Non-Offending Caregivers' Experiences at a Southern California Children's Assessment Center

Jenilynn Marie Pendergraft
Santia Gloria Magallanes

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NON-OFFENDING CAREGIVERS’ EXPERIENCES AT A
SOUTHERN CALIFORNIA CHILDREN’S
ASSESSMENT CENTER

A Project
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Social Work

by
Santia Gloria Magallanes
Jenilynn Marie Pendergraft
June 2017
NON-OFFENDING CAREGIVERS; EXPERIENCES AT A
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Approved by:

Dr. Carolyn McAllister, Faculty Supervisor

Dr. Janet Chang, M.S.W. Research Coordinator
ABSTRACT

Victims of child maltreatment are often subjected to both repeat interviews and physical exams over the course of an investigation. There are specialized centers across the country that serve this highly at-risk population with the goal of minimizing further traumatization of victims by repeat interviews and exams. These centers must maintain a high standard of practice and undergo outside scrutiny and evaluation, in order to best serve their clients and recognize possible shortcomings. An evaluative, pilot study was conducted at a Southern California Children’s Assessment Center (SCCAC). The purpose of this pilot study was to gain more knowledge about caregivers’ overall experiences at the center and the population’s willingness to participate in future studies. Twelve participants were identified through convenience sampling and completed a qualitative interview. Demographic information was input into SPSS and analyzed through descriptive statistics. In addition, interview response content was analyzed by the use of triangulation. Overall findings support existing literature which states that clients are generally satisfied with their experiences at the SCCAC. The significance of this study for social work will enhance the understanding of the need for additional policies to ensure proper training. This study will also benefit the field of child welfare by providing a small amount of insight into how different components of service factors may affect diverse individual’s experiences during a difficult time. This study will allow child welfare
professionals to further customize their engagement approach and provide services that are considerate and effective for each individual.
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DEDICATION

I must first thank my husband Derrick for selflessly supporting my educational journey and being there for our children, so that I could pursue my dreams. Thank you to my daughters, Alyce and Alexis, without whom I would be lost. I love you all and appreciate the endless days and nights you have spent sharing me with my academic obligations, even when you did not want to. I would like to thank my parents, Robert and Sandy Magallanes, for the tireless love and support you have given me and your grandchildren. I may have taken the long road, but I am finally here! I want to thank my sister, Angel, for believing in me, even when I did not believe in myself. Your vision has led me here and you are the ultimate example of determination, resilience, and courage. Finally, to my research partner and friend, Jenilynn, thank you for always letting me be me and embracing the “squirrel” at 2pm or 2am. You are smart, patient, and organized; I could not have chosen a better partner. We did it!

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I would like to thank someone special who has supported me through thick and thin and for better or for worse. This person is truly my rock, my spouse Jeremy Pendergraft. I would also like to thank my research partner, Santia Magallanes for being supportive, flexible, and understanding throughout this process.

Jenilynn Pendergraft
# TABLE OF CONTENTS

ABSTRACT ................................................................................................................................. iii

ACKNOWLEDGEMENTS........................................................................................................... v

CHAPTER ONE: INTRODUCTION

Problem Statement ..................................................................................................................... 1
Purpose of the Study .................................................................................................................. 5
Significance of the Study for Social Work ........................................................................... 7

CHAPTER TWO: LITERATURE REVIEW

Introduction .............................................................................................................................. 9
Multidisciplinary Centers ....................................................................................................... 9
Theories Guiding Conceptualization ................................................................................... 14
  Crisis Intervention .............................................................................................................. 14
  Trauma Informed Care .................................................................................................... 16
Summary ................................................................................................................................. 18

CHAPTER THREE: METHODS

Introduction .............................................................................................................................. 20
Study Design .......................................................................................................................... 20
Sampling ................................................................................................................................ 21
Data Collection and Instruments ....................................................................................... 23
Procedures ............................................................................................................................. 23
Protection of Human Subjects ............................................................................................. 24
Data Analysis .......................................................................................................................... 25
Summary ................................................................................................................................. 26
CHAPTER ONE
INTRODUCTION

Problem Statement

Victims of child maltreatment may often be confronted with a series of unfamiliar and/or traumatic events, after allegations of mistreatment have been revealed and the perpetrator/s of their abuse have been exposed. Specialized centers have been developed throughout the United States that are designed to minimize further traumatization of victims and their families during the difficult period of initial investigation. These centers must maintain a high standard of practice and undergo outside scrutiny and evaluation, in order to best serve their clients and recognize possible shortcomings.

There are many aspects to consider when investigating, treating, and addressing child maltreatment. Although there are different categories of child maltreatment, for purposes of clarity the following definition has been provided:

The Federal Child Abuse Prevention and Treatment Act of 1984 (CAPTA) defines child abuse as any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation; or an act or failure to act which presents an imminent risk of serious harm (Gonzalez, pg. 95, 2012).

One of the primary duties during the process of investigating child abuse allegations is for practitioners and front-line workers to ensure that children and
their families are treated in a respectful and sensitive manner. Though referrals to Child Protective Services have continued to rise over the last two decades, nationally, rates of overall abuse have remained steady; it remains paramount that immediate recognition of the potential harm that both short and long-term trauma may inflict upon victims and their families be given during the initial phases of intervention (National Child Traumatic Stress Network 2008). Research from Herrmann, Banaschak, Csorba, Navratil, and Dettmeyer (2014) reports that the combined data of 39 studies focused on the prevalence of child sexual abuse from 28 countries, over the span of 1994-2007; the study revealed that 10-20% of girls and 5-10% of boys are victims of child abuse. Again, demonstrating that there is a great need for properly trained staff to provide critical services; it is important to note that the international figures did not include physical abuse of a non-sexual nature, which would likely increase rates of overall abuse among children.

Over time, many child abuse experts have come to recognize problems with inconsistent methods of investigation and the danger untrained individuals can pose when investigating or examining victims of child maltreatment. These inconsistencies prompted the development of Child Advocacy Centers (CACs), sometimes known as Children’s Assessment Centers, which serve children and families affected by physical or sexual abuse by providing multiple investigatory services in one community-based location with the intention of reducing trauma (Snell, 2003). As mentioned, it is extremely important to recognize the potential
effects that this type of trauma can have on children and their families, and more important to minimize those effects through timely service with appropriate intervention in the beginning stages of crisis. The CAC offers an opportunity for multiple professionals from different agencies to collaborate without repetitive and unnecessary victim questioning throughout an often long journey through the child welfare and legal systems (Snell, 2003).

