesis was not supported.

While not predicted through the hypotheses, the paired-samples t-test also did not show a significant difference from the 6-month mark of treatment to the endpoint of treatment for those victims who completed all levels of assessments. Assumption testing suggested that the difference of scores from before to the 6-month mark of treatment have no outliers and are normally distributed. Results from 6 victims showed that participant's Total Hope score after completing treatment (M=4.97, SD= 1.25) was not significantly higher than at the 6-month point of treatment

(*M*= 4.37, *SD*= 1.09), *t* (5) = -2.40, *p* > .05 (two-tailed). The mean difference was -0.60 (*SD*= .61), with a 95% CI [-1.23, .04], and reflect a large effect size with Cohen's *d*= .98.

A paired-samples *t*-test was run to look at the difference of scores from before treatment to after completing treatment for NOCs. Assumption testing suggested that the difference of scores from before to after treatment have no outliers and are normally distributed. As not all participants took endpoint assessments (either due to not initiating treatment or terminating treatment early and not returning for assessments), this data was not collected for all participants. Results from 15 NOCs showed that participant's Total Hope score after attending treatment (*M*= 55.00, *SD*= 5.39) was significantly higher from before they attended treatment (*M*= 51.93, *SD*= 5.30), *t*(14) = 4.71, *p* < .001 (two-tailed). The mean difference was 3.07 (*SD*= 2.52), with a 95% CI [1.67, 4.46], and reflect a very large Cohen's *d*= 1.22. The hypothesis was supported.

Results from 16 NOCs showed that participants' Total Hope scores at the 6-month point of treatment (*M*=51.25, *SD*= 7.35) was not significantly different from before they attended treatment (*M*= 52.81, *SD*= 1.43), *t*(15)= -1.06, *p*> .05 (two-tailed). The mean difference was -1.56 (*SD*= 5.90), with a 95% CI [-4.71, 1.58], and reflect a very large effect size with Cohen's *d* = 1.22. The hypothesis was not supported. As not all participants attended treatment for 6-months, this data was not collected for all participants.

Results from 10 NOCs showed that participant's Total Hope score at the endpoint of treatment (*M*= 54.50, *SD*= 5.44) was significantly higher than their Total Hope score at the 6-month point of treatment (*M*= 50.70, *SD*= 6.50), *t*(9)= 3.12, *p* <.05 (two-tailed). The mean difference was 3.80 (*SD*= 3.85), with a 95% CI [1.04, 6.56], and reflect a large effect size with Cohen's *d* = 3.85. While this was not predicted through the hypotheses, it does suggest some change in Total Hope scores from the mid-way point of treatment to the completion of it.

Hypothesis 7

Baseline Assessments. Child/adolescent ages 8-16 baseline Total Hope scores (*M*= 3.95, *SD*= 1.15) were significantly positively correlated with baseline posttraumatic symptoms (as measured by the TSCC, PTS T-score) (*M*= 56.08, *SD*= 22.11), *r*= .58, $p < .05$, not supporting the hypothesis. This finding suggests that children ages 8-16 with higher hope scores at baseline also had higher PTS when measured with the TSCC. Note that this mean of 56.08 still falls in the within normal limits range for presence of PTS. Child ages 3-12 baseline Total Hope Scores were not significantly correlated with baseline PTS (as measured by the TSCYC, PTS-TOT T-Score) (*M*= 78.85, *SD*= 28.78), *r*= -0.64, $p > .05$, also not supporting the hypothesis. Child/adolescent ages 8-17 baseline Total Hope scores were not significantly correlated with baseline PTS (as measured by the CRIES-13 Total score) (*M*=36.03, *SD*= 11.88), *r*= .08, $p> .05$, also not supporting the hypothesis. When measuring for only Intrusion and Avoidance symptoms (as measured by the CRIES-13 Intrusion-Avoidance score) (*M*=28.63, *SD*= 10.91), child/adolescent ages 8-17 baseline Total Hope scores also were not significantly correlated with PTS, *r*= -0.12, $p> .05$, also not supporting the hypothesis.

Six-Month Assessments. Child/adolescent ages 8-16 six-month Total Hope scores (*M*=4.02, *SD*= 1.05) were not significantly correlated with six-month posttraumatic symptoms (as measured by the TSCC, PTS T-score) (*M*= 50.25, *SD*= 11.18), *r*= .80, $p > .05$, not supporting the hypothesis. Child ages 3-12 six-month Total Hope Scores were not significantly correlated with six-month PTS (as measured by the TSCYC, PTS-TOT T-Score) (*M*= 68.50, *SD*= 22.97), *r*= -0.15, $p> .05$, also not supporting the hypothesis. Child/adolescent ages 8-17 six-month Total Hope scores were not significantly correlated with six-month PTS (as measured by the CRIES-13 Total score) (*M*= 34.00, *SD*= 14.92), *r*= .34, $p > .05$, also not supporting the hypothesis. When measuring

for only Intrusion and Avoidance PTS (as measured by the CRIES-13 Intrusion-Avoidance score) (*M*= 26.44, *SD*= 11.73), child/adolescent ages 8-17 six-month Total Hope scores also were not significantly correlated with PTS, *r*= -0.25, *p* > .05, also not supporting the hypothesis.

Endpoint Assessments. Child/Adolescent ages 8-16 endpoint Total Hope scores (*M*= 4.67, *SD* = 1.28) were not significantly correlated with endpoint PTS (as measured by the TSCC, PTS T-score) (*M* = 46.50, *SD*= 7.94), *r* = .43, *p* > .05, not supporting the hypothesis. Child ages 3-12 endpoint Total Hope Scores could not be computed due to insufficient endpoint PTS (as measured by the TSCYC, PTS-TOT T-Score) (*M*= 63.17, *SD* = 22.86, N = 3). Child/adolescent ages 8-17 endpoint Total Hope scores were not significantly correlated with six-month PTS (as measured by the CRIES-13 Total score; *M*= 28.82, *SD*= 12.72) *r*= .19, *p*> .05, not supporting the hypothesis. When measuring for only Intrusion and Avoidance PTS (as measured by the CRIES-13 Intrusion-Avoidance score) (*M*= 24.09, *SD*= 12.31), child/adolescent ages 8-17 endpoint Total Hope scores were also not significantly correlated with PTS, *r*= .38, *p* > .05, also not supporting the hypothesis.

