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Counseling Competencies for Child Maltreatment Risk Assessment and Management

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UNIVERSITY OF NORTHERN COLORADO

Greeley, Colorado

The Graduate School

COUNSELING COMPETENCIES FOR CHILD MALTREATMENT
RISK ASSESSMENT AND MANAGEMENT

A Dissertation Submitted in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Philosophy

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College of Education and Behavioral Sciences
Department of Applied Psychology and Counselor Education
Counselor Education and Supervision

August 2015

This Dissertation by: Janessa Marie Parra

Entitled: *Counseling Competencies for Child Maltreatment Risk Assessment and management*

has been approved as meeting the requirement for the Degree of Doctor of Philosophy in College of Education and Behavioral Science in School of Applied Psychology and Counselor Education, Program of Counselor Education and Supervision.

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ABSTRACT

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Child maltreatment is a widespread epidemic that has relevance to the work of counselors. The counseling profession has not yet established a set of standards that provide comprehensive guidance on how to prepare counselors to work with clients impacted by child maltreatment. The purpose of this dissertation study was to discover the domains and competencies necessary to prepare master's-level counselors to assess and manage the risk of child maltreatment with clients. Twenty counseling and five non-counseling experts participated in this multi-round Delphi study. These expert participants provided their opinions through a series of three structured surveys. Expert-participants created and reached consensus on a list of 45 competencies across four domains that detailed the necessary knowledge and skills required of counselors to assess the risk and manage the impact of child maltreatment in their clients. Counseling training programs can begin to incorporate these competencies into their programs as a way to address the current lack of training on child maltreatment.

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CHAPTER I

INTRODUCTION

In 2011, Child Protection agencies in the United States received an estimated 3.4 million referrals involving approximately 6.2 million children (U.S. Department of Health & Human Services, [USDHHS], 2012). Additionally, the statistics describing the number of referrals likely do not fully capture the prevalence of child abuse and neglect. In this dissertation study, child maltreatment refers to abuse and neglect. According to Child Protective Services (CPS) surveys, reports to CPS may underestimate the true occurrence of child abuse and neglect (Finkelhor, Turner, Ormrod, Hamby, & Kraek, 2009). In a national sample, Finkelhor and associates (2009) found that one in seven children between the ages of infancy and 17 experience child maltreatment, and many of these instances may go unreported.

Of those referrals to CPS, mandated professionals made 57.6%, while mental health professionals made only 4.7% (U.S. Department of Health & Human Services, [USDHHS], 2012). Considering the many ways in which mental health professionals are involved in communities and with families, the percentage of reports these clinicians made seems extremely low. Studies have shown that professionals in the mental health fields underreport child maltreatment for a variety of reasons despite the potential consequences to children and to themselves (Alvarez, Kenny, Donohue, & Carpin, 2004; Bavolek, 1983; Faller, 1985; Hinson & Fossey, 2000). Bearing in mind the low

percentage of reports mental health professionals made to CPS compared to other groups of mandated reporters, coupled with evidence indicating many unreported cases of child abuse and neglect, there is an exigent need to increase the competency of mental health professionals to recognize and respond to child abuse and neglect.

Determining what competencies are necessary to work with both children and adult clients before, during, and after a child maltreatment report is the first step toward this goal of improving services to children and families involved with child maltreatment. Competence can be defined as “an individual’s capability and demonstrated ability to understand and complete certain tasks in an appropriate and effective manner consistent with the expectations for a person qualified by education and training in a particular profession or specialty thereof” (Kaslow, 2004, p. 775). Furthermore, competency is discipline specific (Kaslow, 2004). The field of mental health encompasses a wide array of disciplines—psychology, counseling, and social work, as well as all of their specialties—and reflects diverse training and practice levels. Therefore, the purpose of this study is to build on the work done in psychology to inform the development of competencies that are specific to the training of master’s-level counselors in child maltreatment risk assessment and management. These competencies are meant to set a standard for counselors to assess and manage the risk of child maltreatment with any child or adult client, including victims and perpetrators of child maltreatment. In this study, the assessment for risk of child maltreatment is defined as identifying if the client is experiencing child maltreatment (either as a victim or as a perpetrator), gathering enough information to make the decision to report, and the actual act of reporting to

Child Protective Services. Impact management of clients experiencing child maltreatment is defined as advocating for the client during and after the risk assessment and continuing a working relationship with the client once the risk assessment is over.

Background and Context

For most professionals, including counselors, the mandated reporting of child abuse and neglect is both a legal and an ethical obligation. Beyond the mandate to report, counselors also have the responsibility to competently serve clients and protect client welfare (American Counseling Association [ACA], 2014). In order to fully understand the complexity of the role of counseling in child maltreatment, the exploration of the history and current context of child maltreatment is necessary. When this obligation for counselors was first introduced, researchers focused on facilitating mandated reporting for professionals because federal and state laws concentrated on identification of child maltreatment. Today, federal and state laws also focus on family preservation and treatment, which requires counselors to take a more active role in child maltreatment risk assessment and management. The history of child protection legislation is presented in order to highlight the increasing demand for counselors to become more active in working with clients impacted by child maltreatment.

History

Child abuse and neglect is a worldwide epidemic that has only in recent history been recognized as preventable (Lynch, 1985). According to Lynch (1985), in the early 1900's, authors wrote about child abuse to give advice to pediatricians and young mothers; however, the medical field did not recognize it as a problem at that time. In

1962, Kempe and colleagues published a description of the battered child syndrome, defining it as “a clinical condition in young children who have received serious physical abuse” (Kempe, Silverman, Steele, Droegemueller, & Silver, 1962, p. 105). This publication ignited a movement to protect children and prevent further abuse (Lynch, 1985; U.S. Department of Health & Human Services, 2010). As a result of this landmark article, authors in other countries began publishing work describing the implications of child abuse and neglect (Lynch, 1985).

With the medical field increasing the focus of research on non-accidental injuries on children, individual states and the federal government started to make systematic attempts to control this pandemic through identification and prevention. After Kempe and his colleagues published the seminal article in 1962, the Children’s Bureau began pushing for states to require medical professionals to report suspected abuse, officially classifying child abuse as a medical condition (Levine, et al., 1995). By 1967, all states had deliberated on the importance of reporting laws (Myers, 2008) in the hope that abused children would be identified and parents would be prosecuted for the abuse. In 1974, the federal government took an active role in managing this epidemic through the enactment of the Child Abuse Prevention and Treatment Act (CAPTA) (U.S. Department of Health & Human Services, 2010). This legislation guided child protection and provided funding to states to improve investigation and reporting of allegations of abuse and neglect (*Child Abuse Prevention and Treatment Act of 1974*, 1974). The expectation was that more professionals would begin reporting the abuse they suspected. Nationally, CAPTA set the standard for state reporting laws, and states subsequently began to expand

their reporting laws to include a variety of mandated reporters to the list (Kalichman, 1999). States established statutes identifying specific individuals required to report child maltreatment (Child Welfare Information Gateway, 2012; Levine et al., 1995; Weinstein, Levine, Kogan, Harkavy-Friedman, & Miller, 2000). By the mid-1970s, the reporting statutes included mental health professionals and others in helping professions (Levine et al., 1995).

Since the 1970s, this trend of research influencing legislation has continued. In the decades that followed, researchers began focusing on the different types of child maltreatment and their impact on the developing child (Bryer, Nelson, Miller, & Krol, 1987; Hart, Germain, & Brassard, 1987; K.A. Kendall-Tackett, Williams, & Finkelhor, 1993; Sedlak & Broadhurst, 1996). Authors also started to recognize the effects of foster care placement and the impacts of aging out of foster care (Barth, 1991; Children's Bureau, n.d.). Therefore, the focus of legislation shifted from the removal of children in dangerous situations—per the regulation of CAPTA in 1974—to finding permanent homes—an enactment of the *Adoption Assistance and Child Welfare Act of 1980*—to family preservation and stability—an implementation of the *Adoption and Safe Families Act* (1997). Each of these laws added a step toward not only preventing abuse but also treating families and children impacted by child maltreatment. Further amendments to the national laws subsequently caused states to change their laws; for example, in 1988, The *Child Abuse Prevention, Adoption, and Family Services Act* broadened the types of maltreatment included in the definition, which included physical or mental injury, sexual

abuse, sexual exploitation, and maltreatment. This clarification caused states to include other mandated reporters in their law (Kalichman, 1999).

Overall, the focus of child protection moved from safeguarding children to the preservation of the family system. With each subsequent act, services for family members increased. In 2001, *Promoting Safe and Stable Families Amendments of 2001* brought recognition to healthy marriages and parental relationships as protective factors toward reducing the incidence of child maltreatment. Funding was allocated for therapeutic treatment of children and their families (Promoting Safe and Stable Families, 2001). The *Keeping Children Safe Act* (2003) and *Fostering Connections to Success and Increasing Adoptions Act of 2003* both addressed the impacts of child maltreatment. These acts increased the services offered to children involved within the system, expanding educational, medical, and mental health support. Altogether, these legislative changes have increased the role of mental health providers in individuals and families involved with child maltreatment.

In 2010, CAPTA was reauthorized, requiring states to review their laws, practices, policies, and procedures to ensure the protection of children. The law encouraged states to identify infants with Fetal Alcohol Spectrum Disorder (FASD), increase collaboration with domestic violence services, and utilize the practice of differential response (*Child Abuse Prevention and Treatment Act (CAPTA) of 2010*, 2010). As discussed above, every change to the national law creates new amendments to state laws.

With the focus on domestic violence, FASD, and differential response, the role of professional counselors in promoting safety in families and collaborating with CPS has increased. The increasing recognition of widespread child maltreatment, combined with the legislative demands for the treatment of these individuals and their families, necessitates that counselors become competent to service clients impacted by child maltreatment.

Current Context

The past 40 years has produced an increased awareness of child maltreatment. This has led to the passing of legislation that supports the prevention of child abuse and the treatment of children and families impacted by it. With the increase in funding directed toward research for improving care for children and families involved within Child Protective Services, researchers are now moving beyond a focus on mandated reporting as the only source of prevention (e.g. Dempsey & Day, 2011; Fergusson, Boden, & Horwood, 2008; Graham et al., 2010; Wolfe & McIsaac, 2011). Today, researchers are focusing on the impacts of child maltreatment on the family system (e.g., Dempsey & Day, 2011; Wolfe & McIsaac, 2011). Current studies are also concentrating on the utilization of family resilience to overcome the systemic stress of child maltreatment (e.g., Walsh, 2003)

The role of counselors in the child protection system is dependent on the practices of the Child Welfare System as a whole. Along with the legislation, many state Child Welfare Systems are moving toward strength-based approaches with families (National Technical Assistance and Evaluation Center for Systems of Care, 2008). According to

Epley, Summers, & Turnbull, (2010), family-centered practice—which the researchers defined as the practice of providing family choice, focusing on the family unit, and focusing on family strength—has become increasingly common. Families are now given the opportunity to utilize their strengths to overcome family stressors (National Technical Assistance and Evaluation Center for Systems of Care, 2008). Family group meetings that include all family members and professionals involved in the process are now common activities within family-centered practice within CPS (Epley, et al., 2010; National Technical Assistance and Evaluation Center for Systems of Care, 2008). The increasing participation of families in the child protection system suggests that families are in need of advocacy and support. The role of the counselor in this strength-oriented system can no longer be limited to mandated reporting requirements; clients need a caring, familiar advocate who can help them find their strength and resilience.

Building off the concepts of family-centered practice, Walsh (1996) developed the theory of family resilience: the ability for a family system to survive and recover from disruptive life challenges. Looking beyond the individual for resilience, Walsh focused on the family as a functional unit (1996), suggesting that accessing crucial family processes of resilience can help families become stronger and more capable in meeting future challenges (Walsh, 2003). These two strength-based approaches—family-centered practice and family resilience framework—provide evidence that pathologizing families is an approach of the past. Counselors need to be prepared to work within this resilience-focused belief system and become advocates for the individuals and families with whom

they are working. Mandated reporting is only a small part of the responsibility counselors have when working with families experiencing child maltreatment.

Over the past few decades, researchers have focused on mandated reporting practices and the training of professionals to complete their ethical and legal obligation; very few studies move beyond mandated reporting when discussing training needs for professionals (Allen & Crosby, 2014; Alvarez et al., 2004; Levine et al., 1995; Sigel & Silovsky, 2011). Currently, training on child maltreatment is lacking and does not adequately prepare counselors to protect client welfare (Milton & Pease-Carter, 2011; Wachter Morris & Barrio Minton, 2012). More research needs to be done to clarify the role of counselors in this process and the training requirements that will ensure competence in working with clients through this process.

The psychology profession has shifted from focusing solely on training on reporting practices to focusing on client welfare when working with clients affected by child maltreatment. In 1996, the American Psychological Association (APA) implemented a task force to standardize training for mandated reporting of child maltreatment (Damashek, Balachova, & Bonner, 2011). APA recommended teaching definitional issues, prevalence and consequences of child abuse and neglect, developmental theories of behaviors in adults who abuse and neglect children, recognition of abuse and neglect, legal involvement, medical and mental health professionals' intervention practices, and CPS' response mechanisms (Damashek et al., 2011). The purpose of the task force was to increase awareness of child maltreatment and to increase the number of reports psychologists made to CPS.

Since 1996, the literature in the psychology profession has evolved beyond increasing mandated reporters' disclosures to focusing on risk assessment and management of child maltreatment. In order to address psychologists' roles in detecting and treating child abuse and neglect, Damashek and associates (2011) added to the work of the 1996 task force to create competencies for training psychologists in the field of child maltreatment. The authors produced a conceptual article that focused on eight core areas, including assessment, treatment, multidisciplinary collaboration, advocacy, professional ethics, research, research ethics, and professional development (Damashek et al., 2011). The authors discussed competencies at the knowledge, skill, and attitude levels (Damashek et al., 2011). These competencies represent an important step toward standardizing training in the mental health field; however, there is still a gap in the research for the training needs of counselors on child maltreatment risk assessment and management.

Distinguishing the training needs of counselors from those of psychologists is as difficult a task as defining counseling as a separate entity from psychology; in fact, many would argue that there is no difference between the professions (Hanna & Bemak, 1997). Therefore, the training should be the same. Others, however, see a clear and distinguishable difference (Ponton & Duba, 2009). Psychologists tend to use a medical model of diagnoses, pathology, and medications (Duffey & Somody, 2011). Furthermore, psychologists are licensed at the doctoral level, while counselors only require a master's degree to be licensed (Duffey & Somody, 2011). The counseling profession is most concerned with positive human change (Van Hesteren & Ivey, 1990), and its wellness

perspective and developmental, contextual focus distinguish it from other mental health disciplines (Duffey & Somody, 2011).

Considering this difference, it is important to engage in a process to determine both the degree to which the established competencies fit for the training of counselors and allow for the establishment of discipline-specific competencies. Perhaps the missing pieces from Damashek, and colleague's (2011) competencies for psychologists may include focusing on family resilience factors and building on family strengths to help individuals and families overcome the crisis of child maltreatment (Walsh, 2003).