A process referred to as forensic interviewing has become one of the most important tools utilized during child abuse investigations at CACs to elicit accurate information from children (Anderson et al., 2015). In addition to forensic interviewing, pediatric physicians specializing in evidentiary medical exams may conduct assessments when allegations of physical or sexual abuse are present. The forensic interviewers and pediatric physicians who perform these practices and procedures are typically part of a larger multidisciplinary team. Multidisciplinary teams are useful in coordinating all pieces of a child abuse investigation and have been shown to reduce system-induced trauma and increase the general effectiveness of the investigation process (Anderson et al., 2015). These teams meet to discuss the overall particulars of each case and make decisions and recommendations about what to do next in each case regarding specific barriers, strategies, and outside information (Anderson et al., 2015).

Researchers have an interest in conducting surveys to obtain information about the experiences of caregivers of clients at a Southern California Children’s
Assessment Center (SCCAC) due to the lack of studies done regarding caregiver satisfaction. The SCCAC, in addition to some of its collaborative agencies and community affiliates, are also interested in researchers gaining more knowledge about individual experiences and identifying gaps in service.

Generally, it is important for human service agencies and its employees to know whether or not they are providing quality service. Direct feedback from individuals who have accompanied others through their experiences at a facility or who have been part of the service process themselves, can be very useful in helping providers identify what is working well and what is not. Once areas of concern are identified, agencies can narrow down which issues are the most problematic and make changes when necessary. In contrast, when studies, research, and evaluation provide agencies with evidence that they are meeting or exceeding expectations in certain areas of service, they can build on those strengths and share their service models with others to improve human service on a broader scale. As an example, a study of four CACs in different states in the U.S. reported caregivers and minor clients were satisfied with very specific areas of their experiences at the centers, which may indicate great benefit for CAC agencies seeking improvement (Cross et al., 2008). Though overall available literature regarding CACs has been of a positive nature, the research on non-offending caregivers’ experiences of CAC’s remains limited. Thus, this study intends to expand the knowledge available about non-offending caregivers’ satisfaction at the SCCAC.
Purpose of the Study

The purpose of this study is to explore non-offending caregivers’ experiences with a Children’s Assessment Center in Southern California (SCCAC). This study utilized a qualitative design. Open-ended questions were asked during individual face-to-face interviews with 12 caregivers who have received service, in order to gain specific information to be used in finding any trends among caregivers’ experiences with the SCCAC. In addition, the study identified themes that are collectively expressed by caregivers and possible gaps in service to be reported to the SCCAC for evaluation purposes.

The SCCAC has published some statistics which will be useful during survey development. In each of the years 2013 and 2014 the SCCAC served over 1300 children under the umbrella of five different abuse allegation categories; these categories included children having been a witness to violence, victims of neglect, victims of physical abuse, victims of sexual abuse, or other types of child maltreatment (Children’s Assessment Center, 2015). These figures demonstrate that an overwhelming 64% of clients were seen for at least sexual abuse and 35% for at least physical abuse. In addition, SCCAC reports that the relationship of the offender to the child were as follows: parents 431 or 32%, other relative 190, other known person 141, parent’s girlfriend or boyfriend 85, stepparent 45, and unknown 62 (Children’s Assessment Center, 2015). These percentages indicate that further inquiry is needed about CAC practice standards in the areas of Trauma Informed Practice (TIP), also commonly
referred to as (TIC), due to the extreme affects that these types of abuse can have and the additional trauma that can occur when perpetrated by a parent. TIC requires practitioners to view clients through a trauma informed lens, which acknowledges client’s experiences with trauma and the active role that it has played in their lives (Substance Abuse and Mental Health Services Administration, 2015). The more informed social workers are about TIC, the more effective they can be right from their initial engagement with this client population.

Once data has been collected and results have been formed, the SCCAC will benefit from the knowledge gained about their clients, as well. Positive client feedback can help the agency identify possible areas of strength already at the center and allow administrators and staff to build on them. In contrast, negative client feedback can draw attention to areas of further focus at the center, which will allow the SCCAC to gain a starting point from which to make improvements. Another benefit to the knowledge gained from this study may come in the form of identification of specific needs or a lack of service to specific areas. For example, the data may show that some clients must drive an unreasonable distance to the SCCAC, which may cost them lost wages, school absences, or possibly financial strain. As a result, SCCAC administrators could consider exploring different areas of Southern California to open a second facility, either full-time or part-time and begin the research needed to request such funding. The center serves a large demographic of clients from many surrounding areas. This wide variation in client population will likely result in implications for both policy and practice.
As mentioned, the SCCAC served 1300 plus children in the year 2014. The agency reports that 657 clients were Hispanic, 406 were White, 257 were African American, and 41 were either unknown or of other descent (Children’s Assessment Center, 2015). The Hispanic client figure equates to a staggering 48% of clients served in 2014, which is a significant implication for current workers and for the proposed study to evaluate accessibility to alternative language materials and services. These statistics will continue to allow researchers to gain some insight about the client population prior to the full implementation of the caregiver study, as there is little to no other research published about the SCCAC.

Significance of the Study for Social Work

The engagement phase of the generalist intervention model requires social service practitioners to demonstrate an effective grasp of appropriate communication skills, among other rapport building tasks. The results from this study seek to enhance these skills by allowing practitioners to gain insight about this particular population’s feelings, observations, and experiences during the initial phases of investigation. Moreover, survey results will enhance the understanding of the need for additional policies to be put in place that can ensure that proper trainings be implemented in the area of TIC throughout social work practice. A benefit to the field of child welfare will be that this research will provide a small amount of insight into how different components of service
factors may affect diverse individual’s experiences during an often difficult time. Thus, allowing child welfare professionals to further customize their engagement approach and make efforts to provide services that are both considerate and effective for each individual. Researchers intend to examine the experiences of caregivers whose children received services at the Children’s Assessment Center located in Southern California.
CHAPTER TWO
LITERATURE REVIEW

Introduction

Chapter two consists of literature relevant to this study. The chapter is divided into two main sections. The first is on multidisciplinary centers that focus on children who have been physically and sexually abused. These centers perform a variety of services to reduce trauma. The second section contains literature related to theories of conceptualization and is broken down into two subcategories; the first is centered on crisis intervention and the second highlights Trauma-Informed Practice (TIP) when working with children.