The results of these analyses showed that this hypothesis was not supported.

Hypothesis 8

Baseline Assessments. NOCs with children under the age of 12 were administered the Parenting Stress Index-4 (PSI-4). At earlier stages of data collection, due to lack of access to the full version, NOCs with children under the age of 12 were administered the Parenting Stress Index Fourth Edition, Short Form (PSI-4-SF). For this reason, two different correlations had to be run based on which assessment was provided. NOCs initial Total Hope score (*M*= 51.81, *SD*= 5.81) was not significantly correlated with initial parenting stress scores (as measured by the PSI-4-SF) (*M*= 77.83, *SD*= 22.01), *r*= .46, *p* > .05, not supporting the hypothesis. NOCs initial

Total Hope score was not significantly correlated with initial parenting stress scores (as measured by the PSI-4 Full Form) (M= 212.72, SD = 62.37), r = -0.05, p > .05, also not supporting the hypothesis. NOCs with children over the age of 11 were administered the Stress Index for Parents of Adolescents (SIPA). NOCs initial Total Hope scores was not significantly correlated with initial parenting stress (as measured by the SIPA) (M= 213.00, SD = 43.57), r = -0.13, p > .05, also not supporting the hypothesis.

Six-Month Assessments. NOCs six-month Total Hope score (M= 51.25, SD = 7.35) was not significantly correlated with six-month parenting stress scores (as measured by the PSI-4-SF) (M= 76.25, SD= 11.98), r= -0.65, p > .05. NOCs six-month Total Hope score was not significantly correlated with six-month parenting stress scores (as measured by the PSI-4 Full Form) (M= 262.00, SD= 77.90), r= -0.87, p > .05, also not supporting the hypothesis. NOCs six-month Total Hope score was not significantly correlated with six-month parenting stress scores (as measured by the SIPA) (M= 195.50, SD= 59.97), r= .64, p > .05, thus not supporting the hypothesis.

Endpoint Assessments. NOCs endpoint Total Hope score (M= 51.61, SD= 13.50) was not significantly correlated with endpoint parenting stress scores (as measured by the PSI-4-SF) (M= 87.00, SD= 31.19), r= -0.87, p > .05, thus not supporting the hypothesis. NOCs endpoint Total Hope score was also not significantly correlated with six-month parenting stress scores (as measured by the PSI-4 Full Form) (M=209.94, SD= 70.79), r= -0.43, p > .05, also not supporting the hypothesis. NOCs endpoint Total Hope score was also not significantly corelated with six-month parenting stress scores (as measured by the SIPA) (M= 228.57, SD= 25.65), r= -0.38, p > .05.

The results of these analyses show that this hypothesis was not supported.

Hypothesis 9

Baseline parenting stress scores were utilized to test this hypothesis. Assumption tests suggested that there were no outliers in the PSI-4-SF scores for NOCs whose children experienced intrafamilial or extrafamilial sexual abuse, and stress scores were normally distributed. Levene's test suggested that variances in PSI-4-SF scores in both groups were statistically equivalent, $F(13) = .09$, $p = .77$. An independent-samples t-test was performed to compare mean parenting stress scores (PSI-4-SF) between parents whose children experienced either intrafamilial or extrafamilial child abuse. Results from 15 participants (12 Intrafamilial, 3 Extrafamilial) showed that NOCs whose children experienced intrafamilial sexual abuse (M= 78.13, SD= 21.52) were not significantly different from NOCs whose children experienced extrafamilial sexual abuse (M= 76.67, SD= 29.01) on their stress levels on the PSI-4-SF, $t(13) = .10$, $p > .05$, with the difference to have a 95% CI [-30.37, 33.29]. The difference presents a very small-sized effect, Cohen's d = .06.

Assumption tests suggested that there were no outliers on the PSI-4 Full Form for NOCs whose children experienced intrafamilial or extrafamilial sexual abuse, and stress scores were normally distributed. Levene's test suggested that variances in PSI-4 scores in both groups were statistically equivalent, $F(7) = .82$, $p = .39$. An independent-samples t-test was performed to compare mean parenting stress scores (PSI-4 Full Form) between parents whose children experienced either intrafamilial or extrafamilial child abuse. Results from 9 participants (6 intrafamilial, 3 extrafamilial) showed that NOCs whose children experienced intrafamilial sexual abuse (M= 179.17, SD= 30.08) were significantly different from NOCs whose children experienced extrafamilial sexual abuse (M= 279.83, SD = 56.25) on their stress levels on the PSI-4, $t(7) = 3.62$, $p < .05$, with the difference to have a 95% CI [-166.50, -34.83]. The difference

presents a large-sized effect, Cohen's d = 2.56. Surprisingly, this finding showed that parents whose children experienced intrafamilial abuse had lower mean scores on the PSI-4 than parents whose children experienced extrafamilial abuse, and thus the hypothesis was not supported.