Counseling competencies may also focus on maintaining or rebuilding the therapeutic relationship, as that is an extremely important factor in the field (Grencavage & Norcross, 1990) and a common barrier to reporting among professionals (Alvarez, Donohue, Kenny, Cavanagh, & Romero, 2005; Levine et al., 1995). Similarly, opportunity for catharsis is also an important factor in counseling (Grencavage & Norcross, 1990), and Damashek, and colleague's (2011) did not present this consideration in their competencies. Damashek, and colleagues (2011) focused on training with evidenced-based practices in working with families; however, when developing competencies for counselors, instilling preparation techniques to maintain an open, non-judgmental attitude with clients and families experiencing child maltreatment and in need of catharsis is a component that may also be particularly relevant. When considering the different focus of professional counselors and psychologists, it is clear that training for counselors needs to focus not only on the individual but also his or her family, community, and culture. Competencies developed for counselors should be consistent with the focus of the

profession. Currently, very little research has focused on the current practices of professional counselors with assessing risk and managing risk of child maltreatment.

Purpose of the Study and Research Questions

The purpose of this dissertation study is to establish the competencies counselors need to assess and manage the risk of child maltreatment with clients. Assessing for risk of child maltreatment, in both child and adult clients, includes identifying if the client is experiencing child maltreatment (either as a victim or as a perpetrator), gathering enough information to make the decision to report, and the actual act of reporting to Child Protective Services. Managing the risk of child maltreatment for clients, both children and adults, includes advocating for the client during and after the risk assessment and continuing a working relationship. This study is guided by two theoretical perspectives. The first- Family Resilience Framework, is used to provide a foundational understanding of the complexity of the topic; the second- social constructivism, guides the research design. A Delphi approach, guided by a social constructivist lens, will be used to create a process for training competencies that provide guidance for counselor preparation programs.

Research Questions

The questions guiding this Delphi study are as follows:

- Q1. How is a counselor's role in child maltreatment risk assessment and risk management defined?
- Q2. What are the domains of competence for counselors working with individuals and families experiencing child maltreatment?

- Q3. What are the necessary competencies for counselors to identify child abuse and neglect, to fulfill the mandate to report child abuse and neglect, and to work with clients after a report of child abuse and neglect?

Throughout the development and analysis of this study, I analyzed the cultural and historical context of each individual expert—including this author (Prawat & Floden, 1994). In social constructivist theory, the perspective of the investigator influences the interpretation of the results of a study (Heppner, Wampold, & Kivlighan, 2008). Heppner, and associates discussed that the investigator cannot be separated from the object under investigation or his or her understanding of the participants' constructions. Throughout this investigation, this author's own constructions influenced the interpretation of the relevant literature, the construction of the surveys, and the interpretation of the participants' responses.

Rationale and Significance

As many researchers have highlighted, since CAPTA was enacted, numerous counselors have confronted the challenges of mandated reporting with child abuse and neglect and subsequently repairing the therapeutic relationship after the disclosure (Abrahams, Casey, & Daro, 1992; Alvarez et al., 2005; Bavolek, 1983; Baxter & Beer, 1990; Champion, Shipman, Bonner, Hensley, & Howe, 2003; Levine et al., 1995; Pollak & Levy, 1989; Reiniger, Robison, & McHugh, 1995). Oftentimes, counseling professionals lack the confidence and the competence to manage this legal mandate (Alvarez et al., 2005; Anderson et al., 1993; Delaronde, King, Bendel, & Reece, 2000; Levine et al., 1995). Issues of confidence and competence may contribute to findings such as those found in the 2011 Child Maltreatment Report, including the fact that mental

health providers make relatively few of the reports among required professionals—4.6% of the 57.6%, as noted above. Therefore, many researchers have established the need for increasing competence and confidence through training (Alvarez et al., 2005; Donohue, Carpin, Alvarez, Ellwood, & Jones, 2002; Pollak & Levy, 1989). While many mental health programs may incorporate some form of training on mandated reporting or child abuse and neglect (Champion et al., 2003; Council for Accreditation of Counseling and Related Educational Programs, 2009), the counseling profession has not yet established a set of standards that provide comprehensive guidance on how to work with clients experiencing child abuse and neglect.

The American Counseling Association Code of Ethics, Standard C.2.a, requires counselors to work within the scope of their competence based on their education and training (ACA, 2014). Mandated reporting and promoting client welfare are legal and ethical obligations that cannot be avoided. Therefore, it is imperative that counselors entering the field have the skills to not only assess for the risk of child maltreatment and make a report to CPS but also to continue to manage client welfare during and after a report is made. Consequently, the counseling field needs to establish training standards in order to prepare competent counselors for working in the real world.

Delimitations

This study is meant to discover the domains and competencies necessary to prepare master's-level counselors to work with individuals and families in their communities. In order to create appropriate boundaries for the scope of this study, several parameters need clarification, including limits to the aspects of child maltreatment

studied here, the target audience for the competencies created, and the population sampled. Child maltreatment is a worldwide epidemic that affects countries across the world. As a result, researchers have published countless studies on the identification, prevalence, impacts, and treatment of each type of maltreatment. This study presented literature and questions to the expert- participants to guide the development of the domains and competencies necessary to fully capture the role of the counselor in child maltreatment risk assessment and management in the United States. The presentation of an exhaustive literature review on each individual type of maltreatment and the history of its treatment is beyond the scope of this study. Instead, the literature review provides a broad overview of each of the types of maltreatment in order to establish the need for training in counselor education.

Furthermore, in order to limit the scope of this study to developing necessary training competencies for counselors across specialties, the literature and questions prompted the expert- participants to consider those necessary competencies needed to manage client welfare before, during, and after a report is made. This study asked the expert- participants to avoid identifying specific treatment modalities in order to highlight the core skills needed to ensure positive client outcomes. The literature pulled in the management section included commonalities of practice that should be part of training master's-level counselors regardless of their therapeutic preferences. These competencies were specifically designed for master's-level students in a counseling program. The goal was to create competencies training programs can incorporate as part of general counseling curricula. Therefore, this study limited the role of the counselor to the

activities, skills, and knowledge needed to assess for the risk of child maltreatment and support the client before, during, and after CPS involvement. This study does not focus on specific treatment modalities that require additional training outside a counseling program.

To create competencies to address a broad range of clients, expert- participants were asked to consider all types of clients, regardless of age, ethnicity, or role in the child maltreatment (e.g. victim, perpetrator, sibling, or non-offending parent). As with many other counseling competencies, having multicultural awareness while developing these is important. However, it is beyond the scope of this study to develop competencies for specific types of clients. Instead, the expert- participants were prompted to consider the basic domains and competencies counselors need to work with any client that may experience child maltreatment.

In a Delphi Study, the selection of participants who best fit the subject needing consensus is paramount. Child maltreatment is a concern across the world, and each country has its own laws, regulations, and expectations of professionals working within its borders. As a consequence, this study recruited participants from the pool of experts working within the United States. Furthermore, to best address the lack of counseling-specific research on this phenomenon, counselors and counselor educators who meet the definition of an expert comprised the majority of the participants. To receive expert consideration in this study, a participant needed to meet one or more of the three following areas: (1) clinical experts who specialize in working with children and families or in working with perpetrators of child maltreatment; (2) research experts with a focus

area in child maltreatment; (3) education experts with a specialty in one of the following: child maltreatment, crisis, and trauma. This study also included outside disciplines for the remaining panel members, whose expertise and experience with child maltreatment in relation to the counseling field will ensure participation. These experts were included to provide a more rounded view on the role of the counselor in child maltreatment as seen by other professionals.

Finally, in most qualitative and quantitative studies, participants are expected to complete the study without a researcher's influence. In a Delphi Study, the researcher is allowed and expected to provide controlled feedback to participants for the purpose of reaching consensus. In this study, beyond the exposure of other participant responses, expert- participants also received three articles to review, along with the definitions of the study. This was to ensure that each participant has an equal base of knowledge of the current literature when making decisions.

Definition of Key Terms

This research study uses terms that require complete definitions as they relate to mandated reporting.

Child Abuse and Neglect. CAPTA (2010) defines child abuse and neglect as

Any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation, or an act or failure to act which presents an imminent risk of serious harm" (p. 6).

In this definition, a "child" is any person who is under the age of 18 who is not an emancipated minor. The federal legislation provides direction for states by providing the minimum definition of child abuse and neglect. Each state has the discretion to create the

specific definitions of abuse and neglect, including what constitutes specific types of maltreatment, which is subdivided into different forms of neglect and abuse (CAPTA, 2010).

Child Maltreatment. In this study, the definition of child maltreatment is synonymous with the definition of child abuse and neglect.

Child Protective Services. This is the specific name of the government service that responds to reports of child maltreatment.

Competence. According to Falender & Shafranske (2007), the construct of competence is complicated and difficult to define. This study will use Kaslow's (2004) definition of competence, which is as follows:

Competence refers to an individual's capability and demonstrated ability to understand and do certain tasks in an appropriate and effective manner consistent with the expectations for a person qualified by education and training in a particular profession or specialty thereof. (Kaslow, 2004, p. 775)

Competencies. In counseling, competency statements refer to the minimum skills, behaviors, and professional disposition needed to perform effectively when working with specific client populations.

Risk Assessment. For the purposes of this study, risk assessment will be defined as the skills and actions required of counselors to identify clients at risk for child maltreatment and report suspicions of abuse to Child Protective Services.

Risk Management. For the scope of this study, child maltreatment management is defined as the skills and actions required of the counselor to ensure client welfare during and after a child protection report.

Mandated Reporting. According to the Child Welfare Information Gateway (CWIG) (2012), mandated reporting can be defined as the legal obligation of identified persons to report child maltreatment under certain conditions. Each state has created legislation on mandated reporting of child maltreatment. Approximately 48 states require counselors, therapists, and other mental health professionals to report any suspected child maltreatment. Definitions of the mandated reporting laws are contained in the literature review.

CHAPTER II

REVIEW OF THE LITERATURE

The purpose of this literature review is to thoroughly explore risk assessment and management of child maltreatment and the application of the literature to the development of training competencies. To begin this review, the first section presents literature describing and supporting competence and the need for defined competencies. Following this, I review in depth the theoretical framework guiding this study. The history of child protection, paired with an overall definition of what constitutes child maltreatment, constitutes the foundation of the literature base. I then explore literature on the role of counselors with child maltreatment risk assessment and management. This section also includes a focus on counselors' beliefs and attitudes about mandated reporting and other barriers found in the literature for disclosure and working with clients experiencing child maltreatment. Following this section, I provide a brief review of the common factors necessary for working with clients during and after the initial assessment of risk for child maltreatment. The final section subsequently takes an in-depth look at the literature on training for child maltreatment risk assessment and management for mandated reporters, with a specific focus on counselors.

Competency

According to the American Counseling Association Code of Ethics (2014), counselors have a professional responsibility to work within the boundaries of their

personal and professional competence. In order to do this, counselors need to receive training to work with a diverse client population. The research presented in the previous section suggests that many counselors may not be prepared to adequately work with clients affected by child maltreatment. This section defines and examines the concept of counselor professional competence. Furthermore, this section reviews the trend of establishing competencies with specialized populations within the counseling field.

Definition of Professional Competence

The American Counseling Association Code of Ethics (2014) defines the boundaries of competence as:

Counselors practice only within the boundaries of their competence based on their education, training, supervised experience, state and national professional credentials, and appropriate professional experience. Whereas multicultural counseling competency is required across all counseling specialties, counselors gain knowledge, personal awareness, sensitivity, dispositions, and skills pertinent to being a culturally competent counselor in working with a diverse client population (p. 8).

This statement clearly demands that counselors understand and practice within their scope of competence. However, understanding where the threshold of competence falls within the counseling field creates a ubiquitous challenge. The concept of professional competence is difficult to define (Falender & Shafranske, 2007; Kitchener & Anderson, 2010). Oftentimes, competence is easier to identify when it is lacking rather than establishing the line that distinguishes competence and incompetence (Kitchener & Anderson, 2010). Competence has been defined in multiple ways in psychology literature (Falender & Shafranske, 2007; Kaslow, 2004). Knowledge, performance, and outcomes are common accepted elements of competency (Proctor, 1991; Reilly, Barclay, &

Culbertston, 1977), as are the use of communication, clinical reasoning, emotions, values, and reflection in daily practice (Epstein & Hundert, 2002). Kaslow (2004) and Rodolfa and associates (2005), highlighted the importance of behaving in a consistent and ethical manner that is aligned with the standards and guidelines of the profession and added that to their definition of competence. Capacity and integration of knowledge, skills, personal-professional values, attitudes, and profession-specific factors into professional practice are also important elements to establishing competence (Meier, 1993). As the construct of competence is investigated, the definition of professional competence increases in complexity due to its importance.

For the purpose of this study, competence will be defined as “the knowledge, skills, and professional behaviors required for master’s-level counselors to assess and manage the risk of child maltreatment with their clients.” The goal of this study is to establish those domains in which counselors need to be trained and then assessed on their level of competence when working with clients affected by child maltreatment. According to McIlvried and Bent (2003), domains of competency are “fundamental clusters of integrated knowledge, skills, and attitudes.” These are considered elements of competency (Rodolfa et al., 2005) and they are all vital to assessing competence in counseling trainees.

Trend of Establishing Competencies

As evidenced above, psychologists have established the definition of competence in the mental health field. Despite the lack of literature forming its own definition of competence, the counseling field has developed competencies for the field. Most of the

established competencies in the counseling field deal with special populations like transgender clients (Burnes et al., 2010), special issues like advocacy (Lewis, Arnold, House, & Toporek, 2003), or specialty areas like career counseling (NCDA Professional Standards Committee, 1992). These competencies establish a framework for training, practice, and research for counseling professionals, supervisors, and educators. Sue, Arrendondo, and McDavis (1992) pointed to the concerning lack of development with multicultural competencies and standards for the counseling profession and the inadequacies of training programs in addressing cultural matters.

Similarly, Harper and colleagues (2013) created competencies for counseling lesbian, gay, bisexual, queer, questioning, intersex, and ally individuals in order to ensure that counselors are providing an environment of acceptance to promote client welfare. In the introduction of its competencies, the NCDA Professional Standards Committee (1992) stated that “Professional competency statements provide guidance for the minimum competencies necessary to perform effectively a particular occupation or job within a particular field” (pg. 1). The trend for establishing competencies is to define the necessary level of competence to ensure that counselors are practicing within their scope of practice.

Theoretical Framework

As stated in Chapter I, two theoretical lenses—the framework of family resilience and social constructivism—along with the development of the questions behind the Delphi, drive this literature review. The first—Family Resilience Framework, is used to provide a foundational understanding of the complexity of the topic; the second- social

constructivism, guides the research design. This section provides overviews of the family resilience framework and social constructivism. Finally, this section will present a brief discussion of competencies in relation to these frameworks.

Family Resilience

The concept of resilience is of great interest to the mental health community. In 1987, Rutter studied the adaptive responses in children under adverse circumstances and developed the concept of resilience, which can be defined as “the ability to survive and recover from disruptive life challenges” (Walsh, 2003).

