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Counselors' affective responses to childhood sexual abuse disclosure

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COUNSELORS' AFFECTIVE RESPONSES TO CHILDHOOD SEXUAL ABUSE DISCLOSURE

By

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Extant research has revealed that the counselor's response to the clients' disclosure of child sexual abuse experiences have a significant impact on their well-being, continuation in therapy, and progress in treatment. Despite the growing body of literature on the need for more sensitive and professional responses to child sexual abuse disclosure, clients continue to report negative responses and experiences with counseling professionals.

To date, few studies have investigated the counselor's affective responses to a client who discloses a child sexual abuse history. The purpose of this study was to investigate the range of counselor's affective responses when confronted with the topic of child sexual abuse and to investigate what factors influenced these reactions.

Results of the current study indicated that counselors with a personal history with CSA scored similarly to those with no CSA history on the Affective Responses to Child

Sexual Abuse Scale (ARCSAS). However, there was a statistically significant difference in affective responses by degree and CSA history. Counselors with a personal history of CSA and who held a master's degree responded with greater sensitivity to the topic of CSA than those with a doctoral degree and no personal experience with child sexual abuse.

Results of the study indicated that type of CSA training was not a statistically significant factor in affective responses to CSA; however, the amount of CSA training and increased experience with CSA clients did have a positive influence on counselors' affective responses to CSA. The results of the factor analysis indicated that the ARCSAS was a moderate measure of counselor affective responses with a two-factor structure.

The results of the study suggested that measuring affective responses to child sexual abuse is a complex and multidimensional construct with many variances. In addition, the findings of the study support the importance of counselors and counselors-in-training to be prepared prior to their first exposure to CSA clients to illicit more positive responses to CSA. Thus, the results of this study support the need for more child sexual abuse training and experience in order to deflect any negative responses on clients who disclose child sexual abuse.

DEDICATION

This dissertation is dedicated to the loves of my life, Tommy Allen Gardner and Nikki Gardner. Tommy, thank you for your support and patience through our 19 years together. Not only are you my best friend, sticking with me through good times and bad, but you have shown me the true meaning of unconditional love. Nikki, I thank God every day for the blessing you have been to me. From the moment of your birth, you have shown me what it is to truly love another unconditionally. Lastly, but not least, I thank God for the many blessings and gifts He has bestowed upon me. This study is also dedicated to the many child sexual abuse survivors who have overcome great obstacles to utilize their painful experiences to help others and for those who continue to contribute to the counseling profession.

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There is only one corner of the universe you can be certain of improving, and that's your own self.

-Aldous Huxley

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CHAPTER I

INTRODUCTION

Imagine being a 20-year-old college student who has entered the university counseling center for the first time. A female counselor who is a graduate student greets you during the first session and you disclose sexual abuse by your father from the age of 5 to 16 years of age. After disclosing this for the first time to anyone, the counselor responds with a surprised and shocked look, followed by anxiety and visible discomfort. The counselor then tells you that she is unfamiliar with your problem and needs to talk with her supervisor. She excuses herself and leaves the room. The counselor returns and tells you that you need to see her supervisor in her office.

Once in the supervisor's office, you find yourself in front of a large desk sitting in a straight back chair. You look around and you notice that the plaque on the supervisor's desk indicates that she has a doctoral degree. You sit across from her and she asks you, "What can I do for you?" You stammer and stutter out that this is the first time you have sought therapy for sexual molestation. The supervisor gives no empathetic response and provides little support or information. She tells you to set up another appointment. Your initial response is shock at the question of "what I wanted" when you expected the counselor to be understanding and empathetic to your situation. The next feeling was that of humiliation and discouragement that this "professional" was asking you more

questions than providing answers. How would you feel and what would you do if you were this client?

This experience may seem improbable or uncommon in a professional mental health setting; however, this actual event happened to me. After that negative experience with the counseling center, 10 years passed before I finally sought counseling for my childhood sexual abuse. The primary reason that it took me so long to return to counseling was the rejection and lack of support I felt with my first experience with counseling and a counselor.

The counselor's unsupportive and negative responses to the client's disclosure of child sexual abuse can negatively impact the client in various ways (Denov, 2003). Counselors who are unaware of the sensitive nature of working with a client with a child sexual abuse history can result in harming the client, impeding the client's progress in treatment, or interfering with the client's return to counseling (Pearlman & Saakvitne, 1995).

Deleterious Effects of CSA

Child sexual abuse (CSA) has been described as a serious problem that has immediate and long-term deleterious consequences for children and adults (Briere & Elliot, 1994). Studies have revealed greater psychological distress and disturbances for men and women with a history of CSA (Neumann, Houskamp, Pollock, & Briere, 1996; Polusny & Follette, 1995). Child sexual abuse has been connected with an increased prevalence of psychological, behavioral, and interpersonal problems in individuals surviving child sexual abuse compared to those with no sexual abuse history (Neumann

et al., 1996). Child sexual abuse has been associated with both immediate and long-term interference with interpersonal relationships, psychological, and physiological functioning (Polusny & Follette, 1995).

It is estimated that by the age of 18, one in three women and one in five men will have experienced some form of child sexual abuse (Whetsell-Mitchell, 1995). For the college population, approximately one-third of students who sought counseling at a university counseling center reported experiencing childhood sexual abuse. More recently, Bolen and Scannapieco (1999) conducted a meta-analysis of the prevalence of CSA within the general population and estimated that 30% of women and more than 13% of men experienced child sexual abuse.

Several studies have associated negative outcomes for the CSA survivor in terms of greater psychological and physiological symptomology, such as "self-denigration, disassociation, and borderline symptoms," because of negative responses to CSA disclosure (as cited in Ullman, 2003, p.103). Ullman reviewed 23 studies from 1987 to 2001 that documented both positive and negative reactions to CSA disclosure. The sample size of the studies ranged from 20 to 399 participants. Among the negative reactions cited included:

> blame, disbelief/invalidation, belittling, rejections, disgust, hostility, exploitation/victimization by therapists, denying, ignoring, or minimizing the abuse, claiming the victim made it up/fantasized it, overprescribing drugs to victims, lack of action to stop abuse/remove offender from home, punishing/scolding, hostile/angry responses, egocentric response, lack of

caring/being let down by others, stigma, being made fun of by others (Ullman, 2003, p. 104).

Sensitivity of Child Sexual Abuse Survivors

Working with child sexual abuse survivors can be extremely difficult, challenging, and quite complex. Because of the interpersonal nature and sense of betrayal associated with child sexual abuse, CSA survivor's often have deficits in interpersonal relationship skills and can hold distorted perceptions of self as well as others (McGregor, Thomas, & Read, 2006; Schaefer & Kaduson, 2006). The CSA survivors' heightened sensitivity to any indication of negative responses exhibited from the counselor makes the counselor's role especially challenging (McGregor et al., 2006). McGregor, Thomas, and Read described two types of common mistakes displayed by counselors when confronted with sensitive information (i.e., child sexual abuse), which they label as *therapy errors*. These include *distancing* and *intrusion*. *Distancing errors* refer to any abrupt withdrawal of empathy and/or denial of countertransference (e.g., disgust, shame, helplessness, anger, or exaggerated objectivity). *Intrusion errors* allude to the counselor having excessive influence or control over the client that can harm the client. Because of the CSA survivor's heightened awareness of any negative affective responses from the counselor, such as lack of empathy, misunderstanding, and/or an inability to cope with hearing about accounts of CSA, it is important that counselors are sensitive to and careful with this population.

The child sexual abuse survivor's greater acuity for therapy errors makes the therapeutic relationship and therapist's response an especially crucial component of

psychotherapy success with this population (McGregor, Thomas, & Read, 2006). Additionally, the wellbeing and therapeutic progress of child sexual abuse clients appears to be dependent on the counselor's response to the disclosure of CSA by the client (Denov, 2003). Ullman (2003) has asserted, "reactions to abuse victims and adult survivors [CSA disclosure] are a salient and influential factor that affect recovery from abuse…" (p. 113).

CSA Disclosure

Representative sample studies have indicated that approximately 30% of female victims of CSA never disclose their child sexual abuse experiences (Ullman, 2003), and if they do disclose the CSA, more than 5 years may have passed after the event occurred (Jones, 2000). One study conducted by McMillen & Zuravin (1998) found that 42% of clients in a sample of 154 women seen by child protective services or AFDC did not disclose their CSA experiences to their therapist (Ullman, 2003).

Child sexual abuse survivors reported hesitancy in disclosing their sexual abuse experiences to mental health professionals primarily due to concerns of negative reactions (Ullman, 2003), especially if the perpetrator was female (Denov, 2003). Child sexual abuse survivors reported "their greatest difficulty associated with disclosing their abuse was the fear of not being believed" (Denov, 2003, p. 54). The nondisclosure of CSA may be harmful; however, disclosure of CSA in and of itself is not enough to alleviate the effects of CSA.

Therapist Response

Cavanagh, Read, and New (2004) asserted that studies of clinicians in the U.S. and U.K. have failed to identify the majority of abuse cases reported to researchers and continue to find low levels of abuse identification by mental health services. In addition, they also reported the lack of follow-up and low levels of response after a client discloses child sexual abuse. The therapists' follow-up should include the following: (a) offering information or support, (b) referring for counseling, (c) documenting the abuse in files, (d) asking about previous disclosure or treatment, (e) including abuse in summary formulations or treatment plans, and (f) considering reporting to legal or protection agencies. Cavanagh, Read, and New provided an overview of possible barriers to inquiry and appropriate responses to child abuse: (a) concerns about offending or distressing clients, (b) fear of vicarious tramatization, (c) fear of inducing false memories, (d) the client being male, (e) the client having a diagnosis indicative of psychosis, and (f) the clinician being a psychiatrist (p. 138).

Previous research has revealed that supportive and positive responses can induce empathy and elicit greater positive results in therapy; whereas, negative social reactions, such as disbelief and minimizing the client's sexual abuse experience, especially by counseling professionals, can be harmful to clients (Denov, 2003; Knight, 1997; Ullman, 2003). The counselor's unsupportive and negative responses to the client's disclosure of child sexual abuse can negatively impact the client in the following ways: (a) increasing the client's sense of distrust or betrayal, (b) inciting feelings of anger, and (c) leading to the CSA survivor questioning or denying the sexual abuse experience (Denov, 2003). Negative professional responses were "those in which victims reported that professionals

were unsupportive of their disclosure and that they were generally dissatisfied with the professional intervention" (Denov, 2003, p. 52). Participants in Denov's study reported negative professional responses as those in which the counselor was visibly uncomfortable and resistant to discussing the victimization, or minimizing the sexually abusive acts, especially if the abuse was at the hands of a female perpetrator.

Sexual abuse is a topic that has been described as eliciting strong emotional responses in counselors (Alpert & Paulson, 1990; Kitzrow, 2002). Because of the sensitive and emotional nature of childhood sexual abuse, counselor may experience incongruent cognitive and emotional reactions, leading to avoidance of this topic (Ferrara, 1998 & 1999). Counselors who are unaware of the sensitive nature of working with a client with a sexual abuse history may inadvertently result in harming the client, impeding the client's progress in treatment, or interfering with the client's return to counseling (Pearlman & Saakvitne, 1995). The counselor's unsupportive responses and any display of disbelief of the client's sexual abuse experience can exacerbate the deleterious effects of the sexual abuse, which can be detrimental and contribute to secondary or vicarious traumatization for the client (Pearlman & Saakvitne, 1995). This lack of emotional awareness or emotional block has been described as occurring through a process of countertransference (Cheung & Boutte-Queen, 2000), vicarious traumatization (Pearlman & Saakvitne, 1995), or cognitive dissonance (Ferrara, 1998, 1999).

A related issue to countertransference that can often influence the counselors' willingness to address child sexual abuse is the counselors' own personal sexual abuse history (Emerson, 1988). Several studies have revealed the high prevalence rates of child

sexual abuse among mental health practitioners and counselors in training (Alpert & Paulson, 1990; Emerson, 1988, Follette, Polusny & Milbeck, 1994; Little & Hamby, 1996; Nuttall & Jackson, 1994; Parisien & Long, 1994; Polusny & Follette, 1995; Pope & Feldman-Summers, 1992). Alpert and Paulson (1990) and Emerson (1988) suggested that students who enter a counseling program may soon find that unresolved child sexual abuse issues quickly surface. Counseling trainees who enter counseling programs with unresolved childhood sexual abuse histories may have difficulty effectively counseling clients who disclose CSA until they have sufficiently resolved their own child sexual abuse issues (Emerson, 1988). Thus, the counselor's own personal CSA experience can result in issues of transference that may lead in misdirecting or hindering the client's progress, resulting in ineptness at working with sexually abused clientele (Emerson, 1988; Jones, 2002; Jones, Robinson, Minatrea, & Hayes, 1998).

CSA Training

The counselor's first experience and opportunity for appropriate responses with CSA survivors is most likely to occur at a very late stage in their clinical training program, if addressed at all. Most counselors' first encounter with CSA may be in their externship or internship rather than as part of their clinical coursework. The consequence of such inadequate or delayed training is the risk of inadvertently retraumatizing (often referred to as secondary victimization) the CSA survivor (Denov, 2003; Frazier & Cohen, 1992). A lack of child sexual abuse awareness has also been associated with the mental health trainees' perceptions of their competence. Counseling trainees lacked awareness of the dynamics involved in working with CSA clients as indicated by their underestimation

of the length of time clients needed to effectively process their sexual abuse trauma (Parisien & Long, 1994). Even more disturbing is the fact that although trainees had little experience in counseling CSA clients, they were often overly confident in their ability to counsel this population (Parisien & Long, 1994). Thus, the counselors' lack of awareness of their negative feelings toward child sexual abuse issues can influence their reactions and interactions with clients, often interfering with the clients progress and treatment in therapy (Frazier & Cohen, 1992). Westwood (1994) has suggested that the development of *self-awareness* of one's personal feelings and attitudes may be as important in counselor preparation and competency as skills and knowledge.

Several researchers have suggested that counselors need specialized education, training, and supervision to deal effectively with the specific problems encountered by CSA survivors (Alpert & Paulson, 1990; Denov, 2003; Etherington, 2000; Kitzrow, 2002; Parisien & Long, 1994; Tudiver, McClure, Heinonen, Scurfield, & Kreklewetz, 2000; Winkelspecht & Singg, 1998). Pearlman and Saakvitne (1995) provided support for the need of specialized CSA training and attention to the affective responses of mental health professionals: (a) the high prevalence of CSA in the general and clinical population, (b) the often challenging post-trauma symptomatology and psychological disruptions experienced by CSA clients, (c) the importance of the mental health professional to develop a therapeutic relationship with the CSA survivor in order for healing to occur, (d) the effect of countertransference and vicarious traumatization issues on the mental health professional, and (e) the unique challenges of countertransference and vicarious traumatization for mental health practitioners with a personal history of CSA (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995).

Several studies have found that training on CSA can significantly increase disclosure and initiation of appropriate care for those who do disclose (Cavanagh et al., 2004). Currier and Briere (2000) found that mental health staff who received a one-hour lecture on assessing sensitive issues identified significantly more sexual violence than those who did not receive the lecture (Cavanagh et al., 2004). Several factors can increase counselor confidence and perception of effectiveness in addressing sexual abuse issues: (a) advanced degree, (b) graduate course focusing on CSA issues, (c) active involvement in additional CSA training experiences, and (d) working with CSA clients (Dillihunt, 1997).

The negative reports by clients who disclose their sexual abuse experiences to counselors should be cause for alarm in the counseling profession and to programs in counselor education. Many counselors will encounter a client who has been traumatized by child sexual abuse and/or experiencing psychological, behavioral, and/or social symptomology (Jones, 2002). It is important that mental health counselors are aware of their affective response to childhood sexual abuse issues before their first encounter with a client who presents with a sexual abuse history. The counselor's initial response to sexual abuse disclosure is crucial to the wellbeing of clients who seek therapy for resolution of their child sexual abuse history. Supportive professional responses such as validation of the survivor's sexual abuse experiences can often mitigate the deleterious effects of CSA for the client (Denov, 2003; Ullman, 2003). Increasing the awareness of the counselor's own emotional reactions can assist in responding in an appropriate, supportive, and professional manner to clients who disclose experiences with child sexual abuse.

Statement of the Problem

Review of the literature supports the occurrence of countertransference issues (Pearlman & Saakvitne, 1995) and negative emotional responses among mental health professionals who have been working with victims of trauma for an extended period of time (Jones, 2002; Jones et al., 1998). To date, few studies have empirically examined the *counselor's* affective responses to the client's disclosure of a sexual abuse history. Moreover, research on the *novice* counselor's responses to sexual abuse disclosure is scant (Cheung & Boutte-Queen, 2000; Jones, 2002; Jones, et al., 2002; Knight, 1997).

Much of the literature on the impact of counselors working with sexually abused clients has focused primarily on attitudes and burnout, not specifically on the affective responses by counselors who first encounter the topic of sexual abuse (Cheung & Boutee-Queen, 2000). During counselor training, one's first experience with sexually abused clients is often quite limited with little instruction on how to appropriately respond (Alpert & Paulson, 1990; Kitzrow, 2002), which in turn may be a factor in negative reports by sexually abused clients who do disclose their experiences to counselors (Denov, 2002; Knight, 1997). In addition, much of the existing literature on affective responses to sexual abuse has focused on a specific segment of the mental health field, primarily on psychologists and *other* professionals such as law enforcement, social workers, and teachers. A group that has often been ignored includes counselors who work with sexual abuse trauma in a therapeutic setting. Even sparser is research on the novice

counselors' responses in their graduate training (Cheung & Boutee-Queen, 2000; Knight, 1997). Previous studies have been limited by regional location, such as Hong Kong (Cheung & Boutee-Queen, 2000), Vermont (Little & Hamby, 1996), or Maryland (Knight, 1997). A more comprehensive and nationwide investigation needs to be conducted in order to obtain a more accurate picture of the counselor's response to a client's sexual abuse disclosure.

Given the sensitive nature of the topic of sexual abuse, the prevalence of mental health counselors who themselves have been sexually abused, and the implications for the well-being of the client, it was surprising to find little information on the counselor's affective responses to child sexual abuse. It has been suggested that mental health educators have an obligation to inform mental health practitioners about the hazards of providing care to CSA clients and train them in the prevention and treatment of vicarious trauma (Figley, 1995; Pearlman & Saakvitne, 1995). However to date, only modest attempts have been made to address this gap in educating counselors to work with sexually abused clientele.

Purpose of the Study

There were several objectives for this study. First, counselors throughout the United States, who identified as members of American Counseling Association, were surveyed in order to identify the range of affective responses to the issue of child sexual abuse. Second, another purpose of the current study was to investigate what factors influenced the counselors' affective responses to child sexual abuse. Several factors were investigated: (a) the counselor's own personal history of sexual abuse, (b) the type of

child sexual abuse training (e.g., training in asking about child sexual abuse and training in appropriately responding to disclosure of child sexual abuse), (c) level of education, and (d) level of experience in treating child sexual abuse clients.

Research Questions

To explore the affective responses of counselors to the topic of child sexual abuse, the following research questions were examined:

1. What were the affective response levels (low, medium, high) of counselors to the topic of child sexual abuse?
2. Was there a statistically significant difference between the affective responses of participants who reported a personal child sexual abuse history and those with no such history?
3. Was there a statistically significant difference in affective responses of participants with the type of child sexual abuse training received?
4. Was there a statistically significant difference in the affective responses of participants who reported training in asking a client about CSA?
5. Was there a statistically significant difference in the affective responses of participants with training in appropriately responding to a sexually abused client?
6. Was there a statistically significant difference in the affective responses of participants and the number of child sexual abuse clients counseled?

