Spring 2013

Developing competency in counseling survivors of sexual assault

Grace Meyer
James Madison University

Developing Competency in Counseling Survivors of Sexual Assault

Grace Meyer

A research project submitted to the Graduate Faculty of

JAMES MADISON UNIVERSITY

In

Partial Fulfillment of the Requirements

for the degree of

Educational Specialist

Graduate Psychology

May 2013

Dedication

This project is dedicated to my husband Chris for his tremendous support and encouragement throughout my development as a counselor thus far. Thank you for inspiring me with your unwavering optimism and for continuously reminding me of the power of kindness, love and laughter through the example you set.

Acknowledgments

I'm tremendously grateful to my family, especially my parents, brother, Grandma Alice, and Aunt Claudia, for showing me how to listen and to care for others unconditionally. I'm appreciative of my friends and my dog Cooper for being such an important part of my self-care practice. I thank all of the clinicians at the Varner House and the JMU Graduate Psychology counseling faculty I've been fortunate enough to learn from, particularly Jack Presbury, Renee Staton, Lennie Echterling, Eric Cowan, and Jennifer Cline, for their guidance and their passion for helping others. I especially recognize Debbie Sturm for her steadfast support, warm and selfless nature, and fantastic sense of humor that has helped me more than she knows throughout the past two years. Finally, I extend my deepest gratitude to the survivors of sexual assault that I have had the privilege of working with who have allowed me to witness the power of resilience and the human spirit firsthand.

Table of Contents

Abstract

The purpose of this research project is to explore how novice counselors develop competency in working with survivors of sexual assault and rape. The project contains a review of current literature on aspects of sexual assault that are important to be aware of when counseling survivors. This includes a definition of applicable terminology, the contemporary prevalence of sexual assault in the United States of America, unique aspects of working with survivors of sexual assault, and a review of symptoms and typical problems commonly presented by this population. This research project also includes firsthand accounts of the experiences of three clinicians who specialize in working with survivors of sexual assault. The accounts address how these clinicians developed competency in providing treatment to this population and suggestions that they have for beginning counselors. Finally, this project provides specific recommendations for inclusion in the curriculum and training of novice counselors by integrating findings from current literature and the accounts of clinicians.

Introduction

Every two minutes, someone in the United States of America is sexually assaulted. In reference to individuals ages twelve or older, this equates to an average of 207,754 victims of sexual assault and rape each year (Rape, Abuse & Incest National Network, 2009). This statistic does not even account for all of the children who are the victims of sexual abuse. These frightening yet factual averages clearly demonstrate the need for effective support for all those affected by this terrible reality. Note that for the purposes of this project, individuals who have experienced a sexual assault will be referred to as *victims* when discussing statistics about crime and *survivors* when talking about treatment, particularly in reference to counseling, as these are the preferred terms in said contexts.

Following the experience of a sexual assault or rape, survivors can experience physical and emotional problems. These issues include but are not limited to medical injuries, sexually transmitted diseases, pregnancy, depression, post-traumatic stress disorder, and substance abuse. Left untreated, these physical and emotional issues can worsen and lead to significant suicidal ideation as well as a slew of other long-term problems (Frazier, Conlon, & Glaser, 2001; Klump, 2006; Levers, 2012).

Considering the enormous prevalence of sexual assault and rape in our society as well as the serious implications for survivors, it is imperative that survivors have access to effective treatment. One of the main resources for individuals seeking care is counseling. Counseling interventions can be administered through a variety of mediums including sexual assault hotlines, individual treatment, and group therapy. Despite the

method of intervention, it is important that the clinicians administering mental health care be trained and well-versed in working with the sexual assault survivor population.

In addition to the complex physical and emotional issues presented by survivors of sexual assault, there exists another unique aspect of counseling that clinicians must be able to effectively address when working with this population. Unlike the victims of other criminal situations, individuals who have experienced a sexual assault are responsible for initiating their own legal discourse when pursuing justice. This encompasses being the source of evidence collection and acting as a witness. Counselors must often serve as advocates and educators for their clients in these contexts. The fact that there is a small window of time for collecting effective evidence and time limits on reporting vary by state makes it even more necessary for counselors to be prepared and knowledgeable about the topic (Rape Victim Advocacy Program, 2005).

In looking at how novice counselors become trained in their field, one must consider the Council for Accreditation of Counseling and Related Educational Programs [CACREP], one of the most utilized counseling program accreditation boards. CACREP has strict standards that counseling programs must adhere to in order to be accredited. Despite the prevalence of sexual assault in our society, CACREP only has one standard addressing crisis intervention. This standard requires CACREP accredited programs to provide an understanding of the counseling process in a multicultural setting to their students, specifically focusing on "crisis intervention and suicide prevention models, including the use of psychological first aid strategies" (CACREP, 2009). Providing treatment to survivors of trauma and sexual assault is never specifically addressed in this or any other CACREP standard.

If counselor training programs are not focusing on working with survivors of sexual assault, how do counselors develop competency in this area? This project will explore current findings in the literature regarding counseling survivors of sexual assault as well gather firsthand accounts from counselors who specialize in this field. The project will culminate in a list of specific recommendations for inclusion in the curriculum of counselor education programs to train novice counselors in the area of sexual assault.

