


2017

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Recommended Citation

Foster, J. M. (2017). A Survey of Students' Knowledge about Child Sexual Abuse and Perceived Readiness to Provide Counseling Services. *The Journal of Counselor Preparation and Supervision*, 9(1). <http://dx.doi.org/10.7729/91.1165>

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A Survey of Students' Knowledge about Child Sexual Abuse and Perceived Readiness to Provide Counseling Services

Abstract

Master's level students in counselor education and counseling psychology (N = 304) were surveyed to explore their knowledge about child sexual abuse (CSA) and perceived readiness to provide related counseling services. While students demonstrated general knowledge about sexual abuse, preparedness to counsel was rated much lower with 69% of students indicating low levels of competency. Data was analyzed to explore demographic characteristics that led to increased readiness scores. Indicators of statistically significant higher readiness scores included: prior work or volunteer experience with victims of sexual abuse, participation in CSA trainings, and supervised field experience. Implications for student training and recommendations for counselor preparation programs are delineated.

Keywords

sexual abuse, training, preparation, counseling, supervision, competency

It is estimated that a large number of children (1:4 girls, 1:6 boys) will be sexually abused before reaching adulthood (Centers for Disease Control and Prevention, 2005; National Association of Adult Survivors of Child Abuse, 2015). In meta-analysis of 65 studies on child sexual abuse (CSA) in 22 countries, 7.9% of men and 19.7% of women acknowledged a sexual abuse history. The researchers concluded that CSA was much more prevalent globally than previously thought (Pereda, Guilera, Forns, & Gómez-Benito, 2009).

Since sexual abuse often goes unreported, and many children do not disclose their experiences, the rates of CSA may be much higher than statistics indicate (Green, 2008).

Following sexual abuse, approximately one-third of children appear asymptomatic; whereas, around half exhibit severe symptoms (Adler-Nevo & Manassis, 2005). Problems can occur in multiple domains (e.g., social, cognitive, academic, physical, spiritual, and emotional) (Goldfinch, 2009; Tomlinson, 2008), and children in treatment for CSA are frequently diagnosed with one or more mental health disorders (Briere & Lanktree, 2008). Despite immediate and future negative consequences of CSA, early intervention often results in successful outcomes (Green, 2008).

For adults with *unresolved* trauma, the effects of CSA are long reaching. Many survivors experience intrapersonal and interpersonal difficulties that negatively impact their general health and wellbeing (Parker, Fourn, Langmuir, Dalton, & Classen, 2007). These challenges may lead survivors to seek counseling. According to a meta-analysis of 40 studies, an average of 50% of women and 28% of men who enter counseling have a CSA history (Read, Goodman, Morrison, Ross, & Aderhold, 2004). For some clients, their counselor is the first person to whom they disclose their abuse. With numerous clients sexually abused as children, it would seem imperative that counselors are ready to assist, yet this is not the case.

The majority of practicing clinicians, including school counselors, psychologists, social workers, mental health counselors, and nurses, report that they had little to no training in the area of child sexual abuse and were unprepared to address the needs of CSA victims (Day, Thurlow, & Woolliscroft, 2003; Goldman & Padayachi, 2005; Lokeman, 2011; Winkelspecht & Singg, 1998). In one study, 81% of counselors said they were under-equipped, uncomfortable, and not very competent to provide services to CSA survivors (Day et al., 2003). School counselors in another study struggled to identify warning signs of CSA, lacked counseling skills for working with victims, and under-reported concerns of possible CSA, despite their role as mandated reporters (Goldman & Padayachi, 2005). Hinkelman and Bruno (2008) assert that addressing CSA requires a special skillset that many school counselors do not possess because their training programs failed to equip them. Yet, there is a discrepancy between the number of programs that reported preparing their students to work with clients who have experienced trauma (69%), and students from those same institutions that reported receiving training (31%) (Lokeman, 2011).

Similar to teachers-in-training, students in the helping fields will interact with children during internship experiences, and must be prepared to recognize signs of abuse, properly handle a disclosure, report suspected abuse, and provide treatment or referrals (McKee & Dillenburger, 2009). Thus preparation in the area of CSA must start in the classroom, and then be continued while under supervision in the field. With professional counselors reporting lack of training, one must look to students-in-training programs to investigate the extent and quality of preparation that they are receiving to work with this population. This study utilized survey research to investigate students' knowledge of sexual abuse and explored their level of preparedness for providing counseling services to child victims, adult survivors, and

nonoffending parents or caregivers of child victims. The results indicated there is a vital need for specialized preparation in CSA in training programs.

