

## Effective Practices for Sexually Traumatized Girls: Implications for Counseling and Education

Lee Underwood, Sarah E. Stewart & Anita M. Castellanos

### Abstract

The sexual traumatization of female adolescents is becoming increasingly visible in the counseling field. This paper will outline the prevalence of sexual abuse on female adolescents with emphasis on effective practices used in the field. In addition, implications for counselors and counselor educators will be discussed. Multicultural considerations are also reviewed.

Keywords: sexual traumatization, symptomatology, survivors, adolescents.

---

The sexual traumatization of female adolescents has become increasingly visible in the counseling field. The effects of sexual abuse on mental health have gained public attention over the past decade and enticed research for practical application in counseling. Countless studies have confirmed that sexual abuse facilitates high levels of psychological and behavioral symptomatology among adolescents (Boney-McCoy & Finkelhor, 1995) and has strong associations of interpersonal and psychological problems. As a counselor or counselor educator, it is essential to have an awareness of effective practices and interventions for use in treatment with sexual abuse survivors, as encountering such issues is inevitable. With growing sexual abuse and traumatization cases, the need for knowledge, understanding, and implementation of effective practices becomes evident.

Counselors and researchers are both aware of the gap that separates research from practice. A frequent point of contention is that treatments are not supported by research to support their efficacy. However, the effectiveness of some limited interventions among adolescent female survivors of sexual abuse has been examined. The authors have synthesized the literature regarding effective interventions utilized in the treatment of sexually abused adolescent females, in order to bridge the gap between research and practice. First, some terms and definitions will be examined.

One term that is frequently used in the literature is *sexual traumatization*. This term encompasses the effects of “a child’s premature and inappropriate experience with sexuality” (Brown, 2004, p. 28). Additionally, the *effective treatments* refer to treatments that have been tested and have proven to be effective in reducing the symptomatology of female adolescent survivors.

Survivors of sexual abuse may experience single or multiple incidents impacting physical, behavioral, cognitive, or emotional functioning (Green, 1996; Stauffer & Deblinger, 1996). In general, adolescents experience higher rates of victimization than adult victims (Menard, 2002) and subsequently, after a traumatic experience, females are more likely to develop psychological disorders (Foa & Rothbaum, 1998; Rowan, Foy, Rodriguez, & Ryan, 1994). Females who are sexually abused have a heightened risk of developing posttraumatic stress disorder (McLeer, Callaghan, Henry, & Wallen, 1994) but this disorder does not encompass all symptoms experienced in sexually traumatized survivors (Rowan & Foy, 1993). Additional symptoms can include low self-esteem, feelings of guilt, and depression. The risk of developing chronic disorders such as borderline personality and dissoicative identity disorder also increases after being sexually traumatized (Murray, 1993).

Adolescents are at a greater risk for developing all of these problems. Research reveals that many of these females are suffering much at the hands of perpetrators. According to a national survey by Tjaden

and Thoennes (2000), 32.4% of female sexual assault cases were between the ages of 14 and 17. An analysis of sexual assault crimes reported to law enforcement between 1991 through 1996 revealed that juveniles (under the age of 18 at the time of assault) formed the majority of victims with high rates of forcible fondling (84%), forcible sodomy (79%), and sexual assault with an object (75%) (Snyder, 2000). Other forms of sexual abuse exist throughout the literature, such as unforced verbal manipulation, being asked to pose in sexually positions or undress provocatively, fondling the perpetrator's genitals, oral manipulation (Berliner & Elliott, 1996; Rowan, Foy, Rodriguez, & Ryan, 1994). Snyder's (2000) report also indicated that the risk of sexual victimization peaks dramatically between the ages of 10 to 14-years-old and recedes by 20 years of age. Female adolescents develop during a critical time where sexual abuse is likely to occur and carries grave consequences.

Developmentally, during the adolescent years, females focus on issues of socialization, self-consciousness, pubertal changes, social peer competence, identity, self-concept, and sexuality. Therefore, the introduction of traumatic life changes (i.e., sexual assault) during the adolescent period increases likelihood of developing emotional and behavioral disturbances (Compas, Howell, Phares, Williams, & Giunta, 1989; Siegel & Brown, 1988; Simmons & Blyth, 1987; Simmons, Blyth, Van Cleave, & Bush, 1979; Simmons, Burgeson, Carlton-Ford, & Blyth, 1987). In addition, the introduction of inappropriate or premature sexuality experiences may teach adolescents to fulfill non-sexual needs with sexual action (Green, 1996). This may cause promiscuousness or socially-inappropriate sexualized behavior. This developmental disruption can lead to female adolescents feeling stigmatized, powerless and betrayed while simultaneously manifesting itself in a variety of clinical issues.

#### *Prevalent Issues*

Sexual abuse has profound effects on the female experience. The developing sense of self is altered and adulthood mental health is fundamentally compromised. The range of potential disorders and symptoms that may develop due to sexual abuse include depression, anxiety, aggression, dissociation, poor self-concept, flashbacks, compulsions, and a sense of loss. Although the symptoms or disorders vary based on individual characteristics, studies indicate that there are some prevalent issues highly correlated with sexual abuse. Substance abuse has been documented throughout literature as a reoccurring theme with sexually traumatized female adolescents. Kilpatrick, Edmunds, & Seymour (1992) reported that female rape victims had higher rates of substance abuse than non-victims. This study also reported specific substances, such as marijuana and cocaine, can increase the chance of abuse in females who have been raped. Substance abuse may be introduced to females adolescents by the perpetrator or can be used as a coping mechanism, which perpetuates the chemical abuse cycle throughout the female's lifespan. Additionally, in some cases substance abuse is introduced by parents (Donohue, Romono, Hill, 2005) the literature and child protective services reveal that child abuse and neglect are related to parental substance abuse.

There are also differences in both age and gender in how adolescents respond to experiencing sexual abuse. Adolescents, overall, experience lower self-esteem, social support and sexual anxiety after experiencing sexual trauma (Feiring, Taska, and Lewis, 1999). However, girls experience more intrusive thoughts, hyperarousal, sexual anxiety, personal vulnerability, perceiving the world as a dangerous place, and lower levels of eroticism.

Another prevalent issue amongst survivors is suicidality. Joiner et al. (2007) stated that physical abuse and violent sexual abuse during childhood are risk factors for suicide, and are greater risk factors than verbal abuse and molestation. Consequently, it is also important for counselors to assess for suicidal ideation when working with this population and to integrate it into the treatment plan.