Assumption tests suggested that there were no outliers on the SIPA for NOCs whose children experienced intrafamilial or extrafamilial sexual abuse, and stress scores were normally distributed. Levene's test suggested that variances in SIPA scores in both groups were statistically equivalent, $F(12) = .03$, $p = .86$. An independent-samples t-test was performed to compare mean parenting stress scores (SIPA) between parents whose children experienced either intrafamilial or extrafamilial child abuse. Results from 14 participants (8 intrafamilial, 6 extrafamilial) showed that NOCs whose children experienced intrafamilial sexual abuse (M= 191,50, SD= 32.61) were significantly different from NOCs whose children experienced extrafamilial sexual abuse (M= 241.67, SD= 41.50) on their stress levels on the SIPA, $t(12)$= -2.54, p <.05, with the difference to have a 966% CI [-93.21, -7.13]. The difference presents a very large-sized effect, Cohen's d = 1.37. This finding showed that parents whose children experienced extrafamilial sexual abuse had higher stress scores on the SIPA than parents whose children experienced intrafamilial sexual abuse; thus, the hypothesis was not supported.

The results of these analyses show that this hypothesis was not supported.

Hypothesis 10

Total Hope. Baseline Child Total Hope scores were utilized to test this hypothesize for victim participants. Assumption testing suggested that there were no outliers in the Total Hope scores for children who experienced intrafamilial sexual abuse versus extrafamilial sexual abuse, and hope scores were normally distributed. Levene's test suggested that variances in Total Hope scores for children who experienced intrafamilial versus extrafamilial sexual abuse were

statistically equivalent, $F(30) = .04$, $p = .95$. An independent-samples *t*-test was performed to compare Total Hope scores between children who experienced intrafamilial versus extrafamilial sexual abuse. Results from 32 participants (20 intrafamilial, 12 extrafamilial), showed that children who experienced intrafamilial abuse ($M= 4.06$, $SD= 1.06$) were not significantly different from children who experienced extrafamilial abuse ($M= 4.24$, $SD = 1.05$) on their Total Hope scores, $t(30) = -0.45$, $p > .05$, with the difference to have a 95% CI [-0.96, .62]. The difference presents a very small-sized effect, Cohen's $d= .17$. The hypothesis that children who experienced intrafamilial abuse will have lower Total Hope scores than children who experience extrafamilial abuse was not supported.

Pathways Scores. Baseline Child Pathways Hope scores were utilized to test this hypothesis for victim participants. Assumption testing suggested that there were no outliers in the Pathways Hope scores for children who experienced intrafamilial sexual abuse versus extrafamilial sexual abuse, and hope scores were normally distributed. Levene's test suggested that variances in Pathways Hope scores for children who experienced intrafamilial versus extrafamilial sexual abuse were statistically equivalent, $F(30) = .20$, $p = .66$. An independent samples *t*-test was performed to compare Pathways Hope scores between children who experienced intrafamilial versus extrafamilial sexual abuse. Results from 32 participants (20 intrafamilial, 12 extrafamilial), showed that children who experienced intrafamilial sexual abuse ($M= 12.25$, $SD= 3.63$) were not significantly different from children who experienced extrafamilial abuse ($M= 12.92$, $SD= 3.03$) on their Pathways Hope scores, $t(30)= -0.53$, $p >.05$, with the difference to have a 95% CI [-3.22, 1.88]. The difference presents a very small-sized effect, Cohen's $d= .20$. The hypothesis that children with intrafamilial sexual abuse would have higher hope scores than children with extrafamilial sexual abuse was not supported.

Agency Scores. Baseline Child Agency Hope scores were utilized to test this hypothesis for victim participants. Assumption testing suggested that there were no outliers in the Agency Hope scores for children who experienced intrafamilial sexual abuse versus extrafamilial sexual abuse, and hope scores were normally distributed. Levene's test suggested that variances in Agency Hope scores for children who experienced intrafamilial versus extrafamilial sexual abuse were statistically equivalent, $F(30)= .06$, $p = .81$. An independent samples *t*-test was performed to compare Agency Hope scores between children who experienced intrafamilial versus extrafamilial sexual abuse. Results from 32 participants (20 intrafamilial, 12 extrafamilial), showed that children who experienced intrafamilial sexual abuse ($M= 12.05$, $SD= 3.79$) were not significantly different from children who experienced extrafamilial abuse ($M= 12.50$, $SD= 3.58$) on their Agency Hope scores, $t(30) = -0.33$, $p > .05$, with the difference to have a 95% CI [-3.22, 2.32]. The difference presents a very small-sized effect, Cohen's $d = .12$. The hypothesis that children with intrafamilial sexual abuse would have higher hope scores than children with extrafamilial sexual abuse was not supported.

Chapter 6: Discussion

The current study examined the role of hope scores on sexual abuse treatment outcomes for children and non-offending family members attending treatment at FLP. Overall, the study found that baseline hope scores were not predictive of sexual abuse treatment outcomes. In examining the participants' hope scores at the onset of treatment, we found that individuals seeking sexual abuse treatment, including children/adolescents and siblings, did not initiate services with lower overall hope scores than that of the normative sample on these assessments (Snyder et al., 1991; Snyder et al., 1996, Snyder et al., 1997). This could be a possible explanation for the lack of predictive value of these baseline scores. That is, the baseline hope scores were not initially low

enough to substantiate a significant increase of scores during the treatment process. However, in considering the world of literature's findings of potential positive outcomes for individuals who harbor high levels of hope performance (Day et al., 2010, Hand, 2008, Munoz et al., 2020), this insignificant finding of high baseline hope for the CSA population is still important for clinicians to know. Interestingly, we did find that NOCs had a significant increase in hope from the baseline point of treatment to the endpoint of treatment. We noticed an interesting pattern, in that the levels of hope tended to slightly dip at the midpoint (6-month) point of treatment, and then increased between the midpoint to end of treatment. This may be related to observed changes seen in the caregiver's child, or increased hope in seeing the family complete the treatment process. Additionally, research findings that NOCs often identify as "secondary victims," could be a potential explanation for this increase in hope throughout treatment, as the caregivers' complete modules of psychoeducation, affect expression, coping, and processing as the victims address in their treatment (Cohen & Mannarino, 2022, Davies & Bennett, 2021; Fuller, 2016; Theimer et al., 2020; and Vilvens et al., 2021).

