Sexuality Counseling Guidebook

Key Issues for Counselors and Other Mental Health Professionals

Volume VIII
Special Theme: Sexual Trauma

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PROLOGUE

This is the eighth volume of the Sexuality Counseling Guidebook, and it was created by students in the Summer 2015 course, Advanced Clinical Topics in Couple and Family Counseling: Sexuality Counseling, in the Department of Counseling and Educational Development at the University of North Carolina at Greensboro. Students in this course are advanced-level master's students, typically in the Couple and Family Counseling and Clinical Mental Health Counseling tracks. The focus of this volume of the Sexuality Counseling Guidebook is on counseling related to sexual trauma.

What does it mean for a client to have positive sexuality?

When talking about positive sexuality with clients, qualities that should *not* be included are negative, shaming attitudes towards the client's sexuality and body image. While we recognize that healthy boundaries should exist within a client's sexual functioning, counselors should strive to promote an increased level of openness around client sexuality. Additionally, counselors should recognize the socialization and cultural institutionalization of sex in our society in combination with a client's personal value system and upbringing. However, we hope that counselors can help facilitate clients overcoming more systemic views of negative sexuality and develop their own authentic values around positive sexuality.

In what ways can sexual trauma hinder clients' ability to move toward positive sexuality?

Sexual trauma can have lasting effects on individuals' views of sexuality. Although responses to traumatic experiences can vary, they tend to lead to a number of difficulties in relation to sexuality. Trauma can lead to negative views of sex and the body and can lead to a climate of secrecy that inhibits conversations about sexuality. Individuals could also develop hyposexual or hypersexual responses and may struggle with issues of power and control in their lives and future relationships. In addition, trauma can affect views towards positive sexuality that could become systemic in their own families and intergenerational patterns. Traumatic experiences may also lead to a lack of emotional connection during sexual engagement, and individuals may have difficulty understanding and engaging in intimacy. Victims and survivors may have high levels of internalized shame and responsibility in regards to the trauma as well as symptoms of post-traumatic stress.

How can counselors help clients move toward positive sexuality in the aftermath of sexual trauma?

Counselors should see the uniqueness in the client's story, understand their values and expectations when it comes to sexuality, and cater their interventions to the client's goals. It is vital for counselors to recognize and validate common reactions of shame and guilt, and then normalize them. Additionally, counselors can be instrumental in aiding clients to challenge and reframe their distorted or scarred perceptions of sexuality. Ultimately, the therapeutic alliance should empower the client to develop towards positive sexuality in the aftermath of sexual trauma.

How can counselors deliver interventions that are sensitive to the unique needs of clients who have experienced sexual trauma?

Each individual and family impacted by sexual trauma will have unique needs. Counselors can best meet their clients' needs by meeting the client where they are in their healing process. It is important to encourage the client's input into the type of interventions and pace that is used in session. The use of evidence-based practices can facilitate appropriate, trauma-informed care. Additionally, counselors should be aware that clients can be retraumatized through discussing their trauma and provide for opportunities for the client to take breaks to ground themselves or determine what information they do or do not feel comfortable sharing. A potential tool for use in sessions could be anchoring through use of the senses, to maintain a feeling of safety and security in the present moment. Generally, it is of the utmost importance to maintain the client's sense of safety, both in session and beyond.

Please see Dr. Christine Murray's faculty web-page to access previous volumes of this guidebook: http://ced.uncg.edu/people/faculty-profiles/dr-christine-murray/.

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Chapter 1: Child Sexual Abuse

By Alan Ackerly, Helen Marie Humphrey, and Rossana Magalhaes

Background and Introduction

Many children are survivors of sexual abuse. With researchers espousing a large number of different estimates of the frequency of sexual abuse of children, it is difficult to determine the exact number of victims. Although the rates of childhood sexual abuse have been decreasing (Finkelhor, 2009), one common estimate is that between 30-40% of females and 13% of men are survivors of child sexual abuse (Bolen and Scannapieco, 1999). There are estimates both above and below the statistics cited by Bolen and Scannapieco (1999), but it is clear that at least tens of thousands of children experience sexual abuse every single year in the U.S. (Douglas and Finkelhor, 2015). The unfortunate frequency of sexual abuse of children dictates that professional counselors must be prepared to work with this population. Even counselors who do not work directly with children will likely need to serve survivors of childhood sexual abuse as the repercussions of this type of abuse can arise in couple's counseling, family counseling, substance abuse counseling, and individual adult counseling.

This chapter will provide a basic primer to understanding the impact of sexual abuse on children as well as how professional counselors can best support survivors. Because most incidents of child sexual abuse occur between a child and someone they know and trust (Finkelhor, 2009), survivors may struggle with trusting others or building healthy intimate relationships (Godbout, Sabourin, & Lussier, 2009). By intervening early and beginning the healing process as soon as possible, professional counselors can support children survivors of sexual abuse to work with any trauma from the abuse in order to attempt to identify and modify any harmful behaviors and beliefs before they become deeply entrenched. Children communicate differently from adults and are impacted differently from sexual abuse, so it is essential that counselors take a child-focused approach when working with child survivors of sexual abuse.

Review of Relevant Research

Child sexual abuse (CSA) occurrence, its consequences, preventive interventions, and aftereffects have been the focus of attention for academic, civil, and governmental organizations for more than three decades. Throughout those years, the literature in CSA has expanded significantly and has become highly inter-disciplinary. The amount of empirical research is vast in number and in areas of interest. Therefore, for the purpose of this work, we will address three areas related to counseling sexually abused children: prevention, interventions and empirically supported treatments.

According to The National Child Abuse and Neglect Data System (NCANDS), in 2008 approximately 772,000 children were victims of child abuse and neglect. Nine percent of them suffered sexual abuse. A recent longitudinal study, including 118 mother-child dyads, found that 50% of the perpetrators were members of the family and 48% were non-family members (Zajac, Ralston & Smith, 2015). Definitions of CSA differ among authors and organizations. According to the Child Abuse Prevention and Treatment Act (acf.hhs.gov, 2015), the term *sexual abuse* includes the persuasion or coercion of a child to engage or assist others to engage in any sexually explicitly behavior, which includes such acts as rape, statutory rape, prostitution, molestation, incest or other form of sexual abuse of children.

Preventive efforts, aiming to reduce the incidence of CSA, have increased in the last years. Child-centered prevention programs continue to be developed, intending to lessen the incidence of child sexual abuse through expanding knowledge of children on the subject. The effectiveness of a newly developed prevention program named "Cool and Safe," based in Germany, showed an increase in familiarity with behavior intentions and secure behaviors. It also showed greater intentions from children who participate in these programs to show their emotions and report eventual negative experiences they have experienced (Müller, Röder & Fingerle, 2014). The use of Internet to promote

and deliver preventive programs has become a trend. A study highlighting the perspectives of web-based training compared to face-to-face training concluded that the Internet should be included as a topic (e.g. internet safety issues) and as a methodology (e.g. E-Learning), and demonstrated that children highly accept Internet based training (Mueller, Röder, Hein, Fingerle & Maisch, 2014).

Counselors need to be prepared and aware of the diversity of interventions suited to child victims of sexual abuse. It is central for mental health professionals to explore direct and indirect support systems that could be available for victims and their families. Counselors working with child victims of sexual abuse may be able to increase treatment outcomes upon involving the non-offending mothers or maternal figures into treatment. According to Zajac et al. (2015), maternal support following disclosure of sexual abuse has positive implications for short and long-term adjustment of child victims of sexual abuse. In addition, the study concluded that if the victim's mother had an unforgiving behavior, it ultimately was linked to self-report of higher PTSD symptoms. Sexually abused children present a variety of emotional and behavioral distress after the disclosure of the abuse. They could present for counseling when experiencing diverse symptomatology such as emotional dysregulation, anger, self-injury, and PTSD.

Therefore, counselors should aim to use person-oriented interventions to better understand and address the complex topic of child sexual abuse (Sawyer & Hansen, 2014). The present literature on child sexual abuse also suggests Trauma-focused cognitive behavioral therapy (TF-CBT) and the trauma narrative intervention as an empirically supported approach to address CSA. The narrative intervention presented in a safe environment, provides the child with the support to facilitate and recall the information of their abuse, the inherent painful process of disclosure and the facilitation of the healing process (Foster, 2014).

Possible Counseling Issues

There are many counseling issues that may arise while working with a child survivor of sexual abuse. Firstly, the counselor must understand the legal implications of child sexual abuse, be willing to testify in court as needed, coordinate with various agencies, monitor for risk factors, and engage in advocacy efforts (Gil, 1991). Counselors should be prepared to look for, and treat, a range of symptoms, including those of Posttraumatic Stress Disorder, and depression, as well as somatic symptoms. Low self-esteem, psychological distress, sexualized behaviors, behavioral issues, issues with memory, problems with academic functioning, and lack of social skill may also manifest as symptoms (Benuto & O'Donohue, 2015). When conceptualizing a case, the counselor should consider developmental factors (i.e. age), the client's relationship to the offender, the family's level of dysfunction, and environmental stability (Gil, 1991).

In severe cases, the counselor may encourage the caretaker to obtain an fMRI of the child's brain, in order to assess potential physiological effects of sexual abuse (Hart & Rubia, 2012). Discerning abnormal brain structure and functioning as a result of sexual abuse would provide target areas for therapy, and influence the practitioner's approach to treatment. It may also expand the counselor's insight into and compassion for more challenging clients. Furthermore, such knowledge would provide the opportunity to collaborate with other healthcare professionals in order to provide holistic care.

While sexual abuse is always a violation, children do not always experience it as traumatic (McNally & Geraerts, 2009). In such cases, the counselor should skillfully address whatever symptoms may be present (i.e. somatic symptoms), and discuss the sexual abuse event without transferring a sense of trauma onto the child survivor. It is imperative that the counselor views each child survivor as a unique individual whose experience of sexual abuse should not be overgeneralized (Gil, 1991).

The type of therapy selected for treatment should be determined by the child's most pressing symptoms. For example, CBT has been shown to be more effective in addressing low self-concept, behavioral problems, and distress, while play therapy typically better addresses social functioning

(Benuto & O'Donohue, 2015). Decisions to include family members, or to utilize group therapy should also be considered according to the presenting problem, and should not compromise the client's safety.

Additional Guidelines for Counseling Practice

It is important for the counselor to maintain a holistic approach to the process, and to consider biopsychosocial implications of abuse. The counselor would do well to consider Bronfenbrenner's (1979) ecological model of human development when conceptualizing a case, in order to understand the child's needs, including the need for the counselor's advocacy on his or her behalf (i.e. working with teachers to ensure greater safety at school).

The counselor must consider culture-of-origin values throughout the counseling process in order to provide effective treatment. For example, children, or their parents, may refrain from confronting a related offender, in order to preserve the family unit, if their culture values family togetherness above individual wellbeing (Kenny & McEachem, 2000). Such cases require a creative approach to ensuring safety and prevention in accordance with the law that also seeks to honor the client's values.

The counselor should also pay attention to the implications of sexual abuse upon a client's spirituality. While it may be outside of the counselor's scope of practice to implement spiritual interventions, he or she should assess the child's spiritual development, and make referrals as needed (Ganje-Fling & McCarthy, 1996). Spirituality often provides ways to cope with trauma, which can be explored in counseling; but trauma can also create internal conflict over one's spiritual beliefs. For example, feelings of despair and hopelessness may arise when questioning why God allowed the sexual abuse to occur, which can contribute to low self-worth and self-blame (Ganje-Fling & McCarthy, 1996). By exploring both the spiritual and psychological work that needs to be done, the counselor can provide a more holistic approach to treatment, even for young clients.

What resources are available to help professionals learn more about this topic?

Online PDF Booklets:

- Child Physical and Sexual Abuse: Guidelines for Treatment
    - https://mainweb-v.musc.edu/vawprevention/general/saunders.pdf
- Sexual Abuse Counseling: A Guide for Parents and Children
    - http://www.ksacc.ca/docs/sexual_abuse_counselling_a_guide_for_parents_and_children.pdf?LanguageID=EN-US
- Child Sexual Abuse Prevention and Risk Reduction
    - http://www.nsvrc.org/sites/default/files/Publications_NSVRC_LiteratureReview_Child-Sexual-Abuse-Prevention-and-Risk-Reduction-review-for-parents_0.pdf
- Preventing Child Sexual Abuse Within Youth-serving Organizations
    - http://www.cdc.gov/violenceprevention/pdf/PreventingChildSexualAbuse-a.pdf

Web sites:

- The Sexual Assault Center
    - http://www.sacenter.org/home
- The Children's Bureau
    - http://www.acf.hhs.gov/programs/cb/focus-areas/child-abuse-neglect
- The Crimes Against Children Research Center
    - http://www.unh.edu/ccrc/index.html
- The National Children's Alliance
    - http://www.nationalchildrensalliance.org

Books:

- *Emotion Regulation in Psychotherapy: A Practitioner's Guide*
    - Leahy, R. L., Tirch, D. D., & Napolitano, L. A. (2011). *Emotion regulation in psychotherapy: A practitioner's guide*. New York: Guilford Press.