Additionally, there are several risk factors that have been identified and are associated with childhood sexual abuse (Fleming, Mullen, & Bammer, 1997). These risk factors were found to be different in children under the age of 12 and adolescents over the age of 12. Adolescents experiencing physical abuse and having a mentally ill mother were found to be the two main risk factors for sexual abuse. Additionally, another study found that youth who had been sexually abused had a suicide rate that was 10.7 to 13 times the national rates (Plunkett, Toole, Swanston, Oates, & Parkinson, 2001). This predisposition and these risk factors suggest a population that prevention programs can target for sexual abuse and suicide. Treating any risk of perpetration is a priority and child protection issues need to be addressed early in therapy. Sessions cannot be kept confidential when involving youth who are at risk for being abused.

### *Techniques to Treatment*

During adolescence the developmental focus is on the psychosocial crisis of group identity versus alienation, according to Erikson's model (Newman & Newman, 2003). When female adolescents are sexually abused, confusion and mistrust become a part of this developmental stage (Sapsford, 1997). Healthy body awareness is stunted while feelings of shame, self-worthlessness, and guilt grow. Given the prevalence of sexual traumatization and the developmental challenges that these survivors subsequently face, it is crucial for counselors and counselor educators to use effective treatments with this population. The literature indicates several effective treatment modalities. Amongst these modalities are time-limited same-gender groups, art therapy, family therapy, eye movement desensitization and reprocessing, psychophysiological trauma-work (Corder, 2000; Murphy, 2001; Bagley and LaChance, 2000), mode deactivation treatment (Apsche & Ward, 2004) and dialectical behavioral treatment (Linehan, 1993). There are additional elements of treatment that facilitate effective practices, such as the therapeutic relationship, the counselor's gender, narratives of disclosure, and anchoring (Sapsford, 1997; Brown, 2004; Moon, Wagner, & Kazelskis, 2000).

### *Time Limited Same Gender Group Therapy*

Time limited same gender group therapy has been considered a cost effective method of providing services to an increased number of clients (Yalom, 2005), and group therapy has been identified as the treatment of choice when working with sexually abused adolescents (Lindon and Nourse, 1992). Irvin Yalom (2005), indicates that for survivors of childhood sexual abuse, group therapy provides benefits beyond what individual therapy is able to provide in that it results in increased empowerment and psychological well-being (Westbury & Tutty, 1999). Additionally, Westbury and Tutty (1999) compared sexual abuse survivors receiving group therapy to a control wait-listed group (all participants were simultaneously in individual therapy) and they found that those receiving group therapy reduced their depression and anxiety levels by statistically significant amounts. However, despite the merits of group therapy for survivors there are additional implications for this population. Adolescent females are developmentally focused on establishing an identity within their peer group, thus group therapy complements the developmental stage well. Welldon (1993) reports that in the group atmosphere, sexual abuse victims are able to replace secrecy and isolation with disclosure and belonging. Lindon and Nourse (1992) founded a group approach for treating sexually abused adolescent females emphasizing three main constructs. These constructs include skills training, psychotherapeutic interventions such as the empty chair, and an educational piece involving the female sexual anatomy. Self-reports indicated this treatment was effective and the girls demonstrated an increase in positive feelings about themselves.

### *Feminine Group Therapy Model*

A feminine group model that is body-focused has been used to facilitate healing in adult survivors (Westbury & Tutty, 1999). The model utilized Integrative Body Psychotherapy which is an approach that addresses cognitive, emotional, physical, and spiritual elements. Relaxation exercises, visualization and other techniques were used as well. However, currently there is no research testing the efficacy of this model with adolescents. Both the control group and the treatment group received individual therapy in this study and both showed improvements on various psychological constructs. However, the treatment group, showed statistically significant improvements on both depression and anxiety levels.

### *Art Therapy*

Some practitioners have also utilized art therapy in group and individual settings. Brown and Latimir (2001) combined cognitive approaches with art therapy in a group setting with sexually abused adolescent females. Cognitive restructuring is required to counter false beliefs that have developed, such as believing that sexual abuse was one's fault. Beck (1976) has indicated that mood disturbances and relevant emotional difficulties occur because of cognitive distortions regarding the sexual assault. It is postulated that these beliefs lead to distress and distressing behaviors. Therefore, it is believed that the alleviation of these beliefs will lead to the correction of these behaviors. Jehu (1989) has found empirical support for the effectiveness of challenging cognitive distortions in victims of sexual abuse. The most common cognitive changes that are related to abuse involve a negative view of the self and feelings of guilt, perceiving oneself as both helpless and hopeless, and having difficulty trusting others (Briere, 1989, p.9). Dissociation is a defense mechanism that is often utilized in the midst of sexual abuse. This is an effort to retain a positive sense of self while simultaneously suppressing parts of the trauma from consciousness. This is a coping mechanism for dealing with the abuse. Therefore, there is a gap between thinking and feeling, and it has been argued that verbal therapies alone may encourage the survivor to reinforce that gap. This is the logic for using more expressive modalities such as art therapy that reintegrate the cognitive with the emotional. Goals for a group like this may involve acting out distressing thoughts and feelings symbolically through art rather than behaviorally, the reframing of cognitive distortions related to guilt and shame, and the utilization of transference for the group to have a healing "family" experience.

### *Family Therapy*

Although group therapy may recreate a sense of family, some researchers have found family therapy itself to be effective in treating sexually traumatized females. In the midst of group work Welldon (1993) found that the group's process of dysfunction was related to the group members' family dysfunction processes. Since the co-morbidity of substance abuse and child abuse and neglect is also an issue, some practitioners (Donohue, Romono, and Hill, 2005) have utilized a behavioral model to treat child abuse and substance abuse concurrently. The relationship between drug abuse and child abuse can become a vicious cycle. For example, the after effects of drug useage, such as irritability, can lead a parent to physically strike a child and the after effects of child abuse can lead a parent to feel guilty and abuse substances. This may highlight the need for family treatment as well.

### *Eye Movement Desensitization and Reprocessing*

Eye movement desensitization and reprocessing (EMDR). This is a controversial treatment modality that alleges to reduce or eliminate traumatic memories and psychological symptoms. Implementing EMDR starts by instructing the client to follow the therapist's finger in left-right eye movements in rhythmic form (Erwin, 2001) while thinking of a traumatic image, physical sensation of trauma, and a negative self-cognition or emotion (Wilson, Becker, & Tinker, 1995). This approach is

typically used with clients who experience any traumatic event, but can also be used with specific traumas, such as sexual abuse. The foundation of the approach is that desensitization will occur while the client reports the images, cognitions, emotions or physical experience. Early efficacy studies on EMDR (Shapiro, 1989), indicated clinical significance but were typically criticized for methodological shortcomings. These critics included that the study had no control group, small sample size, limited or non-representative samples, no pre- and posttreatment assessments, and there was no objective or standardized measures (Acierno, Hersen, Van Hasselt, Tremont, & Meuser, 1994; Herbert & Meuser, 1992; Lohr et al., 1992). Eye movement desensitization and reprocessing research increased in the mid-1990s but show mixed results on its efficacy.