We also predicted that higher hope levels at the onset of treatment would be more indicative of successful treatment outcomes, while lower hope levels at the onset of treatment would be more indicative of unsuccessful treatment outcomes (i.e., not initiating services or early termination). We found that in victims, siblings, and NOCs, this was not the case, which is not aligned with previous literature on this topic (Day et al., 2010, Swanston et al., 1999). There was no significant relationship between baseline hope scores and treatment outcomes for the participants in this study. However, it is important to note that this finding is likely due to the uniformity of baseline hopes scores largely falling in the medium/moderately hopeful ranges, similar the normative sample, which was not a sexual abuse sample (Snyder et al., 1991; Snyder et al., 1996, Snyder et al., 1997).

Additionally, the reasons why families did not initiate treatment after the baseline assessments were not separately recorded for this study. Future research might look at the reasons why families do not initiate services after the intake process to examine their role in the hope-treatment outcome relationship.

Many of the families who did not initiate services did not begin treatment due to not meeting eligibility and/or lack of clinical indication for services. These reasons ranged from presence of significant self-harm behaviors or suicidal ideations, behavioral disturbances requiring more intensive levels of care, current treatment by other providers (posing duplication of services ethical dilemmas), and lack of willingness of the victim to discuss their abuse, indicating lack of readiness to begin the TF-CBT treatment process. Other reasons included lack of childcare for non-attending children and parent lack of availability due to work. These factors were outside of the scope of control, and therefore their hope levels at the baseline assessments may not have been predictive of their treatment outcomes due to these factors which prevented their initiation of group and individual counseling.

We expected to find a stronger correlational relationship between victim hope scores with NOC hope scores than with sibling hope scores. However, results did not support this hypothesis. Surprisingly, while the NOC scores were significantly, positively correlated with victim hope scores (e.g., higher NOC scores were associated with higher victim hope scores), we found a stronger correlational relationship between victim and sibling hope scores. It is unclear as to why this finding might be, as previous literature on this topic found the opposite—that caregiver scores were more strongly correlated (Afifi & MacMillan, 2011; Domhardt et al., 2015 Traub & Boynton-Jarrett, 2017). However, it has been pointed out that this question in literature has not been widely

examined, which may be another reason why our findings are not fully consistent with other studies (Westburg & Martin, 2003).

This finding that sibling hope scores are more strongly correlated with victim hope scores than the caregivers could be indicative of another future direction for research; however, it should also be considered that many of the families had non-traditional family systems, including stepparents, single parent households, and some foster families, which could be another explanation for this finding between biological siblings versus NOCs. Research might also examine the correlation of hope among siblings with their victim siblings, and potential alignment of ACE scores, as this has not yet been widely studied.

Our hypothesis that PTS would be negatively associated with hope scores (e.g., higher PTS associated with lower hope scores), was also not supported in the data. This finding was upheld when measuring with the CRIES-13, TSCC, and TSCYC at all points of assessment (baseline, midpoint and endpoint). This finding goes against some previous literature findings, in that individuals with higher levels of hope often saw increased PTG (Kaye-Tzadok & Davidson-Arad, 2016). However, it is not entirely surprising that the data goes against the overall research's findings, as some recent literature has also found no significant relationship between PTS reduction and hope levels (Arnault & Sinko, 2019). This study's support of these recent findings is indicative of further need for research on this topic. This finding is, however, especially interesting when considering the lack of significance at the endpoint of treatment, as typically individuals are discharged after completing all treatment goals. However, in considering the low percentage of clients who successfully completed treatment due to completion of treatment goals (27.4%), it is hard to draw definitive conclusions for this finding.

Other unexpected findings were the lack of significance of hope with parenting stress. That is, hope scores were not significantly correlated with the levels of stress caregivers reported throughout treatment. We predicted that increased hope would be associated with decreased stress due to previous findings that high hope was correlated with overall wellbeing and decreased distress (Alşen Güney, 2020; Conner et al., 2012; Hirsch et al., 2012; Smith et al., 2017). We also found lack of significance for intra- versus extrafamilial sexual abuse and parenting stress. However, due to the need for three different assessments on this measure (PSI-4, PSI-4-SF, and SIPA), we were unable analyze any single measure for all NOC participants, and it is possible that this would have resulted in significant findings between the nature of the perpetrator of the abuse and parental stress.

Finally, we found that children who experienced intrafamilial abuse did not have significantly lower hope scores than children who experienced extrafamilial abuse. We predicted this decrease in hope for individuals who experienced intrafamilial abuse due to the component of moral injury that CSA by a family member contributes to long-term consequences (Griffin et al., 2019; Richardson et al., 2022). We also expected to see this significance due to the decrease of resilience seen in individuals who experienced intra- rather than extrafamilial abuse in previous literature ((Hyman & Williams, 2001; Williams & Nelson-Gardell, 2012; Wright et al., 2019). Further factors should be examined to explore potential contributing factors to these findings.

Study Limitations and Research Implications

There were many limitations to this study that may have impacted results. First, this study had a small sample size (N= 106, 34 families), limiting data points and amount of treatment outcomes able to be examined for the purpose of this study. Had a larger sample size been used, there would have been potentially increased opportunity to examine endpoint assessments to better

establish the possible relationships between baseline hope and other endpoint factors. Due to the limited number of families that fully completed all datapoints, many factors could not be examined for all participants. Future research should try to gather data at all points for all participants. However, due to this study's goal of examining hope with treatment outcomes, early termination of services were included for the initial hope score as a potential predictor of early treatment dropout.