Rationale for CSA Training

Given the statistical likelihood of working with survivors of CSA, future helpers need to be well prepared. Lack of preparation has the potential for negative outcomes for both counselors (e.g., burnout, compassion fatigue, vicarious trauma, feeling incompetent, unethical behavior) and clients (improper referral, inadequate treatment, further silencing) (Adams & Riggs, 2008; Cavanagh, Read, & New, 2004; Pearlman & Saakvitne, 1995; Read, Hammersley, & Rudegeair, 2007). While lack of preparation results in negative outcomes, proper training can equip future counselors to identify abuse and initiate treatment. Specific areas for CSA training include: (a) inquiring about abuse, (b) exploring details of the trauma, (c) conveying empathy, (d) implementing evidence-based approaches, (e) self-care, and (f) supervision (Foster, 2011). Each of these components is discussed briefly below.

First, proper training prepares students to ask clients about abuse history and respond in a supportive manner. Although clients may have already completed an intake, it is also important for counselors-in-training to ask about abuse directly. Many clients skip this portion of an intake, answer falsely to avoid the topic or because they believe it is not relevant to their current issue, or answer “no” because they do not define their experience as abusive or out of fear that they will be accused of abusing their own children (SAMHSA, 2000). Students must learn how to communicate that CSA can be discussed openly in the safety of the therapeutic relationship.

Along with asking about a CSA history, counselors-in-training need to be ready to openly explore the abuse. Counselors may be hesitant to do this out of fear that they will

retraumatize their clients (Cavanagh et al., 2004). Others may unconsciously shift focus away due to inability to hear details of the trauma or counter-transference (Ventura, 2010). This avoidance communicates that abuse experiences must be kept silent (Crenshaw & Hardy, 2007). Exploring details of another's trauma is challenging and makes counselors aware of their vulnerability to pain, violence, and mortality. Thus training is essential to increase ability to explore trauma histories, including the often painful and frightening details (Foster & Hagedorn, 2014a).

Ability to convey empathy is another essential component of training. While listening to the details of the abuse, unprepared counselors may unknowingly withdraw empathy and distance themselves from clients as a form of self-protection (McGregor, Thomas, & Read, 2006). Emotional distance may hinder clients' progress and communicate that the sexual abuse is something to be ashamed of (Pistorius, Feinauer, Harper, Stahmann, & Miller, 2008). Victims are highly perceptive to their counselors' readiness to hear about abuse and are unlikely to share if they believe the counselor is unavailable (Jones & Morris, 2007). Counselors have an opportunity to offer hope and understanding through conveying empathy (Jenmorri, 2006).

In addition to the ability to convey empathy, students must be knowledgeable about CSA treatment and able to implement evidenced-based approaches. Effective methods have been established for CSA victims. For example, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) effectively reduces anxiety, depression, and trauma related symptoms (Cohen, Mannarino, Berliner, & Deblinger, 2000; Cohen, Mannarino, & Deblinger, 2006). In a meta-analysis of 21 randomized controlled studies of trauma treatments, TF-CBT was the only approach to meet the "well-established criteria for children and adolescents exposed to

trauma because the treatment was found to be statistically significantly superior to psychosocial placebo or to other treatment" (Silverman et al., 2008, p. 160). Lack of awareness of and training with approaches such as TF-CBT may result in inappropriate referrals or failure to provide adequate treatment. When counselors are knowledgeable about CSA treatment, they can communicate to their client the benefits of counseling and instill hope (Foster, 2011).

Another key part of student training is to discuss the necessity of self-care. Unfortunately, many counselors receive minimal self-care training (Culver, 2011). This is especially problematic for helpers who assist trauma victims as they are at a greater risk for burnout, compassion fatigue or secondary traumatic stress (also referred to as vicarious traumatization) (Craig & Sprang, 2010; Culver, 2011; Jenmorri, 2006; Sommer, 2008; Stewart-Spencer, 2009; Trippany, White-Kress, Wilcoxon, 2004). In order to maintain effectiveness, helpers must engage in activities to decrease these risks such as developing a wellness plan. Proper education about compassion fatigue can increase students' readiness to work effectively with CSA victims.

Finally, supervision is an essential element to trauma work for beginning helpers (Foster, 2011; Sommer, 2008). Novice counselors often experience a variety of challenges, including questioning their own worldview and previously held assumptions about CSA (Eave, 2011). Supervisors with expertise in the area of trauma guide inexperienced counselors as they explore the personal impact of working with survivors. Supervisors model special skills and help supervisees navigate challenges that arise. Supervisors also watch for signs of vicarious traumatization (Sommer, 2008). For specific guidelines for CSA supervision see Pearlman and Saakytne (1995), Etherington (2000), and Maidenberg (2004). In sum, there are

multiple areas that students need specific training: inquiring about abuse history, exploring the trauma, demonstrating empathy, implementing effective approaches, engaging in self-care, and learning through supervision.