Sexual Assault in Current Literature

To effectively explore interventions used in counseling survivors of sexual assault, one must first be familiar with the legal definitions of sexual assault and rape. According to the United States Bureau of Justice, the term sexual assault refers to "a wide range of victimizations, separate from rape or attempted rape" (2012). This encompasses attacks or attempted attacks where a victim receives unwanted sexual contact from an offender. It is important to note that an act does not have to involve force to be considered sexual assault. Sexual assault includes grabbing, fondling, and verbal threats.

The United States Bureau of Justice defines rape as "forced sexual intercourse including both psychological coercion as well as physical force" (2012). Forced sexual intercourse refers to vaginal, anal, or oral penetration by the offender. This definition encompasses attempted rape which includes verbal threats of rape as well. It is important to note that the term sexual assault may signify rape but does not necessarily imply that a rape occurred.

Gender and Race

Of the 207,754 people ages twelve and older sexually assaulted each year in the United States of America, all genders are affected though women to the highest degree. According to the National Institute of Justice & Centers for Disease Control & Prevention, 1 out of every 6 American females has been the victim of an attempted or completed rape within her lifetime. This equates to over 17.7 million American women nationwide. Overall, 2.8% of American women have been the victims of an attempted rape and 14.8% have been the victims of a completed rape in their lifetime (1998).

With regards to American men, 1 in 30 has been the victim of a sexual assault or rape. This statistic illustrates that while males are significantly less likely than females to experience a sexual assault, the risk is still present. Overall, 3% of American men nationwide have experienced attempted or completed rape within their lifetime. No such statistics are currently available for the transgender population (National Institute of Justice & Centers for Disease Control & Prevention, 1998).

The National Institute of Justice & Centers for Disease Control & Prevention identified the breakdown of the prevalence of sexual assault for women by race as well. Of the 17.6% American women nationwide who have been the victims of rape or attempted rape, 17.6% are Caucasian, 18.8% are African American, 6.8% are Asian Pacific Islander, 34.1% are American Indian or Alaskan, and 24.4% are mixed race. No such statistics are available through the National Institute of Justice & Centers for Disease Control & Prevention for men or the transgender population at this time (1998).

Similarly to gender and race, no age group is exempt from the risk of experiencing sexual assault, rape or attempted rape. According to the United States Bureau of Justice, 15% of all sexual assault and rape victims in the United States are under the age of 12. Ages 12 through 34 appear to be the highest risk years for sexual assault and rape with 80% of all sexual assault and rape victims being under age 30. This breaks down to 29% of victims being ages 12 through 17 and 44% of victims being age 18 or under. Within the bracket of ages 16 through 19, females are four times more likely than the general population of the United States to be the victims of rape, attempted rape, or sexual assault (Rape, Abuse & Incest National Network, 2009). Counselors should be

aware that while any person can be the victim of a sexual assault or rape, there are certain populations that are at a higher risk.

Common Presentations of Survivors

Survivors typically experience a wide variety of physical and emotional issues following a sexual assault. Although survivors do not always bear physical injury following an assault, there exists a wide range of medical consequences that one can experience. Immediate injuries include but are not limited to cuts, abrasions, bruising, broken bones, and gynecological trauma. Long term physical consequences include sexually transmitted diseases, unwanted pregnancy, future sexual dysfunction, and unexplained somatic illness (Levers 2012; Petrak & Hedge, 2002).

Though physical injury is often what is first attended to following an attack, the psychological impact of a sexual assault can be even more severe. This is considered by many mental health specialists to be one of the most difficult and disturbing types of trauma a person can experience (Frazier, Conlon, & Glaser, 2001; Levers, 2012). According to the World Health Organization, victims of sexual assault are 3 times more likely to suffer from depression, 6 times more likely to suffer from post-traumatic stress disorder, 13 times more likely to abuse alcohol, 26 times more likely to abuse drugs, and 4 times more likely to contemplate suicide (Rape, Abuse & Incest National Network, 2009). What's more, survivors of sexual assault will often experience several of these emotional reactions simultaneously. To grasp the psychological impact that sexual assault can have on an individual, one must understand the definitions of these presentations and some of the unique aspects that arise within the sexual assault survivor population.

Depression and substance abuse. The DSM-IV classifies a major depressive episode as a two week period where five or more of the following symptoms are present: a depressed mood for most of the day, a loss of interest in most activities, significant weight loss or gain or a significant change in appetite, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue or loss of energy, excessive feelings of worthlessness or guilt, decreased ability to concentrate, and recurrent thoughts of death. These symptoms must be causing significant impairment in daily functioning to meet criteria for a diagnosis of depression. Furthermore, at least one of them must be a depressed mood or loss of interest (2000).

One important aspect to note regarding depression in sexual assault survivors is the role that re-victimization can play. Research has shown that childhood sexual abuse is correlated with an escalated risk of sexual assault in adulthood for males and females (Petrak & Hedge, 2002). One model proposed by Browne and Finkelhor explores possible causes of this finding. This model emphasizes the devastating and enduring feelings of powerless that childhood survivors of sexual abuse can experience. This model also suggests that these survivors often develop a negative self-image that can lead to drug and alcohol abuse, promiscuous sexual behavior, and criminal activity in adolescence and adulthood (1986). This can put these survivors at a greater risk of experiencing another sexual assault later in life.