Additionally, the lack of uniformity of assessments posed a challenge for measuring the PTS and parenting stress among the various participants. This lack of a singular assessment utilized is due to best-clinical practice techniques in using assessments that are administered based on age range, in contrast to existing literature examining all children regardless of age range. Future research should attempt to find one assessment or screener that can be applied regardless of child age to ensure all participants may be measured on the same scale of scores and reduce missing datapoints. Additionally, the shift of the clinic's use from the PSI-4-SF to the PSI-4 after three years of data collection required the researcher to apply these measures separately rather than having the same questionnaire administered to all caregivers in treatment. Eliminating this limitation from future data might allow for a larger group of participants to be compared in each hypothesis testing.

Other limitations include the lack of control used in this study. The clinic at which the participants seek services is primarily focused on clinical treatment, and therefore control measures are not and cannot be taken for the best interest of the clients. As the clinic is also a training facility, the clinicians gathering data frequently change, not allowing for uniformity of clinicians administering the assessments, which could allow for some minor error in the data collection

process. Studies seeking higher levels of control should use the same researchers to collect data over time to reduce potential discrepancies or missing data.

Finally, the largest limitation of this study was a two-year period during which the clinic had to transition to telehealth services due to the global COVID-19 pandemic. As data were only collected for five years, this two-year period resulted in a significant amount of lost data. Due to copyright laws and need for privacy of assessments, only the CRIES-13, ACE, and Hope scales were able to be administered during this period, eliminating the possibility to gather data for parenting stress and PTS for participants who engaged in treatment during this time. Not only did this global pandemic directly impact data collection and accessibility to treatment (some families were unable to participate due to lack of devices or internet access at home), it also contributed additional familial stress that could not be controlled, and the levels of stress regarding the pandemic were not measured during this time in treatment. Although this factor was outside of the clinic's control, future research may wish to include data after the effects of the pandemic have subsided or include a measure to establish level of stress or traumas the pandemic has caused for the families.

Chapter 7: Conclusion

Although the findings of this study did not support our hypotheses, they bring to light several more questions that might be examined in future research— what factors contribute to the relationship between sibling and child hope scores? Does extrafamilial versus intrafamilial abuse have long-term consequences on the families' presentation? Does hope have any correlational value to the treatment outcome in this population? Does treatment model play a mitigating role between baseline scores and treatment outcome? This study provides multiple directions for future research to take and has potential to alter clinical applications of hope in sexual abuse treatment.

References

Abidin, R.R. (2012). Parenting Stress Index-Fourth Edition (PSI-4). Psychological Assessment Resources.

Afifi, T. O., & MacMillan, H. L. (2011). Resilience following child maltreatment: A review of protective factors. *The Canadian Journal of Psychiatry, 56*(5), 266–272. https://doi.org/10.1177/070674371105600505

Alşen Güney, S., Bağ, Ö., Kaya, H., & Arıer Arısın, S. (2020). How do childhood and parental anxiety features affect the consequences of child sexual abuse? *Journal of Child Sexual Abuse, 29*(4), 413–431. https://doi.org/10.1080/10538712.2019.1709243

American Academy of Pediatrics (2010). The Children's Impact of Event Scale (13) (CRIES-13). https://emdrresearchfoundation.org/toolkit/cries-13.pdf

American Psychiatric Association (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Washington, DC: Author.

American Psychological Association. (n.d.). *Sexual Abuse.* https://www.apa.org. Retrieved February 8, 2022, from https://www.apa.org/topiccs/sexual-assault-harassment

Arnau, R. C., Rosen, D. H., Finch, J. F., Rhudy, J. L., & Fortunato, V. J. (2007). Longitudinal effects of hope on depression and anxiety: A latent variable analysis. *Journal of Personality, 75*(1), 43–64. https://doi.org/10.1111/j.1467-6494.2006.00432.x

Baxter, M. A., Hemming, E. J., McIntosh, H. C., & Hellman, C. M. (2017). Exploring the relationship between adverse childhood experiences and hope. *Journal of Child Sexual Abuse, 26*(8), 948–956. https://doi.org/10.1080/10538712.2017.1365319

Bethell, C.D., Newacheck, P., Hawes, E., Halfon, N. (2014). Adverse childhood experiences: Assessing the impact on health and school engagement and the mitigating role of resilence. *Health Affairs, 33*(12), 2106-2115. https://doi.org/10.1377/htlhaff.2014.0914

Briere, J. (1996). Trauma Symptom Checklist for Children (TSCC), Professional Manual. Odessa, FL: Psychological Assessment Resources.

Briere, J. (2005). Trauma Symptom Checklist for Young Children (TSCYC): Professional Manual. Psychological Assessment Resources, Inc. Odessa, FL.

Briere, J. N., & Elliott, D. M. (1994). Immediate and long-term impacts of child sexual abuse. The Future of Children, 4(2), 54. https://doi.org/10.2307/1602523

Browne, A., & Finkelhor, D. (1986). Impact of child sexual abuse: A review of the research. *Psychological Bulletin, 99*(1), 66–77. https://doi.org/10.1037/0033-2909.99.1.66

Burke Harris, N. and Renschler, T. (version 7/2015). Center for Youth Wellness ACE-Questionnaire (CYW ACE-Q Child, Teen, Teen SR). Center for Youth Wellness. San Francisco, CA.

Child Welfare Information Gateway. (2012). Trauma-focused cognitive behavioral therapy for children affected by sexual abuse or trauma. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.