Current Counseling Standards for Training

Despite the increasing awareness of the need to train students to address trauma, current accreditation standards set forth by the American Counseling Association (ACA) and the Council for Accreditation of Counseling and Related Programs (CACREP) do not require training programs to offer a course or other form of intensive training specific to sexual abuse (ACA, 2015; CACREP, 2009). The 2009 CACREP Standards do stipulate that all counselors understand the “effects of crises, disasters, and other trauma-causing events on person of all ages” (CACREP, 2009, p. 10). Child sexual abuse is one type of trauma that counselors must be prepared to address, but the standards are silent on the specific requirements of training and how much time must be dedicated to each type of trauma.

Unfortunately, many counseling programs are not adequately preparing students. One study indicated that 79% of programs sampled did not require students to take a course in trauma (Stewart-Spencer, 2009). This sends a message to students that “trauma is not an important aspect of counselor education and is unnecessary training for the mental health profession” (Stewart-Spencer, p. 78). Trauma training may not be viewed as essential despite the high likelihood that students will work directly with individuals who have experienced trauma (Champion, Shipman, Bonner, Hensley, & Howe, 2003), and training programs may fail to provide preparation for vicarious traumatization unless they are mandated to do so (Sommer & Cox, 2005).

Rationale for Study

Although some research has examined the level of preparedness of practicing counselors in the field (Bryant, 2009; Day et al., 2003; Eave, 2011; Lokeman, 2011; O'Halloran & O'Halloran, 2001; Winkelspecht & Singg, 1998), students' level of readiness for counseling victims and knowledge about sexual abuse is largely unknown. Only one qualitative study was found which involved semi-structured interviews with six counselors-in-training to examine perceptions on their education and confidence working with children who have experienced interpersonal trauma (Fitzgerald, 2013). The students in this study disclosed that they felt ill-prepared and lacked confidence with this specific population. Specifically, six themes emerged from the interviews, including: "(a) adverse emotional and physical reactions; (b) increased empathy for self and others; (c) changes in how counselors-in-training view their own families; (d) changes in professional expectations; (e) ways counselors-in-training cope; and (f) training issues" (p. 86). To further explore this topic with a large sample of students, a survey was developed and administered to identify students' current knowledge and perceived competence with regard to CSA counseling. The following questions guided the study:

Research Question 1: What do trainees know about CSA?

Research Question 2: To what degree do trainees feel prepared to provide counseling services to CSA child victims, nonoffending parents or caregivers, and adult survivors of CSA?

Research Question 3: What demographic factors increase trainees' knowledge and perceived readiness to provide counseling for CSA?

Method

Participants

Following the university's Human Subjects Institutional Review Board approval, master's level counselor education and counseling psychology students were asked to respond to an anonymous paper and pencil survey. The survey was distributed during a single semester at a large CACREP-accredited university in a Midwestern state in the U.S.

Of the 482 students enrolled in courses (at the main campus and three regional campuses), 304 completed the survey yielding a 63% response rate. All 304 surveys were usable for data analysis; however, responses varied on some of the demographic items. The items with the lowest response rate were ethnicity, which was answered by 78% ($n = 238$) of the sample and gender, which was answered by 91% ($n = 278$) of the sample. This may be due to fear that students would be identified in a program that is predominately White and female.

Demographically, 69 % ($n = 209$) of the graduate students in the sample were women, 22% ($n = 68$) men, and 1 student identified as other. Whites comprised 61% ($n = 185$) of the respondents; the remaining respondents were Black (9%, $n = 26$), Hispanic (4%, $n = 12$), multiracial (3%, $n = 10$), and Asian (2%, $n = 5$). Sixty percent ($n = 181$) of the respondents were age 20–29 years, 24% ($n = 72$) were 30-39, 9% ($n = 27$) were age 40-49, 6% ($n = 19$) were age 50-59, 1% ($n = 4$) were age 60 and older. Sixty-five percent of the students were in counselor education, and 35% counseling psychology. Among the counselor education specialties, mental health counseling was indicated as the field of study by 24% ($n = 74$) of the students, school counseling by 18% ($n = 54$), marriage and family by 13% ($n = 38$), college counseling by 6% ($n = 18$), rehabilitation counseling by 2% ($n = 6$), and dual enrolled by .3% ($n = 1$). Forty-five percent ($n = 137$) of the entire sample of students (counselor education and