Similarly, women who have experienced a sexual assault in their adult years are at a higher risk of experiencing another sexual victimization partially due to feelings of helplessness and learned negative self-image (Testa, VanZile-Tamsen & Livingston, 2007). Research has shown that adult survivors of sexual assault who are re-victimized

tend to use more maladaptive coping strategies and experience an increase in their symptoms of depression. Maladaptive coping strategies include engaging in high risk sexual behavior, withdrawing from peers, and the excessive use of alcohol or drugs (Najdowski & Ullman, 2011).

As current research shows that survivors of sexual assault are significantly more likely to abuse alcohol and drugs, it is essential that counselors draw the connection between these behaviors and a survivor's experience of depression. Furthermore, alcohol and drug abuse in survivors of sexual assault has been linked to an even greater risk of experiencing another assault (Messman-Moore & Brown, 2006; Ullman, Najdowski, & Filipias, 2009). In order to best serve their clients, counselors should be aware of the impact of substance use on depression for treatment and client education purposes (Rape, Abuse & Incest National Network, 2009).

Post-traumatic stress disorder. The DSM-IV defines post-traumatic stress disorder [PTSD] as a reaction to a traumatic event that involves a real or perceived threat to one's own life or to another's. This reaction must encompass persistent re-experiencing of the event, the avoidance of stimuli associated with the trauma, and the experience of persistent symptoms of increased arousal. To meet the criteria for PTSD, these symptoms must be causing significant impairment in daily functioning. They must also be present for at least one month (2000).

Research has shown that the type of trauma experienced by an individual is the highest risk factor for the development of PTSD. For women, the best predictor is the presence of a sexual assault or rape (Bromet, Sonnega, & Kessler, 1998; Klump, 2006). For individuals who develop PTSD following a sexual assault, the recovery rate has been

found to be slower than in trauma cases not involving a sexual assault (Gilboa-Schechtman & Foa, 2011; Klump, 2006). Thus, it is important to explore what leads to PTSD in survivors of sexual assault.

The development of PTSD following a sexual assault has been correlated with pre-assault variables, assault variables and post-assault variables. Pre-assault variables include the presence of lifetime depression, alcohol abuse prior to the trauma, childhood abuse, and a history of victimization. Factors during an assault that impact the development of PTSD include the seriousness of the injury sustained and the perceived threat to the survivor's life during the assault. Variables following an assault that have been linked to PTSD include perceived social support, type of coping mechanisms employed, the amount of anger and disassociation present following the assault, and individual cognitions (Klump, 2006).

In terms of individual cognitions, research has found that women who experienced guilt and self-blame following their sexual assault had increased PTSD symptom severity. In these cases, PTSD symptom severity increased the most when the woman maintained the cognition that her attack could be attributed to something lacking in her character (Koss, Figueredo, & Prince, 2002). In order to best serve their clients, counselors should be prepared to address this cognition and understand the impact of the client's guilt and the effects of pre-assault, assault, and post-assault variables on the development of PTSD.

Legal Processes

A unique aspect of sexual assault and rape is that if the victim of an attack wants to pursue legal action against the perpetrator, he or she has to take on several active roles

in the process. Counselors should note that 54% of survivors choose not to report their assault to the authorities due to the intrusive and time consuming nature of the process (RAINN, 2009). Counselors should be prepared to validate and explore this with these clients as to normalize this decision.

For survivors who do wish to report their assault, the legal process is dissimilar to other crimes such as in cases involving murder or theft. Following a sexual assault, the onus falls on the victim to contact the police, make the decision to press charges, and act as a witness and a source of evidence. Thus, counselors working with clients who choose to move through the legal process should be prepared to act as advocates, educators and supporters. To be able to effectively do this, counselors must be knowledgeable about the initial evidence collection phase, time limits of reporting, and the legal sequence of events following a decision to press charges (Rape Victim Advocacy Program, 2005). It is important to note that the following information is only relevant if a survivor is able to identify his or her perpetrator. If not, counselors should be prepared to address fears about the unknown that the client may present with regarding their assault experience and their subsequent safety.

A counselor's role in the evidence collection process can look different depending on when a survivor presents for counseling services. If an individual who has just been sexually assaulted seeks treatment, a counselor should be able to provide relevant information about evidence collection. This includes the locations where a survivor can be administered the sexual assault evidence collection kit and an overview of what the kit entails. Depending on the hospital, this may also be called a Rape Kit, a Sexual Assault Forensic Evidence (SAFE) kit, a Sexual Offense Evidence Collection (SOEC) kit, or a

Physical Evidence Recovery Kit (PERK). The forensic professional who administers this kit must be a Sexual Assault Nurse Examiner (SANE) or a forensic examiner. It is imperative that these individuals have received specialized forensic examination training so that the chain of custody can be upheld and any evidence gathered can be stored properly and later used in court (Rape, Abuse & Incest National Network, 2009).