Researchers have debated whether resilience is an innate (Anthony & Cohler, 1987) or environmental trait in individuals (Wolin & Wolin, 1993). In a meta-analysis of resiliency studies, Masten, (2001) found that resilience is a common rather than an uncommon phenomenon. Researchers determined that factors of resiliency include self-regulation skills, positive self-view, and motivation to be effective in an environment (Luthar, Cicchetti, & Becker, 2000; A. S. Masten, Best, & Garmezy, 1990; A.S. Masten, 2001). Additionally, a common factor in resilient individuals is their connections to caring adults in either their family or their community (Masten & Coatsworth, 1998). Walsh (1996) noted a significant connection between individual resilience and the influence of the family system on the individual. These qualities of resilience can be developed at any time during the life cycle (McCubbin, H. I. & McCubbin, 1988; Rutter, 1987; Walsh, 2003). This suggests that resilience is both an individual and a family system trait.

Serious crises affect the whole family system, not just the individual (Walsh, 1996; Walsh, 2003). Throughout the lifespan, all families run into problems. McCubbin, and McCubbin (1988) described stressors, or problems, as demands placed on the family that may cause changes to the system. Stressors can derail family function, and the process in which they respond to these stressors can either strengthen or destroy the family system (Walsh, 2003; McCubbin & McCubbin, 1988). Therefore, it is imperative to look at system-wide resilience rather than just focusing on the individual (Walsh, 1993; Walsh, 2003; Hawley & DeHaan, 1996). Many researchers have moved beyond individual resilience to look at factors contributing to family resilience (Walsh, 2003; McCubbin & McCubbin, 1988; Black & Lobo, 2008).

McCubbin and McCubbin (1988) defined family resilience as “characteristics, dimensions, and properties of families which help families to be resilient to disruption in the face of change and adaptive in the face of crisis situations (p. 247).” Like individual resilience, family resilience can be developed at any time and can be enhanced during times of stress (Black & Lobo, 2008; Masten, 2001; Rutter, 1987; Walsh, 2003). Many factors such as family dynamics, parental strength, relationships between family members, and the social environment of the family are components of family resilience (Black & Lobo, 2008; Luthar et al., 2000; Walsh, 2003). The connection and contentment of both the family and the individual within the family impact the resilience of the system (Black & Lobo, 2008). A focus on these factors during times of crisis can increase the family’s ability to move through crisis (Walsh, 2003).

In order to take a strength-oriented approach to families in crises, a shift from viewing families as damaged to viewing them as challenged is imperative (Walsh, 1993). Walsh (2003) introduced the family resilience framework, which guides counselors to build on the resiliency factors in families that allow them to survive and rebuild in the midst of overwhelming stress (Walsh, 1993; Walsh, 2003). The family resilience model focuses on strengths during times of crisis and in overcoming adversity (Walsh, 2003). Walsh (2003) identified the many protective factors families use to overcome adversity, including their meaning making of the crisis, their family organizational pattern, and their communication and problem solving abilities. Focusing on family relationships and the connections and contentment of the individuals in the family is important in helping a family overcome crisis involving child maltreatment (Walsh, 2003; Black & Lobo, 2008). Children and parents need positive connections to each other and to others in the community to heal and grow from the disruption in their system (Black & Lobo, 2008; McCreary & Dancy, 2004; McCubbin, & McCubbin, 1988).

Therapeutic uses of this framework are multifarious. The counselor must first see through the crisis to access those family strengths that will aide in healing. Establishing hope for the future (Aronowitz & Morrison-Beedy, 2004) and affirming family strengths and possibilities (McCreary & Dancy, 2004) are ways in which a counselor can begin to access and enhance a family's natural resilience. Using this framework, the counselor and clients are able to work together to find new possibilities in their situation and overcome the barriers to change (Walsh, 2003).

Social Constructivism

Social constructivism is the guiding theoretical perspective in the research design of this study. A theoretical perspective is defined as “the philosophical stance informing the methodology and thus providing context for the process and grounding its logic and criteria” (Crotty, 1998, p. 3). Before describing the theoretical perspective, it is important to define the guiding epistemology. Crotty (1998) defined epistemology as “a way of understanding and explaining how we know what we know” (p. 3). Constructionism asserts that individuals construct meanings as they engage in the world they are interpreting (Crotty, 1998). Truth is subjective in a constructionist viewpoint, and it depends on the individual perspective of what is already there (Crotty, 1998). Social constructivism assumes that the group surrounding the individual also assigns meaning to what is already there, and the individual contributes and agrees to this shared understanding. In this study, constructionism is the guiding epistemology, and social constructivism is the theoretical framework.

Social constructivism grew out of Vygotski’s idea of zone of proximal development (Vygotsky, 1978), which asserted that a child’s learning and creation of meaning is influenced by his or her environment. Berger and Luckmann, (1991) defined social constructivism as “a theory of knowledge acquisition where groups construct knowledge for one another, creating a culture of shared meanings.” Social constructivism is based on specific assumptions about reality, knowledge, and learning (Berger & Luckmann, 1991; Kim, 2001; Lincoln & Guba, 1985), which are described below.

Reality. Those who adopt a social constructivist theoretical perspective assume that reality does not exist until it is invented by society (Kim, 2001). Properties of the world, including knowledge, artifacts, and beliefs, are created mutually by members of society (Kim, 2001; Kukla, 2000). Social constructivism takes into account each individual's contribution to the creation of reality (Lincoln & Guba, 1985). Therefore, each individual's perspective adds to the construction of the truth and is equally important.

Knowledge. The assumption of social constructivism is that knowledge is developed through a process of negotiation within a community and is affected by cultural and historical contexts (Prawat & Floden, 1994). This is also considered a product of human beings, and it does not exist outside cultural constructs (Kim, 2001; Prawat & Floden, 1994). Each individual contact with another individual and with an environment creates knowledge (Kim, 2001).

Learning. Learning is both a social and individual process (Kim, 2001). Learning best takes place when an individual fully engages with others and an environment (McMahon, 1997).

In order to fully understand the concept of social constructivism, it needs to be delineated from the concept of constructivism, constructionism, and social constructionism. As compared with social constructivism, the epistemological concept of constructivism posits that the individual constructs meaning rather than discovers it (Schwandt, 1994). Constructionism, another theory of knowledge, also focuses on the individual and posits that individuals best gain knowledge through the active construction

of objects (Crotty, 1998). This differs from social constructivism in that constructivism only looks at the individual contributions to reality and disregards the contributions of the group. Social constructivism, in contrast, assumes that meaning is constructed in groups rather than the individual, and it focuses on how the group makes meaning out of knowledge. For example, the concept of child maltreatment in a constructivist view point would assume that personal experience and attached meaning of the phenomenon constructed an individual's definition of child maltreatment. This does not fully account for the combined meaning society creates, which describes child maltreatment as a global epidemic.

Like social constructivism, social constructionism maintains that meaning and understanding of the world is developed in coordination with other human beings through language (Leeds-Hurwitz, 2009). According to Boghossian (2001), social construction refers to the things, facts, and beliefs society created that otherwise would not have existed and could differ if societal factors were different. Social constructionism differs from social constructivism in that the former focuses on the group's construction of artifacts, while the latter centers on the distinct learning of the individual that takes place because of the interactions of the group (Crotty, 1998).

Theoretical Framework and Building Competencies

This study used two theoretical perspectives: family resilience framework and social constructivism. Similar to family resilience framework, social constructivism acknowledges that individuals are within a system and influenced by a system. When considering developing competencies for child maltreatment risk assessment and

management, it is important to consider the whole system involved with the experts, the counselors receiving training, and the clients themselves. Throughout this literature review, the perspective of the clients, the counselors, the counselor educators, and the overarching systems involved with these groups are presented. This literature review starts with an understanding of how the system is developed and then delves into the definitions, prevalence, and impacts of child maltreatment. Next, a discussion of the legal mandate to report suspected child maltreatment is presented, with literature supporting the counselor's role in child maltreatment risk management to follow.

History of Child Maltreatment

In order to understand the complexity and importance of child maltreatment risk assessment and management in the counseling field, it is imperative to examine the history and definitions of child maltreatment. Child maltreatment is an epidemic that spans across countries and throughout history (Lynch, 1985). Although laws protecting children have emerged over the last 40 years, the need to protect children has been an identified need throughout history (Kalichman, 1999). In this section, the history of child protection in the United States is presented first in order to fully understand the laws and systems governing the need of counselors to be prepared to assess for and manage the risk of child maltreatment.

Understanding the historical context of the child welfare system sets the stage for identifying the role of counseling in child maltreatment. The child welfare system has developed over the years from simply identifying child maltreatment and removing children from unsafe environments to family preservation and recognizing the

consequences of child maltreatment on the mental health of the victims and their families (Dempsey & Day, 2011; Epley et al., 2010; Wolfe & McIsaac, 2011). This section explores a chronological review of the history of legislation and the advocacy groups that influenced them.

During the late 1800s, volunteer advocacy groups were in charge of protecting children. A scarcity of laws that allowed the government to become involved in the protection of children existed at this time (American Humane Association [AHA], n.d.). In the United States, organizations such as the American Humane Association and the New York Society for the Prevention of Cruelty to Children were established as early as the 1870s in response to infant mortality and maternal health (Kalichman, 1999). At the time, both the American Humane Association and the New York Society for the Prevention of Cruelty to Animals were focused on advocating for animal rights (AHA, n.d.; New York Society for the Prevention of Cruelty to Children, [NYSPCC], 2014).

In 1873, a famous case regarding an abused child named Mary Ellen sparked a movement to protect children (AHA, n.d.; NYSPCC, 2014). By 1875, both agencies began investigating child maltreatment and advocating for child protection laws (AHA, n.d.; NYSPCC, 2014). At the time, authorities focused on ending the abuse through investigation and removal of the children in those situations, along with the prosecution of those responsible for the abuse (AHA, n.d.); the emphasis on the safety of children shadowed family preservation and mental health treatment. By 1900, many states and other countries adopted similar advocacy agencies that took responsibility for investigating and prosecuting child maltreatment cases (NYSPCC, 2014).

In response to the growing advocacy for children, the federal government commissioned the Children's Bureau in 1912 as the first federal agency focused on improving lives for children and families (Ellett & Leighninger, 2006). By 1926, states then began creating their own county- and state run-child welfare boards (Ellett & Leighninger, 2006).

The Social Security Act of 1935 subsequently incorporated the Children's Bureau into Title V, which allotted funds for state public welfare agencies to protect and care for dependent and neglected children (Children's Bureau, n.d.). At this time, concerned citizens filed reports, and the effects of child maltreatment were still unknown. Until the 1960s, the responsibility of child protection fell to non-governmental agencies, as most states could not offer child protective services statewide or 24-hour response (Myers, 2008).

However, the 1960s brought a new focus on child maltreatment. Kempe and colleagues published 'The Battered Child Syndrome' in 1962, calling for action from medical professionals in identifying and working toward prevention of child maltreatment (Kalichman, 1999; Kempe et al., 1962; Levine et al., 1995). Along with this new publicity of child welfare, amendments to the Social Security Act identified Child Protective Services (CPS) as part of all public welfare (Myers, 2008; Levine, et al., 1995; Kalichman, 1999). By July 1975, these new amendments required states to offer statewide child welfare services, including the requirements for states to develop plans for children in foster care and provide services to expedite the child home (Close, 1962; Cohen & Ball, 1962). While the amendments represented steps toward safety for

children, a committee of professionals also decided that mandated reporting laws were necessary and, by 1963, the Children's Bureau published language for states requiring doctors and hospitals to report suspected abuse (Close, 1962; Myers, 2008). Between 1963 and 1967, all states had adopted reporting laws (Myers, 2008), which increased the number of children receiving services by 50% (Children's Bureau, n.d.). The focus of child protection began to move from intervention only to prevention with the addition of the different mandated professionals (Kalichman, 1999), and the prevalence of child abuse and neglect became clear (Myers, 2008).

The federal government played a small role in child abuse prevention until 1974 and the enactment of the Child Abuse Prevention and Treatment Act (CAPTA) (Children's Bureau, n.d.; Child Abuse Prevention and Treatment Act, [CAPTA], 1974; Myers, 2008). CAPTA provided funding to states to improve investigation and the process of reporting allegations of abuse and neglect (CAPTA, 1974). That same year, the federal government created The National Center on Child Abuse and Neglect to oversee CAPTA and fund research on child abuse (Myers, 2008). With the focus on preventing children from staying in foster care, the Children's Bureau began funding research for the efficacy of home-based services such as nurse visiting and homemaking (Children's Bureau, n.d.). Home-based services began concentrating on family preservation, although those efforts were still a long way from focusing on the mental health impacts of child maltreatment. Professionals were beginning to realize the influence of removing children from their homes on both their personal and racial development (Myers, 2008). A series of published resources from the 1970's that

included the prevention, intervention and treatment of child maltreatment provides evidence of the alarm raised for the impact of child maltreatment on individuals and families (Children's Bureau, n.d.). These publications targeted early childhood program providers, educators, medical staff, and residential staff (Child Welfare Information Gateway, n.d.). With the mental health profession still defining itself as part of the medical profession at that time, there was no need to publish guidelines separately.

By the beginning of the 1980s, the increased number of children in foster care became alarming, requiring the government to introduce the *Adoption Assistance and Child Welfare Act of 1980* (1980). This act required states to make efforts to avoid removing children from their abusive families or to aide families in recovering their children from foster care. Criticism arose from Adoption Assistance and Child Welfare Act, with the entity accusing CPS workers of leaving children in unsafe environments without actually reducing the number of children in foster care (Gelles, 1985). During the 1980s, the Children's Bureau targeted funding research on foster care, including mandating states to provide statistics of the children served (Children's Bureau, n.d.). After a closer inspection of the statistics, the bureau found that many children were aging out of foster care, which led congress to pass a federal program to support Independent Living Services (Children's Bureau, n.d.). While the 1980s did not feature many of legislative changes, a heightened awareness of the effects of foster care placement on children and the impacts of aging out of foster care arose in this decade.

The 1990s brought a renewed focus on family preservation and stability for children. Top political leaders like Dr. Louis Sullivan, the United States Secretary of

Health and Human Services, initiated awareness through public service announcements calling for communities to develop local prevention and treatment strategies (Children's Bureau, n.d.). This led to laws authorizing funding for services to help preserve, support, and reunify families in crisis (*Family Preservation and Support Services Program Act*, 1993), which specifically addressed linking families to mental health services. *The Multiethnic Placement Act* (1994) and the *Adoption and Safe Families Act* (1997) focused on safety, providing timelines for children together reunite with their families or become eligible for adoption, regardless of the child's or adoptive parents' race. While keeping children safe became a priority, these acts also directed funding toward family preservation, including the offer of counseling services to members of the family (*Adoption and Safe Families Act*, 1997, *The Multiethnic Placement Act*, 1994).

As is evidenced through the growth of care offered with each legislative act, protecting children moved from a focus solely on the children to a focus on the family system. Removing children and placing them in foster homes was simply not enough to manage and cure the epidemic of child maltreatment. In 2001, the *Promoting Safe and Stable Families Amendments of 2001* included strengthening parental relationships and promoting healthy marriages to the list of funded activities. This allowed CPS to begin focusing on potential parental issues that could serve as underlying causes leading to child maltreatment. This trend continued in the *Keeping Children Safe Act* (2003) which not only reauthorized CAPTA for another five years but also mandated that any child under the age of 3 who suffered from substantiated abuse or neglect receive referral to an

early intervention program. This allowed families to obtain funded services for children to address any developmental delays.