Cohen, J. A., & Mannarino, A. P. (2022). Trauma-focused cognitive behavioral therapy for children and families. *Child and Adolescent Psychiatric Clinics of North America*, *31*(1), 133–147. https://doi.org/10.1016/j.chc.2021.05.001

Cohen, J. A., Deblinger, E., & Mannarino, A. P. (2018). Trauma-focused cognitive behavioral therapy for children and families. *Psychotherapy Research, 28*(1), 47–57. https://doi.org/10.1080/10503307.2016.1208375

Conner, C. M., Maddox, B. B., & White, S. W. (2013). Parents' state and trait anxiety: Relationships with anxiety severity and treatment response in adolescents with autism spectrum disorders. *Journal of Autism and Developmental Disorders, 43*(8), 1811–1818. https://doi.org/10.1007/s10803-012-1728-0

Copeland, W. E., Keeler, G., Angold, A., & Costello, E. J. (2007). Traumatic events and posttraumatic stress in childhood. *Archives of General Psychiatry, 64*(5), 577. https://doi.org/10.1001/archpsyc.64.5.577

Davies, M. A., & Bennett, D. B. (2021). Parenting stress in non-offending caregivers of sexually abused children. *Journal of Child Sexual Abuse*, 1–16. https://doi.org/10.1080/10538712.2021.1985676

Davydov, D. M., Stewart, R., Ritchie, K., & Chaudieu, I. (2010). Resilience and mental health. *Clinical Psychology Review, 30*(5), 479–495. https://doi.org/10.1016/j.cpr.2010.03.003

Day, L., Hanson, K., Maltby, J., Proctor, C., & Wood, A. (2010). Hope uniquely predicts objective academic achievement above intelligence, personality, and previous academic achievement. *Journal of Research in Personality, 44*(4), 550–553. https://doi.org/10.1016/j.jrp.2010.05.009

de Arellano, M. A. R., Lyman, D. R., Jobe-Shields, L., George, P., Dougherty, R. H., Daniels, A. S., Ghose, S. S., Huang, L., & Delphin-Rittmon, M. E. (2014). Trauma-focused cognitive-behavioral therapy for children and adolescents: Assessing the evidence. *Psychiatric Services, 65*(5), 591–602. https://doi.org/10.1176/appi.ps.201300255

Deblinger, E., Mannarino, A. P., Cohen, J. A., Runyon, M. K., & Steer, R. A. (2011). Trauma-focused cognitive behavioral therapy for children: Impact of the trauma narrative and treatment length. *Depression and Anxiety, 28*(1), 67–75. https://doi.org/10.1002/da.20744

Dixson, D. D. (2017). Hope across achievement: Examining psychometric properties of the Children's Hope Scale across the range of achievement. *SAGE Open*, *7*(3), 215824401771730. https://doi.org/10.1177/2158244017717304

Domhardt, M., Münzer, A., Fegert, J. M., & Goldbeck, L. (2015). Resilience in survivors of child sexual abuse: A systematic review of the literature. *Trauma, Violence, & Abuse, 16*(4), 476–493. https://doi.org/10.1177/1524838014557288

Doran, G. T. (1981). There's a SMART way to write management's goals and objectives." and Miller. *Arthur F. & Cunningham, James A" How to avoid costly job mismatches" Management Review*, *70*(11).

Duggal, D., Sacks-Zimmerman, A., & Liberta, T. (2016). The impact of hope and resilience on multiple factors in neurosurgical patients. Cureus. https://doi.org/10.7759/cureus.849

DuMont, K. A., Widom, C. S., & Czaja, S. J. (2007). Predictors of resilience in abused and neglected children grown-up: The role of individual and neighborhood characteristics. *Child Abuse & Neglect, 31*(3), 255–274. https://doi.org/10.1016/j.chiabu.2005.11.015

Edmond, T., Auslander, W., Elze, D., & Bowland, S. (2006). Signs of resilience in sexually abused adolescent girls in the foster care system. *Journal of Child Sexual Abuse, 15*(1), 1–28. https://doi.org/10.1300/J070v15n01_01

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. *American Journal of Preventive Medicine, 14*(4), 245–258. https://doi.org/10.1016/S0749-3797(98)00017-8

Finkelhor, D., Shattuck, A., Turner, H. A., & Hamby, S. L. (2014). The lifetime prevalence of child sexual abuse and sexual assault assessed in late adolescence. *Journal of Adolescent Health, 55*(3), 329–333. https://doi.org/10.1016/j.jadohealth.2013.12.026

Fuller, G. (2016). Non-offending parents as secondary victims of child sexual assault. *Trends & Issues in Crime & Criminal Justice*, *500*, 1–7.

Gladstone, G. L., Parker, G. B., Mitchell, P. B., Malhi, G. S., Wilhelm, K., & Austin, M.-P. (2004). Implications of childhood trauma for depressed women: An analysis of pathways from childhood sexual abuse to deliberate self-harm and revictimization. American *Journal of Psychiatry, 161*(8), 1417–1425. https://doi.org/10.1176/appi.ajp.161.8.1417

Gorey, K. M., Richter, N. L., & Snider, E. (2001). Guilt, isolation and hopelessness among female survivors of childhood sexual abuse: Effectiveness of group work intervention☆. *Child Abuse & Neglect, 25*(3), 347–355. https://doi.org/10.1016/S0145-2134(00)00255-6

Griffin, M. L., & Amodeo, M. (2010). Predicting long-term outcomes for women physically abused in childhood: Contribution of abuse severity versus family environment. *Child Abuse & Neglect, 34*(10), 724–733. https://doi.org/10.1016/j.chiabu.2010.03.005

Griffin, B. J., Purcell, N., Burkman, K., Litz, B. T., Bryan, C. J., Schmitz, M., Villierme, C., Walsh, J., & Maguen, S. (2019). Moral injury: An integrative review. *Journal of Traumatic Stress*, *32*(3), 350–362. https://doi.org/10.1002/jts.22362

Guerra, C., Farkas, C., & Moncada, L. (2018). Depression, anxiety and PTSD in sexually abused adolescents: Association with self-efficacy, coping and family support. *Child Abuse & Neglect, 76*, 310–320. https://doi.org/10.1016/j.chiabu.2017.11.013

Hand, M. P. (2008). Psychological resilience: The influence of positive and negative life events upon optimism, hope, and perceived locus of control. VDM Verlag Müller.