Justification of the Study

The current study is important for counselor educators and the counseling profession. This line of research identified the range of affective responses of counselors when confronted with a client's report of child sexual abuse history. The information collected in this study increases the body of counselor knowledge in addressing child sexual abuse issues. It provides counselors and educators alike with greater self-awareness of negative reactions that may re-traumatize clients who have already been harmed by a child sexual abuse history.

This research assisted counselors in screening for any issues of transference or counter-transference that may impede the client's progress in treatment. The instrument used in this study was beneficial in assisting counselor educators in identifying and screening beginning counselors who may be more susceptible to negative affective responses. Counselors who are susceptible to negative affective reactions can be provided with effective methods to reduce these abreactions prior to actually working with CSA survivors. Finally, identifying and addressing affective responses can result in increasing more appropriate responses to CSA clients, thus reducing the number of clients who report unsatisfactory experiences with mental health professionals.

The current investigation added to the sparse literature on examining affective responses as it related to child sexual abuse. Another benefit of this study was assisting counselors in becoming aware of any unresolved emotional responses that may impede and interfere with the client's treatment and progress. In addition, this study focused

more attention on the importance of the counseling profession in addressing child sexual abuse in counselor training.

Grossman, Levine-Jordano, and Shearer (1990) stressed that it is important that counselor educators address the student's emotional reactions in order to normalize their subjective reactions, prepare students to anticipate areas of particular emotional sensitivity, and to inform them of personal and professional resources to deal with these reactions that will benefit the student and not harm the client. Ultimately, this researcher believes this study will benefit counselors in dealing sensitively and efficaciously with clients who present a history of child sexual abuse through preventing future vicarious traumatization for the client and/or the counselor.

Limitations & Threats

There are some limitations to be noted in this study. First, the format of the survey will be a web survey with recruitment via email. Past research has revealed low response rates via web surveys compared to mails surveys (as cited in Kiernan, Kiernan, Oyler, & Gilles, 2005). However, recent studies have reflected similar or greater response rates with longer and more substantive responses to qualitative questions via web surveys as compared to mail surveys (Dominelli, 2003; Kiernan, et al., 2005; Kittleson, & Brown, 2005). Dominelli (2003) reported that validity of using a Web survey is "strong due to the extensive reach of the Internet" (p. 411). More recently, Huang (2006) found that print and Web surveys provided similar results and provided greater responses in collecting sensitive information with less social desirability bias.

Another threat to validity is that the sample may not be representative of the population of counselors. However, due to the survey extending nationwide to American Counseling Association (ACA) members, a large sample size was anticipated with high response rates, which minimized this threat. Currently there are over 45,000 members of ACA. The American Counseling Association is the world's largest association exclusively representing professional counselors in various practice settings (http://www.counseling.org/AboutUs, 2005). However, there is still the possibility that the results may not be applicable to other mental health settings that do not identify themselves as members of the American Counseling Association.

Another consideration that threatens generalizeability is that the sample may lack heterogeneity of race and gender, often over-representing Caucasians and women. However, this is not expected to have a large impact on generalizeability due to the fact that the majority of the counseling field is composed predominately of females and Caucasians. Wilk et al. (2002) have reported that since 1996, the composition of counselors has been predominantly female with women currently representing about 70% of counseling professionals practicing today, outnumbering men three to one. Estimates of current ethnic composition of counseling professionals reflect that about 80% identify as Caucasian, 4% African-American, and 2% identify as Latino (Wilk et al., 2002).

Another threat to the current study is the self-report format of the survey in which participants may respond with a social desirability bias. The content of the items on the Affective Responses to Child Sexual Abuse Scale (ARCSAS) are sensitive in nature and participants may be inclined to respond with "socially desirable" answers in order to not be perceived negatively (e.g., unsympathetic or lacking empathy) to clients who disclose child sexual abuse, which may confound the results. However, this threat was minimized by using a self-administered Web survey, which has shown to reduce social desirability bias and result in greater responses when investigating and collecting sensitive information (Huang, 2006).

Finally, another complication that may be a threat is the lack of consensus as to what constitutes child sexual abuse, with definitions varying from one study to another. To minimize this threat, the researcher has used a broader and detailed description and definition of CSA.

Definition of Terms

1. *Affective Responses*: entire body of feelings (emotional, cognitive, psychological, and/or physical reactions) that a counselor may experience toward a client who has disclosed and/or experienced childhood sexual abuse or toward the topic of child sexual abuse (Cheung & Boutte-Queen, 2000; Knight, 1997).
2. *Affective Responses to Child Sexual Abuse Scale (ARCSAS):* 41-item instrument developed by the researcher to measure 11 categories of affective responses to child sexual abuse. A full description of this instrument can be found in the instrumentation section of chapter three.
3. *American Counseling Association* (*ACA*): A "not-for-profit, professional and educational organization that is dedicated to the growth and enhancement of the counseling profession." ACA was founded in 1952 and is the world's largest association exclusively representing professional counselors in various practice settings with nearly 45,000 members. ACA helps counseling professionals develop their skills and expand their knowledge base (http://www.counseling.org/AboutUs, 2005).
4. *Child Sexual Abuse Definition (CSA):* The imposition of sexually inappropriate acts (including noncontact sexual abuse) on a child or adolescent (under the age of 18) for the sexual gratification of another person who is in a position of power or control over the child, including acts perpetrated by peers (APA, 2001; Blume, 1990; National Clearinghouse on Child Abuse & Neglect, 1993; Whetsell-Mitchell, 1995).

5. *Contact Sexual Abuse:* Sexual behaviors such as frottage, fondling, kissing, oral sex, digital or object penetration, intercourse, or pornography (Faller, 1993; Whetsell-Mitchell, 1995)
6. *Counselor:* "A professional (or a student who is a counselor-in-training) engaged in a counseling practice or other counseling-related services. Counselors fulfill many roles and responsibilities such as counselor educators, researchers, supervisors, practitioners, and consultants" (ACA, 2005, p. 20).
7. *Counselor Educator*: "A professional counselor engaged primarily in developing, implementing, and supervising the educational preparation of counselors-in-training" (ACA, 2005. p. 20).
8. *Counselor Supervisor*: "A professional counselor who engages in a formal relationship with a practicing counselor or counselor-in-training for the purpose of overseeing that individual's counseling work or clinical skill development." (ACA, 2005, p. 20).
9. *Countertransference*: Activation of the counselor's own unresolved, conscious or unconscious conflicts or reactions that accompany work with trauma victims that often may interfere with the process of treatment and with the client's progress (Figley, 1995; Pearlman & Saakvitne, 1995).
10. *Incest:* Sexually abusive acts or sexual overtones perpetrated by blood relatives (intrafamilial), relatives by marriage (extrafamilial), or quasi-relatives, which are persons in parental or caretaker roles who have an ongoing emotional bond with the child (Glantz & Hunt, 1996; Witchel, 1991).

11. *Licensed Professional Counselor* (*LPC*): Any person who presents himself to the public by any title or description of services incorporating the words licensed professional counselor and who offers to render professional counseling services to individuals, groups, or organizations, corporations, institutions, government agencies or the general public for a fee, monetary or otherwise (http://www.lpc.state.ms.us/t3/rulesandregs.htm#CHAPTER%201 2004).
12. National Clearinghouse on Child Abuse and Neglect Information *(NCCANI):* NCCANI is a service of the Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services. The Clearinghouses was established in 1974 by the Child Abuse Prevention and Treatment Act to collect, organize, and disseminate information on all aspects of child maltreatment (NCCANI, 1993).
13. *Non-Contact Sexual Abuse*: Sexual comments, exhibitionism, voyeurism, showing pornographic material, inducing child to undress or masturbate self (Faller, 1993; Whetsell-Mitchell, 1995).
14. *Posttraumatic Stress Disorder (PTSD)*: a mental disorder with characteristic symptoms that develops following exposure to an extremely traumatic stressor, through direct personal experience or witnessing of an event that involves actual or threatened death or serious injury to oneself or another person; or learning about an unexpected or violent death that has lasted for more than one month. Also includes sexually traumatic events that include developmentally inappropriate sexual

experiences without threatened or actual violence or injury is also included (APA, 2000).

15. *Professional Counseling*: The practice of professional counseling has been defined by the American Counseling Association as, “The application of mental health, psychological, or human development principles, through cognitive, affective, behavioral or systematic intervention strategies, that address wellness, personal growth, or career development, as well as pathology” (http://www.counseling.org/Counselors/ pamphlet on the definition of professional counseling, 2005).
16. *Vicarious Traumatization (VT):* “A process of change resulting from empathic engagement with trauma survivors” that can occur to anyone working with trauma issues (Pearlman & Saakvitne, 1995, p. 52). VT can often have a negative impact upon the helper, leading to counter-transference issues (e.g., feeling overly responsible or committed in assisting the survivor). VT has been referred to as s*econdary traumatic stress, secondary traumatization, counter-transference, compassion fatigue,* or *empathic strain.*

CHAPTER II

REVIEW OF RELEVANT LITERATURE

This chapter provides a general overview of the existing information on child sexual abuse (CSA). The topics to be covered include: (a) definitions of CSA, (b) prevalence of CSA, (c) clinical diagnosis of CSA, (d) sequelae of child sexual abuse, (e) affective responses to CSA, (f) effects of counselor responses to clients with a child sexual abuse history, and (g) methods of measuring affective responses to sexual abuse.

General Overview of Child Sexual Abuse

The following information is offered as a general overview of research findings concerning child sexual abuse. One must keep in mind that the majority of the information on the nature, prevalence, and impact of child sexual abuse has been as a result of retrospective studies of adults abused as children (Finkelhor, Hoteling, Lewis, & Smith, 1990). Due to variances in definition of sexual abuse, sample variations, and methodological design issues, results may fluctuate substantially from one study to the next.

Child Sexual Abuse Defined

Currently, there is no universal definition of CSA that is used consistently across professional disciplines (APA, 2001). To complicate matters, other terms have been used to describe CSA including *incest, sexual victimization, sexual exploitation, or child molestation,* (Whetsell-Mitchell, 1995, p.3).

In research studies, the definition of sexual abuse (which subsequently influences the prevalence rates) has been somewhat capricious for several reasons (Finkelhor, 1994). One of the major problems is the lack of a common definition for CSA. The term child sexual abuse varies widely from study to study due to differing research methodologies, demographic locations, sample or population variations, and other dimensions such as age of victim, age differentials between victim and offender, and the delineation of contact versus noncontact sexual acts (Finkelhor, 1994; National Clearinghouse on Child Abuse and Neglect, 1993; Stinson & Hendrick, 1992). Rates of reported CSA cases have also been shown to vary with direct versus indirect inquiry of survivors (Glantz & Hunt, 1996; Stinson & Henrick, 1992). Application of a broader and more comprehensive definition of CSA has been utilized since it allows the researcher to report on a greater variety of behaviors (e.g., noncontact vs. sexual contact), thus providing a more diverse representation of what constitutes sexual abuse (Whetsell-Mitchell, 1995).

According to the National Clearinghouse on Child Abuse and Neglect (NCCANI, 1993) clinical definitions of sexual abuse are related to statutes, but the deciding factor for defining sexual abuse as abusive or nonabusive is whether or not the encounter has a traumatic impact on the child. Three factors are used in differentiating clinically abusive from nonabusive acts: power differential, knowledge differential, and gratification differential. Power differential refers to the perpetrator controlling the child through manipulation, physical intimidation, or force to comply with the sexual activity or a sexual encounter that is not mutually conceived. Knowledge differential implies that the perpetrator may be older, more developmentally advanced, or more intelligent than the victim. Gratification differential refers to the intention of the perpetrator to engage in sexual activity with the child for the primary purpose of obtaining sexual gratification (NCCANI, 1993).

For purposes of this study, a more distinctive and broader definition of child sexual abuse was used. This study defined child sexual abuse as:

> *The imposition of sexually inappropriate acts (including noncontact sexual abuse) on a child or adolescent (up to age 18) for the sexual gratification of another person who is in a position of power or control over the child, including acts perpetrated by peers.*

This definition is a compilation of several authors' description of child sexual abuse (APA, 2001; Blume, 1990; NCCANI, 1993; Whetsell-Mitchell, 1995). This

definition of CSA refers to both contact and non-contact sexual abuse. *Contact sexual abuse* includes such acts as fondling of genitalia, masturbation, oral-genital contact, digital penetration, and vaginal or anal intercourse. Non-contact sexual abuse includes acts such as sexual comments, exposing intimate parts, voyeurism, showing child pornographic materials, or inducing child to undress and/or masturbate self.

In this study, child sexual abuse can also allude to the term *incest*. Incest involves sexually abusive acts or sexual overtones perpetrated by blood relatives (intrafamilial), relatives by marriage (extrafamilial), or quasi-relatives, which are persons in parental or caretaker roles who have an ongoing emotional bond with the child (Glantz & Hunt, 1996; Witchel, 1991).

Clinical Diagnosis of Sexual Abuse

The clinical diagnosis of sexual abuse can often be complicated by co-morbid disorders, such as major depression, social phobia, generalized anxiety and panic disorders, obsessive-compulsive disorders, substance abuse, or more severe problems such as psychosis, suicidal tendencies, or personality disorders (Cloitre, 1997). Clients may not be accurately assessed with Posttraumatic Stress Disorder (PTSD) as a primary diagnosis without adequate assessment for a history of child sexual abuse.

The clinical diagnosis of the sequela of sexual abuse most closely fits the American Psychological Association's (2000) *Diagnostic and Statistical Manual of Mental Disorders-IV-TR* criteria for Posttraumatic Stress Disorder (PTSD). PTSD is

defined as a mental disorder (code 309.81) with characteristic symptoms that develop following exposure to an extremely traumatic stressor and symptoms that have lasted for more than one month. The stressor may occur through direct personal experience or witnessing of an event that involves actual or threatened death or serious injury to oneself or another person; or learning about an unexpected or violent death. This diagnosis also takes into account any sexually traumatic events or experiences that may be developmentally inappropriate *without threatened or actual violence or injury*.

The criteria for PTSD stipulate that the person may feel intense fear, helplessness, horror, and reexperiencing of the event through intrusive recollections, dreams, or flashbacks. The person may also experience intense psychological distress and/or physiological reactivity at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event or experience persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness. The individual may also experience persistent symptoms of increased arousal.

The *Diagnostic and Statistical Manual of Mental Disorders-IV-TR* (APA, 1994) does not diagnose sexual abuse as a major disorder, but mainly as an additional code or V-code. The *DSM-IV-TR* distinguishes between sexual abuse of an adult or sexual abuse of a child by either perpetrator or as a victim. When the sexual abuse is of an adult (i.e., by partner), then the diagnostic code is V61.12. If the sexual abuse is of an adult by someone other than a partner, then the diagnosis is V62.83. However, if the sexual abuse

is of an adult and the focus is on the victim, code 995.81 is used. Sexual abuse of a child is identified by V61.21. If the focus of attention is on the child victim, then code 995.53 is applicable (APA, 2000).

CSA Prevalence

It is estimated that by the age of 18, one in three women and one in five men will have experienced some form of child sexual abuse (Whetsell & Mitchell, 1995). In 1990, Finkelhor, Hotaling, Lewis, and Smith conducted a national survey and estimated that 27% of women and 16% of men experienced some form of sexual abuse as a child. In general, most professionals estimate that between 25% to 33% of women and 3% to 24% of men have experienced some form of child sexual abuse (NCCANI, 1993). It has been suggested that approximately one out of three girls and one out of seven boys have experienced sexual abuse before age 18 (Bolen & Scannapieco, 1999).

Stinson & Hendrick (1992) and Finkelhor (1994) distinguished between *incidence* and *prevalence* rates of CSA. *Incidence* refers to the number of new cases of reported CSA cases each year; *prevalence* refers to the percentage of persons who experience sexual abuse anytime during their childhood. For purposes of this study, *prevalence* will be used rather than incidence.

Prevalence rates vary depending on several factors. The results may differ depending on the population studied or the definition of child sexual abuse employed by the researcher as well as the researcher's methodology (Finkelhor, 1994; Stinson &

Hendrick, 1992). Another factor in the prevalence rate also stems from whether the researcher directly or indirectly inquires of participants' sexual abuse history. Stinson and Hendrick (1992) found that clients were significantly more likely to disclose their CSA experience if queried directly (asked directly if they had experienced any sexual abuse). In addition, disclosure of child sexual abuse was elicited more often after establishment of rapport during the intake as well as if a greater number of screening questions were asked (Williams, Siegal, & Pomeray, in press, as cited in Bolen & Scannapieco, 1999)

Among the general population, the majority of large sample studies have consistently shown gender differentials for the prevalence of child sexual abuse (Finkelhor, 1994; Walker, Carey, Mohr, Stein, & Seedat, 2004). Walker et al. (2004) concluded that most studies support child sexual abuse prevalence rates of females to be between 5.8% to 34%, and 2% to 11% for males. Similar prevalence rates have also been reported in the Australian population (Najman, Dunne, Purdie, Boyle, & Coxeter, 2005). In general, most studies have revealed that more than one-third of women (33%) and approximately one-sixth of men (17%) have reported a history of CSA. A meta-analytic study found that the rate of PTSD was higher in girls and women with CSA histories than in males, reflecting gender as a risk factor for the development of pediatric PTSD following CSA (Walker et al., 2004).

Among the college population, studies on the prevalence of CSA among female college students ranged from 15% to 62% (Frazier & Cohen, 1992). Stinson & Hendrick

(1992) estimated that approximately one-third of college students presenting for counseling in university counseling centers had experienced child sexual abuse. Witchel (1991) found a similar result among her sample of 1577 college students, with 34% experiencing sexual abuse before the age of sixteen. A review of a sample of females participating in treatment in a counseling center at a Midwestern University revealed the frequency of reported sexual victimization experiences among this setting to be 40% (Frazier & Cohen, 1992).

Several studies have revealed the high prevalence of CSA among mental health professionals as well. Follette, Polusny, and Milbeck (1994) surveyed 558 mental health and law enforcement professionals and found the rate of CSA among therapists to be 29.8% and 19.6% for officers. Gender differentials have also been revealed among mental health professionals, with higher rates of CSA reported among females (Pope & Feldman-Summers, 1992). Pope and Feldman-Summers' (1992) survey of 500 male and female psychologists revealed that 69.93% of females and 23.85% of males had experienced some form of physical or sexual abuse. Finkelhor's et al. (1990) sample of mental health practitioners revealed that approximately 27% of women and 16% of men reported a history of child sexual abuse.

Gallop, McKeever, Toner, Lancee, and Lueck, (1995) compared the psychological wellbeing of nurses who were sexually abused with non-abused nurses. They found that nurses with a history of sexual abuse had significantly higher distress

scores and lower self-esteem than their peers with no such history of abuse. Ten percent of nurses with a CSA history reported that their experiences had a moderate impact on their decision to become a nurse. However, about half of the nurses had made comments suggesting that the abuse had an impact on some aspect of their practice.

Sequelae of Child Sexual Abuse

Child sexual abuse (CSA) has been described as a serious problem that has immediate and long-term deleterious consequences for children and adults (Briere & Elliot, 1994). Numerous studies have revealed the association between child sexual abuse and greater psychological distress for both males and females (Neumann, Houskamp, Pollack, & Briere, 1996; Polusny & Follette, 1995). Retrospective studies of adults have revealed the increased prevalence of psychological, behavioral, and interpersonal problems among survivors of sexual abuse compared to those with no such history of sexual trauma (Neumann, et al. 1996). Child sexual abuse has been correlated with long-term interference with interpersonal relationships, psychological, and social functioning (Grice, Brady, Dustan, Malcolm, & Kilpatrick, 1995; Neumann et al., 1996; Polusny & Follette, 1995; Ratican, 1992).