One study investigated the effects of EMDR on traumatic memories and psychological symptoms while taking into considerations the critics from previous study reviews (Wilson, Becker, & Tinker, 1995). Within the experimental group, EMDR produced reduction of symptoms and increase in positive cognitions. This study assisted facilitation of EMDR being judged as validated treatment by the APA Division 12 Task Force (Erwin, 2001). Since research around EMDR is still growing, the approach itself has undergone numerous modifications. Counselors should be aware that specific training of this approach is necessary before implementing with sexually abused female adolescents.

#### *Mode Deactivation Therapy*

Mode Deactivation Therapy (MDT) was developed in response to the difficulty in treating youth with high levels of co-morbidity, which resulted in ongoing resistance to current treatments modalities as well as being considered treatment failures in both the outpatient and residential settings. Apsche, Bass & Murphy (2004) have demonstrated that MDT is effective in reducing aggression and suicidal ideations within this population. Through the synthesizing of an applied CBT methodology as well as Linehan's work with Dialectical Behavior Therapy (DBT), MDT was developed for youth who displayed a reactive conduct disorder, personality disorders/ traits, and Post Traumatic Stress Disorder symptomology. Apsche et al (2004) have demonstrated the effectiveness of MDT in reducing aggression, specifically with youth who display the aforementioned diagnostic traits (Apsche, et al 2004; Apsche & Ward 2004). Apsche & Siv (2005) further emphasize the need for an efficacious methodology by positing the development of personality disorder traits/features as a coping mechanism by these youth. This methodology encapsulates the needs of these youth who present with a complicated neglect, multi-axial diagnoses, as well as often being the victims of sexual, physical, and/ or emotional abuse.

Mode Deactivation Therapy also includes a series of mindfulness exercises that are specifically designed for these adolescents. Exercises incorporated within the client workbook designed to allow the youth to practice the technique which helps ensure trust, reduce anxiety and increase commitment to treatment as it helps develop mindfulness skills for the youth. The mindfulness skills result in development of the youths heightened awareness of their fears, triggers and beliefs which helps, them to use this new coping strategies in place of the aggressive behaviors.

Several studies indicate that MDT has been more effective than standardized CBT in the treatment of this population of youth (Apsche et al, 2004). Mode Deactivation Therapy is the only evidence based treatment that has relied upon a sample size of 70% of African American adolescents (Apsche et al, 2004). There are three MDT studies of family interventions (Apsche & Ward, 2004). MDT has also been demonstrated as effective in a series of case studies (Apsche & Ward, 2004 and an empirical study which shows that it was more effective then standard CBT and social skills training (Apsche, Bass, Siv, 2005). Preliminary results of several recent case studies has shown MDT to be effective in reducing suicidal ideation and in reducing fire setting behaviors (Apsche & Siv, 2005). The study of this methodology is important on several levels. The first level being the need to provide evidence based therapy for youth with deficits in multiple areas regarding their trauma.

### *Dialectical Behavioral Therapy*

Linehan (1993) developed Dialectical Behavior Therapy in an effort to effectively treat individuals with borderline personality disorder. Many providers have adapted DBT interventions for juveniles involved in corrections facilities. Dialectical Behavior Therapy posits that some individuals react to emotional stimulation abnormally due to their upbringing and certain, unknown biological factors. This program consists of two main components, weekly psychotherapy sessions and weekly group therapy sessions. Individual sessions address incidents that may have occurred during that week and conflict resolution skills. Group therapy sessions address interpersonal skills, emotional regulation, and tolerance/acceptance of distress, which are core components to an adolescent's development. As mentioned above, DBT provides services to individuals who are diagnosed with borderline personality disorder. DBT focuses on decreasing a variety of behaviors. These behaviors range from being self-injurious, behaviors that interfere with therapy, response to quality of life, and responses to posttraumatic stress symptoms. However, DBT places emphasis on enhancing certain characteristics, such as self-esteem, acquiring additional goals, and learned behavioral skills from the group.

There have been some reports of positive outcomes from DBT treatment. Linehan (1993) has been actively replicating studies, utilizing DBT. In replicating her study, Linehan (1993) found that individuals, who received DBT treatment, displayed significant reductions in substance abuse, a significant increase in keeping individuals in therapy, and a significant increase in social and global conditions. Linehan (1993) discovered that adolescents, who received DBT, reported less crisis situations and a decrease in suicidal ideation.

### *Psychophysiological Trauma Work*

Psychophysiological integrates the body's physiological response to trauma with the psychological effects. Assumptions of these treatment modalities are that the body stores the traumatic memories (Rothschild, 2000) and the physiological survival response (flight or fight) becomes triggers when the memory is stimulated (Baranowsky, Gentry, & Schultz, 2005). Once memories are stimulated the body experiences survival mode, via anxiety, increased heart rate, fear, shortness of breath and increased body temperature. These emotions of fear or anxiety are then paired with the stimuli (i.e. sexual traumatization) (Baranowsky et al., 2005). Modalities based on these assumptions contend that relying on cognitive treatments alone are futile based on limited cognitive processing during stimulated survival modes within the body (Baranowsky et al., 2005). Since the body, mind, and behavior cannot be separated, treatment approaches from this discipline address all aspects affected by trauma. Herman (1992) created three stages of trauma recovery consisting of (1) safety and stabilization, (2) remembrance and mourning, and (3) reconnection. The first stage is essential to treatment. At this stage, counselors create a safe environment (therapeutically and physically) while helping the client increase their internal and external control ((Baranowsky et al., 2005). In the second stage, the client tells their story so that healing can begin. The final stage reconnects the client to the present, conscious self with acknowledgement to current relationships. In general, psychophysiological modalities of treatment for sexual trauma have a long road to travel in the counseling field; however, research and continued attention appears promising.

### *Treatment Approaches*

Apart from distinct treatment modalities, there are aspects of approaches that counselors can use to facilitate positive treatment outcomes. These include creating a safe therapeutic relationship (Sapsford, 1997), understanding the impact of the counselor's gender (Moon, Wagner, & Kazelskis, 2000), using narratives of disclosure to create new meanings in abuse experiences (Brown, 2004) and implementing anchors (Bandler & Grinder, 1979;Rothschild, 2000). Although these are not individualistic modalities of treatment, they are areas in which counselors can build awareness and increase positive therapeutic outcomes.