The sexual assault evidence collection kit may vary depending on the hospital but generally it includes detailed instructions, swabs, combs, blood collection devices, documentation forms, bags, envelopes, and sheets for collecting evidence. The forensic examiner will often begin by asking the victim for a complete medical history followed by performing a head to toe physical examination including the genital area. During this process, the examiner will collect clothes of the victim, especially undergarments, blood samples, hair from the head and pubic areas, a urine sample, and other body secretion samples. Throughout this process, the forensic examiner will also often obtain photo documentation (Rape, Abuse & Incest National Network, 2009). Counselors should note that this invasive and painful examination would be intrusive for any person to experience and can thus feel even more humiliating and degrading to one who was just sexually assaulted. Counselors should be prepared to process the experience of this examination with clients who have been administered the kit.

In the legal process, a lack of physical evidence can hamper the likelihood of proving that an assault occurred. Thus, when working with a survivor who has not been administered the kit and wants to press charges, a counselor may want to inform him or her that actions such as urinating, bathing, changing clothes or cleaning up the scene of the attack reduce the chances of the forensic examiner and police finding the

perpetrator's DNA (Rape, Abuse & Incest National Network, 2009). Concurrently, counselors should focus on normalizing these responses following a sexual assault, especially if they have already occurred, so as to not create guilt or second guessing within a client. Many survivors may not know about the evidence collection process or may not feel comfortable being administered a sexual assault evidence collection kit due to its invasive nature. Counselors must once again focus on normalizing and validating this reaction.

In addition to being able to have a discussion about the evidence collection process, counselors may also benefit survivors by offering to accompany them to any police interviews for support and advocacy and by providing them with information about the rest of the legal sequence of events. This includes reviewing possible outcomes of the legal process. Out of the 46 of 100 rapes reported to the police, 9 of these perpetrators will be prosecuted and only 3 will ever spend a single day in jail for the assault (RAINN, 2009). While counselors should encourage and support clients in their decision to press charges, they may also want to work with them to identify additional ways that they can draw meaning from the legal process. This may include a client's goal of advocating for his or herself and protecting others through pressing charges.

Once the decision to press charges has been made, the police will often begin an investigation that hinges on victim and witness interviews and the prior collection of evidence. If interviews and evidence gathered point to the occurrence of a sexual assault, the suspect will be arrested and taken into custody at which point he or she will appear before a magistrate where conditions for bail are determined. After this, there will be a

preliminary hearing where the legal case against the defendant will be summarized (Rape Victim Advocacy Program, 2005).

The next event in the process is the arraignment, where the defendant appears before the judge to enter a plea. During an arraignment, which can be completed in written form, a speedy trial can be demanded or waved. At this point, if there is to be a trial a date is set. In the time period between this and the pre-trial hearing, the state and defense examine the case which often includes exploring hospital reports, victim and witness interviews, and depositions. At the pre-trial hearing, the judge, state, and defense gather to either agree on a plea or bargain or prepare their case for trial. If the decision is to pursue a trial, parties will reconvene at a later date to present their cases (Rape Victim Advocacy Program, 2005).

Following the presentation of cases at a formal trial, the judge or jury finally reaches a verdict on whether the suspect is guilty. When a suspect is found guilty, a penalty for the sexual assault is imposed. At this point, the victim has the opportunity to present an impact statement to the judge or jury to be taken in as evidence. Even after the verdict and sentencing is reached, it is important to note that the defense may have the opportunity to appeal the verdict (Rape Victim Advocacy Program, 2005).

Counselors should be aware of the forensic processes and legal timeline so that they can prepare their clients for the events to come and the reality that the process may take months to years depending on the situation. This drawn out sequence of events is often one that can be re-traumatizing (Petrak & Hedge, 2002). Thus, a survivor may need guidance and reinforcement as well as education from his or her counselor. This becomes

especially relevant at times when a survivor is asked to face the perpetrator, provide an account of the attack, or answers questions about the assault from the defense.

Treatment Modalities

Though just under half of survivors of sexual assault and rape choose not to report their attack to the police, a significantly larger percentage of this population seeks treatment following their experience (Rape, Abuse & Incest National Network, 2009). There are a variety of different services offered to survivors of sexual assault depending on the location of the individual. In the United States, there exist both rape crisis centers and domestic violence shelters that offer prevention and response services. Both of these resources often have 24-hour crisis hotlines that can provide crisis counseling and information about referrals to survivors. These centers also often employ advocates who can educate survivors on their legal rights and options regarding the assault. Finally, such agencies will normally provide individual and/or group counseling to survivors (Riger et. al., 2002).

Though these centers may be home to the clinicians most trained and well-practiced in working with the sexual assault and rape survivor population, a survivor can present in any counseling setting. This can include a primary school environment, a higher education institution, or a community counseling center. Thus, all counselors should have a basic working knowledge of the primary problems typically faced by survivors. Although rape itself is an extraordinarily traumatic event, it is important for counselors to note that the time immediately following an assault can be equally damaging for a survivor. Counselors and victim advocates must be knowledgeable about

secondary victimization where survivors may experience negative treatment that encompasses victim-blaming and insensitivity (Campbell, 1998; Riger et. al., 2002)

Effective Interventions. Though research on the best practices for working with survivors of sexual assault is limited, the two treatment modalities with the most empirical support are exposure therapy and cognitive behavioral therapy (Russell & Davis, 2007). Counselors may draw from both of these theories depending on the presentation of their client. Though the following discussion on these modes of intervention is not meant to be exhaustive, it will explore basic information about techniques that are frequently used with survivors of sexual assault in counseling.

