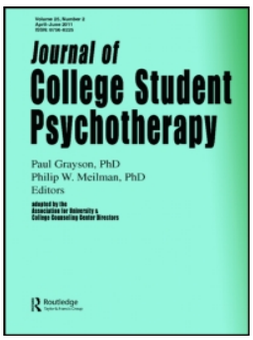

Journal of College Student Psychotherapy

ISSN: 8756-8225 (Print) 1540-4730 (Online) Journal homepage: http://www.tandfonline.com/loi/wcsp20

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To cite this article: Tiffany M. Artime & Katherine R. Buchholz (2016) Treatment for Sexual Assault Survivors at University Counseling Centers, Journal of College Student Psychotherapy, 30:4, 252-261, DOI: 10.1080/87568225.2016.1219610

To link to this article: http://dx.doi.org/10.1080/87568225.2016.1219610

Published online: 28 Sep 2016.

JOURNAL OF COLLEGE STUDENT PSYCHOTHERAPY
2016, VOL. 30, NO. 4, 252–261
http://dx.doi.org/10.1080/87568225.2016.1219610

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Treatment for Sexual Assault Survivors at University Counseling Centers

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ABSTRACT

University Counseling Centers (UCCs) provide important services for sexual assault survivors, yet little research has been conducted on interventions used by clinicians in this unique setting. As a preliminary investigation, UCC professionals were asked about services provided to survivors of sexual assault and staff perceptions of the effectiveness of these interventions. Supportive counseling was perceived to be the most effective relative to other interventions, and many participants indicated that they did not use or were not sure if other evidence-based interventions were effective with student victims. Several recommendations for future research on sexual assault services in UCCs are suggested.

KEYWORDS

College students; counseling; mental health; sexual assault; trauma

Since the reauthorization of the Violence Against Women Act in 2013, federal and state governments have increased pressure on campuses to attend to the epidemic of sexual assault. Estimates from the National Crime Victimization Survey, Campus Sexual Assault Study and other studies indicate an alarming prevalence of sexual assault perpetrated against students, with 5% of women experiencing an attempted or completed rape during any 1-year period, and 20%–25% of women and 6% of men reporting being assaulted at some point during college (Fisher, Cullen, & Turner, 2000; Humphrey & White, 2000; Krebs, Lindquist, Warner, Fisher, & Martin, 2007; Sinozich & Langton, 2014).

A call to action

The White House has called for improvements in campus responses to students who have been sexually assaulted (White House Task Force to Protect Students from Sexual Assault, 2014), including mental health services. The majority of sexual assault survivors experience various negative acute and/or chronic consequences following sexual victimization including emotional distress, depression, anxiety, post-traumatic stress, dysfunctional beliefs, shame, avoidance, dissociation, interpersonal problems, sexual dysfunction, substance abuse, physical

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injuries, somatic complaints, and revictimization (e.g., Calhoun, Mouilso, & Edwards, 2012; Rothbaum, Foa, Riggs, Murdock, & Walsh, 1992). Although there are barriers to service utilization among sexual assault survivors who are experiencing psychological distress, research has shown that 8% of student survivors used psychological services within the year (Nasta et al., 2005). A review of studies that have examined service utilization among sexual assault survivors demonstrated that findings vary considerably by the demographic characteristics and size of the samples, type of assault, and the services sought (Sabina & Ho, 2014). Among the studies reviewed, 4%–42% of survivors who had experienced a campus sexual assault sought mental health services during college; which is obviously a wide range that may depend on methodology, type of assault, and type of services. In one study, among college students who had been sexually assaulted, 20% of victims selected on-campus services compared to 6% of victims using off-campus services (Nasta et al., 2005; Sabina & Ho, 2014). These studies highlight the importance of on-campus treatment to address students' mental health needs after sexual victimization.

Although this need may be apparent, there is a lack of research investigating services actually provided. In fact, other than measures of satisfaction, evaluation of the helpfulness of campus mental health services for sexual assault survivors is absent from the literature (Sabina & Ho, 2014). Outside of the University Counseling Center (UCC) setting, mental health researchers have identified many effective, evidence-based interventions for the immediate and long-term sequelae of psychological reactions to sexual assault including treatments such as Cognitive Processing Therapy, Prolonged Exposure, and Trauma-Focused Cognitive Behavioral Therapy (Foa, Keane, Friedman, & Cohen, 2008; Neville & Heppner, 2002; Russell & Davis, 2007). However, it is not clear if these treatments are being utilized in UCCs and if they are similarly effective in these settings (Kress, Williams, & Hoffman, 2007). Mental health professionals in UCC settings may approach treatment differently than community or hospital-based clinicians given unique factors associated with college students such as the high rate of alcohol-facilitated and acquaintance-perpetrated sexual assaults, developmental considerations of young adults, and session limits in UCCs (Hensley, 2002; Klump, 2006; Kress et al., 2007). Therefore, it is important to evaluate their perceptions of what has been effective in order to guide efforts to disseminate evidence-based practices to this setting.