In 2008, the focus shifted from young children to those children about to age out of foster care—much like the switch in the 1980s. The *Fostering Connections to Success and Increasing Adoptions Act of 2008* allowed for youth age 16 or older to receive services, including help with housing, education, and training. This act also provided grants to non-profit agencies to help reconnect children and families in or at risk of foster care to services such as family group decision-making meetings (*Fostering Connections to Success and Increasing Adoptions Act of 2008*, 2008). Furthermore, this act recognized the importance of family connections to children in foster care. This is consistent with the foundations of the family resilience model, which assumes that individuals are part of a family system and need that arrangement to help access their resiliency factors to work through crises.

As a way to help youth succeed after permanent removal from their parents, the *Uninterrupted Scholars Act* (2013) allowed child welfare agencies to access student records, easing the process of finding educational stability for students in foster care (United States Government Accountability Office, 2014). This supports the need for professionals to recognize that the responsibility of protection does not stop at detection of child maltreatment.

The most recent legislation for general child protection occurred in 2010 with the *CAPTA Reauthorization Act* and the *Child and Family Services Improvement and Innovation Act (CFSIIA)* (2011). In addition to extending the funding for another eight

years, these acts called for more focus on the emotional welfare of children removed from homes. The *CFSIIA* specifically requires “the monitoring and treatment of emotional trauma associated with a child’s maltreatment and removal from home” (Child Welfare Information Gateway, 2013, p. 3). After more than a century of legislation, the emotional trauma associated with child maltreatment is finally addressed as a requirement.

To summarize, child protection has come a long way, from a group of concerned citizens to the trained professionals of today. Only now are the impacts and consequences of child maltreatment regularly addressed in legislation. With the addition of mental health considerations, counselors need to become familiar with their role in the child protection movement. A counselor’s responsibility extends beyond the mandated responsibility to report, as is seen in the movement from simply protecting the child to helping that child and his or her family. Given the prevalence and widespread impact of child maltreatment, counselors have the responsibility to recognize, assess, intervene, and manage their clients affected by child maltreatment.

Child Maltreatment Risk Assessment

Understanding what legally constitutes child maltreatment is a beginning step for counselors in assessing risk of child maltreatment. In this study, risk assessment is defined as the process of identifying and reporting child maltreatment. In the following section, the overall definition of child maltreatment is presented, with the definition, prevalence, and impact of the different types of child maltreatment to follow. Next, a

discussion of the impacts of child maltreatment as it relates to the counseling role is presented, and a presentation of literature regarding mandated reporting follows.

Definition

Understanding what legally constitutes child maltreatment is a beginning step for counselors in assessing risk of child maltreatment. For the purposes of this study, the federally accepted definition for child maltreatment, as stated in *The Child Abuse and Treatment Act of 2010*, is utilized. *The Child Abuse and Treatment Act of 2010* defined child maltreatment as:

the term ‘child abuse and neglect’ means, at a minimum, any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse or exploitation, or an act or failure to act which presents an imminent risk of serious harm.

Furthermore, “the term ‘child’ means a person who has not attained the lesser of
(A) the age of 18; or
(B) except in the case of sexual abuse, the age specified by the child protection law of the state in which the child resides.” (*CAPTA*, 2010, p. 6)

To further clarify the definition of maltreatment, federal and state governments identified and defined multiple forms of abuse, including physical, emotional, sexual, neglect, and sibling. The next section discusses each form of abuse, including the common definition and the prevalence of the abuse. In addition, a discussion of the impact of each abuse is presented in consideration of the assessment and management required of counselors.

Each state has included in their statutes the specific definition of each type of abuse. Although the definitions may differ on the wording, it is beyond the scope of this research to present all fifty definitions here. In order to present definitions that represent

the majority of states, the definitions presented here are from the U.S. Department of Health and Human Services. Additionally, aggregate data summarizing patterns in state statutes are included when available. In addition to the definition, the prevalence and impact on individuals experiencing each type of abuse is presented.

Physical Abuse

Definition. The U.S. Department of Health and Human Services defines physical abuse as: “any non-accidental physical injury to the child and can include striking, kicking, burning, or biting, or any action that results in a physical impairment of the child” (Child Welfare Information Gateway, [CWIG], 2013, p 2). It is important for counselors to know and understand the statutes of the state in which they live and practice, as the above definition may be more or less inclusive than some state statutes. Based on the above definition, this may be the most recognizable form of abuse due to the obvious marks left behind as a result of the behaviors (Levine, et al., 1995; Kalichman, 1999). There are some states (e.g., Arizona, Arkansas, Florida, Kentucky, Louisiana), however, that define physical abuse as any threat of harm or risk of harm to a child’s health (CWIG, 2013). For example, in Arkansas, certain physical punishment is considered abuse depending on age (e.g., hitting a child under the age of 6 on the face), regardless of whether a mark is left (Child Welfare Information Gateway, 2010). Therefore, detection of physical abuse becomes gray, as no actual physical contact needs to happen in these states in order to receive consideration as physical abuse.

When discussing the definition of physical abuse, it is important to differentiate between physical abuse and “corporal punishment.” There are currently 19 states that

allow for corporal punishment. The state of Colorado, for example, defines corporal punishment as: “Parent/guardian/person with care and supervision of minor can use reasonable and appropriate physical force if it is reasonably necessary and appropriate to maintain or promote welfare of child” (Child Welfare Information Gateway, 2010, p. 2). In states where corporal punishment is permissible by statute, it adds complexity to recognizing physical abuse, as it must be differentiated from corporal punishment. Counselors are responsible for using clinical judgment to assess whether the form of punishment used rises to the level of physical abuse.

Prevalence. Physical abuse is the most commonly and easily detected form of abuse. In 2011, physical abuse comprises approximately 17.6 percent of substantiated reports, totaling approximately 118,825 children (USDHHS, 2012). Most of these children were less than 2 years old, and 70,209 children were school age (USDHHS, 2012). With the numbers presented, many counselors, especially school counselors, are in contact with children and their families impacted by physical abuse.

Impact. Knowing the definition and pervasiveness of physical abuse only addresses some counselors’ responsibilities for assessing risk of physical abuse and further managing clients struggling. Knowing the short- and long-term consequences of physical abuse is important in assessing and monitoring future abuse and helping both child and adult clients overcome the impact of the abuse.

Studies have shown that physical abuse can affect current and future behavior in children (Bryer et al., 1987; Chu & Dill, 1990; Kaplan, Pelcovitz, & Labruna, 1999; Malinosky-Rummell & Hansen, 1993). Children who are physically abused tend to

become more aggressive toward others, can be anxious or fearful, dissociate, and have low self-esteem (Chu & Dill, 1990; Kaplan et al., 1999). Physically-abused children tend to be less intimate with peers (Parker & Herrera, 1996) and have been found to be more disliked than non-abused children (Salzinger, Feldman, Hammer, & Rosario, 1993). Counselors need to learn to recognize the symptoms of physical abuse, not only to report it, if needed, but also to help children work through their trauma.

When left untreated, consequences of physical abuse can affect functioning in adulthood. Adult survivors of physical abuse have been found to have short-term memory deficits (Bremner et al., 1995), poor adult relationships, and mental health disorders (Bryer et al., 1987; Malinosky-Rummell & Hansen, 1993). Fergusson and associates (2008), specifically discovered a strong association of depression and a history of child physical abuse, as well as the fact that social and family context had an impact on whether survivors developed depression. It is important for counselors to identify and understand the risk factors and consequences of physical abuse to better work with families after physical abuse is uncovered.

Emotional Abuse

Definition. Emotional abuse is another form of child maltreatment. According to the USDHHS (2010), psychological or emotional maltreatment is defined as

the act or omission, other than physical abuse or sexual abuse that caused, or could have caused conduct, cognitive, affective, or other mental disorders and includes emotional neglect, psychological abuse, and mental injury. Frequently occurs as verbal abuse or excessive demands on a child's performance (p.132).

The Child Welfare Information Gateway (2010) shows common language in state definitions around emotional abuse included: "Injury to the psychological capacity or

emotional stability of the child as evidenced by an observable or substantial change in behavior, emotional response, or cognition and injury as evidenced by anxiety, depression, withdrawal, or aggressive behavior (p. 3).”

Emotional abuse is difficult to define and identify. Levine and colleagues (1995) asserted that the difficulties counselors have with reporting emotional abuse is due to the lack of clarity of what constitutes emotional abuse. They found that most counselors’ definitions of emotional abuse varied, ranging from parent-child interactions to child behaviors and parent behaviors (Levine, et al., 1995). Compared to the definition of the federal government, counselors tend to narrow the scope of emotional abuse depending on their interpretation of the law. Kalichman (1999) suggested that most definitions of emotional maltreatment are explained on the basis of signs of the abuse, categorizing it as a broad and vague form of abuse.

To further define emotional abuse, Hart and associates (1987), identified seven subtypes of caregiver emotional abuse. These included: rejecting, degrading, terrorizing, isolating, missocializing, exploiting, and denying emotional responsiveness (Hart, et al., 1987). While these categories may help counselors to identify emotional maltreatment, there is still a concern that other emotionally-abusive parenting behaviors are not captured in these domains (McGee & Wolfe, 1991). The multiple definitions and different interpretations extant in the literature make counselors’ task of defining, identifying, and reporting child emotional abuse difficult. As the presented literature signifies, counselors could justify any act of poor parenting as emotional abuse and consequently feel justified in reporting it. Much like with physical abuse, counselors are

responsible for knowing and understanding the state statutes defining emotional abuse in order to better inform their judgment when considering reporting.

Deciding where exposure to domestic violence belongs in the definition of child emotional abuse is an additional complicating factor. Kalichman (1999) included witnessing violence, specifically domestic violence, as emotional maltreatment. The Child Maltreatment report of 2011 (U.S. Department of Health & Human Services, 2012) defined domestic violence as “Incidents of interspousal physical or emotional abuse perpetrated by one of the spouses or parent figures upon the other spouse or parent figure in the child’s home environment (p. 117).” Currently, only 20 states have state laws or statutes likening child witnesses to domestic violence as emotional abuse (State Child Welfare Policy Database, 2009). With this lack of specific statutes in certain states supporting identification of exposure to domestic violence as a form of child maltreatment, the counselor must judge whether the exposure to domestic violence meets the definition of emotional abuse.

Prevalence. While difficult to define, emotional abuse may also be the most prevalent and most harmful form of abuse (Wiehe, 1997). It is often under-reported because children, families, and mental health professionals often do not recognize the emotional maltreatment present (Glaser, 2002; Horton & Cruise, 2001). Furthermore, emotional abuse is considered the hardest forms of abuse to substantiate because of the lack of physical evidence and the difficulty in connecting the concerns in the child’s behavior to the acts or omissions of the parents’ behavior (Kalichman, 1999; Levine, et al., 1995). In 2011, only 60,839 children, or nine percent of all substantiated reports,

suffered from emotional abuse (USDHHS, 2012). However, the above numbers do not include child witnesses to domestic violence. According to the latest statistics of state child welfare agencies, approximately 36% of victims and non-victims were exposed to domestic violence (USDHHS, 2012).

Impact. In addition to the fear, violence, or rejection children from emotionally maltreating families receive from their caregivers, they often grow up in a family environment that fails to provide appropriate developmental opportunities and stimulation (Wolfe & McIsaac, 2011). According to Garbarino, Eckenrode, and Barry (1997), the impact on the child is dependent on the interaction between aversive parenting behaviors and the vulnerability and strength of the child. Emotional maltreated children tend to struggle with internal regulation of their emotions due to the surrounding environment (Wolfe & McIsaac, 2011) and tend to internalize their emotions for fear of their caregivers (Klorman, Cicchetti, Thatcher, & Ison, 2003).

The consequences of emotional abuse continue on into adulthood. Emotional maltreatment may be a stronger predictor to long-term psychological problems—including poor emotional regulation, social impairment, low self-esteem, and suicidal behavior—than the other forms of abuse or neglect (Wolfe & McIsaac, 2011; Kaplan et al., 1999). Carpenter and colleagues (2009), found that adults with a history of childhood emotional abuse were more likely to have depressed cortisol levels and have Axis I psychiatric disorders than those who did not report a history of emotional abuse. In consideration of these findings, counselors are likely to have clients with a history of emotional maltreatment.

With such a large number of children identified as potential victims of emotional abuse, counselors need to understand and know how to work with survivors of emotional abuse. Due to the consequences to both children and the surviving adults, counselors are obligated to be aware of the likelihood that childhood emotional abuse has impacted their client. As Wolfe and McIsaac (2011) suggest, this problematic and abusive parenting style is preventable and a community concern, as it has a widespread impact on the lives of both the victims and perpetrators of the abuse. Recognizing and assessing parenting concerns and a potential history of abuse in clients, regardless of the presenting concerns of the client, is essential for counselors in managing child maltreatment.

Sexual Abuse

Definition. The U.S. Department of Health and Human Services, Administration for Children and Families (2012) defined sexual abuse as:

A type of maltreatment that refers to the involvement of the child in sexual activity to provide sexual gratification or financial benefit to the perpetrator, including contacts for sexual purposes, molestation, statutory rape, prostitution, pornography, exposure, incest, or other sexually exploitative activities. (p. 125)

CAPTA (2010) added that in cases of sexual abuse, the definition of “child” limited to under the age of 18 does not apply; states are required to determine the legality of age in sexual abuse cases. Each state varies in its definition of sexual abuse, sometimes specifying various acts as sexual abuse and sexual exploitation (USDHHS, 2012).

Finkelhor, Turner, Ormrod, and Hamby (2009) identified seven types of sexual victimization:

Sexual contact or fondling by an adult the child knew, sexual contact or fondling by an adult stranger, sexual contact or fondling by another child or teenager,

attempted or completed intercourse, exposure or ‘flashing,’ sexual harassment, and consensual sexual conduct with an adult (p. 2).

In order for counselors to best evaluate for sexual abuse in clients, it is important for them to familiarize themselves with federal and state laws, as well as the wide variety of behaviors that equate to sexual abuse. This knowledge informs better decision making and protects counselors from potential legal consequences.

Prevalence. Sexual abuse may be the most researched—and thereby recognized—maltreatment. In 2011, 9.1% of the victims reported to state Child Protective Services were sexually abused (USDHHS, 2012). This percentage does not include alleged maltreatments or those that could not be substantiated (USDHHS, 2012). Finkelhor and colleagues (2009) found that 6.1% of children surveyed were sexually abused, and one in twenty girls between the ages of 14 and 17 reported being the victim of a sexual assault.

Impact. The consequences of sexual abuse are great. According to Kendall-Tackett, Williams, and Finkelhor (1993), children who have been sexually abused tend to have inappropriate sexualized behaviors, depression, withdrawal, aggression, regressive behaviors, self-injury, and instances running away. Post-traumatic stress disorder is also present in many children who have been sexually abused (Briere & Elliott, 1994; Kendall-Tackett et al., 1993). Briere and Elliott (1994) found that children who are sexually abused often confront low self-esteem, negative self-perception, depression, anxiety, and dissociation. Overall, the impact of sexual abuse on children is severe, as it clearly affects all parts of their lives. These symptoms also carry into adulthood. Adults who were sexually abused as children often have disrupted adult relationships, eating

disorders, inappropriate sexualized behaviors, depression, and suicidal ideation (Beitchman et al., 1992).