Multidisciplinary Centers

Multidisciplinary child assessment centers are located throughout the nation and provide a variety of services dedicated to their specialization. These centers provide collaboration between child welfare social workers, law enforcement and medical personnel in order to reduce trauma in children that are disclosing physical and sexual abuse during the interview process. Multidisciplinary child assessment centers also provide a child friendly environment to put children at ease. The focus of the following section is to examine multidisciplinary centers that serve children.
Wherry, Huey, and Medford (2015) conducted research on these types of centers and sent out surveys nationally, specifically to Children Advocacy Center (CAC) directors. These researchers were interested in several areas of knowledge such as Post Traumatic Stress Disorder (PTSD), the criteria for referring victims of physical and sexual abuse to evidence-based treatment, use of reliable, valid, and normed measures in assessing abused children and the need for staff trainings. Wherry and colleagues (2015) found that overall the CACs across the nation were doing a good job at identifying PTSD symptoms and also referring children to mental health treatment services. The researchers did state that although the CACs were doing a good job in identifying and referring children, they still had progress to make in identifying PTSD symptoms (Wherry, Huey, & Medford, 2015). There were limitations to this study including that the response rate was only 36%. The authors stated that it was a sufficient amount to conduct the study, though they would have liked more respondents. The researchers also could not verify that directors were the ones who filled out the surveys and not someone else. Not all the directors who completed the survey answered all the survey questions and the survey was untested. These limitations provide enough evidence to conduct further research on this subject.

Cross and colleagues (2008) discussed some of the general findings of evaluations done on four separate CACs located in Dallas, TX, Pittsburg, PA, Charleston, NC, and the Nation’s first CAC created in 1985 in Huntsville, AL. The study revealed that the CAC cases reviewed demonstrated positive coordinated
efforts among professionals involved, a greater likelihood of police involvement, and evidence that children were more likely to receive referrals for forensic and mental health services (Cross et al., 2008). Moreover, non-offending caregivers who were surveyed reported a high level of satisfaction with the CAC process as a whole, with additional reports that children felt less scared during CAC interviews than they had in other settings (Cross et al., 2008).

Wolfteich and Loggins (2007) focused on the CAC model in relation to traditional services offered by child protection workers. This study looked at revictimization outcomes, the legal aspects of the case such as substantiation of allegations, prosecution of the perpetrator, and finally at how efficiently the model is working with this population. The researchers focused on a large metropolitan area in Florida, and the sample consisted of one hundred and eighty-four child abuse and neglect cases over a five-year period. The results found that the CAC model had a higher frequency of substantiation, though these cases were more severe and had more evidence to help with the substantiation of abuse. The cases which used the CAC model were closed much sooner than the traditional cases, although it is unclear if this led to more positive outcomes. The prosecution and arrest outcomes for both traditional cases and CAC model cases were the same. One limitation to this study included the availability of legal data which hindered the ability to look at the legal outcomes when a multidisciplinary team is used. Additional limitations were small sample size and missing data. Overall, this study showed that there were better outcomes when a variety of
agencies worked together to prevent further victimization of the child and
provided the necessary services to improve the child’s outlook.

Bonach, Mabry, and Potts-Henry (2010) focused on caregiver’s satisfaction with a CAC in a rural community in the eastern region of the United States. This study wanted to examine the perceptions of the non-offending caregiver in regards to how the CAC accomplished their functions and how these perceptions relate to the caregiver’s overall perception of their CAC experience (Bonach, Mabry, & Potts-Henry, 2010). Bonach and colleagues (2010) measured the CACs information and logistical coordination, their responsiveness and client comfort provided, and the courteousness of the staff and their helpfulness. They also examined the satisfaction with child welfare services, law enforcement and victim advocacy. The researchers found that caregivers were satisfied with their experiences at the CAC and that this satisfaction was linked to how the participants were treated. The courteousness and helpfulness of the staff was mentioned favorably. Limitations of the study include the use of a Likert-type scale that was not tested for reliability and validity outside of the study, and the sample size was small and specific to one CAC located in the eastern region of the United States. More research needs to be conducted to see if this study’s findings can be replicated in a different area.

Another study looked at the reasons for using CACs in addition to suggestions for improving these centers. Newman, Dannenfelser, and Pendleton (2006) surveyed two hundred and ninety child welfare social workers and law
enforcement officers who used CAC’s. These researchers inferred the reasons for using the centers as well as ways the centers could be more helpful. Participants narrowed the reasons they used CACs to include a child friendly environment, support, referrals, assistance with counseling, medical exams, interviewer expertise, protocol, and access to video, audio and a two-way mirror (Newman et al., 2006). These researchers also found that the centers can be more helpful by increasing staff availability, providing more equipment and resources and finally increasing collaboration and communication between all agencies involved.

Another study on multidisciplinary centers in the Midwest focused on a cognitive-behavioral group treatment for sexually abused children and their non-offending caregivers after a child’s disclosure of sexual abuse. Hubel and colleagues (2014) looked at symptom presentation, outcomes, and social validity in a 12-week cognitive-behavioral group with 97 participants. The group worked on three main areas including the individual, interpersonal relationships, sexual development and behaviors (Hubel et al., 2014). This study showed that caregivers and the children, who participated, rated the group favorably and were satisfied with the treatment, overall. Researchers were also able to show that a thorough assessment should be conducted on sexually abused children to ensure time sensitive referrals and/or treatment for these children. There were limitations to this study, as well. The first limitation was that the participants were actually seeking treatment and the study did not include participants who may not
want to disclose to authorities or include any children who may not have had support by caregivers to seek treatment. Another limitation is that the researchers did not follow up with the participants and finally the researchers did not use a control group. Future research on this matter should include children, who are not supported by caregivers, follow up with participants after the group has concluded and the use of a control group to compare the effectiveness of the group treatment.