- *ACT Made Simple: An Easy-to-Read Primer on Acceptance and Commitment Therapy*.
    - Harris, R. (2009). *ACT made simple: An easy-to-read primer on acceptance and commitment therapy*. Oakland, CA: New Harbinger Publications.
- *The Healing Power of Play: Working with Abused Children*
    - Gil, E. (1991). *The healing power of play: Working with abused children*. New York: Guilford Press.
- Child Sexual Abuse: Best Practices for Interviewing and Treatment
    - Mueller, A., Röder, M., Hein, S., Fingerle, M., & Maisch, E. (2014). Preventing child sexual abuse: Web-based training as a promising step. *Psychology And Education: An Interdisciplinary Journal*, *51 (1-2)*, 14-25.

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Chapter 2: Male Victims of Sexual Assault

By Jennifer Schenker and Sation Konchellah

Background and Introduction

Sexual assault is widely believed to be a crime perpetrated primarily against women. While 91% of sexual assaults are perpetrated against women, the remaining 9% account for over 2 million men in the United States that have been the victim of sexual assault or rape (National Sexual Violence Resource Center, 2015). By definition, "Sexual assault of men can include unwanted touching, fondling, or groping of a male's body including the penis, scrotum or buttocks, even through his clothes. Rape of a man is any kind of sexual assault that involves forced oral or anal sex." (Brown University Health Promotion, 2015). According to the National Sexual Violence Resource Center, rape is the most under-reported crime. It is estimated that 65% of sexual assaults are not reported to law enforcement officials (NSVRC, 2015). It is believed that traditional male social norms associated with strength, power, and masculinity further impact reporting, thus it has been difficult for researchers to collect accurate statistics. The numbers listed above are likely gross underestimates. Furthermore, reporting sexual assault of men is often impacted by the perception that it may be more difficult for men to be taken seriously or believed (Kassie, 2015).

Additional factors that may deter men from reporting sexual assault may be tied to myths correlating sexual abuse or assault with the victim being gay if the perpetrator was also male. Inasmuch, Bullock and Beckson state that reasons for excluding consideration of males as victims have been manifold. They contend that these reasons often include 1) the misconceptions that men in the civilian community simply cannot be victims of sexual assault; 2) that the incidence of sexual assault of males is so rare as to not merit attention; 3) that male victims are more responsible for their assault than female victims; and 4) that male victims are more likely to be homosexual and therefore actually wanted the assault" (2011). In addition, male victims are less likely to come forward which consequently further skews existing the data. Kassie also notes that gay men may be targets of sexual assault because of gay-bashing, or due to the assailant's own conflicting feelings of attraction to other men. The author further states that it can be difficult for gay men to come forward due to the mistaken perception of the LGBTQ community as promiscuous (Kassie, 2015).

Awareness of barriers to accessing mental health counseling, unique challenges associated with male victims of sexual assault and treatment considerations for a traumatic experience that is frequently misunderstood and underappreciated in mainstream culture is key to providing support services to male victims of sexual assault. This chapter will provide an overview of the relevant research, counseling considerations and resources for counselors working with male victims of sexual assault.

Review of Relevant Research

According to the most recent National Crime Victimization Survey (NCVS) conducted by the Bureau of Justice Statistics, over the past 10 years, the prevalence of reported sexual assaults perpetrated against male victims ranged from a low of 2.4% of reported assaults in 2004 to 37.8% of reported sexual assaults in 2012 (U.S. Department of Justice, 2014). In 2013, 11.3% of the reported sexual assaults that were included in the NCVS were perpetrated against male victims. The literature notes that there is a paucity of research and data regarding male victims of sexual assault (U.S. Department of Justice, 2014). While one factor may be that the overall proportion of male victims is small compared to the numbers of female victims, societal constructs of masculinity and hegemony may also contribute to the number of victims that come forward. Sexual assault is a traumatic experience and the reporting process can be arduous at best. There might be many different reasons for male victims to avoid reporting their assaults.

In many societies, including those in the West, men are often seen as hypersexual beings who would almost never turn down sex, particularly heterosexual sex. According to an article in the American Journal of Public Health, authors Stemple and Meyer state, "The idea that, for men, virtually all sex is welcome likely contributes to dismissive attitudes toward male sexual victimization" (Stemple and Meyer, 2014). It is not uncommon for people to gender stereotype when it comes to sexual assault; women are often seen as "victims" and men as "perpetrators" when that is not always the case. This problematic understanding of sexual assault may exacerbate issues with underreporting and victims seeking support. Stemple and Meyer mentioned, "Not only does the traditional sexual victimization paradigm masks [sic] male victimization, it can obscure sexual abuse perpetrated by women as well as same-sex victimization" (2014). Traditional definitions of sexual assault and rape marginalize and disenfranchise many different people which could potentially lead to increased shame, underreporting, and victim-blaming. It is not uncommon for male victims to be seen as "weak" because they did not stand up for themselves and many people may not believe that it is "possible" for males to be victims of sexual assault. Researchers Bullock and Beckson reported, "Male victims are held more accountable in scenarios where they do not offer resistance and do not fight back or appear scared, which is especially problematic, as many male and female victims react to extreme physical threats with 'frozen helplessness'" (2011). Traditional definitions of rape often refer to penetration which does not account for situations where a male might be made to penetrate someone else. Stemple and Meyer add that "...to the extent that males experience nonconsensual sex differently (i.e., being made to penetrate), male victimization will remain vastly undercounted in federal data collection on violent crime" (2014).

Possible Counseling Issues

Seeking help can be an initial barrier for male victims who may find themselves devoid of social support systems. Sexual abuse or rape crisis centers rarely provide treatment that is designed for male survivors. Further, as previously discussed, there can be reluctance to come forward and disclose sexual assault to law enforcement or medical professionals because of societal gender stereotypes. Perceptions of male victims by counseling professionals and victims perceptions of the how they will be received in reporting and/or seeking counseling may have a great impact on the likelihood of seeking help from a mental health professional after an assault. Issues that may arise surround male victims' sexual or gender identity after a sexual assault (National Alliance to End Sexual Violence, 2015). Questions about masculinity, manhood, shame or self-doubt may cause internal conflict or turmoil. Physiological responses such as experiencing an erection or ejaculation during the assault may also cause confusion, shame or self-doubt, although they are involuntary responses. Effects of a sexual assault may include flashbacks, anxiety, depression, Post Traumatic Stress Disorder (PTSD), rape-related phobias, sleep disturbance, sexual dysfunction, Sexually Transmitted Infections (STIs), anger, or social isolation in addition to a host of other psychological or physiological stressors.

As counselors, understanding how our own responses can impact a client and range from providing a safe, empathic place of where healing can begin to retraumatization, distrust and feelings of betrayal related to mental health professionals (Denov, 2003). It is important that counselors provide a positive, supportive and understanding stance demonstrating empathy, and understanding of the distress and/or fear that conversations about the assault may evoke. Being sure to take the assault seriously- being both compassionate and professional in the handling of this sensitive information. Employing an awareness and avoidance of negative responses. Especially being cognizant of resistance to discussing, minimization, reactions of shock and/or disbelief and appearing uncomfortable and referring to a trauma specialist when appropriate or consulting when necessary.

Additional Guidelines for Counseling Practice

As always, it is important that counselors uphold the ethical guidelines of the American Counseling Association. The moral principles of justice, beneficence, and nonmaleficence would be

particularly relevant when working with clients who have been sexually victimized as well as maintaining a non-judgmental attitude, sensitivity and respect. Similar to other instances of abuse, counselors should take care to listen for what is unsaid; paying close attention to nonverbal behaviors in addition to cues that may be present when a young person or child describes their experience. Words or phrases can give insight into complex issues that a client may be facing to include: social pressures, peer group factors or internalized oppression (Durham, 2003). When clients present with sexual trauma it is important to create a safe clinical environment and to ensure that all steps are taken to minimize triggering. It would be important to meet the client where they are and allow them to lead whenever possible.

Professionals must keep in mind that sexual assault is not limited by gender. Counselors are encouraged to respond in the same way that they would when faced with a female survivor of sexual assault. "It may be challenging for some to think of men being the victims of sexual crimes because it is challenging to recognize men as "victims" and still think of them as men. This socialization can make it less likely for men to seek services and can make it less likely that appropriate services are available" (National Alliance to End Sexual Violence, 2015). It is important to note that it may be difficult to find local support for male victims given the narrow definition of sexual assault and the lack of acknowledgment of males as victims. Bullock and Beckson caution that "...agencies least likely to provide services to male sexual assault victims are law enforcement officials and feminist-based rape crisis centers or hotline workers" making it necessary for counselors to help their clients find the best resources and to advocate for appropriate care (2011).

Sexual assault can be difficult as there may be many factors to consider. "The experience of sexual assault may affect gay and heterosexual men differently. Rape counselors have found that gay men have difficulties in their sexual and emotional relationships with other men and think that the assault occurred because they are gay. Heterosexual men often begin to question their sexual identity and are more disturbed by the sexual aspect of the assault than any violence involved" (Brown University Health Promotion, 2015). In addition, working with victims who identify as transgender might add other variables to the way they experience their trauma. The National Alliance to End Sexual Violence state on their website, "Advocates and policymakers must also address the prevalence of sexual assaults targeting gay and transgender males, or those perceived to be so, perpetrated by other males who victimize those who do not fit into cultural norms around masculinity and sexuality" (National Alliance to End Sexual Violence, 2015). As counselors, advocacy is part of our jobs and we must try to advocate for our clients in whatever ways that we can so that our clients may gain the support that they need to be well.

Resources available to help professionals learn more about this topic

- https://www.rainn.org/get-information/types-of-sexual-assault/male-sexual-assault Rape, Abuse & Incest, National Network
- https://1in6.org/ mission is to help men who have had unwanted or abusive sexual experiences in childhood live healthier, happier lives. They also offer an Online Support line- https://hotline.rainn.org/1in6/terms-of-service.jsp
- The National Sexual Assault Hotline - Call 1-800-656-HOPE (4763) to be connected to a trained staff member from a local sexual assault service provider in your area.
- http://www.malesurvivor.org/ a website that has a lot of good information and resources for professionals, survivors, and family members of survivors.
- http://www.aftersilence.org/male-survivors.php a website that has information, resources, and online support forums for victims and survivors.

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Chapter 3: Elder Abuse and Sexual Assault

By LaQueta Bartley

Background and Introduction

Elder abuse is any form of mistreatment that results in harm of loss to an older person. It is generally divided into the categories of physical abuse, sexual abuse, psychological abuse, financial abuse, domestic violence, and neglect. The specific legal definition of sexual abuse and assault varies from state to state (Burgess, 2005). In the United States the issue of elder mistreatment is gaining attention of the law. An NIJ nationally representative study of more than 7,000 elders found that approximately one in ten elders reported experiencing at least one form of elder mistreatment in the past year (NCPEA, 2008). Due to significant underreporting, it is estimated that as many as five million older Americans may be victims of abuse, neglect, and/or exploitation every year. Elder abuse is estimated to cost Americans tens of billions of dollars annually in health care, social services, investigative and legal cost, and lost income and assets (NCPEA, 2008).

Abuse and neglect are difficult to define because of their multiple meaning. Abuse types have to be categorized in various ways including physical, psychosocial, and financial abuse and neglect (Nahmiash, 2000). The four types of abuse that is going to be discussed in this chapter is physical, sexual, violence, and financial abuse. In relation to physical abuse the perpetrators may be acquaintances, sons, daughters, grandchildren, or others. Some of the indicators for physical abuse may include sprains, dislocations, fractures, broken bones, burns from cigarettes, appliances or hot water, abrasions on arms legs, and/or torso, internal injuries, and bruises. In cases of physical abuse one should look for patterns or clusters of indicators that suggest a problem (NCPEA, 2008).

In sexual abuse, the perpetrators include attendants, employees or care facilities, family members, and others. Though the majority of victims are women, older men have been sexually abused in both domestic and institutional settings. Indicators and signs that sexual abuse is occurring is genital pain, irritation or bleeding, bruises on external genitalia or inner thighs, difficulty walking or sitting, torn, stained or bloody underclothing, and sexually transmitted diseases. Some behavioral indicators may include inappropriate sex-role relationship between victim and suspect or inappropriate, unusual, or aggressive sexual behavior (NCPEA, 2008).

Another important aspect of elder abuse is domestic violence. In the elderly community there are two ways to describe domestic violence. "Domestic violence grown old" is when domestic violence started earlier in life and continued into old age. "Late onset domestic violence" begins in old age. Some reasons why violence may take place at this time in a relationship are because of retirement, disability, changing roles of family members, and sexual changes (NCPEA, 2008). Older women whose relationships with their partners were abusive and strained when they were younger and older women who enter relationships later in life are the main population who are at risk.

The reason I wanted to include financial abuse is because when people think of abuse and the elderly it is not one that is thought about. In all actuality financial abuse is the second most common form of abuse that takes place in the elderly community (Mulroy, 2011). In financial abuse the perpetrators include but are not limited to sons, daughters, grandchildren and spouses. The perpetrator may have a substance abuse, gambling, or financial, stand to inherit and feel justified in taking what they believe is "almost" or "rightfully" theirs, fear that their older family member will get sick and use up their savings, depriving the abuser of an inheritance and have had a negative relationship with the older person and feel a sense of entitlement. Those who are at risk are older people who are in isolation, loneliness, recent losses, physical or mental disabilities, lack of familiarity with financial matters, and have family members who are unemployed and/or have substance abusers problems. Some indicators of financial abuse are unpaid bills, eviction notices, canceled checks, withdrawals

from bank accounts, unusual activity, belongings or property are missing, amongst other things (NCPEA, 2008).