Herrman, H., Stewart, D. E., Diaz-Granados, N., Berger, E. L., Jackson, B., & Yuen, T. (2011). What is Resilience? *The Canadian Journal of Psychiatry, 56*(5), 258–265. https://doi.org/10.1177/070674371105600504

Hirsch, J. K., Visser, P. L., Chang, E. C., & Jeglic, E. L. (2012). Race and ethnic differences in hope and hopelessness as moderators of the association between depressive symptoms and suicidal behavior. *Journal of American College Health*, *60*(2), 115–125. https://doi.org/10.1080/07448481.2011.567402

Hoy, B. D., Suldo, S. M., & Mendez, L. R. (2013). Links between parents' and children's levels of gratitude, life satisfaction, and hope. *Journal of Happiness Studies, 14*(4), 1343–1361. https://doi.org/10.1007/s10902-012-9386-7

Hyman, B., & Williams, L. (2001). Resilience among women survivors of child sexual abuse. *Affilia, 16*(2), 198–219. https://doi.org/10.1177/08861090122094226

Jonkman, C. S., Verlinden, E., Bolle, E. A., Boer, F., & Lindauer, R. J. L. (2013). Traumatic stress symptomatology after child maltreatment and single traumatic events: Different profiles: traumatic stress symptomatology in children. *Journal of Traumatic Stress*, *26*(2), 225–232. https://doi.org/10.1002/jts.21792

Kahn, A. S., Jackson, J., Kully, C., Badger, K., & Halvorsen, J. (2003). Calling it rape: Differences in experiences of women who do or do not label their sexual assault as rape. *Psychology of Women Quarterly, 27*(3), 233–242. https://doi.org/10.1111/1471-6402.00103

Kaye-Tzadok, A., & Davidson-Arad, B. (2016). Posttraumatic growth among women survivors of childhood sexual abuse: Its relation to cognitive strategies, posttraumatic symptoms, and resilience. *Psychological Trauma: Theory, Research, Practice, and Policy, 8*(5), 550–558. https://doi.org/10.1037/tra0000103

Kaye-Tzadok, A., & Davidson-Arad, B. (2017). The contribution of cognitive strategies to the resilience of women survivors of childhood sexual abuse and non-abused women. *Violence Against Women, 23*(8), 993–1015. https://doi.org/10.1177/1077801216652506

Mannarino, A. P., Cohen, J. A., & Deblinger, E. (2014). Trauma-Focused Cognitive Behavioral Therapy. In S. Timmer & A. Urquiza (Eds.), Evidence-based approaches for the treatment of maltreated children (Vol. 3, pp. 165–185). Springer Netherlands. https://doi.org/10.1007/978-94-007-7404-9

Marshall, K., Venta, A., Henderson, C., Barker, M., & Sharp, C. (2017). Linguistic analysis as a method for assessing symptoms after sexual trauma among female adolescent psychiatric inpatients. *Journal of Child Sexual Abuse, 26*(8), 910–926. https://doi.org/10.1080/10538712.2017.1354349

Munoz, R. T., Hanks, H., & Hellman, C. M. (2020). Hope and resilience as distinct contributors to psychological flourishing among childhood trauma survivors. *Traumatology, 26*(2), 177–184. https://doi.org/10.1037/trm0000224

Negele, A., Kaufhold, J., Kallenbach, L., & Leuzinger-Bohleber, M. (2015). Childhood trauma and its relation to chronic depression in adulthood. *Depression Research and Treatment, 2015*, 1–11. https://doi.org/10.1155/2015/650804

Pilkington, P. D., Bishop, A., & Younan, R. (2021). Adverse childhood experiences and early maladaptive schemas in adulthood: A systematic review and meta-analysis. *Clinical Psychology & Psychotherapy, 28*(3), 569–584. https://doi.org/10.1002/cpp.2533

Ports, K. A., Ford, D. C., & Merrick, M. T. (2016). Adverse childhood experiences and sexual victimization in adulthood. *Child Abuse & Neglect, 51*, 313–322. https://doi.org/10.1016/j.chiabu.2015.08.017

Richardson, N. M., Lamson, A. L., & Hutto, O. (2022). "My whole moral base and moral understanding was shattered": A phenomenological understanding of key definitional constructs of moral injury. *Traumatology.* Advance online publication. https://doi.org/10.1037/trm0000364

Ross, S. L., Sharma-Patel, K., Brown, E. J., Huntt, J. S., & Chaplin, W. F. (2021). Complex trauma and Trauma-Focused Cognitive-Behavioral Therapy: How do trauma chronicity and PTSD presentation affect treatment outcome? *Child Abuse & Neglect, 111,* 104734. https://doi.org/10.1016/j.chiabu.2020.104734

Saint Arnault, D., & Sinko, L. (2019). Hope and fulfillment after complex trauma: Using mixed methods to understand healing. *Frontiers in Psychology, 10*, 2061. https://doi.org/10.3389/fpsyg.2019.02061

Salloum, A., Lu, Y., Chen, H., Quast, T., Cohen, J. A., Scheeringa, M. S., Salomon, K., & Storch, E. A. (2022). Stepped care versus standard care for children after trauma: A randomized non-inferiority clinical trial. *Journal of the American Academy of Child & Adolescent Psychiatry*, S0890856722000065. https://doi.org/10.1016/j.jaac.2021.12.013

Schultz, D., Tharp-Taylor, S., Haviland, A., & Jaycox, L. (2009). The relationship between protective factors and outcomes for children investigated for maltreatment. *Child Abuse & Neglect, 33*(10), 684–698. https://doi.org/10.1016/j.chiabu.2009.04.004

Sheras, P.L., Abidin, R.R., & Konold, T.R. (1998). Stress index for parents of adolescents: Professional manual. Lutz, FL: Psychological Assessment Resources.