Noll, Horowitz, Bonanno, Trickett, and Putnam (2003) also discovered that adult survivors of sexual abuse were more likely to inflict self-harm, which could be a way of internalizing pain, taking control of their own bodies, and an effort to end depersonalization (Osuch, Noll, & Putnam, 1999). Many clinicians will inevitably face treating and potentially identifying a victim of sexual abuse. Understanding the impact, as well as identifying the behaviors, is imperative to preventing sexual abuse.

Neglect

Definition. Neglect is the most commonly reported most broad form of child maltreatment. Neglect is commonly defined as “ the failure of a parent or other person with responsibility for the child to provide needed food, clothing, shelter, medical care, or supervision to the degree that the child’s health, safety, and well-being are threatened with harm” (USDHHS, 2012, p.3). In addition, approximately 24 states include educational neglect as part of their definition, and some states include failing to seek mental health care as part of medical neglect (CWIG, 2010). Colorado, for example, uses the following designations:

A child is ‘neglected’ or ‘dependent’ if:

- The parent, guardian, or legal custodian has subjected the child to mistreatment or abuse or has allowed another to mistreat or abuse the child without taking lawful means to stop such mistreatment or abuse and prevent it from recurring;
- The child lacks proper parental care through the actions or omissions of the parent, guardian, or legal custodian;
- The child’s environment is injurious to his or her welfare;
- The parent, guardian, or legal custodian fails or refuses to provide the

- child with proper or necessary subsistence, education, medical care, or any other necessary care;
- The child is homeless, without proper care, or not domiciled with his or her parent, guardian, or legal custodian through no fault of such parent, guardian, or legal custodian;
- The child has run away from home or is otherwise beyond the control of his or her parent, guardian, or legal custodian;
- The child tests positive at birth for either a schedule I or schedule II controlled substance, unless the child tests positive for a schedule II controlled substance as a result of the mother's lawful intake of such substance as prescribed. (CO Rev. Stat. §§ 19-1-103; 19-3-102)

As evidenced in the definition of neglect in Colorado, there are several subcategories of neglect, such as physical, emotional, medical, environmental, educational, abandonment, and lack of supervision. The USDHHS (2012) defines neglect as “a type of maltreatment that refers to the failure by the caregiver to provide needed, age-appropriate care although financially able to do so or offered financial or other means to do so” (p. 125). Neglect is often understood as the omission of parental activity rather than the omission of an act (CWIG, 2011).

Prevalence. According to CAPTA (2003), more children suffer from neglect than any other form of maltreatment. The 2011 Child Maltreatment report (USDHHS, 2012) specifies that 78.5% of the victims reported to state Child Protective Services were neglected. An additional 10.3% of the victims were categorized as “other” forms of abuse, including parental drug abuse and lack of supervision, which in states such as Colorado is considered neglect (USDHHS, 2010).

The USDHHS (2010) found that 66.7% of children who died due to child maltreatment were neglected or suffered from a combination of neglect and another form of abuse. With the enormous number of children impacted by neglect every year, the

chances of a counselor coming into contact with a family suffering with issues of neglect are high.

Impact. The consequences of neglect, much like the other forms of maltreatment presented in this review, can be great and last throughout a lifetime. Trickett and McBride-Chang (1995) showed that children suffering from neglect tend to have peer problems, are withdrawn, have less pro-social behaviors, are insecure, are attached, and are more likely to be delayed in language skills than those children who suffer from other forms of abuse. Neglect can also result in death (Appleton, 2012), as the USDHHS report of 2010 discussed in the previous section suggests.

Furthermore, the impacts of neglect are not limited to childhood. Childhood neglect can lead to lower academic ability, increased risk of criminal behavior, substance abuse (Hildyard & Wolfe, 2002), and obesity (Lissau & Sorensen, 1994). Adult survivors of neglect have been found to be at increased risk for developing a personality disorder (Hildyard & Wolfe, 2002; Johnson, Smailes, Cohen, Brown, & Bernstein, 2000). Johnson and associates (2000) maintained that those participants who indicated childhood emotional neglect were associated with increased risk for avoidant, paranoid, and Cluster A personality disorders; those who indicated a history of physical neglect were at an increased risk for schizotypal personality disorders; finally, those who reported a history of supervision neglect were at an increased risk for passive-aggressive and cluster B personality disorders. With these severe consequences of neglect, coupled with the large number of victims and potential survivors, counselors will face the prospect of working with a client struggling with these issues during some point in their career.

Much like the other forms of abuse, neglect is not black and white. While the most common, very little research has been done on neglect. One possibility for this could be the hidden nature of the effects to children and adults suffering from neglect. Oftentimes, families suffering from poverty tend to have many similarities to those suffering from neglect (Charlow, 2001). For example, families may not be able to afford to find adequate child care or simply do not have the money to buy coats for children. This differs from the parents who choose to leave their children unattended while using substances or buy themselves new clothes while choosing not to buy a coat for their children. Additionally, children suffering from poverty are more likely to report neglect than those who are from wealthier families (Sedlak & Broadhurst, 1996). According to Duva and Metzger (2010), there is often an overlap between poverty and neglect, as many impoverished families live in inadequate, unsafe environments, and parental stress tends to cause more instances of inadequate supervision, substance abuse, and domestic violence. This is an important training point for counselors, as there many clients may that straddle the line between neglect and poverty. Therefore, many counselors may face the struggle of making the decision between submitting a report to CPS and referring to community services.

Sibling Abuse

Thus far, the review of literature has discussed four common forms of child maltreatment: physical, emotional, sexual, and neglect. According to Wiehe (1997), there are also four forms of family violence: child, elder, domestic, and sibling. Child violence is captured in the previous sections. Oftentimes, however, sibling violence is not

discussed (Wiehe, 1997). The purpose of this section is to incorporate this aspect of family violence into the framework for conceptualizing neglect as it pertains to the broad category of child maltreatment. As the next section explains, sibling abuse impacts children and families in ways that are similar to parental abuse, and counselors need to be prepared to recognize and work with families experiencing this type of maltreatment.

Definition. (Stutey, 2013) discussed the lack of federal or state laws, statutes, or even guidelines that refer to sibling abuse. Sibling abuse can be defined as “any type of intentional, unidirectional, emotional, physical, sexual, or relational act of aggression or violence inflicted on a child by a sibling or step-sibling ranging from mild to extreme that is inconsistent with typical development” (Stutey & Clemens, n.d., p 13). Researchers have found that physical, sexual, and emotional abuse happens between siblings (Caspi, 2012; Stutey & Clemens, n.d.; Wiehe, 2002). When identified, sibling abuse is often reported as a form of parental neglect through lack of supervision and failure to protect (Caspi, 2012).

Prevalence. Finkelhor and associates (2009) categorized assault between siblings as one of the three most common victimizations from the ages of 2 to 5, and the peak period for assault between siblings was between the ages of 6 and 9. Wiehe (2002) reported that an estimated 800 children out of 1,000 hit a sibling every year. In 2009, Finkelhor and colleagues found that nearly half of the children under 10 had dealt with siblings hitting them multiple times throughout the year. Other forms of maltreatment, including emotional and psychological abuse, happens from siblings. Button and Gealt (2010) discovered that 42% of their sample reported psychological maltreatment from a

sibling. Considering the prevalence and the similar effects on the developing child, counselors should be prepared to assess the risk of sibling abuse and know how to work with those affected by it (Stutey, 2013; Stutey & Clemens, n.d.).

Impact. As indicated in previous sections, child maltreatment, regardless of the type, has an impact on childhood and into adulthood. Sibling abuse is no different than any of the other forms of maltreatment introduced in this review of literature. Victims of sibling abuse reported similar negative effects as victims of child maltreatment (Noland, Liller, McDermott, Coulter, & Seraphine, 2004; Simonelli, Mullis, Elliott, & Pierce, 2002). Wiehe (1991) found that adult survivors of sibling abuse reported problems with alcohol, drugs, and sex. In addition, Simonelli and associates (2002) observed that those victims of sibling abuse were more likely to continue the cycle of abuse as both the perpetrator and the victim. While there are currently no laws protecting children from sibling abuse, it is imperative that counselors are able to assess and work with clients who suffer from sibling abuse.

Integration and Impacts of Child Maltreatment

The previous section delineated among the five different types of child maltreatment: physical, emotional, sexual, neglect, and sibling. The definition, prevalence, and impact of each were presented and connected to the need for counselors to not only assess the risk for but also be prepared to manage working with clients affected by child maltreatment. In each of the types of child maltreatment, short- and long-term consequences were common. Many mental health disorders (Johnson et al., 2000), social problems (Chu & Dill, 1990; Kaplan et al., 1999), and health issues

(Moeller, Bachmann, & Moeller, 1993) can be traced back to a history of child maltreatment. The impacts on functioning represent a common theme throughout the forms of abuse. Despite the type of abuse, adults reporting a history of maltreatment are more likely to be depressed (Waite & Shewokis, 2012), just as children are likely to exhibit behavioral problems (Hildyard & Wolfe, 2002; Parker & Herrera, 1996; Trickett & McBride-Chang, 1995). Therefore, it is imperative that counselors are prepared to manage the fallout after maltreatment is identified. Based on the known cases of child maltreatment and the suspected number of unreported cases of child maltreatment, many clients who see counselors are likely to have suffered from child maltreatment in some way during their lives.

Determining whether a client has been impacted by child maltreatment is difficult. As evidenced above, this task is not always obvious. The challenge of distinguishing between abusive and neglectful methods of parenting and poor parenting is difficult (Wolfe & McIsaac, 2011). Similar to the concerns with physical abuse, yelling at a child does not constitute emotional maltreatment any more than spanking a child and not leaving a mark constitutes physical abuse. This can also be seen when attempting to distinguish between poverty and neglect (Charlow, 2001) and from sibling rivalry and sibling abuse (Caspi, 2012). When assessing for the risk of child maltreatment, counselors must be aware of the definitions of the maltreatment they suspect in their state of residence and be prepared to communicate these to the proper authorities. Likewise, when working with a client, naming poor parenting as abusive could lead to negative effects on the family system (Charlow, 2001).

Beyond identifying the differences between poor parenting and abuse, counselors need to be able to distinguish between developmentally appropriate behaviors from the abused child. For example, counselors may mistake normal developmental sexual behaviors as sexualized behaviors due to sexual abuse (Finkelhor, 1994). Kalichman (1999) discussed the difficulty for mental health professionals to identify sexual abuse, as they only become aware of the facts through verbal disclosures or identification of child behaviors and emotional reactions. This leaves the identification of sexual abuse to the clinical interpretation of the counselor, which is often ambiguous and vague (Levine, et al., 1995). Levine and colleagues (1995) discussed the fact that mental health professionals often make reports based on a child's sexualized behaviors without a specific disclosure of sexual abuse. This gray area is common throughout all forms of maltreatment, which makes the counselor's role as a constant assessor of maltreatment key.

Mandated Reporting

Thus far, this literature review has discussed child maltreatment and its definition, prevalence, and impact. It is important for counselors to comprehend the impact of child maltreatment in order for them to understand why mandated reporting child maltreatment is helpful to their clients. Mandated reporting child maltreatment is an important part of assessing for the risk of child maltreatment. This section summarizes mandated reporting laws, the prevalence of reporting, and the literature centering on current practices of mandated reporting, including the common barriers to reporting that many counselors experience.

Mandated reporting laws. As described previously in the introduction to this chapter, mandated reporting laws were developed as a reaction to Kempe and associates' (1962) ground breaking introduction of the battered child syndrome (Kalichman, 1999). As a result, states began including a statute in their laws requiring medical professionals to report concerns for child maltreatment in order to reduce the level of abuse through prevention or early intervention by the state (Levine, et al., 1995; Kalichman, 1999; Smith & Meyer, 1984). By 1966, all states except for Hawaii had adopted legislations requiring medical professionals to report suspected abuse (Kalichman, 1999). In 1964, the American Medical Association published a statement indicating that other professions should also be required to report suspected abuse, stating that "Visiting nurses, social workers, school teachers, and authorities, lawyers, marriage, guidance counselors, and others frequently learn of cases before medical care is demanded or received" (Kalichman, 1999; p. 136). As a result of this publication, mandated reporting laws expanded to human service providers, including counselors (Kalichman, 1999).

According to the Child Welfare Information Gateway (2012), 48 states, the District of Columbia, American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands all require certain professionals to report suspected and observed child maltreatment; the two remaining states, Wyoming and New Jersey, require that all persons to report regardless of profession. Those states that identify specific mandated professionals require counselors, therapists, and other mental health professionals to report (Child Welfare Information Gateway, 2012). The states vary on what is required to be reported; however, common language in statutes indicates a report

is to be made when the reporter suspects or has reasons to believe that a child is being abused or neglected (CWIG, 2012; Kalichman, 1999; Levine, et al., 1995). Researchers have indicated this common language is often confusing and anxiety provoking for mandated reporters, including counselors, as it is vague (Feng, Chen, Fetzner, Feng, & Lin, 2012; Kalichman, 1999; Levi & Portwood, 2011; Levine et al., 1995; S. R. Smith & Meyer, 1984).

Prevalence of reporting. As one of the designated mandated professionals, mental health professionals are required to report child maltreatment. Compared to the other mandated professionals, mental health professionals only constitute a small percentage of the reports made to CPS. In the Child Maltreatment report issued in 2012, of the 57.6% of reports mandated professionals made, mental health professionals disclosed only 4.7% of these (USDHHS, 2012). With the many ways counselors are involved with children and families, with access at schools, private practices, mental health centers, and other non-profit agencies, this number seems remarkably low.

Not all child maltreatment is reported. Meriwether (1986) predicted that up to 68% of abused or neglected children are not reported to Social Services. It is an accepted fact that not all those who are required to report suspicions of child maltreatment actually make that disclosure (Delaronde et al., 2000; Sege et al., 2011; U.S. Department of Health & Human Services, 2010). Delaronde, and associates (2000) found that the majority of mandated reporters do not consistently report all suspected cases of maltreatment. Approximately 6% of professionals consistently fail to report child maltreatment, and about 40% have failed to report child maltreatment during their career

(Zellman, 1990a, 1990b). In a more recent study, it determined that 27% of primary care physicians failed to report their suspicions of child maltreatment despite their belief that it was likely the cause of an injury (Sege et al., 2011). Although this literature is dated, it reflects the most current statistics available regarding mental health professionals reporting patterns.

There is a fine line between reporting enough and reporting too much. According to Kesner (2008), social workers and mental health workers were responsible for the majority of maltreatment reports in the years 1995 to 1997; however, their reports had the lowest substantiation rates, suggesting that mental health workers may not be identifying child maltreatment appropriately. Renninger, Veach, & Bagdade (2002) also discovered that psychologists had a tendency to over report due to the lack of education of what defines abuse and neglect. While it appears that the number of reports mental health professionals made has gone down since 1997, there is still the concern that those children who are suffering from maltreating are not being identified and reported.

Counselors' relationship with reporting. Since states adopted the mandate to report in the 1970s, a multitude of research has centered on the impact of mandated reporting on professionals. The majority of researchers have focused on medical professionals, teachers, and psychologists. However, researchers have conducted few studies on professional counselors specifically. Mental health professionals are often grouped together, with social workers and psychologists serving as the main focus of research studies. This section of the literature review presents the common barriers found across professions to mandated reporting, along with the specific barriers found in the

mental health field. The suggestions from the literature on overcoming these barriers are also detailed.