Review of Relevant Research

Data from the National Crime Victimization Survey of 2000 identified 3,270 of 261,000 rapes and sexual assaults were victims' age 65 or older (Burgess, 2006). In a study that was done at Boston College Connell School of Nursing found that the mean age of the 284 victims in the study was 78.8 years of age (Burgess, 2006). When comparing groups by presence f a disability, there were no significant differences in elders with physical limitations. However, the study did show, elders with dementia compared to those without a diagnosis, were abused more often by persons known to them than a stranger. An explanation of this may be due to the fact that there are a greater number of older adults are living longer in the community because of increase life expectancies (Nahmiash, 2000).

Though the legal definition of sexual assault varies from state to state, there are three main elements. The elements include whether sexual intercourse occurred, whether the act was committed by force, and whether it occurred without the person's consent (Burgess, 2005). Suspects reported through law enforcement had a lower chance of being identified, but once identified, they had a higher chance of police being notified, being arrested, and of being referred to the prosecutor (Burgess, 2006). Of the cases that are reported to police, not many lead to charges and prosecution (Burgess, 2005).

An elder's memory is often a barrier in the investigation of a suspected sexual abuse (Nahmiash, 2000). People that are older may also be reluctant to disclose on their experience because they may be embarrassed or ashamed, especially if they know the attacker. Some fear for the loss of their independence if the report the attack. (Burgess, 2005). Many people of the older community were reluctant to tell anyone about the abuse. A reason that many do not choose to tell anyone about their abuse is because they are rarely believed. Sometimes society tries to place the majority of people in the elderly community as cognitively impaired (Burgess, 2005). The question that is then posed is, "What happens when they are cognitively impaired"?

The issue of reporting takes on an entirely different meaning with a victim who may not be able to communicate its abuse. When the victim cannot communicate it is important that the nurse or investigator make careful observations, document behavior, and report any suspicions of sexual abuse. Unless there is an eyewitness, the only way to usually move forward is to have forensic evidence (Burgess, 2005).

Society's view on the elderly not only affects how sexual abuse is viewed but also domestic violence issues. Though there are not many studies that touch on the issue there are studies that prove violence issues takes place in the older community as well (O'Neill, 2008). The percentage of older people who experience violence ranges from 3%-10%. In a study that was done in Kentucky, 3% of women over the age of sixty reported that they had experienced domestic violence within a twelve month period (O'Neill, 2008). Though elder abuse is a broad topic to discuss on because there are so many facets to it, they all seem to connect on the point that society doesn't think these things take place in the elderly community.

Possible Counseling Issues (e.g., Individual, Family, and/or Couple)

There are many counseling issues that may come up when having an elderly client that has been abused. As licensed counselor it is required for him or her to report if they know of a child or elderly person who is being abused. This may cause a problem if the client does not want to tell anyone or even report it, which studies show many of them do not want to do. Financial abuse may also come up in session because it is the second most common form of abuse in the elderly community. It is important to be very observing because the very person that is bringing them to or is in counseling may be the very one that is abusing them. For example, if the person is their caregiver, it would be very hard to get away from that person to report them to authorities of even to someone else.

Additional Guidelines for Counseling Practice

The intervention model that is most used in cases with elderly abuse is the Five-Element Model Invention. A Multidisciplinary take on treatment is used when treating clients that have been abused (Nahmiash, 2000). The main guideline that needs to be remembered when working with the elderly community is that is you know or suspect any signs of abuse a counselor is mandated to report. It is important to check state laws because they vary from state to state and counselors need to know specific laws pertaining to certain age groups.

What resources are available to help professionals learn more about this topic?

- Crime and Elder Abuse: An integrated Perspective by Brian K. Payne
- Elder Abuse: International and Cross-Cultural Perspectives by Jordan I. Kosberg & Juanita L. Garcia
- National Adult Protective Services Association: http://www.napsa-now.org/
- National Center on Elder Abuse: http://www.ncea.aoa.gov/
- National Committee for the Prevention of Elder Abuse: http://www.preventelderabuse.org/elderabuse/
- RAINN (Rape, Abuse & Incest National Network)

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NCPEA: National Committee for the Prevention of Elder Abuse. (2008). http://www.preventelderabuse.org/elderabuse/

O'Neill, D., O'Dwyer, C., & McGee, H. (2008). Violence between Intimate Partners Knows No Age Limit. British Medical Journal. 337(7667). 424. http://www.jstor.org/stable/20510622

Chapter Four: Sexual Assault among College Students

By Azaria Miller, Haleigh Scherma, and Alyssa Triolo

Background and Introduction

Sexual assault on college campuses has been cause for great concern, with cases gaining high media coverage, such as Emma Sulkowicz carrying the mattress she was assaulted on during her graduation, and recent documentaries, such as *The Hunting Ground*, a film chronicling universities' tendency to cover up sexual assault scandals. Sexual assault, while commonly thought of as rape, is not always limited to such an occurrence. Sexual assault occurs on a spectrum ranging from mild, medium to severe offenses.

College campuses are the perfect mix for sexual assault and dating violence (Carmody et al., 2009). Between their concentrated population, excessive drinking, and increased drug use, college campus attract individuals of the age group at the greatest risk for assault. In fact, it is estimated that 20%-25% of college women will be victims of rape or attempted sexual assault during their college career, making sexual violence a significant public health concern on college campuses (Hines, Armstrong, Reed, & Cameron, 2012).

Although rates for college sexual assault have been high, legal action against colleges was not recognized until 1996 in a revolutionary decision in *Doe v. Petaluma City School District*, which gave a precedent for suing schools for lack of addressing sexual harassment of students. The law enforcement capabilities of Title IX, a federal law that strictly prohibits discrimination based on sex in any federally funded education program, were then further solidified through *Davis v. Monroe County Board of Education.* This court case stated that the school can be liable for private damages if they act with indifference towards a claim by a student that they are the victim of sexual harassment severe enough to disrupt them from enjoying the educational opportunities they have a right to. Within more recent years and added pressure from the Department of Education, the media, and various student groups, Title IX has taken a stronger stance on sexual assault. Colleges across the country are now categorizing sexual assault as institutional sexual discrimination and prosecuting it (Silbaugh, 2015). However, there is still much more that needs to be done in order to make the environment safe for all students.

Review of Relevant Research

Among a sample of college students, women were sexually assaulted at a higher rate than the men studied (Hines et al., 2003). "There were no gender differences in the frequency with which they were assaulted with both male and female victims reporting on average about three sexual assaults in two months...supporting assertions that we need to broaden our conceptualization of sexual assault and rape victimization to include both genders" (Hines et al., 2003, p.935). Most incidents occurred off campus for women but on campus for men. Both genders were primarily victimized by an acquaintance, after a party, with the involvement of alcohol (Hines et al., 2003).

A pervasive factor in the confusion behind sexual assault cases in higher education is the perceived normalcy of promiscuity and high alcohol consumption on college campuses, deemed the hookup culture. Sutton and Simmons (2013) sought to understand the impact of hookup culture on assault on campus. This study "found that engagement in hook-up culture was associated with an increase in sexual assault perpetration among men and victimization among women" (Sutton & Simmons, 2013, p.88). Alcohol and drug consumption are frequently cited as factors in sexual assault cases. Drug-related sexual assaults are more frequent than forcible sexual assaults in women (Lawyer, Resnick, Bakanic, Burkett, & Kilpatrick, 2010). Many of these drug-related assaults involved voluntary alcohol consumption.

Possible Counseling Issues

Survivors of sexual assault generally progress through 2 different phases (Kress et al., 2003). Recognizing which phase of recovery the survivor presents in may increase the effectiveness of the treatment plan. Phase 1, the acute phase, can last anywhere from several hours to several weeks and is characterized by the initial reactions to the traumatic experience, such as: shock, numbing, and disbelief. Phase 2, the reorganization phase, is the long-term recovery stage. This phase is characterized by sleep disturbances, sense of helplessness, depression, self-criticism, blame, and guilt. These symptoms are said to develop as the person continues to struggle to effectively organize the traumatic event.

However, early intervention can prevent more severe reactions. Students need different interventions depending on the stage of recovery they are in. In the acute phase, "counseling may involve reducing emotional distress, enhancing positive coping skills, and preventing the development of intensified trauma reactions" (Kress et al., 2003, p.88). Victims also benefit from education about rape myths, the legal and medical process, and the importance of a strong social support network (Kress et al., 2003). When survivors are in the reorganization phase, a cognitive behavioral therapy approach with an emphasis on cognitive restructuring is recommended. Exposure therapy has also proven effective in minimizing trauma related reactions. Anxiety management therapy benefits survivors showing PTSD reactions especially controlled breathing and deep muscle relaxation (Kress et al., 2003).

Additionally, counselors should be aware of and able to recognize the symptoms of PTSD in their clients who are survivors of sexual assault (Kress, Trippany, & Nolan, 2003). Almost all of survivors of sexual assault experience some trauma-related symptoms shortly following the incident (Kress et al., 2003). 30% to 50% of survivors will continue to have PTSD symptoms throughout their lives. Identifying and assessing the severity of responses to the sexual assault are vital skills for counselors to provide the most effective intervention to the student.

As the survivor tells and retells his or her story, they may experience a secondary assault from the administration or their peers (Ullman, 2010). This secondary assault may consist of victim blaming or disbelief. Survivors may be reluctant to share their story further for fear of being ostracized on campus. In addition, once the assault is reported, the university is required to release information on the assault to students in accordance with the federal Jeanne Clery Disclosure of Campus Security Policy and Campus Crime Statistics Act. Many students do not wish to report acts of assault for fear that their classmates and peers may be able to deduce who was involved. Counselors should know and understand the university's policy on reporting and their role in that system.

Additional Guidelines for Counseling Practice

Each victim experiences an assault differently. Whether the perpetrator was a stranger or an acquaintance can have significant impact on the victim and self-blaming behaviors. Typically, survivors of acquaintance rape are less likely to label their assault as a trauma and will consequently engage in more self blame (Kress et al., 2003). Counseling on a college campus may involve referral to a rape crisis center where the survivor can participate in psychotherapy groups. In addition, a medical referral may be necessary to test for pregnancy or sexually transmitted diseases, as studies have shown that condoms are not used in as many as 70% of sexual assaults, especially if alcohol consumption is involved (Davis et al., 2012). With the support of the survivor, a college counselor can advocate for the victim to the dean of students office. College sexual assault victims have the added challenge of attending class and completing assignments and may need to be temporarily excused from these activities (Kress et al., 2003).

In the battle against sexual assault, educational programs targeted towards first year students have become the first line of defense. However, there have been mixed results in the effectiveness of these programs. There is a significant decrease in the amount of reported sexual assaults in groups of students who were exposed to assault prevention programs in their first year of higher education when

compared with students who were not provided such programs (Rothman & Silverman, 2007). According to Silbaugh (2015), one session educational programs are not effective in changing long term behavior. These programs are better used in conjunction with a larger comprehensive strategy in order to combat sexual assault more effectively. In addition, some popular evidence based programs counselors can explore with high school and college age clients are Safe Dates and a building level intervention, Shifting Boundaries, both of which have been shown to prevent sexual violence. Counselors would also be wise to focus on building relationship skills, addressing social norms and communicating with the school's greater organizations around their policies and practices to improve safety. In order to facilitate campus wide safety, training students in bystander interventions would be idea (Silbaugh, 2015).

What Resources (e.g. Books, Internet Sites, and Journal Articles) Are Available to Help Professionals Learn More About This Topic

- It's on Us: Campaign to End Sexual Assault on Campus: http://itsonus.org/#landing
- National Sexual Violence Resource Center: http://www.nsvrc.org
- Not Alone: https://www.notalone.gov
- McAnulty, R. D. (2012). *Sex in college: The things they don't write home about*. Santa Barbara, Calif: Praeger.
- Ottens, A. J., & Hotelling, K. (2001). *Sexual violence on campus: Policies, programs, and perspectives*. New York: Springer.
- The Hunting Ground http://www.thehuntinggroundfilm.com/

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Silbaugh, K.. (2015). Reactive to Proactive: Title IX's Unrealized Capacity to Prevent Campus Sexual Assualt. *Boston University Law Review*, *95*(3), 1049-1076.

Sutton, T. E., & Simons, L. G. (December 05, 2014). Sexual Assault Among College Students: Family of Origin Hostility, Attachment, and the Hook-Up Culture as Risk Factors. *Journal of Child and Family Studies*, 4.

Ullman, S. E. (2010). *Talking about sexual assault: Society's response to survivors*. American Psychological Association.

Chapter 5: Sexual Violence within Abusive Intimate Relationships

By Joy Kelly

Background and Introduction

Up until the 1970's, the United States had *not* recognized sexual violence inflicted by an intimate partner, or marital rape in similar terms, as a criminal offense. Essentially, rape laws included a marital rape exemption promoting sexual entitlement in marriage, which basically implied that rape was not applicable in marital relationships. As discussed in further detail below, the idea that your spouse or intimate partner could "rape" you was, quite frankly, sociocultural ludicrous.