Smith, L. B., Lenz, A. S., & Strohmer, D. (2017). Differential prediction of resilience among individuals with and without a history of abuse. *Counseling and Values, 62*(1), 106–122. https://doi.org/10.1002/cvj.12052

Snyder, C. R. (1995). Conceptualizing, measuring, and nurturing hope. *Journal of Counseling & Development, 73*(3), 355–360. https://doi.org/10.1002/j.1556-6676.1995.tb01764.x

Snyder, C.R., Cheri-Harris, J.R., Holleran, S.A., Irving, L.M., Sigmon, S.T., Yoshinobu, L., Gibb, J., Langelle, C., & Harney, P. (1991). The will and the ways: Developmentand validation of an individual-differences measure of hope. *Journal of Personality and Social Psychology,* 60(94), 570-585. https://doi.org/10.1037/0022-3514.60.4.570

Snyder, C. R., Hoza, B., Pelham, W. E., Rapoff, M., Ware, L., Danovsky, M., Highberger, L., Ribinstein, H., & Stahl, K. J. (1997). The development and validation of the children's hope scale. *Journal of Pediatric Psychology, 22*(3), 399–421. https://doi.org/10.1093/jpepsy/22.3.399

Snyder, C.R., Sympson, S.C., Michael, S.T., & Cheavens, J. (2001). Optimism and hope constructs: Variants on a positive expectancy theme. In E.C. Chang (ed.). Optimism and pessimism: Implications for theory, research, and practice (pp. 101-125). Washington, D.C.: American Psychological Association.

Snyder, C. R., Sympson, S. C., Ybasco, F. C., Borders, T. F., Babyak, M. A., & Higgins, R. L. (1996). Development and validation of the state hope scale. *Journal of Personality and Social Psychology, 70*(2), 321–335. https://doi.org/10.1037/0022-3514.70.2.321

Steger, M. F., Hicks, B. M., Kashdan, T. B., Krueger, R. F., & Bouchard, T. J. (2007). Genetic and environmental influences on the positive traits of the values in action classification, and biometric covariance with normal personality. *Journal of Research in Personality, 41*(3), 524–539. https://doi.org/10.1016/j.jrp.2006.06.002

Swanston, H. Y., Nunn, K. P., Oates, R. K., Tebbutt, J. S., & O'Toole, B. I. (1999). Hoping and coping in young people who have been sexually abused. *European Child & Adolescent Psychiatry, 8*(2), 134–142. https://doi.org/10.1007/s007870050094

Theimer, K., Mii, A. E., Sonnen, E., McCoy, K., Meidlinger, K., Biles, B., Huit, T. Z., Flood, M. F., & Hansen, D. J. (2020). Identifying and addressing barriers to treatment for child sexual abuse survivors and their non-offending caregivers. *Aggression and Violent Behavior*, *52*, 101418. https://doi.org/10.1016/j.avb.2020.101418

Traub, F., & Boynton-Jarrett, R. (2017). Modifiable resilience factors to childhood adversity for clinical pediatric practice. *Pediatrics*, *139*(5), e20162569. https://doi.org/10.1542/peds.2016-2569

United States Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau (2021). Child Maltreatment Survey, 2020. https://www.acf.hhs.gov/cb/data-research/child-maltreatment

Vilvens, H. L., Jones, D. E., & Vaughn, L. M. (2021). Exploring the recovery of non-offending parents after a child's sexual abuse event. *Journal of Child and Family Studies*, *30*(11), 2690–2704. https://doi.org/10.1007/s10826-021-02082-3

Wamser-Nanney, R., & Vandenberg, B. R. (2013). Empirical support for the definition of a complex trauma event in children and adolescents: Complex trauma event in children. *Journal of Traumatic Stress*, *26*(6), 671–678. https://doi.org/10.1002/jts.21857

Westburg, N. G., & Martin, D. (2003). The relationship between a child's hope, a parent's hope, and student-directed, goal-oriented academic instruction. *The Journal of Humanistic Counseling, Education and Development, 42*(2), 152–164. https://doi.org/10.1002/j.2164-490X.2003.tb00003.x

Williams, J., & Nelson-Gardell, D. (2012). Predicting resilience in sexually abused adolescents. *Child Abuse & Neglect, 36*(1), 53–63. https://doi.org/10.1016/j.chiabu.2011.07.004

Wright, K. A., Turanovic, J. J., O'Neal, E. N., Morse, S. J., & Booth, E. T. (2019). The cycle of violence revisited: Childhood victimization, resilience, and future violence. *Journal of Interpersonal Violence*, *34*(6), 1261–1286. https://doi.org/10.1177/0886260516651090

Yap, M. B. H., Pilkington, P. D., Ryan, S. M., & Jorm, A. F. (2014). Parental factors associated with depression and anxiety in young people: A systematic review and meta-analysis. *Journal of Affective Disorders, 156*, 8–23. https://doi.org/10.1016/j.jad.2013.11.007

Table 1.

Means and Standard Deviations of hope scores in children and adolescents.

Sample Group	Subscale	M	SD
Victims	Total Hope	4.13	1.04
	Pathways	12.50	3.38
	Agency	12.22	3.66
Siblings	Total Hope	3.52	1.32
	Pathways	9.85	3.85
	Agency	9.92	2.96

Victim $N = 32$ and Sibling $N = 13$.

Table 2.

Means and Standard Deviations of hope scores in NOCs.

Sample Group	Subscale	M	SD
All NOCs	Total Hope	51.81	5.81
	Pathways	25.98	4.27
	Agency	25.83	3.58
Female NOCs	Total Hope	50.75	5.61
	Pathways	25.00	4.06
	Agency	25.75	3.49
Male NOCs	Total Hope	54.07	5.76
	Pathways	28.07	4.08
	Agency	26.00	3.89

All NOC $N = 47$, Female NOC $N = 32$, and Male NOC $N = 15$