counseling psychology) indicated that they had completed 20 credit hours or less in the program, 32% ($n = 97$) had completed between 21 and 40 hours, 21% ($n = 64$) had previously completed 41-60 credit hours, and 2% ($n = 6$) had completed more than 60 credit hours. Thirteen percent ($n = 39$) of the respondents were enrolled in an onsite practicum, and 5% ($n = 14$) were enrolled in a field internship. The majority of the participants, 71% ($n = 217$), had no prior training in CSA. Further, 61% ($n = 184$) of the participants had no previous work or volunteer experiences with CSA victims. Finally, 17% ($n = 52$) of the sample disclosed a CSA history, and 52% ($n = 157$) of the sample indicated that a close friend or family member had been a victim of CSA.

Survey Instrument

A review of the empirical literature revealed that a survey related to students' CSA knowledge and perceived readiness did not exist. A brief 26-item survey was created by the author and an assistant who had clinical experience with victims of child sexual abuse. The survey was created based on review of current literature about CSA and treatment. Consensus was reached between the author and assistant about the inclusion of 26 items. Additionally, the survey was reviewed by a content expert in the area of sexual abuse who was not associated with the study. The individual provided feedback on the questions and gave some suggestions for rewording several of the statements to enhance their clarity. The reviewer stated that the survey assessed key knowledge areas related to sexual abuse as well as competencies, which contributed to the face validity of the instrument.

The survey was organized into three sections. Section I consisted of demographic questions, which were used to answer Research Question 3. Section II addressed Research Question 1 and began with a definition of CSA from the Keeping Children and Families Safe

Act, 2003 [42 U.S.C.A. §5106g(4)]:

(a) The employment, use, persuasion, inducement, enticement, or coercion of any child to engage in, or assist any other person to engage in, any sexually explicit conduct or simulation of such conduct for the purpose of producing a visual depiction of such conduct; or (b) the rape, and in cases of caretaker or interfamilial relationships, statutory rape, molestation, prostitution, or other form of sexual exploitation of children, or incest with children.

Students were then presented with 12 statements about CSA with “agree” or “disagree” as response options. For example, students were asked if they agreed or disagreed that: “Children who have been sexually abused usually tell someone as soon as it happens;” “Sexual abuse is frequently a one-time incident;” and “Children who are sexually abused may defend or feel positive toward the perpetrator.” Section III of the survey addressed Research Question 2 and was composed of 10 items that required students to respond to a 4-point Likert-scale from 1 (strongly disagree) to 4 (strongly agree). Students were asked to assess their level of readiness to provide counseling-related services that were identified in the literature as the most common, including readiness to (a) work with a child victim, (b) counsel an adult with CSA history, (c) identify signs and symptoms of sexual abuse, (d) make a mandated report, (e) provide evidence-based treatment interventions, (f) hear details of the abuse, (g) administer assessments related to the trauma, (h) ask questions about suspected abuse without leading, (i) include nonoffending parents/caregivers in treatment, and (j) teach children and adults about CSA prevention. Two items were worded negatively and reverse scored (e.g., I am unprepared to hear a client share details of his or her sexual abuse.).

At the end of the survey, students were asked if they would take a course about CSA as

an elective, and if they thought that a course about CSA should be required. Students were then asked if they have personal history of CSA and if they have a close friend or family member with a CSA history. These questions were included because it is unknown if personal experience may impact students' knowledge about CSA and/or perceived readiness to counsel victims.

The researcher included counseling resources for students as part of the consent process since students may recall their own experiences or the experiences of others that have been abused. Although personal reflection and self-awareness are important characteristics of helpers, the process may be difficult for students who have an unresolved trauma history. Despite the potential for discomfort or recalling of CSA memories, the survey provided students an opportunity to reflect on their knowledge and counseling ability. Furthermore, the results inform the field on the CSA knowledge and perceived competence of students.

Results

Knowledge about Child Sexual Abuse

The first research question investigated students' knowledge about CSA by presenting students with a variety of facts and myths about CSA derived from current literature. The following table lists the twelve areas and the percent of students who answered correctly.