Briere and Elliot (1994) divided the potential psychological and interpersonal sequelae of various symptomology associated with child sexual abuse into six categories: *posttraumatic stress, cognitive distortions, emotional distress, avoidance, impaired sense of self,* and *interpersonal difficulties.* Briere and Elliot (1994) described posttraumatic

stress as psychological symptoms resulting from a highly distressing disruptive event. Cognitive distortions refer to the chronic self-perceptions of helplessness and hopelessness, impaired trust, self-blame, and low self-esteem. Emotional distress refers to aspects of anxiety disorders, anger, and depression. Avoidance occurs as an attempt to cope with the trauma of sexual abuse (e.g., dissociation, substance abuse and addiction, suicidality, and tension-relieving activities such as indiscriminate sexual behavior, eating disorders, or self-injurious behavior). Impaired sense of self refers to the difficulties of individuals with a history of CSA to be able to separate self from others, often leading to problems and difficulties related to suggestibility, gullibility, inadequate self-protectiveness and a greater likelihood of revictimization. Interpersonal difficulties can result from a history of CSA affecting sense of trust, intimacy, and sexual relationships and/or behaviors that may result in isolation, discomfort or interpersonal sensitivity.

Neumann et al., (1996) conducted a meta-analytic review of the long-term sequelae of child sexual abuse and divided the negative consequences into five domains: affective (i.e., anger, anxiety, and depression), behavior (i.e., revictimization, self-mutilation, sexual problems, substance abuse, suicidality, interpersonal problems, and self-concept impairment), and identity/relational (other psychiatric sequelae, and general symptomology. The authors concluded that “across methodologies, sample variation, or measurement error, CSA was a general risk for development of later psychological disturbances”, especially for adult women (p.11).

In addition to the symptomology listed, other studies have found that somatization complaints were more common among individuals with a history of CSA (Briere & Elliot, 1994; Polusny & Follette, 1995). Polusny and Follette found support for the association between personality disorders, such as Borderline Personality Disorders (BPD), with a history of childhood trauma, including both sexual abuse and physical abuse. Research has suggested a strong relationship between sexual victimization or child sexual abuse with diagnosis of multiple psychiatric disorders, including posttraumatic stress disorder, substance abuse, and self-harm (Neumann et al., 1996).

Review of the existing literature on child sexual abuse has revealed the varying prevalence rates of child sexual abuse among both males and females. As a result of experiencing CSA, evidence exists to support the long-term negative impact and traumatization of individuals with such a history. The prevalence of child sexual abuse and the resulting negative consequences on the CSA survivor has significant implications for mental health counselors.

It is inevitable that counselors will at some point in their careers encounter a client who has been traumatized by childhood sexual abuse. However, many counseling professionals continue to report inadequate preparation in their training programs, and many have limited knowledge on how to inquire or respond to clients who have been sexually abused (Dillihunt, 1997; Winkelspecht & Singg, 1998).

Affective Responses of Counselors to Child Sexual Abuse

Alpert & Paulson (1990) have described child sexual abuse training and education as "unique with respect to the great amount of initial resistance and anxiety" that the topic generated from students, educators, and supervisors (Alpert & Paulson 1990, p. 370). They also suggested that the topic of CSA also elicited "strong emotional responses" that needed to be addressed (Alpert & Paulson 1990, p. 370). Resistance and anxiety to teaching on the topic of CSA may be a contributing factor to the inadequate training of counselors.

The counselor's intense emotional reactions that occurs as a result of prolonged exposure to the trauma experienced by clients have been described in many ways: counter-transference, compassion fatigue, empathic strain, secondary traumatic stress/secondary trauma, or vicarious traumatization (Figley, 1995; Pearlman & Saakvitne, 1995). McCann and Pearlman (1990) described the concept of vicarious traumatization in broader terms than countertransference, indicating the impact of hearing traumatic material as altering the therapist's cognitive schemas or cognitions [i.e., a person's knowledge, opinions, or beliefs about oneself, expectations, and assumptions about the world] (Brown, 1999). However, for purposes of the current study, the term countertransference and vicarious traumatization will be used interchangeably.

Issues of countertransference often result in individuals experiencing changes in cognitive schemas or cognitive dissonance (Ferrara, 1998, 1999; Iliffe & Steed 2000;

McCann & Pearlman, 1990). Cognitive dissonance has been used to describe the physiological and psychological states that individuals experience when two cognitions are inconsistent with each other and do not meet the expectations or existing schema of the person (Festinger, 1957, 1964).

The topic of CSA is most likely new information or knowledge that few mental health counselors have been exposed to, which may not fit into their existing schemas. When individuals are faced with no existing schema from which to draw, such as an emotionally laden issue as child sexual abuse, individuals may engage in rationalization, denial, minimization, or withdrawal in order to achieve cognitive harmony (Ferrara, 1998, 1999). Counselors may be overwhelmed by their affective responses and the cognitive demands of such a complex and sensitive topic as child sexual abuse. Thus, counselors with little experience in addressing CSA may avoid discussing sexual abuse issues with their clients, which can be detrimental to the client who presents with such an issue.

Several authors have noted some common emotional reactions and disruptions in cognitive schemas as a result of working with CSA trauma victims (Cheung & Boutte-Queen, 2000; Knight, 1997). Faller (1993) described the most prevalent reaction to CSA as disbelief or belief accompanied by an intense desire for retribution. The reaction of disbelief has been experienced by professionals and lay persons alike in grasping the enormity of the existence of CSA. Others may acknowledge the existence of CSA but

may tend to minimize its traumatic impact. Other emotional reactions to CSA include the following: a) feelings of helplessness/vulnerability; b) anger or revenge, sometimes directed toward the perpetrator and other times at the victim; c) distrust or cynicism; d) loss of safety;

e) diminished personal autonomy; f) diminished esteem; g) interruptions in intimacy; h) rescue fantasies; i) sexual arousal; j) sadness; and k) feeling overwhelmed (Faller, 1993).

The sexual abuse history of the counselor is another salient factor that may affect the health the counselor as well as interfere with effectively treating sexually abused clients (Pope & Feldman-Summers, 1992). Counselors with a history of CSA can contribute a great deal to the field. However, those who have unresolved CSA may be much more susceptible to countertransference issues (Emerson, 1988). Faller (1993) has suggested the following warning signs of countertransference for the counselor working with sexual abuse victims: a) overwhelming feelings of fear, anxiety, disgust, or anger about victimization that it interferes with sound decision making or intervention, evoking a strong desire for retribution; b) experiencing intrusive thoughts or having flashbacks at work; c) recalling previously repressed memories of victimization during involvement in CSA cases; and d) displaying overly punitive responses to the nonoffending parent or offender.

Faller (1993) and Morrissette (2004) have claimed that emotional reactions to child sexual abuse are to be expected, are normal, and are not necessarily an indication of

personal pathology, deficiency, or incompetence. Faller asserted that even with education and training, the topic of child sexual abuse probably arouses more personal reactions than many other issues. Morrissette (2004) asserted that it was "the responsibility of faculty to anticipate student reactions and ensure that safeguards are in place to prepare and support students…" (p. 534).

Effect of Counselor Responses on CSA Clients

Research supports that counselors can be affected by working with survivors of CSA. It is reasonable to assume that the counselor's responses to the CSA client can also have a tremendous amount of influence on the wellbeing of the client (Denov, 2003; Knight, 1997). The counselor can have a negative impact on the client through unconsciously expressing negative affect, attitude, cynicism or skepticism toward the CSA survivor (Jones, 2002). In addition, counselors who do not inquire of a sexual abuse history may also harm the client through avoidance of the presenting issue (Glantz & Hunt, 1996). Discounting or disbelieving client disclosures also perpetuates feelings of shame and guilt in the client (Denov, 2003). Lastly, counselors who do not set firm boundaries with CSA survivors with borderline tendencies can experience burnout or result in inappropriate relationships with clients (Daniluk & Haverkamp, 1993).

There are also potential risks to counselor education programs and supervisors who may be held liable if a trainee vicariously harms a client due to a lack of education and training in the area of CSA (Daniluk & Haverkamp, 1993; Kitzrow, 2002). Thus, it is

imperative that counselors be taught to be aware of countertransference issues and how to provide empathetic and sensitive treatment to survivors of childhood sexual abuse.

Surprising, with the prevalence of mental health professionals with a history of child sexual abuse, only a scant number of studies have examined the effect of working with CSA survivors on the mental health professional and even fewer have focused on their emotional responses (Grossman, Jordano, & Shearer, 1990).

Cheung and Boutte-Queen (2000) have suggested the benefits of identifying the emotional responses to child sexual abuse as an aide in determining whether the counselor has unresolved negative emotional feelings. Identification of such emotional reactions would also provide an opportunity for further specialized training prior to actually working with CSA survivors. The benefits of identifying affective responses to CSA would assist mental health counselors in becoming more aware of their reactions, thus providing them an opportunity to normalize and deal with such strong emotions.

Measuring Affective Responses to CSA

The researcher found three previous studies that addressed the impact of providing services to CSA survivors. Cheung & Boutte-Queen (2000) conducted their study compared social workers and police in Hong Kong. Follette, Polusny, & Milbeck (1994) investigated psychologists and marriage and family therapists and law enforcement professionals from a western state. Knight (1997) conducted her study in Maryland. These two studies included various mental health professionals, such as social

workers, and other professionals such as law enforcement, but little research has addressed counselors specifically.

Cheung & Boutte-Queen (2000) had conducted training in Hong Kong on specific emotional responses of 114 police and social workers' recall of their first child sexual abuse incident. An emotional response to child sexual abuse instrument was used to examine these professionals' emotional responses to CSA. Cheung & Boutte-Queen created an instrument they referred to as the Emotional Responses to Child Sexual Abuse Instrument. This instrument contained 10 categories of emotional responses to 37 statements requesting respondents to indicate on a 1 to 5 Likert-type scale, the lowest level of emotion, to the highest level of emotion associated with the stated emotional response. These 10 categories were labeled as anger, embarrassment, hopelessness, revenge, fear, ambivalence, empathy, guilt, titillation, and vulnerability. Their study revealed that "anger toward the perpetrator" was the most frequent emotional response (*M*= 4.57), with "empathy with the child's plight" following close behind (*M*=4.05). The lowest mean scores were reflected for "embarrassment with other professional" (M = 1.56) and "titillation in response to respondents' own excitement form hearing explicit descriptions of sex acts" (M= 1.82).

Cheung & Boutte-Queen's (2000) study revealed that the two professions included in their study responded similarly in their emotional responses to a first CSA case. Police officers were more likely to have ambivalent and revengeful feelings;

whereas social workers were more likely to have feelings of discomfort (i.e., embarrassment with a perpetrator, fear of being inadequate in handling the situation, titillation in response to involuntary physiological responses to word and description of sex acts, and empathy with the child's plight/condition). Cheung and Boutte-Queen attribute this finding as a being related to "the lack of experiences of social workers in the area of child sexual abuse, the empathetic character of social workers, and the client-centered approach endorsed by this helping profession" (p. 1619).

Both groups responded to low levels of emotions in three categories: "embarrassment about investigating, discussing and reporting intimate sexual behavior in explicit details with other professionals," "titillation in response to own excitement," and "vulnerability to possible rekindling of own victimization" (p. 1617). Cheung and Boutte-Queen (2000) suggested that the initial emotional responses to the topic of CSA "serve as reference points for addressing the importance or self-awareness among helping professionals" (p. 1619).

Some limitations to Cheung and Boutte-Queen's (2000) study were that random sampling was not used. Responses were obtained during ten different workshops on CSA, and a comparison of initial and current emotional responses to CSA was not conducted (i.e., to measure change of feelings over time). The authors suggest that future research should compare emotional responses between and within groups in order to determine if higher responses for certain variables are elicited from respondents with

more recent initial encounters with CSA. They also suggest investigating the impact of the first CSA initial encounter, both personal and professional. Another interesting topic they suggest for examination is whether respondents with a history of CSA have sought counseling and whether their personal experience of CSA influenced their choice of profession.

Follette, Polusny, and Milbeck (1994) conducted a survey of 558 mental health and law enforcement professionals in a western state assessing exposure to and the sequelae of traumatic client material. The authors used the Therapist Response Questionnaire (TRG) to assess the following: a) respondent' professional background and caseload, b) clinical activities related to sexual abuse cases, c) perceived effects of clinical work with SA survivors on psychological functioning, d) use of coping strategies to deal with such effects, and e) personal trauma history. Similar information was elicited from law enforcement personnel using the Law Enforcement Response Questionnaire (LERQ). Finally, the Trauma Symptoms Checklist (TSC-40) was used to assess the extent and nature of traumatic specific symptoms.

Results of Follette, Polusny, and Milbeck's (1994) study revealed that 29.8% of mental health professionals and 19.6% of law enforcement officers reported experiencing some form of physical or sexual abuse as children. They further found that respondents who reported a history of physical or sexual abuse during childhood had significantly higher levels of trauma-specific symptoms than those who reported no such childhood

trauma. Overall, they found that mental health professionals reported relatively low levels of general psychological distress, trauma symptoms, and PTSD symptoms although they did report moderate levels of personal stress. The authors note that one explanation for this finding was that the majority of mental health professional reported participating in some form of personal therapy. Thus, the authors assert that a history of childhood trauma was not associated with differences in mental health professionals' clinical activities (i.e., specialize in treatment of sexual abuse survivors, level of negative clinical response, such as dissociating during therapy) than therapists without a childhood trauma. Therefore, competency of therapists with a history of CSA was not a negative factor

Carolyn Knight (1997) conducted her study after observing that despite the demanding nature of working with CSA survivors, scant attention had been paid to the needs and affective reactions of therapists working with this population. Knight (1997) developed a 21-item questionnaire to examine the clinician's affective reactions to working with CSA survivors and to identify which factors influenced these reactions.

The sample consisted of 177 mental health professionals in the state of Maryland who specialized in working with adult CSA survivors. Individuals employed by public mental health outpatient clinics in Maryland were also included. The sample makeup included those clinicians who identified themselves as mainly MSW (41.4%), PhD's (21.8%) and MD's (15.2%). Interestingly, 29.9% of respondents reported they themselves were survivors of child sexual abuse.

Knight's (1997) original questionnaire contained nine statements in which respondents were asked to indicate the extent to which they agreed or disagreed, and 12 statements asking respondents to indicate the extent to which they experienced the reactions. Through the use of her questionnaire, Knight included the following personal reactions: overwhelmed, impact on emotional intimacy, impact on sexual intimacy, mistrust, embarrassment, intensify problems, negative impact on personal life, vulnerability, anger, sadness, preoccupation with thoughts of client, sexual arousal, tuning out, anger at survivor, blame survivor, blame survivor for adult problems, rescue survivor, and disbelief (p. 24-25).

The results of Knight's study indicated the two most common reactions respondents were most likely to agree were feelings of being overwhelmed and vulnerability in personal relationships. Four responses were identified as least likely to be reported by respondents: a) associated with the negative impact on the their ability to be emotionally and sexually intimate; b) intensified problems they already had; c) there was nothing they could do to alleviate the client's distress; d) it was embarrassing to talk with their clients about their sexual experiences (p. 23). Three reactions were identified as most commonly reported by respondents a) anger and sadness about their client's experiences; b) horror regarding the client's victimization; and c) rescue fantasies.

Two factors emerged which influenced the respondents' personal reactions: a) respondents with less professional practice experience were more likely to feel

overwhelmed by their work; and b) respondents who discussed their personal reactions with their own therapists were more likely to report feeling that working with survivors intensified problems they already had (p. 23).

Knight's (1997) study found evidence that clinicians also engaged in dissociative coping mechanisms, similar to CSA survivors. Clinicians in her sample reported intense feelings, especially anger, sadness, horror, and rescue fantasies, which were positively associated with preoccupation that may lead to vicarious traumatization of therapists. Clinicians also experienced "problems such as blunting and blocking affect, counter transference phenomena, and over-identification with the survivor", which may have a negative impact on the therapeutic relationship (p. 36). Negative impact was evident in respondents who reported feeling angry with their clients and those that reacted with tuning out in sessions, and avoiding discussing painful topics or disbelieving their clients.

As noted by Knight (1997), a lack of awareness and resolution of these intense emotional reactions may have a negative impact on CSA survivors. One significant finding from both studies seems to be that with more professional practice, "therapists may develop mechanisms which allow them to better manage their reactions to challenging practice situations, such as treatment of adult survivors" (Knight, 1997, p. 37).

Summary of Reviewed Literature

In summary, the literature supports that working with child sexual abuse survivors can be a delicate and complex process. Morrissette (2004) asserted that it is not a question of whether counseling students will be affected by disturbing client narratives but rather to what degree. The mental health counselor's emotional responses to the disclosure of CSA can have a tremendous impact on the client's well-being. However, the counselor who does not address these affective responses to child sexual abuse is susceptible to countertransference and vicarious traumatization issues, which may inevitably have a negative impact upon the client. Counselors need to be educated and informed about the signs of developing vicarious traumatization, such as withdrawal, avoidance, persistent sadness, and reduced energy, when working with CSA clients.

Existing literature highlights the complexity of measuring emotional reactions to child sexual abuse. Previous studies have focused on various professionals such as social workers, psychologists, marriage and family therapists, or law enforcement and their emotional reactions to CSA. These studies have resulted in differing emotional reactions based on the respondents' profession as a mental health professional or as law enforcement personnel.

The current study explored the emotional reactions to child sexual abuse of counselors working in the field of mental health. The main objective of this research was to examine an important, often overlooked, component of working with child sexual

abuse clients- the emotional effect on the counselor, which ultimately affects the client's wellbeing. This line of research will be important in educating and preparing mental health counselors to confront and treat child sexual abuse and be more empathetic and responsive to survivors of CSA.

CHAPTER III

METHODOLOGY

This chapter presents the methodology and procedures used to examine the range of counselors' affective reactions to child sexual abuse. This section describes the following: (a) research design and methodology; (b) participants; (c) instrumentation; (d) procedures; and (e) data analyses.

Research Design

To explore the affective responses among counselors to the topic of child sexual abuse, this study used a causal-comparative (ex-post facto) design within a survey format. Causal-comparative designs attempt to establish the cause-effect relationships among the variables in the study without direct manipulation of the independent variables. This type of study was necessary because participant characteristics were preexisting and could not be manipulated or randomized (i.e., gender, education, training, experience, child sexual abuse history) for their effect on the dependent variable (i.e., Affective Responses to Child Sexual Abuse Scale).

According to Heppner, Kivlighan, and Wampold (1999), the ex post facto design has a number of strengths. Ex post facto designs allow the researcher to investigate an

independent variable on the dependent variable in which manipulation of the independent variable is not possible. This design also allows examination of multiple levels or factors of the independent variable on the dependent variable simultaneously.

There are also some limitations to the ex post facto design. One limitation is the lack of random assignment of participants into groups. Although lack of manipulation of the independent variable is an advantage, it is also a limitation. Lastly, conclusions or causality cannot be established based solely on the data collected due to this design capitalizing on the role of chance (Heppner, Kivlighan, & Wampold, 1999, 1999).

Survey research was used to "document the nature or frequency of a particular variable within a certain population" (Heppner et al., p. 201). The function of survey research is to "describe, explain, or explore a phenomena" (Heppner et al., 1999, p. 202). Survey research can be helpful in describing a phenomenon in which information is lacking. Due to the paucity of research on affective responses of counselors to child sexual abuse, survey research is the most applicable for purposes of this study.