Theories Guiding Conceptualization

Crisis Intervention

Cordell and Snowden (2015) examined emotional distress dispositions and crisis intervention for children treated for mental illness. The researchers studied 1,397 children receiving treatment in a multiservice agency for a period of six months. The researchers found that children who exhibited emotional distress were associated with mental health crisis events occurring in programs serving at-risk youth. The most emotionally distressed associated behaviors the participants displayed were anger control problems, while anxiety/anxiousness was the least displayed (Cordell & Snowden, 2015). The study also found that early identification of emotional distress in children is vital for treatment in a clinical setting. One limitation of this study is that secondary data was used, which makes it unclear if all of the participants received the same early assessment tool.
An additional study looked at the Family Crisis Intervention Program (FCIP). Researchers evaluated this program using questionnaires that were distributed to one hundred eighty-three families in crisis and also distributed them to their workers (Al, Stams, Asscher, & Laan, 2014). The study showed that families still had problematic family functioning, though FCIP had improved the parent-child interaction. Moreover, FCIP decreased the level of crisis and increased the level of child safety. Some limitations of this study include the lack of a control group, non-response rate, and that the study did not address the variety of ethnical backgrounds and cultural diversity of the participants. This article shows the positive effects crisis intervention has on children and families. As mentioned, CAC forensic interviewers utilize crisis intervention during their interviews, when needed to help the child work through their current crisis. Additionally, the FCIP article provides evidence that using crisis intervention techniques increases child safety while decreasing the level of crisis symptoms in children when crisis intervention methods are implemented early on.

K. Ginnis, E. White, A. Ross, and E. Wharff (2015) applied the Family-Based Crisis Intervention model to adolescents at risk of suicide in an emergency department. The researchers recognized that traditionally adolescents who had presented with suicidal behaviors in the emergency room would automatically be sent to in-patient psychiatric care which over saturated the facility. Per the model, emergency workers started to implement Family-Based Crisis Intervention care to decrease oversaturation and to assist clients in crisis. The Family-Based Crisis
Intervention Model algorithm consists of cognitive behavioral therapy skill-building, psychoeducation, treatment planning, therapeutic readiness, and safety planning. These steps work to decrease individual clients’ suicidality, and increase their support and education. The model also works to ensure that clients are discharged from the emergency room and decreases their chances of being sent to the in-patient psychiatric facility. CACs also utilize intervention techniques comparable to those outlined in the Family-Based Crisis Intervention model with children and families who receive service at their centers.

**Trauma Informed Care**

According to Knight (2015), TIP is the understanding that a client’s current issues may be a product of their past victimization. Knight’s (2015) article provided considerations and challenges to address in social work practice. There are four considerations that Knight (2015) mentions in the article. One consideration is that social workers should validate the client’s feelings and experiences, along with informing them that what they are feeling is normal. Knight (2015) also mentions that social workers should help their clients understand what has happened in their past and how it can have an emotional impact on them now and in their future, which can then allow the worker to empower them to work through their trauma. A final consideration is that social workers should help clients gain a better understanding of their current challenges and how they can relate to their past victimization. Challenges that social workers might face may appear in clients who do not report past
victimizations, mandatory reporting requirements for historical abuse disclosure, and finally, the impact on the social workers themselves. Training will help social workers combat the challenges they face applying TIP.

Bowen and Murshid (2016) focused on the rationale for a TIP as well as its principles. The rationale for the TIP is that there are many health and social problems linked to trauma and traumatic events which can lead to adverse physical and mental health outcomes. The principles that Bowen and Murshid (2016) focused on include safety of vulnerable populations, trustworthiness and transparency of the policy’s goals, collaboration and peer support, empowerment, promote choice, and the understanding of intersectionality which is the consequence of the combinations of a person’s identities. Being aware that trauma is not distributed equally across society can make social workers more aware of trauma when interviewing clients. Social workers who work with a TIP client will better identify traumas that the client may have experienced.

Pence (2011) focused on trauma-informed forensic investigations of child maltreatment. A qualitative study was conducted in several Southern California counties by infusing trauma information into existing child maltreatment investigations trainings. The study showed an increase in trainee awareness of TIP. Participants stated that they would incorporate what they learned in the trauma informed trainings into their practice. Pence (2011) recommend that trauma information should be implemented in policies and procedures to help
social workers implement TIP. Social workers should also work to reduce trauma while still conducting a full assessment.

Children who enter the foster care system are a vulnerable population and social workers working with these children should operate with a trauma-informed practice. Beyerlein and Bloch (2014) authored a paper on the need of TIP for foster children due to the fact that they have a higher prevalence of traumatic experiences. The authors compiled some recommendations for social workers to implement in their work. Workers should screen for trauma, address the trauma to all involved, partner with family and youth, collaborate with other agencies to maintain safety and permanency, replace existing practices with new ones, and support change (Beyerlein & Bloch, 2014). Child Welfare workers who follow these recommendations will likely improve and maintain placement of children placed in foster care.

Summary

Multidisciplinary centers are used across the nation and have been studied to provide valued information. These studies have examined the knowledge of directors, satisfaction of caregivers with the CAC’s, evaluation of the centers themselves and the reasons for using these centers. Overall, the studies found that the CAC’s had a positive effect on the participants. They also showed that most of the studies needed more research to be conducted. Crisis Intervention studies mentioned earlier showed that when implemented early can
have a positive impact on children and families. More research needs to be conducted to validate the research. TIP studies have shown a positive impact on its participants. Social workers who implement TIP in their work bring awareness of clients past victimization, improve or maintain foster children’s placement and also help reduce trauma in clients. TIP is important for forensic interviewers while conducting child interviews in multidisciplinary centers.
CHAPTER THREE

METHODS

Introduction
Chapter three consists of the methods used in this study. The contents include information regarding the study’s design, sampling, data collection and instruments, protection of human rights, and qualitative data analysis.

Study Design
The purpose of the study was to explore non-offending caregivers’ experiences with a Southern California Children’s Assessment Center (SCCAC). This study utilized a qualitative design. Open-ended questions were asked in order to gain specific information used in finding trends among caregivers’ experiences with the SCCAC. In addition, the study identified themes that were collectively expressed by caregivers and identified possible gaps in service that were reported to the SCCAC for evaluation purposes.

The study consisted of 12 face-to-face interviews with caregivers who had received service at the SCCAC on the same day as their participation in the interview. The intention of administering the questionnaire immediately following the caregivers’ visit was to lessen the influence of any future results that may come from forensic interviewing or medical exams conducted on that day.
Additionally, the immediate interview process promoted anonymity and eliminated the need for client contact information to be released to researchers.