### *Therapeutic Relationships*

It is common knowledge that creating a therapeutic relationship is a critical component of counseling and facilitates therapeutic progress. The relationship between a client and counselor requires clients to experience trust and a sense of safety within a therapeutic setting. For female adolescents who have been sexually traumatized, this is no small feat. Since these girls have been abused by individuals of trust or power, their basic ability to trust people or feel safe with them has been demolished. However, effective therapy cannot begin with this population until a trusting, health relationship has been established (Sapsford, 1997). Counselors should be aware that it may be difficult to establish a trusting relationship with this population. Furthermore, since the likelihood of attachment styles increase with sexual abuse, negative implicit memories of the trauma are encoded into relationship schemas (Schore, 1996). Developing a healthy therapeutic relationship with traumatized clients creates new encodings of positive relational interactions and new relationship representations then become internalized (Rothschild, 2000). Effective trauma-work cannot begin until the counselor-client relationship is developed and a sense of safety is experienced. Safety is the first step in trauma-work therapy (Herman, 1992). Client characteristics, such as personality disposition, may affect the rapport process and additional sessions will be required to establish relationship. Rothschild (2000) noted that with clients of multiple traumas, therapeutic trust may increase after a real or perceived conflict, if it is repaired within the relationship. She calls this "misattunement and reattunement" (Rothschild, 200, 85). She also encourages counselors to prepare trauma clients for situations of real or perceived conflict. Preparation for such encounters can create safety and build the therapeutic relationship.

### *Counselor's Gender*

Another factor in treating sexually abused female adolescents is the impact of the counselor's gender. Treatment with a male counselor was first thought to stunt the girl's participation and impact the counseling relationship progress with this population. Wagner, Kilcrease-Fleming, Fowler, Kazelskis (1993) studied the relationship between level of involvement in therapy and the counselor's gender. They found no significant difference between the counselor's gender and level of involvement over a 6-session period. However, later studies questioned the amount of disclosure within the participation level of the clients in the Wager et al (1993) study. Analyzing the discussions of sexually abused girls', Porter, Wagner, Johnson, and Cox (1996), reviewed client responses regarding abuse- and non-abuse related content. When abused girls were asked abuse-related questions, their findings found no significant difference between the counselor's gender and the client's abuse-related response. These findings suggest that sexually abused females are more likely to discuss abuse-related topics when asked specific abuse-related questions (Moon, Wagner, & Kazelskis, 2000). Another study monitored the impact of a counselor's gender on subjects that were discussed in individual counseling with sexually traumatized female adolescents (Moon, Wagner, and Kazelskis, (2000). The girl's involvement level in counseling was, again, not affected; however, there was reluctance to discuss certain abuse topics with male counselors. Individual characteristics also play a role in the comfort level with a male or female counselor. Characteristics such as age, developmental capacity, abuse history, attitudes towards both genders prior to abuse and the client's pretreatment level of comfort with same or opposite gender counselor (Moon, Wagner, & Kazelskis, 2000). Being aware that the counselor's gender impacts

counseling and that individual characteristics of sexually abused girls are additional factors is equally important as understanding treatment modalities.

### *Disclosure Narratives*

Another element of treatment to facilitate positive treatment outcomes is incorporating narratives of disclosure with current treatment modalities. Narrative treatment approaches have evolved over the past decades and can now be used with female adolescents who have been sexually traumatized. Narrative therapy proposes that clients have stories that need to be told with interpretations and meanings to their experiences (White & Epston, 1990). When these stories are problematic or emphasize discomforting feelings, the client may deconstruct the story and create new meaning. Sexually traumatized female adolescents harbor problem stories about their abuse experiences that may facilitate feelings of fault, shame, or worthlessness (White, 1995). Kamsler, (1990) found that women's stories of childhood sexual abuse had reoccurring themes of self-blame, self-hate, isolation, confusion, and self-doubt. These negative stories are based on personal interpretations and reflect the client's identity (Brown, 2004). Through narrative treatment, female adolescents can re-interpret their experiences into "unjust violent actions" in which they are not responsible (Brown, 2004, 18). This empowering approach leads clients to take action for justice and decrease self-destructive behaviors or unwanted feelings. Incorporating narratives into current effective practices may provide promising results for female adolescents and allow new meaning to be created from their abuse history.

Anchoring, similar to that of neuron-linguistic programming (Bandler & Grinder, 1979), is another element of treatment that can be easily incorporated into a counselor's treatment approach. Anchoring identifies a person, animal, place, activity or object that stimulates feelings of peace or well-being (Rothschild, 2000). For example, a 15-year-old female discussing her sexual abuse history may express a carefree demeanor when thoughts are turned towards her beloved pet schnauzer. Using the body and mind connection with her schnauzer can create an anchor to a peaceful experience. When clients become overwhelmed while processing their trauma, anchors can be used to decrease immediate symptomology. Rothschild (2000) suggests that anchors can be used to separate trauma history from current situations.

### *Implications for Counselors and Counselor Educators*

Considering that at least 20% of women and 5-10% of men were sexually abused as children in the United States (Finkelhor, 1994), it is of utmost importance for counselors to be trained and educated to provide effective treatments for survivors of sexual abuse. Since research on the efficacy of treatment modalities is still evolving, counselors should have some awareness of the prevalence, dynamics, and approaches used with sexually traumatized adolescents. As counselors and counselor educators, preparation in this area is essential through experience under clinical supervision, and educational training.

Since there are formulated therapy groups for this population, it can be assumed that coursework in group counseling could be modified to include treatment for survivor groups. Adolescent females who have been sexually traumatized feel relieved when they participate in therapy groups and hear others disclose similar experiences. It has also been noted that when others share similar experiences that helps the group to be honest and open regarding members' personal experiences (Lindon and Nourse, 1992). Consequently, it may prove beneficial for mental health professionals to refer individual clients to a group and organize same-gender therapy groups with those who have had similar experiences. As counselor educators, training on group therapy with this population could prepare counselors for providing this service in the community. Additionally, since it was found that adolescent female survivors had extreme



difficulties being assertive, counselors and counselor educators should consider integrative assertiveness training into individual or group therapy for survivors.