According to Heppner et al., (1999) a survey design has many advantages. Surveys are fairly easy and inexpensive to create and collect data, requiring simple descriptive statistical analyses. A survey also allows detection of changes in participant's affect, cognition, and behavior to be measured before and after a program.

Heppner et al. (1999) noted one limitation of using a survey was the question of return response rates, which raises questions of external validity. Although there is no

established “acceptable” return rate, the majority of researchers commonly recommend at least a 40% to 50% return rate for mailed surveys (Heppner, et al. 1999). According to Huang (2006), mailed surveys and Web surveys provided similar return response rates with similar results on closed format questions.

Measures

Independent Variables

Several independent variables (factors) were investigated for their effect on the Affective Responses to Child Sexual Abuse Scale (ARCSAS). The following variables were investigated: respondent's education, training, and experience addressing child sexual abuse (i.e., highest level of education, types of CSA training, number of CSA clients, training on asking about a CSA history, and training on responding appropriately to CSA clients). In addition, the effect of the respondent's own personal experience with sexual abuse on the ARCSAS were examined.

Dependent Variables

The Affective Responses to Child Sexual Abuse Scale (ARCSAS) was used as the dependent variable. This instrument provides the definition of child sexual abuse and asked each respondent to rate statements on a 4-point Likert-type scale with anchors ranging from strongly disagree to strongly agree.

Instrumentation

Demographic Questionnaire

The Demographic Questionnaire was developed by the researcher to gather information related to gender, age, race/ethnicity, region of the United States in which

participant resided, highest degree awarded, year of highest degree awarded, current graduate student, type of counselor training program completed, how many years participant has worked in the field, current work setting, and type(s) of certifications or licensures. The demographic questionnaire provides respondents with the researcher's selected definition of child sexual abuse as:

> *The imposition of sexually inappropriate acts (including noncontact sexual abuse) on a child or adolescent (up to age 18) for the sexual gratification of another person who is in a position of power or control over the child, including acts perpetrated by peers* (APA, 2001; Blume, 1990; NCCANI, 1993; Whetsell-Mitchell, 1995).

Based on the above definition of CSA, questions were asked to glean the following information: (a) type of sexual abuse training (i.e., graduate course, continuing education, self-study, internship, other, or none); (b) presence of training on how to ask a client about CSA; (c) presence of training on how to appropriately respond to CSA client; and (d) the number of CSA clients counseled. Respondents were asked about their personal experience with sexual abuse through the following questions: (a) Have you experienced any form of CSA as a child; (b) Have you sought professional therapy; and (c) How was your experience with the therapist (See Appendix A).

Affective Responses to Child Sexual Abuse Scale (ARCSAS)

The Affective Responses to Child Sexual Abuse Scale (ARCSAS) was developed by the researcher in 2007 to assess the emotional responses of counselors to child sexual abuse (See Appendix B). The ARCSAS was adapted from Carolyn Knight's (1997) 21-item questionnaire, which assessed a variety of personal reactions of mental health specialists working with CSA survivors and Cheung & Bouttte-Queen's (2000) work in Hong Kong with police and social workers. Knight (1997) noted several limitations to her study. The dependent measures were based on anecdotal evidence that could be subjectively interpreted and other important reactions to CSA could have been excluded. More importantly, no reliability or validity tests were conducted on her instrument. Cheung & Bouttte-Queen (2000) created a questionnaire containing ten categories of emotional responses to child sexual abuse using 37 items measuring how strongly participants felt. One strength of Cheung & Boutte-Queen's study is that they conducted reliability tests for their 37 items (Cronbach alpha=.91). One limitation of their study is that they did not include counselors and the study was conducted in Hong Kong and may not generalize easily to the American population.

The researcher reviewed each of the authors' emotional reactions to sexual abuse and created a questionnaire containing 11 categories of affective reactions to child sexual abuse. The selection of the 11 categories of affective responses on the ARCSAS has been supported as common reactions of mental health professional's working in the field with

child sexual abuse survivors (Cheung & Boutte-Queen, 2000; Jones, 2002; Knight, 1997; McCann & Pearlman, 1990; Pearlman & Saakviten, 1995). These specific 11 categories of affective reactions were chosen to examine the range of emotions counselors may experience when working with clients who disclose a child sexual abuse history, specifically to assess any transference or countertransference effects, which may interfere with the counselor's empathetic responses to the client.

The ARCSAS contains a total of 41 statements in which participants indicate their degree of agreement on a 4-point Likert-type scale with anchors ranging from strongly disagree to strongly agree (see Appendix B). Total scale scores on the ARCSAS range from 41 to 164. Scores are calculated totaling the scales times on the instrument. Five items require reverse scoring (# 25, 36, 39, 46, and 61). Low scores indicate a more positive affective response to child sexual abuse. High scores indicate greater negative affective response to child sexual abuse. The current study is the first use of the instrument, thus no reliability or validity information is available.

The following sections provide a detailed description of each item on the Affective Responses to Child Sexual Abuse Scale (ARCSAS) that corresponds with each of the 11 affective categories: (a) Ambivalence/Avoidance, (b) Anger, (c) Arousal, (d) Blame/Disbelief, (e) Embarrassment, (f) Empathy, (g) Guilt, (h) Hopelessness/Helplessness, (I) Impact, (J) Transference/Trust, and (k) Worry.

The category of *Ambivalence/Avoidance* refers to any feelings of discomfort with the topic of CSA and whether they experience any avoidance as a result of these feelings. The following four items on the ARCSAS evaluate the category of *Ambivalence/Avoidance*:

10 I have had the experience of tuning out or dissociating when the client talks of their CSA experiences.

20 I feel uncomfortable when I hear about CSA.

30 I avoid listening to client's CSA experiences.

35 I feel revulsion when I hear about CSA.

The category of *Anger* reflects any angry feelings toward the perpetrator, the survivor, the parent, the child, or the supervisor. The following six statements assess the category of *Anger*:

12 I feel anger toward the survivor of CSA.

22 I feel angry with the client who did not tell anyone about the CSA.

32 I feel angry with the parent(s) who did not protect their child from CSA

The category of *Arousal* refers to any feelings of sexual arousal that the respondent may experience when hearing about CSA experiences. The following four statements gauge the category of *Arousal*:

6 I feel sexually aroused after hearing about CSA experiences.

16 I am curious about the details of CSA survivor's sexual experiences.

27 I feel excitement from hearing about explicit descriptions of CSA

The category of *Blame/Disbelief* reflects any feelings of blame or responsibility for the abuse on the CSA survivor. The following three statements evaluates the category of *Blame/Disbelief*:

11 I feel that CSA survivors somehow provoked their sexual abuse.

21 I blame the CSA survivor for their dysfunctional adult life.

31 I don't believe CSA survivors are telling the whole truth about their experiences.

41 I feel that CSA survivors exaggerate their experiences.

The category of *Embarrassment* refers to any feelings of awkwardness in discussing CSA issues with peers, officials, supervisor, or clients. Any discomfort in discussing sexual organs or hearing about CSA issues is also assessed. The following seven statements assess the category of *Embarrassment*:

1 I am embarrassed to ask specific questions about the client's CSA experiences.

23 It embarrasses me to have to name and discuss the sexual organs.

36 It embarrasses me to hear about explicit CSA experiences.

39 I am embarrassed to tell anyone that I have experienced CSA.

The category of *Empathy* assesses the level of empathy of the respondent on the topic of CSA and clients. The following four statements evaluate the category of *Empathy*:

4 I have experienced feelings of sadness after hearing about CSA experiences.

15 I feel a connection with my clients who are CSA survivors.

25 I am more empathetic to CSA survivor's than to my other clients.

40 I am able to respond appropriately to the initial disclosure of CSA by a client.

The category of *Guilt* reflects any remorse in having anger toward the CSA survivor, perpetrator, or self (feelings of incompetence). The following four statements evaluate the category of *Guilt*:

5 I feel guilty about feeling anger toward CSA survivors.

26 I feel guilty about not knowing how to handle and respond to CSA clients.

34 I feel guilty about wanting to hear the details of the CSA survivor's experiences.

The category of *Hopelessness/Helplessness* refers to any feelings of burnout or lack of competency associated with addressing CSA. The following six statements measure the category of *Hopelessness/Helplessness*:

2 I feel hopeless about helping CSA clients.

13 I feel hopeless about successfully treating CSA clients.

33 I feel that there is no way to prevent CSA.

38 I feel helpless about my ability to assist a person who has been sexually abused.

The category of *Impact* refers to any negative effects from hearing about CSA experiences. The following five statements measure the category of *Impact*:

7 Hearing about CSA experience will negatively affect my sexual relationships.

17 Listening to CSA experiences has a negative emotional impact on me.

28 Listening to CSA experiences has a negative psychological impact on me.

37 I feel overwhelmed by listening to CSA experiences.

The category of *Transference/Trust* refers to any feelings of counter-transference or vulnerability, and changes in trust level as a result of hearing or working with CSA survivors that may be as a result of the respondent's own personal experience with CSA:

9 Hearing about CSA elicits bad memories for me.

19 I feel vulnerable after hearing CSA experiences.

8 Hearing about CSA experiences makes me less trusting in personal relationships.

18 I trust myself to work with CSA survivors

29 I trust others less after hearing about CSA.

The category of *Worry* reflects any trepidation in addressing CSA clients or perpetrators. The following four statements gauge the category of *Worry*:

3 I worry that I do not have enough experience or training to treat CSA clients.

14 I worry that CSA could happen to someone I know.

24 I worry I will not be able to work with CSA clients.

Procedures

Approval was obtained from the Mississippi State University Institutional Review Board for the Protection of Human Subjects in Research (See Appendix C). Participants were recruited from email lists of members of the American Counseling Association (ACA). Currently, there are over 45,000 members registered with ACA. However, only approximately 4000 members who identified as counseling professionals were recruited to participate in this study via an email recruitment letter (see Appendix D).

Participants were directed to a secured online Web Survey at http://www.counselingsurveys.org/do.php?survey=s134708. This website was created and managed by Tim Baker, and is a web-based research and learning tool for the community of professional counselors, including practitioners, professors and graduate students in the fields of counseling and school counseling, psychology, and social work. This website is secure, adheres to the ACA code of ethics, and protects the participant's identity. It does not track, collect, or provide the email address or IP address of the participants.

Within the survey, participants were provided with the informed consent form describing the details of the study (see Appendix E). Once participants acknowledged

their willingness to participate in the study, they were presented with the online Web survey that requests demographic information and items on the Affective Responses to Child Sexual Abuse Scale (ARCSAS).

After completion of the survey, participants were provided with a debriefing statement, which included the researchers' contact information and referral sources if needed (See Appendix F). Approximately two weeks after the initial recruitment email was sent out, a follow-up recruitment email was sent to elicit a greater number of responses (See Appendix G).

Data Analysis

All data was analyzed using the Statistical Package for the Social Sciences (SPSS 15.0, 2007). Descriptive statistics (i.e., means, frequencies, and standard deviations) were conducted on the data for all participants. According to Howell's (1992) recommendations, the sample was examined for any violations of assumptions (i.e., homogeneity, independence of observation, and normal distribution). The study was used to identity the range of affective responses among counselors and to explore which demographic variables may influence these responses.

This survey sampled counselors who were members of the American Counseling Association to assess the following: (a) the range of affective responses that counselors have toward CSA (b) the counselors' type of CSA training received, (c) the proportion of counselors with a sexual abuse history, (d) the counselors' training in asking a client

about CSA, and (e) the counselor's training in responding to child sexual abuse disclosure.

George and Mallery (2003) have suggested the following guidelines in determining statistical significance for reliability: a) Cronbach's alpha level of 0.9 is considered Excellent, b) less than 0.8 is considered Good, (c) less than 0.7 is Acceptable, (d) 0.6 is Questionable, (e) less than 0.5 is Poor, and (f) less than 0.5 is unacceptable (p. 231). A widely accepted social science cut-off for alpha has been suggested to be .70 or higher, suggesting good internal consistency of the items in the scale.

Analysis of variance (ANOVA) was used to examine the main and interaction effects of the various independent variables (factors) on the dependent variable, the Affective Responses to Child Sexual Abuse Scale (ARCSAS). In order to ensure that no assumptions were violated, tests of assumptions were conducted on the sample. The data were examined for independence of observations (i.e., each sample was randomly selected from the population). Data were examined for assumptions of normality (i.e., distributions in each of the groups followed the normal curve). The normal Q-Q plot, frequency histogram, and Shapiro-Wilk test were used to confirm normality. Levene's test for homogeneity of variances was used to confirm homoscedasticity (the standard deviations or variances of the populations for all groups were equal).

Alpha was set at .05 to interpret statistical significance. Setting the alpha at the customary .05 refers to a 5% probability that the test would lead to a Type I error (i.e.,

rejecting the null hypothesis when in fact the treatment has no effect) (Gravetter & Wallnau, 2004). To verify the construct of affective responses, an exploratory factor analysis, using the maximum likelihood factor extraction method with direct oblimin (oblique) rotation was conducted in order to analyze the interrelationships among the 11 categories of affective responses. Researchers have suggested that if data are relatively normally distributed, the maximum likelihood factor extraction method is the best choice (Fabrigar, Wegener, MacCallum, & Strahan (1999).

The following research questions were used to identify the range of affective responses of counselors to CSA. An Analysis of variance (ANOVA) was conducted to investigate the first five research questions:

1. There would be a statistically significant difference between the affective responses of participants who report a personal child sexual abuse history and those with no such history.
2. There would be a statistically significant difference in affective responses of participants with the type of child sexual abuse training received.
3. There would be a statistically significant difference in the affective responses of participants who received training in asking a client about CSA.
4. There would be a statistically significant difference in the affective responses of participants with training in appropriately responding to a sexually abused client.

5. There would be a significant a difference in affective responses of participants and the number of CSA clients counseled.

The Pearson product moment correlation coefficient analysis was conducted in order to examine the directionality and relationships between the independent and dependent variables. The Pearson product-moment correlation addressed the following five research questions:

6. There would be an inverse relationship between affective response scores and participants with a child sexual abuse history (lower ARCSAS scores indicate more positive responses).
7. There would be an inverse relationship between affective response scores and participants with the type of child sexual abuse training received.
8. There would be an inverse relationship between affective response scores and participants who report training in asking a client about CSA.
9. There would be an inverse relationship between affective response scores and participants with training in appropriately responding to a sexually abused client.
10. There would be an inverse relationship between affective response scores and the number of CSA clients counseled (experience with CSA clients).

Hair, Anderson, Tatham, and Black (1996) recommended conducting a power analysis to facilitate the researcher's decision to correctly reject the null hypothesis and minimize the risk of making a Type II error (i.e., accepting the H_0 when it is false). A

power analysis was conducted to determine the required sample size for the usually recommended power of .80. An increased sample size will give the statistical test greater power (Hair et al., 1996). According to Machin (1997), with a population size of 50,000, a $\pm$ 5% margin of sampling error would require a sample size range between 245 and 381, which would be sufficient for a 95% confidence level. A sample size of 264 is required given an expected small effect size (d = .20), and an alpha set at .05 for a Pearson r. The sample size in the current study was 299.In addition to the traditional reporting of null-hypothesis significance tests, the effect size information was also included and interpreted in the results section as recommended by the American Psychological Association (2001).

CHAPTER IV

RESULTS AND DISCUSSION

This chapter presents the results of the data analysis. The purpose of this study was to examine the range of affective responses among counselors and to explore whether demographic variables may influence these responses. The Affective Responses to Child Sexual Abuse Scale (ARCSAS) constituted the dependent variable. The independent variables (factors) investigated included: (a) the participant's education, (b) training, and (c) experience addressing child sexual abuse, and (d) participant's own personal experience with sexual abuse. An alpha level of .05 was used for all tests of significance.

Descriptive Statistics

The study included 299 participants who ranged in age from 24 to 79 years (M = 46.11, SD = 12.42). The participants were 71% women (n = 213) and 29% men (n = 86), which was consistent with Wilk et al's. (2002) counseling sample. The racial/ethnic background of the participants is illustrated in Table 1. Of the 299 participants, 241, the majority, were Caucasian (81%), with 25 African-American (8%). An additional 13 participants (4%) reported being Hispanic. These estimates are consistent with other counseling samples (Wilk et al, 2002).

Table 1

Race/Ethnicity of Participants (N =298)

Variable	Frequency	Percentages
Caucasian	241	81
African-American	25	8
Hispanic	13	4
Native-American	7	2
Asian	6	2
Biracial	2	.7
Multiracial	2	.7
Other	2	.7
Missing	1	.3
Total	298	99

Note: Participants who indicated two races/ethnicities were collapsed into the category *biracial*. If more than two races or ethnicities were indicated, then participants were collapsed into the category *multiracial*. The category other included *Haitian* or indicated ethnicity rather than race.

The majority of participants, 98, indicated that they were from the Southern region (33%). The regional location of participants is reported in Table 2. Fifty-four participants were from the Western region (18%), and 49 participants from the Northern and Eastern regions of the United States (35%). Thirty-two participants (11%) reported that they resided in the Midwest.

Table 2

Regional Location Resided (N = 299)

Variable	Frequency	Percentages
South	98	33
West	54	18
North	49	16
East	49	16
Midwest	32	11
Northeast	7	2
Southeast	7	2
Central	2	.7
Australia	1	.3
Total	299	99

The educational background of participants included 140 (47%) who had earned a masters degree; whereas 126 (42%) reported having a doctoral degree. Table 3 presents the participants' highest level of education.

The participants' year of attainment of highest degree ranged from 1968 to 2007. The average year that participants graduated with their highest degree was 1998 (*M* = 1998, *SD* = 9). Thirty-five (12%) participants reported graduating in 2005 (*Mode* = 2005, *SD* = 9). Thirty-two (11%) participants earned their degree in 2006, and 31 participants (10%) earned their highest degree in 2004. Fifty-eight percent of participants graduated after 2000 and 40% graduated before 2000. Ninety-two (31%) participants reported that they were currently graduate students.

Table 3

Highest Level of Education (N =293)

Variable	Frequency	Percentages
Masters	140	47
Doctoral	126	42
Specialist	21	7
Bachelors	6	2
Missing	6	2
Total	293	98

In this study, 198 (66%) of the participants reported completing a counselor education program. Mental Health Counseling and Community Counseling categories were collapsed under Counselor Education. Twenty-three (8%) participants completed a school counseling program. Only 22 (7%) of participants had completed a counseling psychology program (see Table 4). The category *Other* collapses several different disciplines, including the following: developmental psychology, various certifications, expressive arts therapy, general studies, human services, pastoral counseling, physiological psychology, transpersonal psychology, and Registered Nurse.

Table 4

Counselor Training Program Completed (N = 296)

Variable	Frequency	Percentages
Counselor Education	198	66
School Counseling	23	8
Clinical/Counseling Psychology	22	7
Rehabilitation Counseling	13	4
Marriage & Family Therapy	10	3
Educational Psychology	6	2
Student Affairs	4	1
School Psychology	3	1
Social Work	3	1
Special Education	1	0
Other	13	4
Missing	3	1
Total	296	97

The average number of years that participants reported working in the counseling field was 12.63 (*SD* = 10.68). Of the 299 participants, 153 (51%) reported having less than 10 years of experience; whereas, 98 (32%) reported having between 11 to 30 years of counseling experience. Another 32 (11%) participants reported they had over 31 years of experience (see Table 5).