The present study

In response to the national pressure to improve campus responses to survivors of sexual assault, the present study sought to preliminarily investigate the nature of sexual assault services at UCCs by collecting information from UCCs about three main questions: (a) what services do UCCs commonly provide to sexual assault victims, (b) what are the credentials and trauma-

focused training of clinicians providing sexual assault services in UCCs, and (c) what are the mental health professionals' perceptions of the effectiveness of the counseling interventions they use with victims of sexual assault.

Method

Procedure and measure

Mental health professionals employed by UCCs in the United States were recruited with an e-mail sent out to several professional listservs for college counseling professionals (APA Division 17 Society for Counseling Psychology, Association for Counseling Center Training Agencies, and the Association for University and College Counseling Center Directors). The study was screened by the Washington State University Institutional Review Board and found to be exempt. Participants responded by completing an anonymous online questionnaire administered through www.surveymonkey.com.

The survey was composed of items developed for this study assessing the characteristics of the institution and counseling center, the credentials and training of staff involved in sexual assault response, and the UCC's procedures for responding to victims of sexual assault. Additionally, perceived treatment effectiveness was measured by a Likert-type scale asking participants to rate from 1 (*least effective*) to 5 (*most effective*), or *N/A, Don't Know* to what extent various interventions have been effective in treatment of student sexual assault based on their experiences in their college counseling center setting. The interventions included supportive counseling, stress management, general cognitive-behavioral interventions, group treatment, Cognitive Processing Therapy, Prolonged Exposure, Eye Movement Desensitization and Reprocessing Therapy, and Psychological First Aid. An "other" option was provided with an opportunity to specify other interventions used to treat survivors of sexual assault. A qualitative item ended the survey asking what else the participant has found useful/effective for supporting and treating survivors of sexual assault on campus. Items were selected by mental health professionals working in a UCC who were interested in improving their own services by understanding the norms of other institutions and the perceptions of other UCC clinicians.

Participants

Participants included 69 mental health professionals representing various types of colleges and universities; 64% of respondents worked at a public institution and 32% of respondents worked at a private institution. The largest proportion of participants represented large universities of 15,000 students or more (n = 31, 45%), and the remaining professionals came from midsize or smaller institutions composed of 7,500–15,000 students

(n = 21, 30%), 2,500–7,500 students (n = 12, 17%), and under 2,500 students (n = 5, 7%). Counseling centers employed a range of 2.5–30 FTE clinicians, M = 9.74 (SD = 6.35). The number of sexual assault victims seen in each UCC ranged from 2 to 460, M = 67.8, SD = 118.2.

Results

Results for the first goal of the study, describing the kinds of services provided by UCCs to victims of sexual assault, demonstrated that 35% of participants indicated their UCC employs a specific person or group who handles sexual assault response and 20% refer sexual assault victims to off-campus resources for counseling. The majority of participants indicated that their UCC provides crisis response immediately following a sexual assault (97%), treatment during the acute period (within 4 weeks) of distress following an assault (87%), treatment during the 1–3 months following an assault (87%), and treatment for more chronic problems existing more than 3 months after the assault (84%). A large number of UCCs (71%) provide services for victims during sexual assault investigations. Approximately half (52%) had session limits for counseling sexual assault victims and 45% offered unlimited sessions. None of the participants indicated that their UCC does not provide services for sexual assault victims.

The second goal of the study was to describe the credentials and training of clinicians who provide services to sexual assault victims in UCCs. Participants indicated that their UCCs employ a wide variety of mental health and medical professionals who provide services to sexual assault victims. The majority of UCCs utilize psychologists (83%) and doctoral interns (62%) to provide sexual assault services. UCCs also provide sexual assault services through a variety of other mental health professionals including social workers (54%), graduate practicum students (49%), master's level counselors (44%), master's level mental health professionals (41%), psychiatrists (36%), registered nurses or nurse practitioners (15%), family therapists (9%), and internal medicine physicians (3%). A small number of participants (n = 7, 10%) listed "other" professionals including post-doctoral fellows, sexual assault victim advocates, sexual assault nurse examiners (SANE), sexual assault crisis counselors, volunteers, and health educators. A slight majority (54%) of UCCs indicated that they provide "specialized" training for the treatment of sexual assault to service providers, and a minority (44%) of UCCs provide "specialized" training for the treatment of post-traumatic stress disorder (PTSD).