The study’s qualitative design allowed participants to provide specific details regarding their own experiences with issues such as center access and service availability. Whereas a quantitative design would limit responses to choosing predetermined suggestions and answers which may not capture the full-scope of their responses. Additional limitations were considered in the following areas: First and foremost, the sensitive nature of service that the SCCAC provides had the propensity to result in some participant samples having experienced a heightened state of emotion and/or distress, which could limit caregivers’ willingness to be interviewed immediately following their experience. Furthermore, the sensitive nature of service had significantly limited the scope of questions that either a qualitative or quantitative study may have asked due to extreme confidentiality concerns and risk of retraumatization. Therefore, researchers conducted a pilot study, which only made service inquires in order to gauge this population’s willingness to participate in any future, more in-depth studies and gain knowledge about their overall experience with the center.

Sampling

The study used convenience sampling to recruit all participants for the interviews. These participants must have received service from the SCCAC on the day of the interview, in addition to being a non-offending caregiver whose
child or children were seen at the SCCAC on that day and were current clients of the Department of Children and Family Services (DCFS). Although there are many definitions of caregivers, due to the ever-changing status of alleged parental child maltreatment defendants, foster parents, and emergency and temporary placements this study ultimately interviewed specific caregivers. Utilization of non-offending caregivers ensured that research was being conducted with caregivers who were not in the midst of any ongoing investigations or allegations that may have changed their perspective about the CAC and services conducted there.

Furthermore, it must be noted that a vast majority of clients are referred to the center by DCFS, which may result in the client having been brought in on an emergency basis due to a very recent home removal or placement relocation. As mentioned previously, this study is intent on upholding confidentiality and did not ask the questions necessary to determine any other caregiver status than that of a non-offending nature.

As mentioned, this study used convenience sampling to obtain 12 participants who met the aforementioned specific caregiver criteria. Additionally, SCCAC gave permission for research interviews to be conducted with caregivers’ onsite after their child or children’s services had been completed. Moreover, the center attempted to make arrangements for childcare from either student interns or staff members during the interview period.
Data Collection and Instruments

Data for this study was collected through the use of face-to-face interviews. This study consisted of a brief demographic survey and an interview guide. The demographic survey consisted of questions inquiring about the participant’s ethnicity, gender, and age range, as well as the child/children’s gender and age range. The interview guide consisted of several questions that were broken down into three main categories of logistics, comfort, and courteousness/helpfulness. Questions asking about logistical information included inquiry about mode of transportation, distance, difficulty getting to the center, prior information received about SCCAC, and the wait time in the lobby. The comfort section of the interview consisted of questions inquiring about whether or not the child and the participant were made to feel comfortable. The comfort area of questioning also included the effect the building and staff may or may not have had on the child and participant and about their overall comfort. The final category consisted of questions concerning staff’s courteousness and helpfulness, inquiry as to what the next step is after leaving the center and about the participant’s overall experience at the SCCAC. A detailed interview guide and demographic survey is located in Appendix A and B.

Procedures

Data was collected at the SCCAC during normal business hours (Monday through Friday 8am-5pm) on March 7th, 8th, 9th, and 13th, in the year of 2017.
Upon approval from the IRB board, the researchers were given permission by the SCCAC to conduct participant interviews at the facility to ensure continuity of the study and to maintain the confidentiality of participants. Caregiver participants were asked at the beginning and/or end of their child/children’s interview or exam to voluntarily participate in the study. If participants were willing, the adult was led into private meeting area where the interview took place. The child or children were supervised by SCCAC interns or staff in a playroom. The two researchers and the participant were the only individuals in the room during the interview. A consent form was obtained and the interview then took place. The study questions took approximately 10-15 minutes to complete. The participant was informed that the interview would be stopped if at any point they chose to not participate.

Protection of Human Subjects

Due to the sensitive nature of the service provided by the SCCAC, maintaining confidentiality of the participants was of utmost importance throughout this study. The researchers requested that the participants use pseudonyms during the interview. The participants were also asked not to provide any information about the reasons why their child or children were being seen at the center. Participants were asked to consent to research. They were informed about the purpose of the study, that participation of the study was completely voluntary, that they were audio recorded, and who they should
contact if they had any additional concerns. Additionally, participants were asked to mark an “X” instead of their signature on the informed consent and notified that all audio recordings were to be destroyed at the end of the study to maintain confidentiality. Participants were also informed to contact Nancy Wolfe, Director at the Children’s Assessment Center, at (909) 382-3535 or cac@cacsbc.com for any questions or concerns regarding the center. The audio recordings and data were stored on a password protected file on the researcher’s computer. The audio files and data were destroyed to ensure confidentiality after the completion of the study.

Data Analysis

This study used qualitative data analysis techniques. Participant interviews were audio recorded and transcribed verbatim. Transcripts were then reviewed several times by each individual researcher in order to confirm that the data had been correctly recorded. The data was then divided into smaller sections and organized by each question from the interview guide to analyze the data. The student researchers utilized researcher triangulation in analyzing and interpreting the data through the use of coding and some descriptive statistics. Student researchers accomplished this by reviewing the transcripts multiple times for similarities and differences among the participants. Researchers then identified themes and pertinent information to include in the results from the data.
The demographic data obtained during the interviews was coded and entered into SPSS. The study utilized descriptive statistics and frequency distribution of variability to describe the characteristics of the sample. SPSS was utilized to find the mean, medium, and mode of the data. Ethnicity, gender, and age range were also entered into SPSS for frequency distribution and descriptive statistics. The information gathered by the demographic data analysis and identified themes found in the interviews are included in the results section. The results were reported to the SCCAC.

Summary

This chapter consisted of a general outline and methods used for this study. A brief survey of demographic information is included in this qualitative study. Face-to-face interviews were conducted with 12 participants at the SCCAC. Each interview lasted about 10-15 minutes and was audio recorded. Participants were interviewed at the SCCAC after their child or children’s interview and/or exam had been completed. Caregiver interviews were transcribed and examined for themes and pertinent information by both researchers. Confidentiality and anonymity were upheld by using participant pseudonyms, destroying the audio tapes after the conclusion of the study, and having the caregivers mark an “X” on the consent forms rather than using their signature.
CHAPTER FOUR
RESULTS

Introduction

In this chapter, demographics and characteristics representing the non-offending caregivers interviewed in this study will be presented. Major findings regarding logistics, thoughts, feelings, and impressions will be presented as well.