Table 5

Number of Years Working in the Counseling Field (N = 291)

Years	Frequency	Percentages
Less than 1 year	8	3
1-5	93	31
6-10	60	20
11-20	70	23
21-30	28	9
31+	32	11
Missing	8	3
Total	291	97

The majority of participants (127) reported working in a university setting (42%), followed by 67 participants who worked in a community setting (22%). Forty-five (15%) participants reported having a private practice (see Table 6).

Table 6

Current Work Setting (N = 290)

Variable	Frequency	Percentages
University	127	42
Community	67	22
Private Practice	45	15
School	25	8
Hospital	11	4
Other	15	5
Missing	9	3
Total	290	96

Note: The category other includes the following: Retired, Corporate, Government, HMO, or Military

Examination of the data revealed that 117 (39%) participants reported that they were licensed professional counselors, 125 (42%) reported being a National Certified Counselor, 16 (5%) indicated being an Approved Clinical Supervisor, and 9 (3%) indicated they were licensed as a National Clinical Mental Health Counselor. Another 71 (24%) participants reported holding a licensure as some other form of mental health professional (see Table 7). Several participants identified as holding dual or multiple licenses and/or certifications (i.e., NCC and LPC and ACS). Thus, the total reflects percentages greater than 100%.

Table 7

Licenses and Certifications Held by Participants (N = 321)

Variable	Frequency	Percentages
NCC	125	42
LPC	117	39
ACS	16	5
NCMHC	9	3
Licensed Psychologist	18	6
LMHC	16	5
LMFT	10	3
School Counselor	8	3
LCSW	2	1
Total	321	107

Note: Other licensed professionals include variations in state licensure titles for counselors (n = 17, 6%).

The data revealed that 251 (84%) participants received some form of training in child sexual abuse, whether it was a graduate course, continuing education, self-study, internship, or a combination of the four categories. No training in child sexual abuse was reported by 42 (14%) participants. Table 8 provides the mean ARCSAS scores and standard deviations with the reported types of CSA Training. Lower scores indicate more positive affective responses to CSA.

Additional information about *other* forms of CSA training were gathered from open-ended responses from 6 participants (2%). *Other* forms of training included the following: (a) on the job training, (b) in psychiatric unit, (c) domestic violence advocate, (d) sex therapy, (e) personal therapy for daughter who experienced CSA, (f) research, (g) 12 step group for incest survivors, (h) class,
(i) children's advocacy center, (j) externship, (k) play therapy, (l) teaching graduate course, (m) conferences, (n) work with offenders, (o) child protective services, or (p) work with survivors in counseling. Results for tests of assumption (i.e., normality of sample distribution and homogeneity) were satisfactory.

Table 8

Mean Scores and Standard Deviations on ARCSAS and Amount of CSA Training (N = 292)

Variable	Frequency	Percentages	M	SD
No Training	42	14	78.65	11.47
One Training	92	31	77.53	11.43
Two Trainings	72	24	75.51	10.83
Three Trainings	67	22	74.52	10.10
Four Trainings	19	6	71.63	11.51
Missing	7			
Total	292	97		

Note: Lower means scores indicate greater sensitivity to CSA

Participants were asked whether they had received training on *asking about CSA*, and training on *how to appropriately respond to CSA*. The data revealed that 213 (72%) participants received training on asking clients about experiencing child sexual abuse, with the remaining 83 (28%) who received no training on asking clients about CSA. The majority of participants, 218 (74%) reported that they had received training on how to appropriately respond to a client who disclosed child sexual abuse; whereas, 76 participants (26%) reported receiving no training on how to appropriately respond to disclosure of CSA.

Table 9 presents the participant's experience working with CSA clients. The majority of participants, 280 (94%) indicated that they have counseled at least 1 to 5 clients who have disclosed child sexual abuse. Sixteen (5%) participants reported that they have counseled no sexually abused clients.

Table 9

Experience Working with CSA Clients (N = 298)

Number of Clients	Frequency	Percentages
None	16	5
1-5	102	34
6-10	29	10
10+	151	51
Missing	1	
Total	298	100

Participants were asked to respond to questions about their own personal experience with child sexual abuse. Approximately 1/3 of the participants, 86 (29%), reported experiencing childhood sexual abuse. Mean scores on the ARCSAS for men (M = 75.91, SD = 10.93) and women (M = 76.10, SD = 11.08) revealed no statistically significant difference.

Rates of CSA by race were significantly different x^2 (6) = 21.11, p<. 01. Rates of CSA among Caucasians were 25%; whereas, 40% of African-Americans reported experiencing CSA. Rates of CSA among Hispanic participants were 62%; whereas 50% of Asian Americans and 57% of Native-Americans reported a history of CSA.

Rates of CSA history by highest degree were significantly different x^2 (2) = 14.08, p <. 01. Six (29%) participants with a specialist degree reported a history of CSA. Rates of CSA among participants with a doctoral degree were 18%; and 37% for participants with a master's degree.

Of the 86 participants who reported experiencing childhood sexual abuse, 64 (74%) participants reported seeking therapy. Examination of the data indicated that 22 (26%) participants who reported a history of childhood sexual abuse did not seek any form of therapy. Table 10 provides the number of participants' experiences with therapy to address their child sexual abuse experiences. Fifty-two participants (60%) who had experienced CSA reported therapy as a positive experience. Four participants (5%) reported a negative or mixed therapy experience to address their child sexual abuse. Participants' comments of their experiences with therapy are presented in Appendix H.

Table 10

Participants' Experiences with CSA Therapy (N = 57)

CSA Therapy Experience	Frequency	Percentages
Positive	52	60
Negative	1	1
Both	4	5
Missing	29	34
Total	57	100

Mean scores on each item of the Affective Responses to Child Sexual Abuse Scale (ARCSAS) ranged from 1.15 to 3.89. The mean score for all participants was 76.09 (*SD* = 11.05). The lowest score on the ARCSAS was 54 and the highest score was 105. Low affective response scores (65 and below) were scores one standard deviation below the mean. Medium affective scores were scores between 66 and 87. High affective response scores (88 and above) were scores one standard deviation above the mean. Lower scores on the ARCSAS indicate more positive affective responses to CSA and greater sensitivity to CSA. The mean scores and standard deviations for all participants on the ARCSAS are presented in Table 11.

Table 11

Mean Scores on the ARCSAS (N = 299)

Variable	*M*	SD	%	*n*
Low	61.16	3.14	21.4	64
Medium	76.72	6.09	62.5	184
High	92.47	4.20	17.1	51

Note: Lower means scores indicate greater sensitivity to CSA

To test the reliability of the ARCSAS, the internal consistency was measured using Cronbach's alpha coefficient. The alpha coefficient for the whole sample was found to be $r = 0.86$, indicating satisfactory reliability.

ANOVA Results

The first research question stated that there would be a statistically significant difference between the affective responses of participants who reported a personal sexual abuse history and those with no such history. A one-way analysis of variance (ANOVA) revealed no statistically significant difference, F (1, 292) = .152, p = 0.70, in mean scores for child sexual abuse history on levels of the ARCSAS (see Table 12). Participants who reported a CSA history (M = 75.01, SD = 10.54) did not differ significantly from those who reported no such history (M = 76.51, SD = 11.23). The relationship between the affective responses and a history of child sexual abuse was medium with a partial η^2 = .07. Values of .01, .06, and .14 typically represent small, medium and large effect sizes, respectively (Green, Salkind, & Akey, 2000). Participants who reported no history of CSA (M = 76.51, SD = 11.23) scored similarly to those who reported a history of CSA (M = 75.01, SD = 10.54). Results for tests of assumption (i.e., normality of sample distribution and homogeneity of variances) were satisfactory.

Table 12

Analysis of Variance Summary Table for Child Sexual Abuse History and ARCSAS

Source	*SS*	*df*	*MS*	*F*	*p*	η^2
Between Groups	17.79	1	17.79	.152	0.70	.07
Within Groups	33265.65	285	116.72			
Total	35610.42	292				

Although, not initially included as a research question, an analysis of variance (ANOVA) was conducted on CSA history by highest degree. Results of the ANOVA revealed a statistically significant difference for CSA history by highest degree, F (2, 292) = 3.00, p = 0.03 (see Table 13). The relationship between a child sexual history by highest degree on affective responses was large with a partial η^2 = .70. Values of .01, .06, and .14 typically represent small, medium and large effect sizes, respectively (Green, Salkind, & Akey, 2000). There was no statistically significant difference between participants with a bachelor's degree (M = 85, SD = 4.58) or specialist degree (M = 67.67, SD = 10.76). However, according to Tukey's HD *post hoc* tests, participants with a master's degree and a CSA history scored significantly lower (M = 74.85, SD = 10.21) than participants with a doctoral degree (M = 76.73, SD = 10.78), indicating that master-level counselors responded more positively and with greater sensitivity to the topic of CSA. Results for tests of assumption (i.e., normality of sample distribution and homogeneity) were not violated.

Table 13

ANOVA for Child Sexual Abuse History and Highest Degree on ARCSAS

Source	*SS*	*df*	*MS*	*F*	*p*	η^2
Between Groups	1048.83	3	349.61	3.00	.03	.70
Within Groups	33265.65	285	116.72			
Total	35610.42	292				

The second research question stated that there would be a statistically significant difference in affective responses of participants according to type of child sexual abuse training received. A one-way analysis of variance (ANOVA) revealed no statistically significant difference, F (5, 293) = 1.18, p = .11, in mean scores for the type of training and the ARCSAS (see Table 14). The relationship between affective responses and CSA training was small with a partial η^2 = .03. However, upon examination of mean scores, participants who reported receiving *four* different types of CSA training scored the lower on the ARCSAS (M = 71.63, SD = 11.51) than those who reported receiving no CSA training (M = 78.65, SD = 11.47), indicating more positive responses to CSA with increased amounts of training. Results for tests of assumption (i.e., normality of sample distribution and homogeneity) were satisfactory.

Table 14

Analysis of Variance for Type of CSA Training and ARCSAS

Source	*SS*	*df*	*MS*	*F*	*p*	η^2
Between Groups	1079.94	5	215.99	1.8	.11	.03
Within Groups	35245.29	293	120.29			
Total	1766847	299				

The third research question stated that there would be a statistically significant difference in the affective response levels of participants who received *training in asking a client about CSA.* A one-way analysis of variance (ANOVA) revealed a statistically significant difference, F (1, 294) = 6.37, p = 0.01, in mean scores on the ARCSAS for participants who had received training on asking a client about CSA (see Table 15). The relationship between affective responses and training on asking a client about CSA was small with a partial $\eta^2 = .02$. Participants who reported receiving training on asking a client about CSA (M = 75.06, SD = 11.26) scored significantly lower on the ARCSAS than participants who reported no such training (M = 78.61, SD = 9.90). Results for tests of assumption (i.e., normality of sample distribution and homogeneity) were satisfactory.

Table 15

Analysis of Variance for Asking a Client about CSA and ARCSAS

Source	*SS*	*df*	*MS*	*F*	*p*	η^2
Between Groups	756.15	1	756.15	6.372	.01	.02
Within Groups	34912.99	294	118.75			
Total	35669.135	295				

The fourth research question stated that there would be a statistically significant difference in the affective responses of participants with *training in appropriately responding to a sexually abused client*. A one-way analysis of variance (ANOVA) revealed a statistically significant difference, F (1, 292) = .4.50, p = 0.04, in mean scores for training on appropriately responding to a client who disclosed CSA on the ARCSAS (see Table 16). Participants who reported receiving training on how to appropriately respond to a CSA client (M = 75.39, SD = 11.12) scored significantly lower on the ARCSAS than participants who reported no such training (M = 78.49, SD = 10.54). The relationship between affective responses and training on appropriately responding to a client who discloses CSA was small with a partial η^2 = .02. Results for tests of assumption (i.e., normality of sample distribution and homogeneity) were satisfactory.

Table 16

Analysis of Variance for Appropriately Responding to CSA Client and ARCSAS

Source	*SS*	*df*	*MS*	*F*	*p*	η^2
Between Groups	542.09	1	542.09	4.50	.04	.02
Within Groups	35164.62	292	120.43			
Total	35706.71	293				

The fifth research question stated that there would be a statistically significant difference in the affective responses of participants and the number of CSA clients counseled (experience working with CSA survivors). A one-way analysis of variance (ANOVA) revealed a statistically significant difference, F (3, 294) = 4.00, p = .01, in mean scores for number of CSA clients and the ARCSAS (see Table 17). The relationship between affective responses and number of CSA clients was large with a partial η^2 = .84. Participants who reported counseling at least 10 or more CSA clients scored significantly lower on the ARCSAS scores (M = 73.93, SD = 10.46) than those who reported counseling one to five CSA clients (M = 78.33, SD = 11.35). Results for tests of assumption (i.e., normality of sample distribution and homogeneity) were satisfactory.

Table 17

ANOVA for Number of CSA Clients Counseled and ARCSAS

Source	*SS*	*df*	*MS*	*F*	*p*	η^2
Between Groups	1424.96	3	474.99	4.01	.01	.84
Within Groups	34900.27	294	118.71			
Total	36325.23	297				

Correlational Analysis

Table 18 presents the Pearson product-moment correlations for the dependent variable, Affective Responses to Child Sexual Abuse Scale (ARCSAS) and each independent variable (CSA history, type of CSA training, training on asking a client about CSA, training on appropriately responding to CSA, and the number of CSA clients counseled). Results revealed statistically significant inverse relationships for ARCSAS and type of CSA training, asking a client about CSA, and appropriately responding to CSA. A statistically significant positive relationship was found between a history of CSA and type of CSA training. A statistically significant positive relationship was also found between type of CSA training for both asking about CSA and responding appropriately to CSA. Finally, a statistically significant positive relationship was found for number of CSA clients and type of training and asking or responding to CSA. A statistically significant inverse relationship was found between the number of CSA clients and a history of CSA with the ARCSAS.

Table 18

Intercorrelations Between ARCSAS and Independent Variables (N = 299)

Variable	1	2	3	4	5	6
1. ARCSAS	__	-.06	-.17**	-.15*	-.12*	-.18**
2. CSA History		__	.13*	.08	.05	-.19**
3. Type of CSA Training			__	.43**	.38**	.31**
4. Asking about CSA				__	.61**	.32**
5. Responding to CSA					__	.29**
6. Number of CSA Clients (Experience)						__

Note: ** Significant at the 0.01 level; * Significant at the 0.05 level

The sixth research question stated that there would be an inverse relationship between affective response scores and participants with a sexual abuse history. Lower scores on the ARCSAS indicated fewer negative affective responses to child sexual abuse. A Pearson product-moment correlation was used to determine if there was an inverse relationship between participant's ARCSAS scores and a history of child sexual abuse. Results revealed no statistically significant relationship r (299) = -.06, p = .29, for participants who reported a child sexual abuse history and those with no such history on the ARCSAS. Figure 1 represents a histogram of the distribution of scores on the ARCSAS and a history of child sexual abuse.

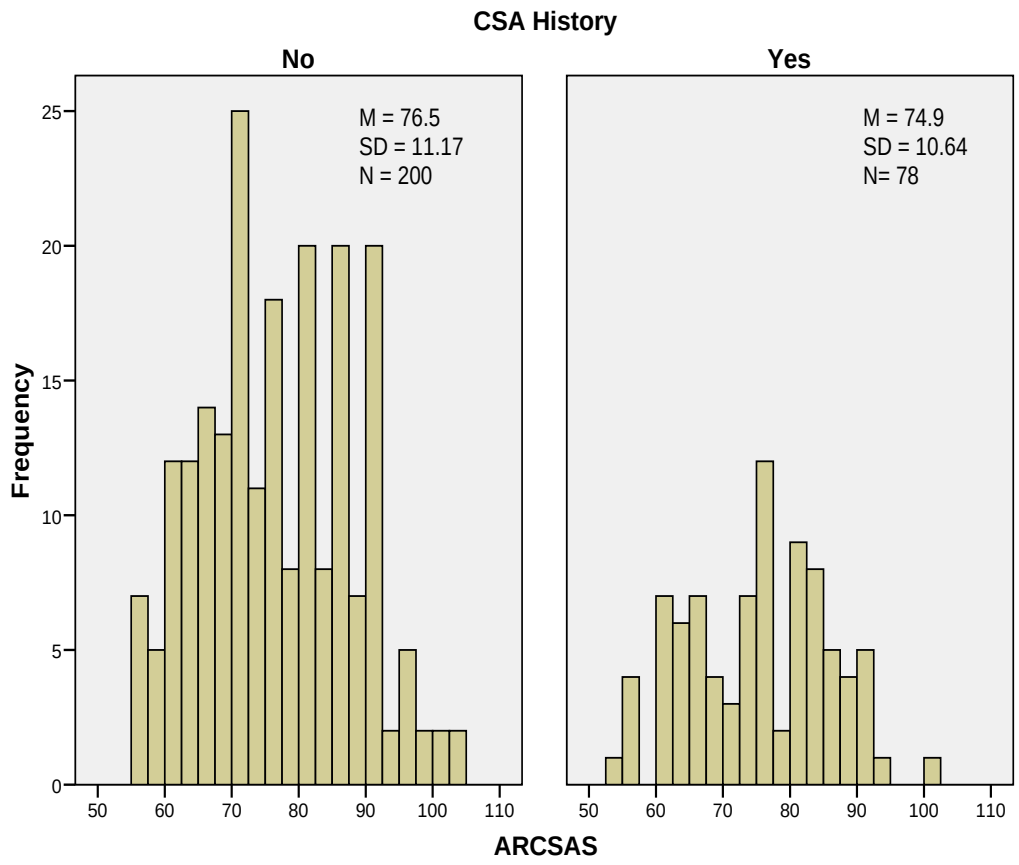

Figure 1: Histogram of Distribution of Scores on the ARCSAS (Child Sexual Abuse History)

The seventh research question stated that there would be an inverse relationship between affective response scores and participants with the type of child sexual abuse training received. A Pearson product-moment correlation was used to determine if there was an inverse relationship between participant's ARCSAS scores and type of child sexual abuse training received. Results revealed a statistically significant inverse relationship r (299) = -.17, p = .004 for child sexual abuse training and the ARCSAS. Figure 2 represents a histogram of the distribution of scores on the ARCSAS and type of child sexual abuse training.