During course progression, counselor educators can enhance training programs by focusing on personality theories that are empirically supported for working with this population, such as Beck's cognitive theory. Educators can include segments regarding the application of cognitive theory to treating survivors of sexual abuse or taking separate time to integrate the impact of sexual abuse on female's developing sense of self. For example, sexual abuse survivors commonly hold cognitive distortions of negative self-concept, guilt, a sense of helplessness or hopelessness, and lack of trust for others. Counselor educators can review specific theories or explore theoretical applications to a survivor's experience. Additionally, cognitive approaches to challenging these distortions could be explored in counseling training programs. This would greatly aid in the preparation of future counselors to face the large number of both adolescent and adult survivors of sexual abuse. With a firm understanding of sexual abuse and its impact, counselors will exit training programs with more confidence to treat or research this population.

Another implication for counselors and counselor educators is to dispel myths regarding treatment of sexual abuse survivors. For example, practitioners may develop treatment plans for sexual abuse survivors that are not unlike treatment plans for clients diagnosed with Posttraumatic Stress Disorder [PTSD]. The symptomatology of survivors and those that meet the diagnosis for PTSD differ. Survivors frequently report symptoms such as "sleep disturbance, difficulties in maintaining concentration, memory problems, irrational guilt, hyper-alertness, and an intensification of symptoms when a victim is exposed to situations or stimuli that resemble the original traumatic event" (Westbury & Tutty, 1999; Briere, 1989, p 9). However, care and discernment should be used making the distinction between a diagnosis of PTSD and other symptomatology that do not meet the criteria for PTSD. Furthermore, many children who have experienced sexual abuse do not meet the diagnostic criteria (Kendall-Tackett, Williams, & Finkelhor, 1993). Rodrigues, Ryan, Rowan & Foy (1996) found that 14% of their 117 survivor clients "met full DSM-III criteria for a PTSD diagnosis at some point during their lives" (p. 943).

A myth in treatment of sexual abuse is the common clinical belief that psychopharmacological treatments and psychotherapeutic treatments are more effective than psychotherapy alone. However, there is no empirical evidence to support this notion (Foa, Keane, & Friedman, 2000). There are other suggestions in the literature that need empirical support. For example, Friedrich (1996) argues that when treating sexually abused children it is necessary to integrate interventions that target attachment issues, regulate affect, and regulate self-perceptions. Although it may be necessary to treat a variety of symptoms, Foa, Keane, and Friedman (2000) indicate there is no empirical evidence that attests to the effectiveness of combining treatments across treatment modalities. When counselors and counselor educators dispel these treatment myths, effective and empirically support treatment for sexual abuse can be promoted.

### *Multicultural Considerations*

There are several multicultural considerations in working with sexually traumatized female adolescents. As a counselor or counselor educator, it is important to be sensitive to the differences and characteristics of each culture and the impact that sexual abuse has on clients within cultural contexts. The first consideration deals with the disclosure and processing of sexual abuse. Emotional disclosure can lead to reduced pathological fear (Rachman, 1980), even if it is written disclosure (Sloan, Marx, & Epstein, 2005). One study demonstrated that even written emotional disclosure of a trauma experience can be an effective treatment at decreasing symptoms (Sloan et al, 2005). However, counselors must be aware that some clients need more sessions based on their level of comfort to disclose sexual abuse.

Several cultures, such as the Latino population, characteristically have lower frequencies of seeking and accessing mental health services (Guerra, 2006). Therefore, when a client is less comfortable disclosing sexual abuse or mistrusts institutionalized services, the progression of therapy can be slowed. Additionally, these clients may experience difficulty establishing therapeutic trust with counselors from a different cultural background. If the perpetrator was a family member, further dynamics may impact the counseling relationship, disclosure rate, and therapeutic trust. This is especially true in cultures that frown upon mental health treatment and could interpret disclosure as family betrayal or cultural denouncement. To combat these effects, counselors can implement culturally sensitive approaches to increase efficacy of treatment. Although individual characteristics also play a role in rate of disclosure, it is important for counselors to recognize the impact of cultural characteristics as well.

Another multicultural consideration is sensitivity in approach, assessment interventions, and research areas. Cultural issues and characteristics affect the perception, detection, expression, and rehabilitation of sexual abuse. Unfortunately, culture tends to be a neglected element (Purvis & Ward, 2006) in areas such as efficacy of sexual abuse assessments, and cultural-specific approaches or interventions. For example, different cultures manifest symptoms of sexual abuse in a variety of forms. In a phenomenological study, sexually abused Aboriginal women had themes of shame, guilt, acute vulnerability, internal fragmentation, invalidation, and cultural shame (McEvoy & Daniluk, 1995). Assessments, approach, and interventions will present differently in this cultural group compared to treating sexual abuse in Asian females. Many aspects of sexual abuse treatment, such as modalities or approaches, have not been researched on various cultures, specifically the Latino culture (Gerra, 2006). Therefore, it is the counselor's responsibility to know appropriate interventions for specific cultures. Overall, counselors must be sensitive when treating sexually traumatized females from diverse cultural backgrounds and continue to advocate for research concerning multicultural-competent treatments of sexual abuse.

The last multicultural consideration concerns spirituality. Some cultures are heavily intertwined with spirituality and this aspect needs to be incorporated in sexual abuse treatment. Clients who have strong spiritual backgrounds may wish to explore the impact of sexual abuse on their spiritual practices or expression. Another issue may arise where a client experiences dissonance between sexual traumatization and their spiritual beliefs. For example, many experience betrayal or anger towards their higher power. Clients may also feel abandoned, confused or punished by their higher power, causing increase distress. Counselors should be prepared to explore these aspects of spirituality and how it relates to a client's sexual abuse.

#### *Implications for Future Research*

Further research should focus on sexually traumatized female adolescents because there are several ways this population tends to be ignored in studies. The first issue is age categories. Often age categories are unidentified to specifically address adolescents. For example, a study may state their study is applicable to all adolescents but their research only studied ages 16-18 or 10-14. Since adolescent development varies greatly, it is difficult to encompass the full range of ages in the adolescence period. In addition, age categories in research frequently bleed into adolescent years (i.e., age categories of 10-14), causing confusion of what is applicable for adolescents. However, measures can be taken to reduce generalization by specifically identifying research that addresses the age range or indicating the limited age range that a treatment is appropriate.

The second issue in research focuses on specific approaches for adult or young survivors of sexual abuse. Many studies evaluate efficacy of treatments for two extremes of adults who were sexually abused as children or focus on young survivors of child abuse. For example, there are a number of outcome studies examining the efficacy of group therapy for adult survivors of sexual abuse (Alexander,

1989; Carver, 1989; Hazzard, 1993; Richter, 1997; Sultan, 1988; Threadcraft, 1993), but more research is needed on the efficacy of treatments with adolescent females. Generating more research on sexually abused adolescents fills a gap in the research and provides an unbroken continuum of care.