***Exposure therapy*.** A counselor's primary goal when using exposure therapy with survivors of sexual assault is to assist them in repeatedly confronting the distressing images and memories of their trauma so that fear and anxiety progressively decrease. The theory behind exposure therapy postulates that survivors may generalize their response of fear and terror during their assault to other situations, people, or objects that remind them of their trauma. For example, if a female was assaulted at a college party, she may come to fear parties or her college campus in general. By imagining these various stressors while practicing relaxation techniques, survivors learn to cope with their distress and gain control over it (Petrak & Hedge, 2002).

Counselors often ask clients to begin by imagining the least fear-producing stressor and gradually working their way up to the most severe. This may involve a client engaging in both imaginal and in vivo exposures to stimuli that produce terror and anxiety. In the example of the female assaulted at a college party, she may begin by imagining herself on her college campus. Later in the process, she may try going to class

during the day on her campus. Finally, she may practice going to a party in the evening. By pairing these exposures with relaxation techniques over time, survivors learn that they do not need to fear the stimuli associated with the trauma that they experienced. Consequently, they are able to explore and redefine their beliefs about what they know about safety in their world (Petrak & Hedge, 2002).

When using exposure therapy, counselors should note that if they ask a client to explore the assault too in depth and too quickly, it may result in a further feeling of loss of control and anxiety. Recognized risks of exposure therapy include increases in anxiety and emotional distress when confronting fear-provoking images and memories (Foa, Hembree & Rothbaum, 2007). Thus, in facilitating this process, counselors must be mindful about proceeding slowly and carefully whilst continuously checking in with their clients so as to not re-traumatize them. If done correctly, research shows that repeatedly re-experiencing a traumatic event can reduce an individual's negative reaction to the trauma (Kress, Trippany, & Nolan, 2003).

***Cognitive behavioral therapy*.** When using cognitive behavioral therapy with sexual assault survivors, a counselor's primary focus is altering a client's cognitions and beliefs about the sexual assault or rape while helping the client to identify and practice adaptive behaviors. Prior to experiencing a sexual assault, cognitive theory suggests that individuals have certain beliefs and expectations about themselves, others, and the world. Following the experience of a sexual assault, survivors often attach meaning to their trauma in an attempt to explain why it occurred. This may include such cognitions as "it's a just world so I am to blame for what happened".

Using cognitive therapy, counselors help survivors to explore how their thoughts, emotions, and behaviors are linked, identifying dysfunctional thoughts and appraising irrational responses to the trauma. In the example of the cognition "it's a just world so I am to blame for what happened", a counselor may ask the client to reflect on the utility of believing that the assault was his or her fault. In doing so, the client may realize that this cognition provides a sense of control that helps him or her feel like a future assault is preventable. Once this is acknowledged, the counselor and client can work towards helping the client to feel in control while reducing self-blame.

Another cognitive therapy technique that a counselor could use in that scenario is a thought record. In keeping this record, the client would identify thoughts that support and conflict with the cognition. Hopefully, the client would eventually accumulate enough evidence to disprove the thought that the assault was his or her fault. Provided that a client does not present for counseling immediately following an assault while in the acute stage of trauma, engaging in cognitive behavioral therapy rather than simply using a supportive approach has been proven to be more effective (Kress, Trippany, & Nolan, 2003; Petrak & Hedge, 2002; Russell & Davis, 2007).

Interventions with recent sexual assault survivors. It is important for mental health professionals to note that a survivor's needs in counseling are largely impacted by variables such as length of time since the assault and level of trauma. (Russell & Davis, 2007; Kress, Trippany, & Nolan, 2003). Counselors who are working with clients who have recently experienced a sexual assault must understand that these individuals may not be able to engage in therapy that requires intense participation related to exploring the assault. Rather, these clients may initially benefit from a more supportive environment

where they experience a greater sense of control. At this point in the therapeutic relationship, goals may include reducing distress, identifying and validating healthy coping mechanisms, and providing education about typical sexual assault symptoms (Kress, Trippany, & Nolan, 2003).

Experiences of Specialists

To capture the voice of professionals, three clinicians who specialize in working with survivors of sexual assault were interviewed. The first clinician has her masters and educational specialist degrees in clinical mental health counseling and is in her residency to become a licensed professional counselor. She has twelve years of experience working with the sexual assault survivor population at a sexual assault prevention, response and treatment counseling center (H. Foster, personal communication, March 14, 2013). The second clinician has her masters in social work. She has twenty years of experience working with survivors of sexual assault in a variety of settings including a regional sexual assault center and a general trauma response counseling agency (J. Leslie, personal communication, March 15, 2013). The third clinician has her doctoral degree in counseling psychology. She has nine years of experiencing working with survivors of sexual assault on three different college campuses (J. Boo, personal communication, March 18, 2013). Henceforth, these clinicians will be referred to as *C1*, *C2*, and *C3*.