Table 1

Trainee's Knowledge about Child Sexual Abuse

Knowledge Areas	% of Students
	Answering
	Correctly
Adult offenders are frequently family members or friends of family	99%
Children often feel guilty or to blame	98%
Immediate disclosure is not typical	97%
Sexual abuse is not often a one-time incident	96%
Physical evidence is not required for reporting suspected CSA	95%
Many victims never disclose their abuse	95%
Positive or protective feelings toward perpetrator are common	94%
Prevalence of CSA for girls	93%
False accusations are uncommon	93%
Child victims of CSA are more likely experience future victimization	87%
Frequency of sexual abuse perpetrated by offenders under 18	76%
Prevalence of CSA for boys	14%

Although the students demonstrated some general knowledge about CSA (see table above), there were some gaps in their understanding that could be addressed in CSA training and coursework. For example, 95% answered correctly regarding the necessity of physical evidence to make an abuse report, yet a small portion of students (5%; $n = 15$) thought this was required. This is an important error to correct as counselors are mandated reporters (not investigators) and must report any suspicion of abuse. It is also important for students-in-training to know that physical evidence in CSA cases is rare (Lewis & Klettke, 2012).

Only 87% ($n = 264$) students knew that CSA is a risk factor for future victimization (e.g., domestic violence, sexual assault). Students need to know about future risks and assist clients (and nonoffending parents and caregivers) to enhance clients' future safety.

Furthermore, only 76% ($n = 231$) of students knew the frequency of CSA perpetrated

by individuals under the age of 18. Students may view only adults as sexual offenders and may not know how to respond to allegations of child on child sexual abuse in terms of reporting and/or treatment. Child initiated sexual abuse accounts for approximately one-third of CSA cases (Finkelhor, Ormrod, Turner, & Hamby, 2005; Kilpatrick et al., 2000). Students-in-training must be ready to address the unique issues that arise when a child perpetrates abuse.

Students scored lowest on a question about the prevalence of male sexual abuse with only 14% ($n = 42$) of students answering correctly. This stands in contrast to the 93% of students who knew the prevalence of CSA for girls. Students may be influenced by culture's portrayal of female victims. Additionally, research in the social sciences, is frequently limited to adult female survivors (Jones et al., 2013; McGregor et al., 2006). It is important for students to know the prevalence of CSA for boys and understand the additional stigma boys face by disclosing (Alaggia & Millington, 2008; Paine & Hansen, 2002).

In sum, the results indicate that students are knowledgeable about some of the basic facts of CSA, yet there are some gaps in their knowledge that could be addressed with proper training and coursework. Faculty members can help correct misinformation through psychoeducation.

Preparedness to Provide CSA Counseling and Related Services

The second research question investigated the degree that students think that they are prepared to provide counseling and related services to child victims, nonoffending parents or caregivers, and adult survivors of CSA. The categories of agree and strongly agree were combined as were disagree and strongly disagree during data analysis to examine students who rated themselves as competent compared with those who felt unprepared. The

following table presents those results in order of most prepared to least prepared.

The individual item results indicate that there are numerous areas in which students feel unprepared for CSA fieldwork.

Table 2

Trainees' Perceived Child Sexual Abuse Competency

Area of Competency	%	of
		Students
		Agreeing or
		Strongly
		Agreeing
Listening to a client's CSA story	81%	
Procedures for reporting CSA	71%	
Asking questions when abuse is suspected without leading	52%	
Providing counseling services to adults with a CSA history	41%	
Identification of CSA (knowledge of risk factors and warning signs)	41%	
Evaluation of trauma symptoms using assessments	30%	
Including nonoffending parents/caregivers in counseling with child	28%	
Providing counseling services to child victims	28%	
Teaching CSA prevention	21%	
Utilizing evidence-based interventions	18%	

Next, the 10 questions were totaled for each student to create a competency score (strongly disagree = 1, disagree = 2, agree = 3, strongly agree = 4) with a possible score of 10 to 40 points. Lower scores indicated lower levels of competency. Total competency scores for the sample ranged from 10 to 39 ($M = 23.4$, $SD = 4.86$). Scores below 25 were considered low competence ($n = 185$, 61%), 25 – 33 = moderate competence ($n = 116$, 38%), and 34 – 40 = high competence ($n = 3$, 1%).

Factors that Increase Student Knowledge and Perceived Readiness

Research Question 3 investigated the demographic factors that increased students' total perceived readiness to provide counseling for CSA. One-way ANOVAs were conducted for each demographic category for the dependent variable of total perceived competence. There were no significant relationships between the demographic variables of age, gender, and race and the preparedness to provide CSA counseling and related services. There were also no significant relationships between the degree program (counselor education or counseling psychology), specific counselor education track (marriage, couple and family, school, mental health, etc.), or personal history of CSA abuse and perceived readiness to counsel.