Researchers have shown that many helping professionals have struggled with reporting child maltreatment for a multitude of reasons (Badger, 1989; Flaherty, Sege, Binns, Mattson, & Christoffel, 2000; Kalichman, Craig, & Follingstad, 1988; O'Toole, Webster, O'Toole, & Lucal, 1999; Tilden et al., 1994; Van Haeringen, Dadds, & Armstrong, 1998; Vulliamy & Sullivan, 2000). Oftentimes, the leading barriers to reporting are concern of what will happen to families, fear of losing the client, and client anger (Abrahams et al., 1992; Alvarez et al., 2005, 2004; Donohue et al., 2002; Faller, 1985; Gilbert et al., 2009; Levine et al., 1995; Lietz, 2006; Morton & Oravecz, 2009; Pollak & Levy, 1989; Renninger et al., 2002; S. R. Smith & Meyer, 1984; Steen, 2009; Strozier et al., 2005; Vulliamy & Sullivan, 2000; Watson & Levine, 1989; Zellman, 1990a). Professionals have also expressed a lack of faith in the system that a report will actually benefit the child (Alvarez et al., 2004; Faller, 1985; Flaherty et al., 2000; Gilbert et al., 2009; Morton & Oravecz, 2009; O'Toole et al., 1999; Renninger et al., 2002; Steen, 2009; Strozier et al., 2005; Van Haeringen et al., 1998; Vulliamy & Sullivan, 2000). Fear of personal consequences such as loss of time, money, and potential legal consequences are also common (Badger, 1989; Brosig & Kalichman, 1992; O'Toole et al., 1999; Vulliamy & Sullivan, 2000). In a survey of medical professionals, they indicated other concerns for reporting, including the unknown outcome, the fear of dissatisfaction with CPS, the concern with losing the relationship with the client, and the desire to avoid court proceedings (Vulliamy & Sullivan, 2000). Pollak & Levy (1989)

found that the reporters' own anxieties about disrupting their relationship with the family and their experience with social services affected their willingness to make the report. Considering these common fears, it is understandable why many professionals dread reporting.

Concerns for the therapeutic relationship. For mental health professionals, the therapeutic relationship with the client is important. As discussed above, a common fear for mental health professionals is the disruption of the therapeutic relationship due to reporting child maltreatment. Researchers have found varied results on the impact of reporting on the therapeutic relationship (Bean, Softas-Nall, & Mahoney, 2011; Kalichman et al., 1988; Levine et al., 1995; Steinberg, Levine, & Doueck, 1997; Strozier et al., 2005; Watson & Levine, 1989; Weinstein et al., 2000). Researchers have found evidence that supported both a negative impact and a positive impact on the therapeutic relationship, both of which are presented below.

Positive impact. A child abuse report can have a positive impact for the client and the therapeutic relationship. Watson & Levine (1989) found that only a quarter of clients terminated counseling after a report was made. Clients were more likely to return to treatment after a report was made if there was a strong therapeutic alliance, longevity in treatment, and more explicit consent procedures (Steinberg et al., 1997; Weinstein et al., 2000). Many of those factors can aid in client progress in treatment. Strozier and colleagues (2005) and Steinberg and colleagues (1997) all asserted that the impact on mandated reporting could have a positive effect on the relationship. The majority of families, according to Fryer, Bross, Krugman, Denson, and Baird (1990), rated the

intervention received from CPS as good or excellent, and they also noted an indicated an improvement in the family life.

Negative impact. Many counselors are concerned that a report will have a negative impact on the client. Researchers have found evidence that validates the therapists' concerns, suggesting a negative impact on the therapeutic relationship in making a child protection report. Many studies report negative results, including clients not returning, after a report has been made (Bean et al., 2011; Levine et al., 1995; Strozier et al., 2005). Oftentimes, mental health professionals indicated that an unsubstantiated report regularly caused more harm than good to the client and themselves (Levine, et al., 1995). In a survey of psychologists, Steinberg and associates (1997) found that about 46% reported clients becoming upset following the report, and 27% dropped out of treatment after the report was made.

Many mental health professionals believe that secrecy is required to encourage clients to be fully open in therapy and that the breach of confidentiality may inhibit client openness (S. R. Smith & Meyer, 1984). This breach of confidentiality can keep clients and their families from seeking therapy (Bean et al., 2011; Levine et al., 1995; Morton & Oravec, 2009; Steen, 2009). According to Horton and Cruise (2001), parents may also prevent their child from continuing in counseling after a report is made, even in a school setting. Levine and colleagues (1995) discuss the fact that clients will sometimes blame the therapists for breaking up their families and betraying them. Therapists also reported incidents of the report damaging the bond between mother and child and traumatizing the victim (Strozier, et al., 2005). Steen (2009) found that reporting on battered woman not

only damaged the relationship between a domestic violence shelter worker and the battered woman, but it also argued that the report discouraged woman from seeking further help. With all of these concerns, the fact that counselors struggle to report child maltreatment after assessing the need makes sense.

Reporting outcomes and counselor reactions. With the potential consequences to the client and the unknown impact on therapeutic relationships, counselors struggle with the decision to report. Levine and colleagues (1995) proposed that the following factors influence the outcomes of reporting: (a) the proximity of the potential abuser to the therapeutic relationship, (b) whether the client was an adult or child, (c) how the report was presented to the client, (d) whether the case involved divorce and child custody disputes, (e) the client's level of involvement in making the report, and (f) the nature of the alleged abuse. The more counselors struggle with the conflict of reporting on their clients, the poorer the client's emotional response and the less likely that the client is going to remain in treatment (Levine et al., 1995; Steinberg et al., 1997). Many counselors weigh the consequences of reporting with their surety that abuse is taking place. Kalichman and associates (1988) found that psychologists were more willing to take the risk of disrupting the relationship if they were confident about the occurrence of the abuse. Weighing potential consequences of the client is a process all counselors will face. As the above literature evidences, the therapeutic outcomes for the client can be dependent on the counselor's self-efficacy of reporting and personal beliefs about the reporting process.

Uses of mandated reporting. Mental health professionals, depending on their beliefs about the Child Protection System when having to report to child protective services, could argue that client welfare is not being protected. According to the ethical codes of the American Counseling Association (2014), client welfare is of the upmost importance in a counseling relationship. These beliefs about CPS and client welfare, along with the flexibility of interpreting the definitions of child maltreatment, allow mental health professionals to use their mandated reporting status to influence client involvement in treatment and treatment outcomes. With countless factors influencing whether counselors report, it is important to review the common uses of mandated reporting in the mental health field. Some research has been conducted on mental health professionals' uses of reporting in the therapeutic relationship. There are both therapeutic and coercive uses of reporting (Anderson et al., 1993; Levine et al., 1995).

Therapeutic uses of mandated reporting. Reporting child maltreatment can have therapeutic uses. Levine and colleagues (1995) identified that the therapeutic uses of reporting are to enhance child safety, show support for a client, lessen client resistance, and help a client maintain self-control. Some therapists delay reporting in order to improve the therapeutic relationship and set limits on childrearing (Anderson et al., 1993). Though the reasons may seem valid, there are ethical concerns for using or delaying reports as a way to manipulate clients.

Coercive uses of mandated reporting. There are also negative ways to use reporting. Therapists can report in order to allow themselves to assert legal control over the client or to force the client into compliance, thereby enforcing attendance and

engagement in therapy (Anderson, et al., 1993; Levine, et al., 1995). They do this by reporting to structure the client's environment, to force a client to take action, to keep a family in treatment, to control a client legally, and to punish a client (Anderson, et al., 1993; Levine, et al., 1995). In addition, some therapists report for their own gains, like venting anger they have for a client (Anderson, et al., 1993). Pollak & Levy (1989) discussed the importance of therapists to identify their own countertransference toward the client, including guilt, shame, sympathy, and anger in order to protect client welfare. Ethically, counselors should always consider client welfare when making therapeutic decisions, much like with mandated reporting, and they should learn to balance their legal obligation with their therapeutic (or personal) reasons.

Shifting responsibility. In order to protect the relationship with their clients, therapists tend to find ways to shift the responsibility of reporting (Alvarez, et al., 2004; Levine, et al., 1995). Therapists do so when they shift responsibility for the mandate to supervisors, to the law, and to the clients (Horton & Cruise, 2001; Kalichman, 1999; Levine et al., 1995). They also make anonymous reports in order to avoid having to speak with their client about the report (Levine, et al., 1995). This is another way in which professionals avoid experiencing the perceived negative consequences of reporting clients to CPS.

Negative view of child protective services. A misunderstanding of the system overall can also inhibit reporting to CPS. Researchers have shown that mental health professionals tend to have a negative attitude toward CPS (Alvarez et al., 2005, 2004; Faller, 1985; Kalichman et al., 1988; Renninger et al., 2002; Steinberg et al., 1997;

Watson & Levine, 1989; Zellman, 1990a). In a survey that Strozier and colleagues (2005) conducted, therapists reported that CPS and counselors had a different focus for the family, and CPS interventions often caused hardships to the family because caseworkers were not trained in the best interests of the child. Therapists also reported that caseworkers were often adversarial with their clients, were unprofessional through their interactions with both the client and the counselor, and often did not do anything for the family after an investigation was concluded (Strozier et al., 2005). Many therapists believe that CPS will not assist children and are also often overworked (Alvarez et al., 2004). Juggling the mandate to report and negative beliefs about CPS, counselors struggle with this legal obligation.

The many reasons why professionals, especially in the mental health field, struggle with making a report to social services are detailed above. As the literature suggests, there is a clear divide between the system and those who are required to report to it. For years, researchers have been identifying these fears and suggesting ways in which professionals can adjust to this legal mandate. As discussed earlier, the literature highlighting the specific barriers facing counselors is limited, and one can infer the same from the literature on other mental health fields, including psychology and social work. While similar to other mental health professionals, counselors must have their own unique training requirements to assess for the risk of child maltreatment and be prepared to manage the care of these clients before, during, and after a report is made.

Role of Counselors in Child Maltreatment Risk Assessment

Thus far, this section has presented child maltreatment risk assessment, introducing each type of child maltreatment and its impact, following with literature defining the mandate to report, the prevalence of reporting, and the current practices of professionals with mandated reporting, including the common barriers to reporting experienced by counselors. As the role strain counselors feel in reporting child maltreatment evidences (Steinberg et al., 1997) and the many different ways professionals use reporting to CPS to affect client outcomes (Alvarez et al., 2004; Anderson et al., 1993; Levine et al., 1995), it is clear that the role of counselors in child maltreatment risk assessment needs to be defined. In this section, the role of the counselor in assessing for the risk of child maltreatment is discussed.

As a mandated reporter, the literature is clear that counselors are required to report suspected child abuse and neglect. Beyond making the report, however, it is not always clear on how to assess risk of child maltreatment and what to do once child maltreatment is suspected. Several researchers, specifically in the school counseling field, have attempted to define the counselor's role (Bryant & Baldwin, 2010; Lambie, 2005; Remley & Fry, 1993). There are four steps to assessing for risk of child maltreatment: (1) identifying child maltreatment, (2) gathering information from the client about the suspected abuse, (3) making the decision to report, and (4) making the report to CPS (Bernstein & Hartsell Jr., 2004; Lambie, 2005; Levine et al., 1995; Remley & Fry, 1993). Identifying these steps are an important move toward pinpointing the counselor's role in assessing for risk of child maltreatment.

Identifying that child maltreatment exists is the first step to assessing for risk of child maltreatment. The definitions and impacts of each type of child maltreatment were presented previously in this literature review. The role of the counselor is to know the definitions of each type of maltreatment and know how to identify each form of abuse and neglect (Henderson, 2013; Levine et al., 1995; Remley & Fry, 1993). Counselors may identify abuse through the behaviors of the client or a verbal report from a client (Bernstein & Hartsell Jr., 2004; Levine et al., 1995; Remley & Fry, 1993). Withdrawal, regression into previous developmental stages, inappropriate personal boundaries, aggression, anxiety, depression, dissociation, behavioral problems, and low self-esteem are all common signs of abuse, regardless of the type (Chu & Dill, 1990; Hildyard & Wolfe, 2002; Kaplan et al., 1999; Noland et al., 2004; Parker & Herrera, 1996; Simonelli et al., 2002; Trickett & McBride-Chang, 1995; Wiehe, 1991). Clients may also self-report perpetrating or being the victim of child maltreatment during sessions (Henderson, 2013; Remley & Fry, 1993). Once the counselor suspects that child maltreatment exists, they can begin gathering information to make the report.

Gathering information to make a report is a precarious role for counselors. Most counselors have difficulty knowing how much information to gather (Henderson, 2013). The threshold for gathering information centers on having a suspicion that maltreatment is happening (Henderson, 2013; Levine, et al, 1995). Many researchers stress that it is important for counselors to report when they suspect abuse is present, not to prove it is happening (Alvarez et al., 2004; Henderson, 2013; Kalichman, 1999; Levine et al., 1995; Renninger et al., 2002). Gathering information, listening and creating a safe space for

the client are the key purposes of the session (Brown, Brack, & Mullis, 2008; Lambie, 2005; Henderson, 2013). It is also important that counselors understand their role in the investigation/potential court processes so they do not interfere or influence the child's statement (Bernstein & Hartsell, 2004; Brown, et al., 2008). Being the first to witness a child or perpetrator's outcry, the counselor may be called upon to testify in court (Remley & Fry, 1993), and any criminal charges may be thrown out if the statements are thought to have been coerced (Bernstein & Hartsell, 2004). Counselors can accomplish this task by utilizing basic counseling skills such as paraphrasing and reflection (Lambie, 2005) in a non-judgmental and unconditional manner (Henderson, 2013).

The third step is making the decision to the report. Many researchers suggest the use of ethical decision making models when deciding to report suspected abuse (Tufford, 2012; Henderson, 2013; Remley & Herlihy, 2010). Consulting with colleagues, especially when the decision is unclear (Henderson, 2013), is an important step in making the decision. Using clinical judgment (Remley & Herlihy, 2010) and erring on the side of caution to ensure client safety (Bernstein & Hartsell, 2004) are common recommendations when making the decision to report.

When making the decision to report, there are two additional factors that are important for a counselor to consider, (1) informing and including the client in the report, and (2) understanding and following the required protocol of their employer. The decision to inform the client of the impending report is important. Many researchers have found that many clients feel empowered when they are included in the decision and making of the report (Henderson, 2013; Steinberg, et al., 1997). Including parents and

children into the report can facilitate the continuity of the therapeutic relationship, reassure parents and children that the counselor is an advocate for the family, and lay the foundation for future clinical work (Henderson, 2013; Remley & Fry, 1993). However, this decision to include the client does come with some risks. Oftentimes, counselors fear further harm to children, retaliation of other family members on the client reporting, and the fleeing of the family before CPS can assess for safety (Levine, et al., 1995; Alvarez, et al., 2005; Hinson & Fossey, 2000; Donahue, et al., 2002). Counselors need to assess their own personal fears and weigh out the potential consequences for the client when deciding to include the client in the report.