C1, C2, and C3 were asked the same series of questions to explore how they developed competency in working with survivors of sexual assault. Questions included "How long have you worked with survivors of sexual assault and what initially drew you to working with this population?", "How did you develop competence and confidence working with survivors of sexual assault?", "What about your training was helpful in preparing you for this work?", "What do you wish had been included in your training to better prepare you?", "What interventions have you found to be the most helpful when working with survivors of sexual assault?", "What unique aspects can you identify about working with this population?", "What recommendations do you have for novice

counselors hoping to specialize in this area?", and "In what ways do you practice self-care?". Several themes emerged in the clinicians' responses.

In terms of gaining competence and confidence working with survivors of sexual assault, all three clinicians placed a strong emphasis on actively pursuing training and education opportunities. The clinicians referenced participation in trainings at workplaces, conferences, and consultation with other professionals as being valuable components of their development. The clinicians also reported frequently reviewing research and findings in current literature to inform their work with clients. Each clinician reported that they did not feel completely prepared to work with this population immediately following the completion of their respective graduate programs. Rather, they endorsed the need to independently seek out other training opportunities and information before and after graduation. The clinicians indicated that they continued to learn and grow in the field even after beginning their work with sexual assault survivors (H. Foster, personal communication, March 14, 2013; J. Leslie, personal communication, March 15, 2013; J. Boo, personal communication, March 18, 2013).

With regards to feeling confident working with survivors of sexual assault, all three clinicians reported that strong supervision was an integral part of the learning process. This supervision encompassed constructive feedback about possible areas of improvement as well as validation for positive aspects of the clinician's treatment of their clients. Additionally, C3 reported that she had several role models present during her development including her supervisor and several other clinicians who were well-versed in working with survivors. Observing these individual's counseling styles was extremely beneficial to her development (H. Foster, personal communication, March 14, 2013; J.

Leslie, personal communication, March 15, 2013; J. Boo, personal communication, March 18, 2013).

In terms of aspects of the clinicians' graduate programs that prepared them to work with survivors of sexual assault, C1 and C2 reported that their crises classes were the most relevant and helpful component of their education. C3 reported that a crisis class was not included in her doctoral program's curriculum although she did receive thorough crisis training at her practicum placement which was helpful in preparing her to work with this population. C3 also indicated that she had the opportunity to take an elective and she chose a women's issues class where a strong focus was placed on trauma and sexual assault. All three clinicians indicated that when given opportunities to tailor their educational experience to their own interest, their choice to do something relevant to trauma and sexual assault was extremely beneficial. This included elective classes, independent research, projects, and presentations on the topic (H. Foster, personal communication, March 14, 2013; J. Leslie, personal communication, March 15, 2013; J. Boo, personal communication, March 18, 2013).

Still, all of the clinicians reported that these experiences were not enough. Despite the fact that each clinician went to a different type of graduate program, all three indicated that the training they received while in school did not fully prepare them to work with the survivor population. The clinicians reported that they would have liked a larger focus on trauma in general in their graduate programs. C1 and C2 mentioned that many of the sexual assault survivors that they have worked with have presented with a history of multiple incidents of trauma. They believe that education on how the experience of multiple trauma events impacts an individual would have been helpful to

explore. Additionally, all of the clinicians reported that it would have been beneficial to learn about the typical presentation of someone who has experienced a trauma as this is something that all clinicians will be presented with and need to be able to identify in their caseload at some point in their work. Finally, C3 reported that a larger focus on group work, specifically as it relates to trauma survivors, would have been helpful (H. Foster, personal communication, March 14, 2013; J. Leslie, personal communication, March 15, 2013; J. Boo, personal communication, March 18, 2013).

When asked about counseling interventions, all of the clinicians immediately referenced the importance of the psycho-educational piece of working with survivors of sexual assault. The clinicians reported that when clients present with some of the usual reactions following a sexual assault such as guilt, a sense of disconnection from themselves, and symptoms of depression or post-traumatic stress disorder, they often feel crazy, confused, and alone. Educating clients about these reactions and that they are typical and temporary is extremely important in the healing process. C1 said the she will actually show a written diagram of some of these reactions to clients so that they can see it for themselves and make sense of their own experiences (H. Foster, personal communication, March 14, 2013; J. Leslie, personal communication, March 15, 2013; J. Boo, personal communication, March 18, 2013).

The clinicians all also endorsed drawing from the cognitive behavioral and exposure therapy approaches. More specifically, the clinicians reported the use of mindfulness techniques and relaxation skills to help their clients cope with flashbacks, avoidance behaviors and persistent fears that they present with. The clinicians also emphasized the importance of validating their clients' resilience and helping them to

build their support networks outside of counseling. Finally, the clinicians all seemed to agree that each individual may require a different approach and while they may frequently draw from certain theories, they tailor their interventions to the needs of their specific clients. In the words of C1, "there isn't a one size fits all therapy approach for working with survivors" (H. Foster, personal communication, March 14, 2013; J. Leslie, personal communication, March 15, 2013; J. Boo, personal communication, March 18, 2013).