In 1978, John Rideout was the first person in our nation's history to be convicted of marital rape, interestingly enough, while still living with his wife (Cecil & Kirkwood, 2001). Thanks to legal reforms, sexual violence within intimate partner relationships, most notably marital relationships, has been recognized legally within the realm of sexual assault offenses. However, the social, cultural and professional treatment implications of intimate partner sexual violence still remain significantly relevant in today's discussion of clinical issues affecting large client populations within individual, couple and family counseling contexts.

Review of Relevant Research

From a research perspective, the concept of marital (or intimate partner) rape, has been widely overlooked within the domestic violence and rape literatures as a whole. In their review of the history, research and practice of marital rape, Bennice and Resick (2003) assert that victims' experience of martial rape has been invalidating in legal, cultural and professional ways for centuries. As it relates to specific research terminology, Phiri-Alleman and Alleman (2008) state, "*Intimate Partner Sexual Violence* refers to rape or sexual assault that occurs between two people who have or have had a consensual sexual relationship" (p. 155). Intimate Partner Sexual Assault is also used interchangeably with the term *marital rape*, which, as cited by Phiri-Alleman and Alleman (2008), Bergen (2006) defines *marital rape* as "…any unwanted intercourse or penetration obtained by force, by threat of force, or when a partner is unable to consent" (p. 155). Similar to the statistics related to reported sexual assault cases in general, the statistical prevalence of sexual violence in intimate relationships is substantially high, outnumbering both stranger and acquaintance sexual assault. Research studies conducted by Bergen (2006), as cited in Phiri-Alleman and Alleman (2008), estimated that more than 7 million women in the United States have been raped by their intimate partners. Bergen's (2006) study of men and intimate partner rape revealed that the most significant research finding was the prevalence of sexual violence, with 53% of men in the sample indicating they had sexually abused their partner at least one time. While reports of sexual violence made by women are much lower compared to self-reports by men (Bergen's study, for example) a population-based study conducted by Smith et al. (2002) revealed that out of the 18 percent of women who reported intimate partner violence of some type, 8 percent were sexually assaulted.

Perhaps most notably due to victim invalidation on multiple levels, as indicated in the major literature review conducted by Bennice and Resick (2003), intimate partner sexual violence, or marital rape, has been a largely unreported, and consequentially, a largely untreated dilemma for years on end. From a legal standpoint, marital rape was legal in all 50 states up until the 1970's due to longstanding conceptual beliefs of mutual matrimonial consent (Bennice & Resick, 2003). However, since 1993, marital rape has been designated as a criminal offense among sexual offense codes which vary state by

state (Phiri-Alleman & Alleman, 2008). Culturally speaking, Bennice and Resick (2003) note that the largely held societal belief (prevalent across many world cultures as well) that martial rape is not "real" rape is disturbingly widespread with the notion that "being raped by one's husband does not fit the cultural schema of the stranger in the dark alley" (p. 233). Bennice and Resick (2003) assert that numerous studies have substantiated the pattern that as the victim-offender relationship becomes more intimate, that the incident is less defined as rape decreases…" (p. 231). Lastly, treatment professionals have also contributed to the invalidation of marital rape cases. According to Bennice and Resick (2003), medical professionals may overlook or dismiss the signs of marital rape while mental health professionals may minimize the concept of marital rape as being a serious risk factor in the treatment of depressed and anxious clients.

In summary, increased research efforts are needed to fully understand sexual violence in intimate relationships/marital rape in order to evaluate, and consequently, impact the effectiveness of medical and mental health treatment interventions, public education and prevention programs, legal ramifications, and large-scale sociocultural advocacy campaigns. Without continued research with this specific population, intimate partner sexual violence will continue to remain a long-standing systemic issue.

Possible Counseling Issues (e.g., Individual, Family and/or Couple)

Similar to other types of sexual violence, the mental health implications of individuals who have experienced sexual violence with an intimate partner are significant. Bergen's (2006) clinical research study indicates, as cited by Phiri-Alleman and Alleman (2008), "…marital rape often has severe and long-lasting consequences for women, especially given that they are raped by someone they presumably loved" (p. 156). Bergen (2006) specifies some of the short-term effects to include anxiety, shock, intense fear, depression, suicidal ideation, disturbed sleeping, and post-traumatic stress disorder, all of which could present as clinical issues in a counseling setting. Potential long-term counseling issues could include further individual mental and physical health concerns, such as depression, low self-esteem and body image, gynecological symptoms (e.g., pelvic pain, vaginal bleeding and discharge and bladder infections), as well as relational/couple issues, such as sexual distress and intimacy issues (Phiri-Alleman & Alleman, 2008).

Additional Guidelines for Counseling Practice

As discussed above, it is imperative for counselors to recognize the legal ramifications of sexual violence, as well as the multicultural dimension of sexual violence within an intimate or martial relationship. Unfortunately speaking, the conceptual idea of marital rape is still not recognized by all individuals, couples or families on a larger, systemic perspective as a whole, both legally and culturally. For example, Finkelhor and Yllo (1985), as cited in Phiri-Alleman and Alleman (2008), argue "…men's sense of entitlement in marriage has historically been both a legal and cultural reality in the United States" (p. 157). Therefore, counselors must develop a reasonable level of multicultural competence in order to address the varying cultural aspects of sexual violence (e.g., male sense of entitlement, male dominance, systems of established patriarchy) in intimate relationships while also recognizing that different cultural groups respond to sexual violence within the context of intimate relationships differently (Phiri-Alleman & Alleman, 2008).

Bennice and Resick (2003) recommend specific guidelines for mental health professionals in the treatment of marital rape clients, including sensitive sexual language in face-to-face clinical interviews, as opposed to self-response questionnaires (e.g. "Has an intimate partner ever forced you to have sex when you did not want to?") (p. 241). As cited by Bennice and Resick (2003), Renshaw (1989) notes that sensitive clinical interviewing may allow the client to (1) reflect their pain in a safe

environment, (2) receive validation from others, thus contributing to a normalizing experience, and (3) obtain a sense of hope in the client feeling they deserve to be helped.

Additionally, if the client is still in the abusive relationship, counseling practice should focus on safety planning and challenging attributions related to client self-blame (Shields et al., 1990). On the other hand, if the client has left the abusive relationship, cognitive-behavioral counseling can address post-abuse traumatic symptoms affecting the client's current reality, including symptom reduction related to anxiety and fear, modification of faulty thinking patterns, and interruption of avoidance patterns (Bennice & Resick, 2003).

What resources (e.g., books, Internet sites, and journal articles) are available to help professionals learns more about this topic?

Books:

Bergen, R. K. (1996). *Wife rape: Understanding the response of survivors and service providers.* Thousand Oaks: SAGE Publications.

Finkelhor, D., & Yllö, K. (1985). *License to rape: Sexual abuse of wives*. New York: Holt, Rinehart, and Winston.

Russell, D.E.H. (1990). *Rape in Marriage*. Bloomington: Indiana University Press.

Websites:

National Sexual Violence Resource Center: http://www.nsvrc.org/

Rape, Abuse, & Incest National Network (RAINN): https://www.rainn.org/

No More: Together We Can End Domestic Violence & Sexual Assault: http://nomore.org/resources/

National Coalition against Domestic Violence: http://www.ncadv.org/

Journal Articles:

Bennice, J. A., & Resick, P. A. (2003). Marital rape: History, research, and practice. *Trauma, Violence, & Abuse, 4*, 3, 228-246.

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Chapter 6: Couples Counseling When One or Both Partners Are Survivors of Sexual Abuse

By Kalyn Hamilton and Sara Smith

Background and Information

According to the National Center for Victims of Crime (2012) an estimated 1 in 5 girls and 1 in 7 boys are victims of child sexual abuse (CSA) by the age of 17. As imagined, this form of child abuse causes many short term effects on the child's psychological development, but counselors need to consider the long term effects this abuse creates for the adult survivor and their relationships with intimate partners.

Adult survivors of CSA usually have a long list of co-occurring mental health issues including (but not limited to) depression, PTSD, low self-esteem, and substance abuse. According to Macintosh & Johnson (2008), survivors of childhood sexual abuse can suffer from feelings of isolation, dissatisfaction with relationships, and have trust issues. They have higher rates of reported sexual dysfunctions, lower levels of marital satisfaction, and are more likely to marry young, engage in risky sexual behaviors, and have relationships end in divorce (Castillo & O'Dougherty Wright, 2009; Macintosh & Johnson, 2008; Sims & Garrison, 2014). The impact of CSA impacts the life of the partner as well: according to Macintosh & Johnson (2008), partners indicated feelings of isolation, pain, anger, frustration, dissatisfaction, and communication problems. Survivors tend to need the assurance of having control over themselves and the relationship as a result of their earlier trauma.

A daunting task for counselors working with this population is finding appropriate methods to address the multifaceted issues presented in both the survivor's life as well as that of his/her partner and the relationship as a whole. A couple in which one or both of the dyad is a survivor of CSA may present with a myriad of presenting concerns.

Lit review of relevant research

Historically counselors working with survivors of childhood sexual abuse would focus on the survivor and exclude the partner as a valuable resource. Outcome studies have shown that this methodology leaves the partner in a state of frustrated helplessness and the relationship vulnerable as one part of the dyadic system undergoes change without the involvement of the whole (Macintosh & Johnson, 2008). More recent research has shown that partner involvement is an integral part of treatment and long term recovery (Sims & Garrison, 2014). Furthermore, the Emotion Focused Therapy (EFT) model postulates that as humans we strive to maintain connection and belonging even in, or maybe even because of, violence or betrayal. The EFT model further suggests that the creation of stable relationship bases can serve as a moderator of traumatic based stress and incorporates the creation of such secure attachment bases as a component of therapy. EFT encourages a focus on the awareness of attachment related process and the level of couple distress. It deals directly with the dyad and facilitates emotional regulation, acceptance and reassurance, self-processing and the challenging of negative self-maps (Macintosh & Johnson, 2008).

According to some research, survivors of sexual abuse report that most or all of their relationships are "empty, superficial, conflictual, or sexualized"; they also commonly report guilt, shame, and mistrust in most of their relationships (Sprei & Courtois, 1988). While this may be due to the negative feelings the reporter feels towards his/her partner, research also suggests that these victims select relationships with partners who have also been abused (and may have become abusive/neglectful) (Sprei & Courtois, 1988).

When one or both members in a committed relationship are victims of abuse, many issues tend to occur, including struggles with personal boundaries, sexual repercussions of abuse (dissociation, flashbacks, and/or triggers), control, self-mutilation and/or suicide, confusing the partner with the abuser, and denial. Despite these all-too-common issues, a couple is a valuable opportunity for a

corrective experience; a relationship filled with support and respect (which was most likely absent in the abusive relationship) can be one of the most powerful challenges to that earlier trauma (Hughes, 1994).

Possible Counseling Issues

Sims & Garrison (2014) conducted a research study on the effects of having a concurrently run support group for male partners of CSA survivors. The male group addressed the feelings of frustration and helplessness they were experiencing and used psychoeducation to illuminate the healing process. The outcomes of this research indicated that the use of partner only groups in conjunction with a survivor only group were advised when confidentiality levels could be created to the agreement of both parties.

Because of the established correlation between survivors of CSA and future adult abusers, it is important for counselors to be attendant to the potential for abuse within the couple, whether overt or covert. Generally, sexual trauma is often expressed within the couple through repeated interpersonal conflict (Herman, 1992), which of course will be a central concern to the couple and their counselor. However, the counselor must always be cognizant of any signs of more harmful abuse, which of course could be difficult to detect; the survivor could consider him/herself to be very caring and loving towards their partner, but because of their previous trauma they may not understand the impact of their abusive behaviors.

Couple's counseling is a unique animal: the counselor is attempting to serve the best interests and wellbeing of both individuals, as well as the relationship itself. This can be a complicated issue, especially when secrets become part of the equation. Counselors need to be prepared to address secrets and their procedure for secret-keeping or secret-telling as appropriate. Specifically, a counselor should be prepared for a client to potentially disclose abuse to the counselor alone and not be ready or prepared to tell their partner. Perhaps they entered into counseling because the echoes of the abuse are affecting their relationship currently, but they are afraid/ashamed/nervous/etc. to explain this to their partner. A counselor must be prepared for this situation and respond in a way that promotes openness and growth, while also protecting the wellbeing of both partners (and the relationship, if possible).

Additional guidelines for practice

Counselors should always follow general ethical principles of beneficence, non-maleficence, justice, fidelity, and autonomy; but in couples counseling, the counselor must consult the American Association for Marriage and Family Therapy Code of Ethics and the American Counseling Association Code of Ethics.

According to Cobia, Sobansky, and Ingram (2004), up to 50% of victims of CSA develop some level of sexual dysfunction later in life. Since sexual dysfunction shows up in couples without the pairing of trauma, and many survivors are hesitant to report past abuse, it is important for counselors to have a screening process with couples to identify those that include past trauma.