A significant difference in the total competency score was identified with three demographic factors: prior work or volunteer experience with CSA victims, participation in CSA trainings, and supervised field experience (e.g., onsite practicum and off campus internship). Individuals with prior work or volunteer experiences with victims of CSA reported significantly more readiness to provide services, $F(1, 295) = 60.57, p < .001 (r = .42)$. Additionally, individuals who had engaged in CSA training had significantly higher perceived competency scores $F(1, 294) = 28.96, p < .001 (r = .42)$. Moreover, students currently enrolled in practicum or internship had significantly higher preparedness scores, $F(1, 293) = 16.06, p < .001 (r = .31)$.

Discussion

This study investigated students' knowledge about CSA and perceived preparedness for providing counseling services along with factors that led to higher readiness scores. The survey highlighted several gaps in knowledge that need to be addressed through instruction, including: the increased risk for future victimization, the frequency of CSA perpetrated by offenders under the age of 18, and the prevalence of male sexual abuse. Additional training has

numerous benefits. For example, survivors' higher risk for future victimization is important for helpers to know so that the safety of clients can be assessed. Knowledge about the frequency of male sexual abuse is also essential so that counselors can help reduce the stigma male victims experience and gain specific skills for counseling males. Additionally, understanding that CSA is frequently perpetrated by other children is important so counselors can provide services or referrals for all children involved. Families in which the abuse has occurred between siblings or relatives may need additional support (Foster, 2014).

Although 9 out of 12 the questions were answered correctly by at least 90% of students, there remains a small group of students with mistaken beliefs that need to be addressed. Unless corrected, students-in-training could potentially harm future clients as a result of these misconceptions (Adams & Riggs, 2008; Cavanagh et al., 2004; Pearlman & Saakvitne, 1995; Read et al., 2007). For example, the belief that you cannot report suspected sexual abuse unless there is physical evidence could lead to a counselor failing to make a report, which could result in the child experiencing further abuse. In a study of school counselors' reporting behaviors, the author concluded that school counselors may suspect more abuse than they actually report (Bryant, 2009). Proper training and competency in reporting protocols is especially important for school counselors as they are often the most knowledgeable person regarding abuse and mandated reporting in their schools (Bryant, 2009).

Another potential area to address is the belief that *many* children lie about their abuse could lead to a counselor responding to a disclosure with skepticism or numerous questions, which could make a victim feel interrogated or worse, disbelieved. Additionally, counselors who do not understand the potential for their client to have positive feelings (e.g., love, a desire to protect) toward perpetrators, may struggle to respond with empathy and understand how

those feelings are valid. Faculty members can help raise awareness about CSA in their courses and correct misconceptions so that students enter the field well prepared.

Along with addressing students' knowledge, faculty members also need to consider students' self-assessment of their readiness to provide CSA services. The results of this survey indicated that the majority of students feel unprepared for most aspects of CSA work. Dillihunt's (1997) dissertation research reached the same conclusion about practicing clinicians stating that "... counselors related feeling 'low confidence' to 'somewhat confident' in their CSA treatment abilities and they perceived their school based CSA training to be 'inadequate' to 'somewhat adequate.'" (p. i). Dillihunt's recommendation was to increase knowledge and specific skills related to CSA. Unfortunately, the problem identified by Dillihunt nearly 20 years ago continues today. This can be remedied through training and proper supervision, which effectively increase helpers' ability to assist clients with a history of sexual abuse (Dugmore & Channell, 2010).

In this study, 59% of the students indicated that they were unprepared to provide counseling services to adults with a CSA history, and the same percent lacked knowledge about how to identify a possible victim of CSA. Seventy percent of the sample revealed that they do not know how to assess trauma symptoms. Seventy-two percent are unready to provide counseling services to child victims or include nonoffending parents/caregivers in counseling. Furthermore, 79% of the students do not know how to provide psychoeducation about CSA prevention, and 82% are not prepared to implement evidence-based interventions. This is especially concerning since evidence-based practices may improve client outcomes as well as increase compassion satisfaction and decrease compassion fatigue and burnout (Craig & Sprang, 2010). Further, evidence-based practices may help clinicians feel more prepared to

“deal with the complexities and horrors of trauma work” (Craig & Sprang, p. 335).

Surprisingly, students rated themselves highest in terms of their ability to hear the details of a victim’s CSA experience (81% agreeing or strongly agreeing that they are prepared). Although they believe they are capable, it is possible that the actual experience will be more overwhelming than they anticipate. “To hear a child talk of abuse, to see her fear, even without hearing the details, can be distressing even for experienced therapists” (Jones & Morris, 2007, p. 236). Supervisors must help students address their ability to stay fully present with the client and avoid pulling away emotionally or shifting focus away from the trauma (Ventura, 2010).