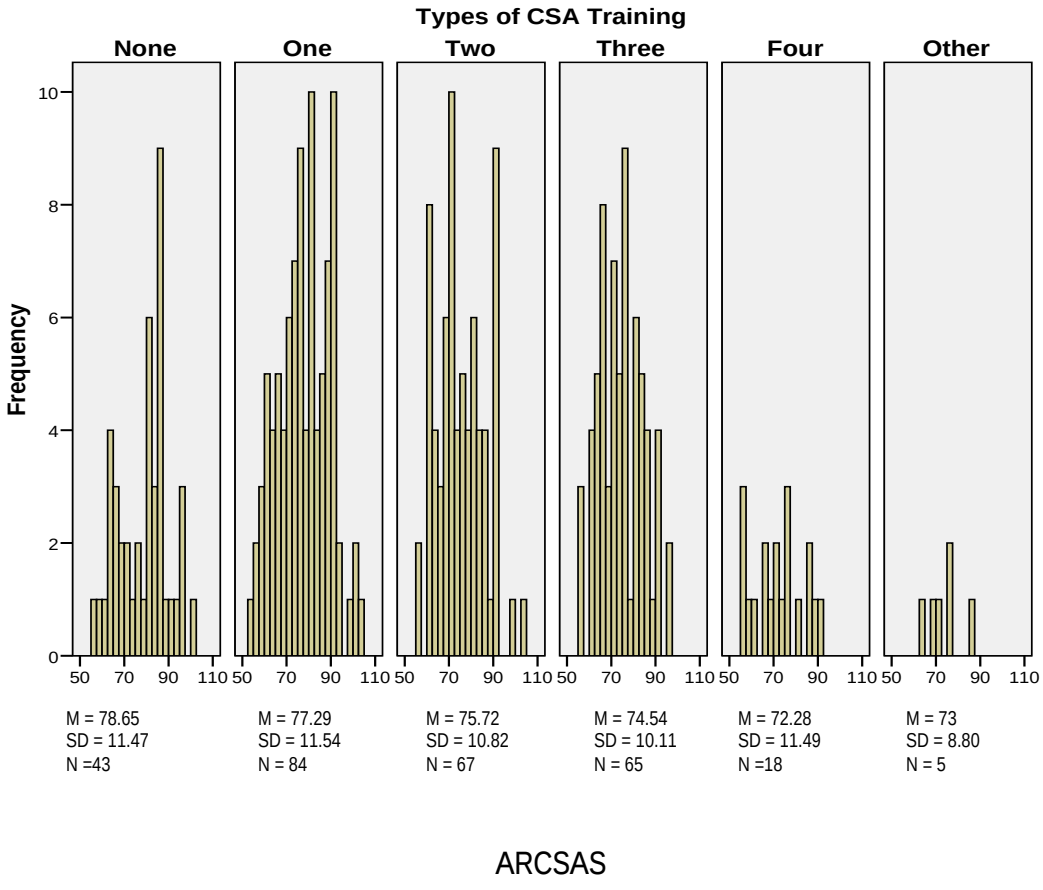

Figure 2: Histogram of Distribution of Scores on the ARCSAS (Type of Child Sexual Abuse Training)

The eighth research question stated that there would be an inverse relationship between affective response scores and participants who report training in asking a client about CSA. A Pearson product-moment correlation was used to determine if there was an inverse relationship between participant's ARCSAS scores and training in asking a client about child sexual abuse. Results revealed a statistically significant inverse relationship $r(296) = -.15$, $p = .01$ for training on asking a client about child sexual abuse history and the ARCSAS. Figure 3 represents a histogram of the distribution of scores on the ARCSAS and training on asking a client about a history of child sexual abuse.

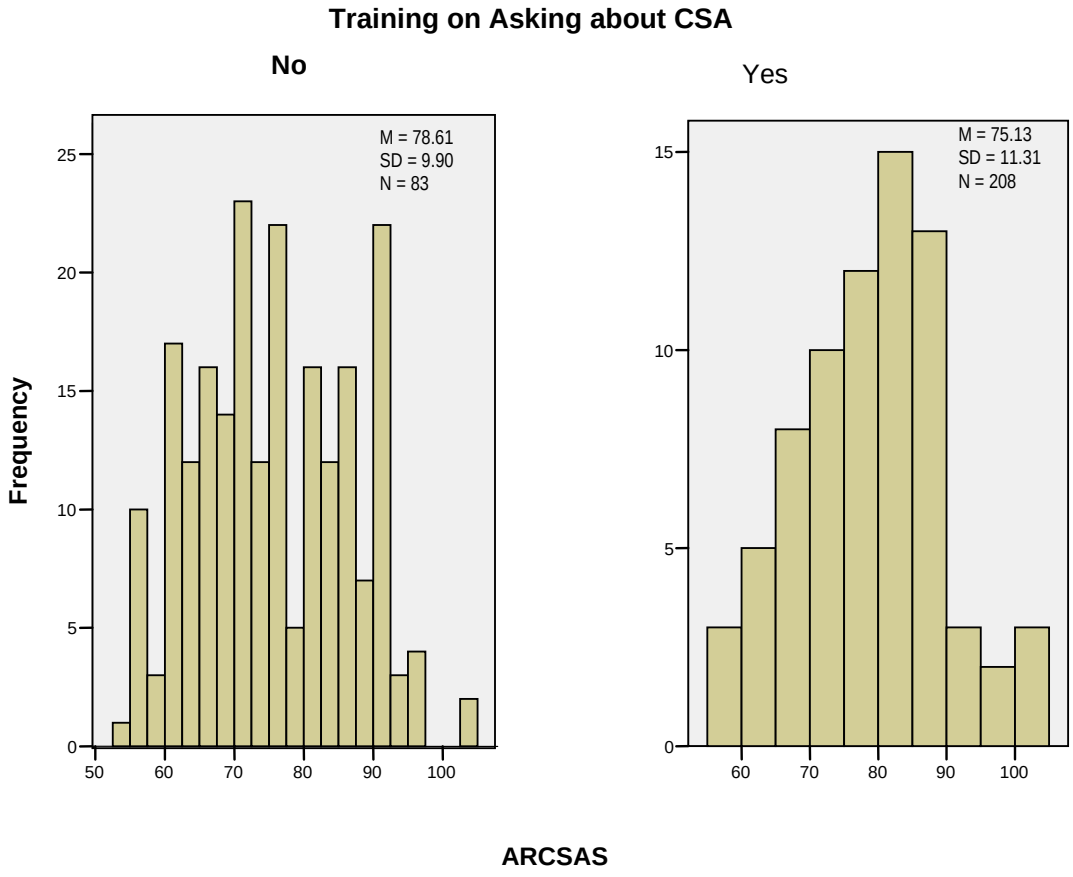

Figure 3: Histogram of Distribution of Scores on the ARCSAS (Training on Asking a Client about a History of CSA)

The ninth research question stated that there would be an inverse relationship between affective response scores and participants with training in appropriately responding to a sexually abused client. Results revealed a statistically significant inverse relationship r (294) = -.12, p = .04 for training on appropriately responding to child sexual abuse disclosure and the ARCSAS. Figure 4 represents a histogram of the distribution of scores on the ARCSAS and training on appropriately responding to a child sexual abuse disclosure.

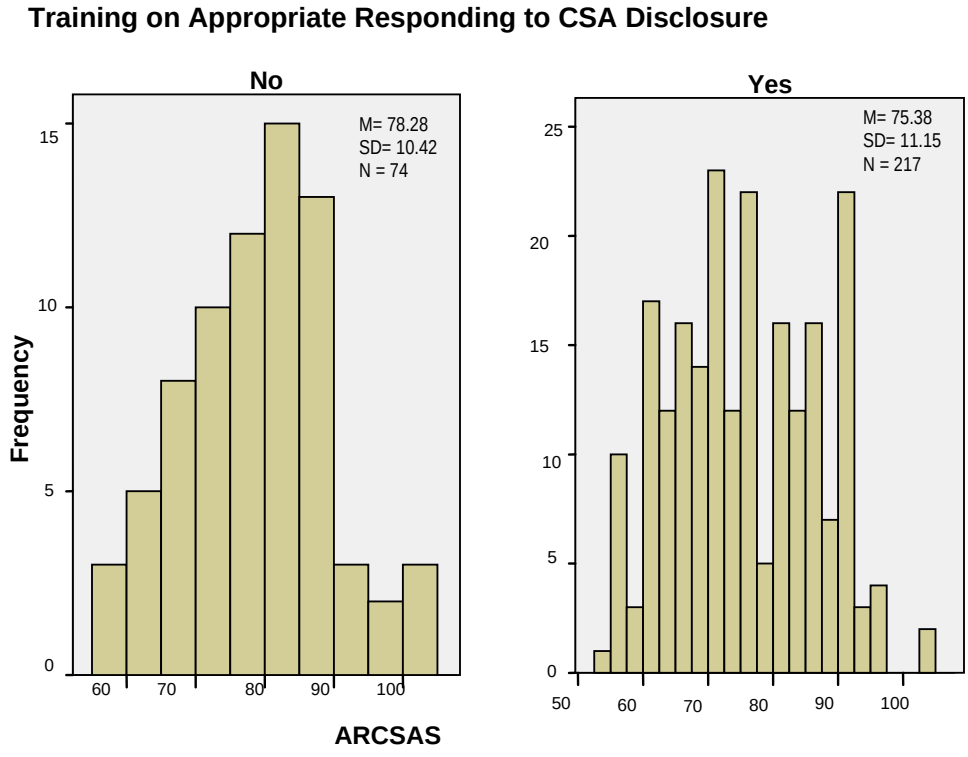

Figure 4: Histogram of Distribution of scores on the ARCSAS (Training on Appropriate Responding to CSA Disclosure)

The tenth research question stated that there would be an inverse relationship between participants' affective response scores and the number of sexually abused clients they have counseled. Results revealed a statistically significant inverse relationship r (298) = -.18, p = .01 for experience with the number of child sexual abuse clients and the ARCSAS. Figure 5 represents a histogram of the distribution of scores on the ARCSAS and counselors' experience with the number of clients who have disclosed child sexual abuse.

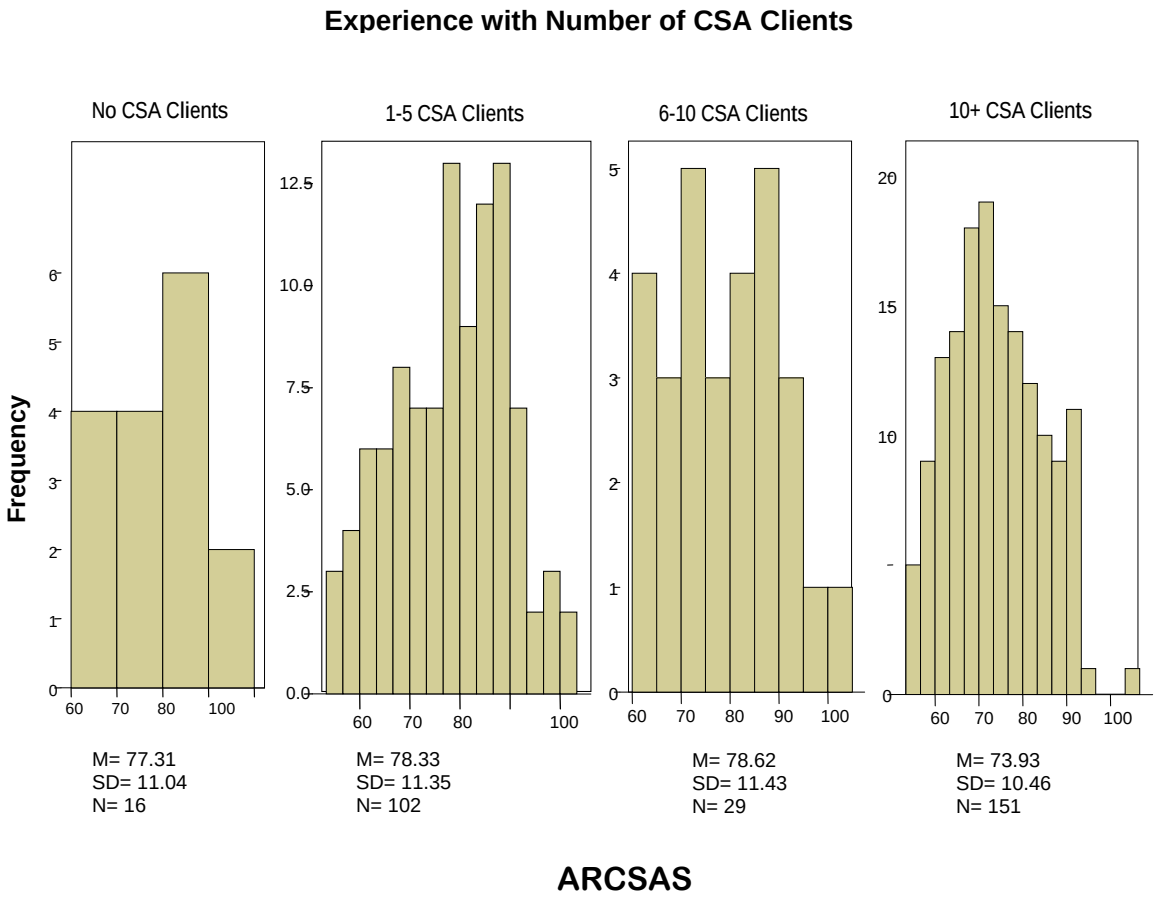

Figure 5: Histogram of Distribution of scores on the ARCSAS (Experience with Number of CSA Clients)

Factor Analysis

Factor analysis is a method to determine the construct validity of an instrument. Fabrigar, Wegener, MacCallum, and Strahan (1999) suggested that if data are relatively normally distributed, the maximum likelihood factor extraction method is the best choice. The maximum likelihood factor extraction method "allows for the computation of a wide range of indexes of the goodness of fit of the model [and] permits statistical significance testing of factor loadings and correlations among factors and the computation of confidence intervals."(Costello & Osborne, 2005, p. 277). Costello and Osborne also recommended using, "the true factor analysis extraction method (i.e., maximum likelihood), oblique rotation (i.e., direct oblimin), and scree plots plus multiple test runs for information on how many meaningful factors might be in a data set" (p. 7).

Hair et al. (1998) suggested that the criteria for significance of factor loadings should consider practical and statistical significance as well as the number of variables (p.111) The rule of thumb is that factor loadings $\pm$ 0.50 are considered practically significant. However, for statistical significance, for a sample of 100, the factor loadings should be $\pm$ 0.55 (p. 112). Costello and Osborne (2005) have suggested that item communalities in social science research typically range between .40 to .70. Hair et al. (1998) stated that the point at which Cattell's scree test criterion curve first begins to straighten out is considered to indicate the maximum number of factors to extract.

The current study utilized an exploratory factor analysis using SPSS 15.0 (2006) default principal component analysis with maximum likelihood extraction method with direct oblimin (oblique) rotation. The parallel analysis criterion (eigenvalues $\geq$ 1.08) resulted in declaring 10 factors for this data set that accounted for 62.30% of the total variance. The criteria used to in order to find the maximum number of factors to extract was Cattell's scree test criterion curve (Hair et al., 1998). Based on the scree test, the final factor analysis indicated that the ARCSAS was a measure of counselor affective responses with a two-factor structure that jointly accounted for 34.53% of the total variance. Table 19 provides the total variance explained for the factor analysis.

Table 19

Total Variance Explained for 10 Factors on the ARCSAS

# of Items	Factor	Eigenvalue	% Variance	Cumulative %
4	1	10.76	26.24	26.24
11	2	3.40	8.29	34.53
2	3	2.54	6.18	40.72
4	4	1.60	3.91	44.62
2	5	.43	3.49	48.11
7	6	1.26	3.06	51.18
4	7	1.17	2.86	54.04
1	8	1.16	2.82	56.86
1	9	1.15	2.81	59.67
1	10	1.08	2.63	62.30

Note: Principle component analysis with maximum likelihood extraction method with direct oblimin (oblique) rotation.

According to the communality output, the selected variables were greater than .54, indicating sufficient explanation. Based on factor matrix loadings greater than or equal to $\pm$ 0.50, fourteen of the forty-two items on the ARCSAS loaded onto two factors. Factor 1 included the following item numbers: 27, 28, 33, and 48. Mean scores for factor 1 were low, ranging from 1.15 to 1.43.

Ten variables loaded onto factor two (Item #: 22, 23, 24, 34, 44, 45, 47, 57, 58, and 59). Mean scores ranged from 1.36 to 3.34 for factor 2. Participants' mean score for Item #34 (I feel hopeless about successfully treating CSA clients) was 2.12 (*SD* = .89). Item communalities were greater than .47, indicating satisfactory explanation. Table 20 presents factor loadings and communalities for the principal component analysis, along with the corresponding item number, description, and category label on the ARCSAS. Table 21 presents the mean scores and standard deviations for each item in factor 1 and 2.

Table 20

Structure Matrix of the Principal Component Analysis of the ARCSAS

Item#	Communality	Factor Loadings	Description	Category
Factor 1: Arousal				
27	1.00	.99	I feel sexually aroused after hearing about CSA experiences.	Arousal
28	.48	.50	Hearing about CSA experience will negatively affect my sexual relationships.	Impact
33	.47	.53	I feel anger toward the survivor of CSA.	Anger
48	.55	.59	I feel excitement from hearing about explicit descriptions of CSA.	Arousal
Factor 2: Efficacy/Competency				
22	.55	.64	I am embarrassed to ask specific questions about the client's CSA experiences.	Embarrass
44	.48	.51	It would embarrass me to have to name and discuss the sexual organs.	Embarrass
57	.81	.52	It embarrasses me to hear about explicit CSA experiences.	Embarrass
59	.74	.81	I feel helpless about my ability to assist a person who has been sexually abused.	Helpless
23	.54	.65	I feel hopeless about helping CSA clients.	Hopeless
34	.58	.73	I feel hopeless about successfully treating CSA clients.	Hopeless
24	.56	.73	I worry that I do not have enough experience or training to treat CSA clients.	Worry
45	.68	.77	I worry I will not be able to work with CSA clients.	Worry
47	.75	.79	I feel guilty about not knowing how to handle and respond to CSA clients.	Guilt
58	.64	.58	I feel overwhelmed by listening to CSA experiences.	Impact

Note: Maximum Likelihood Extraction Method; Oblimin with Kaiser Normalization Rotation Method

Table 21

Mean Scores for Principal Component Analysis of the ARCSAS

Item#	Description	M	SD
Factor 1: Arousal			
27	I feel sexually aroused after hearing about CSA experiences.	1.30	.59
28	Hearing about CSA experience will negatively affect my sexual relationships.	1.43	.63
33	I feel anger toward the survivor of CSA.	1.15	.41
48	I feel excitement from hearing about explicit descriptions of CSA.	1.30	.51
Factor 2: Efficacy/Competency			
22	I am embarrassed to ask specific questions about the client's CSA experiences.	1.50	.59
44	It would embarrass me to have to name and discuss the sexual organs.	1.36	.55
57	It embarrasses me to hear about explicit CSA experiences.	1.67	.63
59	I feel helpless about my ability to assist a person who has been sexually abused.	1.69	.65
23	I feel hopeless about helping CSA clients.	1.39	.52
34	I feel hopeless about successfully treating CSA clients.	1.44	.61
24	I worry that I do not have enough experience or training to treat CSA clients.	2.12	.89
45	I worry I will not be able to work with CSA clients.	1.53	.61
47	I feel guilty about not knowing how to handle and respond to CSA clients.	1.76	.69
58	I feel overwhelmed by listening to CSA experiences.	1.92	.71

Discussion

The purpose of the current study was to investigate the range of affective responses that counselors experienced when confronted with child sexual abuse disclosure based on CSA training, education, and the counselors' personal history with child sexual abuse. The following sections present the descriptive and inferential statistical analyses (ANOVA, Pearson product-moment correlation, and exploratory factor analysis).

Descriptives

Of the participants, 81% indicated their race as Caucasian. The number of Caucasian participants was consistent with an 80% estimate of current ethnic composition of counseling professionals (Wilk et al., 2002). African-American participants and Hispanic participants represented only 8% and 4% of the sample, respectively. In their study, Wilk et al. (2002) provided racial estimates of 4% African-American and 2% Latino or Hispanic origin of counselors. In the study, 71% of the participants reported their gender as female. These results are consistent with other studies, which indicated that women represented about 70% of counseling professionals practicing today (Wilk et al., 2002).

The ages of 43% of participants were greater than 50 years old; whereas 40% of participants reported ages between 31-50 years old, with only 14% of participants reporting ages between 20 and 30. The age of participants varied substantially from Little & Hamby's (1996) survey of clinicians from Vermont of whom 80% were between 31-50 years of age.

Of the participants, 33% indicated that they resided in the Southern region of the United States, with the remaining three-fourth of participants residing in the North, East, and Western regions of the US. This finding may skew the results in that the South may hold more traditional or conservative values and beliefs.