As with many counseling issues, the counselor must consider cultural variations. The issues of sexual assault will vary depending on the gender of the survivor. Men and women will naturally be affected differently by abuse, and we must accept that there are certain gendered stigmas in our society (men may be more shamed or feminized by admitting abuse, while women might be more blamed by her behaviors). The counselor must be able to integrate this component into the couple's work, especially if the non-abused partner has stigmas directed towards the abused partner. Furthermore, some research has suggested racial differences in levels of abuse, effects of abuse, and disclosures of abuse (Bryant-Davis et al., 2009). The counselor must remain knowledgeable of these cultural differences (and emerging research in the subject), while always processing the client's/couple's own personal experiences.

Resources that are available to help learn about this topic

- Surviving Childhood Sexual Abuse (2000) by Carolyn Ainscough & Kay Toon, both clinical psychologists: Self-help book for adult survivors that addresses issues related to the emotional damage of abuse, anxiety, low self-esteem, and more. There is an accompanying workbook (2000) of the same name. ISBN:1-55561-225-3; 1-55561-290-3
- Psychological and Physical Aggression in Couples: Causes and Interventions (2001) by Daniel O'Leary and Erica Woodin. ISBN: 978-1433804533
- The Abuse of Men: Trauma Begets Trauma (2001) by Barbara Jo Brothers. This book explores men within the context of their relationships, families, work, and military; it includes discussions of male sexual abuse survivors. ISBN: 978-0789013798
- Ghosts in the Bedroom: A Guide for Partners of Incest Survivors (1991) by Ken Graber, a social worker. A guidebook to help explain the recovery process to partners of survivors. The book aims to help the reader support their partner while understanding the relationship of their personal feelings in the relationship. ISBN: 1-555874-116X
- Laura Davis authors and co-authors many helpful books on the topic including: The Courage to Heal (2008), Allies in Healing (1991), and Beginning to Heal (2003). ISBN: 978-0061284335; 978-0060968830; 978-0060564698
- Beyond Betrayal: Taking Charge of Your Life after Boyhood Betrayal (2005) by Richard Garter a PhD. Using examples from his years of clinical work, Garter provides illustrative solutions to many problems men face during the healing process. ISBN: 978-1630260361

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Chapter 7: Assessment of Sexual Trauma in Counseling

By Jordan Austin and Kalyn Hamilton

Background and Information

The first stages of the counseling relationship can be the most difficult, awkward, and unpredictable; however, it can also be wonderfully exciting. Counselors and therapists tend to call this first stage "the assessment stage"; while it sounds harshly clinical and cold, this process can be full of richness and intrigue. What the client focuses on, what he/she chooses to disclose, and how he/she presents to a complete stranger can be very elucidating in and of itself. A counselor can attain much through an accurate and holistic assessment and, when sexual abuse enters the storyline, it is vital that an accurate but also empathetic assessment is conducted.

In the counseling field, sexual abuse is simultaneously one of the most pervasive and one of the most difficult topics to address and overcome alongside our clients. Because of general discomfort, societal pressures, and overall cultural shaming attitudes, many victims hesitate to disclose to their closest support system and to their counselors/therapist. Unless a client is coming to counseling solely for the purpose of overcoming sexual abuse/trauma, many clients will omit the act and the impact upon them from their assessment stories. (Coker et al., 2002; Kogan, 2004)

While some pen-and-paper assessments for trauma exist and have been supported by data, not very many are validated that are specific to sexual abuse. If you would like to include sexual-abuse-specific hard copy assessments, you may need to tailor these to your needs (examples included later). When a client discloses sexual abuse naturally through the therapeutic process, it is important to generally follow the client's lead. While follow-up questions or further explorations may be necessary or prudent, the client may or may not be traumatized from the experience(s) and the counselor should respect the client and trust his/her judgment.

Though the counselor should respect the lead of the client, it is also important to assess if and how the previous abuse is currently impacting the client. He may not recognize his own trauma symptoms, internalized cognitions/beliefs, patterns of emotions, or impact upon his relationships. It is vital for the therapist to integrate the knowledge of the abuse into a holistic and comprehensive assessment of the client.

Review of Relevant Research

In order to initiate a corrective therapeutic relationship, establishing a sense of safety and rapport with a client is essential. Though this is crucial for all helping relationships, being a victim of sexual trauma can be devastating, and clients may be experiencing a wide range of emotions from anger, to sadness, to shame. Counselors must consider the fact boundaries have been previously violated for the victim, and insuring trust is an important first factor of therapy. Creating safety may look different for children and adults; for example, an adult may benefit from a worksheet on creating safety while a child may connect through play. Relationship building may require more effort when working with this population, but counselors must honor the client's right for safety and progress appropriate. In addition, overall goals during the initial phase of counseling include assessment of symptoms and strength of current coping skills, as well as collecting memories and information regarding the trauma (McFarlane & Yehuda, 1996; McFarlane & de Girolamo, 1996).

As previously mentioned, few questionnaires have been developed to assess sexual trauma specifically, however, several empirically supported assessment measures for general trauma are available. The Brief Trauma Questionnaire (BTQ), developed by Schnurr, Vielhauer, and Findler (1999) is a 10-item self-report focusing on exposure to traumatic life threat or serious injury, but lacks the critical piece of subjective experience of trauma as well as resulting symptoms. Briere and Runtz's (1989) Trauma Symptom Checklist and the more thorough Trauma Symptom Inventory (Briere, 1995)

focus more in depth on the clinical presentation of the client, such as negative alterations in cognition and mood, hyperarousal, and intrusion symptoms.

Though the aforementioned assessment measures provide a quantitative measure of a client's symptomatic presentation, counselors may also sensitively conduct an unstructured interview regarding details surrounding the sexual trauma, such as memories and affective properties. While early models of treating trauma typically involved talking about the traumatic event in great detail as a central component of treatment (Bartlett, 1995), more recent research suggests individuals may experience an exacerbation of symptoms through intrusive exploration of traumatic events (van der Kolk & McFarlane, 1996). Directly addressing traumatic memories is not always helpful to our clients and it is the counselor's responsibility to continually monitor the intensity and reactions of the client. Rothschild (2000) states victims most at risk for retraumatization when the therapy accelerates faster than client's current coping mechanisms can contain. Thus, if counselors choose to conduct a more comprehensive assessment regarding a client's sexual trauma, it is vital to remain alert and cognizant of any changes in client's demeanor and presentation.

Information a counselor may consider to explore while processing client's experiences with sexual trauma may include relation to perpetrator(s), developmental stage when sexual trauma(s) occurred, number of occurrences, sexual victimization acts experienced, location of traumatic incident(s), prior and current protective factors, coping mechanisms, suicidal ideation and intent to harm. It is also important to remember clients may choose to not disclose sexual trauma on initial intake, thus the manifestation of the assessment process could likely be very unique to each client. Counselors must display comfort of working with client's in sexual trauma recovery while providing validation to support the therapeutic relationship.

Possible Counseling Issues

It is vital for counselors to always follow the client; even if a client discloses sexual abuse, that may not be the reason that they entered counseling; their priorities may not include the sexual abuse and it is imperative that we counselors respect that wish. Additionally, it is important for the counselor to integrate the timing into his/her assessment of the client. The presentation of someone who was abused as a child may be entirely different (or remarkably similar) to someone who was abused as a teen or adult. Furthermore, how much time has passed since the abuse may (or may not) have an impact upon the client's level of functioning or healing.

When a client chooses to disclose assault or abuse, it may be necessary or helpful for the counselor to initiate a conversation about safety (especially with a younger client). The client may be unsure about how the counselor will react or where they might lead the conversation. In order to preserve the relationship and help the client to feel more comfortable, the counselor might consider a safety worksheet.

As the client discloses and begins to address the abuse, it is vital that they maintain a relatively stable and healthy disposition. Readdressing these issues can sometimes be very difficult and it is always a struggle for counselors to help their clients heal while also not retraumatizing them. An important protection against retraumatization is to address and reinforce the client's coping skills and self-care. The client should feel well enough to address these issues and that may take extra precautions outside the session, for both client and counselor.

A counselor *must* familiarize himself with the specific legal requirements in his state of practice. Reporting laws differ from state to state and a counselor needs to be aware of his role in the reporting procedure (especially if children are involved). However, a counselor must also operate in a way that promotes overall wellbeing and safety for his client, as well as the therapeutic relationship (which can be difficult if the disclosure is made during the assessment stage). If a counselor is particularly drawn to the issue of sexual abuse and wants to become more involved in the legal system,

he might consider training to become a forensic interviewer (note that forensic interviewing is a very different style than traditional counselors and might be a difficult transition for some).

Additional Guidelines for Counseling Practice

In addition to general ethical principles including beneficence, autonomy, and nonmaleficence, it is important for counselors and therapists to follow their specific ethical guidelines. The American Counseling Association code of ethics includes an entire section on proper and ethical evaluation, assessment, and interpretation (section E). This section includes

Additionally, it is important to note potential cultural variations in this topic. Although more research is needed on some cultural factors, assessments, and disclosures of sexual abuse, some research has suggested that minorities (women at least) are less likely to disclose sexual abuse (Bryant-Davis et al., 2009). Race may be an important cultural factor that impacts instances of sexual abuse and trauma, be we can be certain that gender plays a significant part. One research study suggested that males more often reported difficulty disclosing childhood abuse because they feared being viewed as homosexual and as victims; in contrast, women's difficulties were more often about feeling responsible, being blamed, and not being believed (Alaggia, 2005).

What resources (e.g., books, Internet sites, and journal articles) are available to help professionals learn more about this topic?

Books

- Rothschild, B. (2000). The body remembers: The psychophysiology of trauma and trauma treatment. New York: W.W. Norton & Co.
- Wilson, J. P., & Keane, T. M. (2004). *Assessing psychological trauma and PTSD*. New York: Guilford Press

Websites

- US Department of Veteran Affairs: National Center for PTSD
  - **http://www.ptsd.va.gov/professional/index.asp**
- Trauma Symptom Checklist (Briere and Runtz, 1989)
  - **http://www.une.edu/sites/default/files/Trauma-Symptom-Checklist.pdf**
- Brief Trauma Questionnaire (Schnurr, Vielhauer, & Findler, 1999)
  - **http://www.ptsd.va.gov/professional/pages/assessments/assessment-pdf/brief_trauma_questionnaire.pdf**
- Trauma Symptom Inventory (Briere, 1995) **available for purchase*
  - **http://www4.parinc.com/Products/Product.aspx?ProductID=TSI-2#Items**

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Chapter 8: Evidence-Based Treatment Approaches for Addressing Sexual Trauma in Counseling

By Samantha Osborne, Stephanie Quinn, and Lisa Santiago

Background and Introduction

The importance of using evidence-based practice is becoming increasingly important for counselors as the field shifts into managed care. Managed care often suggests or requires specific interventions that have a research base (Jordan, 2009). Evidence based practices ensure that the treatment has been researched and suggests positive outcomes for clients. Counseling can be more effective when using these types of treatments (Sexton, 1999). This chapter will focus on evidence based treatment approaches for addressing sexual trauma in counseling.

There are many different therapies that are evidence based for sexual trauma that will not be covered in this one chapter. At the end of the chapter, resources will be listed that will provide further information on the therapies covered in this chapter, as well as others that are recommended. The three main therapies covered in this chapter will be Eye Movement Desensitization and Reprocessing, Trauma- Focused Cognitive Behavioral Therapy, and holistic intensive programs. The first therapy discussed is mainly used for adults, the second mainly for children, and the last is a treatment consideration for adolescents or adults. Ideally, these will provide well-rounded knowledge on different evidence based therapies used to help those who have experienced a sexual trauma.

Review of Relevant Research

Eye Movement Desensitization and Reprocessing

Eye Movement Desensitization and Reprocessing (EMDR) is a short-term intervention intended to help clients reprocess traumatic memories using bilateral stimulation (Posmontier, Dovydaitis, Lipman, 2010). This eight-phase treatment protocol (Posmontier et. al, 2010), is not a theory driven intervention (Edmond, Rubin, Wambach, 1999), and is intended to be used in concert with other treatment modalities (Edmond et. al, 1999). Using EMDR, clients are encouraged to think of a specific memory for reprocessing (Posmontier et. al, 2010). The counselor informs the client of the EMDR procedures, letting them know they can stop at any time if the treatment becomes too intense (Posmontier et. al, 2010). The client is assessed for severity of symptoms, and the pair begins desensitizing the chosen memory with eye movement stimulation (Posmontier et. al, 2010). A new thought or feeling is introduced to the memory, and the client scans their body to determine if any residual negative cognition remains (Edmond et. al, 1999). The client and counselor reprocess the memory until no negative material is detected (Posmontier et. al, 2010). At the end of treatment, the counselor and client discuss the new memories, cognitions and feelings (Posmontier et. al, 2010).

EMDR appears to be an ideal treatment modality for victims of sexual assault trauma for a number of reasons. Primarily, the treatment is time limited and cost effective, many seeing results in as little as three to four 90 –minute sessions (Posmontier et. al, 2010). Additionally, it may be less invasive than similar desensitization treatments because survivors are not required to share details of the traumatic memory with their counselor (Posmontier et. al, 2010). Overall, EMDR requires less in session exposure and fewer between session assignments when compared to traditional prolonged exposure (Rothbaum, Astin, Marsteller, 2005). Finally, EMDR is effective. EMDR has performed as well or better than traditional, long term treatments in randomized controlled trials (Rothbaum et. al., 2005). EMDR participants' symptoms were reduced below clinical levels on measures of trauma-specific anxiety and depression (Edmond et. al, 1999), and negative self-assessment had dropped by 50 percent when compared to the control group (Edmond et. al, 1999). Studies indicate that EMDR is "more effective than routine individual treatment at maintaining therapeutic gains" three months post treatment (Edmond et. al, 1999, p.113).