Data was analyzed to explore if the lack of readiness was related to the number of credits completed. Although students at the end of their program had higher total competency scores, major gaps in their CSA perceived readiness were still evident indicating that many students are leaving the program feeling unprepared.

Several demographic features significantly increased competency scores: previous work or volunteer experience with CSA victims, participation in CSA trainings, and supervised field experience (e.g., onsite practicum and off campus internship). Thus it seems competency is related to exposure to victims, receiving information about CSA, and supervision. Bryant (2009) reported similar findings in a study of school counselors and their child abuse reporting behaviors, uncovering that the school counselors’ knowledge about reporting was a result of past professional experiences.

Students who participated in the survey indicated a desire for additional training in CSA. Ninety-four percent (N = 286) stated that they would take a CSA elective, and 94% of the sample said that they think a course in CSA should be required. It seems students are

aware of their deficits in the area of CSA and desire additional training to address their insufficient skill set.

Students-in-Training with a History of CSA

It is not uncommon for students pursuing a career in a helping profession to have experienced CSA firsthand. In this sample, 17% disclosed a history of CSA. Other studies have indicated that nearly 30% of psychology students (Adams & Riggs, 2008) as well as professional helpers have a childhood trauma history (which may include but is not limited to CSA) (Folette, Polusny, & Milbeck, 1994; Pope & Feldman-Summers, 1992). It is possible that an unresolved experience of abuse could negatively impact students' readiness to counsel survivors of CSA. A research synthesis of 16 different studies published between 1994 and 2003 indicated there is sufficient support for the assertion that personal trauma history increases the risk of vicarious traumatization (Baird & Kracen, 2006). Additionally, students with a trauma history may be at a higher risk for a self-sacrificing defense style, which increases vicarious trauma symptoms (Adams & Riggs, 2008).

Conversely, counselors who understand firsthand the pain of childhood trauma and have processed their experiences have the potential to greatly assist survivors (Gardner, 2008). In this study, students who reported a CSA history did not significantly differ than those with no history of CSA with regard to mean competency scores. For faculty members training future helpers, it is important to consider students' experiences and how those may help or hinder them on their path to becoming a counselor. Supervisors are in a position to identify students who are experiencing vicarious trauma and refer them to counseling to address personal trauma histories that may be unresolved (Adams & Riggs; Foster, 2011).

Implications for Counseling Training Programs

The results indicated that there is a clear need for additional training in the area of CSA. Faculty members can help bridge this gap through providing multiple opportunities for students to attain both knowledge and skills (e.g., workshops, online national trainings such as TF-CBT, elective or required courses, fieldwork with victims). One training program found that an hour long web-based training on the warning signs and symptoms of child maltreatment along with reporting procedures resulted in statistically significant increases in students' knowledge (Kenny, 2007). Trainings like this can be required for students to increase awareness about child abuse.

Although web-based trainings are efficient, students also benefit from processing exposure to trauma in the classroom. Faculty can provide topical lectures, facilitate discussions, and provide opportunities for reflection through assigned readings and journaling (Sommer, 2008). Instructors can share their own reactions to trauma material to normalize the challenges associated with trauma work, which may allow students to share openly their own difficulties (Cunningham, 2003; Fucci, 2008). Additionally, real cases can also be provided, such as narratives written by children about their abuse (Foster & Hagedorn, 2014a; Foster & Hagedorn, 2014b). These firsthand accounts provide students exposure to traumatic content and an opportunity to process it. Exposure to narratives also may increase students' ability to respond appropriately to a clients' disclosure. When using victims stories, faculty members need to be prepared to process students' reactions to the traumatic material (e.g., feeling shocked, overwhelmed, or angry) (Jones, 2002; Foster, 2011).

Along with instruction about trauma and exposure to real life experiences of victims,

instructors must communicate the necessity of self-care, provide opportunities for development of comprehensive plans, and provide accountability for the management of self-care. Guided imagery and breath work have been suggested for use with students learning about trauma (Sommer, 2008). Mindfulness training may also be beneficial for helpers who are working with clients who have experienced trauma (Harrison & Westwood, 2009). Specifically, mindfulness practices enhance helpers' patience and compassion toward themselves and their clients and helps them remain both calm and grounded, especially while clients share details of their trauma.