Another important factor to consider while making the decision to report is recognizing and following the protocols of employers. Many counselors work in different settings, including mental health centers, schools, and hospitals. Each place of employment may have specific procedures to follow (Remley & Fry, 1993; Brown, 2006). Many school systems approach mandated reporting as a team, requiring members to either report to the team with their concerns (McEvoy, 1990), or follow certain reporting procedures (Akande, 2001). School counselors, for example, may be required to inform school administrators, and teachers of the report (Bryant & Milsom, 2005; McEvoy, 1990; Remley & Fry, 1993). Mental health counselors in clinical settings, may also be required to consult with their supervisor, and have certain paperwork to file, when making the decision to report (Brown, 2006). With these workplace specific procedures attached to child maltreatment reporting, it is imperative counselors know how to access and implement these plans.

The final step is reporting to CPS. To do this, the counselor needs to know where to call and what information to provide. All states are required to provide a hotline available to accept child welfare reports 24 hours a day, seven days a week (CAPTA, 2010). To find state-specific reporting information, including phone numbers, counselors can access the Child Welfare Information Gateway, a service offered by the U.S. Department of Health and Human Services. Once the number is located, a counselor needs to be prepared to provide demographic information for the family, including names, addresses, and birthdates of all individuals living in the home (Alvarez, et al., 2005). Counselors need be prepared to communicate their concerns for the family (Levine et al., 1995; CWIG, 2014). Along with the concerns, it is also important for the therapeutic relationship with the client and helpful for CPS if the counselor includes the family strengths in their report (Walsh, 2003; Steinberg, et al., 1997; Henderson, 2013). Identifying and communicating strengths can facilitate the continuity of the therapeutic relationship and aide in the management of risk necessary to help clients and their families overcome the stress of child maltreatment.

Safety for the child is often a significant concern for mandated professionals, including counselors. Professionals often question the safety of a child when sending a child home (Henderson, 2013; Remley & Herlihy, 2010). The role of CPS or law enforcement is to assess for safety (DePanfilis & Salus, 2003). Both have the ability and the authority to gain court orders and control for safety in the home. It is important that counselors consult with CPS or law enforcement if the concern for safety of the child is imminent or there is a potential threat to their welfare (Henderson, 2013).

Child Maltreatment Risk Management

Thus far, this review of literature has focused on assessing risk for child maltreatment and making the report. Assessing for risk is only part of the responsibility the counselor has to a client affected by child maltreatment. Once the decision has been made that a report is necessary, the counselors' role turns to that of advocate during and after the report, and can begin helping the client to recover from this. While there are many treatments available for trauma survivors, it is beyond the scope of this study to discuss all of these here. Instead, this study centers on the common factors that influence client outcomes and applying those to specifically working with clients experiencing child maltreatment within the immediate time frame of a filed report. As the many research studies that discussed professionals' barriers to reporting evidences, client welfare is a common concern when reporting. A competency needs to be established to address this fear so that counselors are better prepared to work with their clients.

With the many different theories and therapeutic approaches available to use to work with clients, the debate over the best method is commonplace. According to the common-factors approach, there is no one best theory (Grencavage & Norcross, 1990). The common-factors approach recognizes that there are key common components of the many theories that influence client outcomes (Grencavage & Norcross, 1990). These common factors include and are not limited to client characteristics, therapist qualities, change processes, and the therapeutic relationship (Grencavage & Norcross, 1990). In this section, the management of clients involved and impacted by child maltreatment is discussed using these common factors.

Client Characteristics

Client characteristics can influence how a client handles a report being made on them. According to Grencavage and Norcross (1990), a client having hope and believing counseling will bring about a positive outcome and can influence client therapeutic outcomes. Hope can be defined as the “expectation greater than zero of achieving a goal” (Stotland, 1969, p. 2). Hope can be ignited through a sense of autonomy over the situation and identification of a goal (Snyder, 1995). According to this notion, clients who believe the act of reporting and that potential CPS intervention could help them will have a positive outcome compared to those clients who have no hope.

Hope may seem like an uncommon feeling in those who are involved with child maltreatment. According to many researchers, child survivors have a feeling of powerlessness over their own emotions and their world (Azar & Wolfe, 1998; D. Finkelhor & Berliner, 1995; Oates & Bross, 1995; Sawyer & Judd, 2012). Oftentimes, these survivors have experienced helplessness throughout their exposure to trauma (Lawson, 2009) and may find it difficult to expect that life could be better. According to Langhinrichsen-Rohling, Monson, Meyer, Caster, and Sanders (1998), a relationship between a history of exposure to family violence and hopelessness was discovered. Trust and security, components that can both influence hope, are negatively impacted when a child is abused (Feiring & Taska, 2005; Graham et al., 2010; Webster, 2001). With these findings, it would be easy to believe that client characteristics will influence treatment negatively.

Oftentimes, counselors can forget that parents involved with child maltreatment can also feel hopeless. According to Levine and Colleagues (1995), perpetrators of child maltreatment may feel hopeless and judged while in counseling. Parents that perpetrate abuse can often have a history of their own abuse, feel depressed, and feel hopeless (Chemtob, Novaco, Hamada, Gross, & Smith, 1997; Dempsey & Day, 2011). Across the different types of abuse, parents can feel scared that their children are going to be taken away and helpless to control the CPS process (Levine, et al., 1995). Societal expectations of maintaining control and having everything put together can inhibit parents from expressing their feelings, which can lead to substance abuse, depression, and other self-destructive feelings (Walsh, 2003). With this feeling of hopelessness, clients may become angry and defensive that the report is being made.

Not all clients involved with child maltreatment will experience hopelessness. Researchers have been interested in clients' ability to succeed despite crisis for many years (Rutter, 1987; Walsh, 2003; Kaufman & Ziegler, 1987). Rutter (1987) found that some children were able to grow up without dysfunction despite the many adverse situations they confronted; certain personal traits of children were found to be a type of protective shield to stressful situations (Anthony & Cohler, 1987). The ability to find an alternative way of looking at things, including a hopeful outlook on life, is listed as one of the many factors of resiliency (Werner & Smith, 1982). According to Walsh (2003), families have the ability to "rally in times of crisis, to buffer stress, reduce the risk of dysfunction, and support optimal adaptation" (p. 13). This resiliency can apply to both the individual and the family. As Lawson (2009) contends, the personal strengths of the

maltreated child can help the child cope with and grow from their abuse. This is similar to the concept of family resilience, where connections and resources help families power through crisis (Walsh, 2003). This outlook can continue into adulthood and can be manifested in therapy.

Therapist Qualities

The sum of a client's characteristics is one factor in influencing client outcomes. Furthermore, the entirety of a therapist's qualities is a second common factor that influences client outcome (Grencavage & Norcross, 1990). The common therapist qualities identified to influence client outcomes are: (1) a counselor's ability to influence hope, (2) unconditional positive regard, (3), demonstration of empathy, (4), being a socially-sanctioned healer, and (5) demonstration of acceptance (Grencavage & Norcross, 1990). As seen in the research presented earlier in the chapter, the qualities of the therapist can influence whether clients return to therapy. Steinberg, Levine, and Doucek (1997) found that clients were more likely to return to therapy when the counselor was confident and explicit with the purpose of the report.

Counselors can influence hope and positive expectations in their clients through access to resiliency. Sawyer and Judd (2012) discussed helping the child client claim power and a sense of control over his or her situation through connection and support. Instilling a sense of protection from both perceived and actual threats can help the client begin to feel a sense of safety and belonging (Sawyer & Judd, 2012). The counselor needs to help the client feel safe during and after a report through collaboration with the child protection worker, (Alvarez, et al., 2005), discussing safety with the client, and

promoting autonomy and ownership over the process (Levine, et al., 1995; Sawyer & Judd, 2012). Reframing and including the client can also add a sense of autonomy over the report, which can also influence hope (Levine, et al., 1995). Empowering clients can influence client characteristics.

Parents are capable of empowerment, as well. According to Levine and colleagues (1995), “parents do not intentionally hurt their children... they are genuinely doing the best they can, given the circumstances” (p. 107-108). By helping clients identify the goal of being a better parent, counselors can reframe the report for the client, influencing their hope in the situation (Levine, et al., 1995). Counselors can also influence the client’s sense of autonomy and control over the situation by including the adult client in the report (Levine, et al., 1995; Alvarez, et al., 2005). This can help ease the client’s fear that the report could lead to disruption in their family’s well-being.

Beyond influencing hope, other therapist qualities can influence client outcomes in treatment during and after a report. Levine and associates (1995) provided several examples—such as reframing, outreach, and non-defensiveness—as ways for a therapist to demonstrate unconditional positive regard, empathy, and acceptance when working with clients involved in child maltreatment. Rogers (1957) indicated that these factors in a therapist are necessary and sufficient to affecting client change. Demonstrating an understanding of the client and separating the client’s behavior and his or her motives can help therapists to influence a client’s desire to continue in therapy (Levine, et al., 1995). According to Weinstein and associates (2001), attempts to engage a client through extra sessions and reaching out to the client via phone calls or home visits are typical activities

that clinicians perform. While the impact of these additional activities has not been studied, these do influence client outcomes, as they demonstrate those common factors Grencavage and Norcross (1990) described.

Change Processes

The principles of change represent a third common factor affecting client change. According to Goldfried (1980), change processes can be defined as the means by which change occurs in counseling. While Grencavage and Norcross (1990) identified many commonalities across studies, the ones most applicable to working with clients immediately during and after a report is made are opportunities for catharsis, fostering insight and awareness, and emotional and interpersonal learning. Considering client outcomes for child maltreatment, these factors are important when treating both perpetrators and survivors of child maltreatment.

Catharsis. Catharsis is considered to be the most important therapeutic principle that influences change in a client. Catharsis, as Bushman (2002) defined, is the cleansing or purging of emotions. A common accepted theory is that expressing emotions are much better for mental health than bottling them up (Bushman, Baumeister, & Phillips, 2001; Freud & Breuer, 1955).

While emotional catharsis is acceptable in most counseling situations, when it comes to expressing emotions about child maltreatment reports or the process, counselors seem uncomfortable (Levine, et al., 1995; Donohue, et al., 2002). Instead of inhibiting client catharsis in this moment, Levine and associates (1995) suggest that counselors take a non-defensive response to client anger and fear. Allowing a client to express him or

herself throughout the process can help influence client acceptance of the report and move the client toward change.

Fostering insight and awareness. Like any other presenting concern in counseling, clients impacted by child maltreatment can benefit from their own personal awareness and insight of their situation. Whether working with perpetrator or survivor, helping the client to become aware and develop of their own personal connection to their experiences will aide in client outcomes (Grencavage & Norcross, 1990; Tracey, 2003). Regardless of the theory or technique employed, providing feedback to clients can influence them to change (Bugental, 1965; Goldfried, 1980). In the context of working with individuals affected by child maltreatment, feedback on thoughts, feelings, behaviors, and patterns of each, could help clients recognize how they are impacted by child maltreatment.

Helping a mother become aware of her unrealistic expectations of her 5-year-old son, whom she punishes when he forgets to bring home his homework, is one example. Through insight and awareness, this mother could recognize that her expectations for her son may come from her desire for him to be successful and a dearth of understanding of his developmental stage. Similarly, a 5-year-old child reporting being beaten for not bringing home his homework could benefit from the awareness that his worth as a human being is not dependent on whether he brings home his homework.

Emotional and interpersonal awareness. Along with fostering of insight and awareness of the self, the process of attaining awareness of emotional and interpersonal awareness can help clients heal from their exposure to child maltreatment. A broad

definition of emotional and interpersonal awareness is “a client’s ability to perceive and understand his or her own and others’ emotions while being able to self-regulate in different environments” (Salovey & Mayer, 1990, p. 190). When considering treatment of individuals involved with child maltreatment, emotional self-regulation is incredibly important. As the literature on the effects of child maltreatment evidences, many survivors struggle with regulating their emotions (Bryer et al., 1987; Parker & Herrera, 1996; Wolfe & McIsaac, 2011) and their interpersonal relationships (Beitchman et al., 1992; Briere & Elliott, 1994; Malinosky-Rummell & Hansen, 1993; Salzinger et al., 1993). A focus on emotional and interpersonal awareness can help influence positive client outcomes.

Perpetrators of child maltreatment could also benefit from a focus on emotional and interpersonal awareness. Change in affect can influence judgment, cognition, and decision making (Isen, 1984). In a study of perpetrators of domestic violence, the results showed that the frequency of negative emotional states influenced aggressive behavior (Margolin & Gordis, 2000), and romantic partners could influence each other’s emotional states (Vivian & O’Leary, 1987). Several researchers have found that assaultive persons tend to have difficulty restraining their positive emotional states (Allen & Tarnowski, 1989; Hamberger & Hastings, 1986; Yelsma, 1996). Increasing client awareness of his or her emotional and interpersonal responses may help them understand the impact of actions on others.

Therapeutic Relationship

Mental health professionals believe that the therapeutic relationship with the client is very important. According to Grencavage and Norcross (1990), mental health professionals are correct, as the relationship between client and counselor is the most common factor across all theories that impacts client outcomes. Lambert and Barley (2001), who found that the therapeutic alliance accounts for 30% of treatment outcome, support this notion. According to (Hobbs, 1962), the positive connection to another human being without being hurt helps clients desire more open relationships with other human beings. A therapist's biggest fear is often the breach of that trust the client develops in the counselor, which binds the relationship together (Bean et al., 2011; Watson & Levine, 1989; Weinstein et al., 2000). This potential breach could influence whether a client might return to counseling.

Many researchers have studied the therapeutic relationship—and its rupture (J D Safran & Muran, 1996; Jeremy D Safran, Muran, Eubanks-Carter, & Stevens, 2001; Samstag, Batchelder, Muran, Safran, & Winston, 1998; Tufford, 2012). A rupture in a therapeutic relationship can be defined as “the breakdown of the positive connection between counselor and client (Safran, Muran, & Eubanks-Carter, 2011). Depending on how the process is handled, reporting to CPS could lead to a rupture in the therapeutic relationship. When reporting, counselors often feel a sense of role strain with their legal duty to report to CPS and their ethical duty to maintain client welfare and the therapeutic relationship (Weinstein et al., 2000). According to Weinstein and colleagues (2000), the greater the feeling of role strain, the less likely the client will have a positive outlook on

the report. When counselors allow their own feelings of the report, the abuse, or their fear to affect their interactions with the client, the client will no longer feel the protection that the therapeutic relationship offers. Dalenberg (2004) discussed this concept in terms of the therapist reaction to client anger; clients reported greater satisfaction with therapists with a genuine response to anger rather than with a flat affect.

However, reporting does not have to rupture the relationship. Researchers have found that both client and therapist characteristics can influence the quality of the relationship (Ackerman & Hilsenroth, 2003; Constantino, Arnow, Blasey, & Agras, 2005). To maintain the relationship, counselors should be prepared to address relationship problems and modify their approach to meet the client's current needs (Grosse Holtforth & Castonguay, 2005; Safran et al., 2001). Researchers have found that counselors have ways of maintaining and strengthening the therapeutic relationship in spite of the report (Levine, et al., 1995; Weinstein, et al., 2000). Many of the examples these researchers have provided involve an active demonstration of empathy, unconditional positive regard, and warmth (Levine, et al., 1995; Weinstein, et al., 2000). A focus on the therapeutic relationship during and after a report is made can help influence client outcome and may influence whether a client will return.