Trauma Focused Cognitive Behavioral Therapy

Trauma Focused Cognitive Behavioral Therapy (TF- CBT) is an evidence-based practice designed to help children and their parents heal from sexual trauma. The goal of this therapy is to reduce negative emotional and behavioral responses through education about distorted beliefs, and by providing a safe space for the child to tell their story. Some maladaptive beliefs that children might experience after a sexual trauma would be that it was their fault, or that they are now damaged because of the abuse (Cohen et al., 2004.) Additionally, children could be acting out as a result of their trauma, or experiencing symptoms of mental health disorders, such as depression or Posttraumatic Stress Disorder (PTSD). Trauma- Focused CBT uses the acronym "PRACTICE" to summarize what they do; these include psychoeducation; relaxation training; affective expression and regulation; Cognitive coping and processing; trauma narrative and processing; in vivo exposure; conjoint parent/child sessions; and enhancing personal safety and future growth (Trauma- Focused, 2012.) Additionally, Trauma-Focused CBT can help the non-offending parents of the child who has experienced a trauma by treating stress management and providing parenting skills. This therapy suggests that the more emotionally stable the parent is, the better able they will be to support their child (Trauma Focused, 2012).

Eleven studies have been conducted evaluating the effectiveness of Trauma- Focused CBT on victims of sexual trauma. Across studies, this therapy is suggested to reduce symptoms of depression, PTSD, and behavioral difficulties (Trauma Focused, 2012). Additionally, these results are sustained six months and one year after treatment (Cohen et al., 2005). In comparison to other interventions, such as Child Centered Therapy, TF- CBT was shown to be more effective in reducing PTSD symptoms (Cohen et al., 2004). As this type of therapy is an accepted evidence- based practice, research today now focuses on the various uses of TF-CBT. For example, one study discusses whether the trauma narrative is imperative to TF-CBT. Results showed that regardless of whether or not a trauma narrative was used, there were positive outcomes for the child and their parents. Children who experienced the trauma narrative group of the study had slightly less trauma related fear and anxiety (Deblinger et al., 2011). TF-CBT has been shown to be effective across race and socioeconomic status in the United States, so research is now focusing on its relevance with children around the world (Dorsey, et al., 2011).

Intensive Integrative Programs

While we have discussed the research for two very specific therapies, it is also important to consider the evidence for larger-scale treatments and the level of care that would be best for clients as they recover from trauma-based symptoms. Observations from various studies reported that sexual trauma is highly associated with PTSD, dissociative disorders, eating disorders, mood disorders, and suicidality, all which may occur in isolation or co-morbidly with one another. (Floen & Elklit, 2007; Mott, Menefee, & Leopoulos, 2012). With such complexities in how sexual trauma can affect an individual, it is important to think about these clients holistically and consider more intensive and integrative treatments. Several studies have shown that such an approach can have significant long-term benefits, reducing their trauma-based symptoms while increasing sustainable positive growth.

One such study by Jepsen, Langeland, Sexton, and Heir (2013) looked at the outcome effects of an integrative inpatient program that used a mixture of psychotherapy and psycho-education over the course of three months. This program included two group sessions a day and one or two individual therapy sessions a week focusing on symptom management, coping strategies, and social skills under the care of a multidisciplinary team of psychiatrists, psychologists, nurses, occupational therapists, art therapists, social workers, and a pastoral staff. All 56 clients had a history of sexual trauma and either showed steady symptoms of post-traumatic stress and dissociation or met criteria for a complex dissociative disorder (CDD). Through eight different clinical assessments given at the end of the program, the study found that the trauma-related symptoms were significantly reduced and that there was a significant increase in interpersonal functioning and stabilization. One year later, the researchers

followed up with the clients and found that their trauma-based symptoms were still significantly lower than at the start of the program and that interpersonal functioning and stabilization had been sustained, with those who had CDD having less success, but still a significant amount from the start of treatment, than those who did not have CDD. The researchers suggested that perhaps a more vigorous program that meets the specific pathological needs of those with CDD would help them lower symptoms even further and aid in the sustainability of their progress.

Possible Counseling Issues

With any specific type of treatment, there will be issues for clients receiving and maintaining access to specialized care. For instance, despite the high-rates of effectiveness of an intensive integrative trauma-focused program, an individual may not have the resources to enter into such a program. Furthermore, there may not be a trauma-focused integrative program in the local area. Advocating for your community's need for an accessible integrative trauma-based program may be helpful in meeting the needs of this population. Furthermore, while an individual may make significant progress within the program, they may not have the support from family or friends to help them sustain it. This issue could warrant the need for families to enter into sessions with the individual before, during, or after completing such a program to talk about the systemic barriers to long-term change and potential means of continued support.

Other issues that may hinder counseling could be that the clients require other case management services that need to be prioritized over counseling. Especially in the situation of sexual trauma, legal needs could be an issue, but other services such as housing and transportation are important and could be necessary for the client to begin to work through healing. Additionally, clients could have co-morbid conditions, such as substance abuse, suicidality, or self harm. It will be up to the counselor's discretion to determine how appropriate different therapies are given where the client is with other mental illnesses (Child Abuse Task Force, 2004 and Cohen et al, 2010).

Additionally, it is important to carefully review contraindications for specific therapies. For example, although the "specific role of eye movements is unclear" (Rothbaum et. al. , 2005, p.608) and other forms of bilateral stimulation may produce similar effects, blindness, severe eye pain or other eye impairments are contraindications for use of EMDR (Edmond et. al, 1999). Similarly, EMDR would be inappropriate for use in clients with low ego strength, severe mental disorders, psychosis, or active suicidal ideation (Edmond et. al, 1999). Because a central goal of EMDR is the reprocessing of memories, clinicians should not introduce EMDR to clients who are actively taking legal action against their perpetrators as the technique could interfere with their ability to accurately recall events (Posmontier et. al, 2010). In using TF-CBT, it is also important to ensure that the child is appropriate for this type of intervention. Children who are exhibiting behavior problems or depression and anxiety without trauma related symptoms are not appropriate for this type of therapy (Cohen et al, 2010).

Additional Guidelines for Counseling Practice

As mentioned, resources for trauma-focused programs may be scarce in your area, or a client may not have the ability to enter into an intensive program. One helpful action step that a counselor could take would be to really get to know the various services in the area that cater to the spiritual, physical, creative, and social needs of clients. It seems the integration of care provides a holistic approach to healing, so even if such integration is not available in an intensive program or a client cannot enter into such a program, providing information about a variety of discrete services may be helpful in allowing the client to still get some of these needs met. Furthermore, especially with cases dealing with children, a therapist may need to become involved in the legal system. Counselors may be expected to testify or provide reports, so gaining knowledge on the legal system will be necessary as well (Child Abuse Task Force, 2004). Additionally, it would be helpful for counselors to seek out trainings and supervision when working with this population. TF-CBT has many trainings and it is

necessary for therapists interested in utilizing this therapy to be fully trained and supervised in providing this therapy.

Finally, it is important to consider any contraindications when utilizing some of these evidence-based treatments. While much of the research on the effects of EMDR is impressive, some have called researchers methodologies into question (Edmond et. al, 1999). EMDR is not an appropriate treatment modality for all psychological challenges and seems best suited for use with trauma survivors not currently experiencing challenges. The list of contraindications for this type of therapy is long, and counselors should be well informed of the limitations of EMDR before beginning treatment.

What resources are available to help professionals learn more about this topic?

-EMDR Institute, INC. http://www.emdr.com/general-information/clinical-applications.html
-RAINN: Rape, Abuse and Incest National Network https://rainn.org
-Journal of Traumatic Stress
-Child Sexual Abuse Task Force and Research & Practice Core, National Child Traumatic Stress Network http://www.nctsnet.org/nctsn_assets/pdfs/TF-CBT_Implementation_Manual.pdf
-Child Welfare Information Gateway https://www.childwelfare.gov/pubs/trauma/
-Trauma Informed CBT Web based learning course from the Medical University of South Carolina http://tfcbt.musc.edu
-Safe Embrace Trauma Healing http://www.safeembracetraumahealing.org/
-The Trauma Center at Justice Resource Institute http://www.traumacenter.org/index.php
-Trauma Center Program Brochure - http://www.traumacenter.org/about/TC_Brochure_2011.pdf

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Chapter 9: Community-Based Response Systems Related to Sexual Assault

By Angiemil Perez

Background and Introduction

Research demonstrates a higher use of mental health and medical services amongst sexually assaulted population years past the assault. Sexual assault is a growing concern amongst the mental health community and is a crime that affects the society at large. According to Golding et al, (1988) because of the major increase in mental health and health cost this is a problem that not only affects the victim but also the community. It also influences the social norms and patterns such as fears of becoming a victim and individuals feeling restricted in their behaviors (Golding et al., 1988).

Other factors to consider is the victims' experience through the process of coming forward about their assault which according to Campbell's (1998) study: Typically, each system—legal, medical, mental health—is studied in isolation. From the perspective of the victims, however, these lines of demarcation may not be as distinct, meaningful, or useful. This flurry of activity is about one event in their lives, one trauma that is then parceled out among many for attention. Focusing on how the legal, medical, and mental health systems respond to victims' needs increases our understanding of victims' experiences with community systems. By taking this more holistic view of how communities respond, we can begin to see what victims experience and evaluate how well our social services are responding to their needs (p. 356)

Review of Relevant Research

Several factors could account for high rates of health services use among the assaulted, like the development of PTSD and other psychiatric disorders amongst those sexually assaulted. From the point of view of social expense it seems that in preventing sexual assault would then result in a decrease of health services use (Golding et al., 1988).

On the front of medical examinations, which can be a very invasive and traumatizing experience, it is necessary to note that not all victims included in the study of McGregor et al. (2002), demonstrated an emotive reaction at the time of the medical examination. As counselors we should be aware that sexual assault victims present differently and do not all follow the same pattern or present within the same symptom cluster.

One finding that was supported across the literature was the uncoordinated and non-collaborative inter-agencies relationship, which can cause negative effects for the victims. However despite the limitations it has been found that victims that visit the hospital or community agency after their assault and receive a rape exam are more likely to file a charges (Campbell, 1998). This same victim however has a long chain of command to work through such as going to the police to meet with a detective about their assault, talk to an attorney about prosecuting the case, receiving counseling from a rape crisis center and other community agencies. This process to prosecute or standard of operation in sexual assault cases is usually long and complicated and potentially can be re-traumatizing for the victims (McGregor et al., 2002).

Many cases are dismissed for insufficient evidence or because charges are dropped or not pursued by the victim. Some literature hypothesizes that victims that choose not to press charges do so because they realize the low conviction rate and prefer to not relive the events with such low chances of prosecution. Other research worth noting is demonstrated that conviction is not necessarily correlated with a positive DNA match, but has been correlated with the collection of evidence including that of a medical exam (McGregor et al., 2002). Additionally another factor accounted for in the literature is the limitations and difficulties for prosecution when at the time of a physical exam there is no trauma or sperm found on the victim (Tintinalli & Hoelzer, 1985).

Possible Counseling Issues (e.g., Individual, Family, and/or Couple)

According to Campbell (1998), the empathy a victim receives or does not receive from the different social services they interact with can have an extreme influence in catapulting clients into healing or deter them from recovery. Therefore as counselors some things to consider is our interaction with sexually assaulted victims, possible emotional consequences for clients that contracted a sexually transmitted infections or pregnancy, and amongst other things their emotions surrounding their pursuit or non-pursuit of pressing charges against the perpetrator (Campbell, 1998).

Possible marital or interpersonal problems commonly emerge amongst sexually assaulted survivors which can lead to higher needs of family, couple, and individual counseling. Users of mental health and medical health services are significantly more likely than nonusers to have a history of sexual assault. It is consistent through the literature that people are more likely to be in treatment or seek mental health care that

have experienced assault than their counter parts. Some research puts the figure as high as 1 in 4 users of mental health services have experienced a sexual assault (Golding et al., 1988). Needless to say, but worth highlighting, as mental health professionals it is important to seek training in trauma focused treatment to be able to meet the needs of our clients and fulfill our ethical obligation to them of acting in beneficence and nonmaleficence.

Additional Guidelines for Counseling Practice

When working with sexual assault victims the coordination of care between agencies is crucial to their recovery which according to some research is a major area of improvement (Cole & Logan, 2007). With many agencies involved there can either be overlap which does not effectively use resources and monies, but worse is the effect on those who slip through the cracks and do not receive the adequate care or follow-up.

There are many community resources such as rape crisis center, medical centers, law enforcement, legal counsel, and much more which counselors should be informed of to connect their clients to. In addition counselors should advocate and work closely with first responders to create a highly sensitive and empathetic process to ensure that victims are not re-traumatized or experience secondary traumatization. It is always integral that as counselors we realize our limitations and refer our clients to a higher level of care or a more specialized care when necessary.