Although infusing trauma education throughout curriculum has benefits, there is also a strong argument for a standalone course. Black (2008) advocated for a course to lower the likelihood that students will experience traumatic stress. Black emphasized preparing them to be reflective practitioners, thus gaining resources to process future exposure to traumatic material. In the pilot study, students who attended a 36-hour course reported an increased competency in providing counseling for individuals who have experienced trauma.

Research has demonstrated that trauma training correlates with burnout, with low levels of training predicting higher levels of burnout (Craig & Sprang, 2010). Since students without training and those with only minimal training are both at a high risk of experiencing vicarious trauma, "students need substantial trauma-specific training in the context of a full semester of coursework or multiple intensive workshops in order to protect themselves against the potential negative impact of trauma counseling" (Adams & Riggs, 2008, p. 32). Training programs that do not properly prepare their students for trauma work, including the potential for vicarious trauma, leave students vulnerable and put their future clients at risk (Sommer, 2008). The research is clear that the helping professionals who work with individuals who

have experienced trauma are also effected emotionally, physically, cognitively, socially, interpersonally, and spiritually and necessitate training in self-care strategies (Pryce, Shckelford, & Pryce, 2007).

Each individual training institution should consider their current curriculum and identify areas for improvement so that students are well prepared to address the needs of CSA victims. Comprehensive training must both heighten one's knowledge about sexual abuse and provide supervised field experiences with CSA clientele (Kenny & Abreu, 2015). According to the authors, trainings are most effective when delivered at multiple check points in a professional's development (pre-service, in-service, and continuing education). Graduate programs provide an introduction to child sexual abuse work, which is best implemented early in the student's program of study. Developing students' knowledge be accomplished through a variety of modalities such as in-person trainings, web-based training, infusion in multiple courses, trauma specific courses, and supervised field-based experiences. The authors discuss 10 specific areas that must be covered for *minimum* competency: (1) reporting procedures and laws, (2) assessment of abuse, (3) symptoms, (4) offenders, (5) nature of CSA relationships, (6) disclosure, (7) blaming the victim/nonoffending mother, (8) empirically based treatments for CSA, (9) values and beliefs, and (10) self-care/vicarious traumatization. The first area, reporting procedures and the law, is especially important for students-in-training who are likely to encounter CSA child victims in their various formal and informal field experiences and are mandated reporters of suspicion of abuse. Although there will likely to obstacles to overcome in the implementation of training (limited room in the curriculum, lack of specific standards addressing sexual abuse, not having a faculty member with expertise in this area), proper preparation in CSA is essential (Kenny & Abreu, 2015).

Limitations and Future Research

The purpose of this study was to identify students' knowledge and perceived readiness to provide CSA counseling. Self-reports are limited as students may not be able to accurately judge their competency and may inflate their scores as a result of social desirability. Future research could evaluate actual competence through providing CSA case studies. Evaluation of students' responses could reveal their decision making ability, which would likely result in a more accurate assessment of students' current abilities and deficits to address through training. Exploration of the decision making process of counseling professionals as it relates to reporting abuse would also be valuable information for the field (Bryant, 2009).

Additional research could also address the limitation that this study was conducted at a single university. Although the sample was comprised of four campus locations and included students in two distinct disciplines, counselor education and counseling psychology, it did not include students from other universities. Students in other accredited or non-accredited programs may have unique experiences related to their training. Having a faculty member with clinical or research experience in the area of CSA, offering a CSA elective, or requiring a course could impact students' knowledge and perceived readiness to provide CSA counseling. A final limitation to note is that the instrument was created by the author for use in this study based on current child sexual abuse literature. There was not an opportunity to perform a test-retest of the instrument, thus the reliability was not established. Further research is needed with the instrument to address this limitation. Although there were several limitations of the study, the results extend the literature on preparation for CSA work by examining current students' knowledge and self-rated readiness.

Conclusion

This study explored students' knowledge about CSA and perceived competence for working with victims of abuse. A survey was developed to assess students' working knowledge of sexual abuse (facts and statistics) and level of perceived preparedness to provide counseling services. The results indicated gaps in knowledge and low levels of competence. Factors that increased readiness included previous work or volunteer experiences with CSA victims, participation in CSA trainings, and supervised field experience. The vast majority students stated that they would take a CSA course if it were offered and believed a course on the topic should be required. The author echoes the call of Oz (2010) to recognize "childhood sexual abuse as a specialized field requiring specialized training both at the graduate level and in continuing postgraduate education" (p. 1). Specific CSA training guidelines need to be established for graduate students (Kitzrow, 2002) so that they can acquire the skills needed to enter the world of victims and facilitate hope and healing.

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