Sixty-one percent of participants reported earning their highest degree between the years of 1999 to 2007. The majority of participants reported possessing a master's degree (47%) or doctoral degree (42%). The percentage of participants reporting earning a doctoral degree was about 20% higher than other studies. Knight (1997) reported 22% of her participants reported earning a PhD. Little and Hamby (1996) reported 23% of her sample reporting having a doctoral degree. However, this finding was not inconsistent with other studies that sampled from professional associations, such as APA (Pope & Feldman-Summers, 1992).

Approximately half of the participants reported less than 10 years of experience working in the counseling field; whereas, 43% of participants reported 11 or more years of experience working in the counseling field. The average number of years of counseling experience reported by participants was 13. This finding is consistent with Knight's (1997) sample of mental health professionals in Maryland in which the average number of years of professional practice experience was 14. Knight (1997) found that the average number of years that her sample reported for experience with CSA survivors was nine. The current study revealed that 180 (61%) participants reported working with more than five clients with a CSA history. However, 102 (34%) had worked with less than five CSA clients, and 16 (5%) had worked with no CSA clients. The majority of participants

reported working in a university setting (42%) or community setting (22%) with some in private practice (15%).

The study revealed that 100 (33%) participants reported receiving child sexual abuse training in a graduate course. This result is consistent with Kitzrow's findings (2002) in her sample of CACREP programs indicating that 31% of respondents offered some graduate course in providing specific training in treating sexual abuse. Sixty percent of participants reported receiving some form of continuing education in CSA; whereas, 14% of participants reported receiving no training in child sexual abuse counseling.

Contrary to Kitzrow's (2002) study that found 33% of participants reported receiving some form of CSA training, the current study revealed that 72% of participants received training on how to ask a client about a child sexual abuse history and 74% received training on appropriately responding to a client who disclosed CSA. These percentages are more consistent with Knight's (1997) study in which she found that 84.5% of sampled therapists had received some form of specialized training to work with CSA survivors and Campbell et al.(1999) in which 78% of their participants reported receiving training on CSA.

The finding that one-third of participants reported a personal experience with child sexual abuse is consistent with other studies conducted by Knight (1997), Little and Hamby (1996), and Pope and Feldman-Summers (1992). Twenty (23%) men and 66 (31%) women reported experiencing some form of CSA. These percentages were similar to Little and Hamby's (1996) survey of Vermont psychologists.

Of the 86 participants who reported a CSA history, only 22 (26%) sought therapy for their abuse. This finding is particularly noteworthy considering the occupation of participants as counselors. Of the participants who responded to the question of seeking therapy to address their CSA, 17% indicated a positive experience with therapy, and 2% indicated a negative or mixed therapy experience. However, 17% of participants with a CSA history did not respond to this question.

ANOVA Results

Research question 1 revealed no statistically significant difference in affective responses (ARCSAS scores) for participants with a sexual abuse history and those with no such history. The index of effect size indicated a medium effect. Although mean ARCSAS scores were not significantly different, there was a statistically significant difference for a history of child sexual abuse by highest degree and the ARCSAS.

The majority of participants reported their highest degree as being a master's or doctoral degree. The observation that participants with a master's degree scored significantly lower than participants with a doctoral degree is interesting. This result indicated that participants with master's degree had fewer negative affective responses than participants with a doctoral degree, which is contrary to what would be expected based on experience and education. However, this could also be interpreted as participants with a doctoral degree willingness to be more candid.

The non-significant finding for a CSA history on the ARCSAS may indicate that history of CSA alone does not seem to affect the level of affective responses and that

measuring affective responses may be a much more complex process. In addition, other factors that were not controlled for in the current study may have influenced the results.

Analysis of Hypothesis 2 revealed no statistically significant difference in ARCSAS scores and the type of CSA training (none, graduate course, continuing education workshop, self-study, internship, or other) received by counselors. The index of effect size indicated only a small effect, although examination of mean scores indicated that participants who received more training in CSA had fewer negative affective responses than participants who reported receiving less CSA training.

Other studies have associated more positive reactions and effects for level of education and experience in working with CSA clients (Badura & Stone, 1998; Knight, 1997). However, the finding that a higher percentage of participants with a master's degree reported a history of CSA may have affected differences in affective responses. The majority of participants (58%) earned their highest degree after 2000. This result could be an indication that more recent counseling graduates are receiving more training in CSA as compared to past years (Alpert & Paulson, 1990; Kitzrow, 2002).

Analysis of Hypothesis 3 revealed a statistically significant difference in the affective response levels of participants who received training in asking a client about CSA. The index of effect size indicated only a small effect. Participants who reported receiving training on asking a client about CSA scored significantly lower on the ARCSAS than those with no such training.

In a study conducted by Cavanagh et al. (2004), 33% of mental health staff (53% identified as nurses) reported receiving some form of training on how to inquire about sexual abuse. The high percentage of participants (72%) who reported receiving training

on asking a client about a history of CSA in the current study differs significantly from Cavanagh et al.

Hypothesis 4 revealed a statistically significant difference in the affective response levels of participants who received training in appropriately responding to a CSA client. The index of effect size indicated only a small effect. Participants who reported receiving training on appropriately responding to a CSA client scored significantly lower on the ARCSAS than participants who reported no such training.

In a study conducted by Cavanagh et al. (2004), 39% of mental health staff (53% identified as nurses) reported receiving training on how to respond to disclosure of sexual abuse. The current study resulted in 74% of participants reporting training on how to appropriately respond to a CSA client. Cavanagh et al. found in their study that those with prior training on asking clients about CSA believed they also knew how to respond to abused clients and provided more information on abuse to a greater percentage of abused clients than those with no such training. Those who received training also were more likely to believe that it was important to offer all abuse clients abuse-related counseling.

Hypothesis 5 revealed statistically significant differences in affective responses of participants who had counseled ten or more CSA clients compared to participants with experience working with only one to five CSA clients. The index of effect size indicated a large effect. Participants with more experience with CSA clients scored significantly lower on the ARCSAS than participants with less experience.

The results of the current study indicated that counselors may be receiving more training in the area of child sexual abuse. The analysis of the data suggested that

counselors with experience working with CSA clients and CSA training (i.e., asking and appropriately responding) can have a positive effect on the level of affective responses to child sexual abuse.

Correlational Analysis

To determine the relationship between the dependent and independent variables, the Pearson product-moment correlations was utilized for the following research questions:

There would be an inverse relationship between affective response scores and participants with a child sexual abuse history.

There would be an inverse relationship between affective response scores and participants with the type of child sexual abuse training received.

There would be an inverse relationship between affective response scores and participants who report training in asking a client about CSA.

There would be an inverse relationship between affective response scores and participants with training in appropriately responding to a sexually abused client.

There would be an inverse relationship between participants' affective response scores and the number of sexually abused clients they have counseled.

Results indicated no statistically significant relationship between affective scores and participants who reported a history of CSA. The index of effect size for this correlation was small. Although not statistically significant, there was an inverse relationship between participants with a history of CSA and their ARCSAS score.

Participants who reported a history of CSA scored lower on the ARCSAS, indicating less negative affective responses to child sexual abuse.

The negative finding for affective responses and the participant's history of CSA is consistent with previous literature (Badura & Stone, 1998; Follette et al., 1994; Knight, 1997; Little & Hamby, 1996). Badura and Stone (1998) found that therapists' personal history of abuse did not significantly influence respondents' perceptions of treating survivors of CSA (as related to perceived competence). Follette et al. (1994) found that a history of childhood trauma was not associated with difference in mental health professional clinical activities (i.e., specializing in treating sexual abuse survivors, levels of negative clinical responses). Knight (1997) found that the therapist's own history of sexual abuse was not associated with respondent's affective reactions to CSA survivors. Little & Hamby (1996) also found no significant differences in emotional responses between abused and nonabused clinicians.

However, Little and Hamby (1996) did find significant differences in their sample of abused and nonabused clinicians in terms of the frequencies of some countertransference problems and in their use of various coping strategies. These differences included greater boundary issues (e.g., sharing one's own sexual abuse experiences and crying with clients) for those who reported CSA histories. Abused clinicians were also more likely to use more coping strategies for dealing with the stress of working with CSA clients.

Results indicated that there was a statistically significant inverse relationship between affective response scores for participants who reported training on asking a

client about CSA and responding appropriately to a CSA client. The indices of effect size indicated a small effect for ARCSAS scores and types of CSA training as well as asking and responding appropriately to CSA. Although not statistically significant, the histogram provides a clear indication that participants who had received more training scored progressively lower on the ARCSAS, indicating less negative affective responses to child sexual abuse with increased amounts of training (see Figure 2, 3, & 4). There were also statistically significant intercorrelations between types of training and asking about CSA and responding appropriately to a CSA client, with a medium effect size. There was also a statistically significant relationship between asking about CSA and responding to CSA. The index of effect size between these two variables was large. These findings seem to indicate that asking and responding to CSA may be components within types of CSA training.

There was a statistically significant relationship between type of CSA training and a history of CSA. The index of effect size for this correlation was small. Participants who reported a history of CSA scored lower on the ARCSAS if they had one, two, or four types of CSA training, indicating less negative affective responses to child sexual abuse with the indicated types of training. Based on amount of training alone, participants who reported no CSA history scored higher on the ARCSAS than those who had a history of CSA, with counselors with no CSA history responding more negatively to CSA. Thus, the results seem to indicate that based on the amount of training alone, counselors with a CSA history do respond with greater sensitivity to the topic of child sexual abuse.

Results for CSA training on affective responses are consistent with previous literature (Badura & Stone, 1998; Follette et al, 1994). Badura and Stone (1998) found that the therapist's personal history of abuse did not significantly influence their perceptions of treating survivors of CSA. Follette, et al. (1994) found that mental health professionals who reported a history of CSA did not differ significantly in negative responses to CSA survivors than those with no such history.

According to previous studies (Knight, 1997; Little & Hamby, 1996), experience and training in child sexual abuse influenced the counselor's response to CSA clients. Knight (1997) found that professional experience had an impact on clinician's affective responses. The majority of clinicians in her study reported receiving specialized training in working with CSA survivors. Knight observed that therapists with less professional experience were more likely to report feeling overwhelmed by working with CSA survivors. Another study by Little and Hamby (1996) suggested that training may be the main factor in the lack of difference between clinicians with or without a CSA history. The authors found no significant difference between clinicians who reported a history of CSA and those with no such history in terms of screening for CSA or diagnostic formulation (i.e., diagnosis and assessment of harm).

This study is consistent with previous studies and suggested that a personal history of CSA does not negatively influence the affective responses of counselors to CSA clients. However, the amount of training in child sexual abuse and amount of experience with CSA clients seems to be the most salient factors in influencing the

affective responses of counselors to CSA. Counselors react more positively to CSA clients if they have received more CSA training and worked with CSA survivors.

It is apparent that measuring affective responses seems to be a much more complex process than studying the counselor's history of sexual abuse alone. However, what is clear is that training and experience in working with CSA clients has a positive impact on the counselor's affective responses to the topic of child sexual abuse.

Factor Analysis

The results of the exploratory factor analysis indicated that the ARCSAS was a moderate measure of counselor affective responses with a two-factor structure. However, contrary to the expected 11 categories as hypothesized, only two main categories emerged. In order to provide a clearer description, new labels were created for the two categories. The label that best described Factor 1 was the category of *arousal*. Four items represented feelings of arousal (i.e., sexual, sexual relationship, anger, or excitement). The results of this category indicated that participants strongly disagreed with items referring to feelings of sexual arousal. Participants did not feel sexually aroused or excited by hearing about CSA experiences and did not feel that hearing about CSA experiences affected their sexual relationship. Participants also strongly disagreed with feeling anger toward CSA survivors.

Eleven items represented factor 2 and the label that best described this factor was *efficacy*. Efficacy implies a *competency* component in describing how participants viewed their ability to work with CSA clients. Participants' mean scores indicated low

levels of embarrassment about the following items: a) asking about the client's CSA experiences, b) discussing sexual organs, or c) hearing about CSA experiences. Participants' mean scores indicated low levels of feeling helpless/hopeless in assisting a CSA client and worry or guilt about working with or having enough training to work with CSA clients. Worrying about having enough experience had a medium effect. Participants' self-perception of trusting themselves to work with CSA survivors was extremely high, regardless of actual training or experience.

Existing literature is minimal in providing empirical evidence to support the resulting factors in the principal component analysis. This is the first use of the ARCSAS instrument and category labels were subjective. Results from the factor analysis indicated that the ARCSAS was a good indicator of arousal in terms of sexual responses and anger. However, the ARCSAS was not clear in delineating feelings of embarrassment, helplessness/hopelessness, worry/guilt, or impact since these categories were clustered into factor 2. A clear explanation of the factor analysis is unclear. The results of factor 2 indicated that the items on the ARCSAS may not be measuring affective responses specifically, but rather the category of efficacy or competency. The results of the factor analysis highlight the difficulty in distinguishing affective responses or arousal from a competency component.

CHAPTER V

SUMMARY, IMPLICATIONS, RECOMMENDATIONS, AND CONCLUSIONS

This chapter presents a synopsis of the findings from the study. The implications of the findings are also included along with recommendations. Recommendations for future research and final conclusions are also provided.

Summary

The current study was conducted in order to examine the range of affective response to child sexual abuse among counselors. This research will add to the counseling literature on responding to child sexual abuse and will identify factors that may affect CSA disclosure among clients. The review of the literature on affective response to child sexual abuse indicated the following:

First, literature on the impact of the counselors' own personal history of child sexual abuse is mixed. Some studies have shown no statistically significant differences between counselors with a history of CSA and those without as it applies to perceived competency (Badura & Stone, 1998; Follete et al., 1994; Little & Hamby, 1996; Pope & Feldman-Summers, 1992). Badura and Stone have pointed out the, "preponderance of literature indicates that therapists' report of a history of personal abuse does not significantly impact their work in the area of CSA" (p.21). However, a more recent study

by Little & Hamby (1996) found a difference between abused and nonabused clinicians in terms of the frequencies of experiencing countertransference problems and the use of coping strategies to handle the stress of CSA work. Knight (1997) suggested that therapists seem to "rely upon coping mechanisms similar to those employed by their clients who are survivors to manage their reactions to their work" (p.38).

Second, the preponderance of literature supported the positive influence of training and experience in working with CSA survivors. Knight's (1997) study found that professional experience had some impact on the clinician's affective response. Clinicians with less professional practice reported feeling more overwhelmed by working with CSA survivors and vulnerability in their personal relationships. Thus, education and training are importance components for counseling professionals who provide services to CSA survivors and for coping with difficult child sexual abuse cases (Follette, et al., 1994).

Third, the literature is still not clear as to the impact that the counselor's emotional reactions have on their actual work with CSA survivors (Knight, 1997). Although the prevalence of existing literature supports no significant differences in perceived competency of mental health therapists, professionals have reported a lack of preparation in their graduate training or internship to address CSA issues and clients (Kitzrow, 2002; Pope & Feldman-Summers, 1992). In addition, it is unclear how a history of CSA actually affects the counselor's sensitivity to the impact of abuse on the CSA survivor (Pope & Feldman-Summers, 1992).

This research study utilized a causal-comparative (ex post facto) design to explore the range of affective responses to child sexual abuse among counselors. Several independent variables (respondent's education, CSA training, experience addressing child

sexual abuse, and the respondent's own personal experience with sexual abuse) were investigated for their effect on the dependent variable, Affective Responses to Child Sexual Abuse Scale (ARCSAS). Two-hundred ninety nine men (n = 86) and women (n = 213) between the ages of 24 to 70 (M = 46.11, SD = 12.42) participated in this study. Of the participants, 81% were Caucasian and 33% resided in the southern region of the United States. Forty-seven percent of the participants had earned a masters degree and 42% had earned a doctoral degree.

The Affective Responses to Child Sexual Abuse Scale (ARCSAS) was used to collect the affective responses of counselors who were members of the American Counseling Association. The ARCSAS consist of 41-items with 11 affective categories. Low scores indicate more affective sensitivity to child sexual abuse. High scores indicate lower affective sensitivity to child sexual abuse. The reliability of the ARCSAS using Cronbach's alpha coefficient was found to be satisfactory, r = 0.86.

A one-way analysis of variance (ANOVA) was used to investigate the following research questions:

There would be a statistically significant difference between the affective responses of participants who report a personal child sexual abuse history and those with no such history.

There would be a statistically significant difference in affective responses of participants with the type of child sexual abuse training received.

There would be a statistically significant difference in the affective responses of participants who received training in asking a client about CSA.

There would be a statistically significant difference in the affective responses of participants with training in appropriately responding to a sexually abused client.

There would be a significant a difference in affective responses of participants and the number of CSA clients counseled.

Results from the ANOVA revealed no statistically significant differences between participant's CSA history or type of CSA training on the ARCSAS. However, statistically significant differences were found between a CSA history and highest degree on the ARCSAS. Participants who held a master's degree and reported a personal history of CSA scored significantly lower (M = 74.85, SD = 10.21) than participants with a doctoral degree and CSA history (M = 76.73, SD = 10.78), indicating more positive affective responses to child sexual abuse.

Results of the ANOVA revealed statistically significant differences in participants who received training on asking a client about CSA and training in appropriately responding to a sexual abused client. Participants who reported receiving training on asking or responding to a CSA client scored significantly lower on the ARCSAS, indicating more positive affective responses to CSA. Results of the ANOVA revealed a statistically significant difference in affective responses to CSA with the number of CSA clients counseled. Participants with experience counseling at least 10 or more CSA survivors (M = 73.93, SD = 10.46) scored significantly lower on the ARCSAS than those who had counseled only 1 to 5 CSA clients (M = 78.33, SD = 11.35).

The Pearson product-moment correlation was used to address the following research questions:

There would be an inverse relationship between affective response scores and participants with a child sexual abuse history (lower ARCSAS scores indicate more positive responses).

There would be an inverse relationship between affective response scores and participants with the type of child sexual abuse training received.

There would be an inverse relationship between affective response scores and participants who report training in asking a client about CSA.

There would be an inverse relationship between affective response scores and participants with training in appropriately responding to a sexually abused client.

There would be an inverse relationship between affective response scores and the number of CSA clients counseled (experience with CSA clients).

Results from the Pearson-product moment correlations indicated no statistically significant relationship between participants who reported a child sexual abuse history and those with no such history on the ARCSAS. Although not statistically significant, there was an inverse relationship for participants with a history of child sexual abuse and the ARCSAS. Upon examination of the histogram (see Figure 1), participants with a CSA history tended to have lower scores on the ARCSAS.

The Pearson-product moment correlations revealed a statistically significant inverse relationship between the type of CSA training (including asking and responding to CSA clients) and ARCSAS scores. Participants with more CSA training scored significantly lower on the ARCSAS.

Results from the Pearson-product moment correlations indicated a statistically significant inverse relationship for experience with the number of CSA clients and the ARCSAS. Participants with experience counseling at least 10 or more clients scored significantly lower on the ARCSAS than participants with experience working with only 1 to 5 CSA clients.

An exploratory factor analysis was used to determine the construct validity of the Affective Responses to Child Sexual Abuse Scale (ARCSAS). The method of extraction used was the maximum likelihood with direct oblique rotation. Upon examination of the scree test, communality, and eigenvalues, the final factor analysis supported that the ARCSAS was a measure of counselor affective responses with a two-factor structure that jointly accounted for 34.53% of the total variance.

Implications and Recommendations

The objective of this research was to investigate the range of affective responses to CSA among counselors based on several independent variables (education, CSA training, and experience) utilizing the ARCSAS. The results of the study form the basis for several implications and recommendation.