When asked about unique aspects of working with individuals who have experienced a sexual assault, C1, C2, and C3 each referenced the need for counselors to provide education and advocacy surrounding legal issues that can accompany counseling this population. The clinicians shared an extreme frustration with how the legal process often unfolds for survivors of sexual assault. C1 reported that the focus seems to be solely on protecting the defendant rather than also focusing on the rights of the survivor. Often times, C1's experience has been that her clients have simply been viewed as witnesses and that the process has been extremely re-traumatizing for them. All of the clinicians reported that in their experience, it has been extremely important for them to spend time with their clients exploring and identifying goals of pursuing legal action. As it can be extremely difficult to prove that a sexual assault occurred, especially without sufficient physical evidence, defendants are often found innocent. Rather than directing clients to simply focus on the legal outcome, counselors may also assist them in considering the process to be an opportunity to stand up for themselves or to protect others. By reframing a client's goal, it ensures that no matter the legal outcome, survivors are able to make meaning out of the events that unfold (H. Foster, personal communication, March 14,

2013; J. Leslie, personal communication, March 15, 2013; J. Boo, personal communication, March 18, 2013).

Additionally, C3 highlighted the impact that trauma can have on a person's ability to be treatment compliant. In C3's experience, it has not been uncommon for survivors of sexual assault on her caseload to no-show or to cancel their appointments at the last minute. C3 reported that with this population, it is important to therapeutically set boundaries about appointment attendance that enables them to feel a sense of control in their treatment while still participating in it as scheduled (J. Boo, personal communication, March 18, 2013).

In terms of the clinicians recommendations to novice counselors who hope to specialize in working with survivors of sexual assault, the resounding message was to put effort into learning as much as you can as often as you can. This encompasses seeking out trainings and educational opportunities, focusing on sexual assault topics in assignments for projects or presentations in one's graduate program, getting involved in local organizations, and understanding the resources that are available in one's community. All three of the clinicians seemed to agree that the development into a competent and confident clinician is a continual growing process that never ceases, even after countless years of experience (H. Foster, personal communication, March 14, 2013; J. Leslie, personal communication, March 15, 2013; J. Boo, personal communication, March 18, 2013).

Finally, the clinicians indicated that the most important part of working with survivors of sexual assault is understanding the importance of effective self-care for themselves as clinicians. Without this, the clinicians reported that it would be impossible

to continue doing the work that they do. The burnout rate in this particular counseling area is high so clinicians must constantly be monitoring their own stress level and needs which may change frequently. The clinicians also reported that some cases trigger them more than others. Being attuned to one's own reactions to different clients is of the utmost importance. When a harder case does present itself, the clinicians indicated that consulting with their colleagues and seeking consultation and supervision is key, no matter how many years of experience they have (H. Foster, personal communication, March 14, 2013; J. Leslie, personal communication, March 15, 2013; J. Boo, personal communication, March 18, 2013).

Recommendations for Inclusion in Curriculum

Due to the prevalence of sexual assault in the United States of America, it is reasonable to expect that beginning counselors will have several survivors on their caseload and will thus need a working knowledge of sexual assault to provide effective clinical treatment. The realization of this working knowledge can be achieved in counselor education programs by the incorporation of a stronger focus on trauma and sexual assault in the curriculum. This can be addressed in established classes or by the creation of a new class specifically designed to educate on trauma. It should be noted that specialists in the field support the inclusion of an additional trauma-focused class in counselor education programs (H. Foster, personal communication, March 14, 2013; J. Leslie, personal communication, March 15, 2013; J. Boo, personal communication, March 18, 2013). Based on the integration of findings in current literature related to counseling survivors of sexual assault and the experiences of specialists in the field, it is recommended that counselor education programs include the following information in their curriculum.

First, beginning counselors should be educated about relevant vocabulary in the field of sexual assault including the legal definitions of the terms “sexual assault” and “rape” and the use of the word “survivor”. Following this, students should be given an overview of the prevalence of sexual assault in the United States of America similar to the summary of current statistics about suicide that most counseling graduate programs provide. This should encompass what is known about the breakdown of sexual assault by gender, age, and race and the populations that are most at risk.

Once novice counselors have received an introduction to the issue of sexual assault, they should be educated about typical presentations of survivors including both physical and emotional injuries. At this point, it is recommended that counselor education programs review common reactions to trauma in general as well as sexual assault specifically. This should include an overview of symptoms of depression and post-traumatic stress disorder and the unique aspects of these presentations in survivors. Counselor education programs should also focus on how individuals may present with multiple negative reactions to a trauma such as comorbid substance abuse and psychological disturbance. Students should be made aware of the impact that experiencing one sexual assault, especially in childhood, has on a person's risk of experience an additional assault. Beginning counselors should be given the opportunity to identify survivors of trauma and their presenting symptoms through reading or role playing case studies.

After learning how to identify typical trauma reactions in clients, students should be educated about effective counseling interventions utilized with the sexual assault survivor population. This should encompass an overview of cognitive behavioral therapy practices, exposure therapy techniques, and the importance of providing psycho-educational information to survivors in order to normalize typical responses to trauma. It would also be beneficial for counselor education programs to provide novice counselors with an overview of the legal system as it applies to survivors who want to press charges against their perpetrators. This should include a review of the evidence collection process which informs students about the sexual assault evidence collection kit and its invasive nature. An emphasis should be placed on the importance of advocacy and the provision

of support and education to survivors no matter what their decision is in regards to reporting.