Presentation of the Findings

Demographics

The sample population consisted of twelve non-offending caregivers who were at the center and completed the interview. Females represented 83.3% of the sample while the males represented 16.7%. The participants ages ranged from 22 to 67. 8.3% of the participants were African American, 8.3% were Asian/Pacific Islander, 8.3% were one or more ethnicities, 25% were White/Caucasian, and 50% were Hispanic or Latino. Fifty percent of the participants stated that this was their first time to the center. The relationship between the participants and the children that were seen at the center was also looked at. The participants that brought the children to the center consisted of 66.7% the mother, 16.7% the children’s father, and 16.7% was identified as other (foster parent). Participants brought 1 to 3 children who were seen at the center
The majority (78.9%) of the children seen were female and 21.1% were male. There were no children aged 7-11 months represented from this sample of participants, however, children aged 0-6 months old represented 5.3%, children aged 8-13 years old represented 21.1%, children 14-18 years old represented 31.6% and the largest represented aged range was 1-7 years old at 42.1%.

**Logistics**

Participants were asked how they got to the center on the day of the interview. All twelve participants stated that they drove their personal vehicle. When asked if the participants traveled more than 10 miles to the center, 9 out of the 12 participants stated that they drove more than 10 miles to get to the center. The average mileage that these participants had to drive was 50 miles. It was also the furthest the participants had to drive and the shortest distance was 5.5 miles. The sample was asked if they found it difficult to get to the center on the day of the interview. Half of the participants stated that it was not difficult to get to the center. The other participants stated that it was hard because they had to take their children out of school or they had to take off work to be able to make the appointment. One participant stated that, “when we initially found out what happened, they took off [school], and now they’ve been taking a day here and a day there, so they are getting behind in school” (Participant 6, March 2017). Another participant stated that, “finding the place, actually, it was hard” (Participant 8, March 2017). The sample was also asked how long they had to
wait in the lobby before being seen at the center. All of the participants stated that they arrived early for their appointment and provided a variety of wait times. The participants did state that they were taken back on time for their appointment. The wait time that the participants stated ranged from 10 minutes to 45 minutes with the average wait time of 15 minutes.

**Operational**

The sample was asked if they received any information about the center prior to the appointment. Six of the participants stated that they did not receive any information. One of the participants stated that, “it was fully [explained], exactly what you guys did today was told to me” (Participant 8, March 2017). Many of the participants stated that they were given some information such as an appointment time and date, as well as, if the children were getting an interview or an exam. Researchers inquired about how the staff treated the participants upon check-in. The participants stated that the staff was friendly and nice. One participant stated that the staff was “friendly, courteous, professional” (Participant 12, March 2017). Another Participant stated, “the dog is awesome” (Participant 5, March 2017). When asked about how the staff treated the participants in the exam/interview room, the participants stated that the staff was friendly, nice, and great. Participant 6 (March 2017) stated “they’ve been very nice. The advocate was very nice and the one that’s interviewing my daughter is very nice. The detective is a little bold, but I guess that’s just how they’re supposed to be. She doesn’t have a friendly demeanor”.

29
The sample was asked about how the staff treated the participants upon completion. The participants overall stated that the staff treated them good, that they were great and that the staff was friendly. One participant stated, “they’ve all been very attentive. They’ve all explained things” (Participant 7, March 2017). Participants were asked if they received services outside the center. Nine out of the twelve participants were referred to counseling services though Victim’s services. Two of the participants were not referred to any outside services and one participant stated that the social worker would follow-up with the participant. Participants were also asked if they were informed about what to expect after leaving the center. Seven of the participants stated that they were not informed and five participants stated that they were informed about what to expect. A participant stated. “actually, yes, the staff here as well as the detective, both, especially the first time with the physical examination, they let us know exactly what was going to happen; what was going to happen with the results, what was going to happen with the pictures that were taken, so that we knew where all that stuff was going” (Participant 1, March 2017).

**Center Impressions**

The sample was asked about how the child felt about coming to the center on the day of the interview. Five of the participants stated that their children were scared and nervous about coming to the center. Two stated that their children did not want to come and that it was bothering them about coming to the center.
Other participants stated that their children felt fine or that they felt good because they knew why they were there.

They were, you know, nervous, and especially, it was, what happened to them was a lot more fresh, so of course, they were very nervous about what was going to happen, but once we got here the atmosphere was very calm and child friendly, so it was fine. When I told them that we were coming back today, and of course they remembered the dog, so I told them, we’re going back to that place with the big dog, and this time they’re just going to talk to you. So, knowing that they were coming back here they were totally at ease (Participant 1, March 2017).

Two participants stated that they told their children that they were at the center for a regular doctor’s appointment or that their children were unaware. Researchers then inquired about how the children were feeling after they were seen at the center on the day of the interview. Participants stated that overall their children felt better or happy after being seen. One participant stated that, “no, she’s still upset. I think a little bit more anxiety since now we just have to wait to see what’s gonna happen” (Participant 6, March 2017).

Researchers inquired about the participant’s initial thoughts or feelings about coming to the center. Overall, participants stated that they were nervous, scared or did not know what to expect. One participant stated that, “to be honest, we thought it was like another police station for kids. You know, regarding kids. That’s what I thought, but once we got here I liked it. It’s a friendly place. They
have the area for the kids, and then they have the dog, so that makes it more comfortable” (Participant 2, March 2017). Another participant stated, “it’s hard because like nobody wants to be in this situation, but as a parent we have to do it, so it’s hard and it’s been really hard with our family, but we’re trying to get past it” (Participant 6, March 2017). Participants were also asked about their current thoughts and feelings about the center. The participants stated that they felt good and that the center was great and wonderful. One participant stated, “our interaction with everybody here has been really, really positive” (Participant 1, March 2017). Another participant stated, “it’s very comfortable, aesthetically so, and everyone’s been really kind” (Participant 5, March 2017). Finally, the participants were asked about their overall experience at the center on the day of the interview. All of the participants stated that the center was very positive, kid friendly, and professional. One participant stated, “awesome, great. I was really pleased actually. Even walking in it’s such a great atmosphere. I didn’t expect that” (Participant 8, March 2017).