What resources (e.g., books, Internet sites, and journal articles) are available to help professionals learn more about this topic?

http://www.familyservice-piedmont.org/sexual-assault (Community Resource)
http://www.conehealth.com/services/sexual-assault/ (Community Resource)
http://www.nccasa.org/need-help/nc-rape-crisis-centers (Community Resource)
http://www.crossroadscares.org/ (Community Resource)
https://tfcbt.org/ (Training)
http://epic.psychiatry.duke.edu/our-work/projects/trauma-focused-cognitive-behavioral-therapy (Training)
http://ncpic.net/2009/trauma-focused-cognitive-behavioral-therapy-tf-cbt/ (Training)
http://www.schoolmentalhealth.org/training/ (Training)

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Chapter 10: Treatment for Adult Sex Offenders

By Sophie Burke

Background and Introduction

Adult sex offenders (ASOs) undoubtedly comprise one of the most controversial and abominable populations in the United States. They are also one of the populations who are in great need of efficacious mental health care and assistance. The author does not condone the types of crimes that ASOs commit. However, these individuals battle unique demons in the forms of intrusive thoughts, images, memories, and urges that can be near impossible to mute or control (Priest & Smith, 1992). Such deep-seated issues require treatment methods that approach the ASO's past "as targets for the development of strengths rather than as deficits to be overcome" (Marshall, Marshall, Serran, & O'Brien, 2011, p. 7).

Before delving into treatment methods and counseling issues for ASOs, it is necessary to distinguish two types of offenders, based on the individual's characteristics and the selection pattern of their victims. According to Priest & Smith (1992) **fixated** offenders, in general, are "sexually attracted to children based on their identification with children and the desire to remain childlike" (p. 28). Often lacking social skills, the fixated client may engage in adult sexual relationships, but more so due to societal pressure. **Regressed** offenders blend more easily into adult society, enjoying both romantic and platonic relationships with peers. "When these adult relationships become conflicted or the offender experiences stress, he or she becomes motivated to interact sexually with a child" (p. 28).

With regard to ASO gender, there is a paucity of research concerning female offenders, and how they differ from the considerably higher male population (McLeod, 2015). Due to social standards, it is generally overlooked for a female to be in a role close to minors, thus an ASO can prolong her behaviors under the radar. McLeod's (2015) comparison study found that female offenders were 77.8% more likely to be a victim's parent, whereas males were usually "other relatives, unmarried partners, or friends and neighbors" (p. 109). Hopefully, this chapter will serve as a fair introduction to any student or professional interested in furthering their knowledge of the ASO population on a broader spectrum.

Review of Relevant Research

Up until the last decade or so, the primary treatment method of ASOs has been characterized by Marshall, Marshall, Serran, & O'Brien (2011) as an "aggressive, confrontational approach that emphasizes admitting guilt" (p. 4). Marlatt's (1982) relapse prevention (RP) model, dominant in the field of ASO rehabilitation, has emphasized aiding ASOs to "identify high risk situations and learn more effective means of coping with stress" (Witt, Greenfield, & Hiscox, 2008, pp. 247-248). A treatment technique such as RP sounds reasonable in theory, except for its focus on the client's deficits rather than their strengths. In addition, "programs modeled after the RP approach included the requirement that each offender… produce an elaborate and detailed account of his offense, including the immediate precursors" (Marshall, Marshall, Serran, & O'Brien, 2011, p. 12). If the offender's account veered from the RP model of sex offending behavior in any way, including "deviant fantasies" as a driving force, the client was accused of non-compliance, and the therapeutic alliance became even more weakened (2011, p. 12). It seems that the RP model, and the cognitive-behavioral approaches that followed, have been criticized for: a) uniformly approaching each ASO as if they had the "same group of deficits" as the next, and b) the punitive, forceful nature of treatment providers as a means of halting the ASO's potential to re-offend (Marshall, Marshall, Serran, & O'Brien, 2011).

Fortunately, *positive psychology*-based methods have gained a greater presence in the counseling of ASOs since the turn of the twenty-first century (Marshall, Marshall, Serran, & O'Brien, 2011, p. 11). "It is the failure of most therapists to use the clients' strengths in dealing with their difficulties that concerns positive psychologists" (p. 18). Instead of boxing into a corner the client who

has committed a heinous crime, the counselor can effect greater change overall by treating the ASO as a co-collaborator in the therapeutic relationship. Rehabilitative counseling can, and should be viewed as a reparative journey taken together for the client and the clinician. One such evidence-based technique is Ward's (2003) Good Lives Model (GLM), which takes a humanizing approach to the offender in recovery (Birgden & Cucolo, 2011, p. 307). Among the four guiding principles of the GLM, perhaps one of the most critical is the "positive strength-based approach to sex offenders in viewing them as interdependent and so reliant on the goodwill of others to *support* them" (p. 307). Through the GLM lens, reform during incarceration can become an empowering, edifying experience. Treatment encourages a web of support to develop among reforming inmates, as well as with their in-house mental health professionals.

Possible Counseling Issues

In order for the ASO client to even consider discussing their illegal history with a counselor, the crucial step of building rapport within a safe therapeutic relationship cannot be emphasized enough. In and outside of prison gates, ASOs are intensely alienated and persecuted, treated as social pariahs incapable of change. Whether incarcerated or on probation, the ASO likely experiences any combination of isolation, fear, depression, and shame (to name a few) that causes a lack of desire or confidence to heal and modify their behaviors. As cited by Birgden & Cucolo (2011), La Fond (2011) describes the devolving nature of sex offender policy, a result of legislation that views this troubled population as "lifelong predators who will seek out new victims as long as they live" (p. 296).

Depending on the U.S. state, the length of time required to be registered as a sex offender can cause irreparable damage to the client's life in numerous ways, including employability, tenancy, and support systems (e.g. family, friends). Whether counseling serves the individual, the ASO and their partner/spouse, or family/relatives, the therapeutic bond can be further strengthened by exploring with the identified patient (IP) their lived experience of the registered sex offender status. This process aids the IP, and loved ones, in developing stronger self-awareness, and building coping skills for the foreseeable future.

Another basic building block of the treatment process involves assessing "the client's perception of his problematic behavior within treatment" (Patel, Lambie, & Glover, 2008, p. 87). For all involved, the process of assisting an ASO to examine themselves and their past wrongs can often seem like a twisting, winding trail through dense forest. It is not uncommon for the client to display manipulative behaviors towards the counselor, or exhibit denial about continuing with sessions, let alone admitting to the crime(s) that they committed (Priest & Smith, 1992). Even if the client is cooperative and open in sessions, and demonstrates a marked effort at self-reform, relapse is always a potential. All this to say, we as counselors must take responsibility in meeting the client where they *currently* fall along Prochaska et al.'s (1992) Transtheoretical Model of Change (TTM) (Patel, Lambie, & Glover, 2008). It is, perhaps, most apt to approach working with ASOs as one would with individuals suffering from alcohol and drug addictions. In regards to the rehabilitative process, Priest & Smith (1992) remark that "the operative word seems to be *control* as opposed to *cure*" (p. 29). If we do not apply TTM, or at least acknowledge the client's own reaction to reform, the potential for growth and success becomes greatly minimized. If we grow impatient and *force* behavior change prematurely, the client will view us as simply one more authority figure threatening "change now, or else..."

Critical to understanding and empathizing with this client population is the detailed knowledge of the ASO's own developmental history, especially their *current* developmental stage. As elaborated in this chapter's introduction, the **fixated** and **regressed** offender types differ considerably in how they self-relate to their victims. The *fixated* type may need counseling based on their intense identification with the victim's age, usually that of a child or teenager. The *regressed*, on the other hand, may benefit more if the counselor focuses on specific periods of stress that drove the client to reject consenting adult company, and instead pursue sexual gratification from a minor (Priest & Smith, 1992). If the

counselor can delve into such dark recesses of the ASO's identity, specifically their desire to sexually offend, then the clinician can view the client through a more complete lens. In session, possible origin stories could even surface and be discussed that aid the client in recognizing what presaged their sexually deviant, and self-destructive behaviors. Although much criticism surrounds the RP model, as expressed by Marshall, Marshall, Serran, & O'Brien (2011); Witt, Greenfield, & Hiscox (2008); and Birgden & Cucolo (2011), the process of counseling ASOs is made more fruitful to their long-term recovery by identifying the painful memories, thoughts, and triggers that could lead to potential relapse.

Additional Guidelines for Counseling Practice

The American Counseling Association's (2014) Code of Ethics' section A.2.e recommends "prior to the beginning of counseling" when working with mandated clients, counselors are to inform the individual of "what type of information and with whom that information is shared" (p. 4). When serving the ASO population, complete and total confidentiality can never quite exist as it ordinarily would if counseling average citizens who are not on probation or incarcerated. Therefore, the utmost caution and clarity should be utilized at the time of communicating informed consent to the potential client. "Limited confidentiality," Priest & Smith (1992) recommend, "wherein the client is informed… that information related to the sexually abusive behavior may be furnished to the… authorities, seems an appropriate solution to this dilemma" (p. 29).

Once treatment is underway, though, the provider "may experience a sense of professional conflict related to the issue of reporting a client's sexually inappropriate behavior" (Priest & Smith, 1992, p. 29). This feeling of *conflict* could become especially problematic if the client had been making marked progress, had established good rapport, but then suffered a relapse. Due to the harsh legal ramifications of failing to report in the context of counseling ASOs, the counselor must prepare themselves for the likely scenario of breaking confidentiality out of necessity. The client should certainly be made aware of such reporting beforehand, but the provider must remember that they carry a responsibility to protect the public, especially minors and those less able to defend themselves.

Finally, due to the intense nature of counseling ASOs in the reform process, it is strongly recommended that treatment providers respect themselves through regular acts of self-care, including personal counseling. At first, counselors of ASOs may experience pride in their ability to sit with clients who are rejected by most laypeople, and referred out by many therapists. However, such work can quickly become isolating and vicariously traumatic in multiple, and sometimes unexpected ways. "It is not unusual for persons to disparagingly inquire of counselors "How can you work with those people?"' (Priest & Smith, 1992, p. 28). The decision to provide treatment to ASOs cannot be made lightly, but there is great potential to improve the system of reform and in turn, lower the rates of recidivism.

What resources are available to help professionals learn more about this topic?

- Read Miller & Rollnick's (2013) *Motivational Interviewing* (Third Edition).
- Listen to The Diane Rehm Show's broadcast from July 7th, 2015: http://thedianerehmshow.org/shows/2015-07-07/sex-offender-registries-and-calls-for-reform
- Read about federal and specific state sex offender registry laws: http://www.justice.gov/criminal-ceos/sex-offender-registration-and-notification-act-sorna
- Visit the International Association of Addictions & Offender Counselors, and access the Journal of Addictions & Offender Counseling: http://www.iaaoc.org/index.html
- Listen to podcasts under Mental Health; Addiction; Multicultural; Family; and Other Topics: http://www.counseloraudiosource.net/Archive/Courses/

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Chapter 11: Treatment for Juvenile Sex Offenders

By Michelle Vann Horton

Background and Introduction

The U.S. Department of Justice defines a juvenile sex offender (JSO) as a minor being 6-17 years of age and engaged in unwanted physical or non-physical (e.g., viewing pornography or sexual suggestions) forms of sexual contact with a minor or adult (Finkelhor, Ormrod, & Chaffin, 2009). The demographics for this heterogeneous population transcend age, gender, race, social economic class, and family dynamics (Finkelhor et al., 2009). Depending on the degree of the offense, JSO's can be placed in outpatient treatment programs or in more rigorous residential treatment facilities and juvenile detention centers (Efta-Breitbach, & Freeman, 2005). Co-occurring issues associated with treating JSO's include Posttraumatic Stress Disorder (PTSD), major depression, personality disorders, and substance abuse (Gerardin & Thibaut, 2004; Letourneau & Borduin, 2008; Parrish, Stanard, & Cobia, 2008). Literature on juvenile sex offending emerged from research on adult sex offenders who reported deviant sexual behavior during adolescence (Walker & McCormick, 2004; Finkelhor et al., 2009). On average, about 50% of adult sex offenders report deviant arousal patterns by the age of 15 (Gerardin & Thibaut, 2004; Parrish et al., 2008). After several years of using interventions designed for adult sex offenders (Longo, 2004; Letourneau & Borduin, 2008) and as the rise of juveniles entering sex offender treatment programs persist (Finkelhor et al., 2009), current research studies are investigating juvenile-specific sex offender treatment options. However, existing literature reports few approaches have been empirically validated for treating juvenile sex offenders and decreasing recidivism rates (Longo, 2004; Letourneau & Borduin, 2008).