Finally, although many counselor education programs discuss the importance of self-care as it relates to counseling in general, it is recommended that programs specifically emphasize this in relation to working with survivors of sexual assault. All three specialists in the field highlighted the role that self-care plays in a counselor's ability to function as an effective counselor for survivors (H. Foster, personal communication, March 14, 2013; J. Leslie, personal communication, March 15, 2013; J. Boo, personal communication, March 18, 2013). Professors in counselor education programs may provide examples of self-care strategies that they successfully employed in their counseling careers. By underscoring the importance of self-care and helping novice counselors to establish a strong focus on it early in their development, counselor education programs will encourage their students to build self-care into their personal practices in the years to come.

References

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders (DSM-IV-TR)*. Washington, DC: American Psychiatric Association.

Bromet, E., Sonnega, A., & Kessler, R. (1998). Risk factors for DSM-III-R posttraumatic stress disorder: Findings from the national comorbidity survey. *American Journal of Epidemiology, 8*(2), 223–255.

Browne, A., & Finkelhor, D. (1986). Impact of child sexual abuse: A review of the research. *Psychological bulletin*, *99*(1), 66.

Campbell , R. (1998). The community response to rape: Victims' experiences with the legal, medical, and mental health systems. *American Journal of Community Psychology,* 26, 355-379.

Council for Accreditation of Counseling and Related Educational Programs (2009). *2009 standards*. Retrieved from http://www.cacrep.org/doc/2009%20Standards%20with%20cover.pdf

Foa, E., Hembree, E., & Rothbaum, B. O. (2007). *Prolonged exposure therapy for PTSD: Emotional processing of traumatic experiences therapist guide*. Oxford University Press, USA.

Frazier, P., Conlon, A., & Glaser, T. (2001). Positive and negative life changes following sexual assault. *Journal of Consulting and Clinical Psychology*, 69, 1048-1055.

Gilboa-Schechtman, E. & Foa, E. B. (2001). Patterns of recovery from trauma: The use of intraindividual analysis. *Journal of Abnormal Psychology*, *110*(3), 392–400.

Klump, M.C. (2006). Posttraumatic stress disorder and sexual assault in women. *Journal of College Student Psychotherapy*, *21*(2), 67 - 83.

Koss, M. P., Figueredo, A. J., & Prince, R. J. (2002). Cognitive mediation of rape's mental, physical and social health impact: Tests of four models in cross-sectional data. *Journal of consulting and clinical psychology*, *70*(4), 926.

Kress, V., Trippany, R. L., & Nolan, J. (2003). Responding to sexual assault victims: Considerations for college counselors. *Journal of College Counseling*, *6*(2), 124-133.

Rape, Abuse, and Incest National Network (2009). *Statistics.* Retrieved from http://www.Rape, Abuse & Incest National Network .org/statistics

Rape Victim Advocacy Program (2005). *Legal or reporting options.* Retrieved from http://www.Rape Victim Advocacy Program.org/pages/legal_options/

Levers, L. (2012). *Trauma counseling: Theories and interventions*. New York, NY: Springer Publishing Company, LLC.

Messman-Moore, T. L., & Brown, A. L. (2006). Risk perception, rape, and sexual revictimization: A prospective study of college women. *Psychology of Women Quarterly*, *30*(2), 159-172.

Najdowski, C. J., & Ullman, S. E. (2011). The effects of revictimization on coping and depression in female sexual assault victims. *Journal of Traumatic Stress*, *24*(2), 218-221.

National Institute of Justice & Centers for Disease Control & Prevention. (1998). *Prevalence, incidence and consequences of violence against women survey*: *Findings from the national violence against women survey.* Retrieved from https://www.ncjrs.gov/pdffiles/172837.pdf

Petrak, J., & Hedge, B. (2002). *The trauma of sexual assault: Treatment, prevention, and*

practice. West Sussex, England: John Wiley & Sons, LTD.

Riger, S., Bennett, L., Wasco, S., Schewe, P., Frohmann, L., Camacho, J., & Campbell, R. (2002). *Evaluating services for survivors of domestic violence and sexual assault*. Thousand Oaks, CA: Sage Publications Inc.

Russell, P. L., & Davis, C. (2007). Twenty-five years of empirical research on treatment following sexual assault. *Best Practices in Mental Health: An International Journal*, 3, 21 – 37 .

Testa, M., VanZile-Tamsen, C., & Livingston, J. A. (2007). Prospective prediction of women's sexual victimization by intimate and nonintimate male perpetrators. *Journal of Consulting and Clinical Psychology*, *75*(1), 52.

Ullman, S. E., Najdowski, C. J., & Filipas, H. H. (2009). Child sexual abuse, post-traumatic stress disorder, and substance use: Predictors of revictimization in adult sexual assault survivors. *Journal of child sexual abuse*, *18*(4), 367-385.

United States Bureau of Justice (2012). *Rape and sexual assault.* Retrieved from http://bjs.gov/index.cfm?ty=tp&tid=317