The next research issue concerns identifying factors of sexual abuse and its impact on the counseling process. Research studies tend to lump sexual abuse into abused- or non-abused categories. Future research needs to specifically address type of abuse (i.e., single or multiple incidents), perpetrator of crime, and identify the developmental time of abuse. The counseling process may be affected depending on whether the abuse was a single incident or a frequent occurrence over time, and understanding perpetrator dynamics. For example, treatment approaches and number of sessions may vary from a single incident of rape by a stranger, to multiple molestation incidents by a parent. Therapeutic needs can vary depending on what type or frequency of abuse occurred. Terr (1994) created two categories of trauma victims, Type I and Type II. Although these distinctions were originally made for children, they are applicable to adolescents and adults. Type I encompasses individuals who have a single traumatic event, while Type II includes repeated traumatization. Type II can be further distinguished with subtypes. Type IIA categorizes individuals who can distinguish between their multiple traumatic events and have a background of stability with sufficient resources. These clients can work on each separate event (Rothschild, 2000). Type IIB clients are unable to separate their multiple traumas and addressing one event can lead to the next. Type IIB then becomes subdivided further; those with a stable background but cannot maintain resilience (R) and those unable to develop resilience (nR) (Terr, 1994; Rothschild, 2000). Including and understanding the type of client assessed in research, will create more specialized and appropriate treatment for this population.

Adding to these identifying characteristics is the developmental time of the abuse. This includes stating that the research participants were (1) abused while infants; (2) abused while young children; or, (3) abused during adolescence. Each characteristic is important when understanding the full impact on the client's experience and their progress through therapy. Research that indicates these specific characteristics may promote more specialized treatment in the counseling field.

Another implication of future research is related to issues pertaining to specific treatment modalities. Demands have been issued on the counseling field for continued research of sexual abuse treatment with adolescent females. Research on treatment modalities is a persistent need as awareness of sexual abuse builds. Although empirical support for effective treatment is growing, research is still in development with this population. Future research may also examine the efficacy of combined treatment for this population. For example, some researchers have made suggestions of combining medication management with psychotherapy (Foa, Keane, & Friedman, 2000) and determining the effectiveness of integrating various treatment modalities. The counseling field plays a major role in treatment of sexually traumatized females and numerous areas of research can facilitate successful therapeutic outcomes.

### *Summary*

Although the trauma that adolescent female victims of sexual abuse have faced can never be undone, the victims may become high functioning survivors. Thus, it may be helpful to conceptualize the end goal of treatment as the facilitation of healing that leads to the transition from victim to survivor and from exhibiting symptomatology to exhibiting adaptive behavior rather than "curing" the trauma (Foa, Keane, & Friedman, 2000). Through the teaching, learning, and utilization of effective treatment methodologies, including same-gender survivors' groups, assertiveness skills training, art therapy, and family therapy, and EMDR counselors and counselor educators can work together to create an atmosphere where adolescent female survivors of sexual trauma may experience healing. Additionally, counselors and counselor educators should develop prevention programs that target those adolescents at-risk for sexual abuse, those that have been physically abused and or have a mentally ill mother. Using effective treatments to create a healing environment and developing prevention programs for those that

are at-risk simultaneously will work together to reduce the impact and occurrence of sexual traumatization.

### References

- Acierno, R., Hersen, M., Van Hasselt, V. B., Tremont, G., & Meuser, K. T. (1994). Review of validation and dissemination of eye-movement desensitization and reprocessing: A scientific and ethical dilemma. *Clinical Psychology Review, 14*, 287–299
- Alexander, P., Neimeyer, R. Follette, V., Moore, M. and Harter, S. (1989). A comparison of group treatments of women sexually abused as children. *Journal of Consulting and Clinical Psychology, 57*(4), pp.479-483.
- Apsche, J. A. Bass, C. K., & Murphy C. J. (2004): An Empirical Comparison of Cognitive Behavior Therapy (CBT) and Mode Deactivation Therapy (MDT) with Males with Conduct and/or Personality Traits and Sexually Reactive Behaviors - *The Behavior Analyst Today, 5* (4), Page 359
- Apsche, J.A., & Siv, A.M. (2005): Page 130: Mode Deactivation Therapy (MDT): A Theoretical Case Analysis on a Suicidal Adolescent -- *IJBCT 1* (2), Pg. 130.
- Apsche, J.A. & Ward Bailey, S.R. (2004): Mode Deactivation Therapy: A Theoretical Case Analysis (Part III) - *The Behavior Analyst Today, 5*(3), Page: 314
- Bagley, C. & LaChance, M. (2000). Evaluation of a family-based programme for the treatment of child sexual abuse. *Child & Family Social Work, 5*(3), 205-213.
- Bandler, R. & Grinder, J. (1979). *Frogs into princes*. Moab, UT: Real People.
- Beck, A. T. (1976). *Cognitive therapy and the emotional disorders*. New York: International Universities Press
- Berliner, L., & Elliott, D. M. (1996). Sexual abuse of children. In J. Briere, L. Berliner, J. A. Bulkly, C. Jenny, & T. Reid (Eds.), *The APSAC handbook on child maltreatment*, 51-71. Thousand Oaks, CA: Sage: Publications.
- Boney-McCoy, S., & Finkelhor, D. (1995). Psychological sequelae of violent victimization in a national youth sample. *Journal of Clinical and Consulting Psychology, 63*, 726-736.
- Brown, A.M. & Latimir, M. (2001). Between images and thoughts: An art psychotherapy group for sexually abuse adolescent girls. In J. Murphy (Ed.), *Art therapy with young survivors of sexual abuse: Lost for words* (pp. 184-200). New York: NY: Brunner-Routledge.
- Brown, C.A. (2004). Recovering identities: A narrative group guidebook for sexually abuse female adolescents. *Dissertation Abstract International, 65*(5-B), UMI 3133463.
- Briere, J. & Runtz, M. (1993). Childhood sexual abuse: Long-term sequale and implications for psychological assessment. *Journal of Interpersonal Violence. (8)*, 312-330.
- Carver, C., Stalker, C. Stewart, E. and Abraham, B. (1989). The impact of group therapy for adult survivors of childhood sexual abuse. *Canadian Journal of Psychiatry, 34*(8), 753-758.