Results of the study indicated that a history of child sexual abuse alone does not influence the affective responses of counselors to the topic of child sexual abuse. However, a history of CSA and education does have an impact. Those participants who reported receiving CSA training and more experience working with CSA clients scored significantly lower on the ARCSAS. Lower scores on the ARCSAS indicated more positive affective response to the topic of CSA. These findings support the increased

exposure of more recent master-level graduates who reported greater exposure to some form of CSA training during their educational program.

The results indicated that the type of CSA training (continuing education, self-study, internship, or graduate course) did not seem to affect the participant's affective responses. However, those who had received specific training on asking a client about a history of CSA and training on appropriately responding to a CSA client reacted more positively to the topic of CSA. Thus, educators and counselors should be aware that training specific to asking and responding to the topic of CSA seems to be a vital component of positive affective responses to CSA.

Affective responses to child sexual abuse is a multidimensional construct with many variances and this was reflected in the results of the Affective Responses to Child Sexual Abuse Scale. Factor analysis supported a two-dimensional structure, one factor identified as arousal and the other as efficacy. It is apparent from the analysis that regardless of education and CSA history, CSA elicits varying emotional responses. However, the current application of the ARCSAS may not be distinguishing affective responses alone and the boundaries between affective responses and efficacy/competency are indistinguishable. Thus, it may be impossible to delineate between affective responses and competency with the current use of the ARCSAS. Therefore, educators and counselors should be aware of both components when addressing or working with CSA clients.

The current study suggests that based on lack of CSA training alone, counselors who had a personal history with CSA responded with greater sensitivity to the topic of CSA than those with no personal exposure to child sexual abuse. Counselors reacted

more positively to CSA clients with more education, training, and experience. Thus, counseling educators and practitioners should be aware of the importance of education, training, and experience when dealing with the topic of child sexual abuse. Counselors with little education, training or experience are placed in a serious catch-22 dilemma of how to proceed with a CSA client. The findings of the current study indicate the importance of counselors and counselors-in-training to be prepared prior to their first exposure to CSA clients, preferably during their graduate training in order to illicit more positive responses to CSA and to deflect any negative responses on the CSA client.

Recommendations for Future Research

First, many authors have stressed the importance of educating and addressing the emotional reactions of counselors to child sexual abuse (Grossman et al., 1990). To date, few studies have actually addressed preparing counselors for this. The following provides recommendations for future research:

The current study was the first application of the ARCSAS, resulting in only a two-factor structure, rather than the original eleven dimensions hypothesized. Thus, future research may need to modify the ARCSAS from its original version in order to elicit broader dimensions of affective responses. Another interesting component that may provide more information to affective responses would be to include the state-trait anxiety inventory (Spielberger & Gorsuch, 1983) to assess the level of anxiety aroused by the participant before and after exposure to the ARCSAS. This would provide a baseline in which to assess the affective responses of participant's upon exposure to the topic of CSA.

This study should be replicated in counseling education departments for beginning master-level students with little exposure to CSA clients. Using novice counselors may provide a clearer indication of affective responses to CSA than was gleaned from the current study, which included mainly more experienced counselors. In addition, this study should be replicated using a larger sample size in order to generalize to a larger population.

The finding that counselors with a CSA history and no CSA training responded more sensitively to the topic of CSA is noteworthy. Although the current study did not find a significant difference in affective responses based on a CSA history alone, personal exposure to CSA could actually be a significant factor in responding more sensitively to CSA clients. Additional research could investigate the influence that a personal CSA history may have on the counselor's choice of profession. Another future research interest would be to delve into the reasons why participants who reported a history of CSA and chose a career as a counselor did not participate in treatment for their CSA experiences.

Conclusions

A review of existing literature on child sexual abuse revealed that counselors and professionals have varying responses to child sexual abuse disclosure. Some studies have shown no significant differences between counselors with a history of CSA compared with those who report no history of CSA (Badura & Stone, 1998; Follete et al., 1994; Pope & Feldman-Summers, 1992). However, other researchers have found differences between abused and nonabused clinicians (Little & Hamby, 1996; Knight, 1997).

This study focused on the relationship between affective responses on several independent variables (history of CSA, education, CSA training, and CSA experience). The results of the current study indicated that education, CSA training, and experience with CSA clients were significant factors in the way in which counselors responded to child sexual abuse and in turn this may have an impact on their response to a CSA client. Due to the small sample size of those who reported a CSA history, the current study did not reveal a statistically significant difference for a history of child sexual abuse. However, this does not rule out that this may be an important component to sensitive responding.

This study adds to the minimal literature on affective responses to child sexual abuse. It highlights the need to educate and train counselors early to efficaciously address clients who disclose a history of child sexual abuse. The results of the current study have revealed that the instrument utilized in this study, the ARCSAS, can be an invaluable tool in providing such early intervention and training to the field of counseling

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APPENDIX A

DEMOGRAPHICS QUESTIONNAIRE

1. Gender: ☐ Male ☐ Female

2. Age: _____

3. Race:

☐ Caucasian
☐ African/Black
☐ Asian
☐ Hispanic
☐ Other: _____

4. Region of the United States in which you reside:
☐ North
☐ South
☐ East
☐ West
☐ Other: _____

5. Highest Degree earned:
☐ Bachelors
☐ Masters
☐ Specialist (beyond Master's)
☐ Doctoral

6. What year did you earn your highest degree:
_____

7. Are you currently a graduate student?
☐Yes ☐No

8. Type of counselor training program you completed:
☐ Counselor Education
☐ School Counseling
☐ Rehabilitation Counseling
☐ Student Affairs
☐ Special Education
☐ School Psychology
☐ Educational Psychology
☐ Other: (Please specify: _____)

9. How many years have your worked in the counseling field? _____

10. Type of work setting currently employed:
☐ University/College
☐ School
☐ Community Agency
☐ Hospital
☐ Private Practice
☐ Other: (Please specify: _____)

11. What counseling Credentials/Licensures do you hold?
☐ LPC
☐ NCC
☐ ACS
☐ NCMHC
☐ Other: _____

12. Child Sexual Abuse (CSA) is defined as:
The imposition of sexually inappropriate acts (including noncontact sexual abuse) on a child or adolescent (up to age 18) for the sexual gratification of another person who is in a position of power or control over the child, including acts perpetrated by peers

13. What type of training have you had in counseling sexual abuse clients? (*Mark all that apply*)
☐ No training
☐ Graduate course(s)
☐ Continuing Education workshop(s)
☐ Self-study
☐ Internship
☐ Other: (Please specify: _____)

14. Have you received training on how to ask a client if s/he has experienced child sexual abuse?
☐ Yes ☐ No

15. Have you received training on how to appropriately respond to a sexually abused client? ☐ Yes ☐ No

16. How many clients have you counseled that have disclosed childhood sexual abuse?
☐ None
☐ 1-5
☐ 6-10
☐ 10+

17. Did you experience any sexual abuse as a child?
☐Yes ☐No

18. If yes to question 12, have you sought professional therapy for your abuse?
☐Yes ☐No

19. How was your experience with the therapist?
☐Positive ☐Negative ☐Other: _____

20. Any additional comments:
_____
_____
_____

APPENDIX B

AFFECTIVE RESPONSES TO CHILD SEXUAL ABUSE SCALE (ARCSAS)

AFFECTIVE RESPONSES TO CHILD SEXUAL ABUSE SCALE (ARCSAS)

	Please rate each item related to Childhood Sexual Abuse **SD**=Strongly Disagree, **D**= Disagree, **A**= Agree, **SA**=Strongly Agree * CSA= Child Sexual Abuse	**SD** 1	**D** 2	**A** 3	**SA** 4
When counseling a client who discloses childhood sexual abuse:					
22	I am embarrassed to ask specific questions about the client's CSA experiences.	1	2	3	4
23	I feel hopeless about helping CSA clients.	1	2	3	4
24	I worry that I do not have enough experience or training to treat CSA clients.	1	2	3	4
25	I have experienced feelings of sadness after hearing about CSA experiences.	1	2	3	4
26	I feel guilty about feeling anger toward CSA survivors.	1	2	3	4
27	I feel sexually aroused after hearing about CSA experiences.	1	2	3	4
28	Hearing about CSA experience will negatively affect my sexual relationships.	1	2	3	4
29	Hearing about CSA experiences makes me less trusting in personal relationships.	1	2	3	4
30	Hearing about CSA elicits bad memories for me.	1	2	3	4
31	I have had the experience of tuning out or dissociating when the client talks of their CSA experiences.	1	2	3	4
32	I feel that CSA survivors somehow provoked their sexual abuse.	1	2	3	4
33	I feel anger toward the survivor of CSA.	1	2	3	4
34	I feel hopeless about successfully treating CSA clients.	1	2	3	4
35	I worry that CSA could happen to someone I know.	1	2	3	4
36	I feel a connection with my clients who are CSA survivors.	1	2	3	4
37	I am curious about the details of CSA survivor's sexual experiences.	1	2	3	4
38	Listening to CSA experiences has a negative emotional impact on me.	1	2	3	4
39	I trust myself to work with CSA survivors.	1	2	3	4
40	I feel vulnerable after hearing CSA experiences.	1	2	3	4
41	I feel uncomfortable when I hear about CSA.	1	2	3	4
42	I blame the CSA survivor for their dysfunctional adult life.	1	2	3	4
43	I feel angry with the client who did not tell anyone about the CSA.	1	2	3	4
44	It would embarrass me to have to name and discuss the sexual organs	1	2	3	4
45	I worry that I will not be able to work with CSA clients.	1	2	3	4
46	I am more empathetic to CSA survivor's than to my other clients.	1	2	3	4
47	I feel guilty about not knowing how to handle and respond to CSA clients.	1	2	3	4
48	I feel excitement from hearing about explicit descriptions of CSA.	1	2	3	4
49	Listening to CSA experiences has a negative psychological impact on me.	1	2	3	4
50	I trust others less after hearing about CSA.	1	2	2	4
51	I avoid listening to client's CSA experiences.	1	2	3	4
52	I don't believe CSA survivors are telling the whole truth about their experiences.	1	2	3	4
53	I feel angry with the parent(s) who did not protect their child from CSA	1	2	3	4
54	I feel that there is no way to prevent CSA.	1	2	3	4
55	I feel guilty about wanting to hear the details of the CSA survivor's experiences	1	2	3	4
56	I feel revulsion when I hear about CSA.	1	2	3	4
57	It embarrasses me to hear about explicit CSA experiences.	1	2	3	4
58	I feel overwhelmed by listening to CSA experiences.	1	2	3	4
59	I feel helpless about my ability to assist a person who has been sexually abused.	1	2	3	4
60	I am embarrassed to tell anyone that I have experienced CSA.	1	2	3	4
61	I am able to respond appropriately to the initial disclosure of CSA by a client.	1	2	3	4
62	I believe that CSA survivors exaggerate their experiences.	1	2	3	4

APPENDIX C

MSU INSTITUTIONAL REVIEW BOARD APPROVAL LETTER

Mississippi State University

September 4, 2007

Yun Hui Gardner
400 Gillespie St.
Apt 114
Starkville, MS 39759

RE: IRB Study #07-186: Measuring the affective responses of counselors to child sexual abuse

Dear Ms. Gardner:

The above referenced project was reviewed and approved via expedited review for a period of 9/4/2007 through 8/15/2008 in accordance with 45 CFR 46.110 #7. Please note the expiration date for approval of this project is 8/15/2008. If additional time is needed to complete the project, you will need to submit a Continuing Review Request form 30 days prior to the date of expiration. Any modifications made to this project must be submitted for approval prior to implementation. Forms for both Continuing Review and Modifications are located on our website at http://www.msstate.edu/dept/compliance.

Any failure to adhere to the approved protocol could result in suspension or termination of your project. Please note that the IRB reserves the right, at anytime, to observe you and any associated researchers as they conduct the project and audit research records associated with this project.

Please refer to your docket number (#07-186) when contacting our office regarding this project.

We wish you the very best of luck in your research and look forward to working with you again. If you have questions or concerns, please contact Christine Williams at cwilliams@research.msstate.edu or by phone at 662-325-5220.

Sincerely,

Katherine Crowley
Assistant IRB Compliance Administrator

cc: Dr. Katherine Dooley

Office for Regulatory Compliance
P. O. Box 6223 • 8A Morgan Street • Mailstop 9563 • Mississippi State, MS 39762 • (662) 325-3294 • FAX (662) 325-8776

APPENDIX D

RECRUITMENT EMAIL LETTER

Dear Participant:

My name is Yun Hui Gardner and I am a doctoral student in the Counseling Education Department at Mississippi State University. I am currently conducting survey research on measuring the affective responses of counselors to childhood sexual abuse

It is my hope that you will complete this short survey that will aid me in completing my dissertation. The information that you provide will be held in strict confidence and no attempt to link your responses to your identity will be attempted.

You will be asked to consent to your participation in the study. You will be asked to provide some demographic information and then respond to several statements about your feelings toward child sexual abuse.

Participation is strictly voluntary and you may choose to omit items or to discontinue the survey at any point. Completion of this research should take no more than 20 minutes.

If you would like to participate in the survey, click on the following URL: http://www.counselingsurveys.org/do.php?survey=s134708

Thank you in advance for your assistance and for the time you have expended.

Sincerely,
Yun Hui Gardner, M.A., LPC, NCC, ACS
Doctoral Candidate
Department of Counseling, Ed. Psychology, and Special Education
Box 9727, 508 Allen Hall
Mississippi State, MS 39759
yunigardner@gmail.com
(662) 574-2994

APPENDIX E

INFORMED CONSENT FORM

The following information is provided so that you can make an informed decision whether you wish to participate in the present study.

My name is Yun Hui Gardner and I am a doctoral student in the Department of Counselor Education at Mississippi State University. I am currently conducting research to complete my dissertation on affective responses of counselors to childhood sexual abuse. It is my hope that this research will identify the range of emotional responses that counselors may experience when confronted with sexually abused clients.

This study requires that you complete an online survey that requests demographic information and a questionnaire on your emotional responses to child sexual abuse. The demographic questionnaire requests that you answer questions pertaining to any personal experiences with child sexual abuse and your experience with therapy if applicable. A debriefing statement is provided listing some counseling referral sources if needed.

For your protection and confidentiality, no personal information or identifying data is requested. You will not be asked for your name on the questionnaires. *Please note that these records will be held by a state entity and therefore are subject to disclosure if required by law. There are no expected physical risks; however, you may experience some slight discomfort and/or embarrassment in answering questions related to sexual abuse. Due to the nature of the subject matter, you have the option of being excluded from this study. You also have the option of omitting any questions you find uncomfortable in answering.

You may contact the MSU Counseling and School Psychology Lab at (662) 325-0717 or the Counseling Center at (662) 325-2091. For additional information regarding your rights as a research subject, please feel free to contact the MSU Regulatory Compliance Office at (662) 325-3294.

If you should have any questions about this research project, please feel free to contact me, Yun Hui Gardner, at (662) 574-2994, yunigardner@gmail.com or Dr. Katherine Dooley at (662) 325-3426, kathyd@ra.msstate.edu.

By clicking the link below, I am consenting to participate in this study and I understand the information disclosed above. I understand that my participation is completely voluntary. I also understand that I may withdraw at any time and may refuse to answer any questions on the questionnaires administered. I further understand that there is no penalty for not participating, withdrawing, or refusing to answer questions. I also understand that I may contact any of the above listed persons if I have any further questions or problems.

APPENDIX F

DEBRIEFING STATEMENT

DEBRIEFING STATEMENT

Thank you for your participation in this study. The purpose of this project was to examine and identify the range of affective responses that counselors may experience when confronted with the topic of child sexual abuse. Previous research has revealed that many clients who have disclosed their sexual abuse histories to counseling professionals have reported negative reactions and experiences. The current study will assist the researcher in obtaining additional insight and knowledge on this occurrence. It is hypothesized that focusing attention on how the counselor is emotionally affected by the introduction to the topic of sexual abuse will aid the counselor to be more sensitive and empathetic in responding to sexually abuse clients. It is my hope that this line of research will ultimately lead to more efficacious treatment of clients who have experienced child sexual abuse, and result in more positive therapy experiences for those who disclose their experiences to counseling professionals.

If you are a Mississippi State University (MSU) student or staff member and experience any adverse reactions or distress after participating in this study, you may receive free services by contacting the following:

Counseling and School Psychology Lab at (662) 325-0717
MSU Counseling Center at (662) 325-2091.

The following is a list of additional resources that may be helpful:

MSU Sexual Assault Services (662) 325-3333; Website: http://www.health.msstate.edu/sas/index.php
Community Counseling Services, Starkville office (662) 323-9261
Mississippi Domestic Violence & Legal resources 1-800-898-3234 (Mon-Fri, 8am-5pm); 1-800-799-7233(After Hours)
Oktibbeha County Hospital Emergency Room (662)-324-4565.
MSU Police (662) 325-2121 or Call 911
SafeHaven: 800-890-6040 or (662) 327-6040
Additional Links for Assistance: http://www.health.msstate.edu/sas/links.php

For additional information regarding your rights as a research subject, please feel free to contact the MSU Regulatory Compliance Office at (662) 325-3294. For any further questions or comments, I can be reached at (662) 574-2994 or yunigardner@gmail.com.

With Regards,
Yun Hui Gardner, M.A., LPC, NCC, ACS
Doctoral Candidate
Department of Counseling, Ed. Psychology, and Special Education
Box 9727, 508 Allen Hall
Mississippi State, MS 39759

APPENDIX G

FOLLOW-UP RECRUITMENT EMAIL LETTER

FOLLOW-UP RECRUITMENT EMAIL LETTER

Dear Participant,

Approximately two weeks ago, you received a request for your participation in completing an online survey on measuring the affective responses of counselors to child sexual abuse. If you have not yet completed this survey, please take a few minutes to do so now. I would greatly appreciate your assistance in completing this survey. The information that you provide will be held in strict confidence and your responses will not be linked to your identity.

This survey requires that you consent to your participation in the study, and then complete a survey asking demographic information and several questions on the affective response to child sexual abuse. Participation is strictly voluntary and you may choose to omit items or to discontinue the survey at any point. Completion of this research should take no more than 20 minutes.

If you would like to participate in the survey, click on the following URL: http://www.counselingsurveys.org/do.php?survey=s134708

Your assistance is greatly appreciated. Thank you in advance for your assistance and for the time you have expended.

Sincerely,

Yun Hui Gardner, M.A., LPC, NCC, ACS
Doctoral Candidate
Department of Counseling, Ed. Psychology, and Special Education
Box 9727, 508 Allen Hall
Mississippi State, MS 39759
yunigardner@gmail.com
(662) 574-2994

APPENDIX H

PARTICIPANTS' CSA THERAPY EXPERIENCES

Comments to Question 19: "How was your experience with the therapist?"

Number	Comment
1.	[I] had to rehash those bad thoughts and feelings
2.	I don't think my counselor was trained in childhood sexual abuse but did allow me to disclose a long
3.	I felt the therapy was patronizing.
4.	I saw several therapists
5.	One counselor was too forceful in trying to get to the repressed memories.
6.	One male therapist propositioned me.
7.	One therapist was a disaster---she cried over my disclosure in a later session and then was defensive
8.	Sometimes I feel like they "know"; but they really don't.
9.	The PhD Psychologist did not seem to have the resources to support my disclosure
10.	My first therapist was not all that positive. Pushed too hard too fast. Second was the positive one
11.	She was helpful in some ways and bossy and advice giving in others.
12.	Some therapists get it...others don't.
13.	Complete analysis
14.	Male- Insensitivity; little processing or standoffish. Female- Sensitivity, Nurturing
15.	The disclosure was helpful but no specific work was done related to the abuse.
16.	Went to multiple therapists for twenty years