The third goal of this study was to assess mental health providers' perceptions of the effectiveness of the counseling interventions they use with victims of sexual assault. Of the eight therapies rated by participants, supportive counseling had the highest average rating of perceived effectiveness (M = 4.56, SD = .67), and prolonged exposure had the lowest average rating

Table 1. Mean Perceived Effectiveness Ratings for Each Type of Intervention.

	Mean (*SD*)	Range	N = "N/A, Don't Know"
Supportive counseling	4.56 (.67)	3–5	6
Psychological first aid	4.02 (.82)	2–5	32
Group treatment	3.94 (1.0)	1–5	31
Cognitive processing therapy	3.81 (.83)	2–5	24
Stress management	3.74 (.88)	2–5	11
General cognitive-behavioral interventions	3.73 (1.0)	1–5	12
Eye movement desensitization & reprocessing	3.13 (1.32)	1–5	45
Prolonged exposure	2.84 (1.42)	1–5	35
Other	4.40 (.52)	4–5	

Note. Ratings based on a scale from 1 *(least effective)* to 5 *(most effective)*.

of perceived effectiveness (M = 2.84, SD = 1.42). Many of the participants indicated that they did not use these interventions (N/A) or did not know if they were effective or not. Means, ranges, and number of "N/A, I don't know" responses for all interventions can be found in Table 1.

In response to an open-ended question inquiring about what else they have found useful and effective for supporting and treating survivors of sexual assault on campus, participants' comments fell into three main categories—interventions, services, and other strategies. Interventions that participants found helpful included psychoeducation, connecting clients to campus/community resources, using a combination of trauma-focused protocols and supportive counseling, prescribing antidepressants, providing written materials, group counseling, sensorimotor and dynamic work, care management, and providing referrals. Noncounseling services connected to UCCs that participants included as helpful were employing advocates to interface with other campus entities, the legal authorities, and medical professionals; establishing separate centers for sexual assault, women, violence prevention, veterans, and addictions; and offering after-hours, 24-hour crisis services. Some participants suggested other campus programs that they also perceived as effective in supporting sexual assault victims including outreach and prevention programming, bystander education, staff/faculty/administration education, peer and student ally programs, and encouraging victims to volunteer for outreach.

Discussion

The present study was a preliminary investigation of services for sexual assault victims and mental health professionals' perceptions of the effectiveness of the services they offer at UCCs in the United States. All respondents reported that their UCC provides some form of service to sexual assault victims, but one fifth of UCCs are referring victims to off-campus counseling services. According to responses received by participants, most UCCs are providing acute and ongoing services following the occurrence of a sexual

assault. Half of UCCs are restricted by session limits sometimes as short as three to six sessions for clients, which necessitate brief and time-limited approaches to treatment. There have been few studies that have evaluated brief therapies for trauma or sexual assault (e.g., Foa, Zoellner, & Feeny, 2006), and the resource constraints of UCCs suggest that they would benefit from further research in this area.

These results also suggest that UCCs employ a wide variety of mental health and medical professionals for sexual assault services. Such interdisciplinary services are likely accompanied by many benefits and challenges that are somewhat unique to the campus setting. Only half of UCCs have formal training for clinicians treating sexual assault or PTSD. Perhaps this is because they hire professionals who are already qualified, trained, and experienced. However, it may also indicate that the mental health professionals in UCCs are not being properly equipped to provide effective services to sexual assault victims due to resource limitations or other factors.

On average, providers perceive supportive counseling to be the most effective treatment for victims of sexual assault. Other evidence-based treatments, including Cognitive Processing Therapy, trauma-focused cognitive behavioral interventions, and Eye Movement Desensitization and Reprocessing Therapy were rated moderately effective on average despite these being the recommended treatments for trauma-related problems by the International Society for Traumatic Stress Studies (Foa et al., 2008; Vickerman & Margolin, 2009). These results may reflect the fact that many UCC clinicians are providing services to sexual assault victims who do not meet criteria for PTSD and/or may perceive supportive counseling as useful for early rather than more structured interventions. Psychological First Aid, an evidence-based early intervention, had the second highest average ratings, which may support these explanations. The rating may also be unique to the small sample recruited for this study thus not generalizing to the perceptions of most clinicians in UCCs.

Additionally, respondents had high ratings of group treatment as an intervention for survivors of sexual assault. There are many types of group interventions, some of which utilize evidence-based strategies (e.g., Cognitive Processing Therapy in group format), which may be used in UCCs with strong group programs and which may enable UCCs to overcome some resource limitations as one or two mental health professionals can provide services to multiple clients. More specific information needs to be gathered about the types of group treatment being used and their effectiveness in helping survivors.