Review of Relevant Research

In normal sexual development, children experiment with self-exploration, self-genital play, and may later turn their curiosity to sex play with peers. During preadolescence, masturbation is common and until puberty, most sexual displays in children are exploratory and not oriented toward orgasm (Gerardin & Thibaut, 2004). What is important to note is that this display of curiosity is non-aggressive in nature and has mutual consent. Statistics report that 90% of JSO's are male and the median age of reported offenders is 14-15 year of age (Gerardin & Thibaut, 2004; Finkelhor et al., 2009). Female juvenile sex offenders usually have experienced more severe abuse and tend to sexually offend at a younger age than males. Additionally, reports of sexual aggression in children 3-4 years of age have been documented, and in general JSO's have an onset age of 6-9 years old (Gerardin & Thibaut, 2004; Finkelhor et al., 2009). Forty-two percent of JSO's report perceiving sex as a way to feel power and control, hurt or punish others, and/or release anger (Gerardin & Thibaut, 2004; Parrish et al., 2008). Parrish, Stanard, and Cobia (2008) reported two types of JSO's, those who assault peers and adults and those who perpetrate against children. Victims of JSO's who assault peers are mostly female and strangers and tend to take place in public areas, including school settings. The victims of JSO's who perpetrate against children are mostly male and take place in the victim's home (Gerardin & Thibaut, 2004; Finkelhor et al., 2009). In 90% of cases, the victim is known by the perpetrator (Gerardin & Thibaut, 2004).

Cognitive-Behavioral Treatment (CBT) with group-based interventions, more specifically CBT-Relapse Prevention, is the most common treatment approach used with JSO's (Longo, 2004; Gerardin & Thibaut, 2004; Walker & McCormick, 2004; Efta-Breitbach, & Freeman, 2005; Letourneau & Borduin, 2008; Parrish et al., 2008). Psychoanalytic and insight-oriented approaches have not proven effective with the JSO population (Efta-Breitbach, & Freeman, 2005; Gerardin & Thibaut, 2004). Parrish et. al. (2008) reported growing support for the use of an existential-humanistic treatment approach to address faulty thinking and the offender's likelihood of engaging in "I-It" relationships. Because offenders themselves may have been objectified, an existential therapist's goal

would be to help offenders develop "I-Thou" relationships. Multisystemic Therapy (MST) is an approach that has long been validated as an effective treatment with juvenile nonsexual offenders, but research studies are aiming to confirm the validity of MST as a potential treatment option for JSO's as well (Efta-Breitbach, & Freeman, 2005; Letourneau & Borduin, 2008). Letourneau and Borduin (2008) acknowledged the need to find treatment options viable for both JSO's and juvenile nonsexual offenders due to several identified known correlates between these two populations. Both JSO's and juvenile nonsexual offenders have higher rates of academic, emotional, and behavioral problems, a history of sexual and physical abuse, family conflict and violence, parental loss and neglect, and exposure to substance abuse (Gerardin & Thibaut, 2004; Parrish et al., 2008). Effective treatment options would focus on the multiple facets that co-occur with JSO's and nonsexual juvenile offenders (Letourneau & Borduin, 2008; Parrish et al., 2008). At this time, the use of pharmacological treatment options remains controversial due to lack of evidence of its success in treatment (Gerardin & Thibaut, 2004; Efta-Breitbach, & Freeman, 2005).

Researchers suggest considering socio-cultural and environmental factors when working with JSO's by incorporating family, peers, and schools in treatment (Longo, 2004; Letourneau & Borduin, 2008; Parrish et al., 2008). Several goals to consider during treatment include: (a) accepting full responsibility of the sexual crime; (b) correcting cognitive distortions; (c) relapse prevention; (d) address the JSO's own victimization; (e) promote awareness and empathy toward the victim; (f) anger management; (g) social skills; (h) psychoeducation on sexuality; and (i) reintegration into the home, just to name a few (Gerardin & Thibaut, 2004; Longo, 2004; Efta-Breitbach, & Freeman, 2005; Letourneau & Borduin, 2008; Parrish et al., 2008). Working with the families of JSO's is also important in order to address family dysfunctions, increase trust within the family, and build a positive family support system (Gerardin & Thibaut, 2004; Letourneau & Borduin, 2008). Treatment is effective with JSO's and their families when they are able to explore their life experiences (family dysfunctions and trauma experiences) and understand how these factors may have influenced their behavior (Parrish et al., 2008).

Possible Counseling Issues

In 2004, The National Incident-Based Reporting System (NIBRS), a program used by the U.S. Department of Justice to collects a wide range of information on victims, offenders, and offenses, reported a small group of minors (younger than age 6) who were reported to law enforcement for sexual offending (Finkelhor et al., 2009; Gerardin & Thibaut, 2004). The ambiguity in determining when a minor is being sexually curious, inappropriately sexually touching, and committing a sexual offense can be very subjective in any given situation. The notion of children, especially very young children, committing sex offenses is a problematic issue equally for parents, law enforcement, and clinical professionals. Counselors must be able to distinguish between harmless sexual contact and when to report allegations of sexual abuse to law enforcement. Clinical judgment must consider consent, aggression, the sexual maturity of the child, and the age difference between the offender and victim when making a determination (Gerardin & Thibaut, 2004). Consultation with supervisors and other agencies allow the counselor to consider other perspectives when making a final decision. The therapeutic relationship continues to play an important part in the therapeutic process toward recovery (Longo, 2004; Efta-Breitbach, & Freeman, 2005; Parrish et al., 2008). Counselor bias and pessimism can be detrimental to a client's wellbeing, especially when a client is not able to have a corrective experience through the client-counselor relationship (Longo, 2004; Letourneau & Borduin, 2008). Because JSO's also rely on counselor's to advocate for them, bias and pessimism could influence the counselor's effectiveness in this role. Finally, ethical and controversial concerns exist in the treatment of juvenile sex offenders as adults in treatment methods (Letourneau & Borduin, 2008).

Additional Guidelines for Counseling Practice

Early intervention is a key component in reducing recidivism rates among juvenile sex offenders (Parrish et al., 2008; Finkelhor et al., 2009). However, few treatment approached have been proven effective in treating youth with sexual behavior problems (Longo, 2004; Letourneau & Borduin, 2008). Counselors should view client's from a holistic perspective, considering cultural and environmental components when establishing a treatment approach and interventions (Longo, 2004). Flexibility of treatment is needed to help meet client needs as they reintegrate into their homes and society (Efta-Breitbach, & Freeman, 2005; Letourneau & Borduin, 2008). Ultimately, counselors should remember that juvenile sexual offenders cannot be cured of deviant sexual behavior; treatment is implemented to reduce the risk of relapse and lead adolescents into recovery (Gerardin & Thibaut, 2004; Letourneau & Borduin, 2008).

What resources are available to help professionals learn more about this topic?

Books

- Bromberg, D.S., & O'Donohue, W.T. (Eds.). (2014). *Toolkit for Working with Juvenile Sex Offender*s. Waltham, MA: Academic Press.
- Perry, G.P., & Orchard, J. (1992). *Assessment and Treatment of Adolescent Sex Offenders*. Sarasota, FL: Professional Resource Press/Professional Resource Exchange.
- Rich, P. (2011). *Understanding, Assessing and Rehabilitating Juvenile Sexual Offenders* (2nd ed.). Hoboken, NJ: John Wiley & Sons Inc.

Journals

- Journal of Child Sexual Abuse
- Sage Journal: Trauma, Violence, Abuse
- Sexual Abuse: A Journal of Research and Treatment

Websites

- Association for the Treatment of Sexual Abusers- http://www.atsa.com/
- Center for Sex Offender Management- http://www.csom.org/
- Sex Offender Management Assessment and Planning Initiative http://www.smart.gov/SOMAPI/index.html

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Chapter 12: Interventions for Non-offending Parents of Children Who Have Been Sexually Assaulted

By Elissa Pope and Kelly King

Background and Introduction

Affecting over 80,000 children and families each year, childhood sexual abuse (CSA) is an important issue for mental health professionals to be aware of (aacap.org). In fact, The National Center for Post-Traumatic Stress Disorder estimates that as many as 16% of our population's boys and 25% of our girls will experience sexual assault. CSA is a traumatic event with wide-ranging impacts for both victims and their family members. Abuse can occur in different contexts: within the family (perpetrated by a caregiver or other relative) or outside of the family. We will focus on CSA perpetrated by someone other than the parent or caregiver, as this configuration presents both unique challenges and the potential for a strong recovery. Across contexts, children survivors of abuse will likely experience a range of troubling symptoms, including but not limited to depression, sleep problems, school refusal, conduct problems, and suicidal behavior (aacap.org). In the case of a non-offending parent/caregiver, we can also expect them to undergo a host of negative reactions, ranging from feelings of anger and guilt to depression, anxiety, and post-traumatic stress disorder (Corcoran, 2004; Hill 2005). In the event that the parent or caregiver is not the perpetrator of the abuse, they can become a very important participant in their child's healing. It is important for counselors to engage this potential.

Review of Relevant Research

A growing body of research examines the experience of non-offending parents, or secondary survivors of childhood trauma, in learning of their child's abuse, providing support to their children, and developing their own ability to cope and adjust (Myrick & Green, 2013). In terms of treatment recommendations, the literature emphasizes joint counseling or strong alliances with the non-offending parent outside of session to promote healing for the entire family. For some of these parents, the therapeutic benefits of participating in their child's therapy will be sufficient. Others, however, may require individual therapy in order to manage their distress and to set goals for how to best support their children (Hill, 2005). Research into the caregiver's experience indicates the following difficulties: resolving feelings about self, the child, the offender, and response systems (police, court, social services, etc.) (Myrick & Green, 2013). Effective interventions for parents may include processing each of these domains and resolving existing conflicts.

Some of these themes were addressed in a study conducted by Hernandez et al (2009). Researchers formed a group for non-offending parents and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) was utilized alongside psychoeducational/supportive interventions. The goal of this study was to improve family functioning following the sexual abuse of a child in the family through interventions aimed to explore sexual abuse, discuss family communication and dysfunction, and empower parents to navigate the legal and child welfare systems. Furthermore, the parent groups utilized TF-CBT skill-training components related to coping and relaxation, cognitive restructuring, and gradual exposure through creation of a trauma narrative. The study showed an improvement in family functioning, highlighting the importance of further development of family-focused interventions for the non-offending parents of sexually abused children.

Another line of inquiry looks at non-offending parent's response to the abuse and its relationship to therapeutic outcomes. One study found that the majority of non-offending parents surveyed both believed and supported their children, while it is important to acknowledge that some choose not to for a variety of reasons (Hill, 2005). Parental involvement has a strong impact on therapeutic outcomes for their children. While parental support has been shown to improve children's adjustment, high levels of parental distress relate to higher levels of distress in the child (Hill, 2005).

These findings suggest that counselors should be aware of the dynamics of each specific case in order to determine if parental involvement would be helpful for the child.

In a review of treatment approaches for child survivors and non-offending parents, Hill finds evidence to suggest the efficacy of the following: individual play therapy for the child with separate meetings for the parent, play therapy with some parental participation and cognitive behavioral approaches consisting of individual and joint sessions (2005). Hill also notes that there are limitations to using non-directive techniques in the aftermath of serious trauma, suggesting that cognitive-behavioral exercises should be incorporated for both children and their parents/caregivers (2005). Several studies have been conducted in which play therapy is utilized with the sexually abused child, and the parents are included in a parent education model (Hill, 2006). With the aim of building the parent-child relationship, the parental involvement can serve to show children an effective use of adult authority, offering an example of difference between assertiveness and aggression (Hill 2006). What's more, this method seems to positively impact the non-offending parent's sense of confidence in key parenting tasks. Furthermore, Mary Costas and Gary Landreth (1999) suggest the use of filial therapy with non-offending parents. This intervention empowers parents as they observe their child's play, helping them to be sensitive to, and accepting of, their child's feelings.

Possible Counseling Issues (e.g., Individual, Family, and/or Couple)

Working with families who have experienced CSA presents a number of challenges and in this section we will note counseling issues of which practitioners should be mindful. Further, we caution that each family should be considered on an individual basis in order to better understand their unique context.

The non-offending parent may feel ambivalence towards the abuse, the perpetrator or the child; particularly when the abuse is intra-familiar (Levy-Peck, McCurley & Wolfe, 2009). It is important for the clinician to understand the complexities of this ambivalence in order to remain non-judgmental. Research into this phenomenon states that this ambivalence may not interfere with the child's progress in counseling insofar as parents can experience ambivalence and act in a decisive, supportive fashion. A parent's ambivalence might be normalized by their counselor as a reaction to discovering new information about a previously trusted and loved relative. It is also important emphasize the parent's desire to support their child and act in ways that communicate this support despite their own internal struggle.

From a children's rights perspective, involvement of a parent in therapy could pay too little attention to a child's need for privacy in counseling (Hill, 2006). At the same time, it is noted that some parents may simply be too distressed for this technique and that their involvement may indeed be a counterproductive experience for the child. It is important for clinicians to be aware of the level of care required for the parent/caregiver in this situation and to monitor how their response is impacting their child's progress.

Additional Guidelines for Counseling Practice

When working with non-offending parents of sexually abused children, counselors should be mindful of the internalized feelings of self-blame often experienced by these individuals. Many feel anger toward the offender, as well as fear about what disclosure of the abuse might mean for the family. Research notes that for many parents, the abuse reinforces feelings of perceived parenting failure and incompetence (Hernandez et al, 2009).

What resources (e.g., books, Internet sites, and journal articles) are available to help professionals learn more about this topic?

- *Mothers of Sexually Abused Children* (www.mosac.net)
- *National Child Traumatic Stress Network (www.nctsn.org/trauma-types/sexual-abuse)*

- *Washington Coalition of Sexual Assault Programs (*www.wcsap.org/sites/www.wcsap.org/files/uploads/documents/NonoffendingCaregivers2009.pdf)

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