Summary

In summary, this chapter presented the demographics and major findings regarding the experiences of non-offending caregivers at a Southern California Children’s Assessment Center. Furthermore, the opinions and experiences derived from 12 face-to-face interviews were used to illustrate the findings that were presented.
CHAPTER FIVE

DISCUSSION

Introduction

This chapter will include a discussion about the findings presented in the previous chapter. Limitations of the study will also be presented, in addition to recommendations for policy and research in the field of social work. This chapter will close with a brief discussion about the implications for social work practice and a summary of findings.

Discussion

The purpose of this study was to explore the experiences of non-offending caregivers with the SCCAC. There were a total of 12 face-to-face interviews conducted at the center, which consisted of primarily females, with participants from a wide age range, and of a predominately Hispanic or Latino background. Notably, the disproportionate Hispanic or Latino sample size of 50% is in line with the most currently reported demographic statistics for the sampled region, according to the United States Census Bureau for the year 2015, which reflects a 49.2% Hispanic or Latino population (United States Census Bureau, 2017).

The results of this study are consistent with existing literature stating that caregivers were generally satisfied with their overall experiences at a children’s
assessment center, citing staff responsiveness, courteousness, and helpfulness as among the factors which improved their service experiences (Bonach et al., 2010). Bonach and colleagues (2010) utilized a small sample size as well, which markedly yielded the same results of the SCCAC caregiver study. Furthermore, in a study conducted by Newman, Dannenfelser, and Pendleton (2006) a relatively large group of social workers and law enforcement officers narrowed down the reasons that they use the CAC’s as a friendly environment for their clients and positive CAC procedures; notably these are the primary professionals utilizing these centers on a consistent basis.

Additional findings reflected the caregivers’ and children’s awareness of the SCCAC’s child-friendly environment, staff and professional approach, along with other factors designed to mitigate the fear and trauma in clients, such as the SCCAC’s dog. As stated in chapter 4, one participant noted that the children were able to identify the location of their return appointment by their positive experience at the place with the big dog, which put them more at ease; it is important to note that the dog was spoken of quite fondly by clients throughout the researchers’ time at the center. Moreover, clients spoke of the professionalism of those involved, informational content, and specific referrals provided to them. These findings coincide with previous literature, which found that caregivers had a high level of satisfaction and children were less scared at four different CAC’s throughout the United States that utilized similar techniques and atmospheres (Cross et al., 2008). Study findings also reflect that the majority
of participants reported receiving referrals to counseling, which supports the
aforementioned service techniques being used to minimize client trauma, which
Wherry and colleagues (2015) identify as a factor in CAC’s positive reviews.
Furthermore, children whose needs are serviced at a CAC are more likely to
receive often necessary mental health referrals (Cross et al., 2008).

Limitation

This study had three primary limitations. First, the limited sample size of
12 participants only allowed for a minimal representation of the targeted
population. This was a result of a pre-determined time-period for interviews and
limited availability of sampling. Another limitation was found in the nature of
caregivers willing to participate in the survey; researchers found that only
caregivers who had positive experiences and were not visibly upset said yes to
the interviews. Researchers are unable to determine whether the responses from
those individuals would have remained positive or been less favorable. Finally,
as projected, the significantly limited scope of questioning and confidentiality
constraints required the interviewer to not ask follow-up questions to certain
responses and to ask the participant to please refrain from discussing any details
pertaining to their case even when they may have wanted to explain their visit in
greater detail.
Recommendations for the Social Work Practice, Policy and Research

The results from this study reflect a need for continued training and curriculum enhancement for social workers who engage with individuals that have been affected by trauma. The surveyed population was interviewed during the initial stages of investigation, which can be the most traumatic and difficult time for many families. The respondents’ answers indicate a clear level of overall satisfaction when they were provided appropriate services in a trauma-informed manner. During this time period individuals are often going through the necessary legal processes, child welfare system, and victim’s services steps that accompany child abuse investigations. In order to minimize the long-term effects of potentially traumatic events, policy should begin dictate that all social workers be educated in TIC. This type of training could be beneficial to micro practitioners and support staff who are working with victims and families during the frontend of service. TIC has evolved greatly over the last few decades and its techniques and approaches could be useful to professionals who may not have had much exposure to such material during their previous education or training.

The study conducted at the SCCAC was intended to be a pilot study, which was meant to gain knowledge about caregivers’ overall experiences at the center and to gauge the population’s willingness to participate in future studies, which required a smaller sample size than a more in-depth study would. Findings indicate that the majority of caregivers are willing to participate in the in-person style interviews while at the SCCAC, which could eliminate the risk of non-
responsiveness from mailed surveys, telephone calls not yielding significant data, or inconsistent third party findings. Therefore, more in-person research should be conducted utilizing a larger sample size over a longer period of time to possibly determine a more representative sample of caregiver responses about their experiences with the SCCAC.

Conclusion

This study finds that the overall experiences of caregivers at the SCCAC were positive. Findings from this study also reflect those of previous studies done at other centers around the country that utilize the CAC model. The evidence indicates a need for continued implementation and development of education, training, and policy in the area and use of trauma-informed care during the initial phases of investigation in order to improve outcomes for victims, families, and caregivers.
Demographic Information

Instructions
Please select the option that best fits you. Thank you for your participation.

1) How many children do you have that are being seen today? ___________

2) How do you Identify?
   a. Male
   b. Female
   c. Transgender FTM (Female-to-Male)
   d. Transgender MTF (Male-to-Female)
   e. Non-Binary/gender fluid/genderqueer
   f. Prefer to self-describe: ___________
   g. Prefer not to say

3) What is your Age? ___________

4) What is your Ethnicity?
   a. African American
   b. Asian/ Pacific Islander
   c. Hispanic or Latino
   d. Native American
   e. White/Caucasian
   f. One or More Ethnicities
   g. Other/ Not Listed

5) Is this your first visit to the Children’s Assessment Center?
   a. Yes
   b. No

6) What is the gender of your child(ren)?
   _______ Male
   _______ Female
   _______ Transgender FTM (Female-to-Male)
   _______ Transgender MTF (Male-to-Female)
   _______ Non-Binary/gender fluid/genderqueer
   _______ Prefer to self-describe: ___________
   _______ Prefer not to say

7) What is the age range of your child(ren) being seen today?
   _______ 0-6 months
   _______ 7-11 months
   _______ 1-7 years
   _______ 8-13 years
14-18 years

8) What is your relationship to the child(ren)?
   a. Mother
   b. Father
   c. Brother
   d. Sister
   e. Grandmother
   f. Grandfather
   g. Aunt
   h. Uncle
   i. Cousin
   j. Other

Developed by: Santia Magallanes and Jenilynn Pendergraft
APPENDIX B

INTERVIEW GUIDE
Interview Guide

What method of travel did you use to get to the Children’s Assessment Center today? (e.g. personal vehicle, public transportation, ride from a friend or family member)

Did you travel more than 10 miles to get here today? YES or NO
   If so, can you please tell me approximately how many miles?