What was particularly noteworthy was the large number of participants who endorsed the "N/A, Don't Know" option when rating the effectiveness of the listed interventions. Among the standardized treatments, the number of participants endorsing "N/A, Don't Know" ranged from 24–45, large proportions of

participants for each intervention rating. Given the nature of the item, it is not possible to distinguish whether participants were indicating that their UCC does not use this intervention or whether they do not know if the intervention is effective. For the former, these results may indicate that UCC clinicians are refraining from using these treatment and further research is needed to determine why evidence-based treatments are not being used. If participants endorsing the "N/A, Don't Know" option are expressing a lack of knowledge about the effectiveness of these interventions in their UCC, it is possible that they do not have outcome measures in place to evaluate their effectiveness. Indeed, two respondents wrote, "We have not formally assessed the effectiveness of any one of the treatment approaches listed," and "It is very difficult for me to comment on how effective these interventions have been across clinicians. We are more individualized than that." The lack of campus-specific program evaluation of trauma-focused interventions reflects its absence from the wider literature as well.

Limitations

There are many limitations of this study, which provide support for needing further research in this area. The sample was a convenience sample and results may reflect a selection bias of mental health professionals who were more interested or knowledgeable about the sexual assault services provided by their UCCs. The sample of UCCs was also very small (69 participants) and is also not proportionately representative of UCCs at institutions in the United States, though the sample did contain professionals from diverse colleges ranging in size and affiliation. Perceptions of effectiveness may be largely anecdotal, and there is no way to determine if they were based on outcome data gathered by UCCs. Furthermore, combining the effectiveness rating option of "N/A" and "Don't Know" prevents any clear inferences to be made about the meaning of the large number of endorsements of this option. Perceptions of these interventions are likely informed by the clinicians' theoretical orientation, which was not assessed. For example, it may be difficult or not applicable to clinicians who work within an eclectic or integrative approach to rate the effectiveness of individual interventions. In order to preserve the anonymity of the study, we were also unable to ensure that multiple professionals did not respond from each school.

Recommendations and future directions

Based on these preliminary descriptive results, we can make several recommendations, especially for future research. First, victims of sexual assault are presenting to all UCCs with a variety of needs depending on the time since the assault. Colleges and universities are uniquely positioned to provide supportive responses to survivors by coordinating among the many parties that might be involved, and UCC professionals can play a critical role in this coordination.

Many of the qualitative responses to the survey highlighted the variety of departments and people involved in sexual assault response on campus. Clinicians need specialized training in using trauma-informed approaches to negotiating the complex systems involved in campus sexual assault response and supporting students in accessing the appropriate resources.

Regarding treatment selection, a large number of UCCs have session limits and resource restrictions, necessitating the adaptation of short-term, brief evidence-based trauma-focused practice to the UCC setting. Additionally, there seems to be a disconnect between treatment recommendations found in the literature for evidence-based, trauma-focused therapies and their use with sexual assault victims in UCCs. In part, this lack of implementation could be related to the perceptions mental health providers have about the usefulness of these interventions for their student survivors, clinicians' theoretical orientations which may be perceived as incompatible with adopting these interventions, and the feasibility of administering these interventions within the UCC setting. Research which informs the adaptation of evidence-based therapies for the UCC setting and specific trainings for clinicians about sexual assault and trauma-focused interventions may help to change these perceptions (Foa, Gillihan, & Bryant, 2013). Additionally, connecting the clinicians' individual approaches in psychotherapy to the best practices in trauma-focused interventions can help to bridge these gaps of difference. As modeled in some other settings such as VA hospitals and clinics, a strategic approach to implementation could provide a pathway to the adoption of evidence-based practices in UCCs by evaluating barriers to implementation and training mental health professionals in these evidence-based interventions.

Most importantly, systematic and controlled efficacy and effectiveness research on the use of evidence-based, trauma-focused treatments needs to be conducted in the UCC setting and with special populations including college students, men, sexual minority clients, international students, student veterans, and racially diverse clients. Program evaluation of sexual assault services needs to be conducted at the institutional level, and randomized control trials implementing adaptations of trauma-focused therapies need to be conducted at the national level. This research can help to ensure that the most effective and sensitive services are being provided to survivors of campus sexual assault.

Acknowledgments

This research was conducted as part of Dr. Artime's predoctoral internship at the Washington State University Counseling and Psychological Services under the supervision of Dr. Susan Simonds.

Funding

Writing of this article was supported by the Department of Veterans Affairs Office of Academic Affiliations, Advanced Fellowship Program in Mental Illness Research and Treatment, the Veterans Affairs Ann Arbor Health Care System, and the Veterans Affairs Serious Mental Illness Treatment Resource and Evaluation Center (SMITREC).

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