- Compas, B. E., Howell, V. P., Phares, V., Williams, R. A., & Giunta, C. T. (1989). Risk factors for emotional/behavioral problems in young adolescents: A prospective analysis of adolescent and parental stress and symptoms. *Journal of Consulting and Clinical Psychology, 57*, 732–740.
- Corder, B. F. (2000). *Structured psychotherapy groups for sexually abused children and adolescents*. Sarasota, FL: Professional Resource Press.
- Donohue, B., Romono, V., & Hill, H.H. (2005). Treatment of co-occurring child maltreatment and substance abuse. *Aggression and Violent Behavior, 11*(6), 626-640.
- Feiring, C., Taska, L. & Lewis, M. (1999). Age and gender differences in children's and adolescents' adaptation to sexual abuse. *Child Abuse & Neglect, 23*(2), 115-128.
- Finkelhor, D. (1994). Current Information on the scope and nature of child sexual abuse. *The Future of Children, 4*(2), 46-48.
- Fleming, J., Mullen, P. & Bammer, G. (1997). A study of potential risk factors for sexual abuse in childhood. *Child Abuse & Neglect, 21*(1), 49-58.
- Foa, E. B., & Rothbaum, B. O. (1998). *Treating the trauma of rape: Cognitive-behavioral therapy for ptsd*. New York, NY: The Guildford Press.
- Foa, E. B., Kenae, T. M., & Friedman, M.J. (2000). *Effective Treatments for PTSD: Practice guidelines from the International Society for Traumatic Stress Studies*. New York, NY: The Guildford Press.
- Friedrich, W. N. (1996a). An integrated model of psychotherapy for abused children. In J. Briere, L. Berliner, J. Bullkely, C.Jenny, & T. Reid (Eds.). *The APSAC handbook on child maltreatment* (pp. 104-118). Thousand Oaks, CA: Sage.
- Green, A. H. (1996). Child sexual abuse in incest. In M. Lewis (Ed), *Child and Adolescent Psychiatry*, (2<sup>nd</sup> ed.), Baltimore, MD: Williams and Wilkins.
- Guerra, G. (2006). Guidelines and culturally sensitive implications when treating child sexual abuse within the Latino population. *Dissertation Abstracts International, 67*(10), 6056B. (UMI No. 3239721)
- Hazzard, A., Rogers, J., & Angert, L., (1993). Factors affecting group therapy outcome for adult sexual abuse survivors. *International Journal of group psychotherapy 43*(4), 453-468.
- Herbert, J. D., & Meuser, K. T. (1992). Eye movement desensitization: A critique of the evidence. *Journal of Behavior Therapy and Experimental Psychiatry, 23*, 169–174
- Herman, J. L. (1992). *Trauma and recovery*. New York, NY: Basic.
- Jehu, D. (1989). Mood disturbances among women clients sexually abused in childhood. *Journal of Interpersonal Violence, 4*(2): 164-84.
- Joiner, T. E., Sachs-Ericsson, N. J., Wingate, L. R., Brown, J. S., Anestis, M. D., Selby, E. A. (2007). Childhood physical and sexual abuse and lifetime number of suicide attempts: A persistent and theoretically important relationship. *Behavior Research and Therapy, 45*(3), 539-547.

- Kamsler, A. (1990). Her-story in the making: Therapy with women who were sexually abused in childhood. In M. Durrant and C. White (Eds.), *Ideas for therapy with sexual abuse*. Adelaide, South Australia: Dulwich Centre Publications.
- Kendall-Tackett, K. A., Williams, L. M., & Finkelhor, D. (1993). Impact of sexual abuse on children: A review and synthesis of recent empirical studies. *Psychological Bulletin*, 113(1), 164-180.
- Kilpatrick, D. G., Edmunds, C.N., & Seymour, A. (1992) *Rape in America: A Report to the Nation*. Arlington VA: National Victim Center.
- Lindon, J. & Nourse, C. A. (1993). A multi-dimensional model of groupwork for adolescent girls who have been sexually abused. *Child Abuse & Neglect*, 18(4), 341-348.
- Linehan, M. M. (1993). *Treating Borderline Personality disorder: The dialectical approach*. New York: Guilford Press.
- Lohr, J. M., Kleinknecht, R. A., Conley, A. T., dal Cerro, S., Schmidt, J., & Sonntag, M. E. (1992). A methodological critique of the current status of eye movement desensitization (EMD). *Journal of Behavior Therapy and Experimental Psychiatry*, 23, 159-167
- McEvoy, M. & Daniluk, J. (1995). Wounds to the soul: The experiences of aboriginal women survivors of sexual abuse. *Canadian Psychology*, 36(3), 221-235.
- McLeer, S. V., Callaghan, M., Henry, D., & Wallen, J. (1994). Psychiatric disorders in sexually abused children. *Journal of the American Academy of Child Adolescent Psychiatry*, 33(3), 313-319.
- Menard, S. (2002, February). *Short- and long-term consequences of adolescent victimization*, Research Report, Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention [OJJDP]: Youth Violence Research Series: Bulletin, NCJ 191210.
- Moon, L.T., Wagner, G.W. & Kazelskis, R. (2000). Counseling sexually abused girls: the impact of sex of counselor. *Child Abuse & Neglect*, 24(6), 753-765
- Murphy, J. (2001). *Art therapy with young survivors of sexual abuse: Lost for words*. Philadelphia, PA: Taylor and Francis Inc.
- Murray, J. B. (1993). Relationship of childhood sexual abuse to borderline personally disorder, posttraumatic stress disorder, and multiple personality disorder. *The Journal of Psychology*, 127(6), 657-676.
- Newman, B. M. & Newman, P. R. (2003). *Development through life: A psychosocial approach*. Belmont, CA: Wadsworth/Thomson Learning.
- Plunkett, A., Toole, B., Swanston, H., Oates, K., and Parkinson, P. (2001). Suicide risk following child sexual abuse. *Ambulatory Pediatrics* 1(5), 262-266.
- Porter, R., Wagner, W., Johnson, J., & Cox, L. (1996). Sexually abused girls' verbalizations in counseling: An application of the client behavior system. *Journal of Counseling Psychology*, 43, 383-388.