Would you say it was difficult for you to get here today? If yes, why? (e.g. taking time off of work, childcare, scheduling flexibility, distance, finding the location, etc.)

What type of information did you receive about the Children’s Assessment Center prior to your appointment today? (e.g. what to expect, how long you would here, etc.)

Approximately how long did you wait in the lobby before being seen?

How did your child feel about the Children’s Assessment Center before coming today?

How is your child feeling now that he/she has been seen?

What were your initial thoughts or feelings about coming to the Children’s Assessment Center today?

What are your current thoughts or feelings about the Children’s Assessment Center?

How did the staff treat you upon check-in?

How did the staff treat you during the exam/interview room?

How did the staff treat you upon completion?

Did the staff refer you to services outside the Children’s Assessment Center? Yes or No
   If so, would you mind informing us which services? Or are you planning on following through with those referrals?
What information, if any, did the staff give you about what to expect after leaving here today?

Overall, how was your experience at the Children’s Assessment Center?

Developed by: Santia Magallanes and Jenilynn Pendergraft
The study in which you are asked to participate is designed to explore non-offending caregivers' experiences at the Children's Assessment Center of San Bernardino. The study is being conducted by MSW students, Saninia Malianes and Jeni Lynn Pendergraft, under the supervision of Dr. Carolyn McAllister, Associate Professor in the School of Social Work, California State University, San Bernardino. The study has been approved by the Institutional Review Board Social Work Sub-committee, California State University, San Bernardino.

PURPOSE: The purpose of the study is to explore non-offending caregivers' experiences at the Children's Assessment Center of San Bernardino.

DESCRIPTION: Participants will be asked questions about practical concerns, overall comfort while at the center, staff courteousness and helpfulness, availability of literature, their experiences during their time spent at the Children's Assessment Center of San Bernardino, and some demographics.

PARTICIPATION: Your participation in the study is completely voluntary. You can refuse to participate in the study or discontinue your participation at any time without any consequences.

ANONYMITY: Your responses will remain anonymous and data will be reported in group form only.

DURATION: It will take 20 to 30 minutes to complete the interview.

RISKS: There are no foreseeable risks to the participants.

BENEFITS: There will not be any direct benefits to the participants.

AUDIO: You will be audio recorded for clarity and to ensure accurate data collection. These will be studied by the research team for use in the research project only. Please initial the following statement:

I understand that this research will be audio recorded, and agree to be recorded for use by the research team only. Place an X mark here: Yes _______ No _______

CONTACT: If you have any questions about this study, please feel free to contact Dr. Carolyn McAllister at 909-537-5559. If you have any questions or concerns regarding
the center, please feel free to contact Nancy Wolfe, Director at the Children's Assessment Center, at (909) 382-3535.

RESULTS: Results of the study can be obtained from the Pfau Library ScholarWorks (http://scholarworks.lib.csusb.edu/) at California State University, San Bernardino after December 2017.

This is to certify that I read the above and I am 18 years or older.

Place an X mark here _____________  Date _____________
APPENDIX D

DEBRIEFING STATEMENT
This study you have just completed was designed to explore the experiences of non-offending caregivers at the Children's Assessment Center of San Bernardino. We are interested in obtaining direct feedback from caregivers about their individual experiences at the Children's Assessment Center of San Bernardino, in order to help the center's staff and administration identify what is working well, areas that may need improvement, and overall gaps in service. This is to inform you that no deception is involved in this study.

Thank you for your participation. If you have any questions about the study, please feel free to contact Dr. Carolyn McAllister at 909-537-5559. If you have any questions or concerns regarding the center, please feel free to contact Nancy Wolfe, Director at the Children's Assessment Center, at (909) 382-3535.

If you would like to obtain a copy of the group results of this study, please contact Dr. Carolyn McAllister (email: cmcallis@csusb.edu) after June 2017.
APPENDIX E

INSTITUTIONAL REVIEW BOARD APPROVAL FORM
CALIFORNIA STATE UNIVERSITY, SAN BERNARDINO
SCHOOL OF SOCIAL WORK
Institutional Review Board Sub-Committee

Researcher(s) ____________________________
Proposal Title ____________________________

# 301723

Your proposal has been reviewed by the School of Social Work Sub-Committee of the
Institutional Review Board. The decisions and advice of those faculty are given below.

Proposal is:

☐ approved
☐ to be resubmitted with revisions listed below
☐ to be forwarded to the campus IRB for review

Revisions that must be made before proposal can be approved:

☐ faculty signature missing
☐ missing informed consent ☐ debriefing statement
☐ revisions needed in informed consent ☐ debriefing
☐ data collection instruments missing
☐ agency approval letter missing
☐ CITI missing
☐ revisions in design needed (specified below)


Committee Chair Signature ____________________________ Date 11/1/2017

Distribution: White Coordinator; Yellow Supervisor; Pink Student
REFERENCES


ASSIGNED RESPONSIBILITIES PAGE

This was a two-person project where authors collaborate throughout. These responsibilities were assigned in the manner listed below.

1. Data Collection:
   Team Effort: Santia Magallanes and Jenilynn Pendergraft

2. Data Entry and Analysis:
   a. Data Entry
      Team Effort: Santia Magallanes and Jenilynn Pendergraft
   b. Data Analysis
      Team Effort: Santia Magallanes and Jenilynn Pendergraft

3. Writing Report and Presentation of Findings:
   a. Introduction and Literature
      Team Effort: Santia Magallanes and Jenilynn Pendergraft
   b. Methods
      Team Effort: Santia Magallanes and Jenilynn Pendergraft
   c. Results
      Team Effort: Santia Magallanes and Jenilynn Pendergraft
   d. Discussion
      Team Effort: Santia Magallanes and Jenilynn Pendergraft