- Purivs, M. & Ward, T. (2006). The role of culture in understanding child sexual offending: Examining feminist perspectives. *Aggression and Violent Behavior*, 11(3), 298-312.
- Rachman, S. (1980). Emotional processing. *Behaviour Research and Therapy*, 18, 51-60.
- Richter, N., Snider, E. & Gorey, K.M. (1997). Group work intervention with female survivors of childhood sexual abuse. *Research on Social Work Practice*. 7(1), 53-69.
- Rodriguez, N. Ryan, S. W., Rowas, A.B., & Foy, D. W. (1996). Posttraumatic stress disorder in a clinical sample of adult survivors of childhood sexual abuse. *Child Abuse & Neglect*. (20), 943-952.
- Rothschild, B. (2000). *The body remembers: The psychophysiology of trauma and trauma treatment*. New York, NY: W. W. Norton & Company, Inc.
- Rowan, A. B., & Foy, D. W. (1993). Post-traumatic stress disorder in child sexual abuse survivors: A literature review. *Journal of Traumatic Stress*, 6(1), 3-20.
- Rowan, A. B., Foy, D. W., Rodriguez, N. & Ryan, S. (1994). Posttraumatic stress disorder in a clinical sample of adults sexually abused as children. *Child Abuse and Neglect*, 18, 51-61.
- Sapsford, L. (1997). Strengthening voices: A soulful approach to working with adolescent girls. *Women & Therapy*, 20(2), 75-87.
- Schore, A. (1996). The experience-dependent maturation of a regulatory system in the orbital prefrontal cortex and the origin of developmental psychopathology. *Development and Psychopathology*, 8, 59-87.
- Shapiro, F. (1989b). Eye movement desensitization: A new treatment for post-traumatic stress disorder. *Journal of Behavior Therapy and Experimental Psychiatry*, 20, 211-217
- Siegel, J. M., & Brown, J. D. (1988). A prospective study of stressful circumstances, illness symptoms, and depressed mood among adolescents. *Developmental Psychology*, 24, 715-721.
- Simmons, R. G., & Blyth, D. A. (1987). *Moving into adolescence: The impact of pubertal change and school context*. Hawthorne, NY: Aldine de Gruyter.
- Simmons, R. G., Blyth, D. A., Van Cleave, E. F., & Bush, D. M. (1979). Entry into early adolescence: The impact of school structure, puberty, and early dating on self-esteem. *American Sociological Review*, 44, 948-967.
- Simmons, R. G., Burgeson, R., Carlton-Ford, S., & Blyth, D. A. (1987). The impact of cumulative change in early adolescence. *Child Development*, 58, 1220-1234.
- Sloan, D. M., Marx, B. P., & Epstein, E. M. (2005). Further examination of the exposure modal underlying the efficacy of written emotional disclosure. *Journal of Consulting and Clinical Psychology*, 73(3), 549-554.
- Snyder, H. N. (2000, July). Sexual assault of young children as reported to law enforcement: Victim, incident, and offender characteristics: A NIBRS statistical report. Bureau of Justice Statistics, NCJ 182990.

- Stauffer, L. B., & Deblinger, E. (1996). Cognitive behavioral groups for nonoffending mothers and their young sexually abused children. *Child Maltreatment*, 1(1), 65-76.
- Sultan, F. & Long, G. (1988). Treatment of sexually/physically abused female inmate: Evaluation of an intensive short-term intervention program. *Journal of Offender Counseling Services & Rehabilitation*. 12(2), 131-143.
- Terr, L. (1994). *Unchained memories*. New York, NY: Basic.
- Threadcraft, H., & Wilcoxon, S. (1993). Mixed-gender group co-leadership in group counseling with female adult survivors of childhood sexual victimization. *The Journal for Specialists in Group Work*. 18(1), 40-44.
- Tjaden, P. & Thoennes, N. (2000, November). *Full report of prevalence, incidence, and consequences of violence against women*, Research Report, Washington, DC: U.S. Department of Justice, Office of Justice Programs, National Institute of Justice, NCJ 183781.
- Veysey, B.M., & Clark, C. (2004). Introduction: Responding to physical and sexual abuse in women with alcohol, other drug and mental disorders. *Alcoholism Treatment Quarterly*, 22(3/4),1-18.
- Wagner, W., Kilcrease-Fleming, D., Fowler, W., & Kazelskis, R. (1993). Brief-term counseling with sexually abused girls: The impact of sex of counselor on clients' therapeutic involvement, self-concept and depression. *Journal of Counseling Psychology*, 40, 490-500.
- Weldon, E.V. (1993). *Group analysis*. London, Thousand Oaks, CA and New Delhi: Sage.
- Westbury, E. & Tutty, L. (1999). The efficacy of group treatment for survivors of childhood abuse. *Child Abuse & Neglect*. 23, 31-44.
- White, M. (1995). *Re-authoring lives*. Adelaide, South Australia: Dulwich Centre Publications.
- White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. Adelaide, South Australia: Dulwich Centre Publications.
- Yalom, I. & Leszcz, M. (2005). *The theory and practice of group psychotherapy*. New York: NY: Basic Books.
- Wilson, S. A., Becker, L. A., & Tinker, R. H. (1995). *Eye Movement Desensitization and Reprocessing (EMDR) Treatment for Psychologically Traumatized Individuals*. *Journal of Consulting and Clinical Psychology*, 63(6), 928-937.

**Author Contact Information:**

Dr. Lee A. Underwood  
Regent University,  
1000 University Drive,  
Virginia Beach, Virginia, 23464.  
Email: [leeunde@regent.edu](mailto:leeunde@regent.edu).



**Authors' Notes**

Lee A. Underwood, Psy.D., Licensed Clinical Psychologist, Regent University and the National Center for Mental Health and Juvenile Justice (NCMHJJ).

Dr. Lee A. Underwood serves as an Assistant Professor with Regent University School of Psychology and Counseling and is a Senior Consultant for the National Center for Mental Health and Juvenile Justice, an affiliate of Policy Research Associates (PRA).

Sarah E. Stewart, MA is Ph.D. student in Counselor Education and Supervision Program at Regent University Scholl of Psychology and Counseling.

Anita M. Castellanos, MA is a Ph.D. student in the Counselor Education and Supervision Program at Regent University School of Psychology and Counseling.

Dr. Lee A. Underwood may be written at Regent University, 1000 University Drive, Virginia Beach, Virginia, 23464. Electronic mail may be sent via Internet to [leeunde@regent.edu](mailto:leeunde@regent.edu).

---

**ADVERTISING IN THE  
INTERNATIONAL JOURNAL OF BEHAVIORAL CONSULTATION AND THERAPY**

**The prices for advertising in one issue are as follows:**

**1/4 Page: \$50.00    1/2 Page: \$100.00    Full Page: \$200.00**

**If you wish to run the same ad in multiple issues for the year, you are eligible for the following discount:**

**1/4 Pg.: \$40 - per issue  
1/2 Pg.: \$75 - per issue  
Full Page: \$150.00-per issue**

**An additional one time layout/composition fee of \$25.00 is applicable**

**For more information, or place an ad, contact Halina Dziewolska by phone at (215) 462 - 6737 or e-mail at: [halinadz@hotmail.com](mailto:halinadz@hotmail.com)**