Integration of Therapeutic Common Factors

In the section above, the common-factors approach was offered as way to address managing clients during and following a child maltreatment report. These factors are not meant to replace the theoretical lens of the counselor, nor do they suggest the best treatment modality for clients experiencing child maltreatment. Instead, these factors are

meant for consideration within the context of treating the client and how best to handle this client-counselor interaction in a way that supports client welfare. Many of these factors are interconnected and can influence the other, like therapist qualities influencing client characteristics, the change process, and the therapeutic relationship. The therapist's ability to identify clients' strengths and help bring them to awareness in order to instill hope, all while using empathy and unconditional positive regard and demonstrating that the client can trust them, is one such example.

A counselor needs to be ready to manipulate the common factors in a way that will reassure the client that the counselor has not changed and the therapeutic relationship will remain steady despite the disclosure of child maltreatment. As discussed in the previous section on mandated reporting, counselors often fear this process for many reasons, including not knowing how to handle the situation before, during, and after a report is made. In order to claim competence, counselors should be able to address each of these common factors within their practice with clients during and after a report is made.

Training

Many of the authors presented above suggest training as a solution to overcoming the barriers to reporting. Training can also aide in a counselor's ability to assess the risk that child maltreatment is occurring and increase their ability to work with clients who have been affected by child maltreatment. Although there are a countless studies on the deficit in the training of professionals on the process and purpose of mandated reporting, there is also a lack of specific guidelines on how to complete this onerous task

(Abrahams et al., 1992; Alvarez et al., 2005, 2004; Anderson et al., 1993; Bean et al., 2011; R. Brown & Strozier, 2004; Delaronde et al., 2000; Donohue et al., 2002; Flaherty et al., 2000; Gilbert et al., 2009; Kalichman et al., 1988; King, Reece, Bendel, & Patel, 1998; Levine et al., 1995; O'Toole et al., 1999; Pollak & Levy, 1989; Renninger et al., 2002; Steen, 2009; Steinberg et al., 1997; Strozier et al., 2005; Van Haeringen et al., 1998; Vulliamy & Sullivan, 2000; Watson & Levine, 1989; Weinstein et al., 2000).

The purpose of this section is to lay the groundwork for developing competence. With that goal serving as a guide, suggestions for overcoming barriers are synthesized and grouped into themes, with a discussion of the current state of training for counselors-in-training on child maltreatment risk assessment and management to follow.

Suggestions from the Literature

Many of the studies presented earlier in this literature review suggest ways to overcome the barriers mandated professionals face when required to report child maltreatment. In this section, these recommendations have been grouped into overarching themes that represent specific competencies for counselors to reach. The main themes found in the literature are content knowledge, the counselor role with the system, the counselor role with the client, addressing countertransference, collaboration with Child Protective Services, and management. These six themes are introduced in that order and supported with the current literature.

Content knowledge. One suggestion within the literature toward the attainment of competence is building content knowledge of child maltreatment and the mandated reporting process. This content knowledge includes training on legal requirements, child

maltreatment definitions, indicators of abuse, and the process of child protective services. In the Delphi study Chen, Fetzer, Lin, Huang, & Feng (2013) presented, the researchers found that medical professionals placed an emphasis on the knowledge and skills of reporting as the most important competencies for working with child maltreatment.

Knowing and understanding the legal requirements is key to having competence in working with this population. A strong knowledge base in reporting laws, including the philosophy underlying the laws, what constitutes reportable abuse in the current state, the types of perpetrators who must be reported, and the statute of limitations on reports, are recommendations of what to include in professional preparation (Renninger et al., 2002; Steinberg et al., 1997). In addition to understanding the legal expectation to report, researchers have suggested training professionals on the legal consequences for failing to report (Alvarez et al., 2004; Besharov, 1990; Kalichman, 1999; Levine et al., 1995). Students need to know that failure to report can lead to criminal charges and civil suits from the victims or their families (Alvarez, et al., 2004). Conversely, students should be informed that professionals who report maltreatment in good faith have immunity from legal repercussions in all 50 states (Besharov, 1990; Alvarez, et al., 2004). Overall, students need to learn to document any decisions to report or not report in order to avoid legal ramifications (Besharov, 1990).

Defining and identifying abuse represent other content knowledge areas for counselors to reach competence. Kalichman (1999) supported the need for counselors to understand the definitions and the indicators of abuse. Individual definitions of the different forms of child maltreatment were presented earlier in this literature review. As

discussed earlier, each state has its own definition of child maltreatment and the subsequent forms of abuse. Counselors need to be prepared to look up the definitions in the state where they practice in order to accurately assess whether their concerns rise to the level of reporting to CPS. Also discussed previously, the identification of child maltreatment can be extremely difficult, and it depends on the state in which the counselor lives. For example, a counselor living in Colorado needs to know that spanking is allowable as long as it is age appropriate and does not leave a mark (Colorado Children's Code, n.d.). However, this permission is not true for all states, as some states like Delaware prohibit causing any kind of physical pain to a child (*Title 11: Crimes and Criminal Procedure, Delaware Criminal Code*, n.d.).

Becoming competent working with clients also includes an understanding of CPS and its role with clients. An understanding of the CPS system will ease the reporting process for professionals, as it will address any preconceived notions the professional might have about the system and will help clarify the caseworker's role in preventing abuse (Delaronde et al., 2000; Strozier et al., 2005). Donohue and colleagues (2002) discussed the importance of sharing knowledge of the CPS investigatory process with the client as a way to maintain a working relationship. Knowing the system of CPS and what happens to families once a report is made is an important training point to help mitigate the negative attitude toward CPS caseworkers and the system (Alvarez, et al., 2005). Alvarez, and colleagues (2004) and Zellman (1990a) suggested that training methods surrounding the process and caseloads of the CPS workers should alleviate some of the animosity felt toward making reports. Knowing what is going to happen to the client will

help the counselor feel competent and confidently share with the client that the aim of the report is to strengthen the client's family.

Counselor role with the system. Knowledge-based training is only one of many components in reaching competency. Building on their knowledge base, counselors should be able to understand their roles in the process of assessing and reporting suspicions of child maltreatment. According to researchers, a counselor's role includes gathering information and advocating for the client. A difficult role, the process of gathering information is to collect enough information to make a report without crossing the line into investigation (Kalichman, 1999; Levine et al., 1995; Renninger et al., 2002). According to Alvarez and associates (2004), training should emphasize that professionals are only required to report suspicion of abuse, not prove that abuse occurred. For many counselors, this fine line can be confusing and difficult to recognize.

Becoming a client advocate is another role a counselor must take. Steinberg and associates (1997) suggested that training should include discussions around the value of informed consent procedures. According to the ACA code of ethics (2014) "Clients have the freedom to choose whether to enter into or remain in a counseling relationship... Informed consent is an ongoing part of the counseling process..." (p. 4). In order to build counselor competence in working with clients involved with child maltreatment, training should focus on how a counselor can include discussions of informed consent with the client when assessing for child maltreatment.

Counselor role with the client. A counselor's primary responsibility is to "respect the dignity and promote the welfare of clients" (ACA, 2014, p. 4). When considering the prospect of training competent counselors in working with clients affected by child maltreatment, this responsibility continues throughout the reporting process. Researchers have found that while current improvements in child abuse training for professionals help raise awareness, it sometimes falls short in affecting clinical performance (Khan, Rubin, & Winnik, 2005). Clinical performance for counselors is of the utmost importance when considering protecting client welfare.

Researchers suggest that counselors should be prepared to inform the client about the report in a way that minimizes anger and to continue working with the client in the aftermath of a mandated report (Steinberg et al., 1997). In 2013, Chen and associates provided a set of training competencies recommended for medical professionals. Similar to the aim of the present study, the authors argued that medical professionals ought to be trained to address the needs of abused children and their families, which goes beyond training on mandated reporting (Chen et al., 2013). The focus on parents or perpetrators of abuse was rated low in importance (Chen, et al., 2013). According to the Family Resilience Framework guiding this study, for counseling professionals, the focus should be on the individual within the context of his or her family system (Walsh, 2003). This includes a focus on working and consulting with parents, even when the identified client is their child.

The family resilience framework can be applied to the assessment of risk of child maltreatment. Child maltreatment can be seen as a symptom of a family in crisis.

Whether the abused individual is an adult, child, or several members of a family, the counselor is still working with the entire family system. Tapping into the family resources that help them overcome and rebound from stress can help counselors mitigate some of the problems that the barriers to reporting section of this literature review addressed (Walsh, 2003). Assessing risk of maltreatment is a two-fold process. The first step is identifying whether child maltreatment exists and needs to be reported. Counselors need to know and understand the definitions and laws of child maltreatment in order to do this. The second step is the continuing assessment of child maltreatment after the suspicion of child maltreatment. Counselors can continue to assess for family strengths and foster family resilience with the purpose of reducing dysfunction and enhancing family and individual functioning and well-being (Luthar et al., 2000). Using the content knowledge, counselors can practice ways to involve the client in the reporting process as a method of maintaining a collaborative relationship in treatment (Alvarez et al., 2004; Bromley & Riolo, 1989). Considering the common negative beliefs that counselors maintain, as discussed previously in this literature review, including the belief that clients will not return to counseling (Bean et al., 2011; Levine et al., 1995; Morton & Oravec, 2009; Steen, 2009), the development of this competency is imperative. It is important that counselors are prepared to manage the emotional impact of reporting for the client.

Addressing countertransference. Building competence in counselors goes beyond focusing on the emotional impact of reporting for the client; training should also concentrate on the counselor's personal reactions and stability during and after the process. According to the ethical codes, in order to maintain an ethical relationship,

“Counselors are aware of—and avoid imposing—their own values, attitudes, beliefs, and behaviors... (and) seek training in areas in which they are at risk of imposing their values onto clients...” (ACA, 2014, p.5). Many counselors report using mandated reporting to manipulate the relationship with the client, as the literature demonstrated above. To help counselors recognize their own values, some authors suggested assessing personal fears and attitudes toward reporting as part of training (Pollack & Levy, 1989; Anderson, et al., 1993). Most of the training programs evaluated and studied have focused on increasing confidence in making a report to CPS (Donohue et al., 2002; Hawkins & McCallum, 2001; Hawley & DeHaan, 1996; McCauley, Jenckes, & McNutt, 2003; Reiniger et al., 1995). This confidence in reporting is important, as clients can perceive a counselor’s hesitation and discomfort when discussing the probability of reporting to CPS.

Beyond increasing self-efficacy, practicing with and expecting client anger is an important component of addressing counselor countertransference. Many counselors fear client anger; therefore, Alvarez and colleagues suggested that training on anger management and self-protection strategies should be included during training programs as a way to ease this fear. Providing students with opportunities to practice, as Renninger, and associates (2002) advocated, is an important addition to training, as it helps counselors-in-training balance the need to make a report, the need to maintain the therapeutic relationship, and the fear that comes with these requirements.

The concept of self-care is an additional training component to help counselors develop competency in addressing their own reactions to the client involved with child maltreatment. The 2014 ACA ethical codes addressed self-care, identifying the need for

counselors to engage in self-care activities in order to meet their professional responsibilities. Sommer (2008) discussed the ethical obligation for counselor educators to prepare counselors to work with trauma victims and be able to cope with vicarious trauma.

Many researchers have suggested that trauma education should include helping counselors recognize their own emotional reactions to clients (Elwood, Mott, Lohr, & Galovski, 2011; Salston & Figley, 2003; Schauben & Frazier, 1995) and normalizing the secondary trauma as a response to working with survivors (Elwood et al., 2011; Steed & Bicknell, 2001). Students should be encouraged to seek supervision when working with this population to help them manage and identify their own secondary trauma reactions (Elwood, et al., 2011).

Collaboration with child protective services. Some studies have moved beyond content and practice as the only strategies to build competence. A few investigators have encouraged counselors to build a collaborative relationship with social services (Alvarez et al., 2004; Besharov, 1990). Training can guide counselors in forming these relationships and working within the system in order to support client welfare (Alvarez, et al., 2004). Alvarez and colleagues (2004) also suggested that collaborative relationships may help professionals understand the process for the client, which may alleviate some of the negative feelings they may have toward CPS. Some researchers included the possibility of inviting guest speakers from CPS into training as a way to address some of the adversity professionals feel toward the system (Chen, et al., 2013).

Building relationships with outside agencies such as CPS can also help counselors recognize their part in the system rather than feeling apart from the system.

Management. Competence in working with child maltreatment extends past a child maltreatment report. The common-factors approach was used previously in this chapter to discuss the management of client welfare during and after a report is made. In this section, specific suggestions from the researchers cited in the literature on child maltreatment about management are presented. The counseling field has conducted some research on training for counselors working with survivors of child maltreatment (Alvarez et al., 2010; Brown, 2006; Bryant & Baldwin, 2010; Kitzrow, 2002; Priest & Nishimura, 1995). Most of these studies focused on training for counselors to be prepared to identify and report child maltreatment (Alvarez et al., 2010; Brown, 2006; Bryant & Baldwin, 2010). The suggestions in these studies mirror the research already presented above, identifying a need for training on specific challenges of counselors, the legal consequences, and identifying child maltreatment. While this helps counselors prepare for the risk assessment part of their responsibility to clients, counselors still need to be prepared to work with survivors of child maltreatment.

In psychology programs, the focus for treating survivors of child maltreatment is training on evidence-based treatments (EBT) (Allen & Crosby, 2014; Sigel & Silovsky, 2011). These EBTs are often manualized, and they require the clinician to follow a specified structure regardless of the specific needs of the client (Allen & Crosby, 2014). According to Allen and Crosby (2014), most clinicians preferred nondirective/unstructured approaches to treating children who experienced trauma in spite the focus in

training programs on EBTs. This difference in attitude and training suggests that despite the push toward EBT during graduate training, clinicians still hold the belief that survivors of trauma should be allowed to discuss their trauma on their own time.

Management of the risk of further child maltreatment can include identifying those family strengths that promote family resilience and using them in the treatment of the family and individual impacted by child maltreatment (Walsh, 2003). The family resilience framework moves the counselor from viewing families as dysfunctional to a more strengths-oriented view of a family in crisis (Walsh, 2003). This view helps aide families and individuals in believing they have the capacity to overcome child maltreatment and help each other heal from the trauma they suffered. This supports the use of the common-factors approach in managing child maltreatment, as no specific approach is highlighted above another. The focus for the competency should be on using those common factors to increase the client's outcome in treatment.

Multicultural awareness. Like with many other counseling topics, training around multicultural considerations when working with clients dealing with child maltreatment is imperative. According to Hays, Prosek, and Mcleod (2010), a client's cultural identity, the cultural match between a client and counselor, and cultural bias all have an effect on the clinical decision making process. Counselor's need to be trained to be aware of their own bias in order to ensure they are appropriately assessing the client for the risk of child maltreatment. Sue, and associates (1992) published multicultural competencies and standards for the counseling profession. As with any other client concern, counselor's need to continue to uphold these standards with their client when

assessing for the risk of child maltreatment. Counselor educators also need to emphasize the importance of these standards when discussing working with specific client problems, like child maltreatment.

Critique of literature. As discussed throughout this literature review, many of the researchers have generalized the mental health field, lumping counselors with psychologists and social workers. Medical professionals, psychologists, and social workers have completed a considerable amount of the research on training for child maltreatment assessment and management. As discussed in chapter 1, the counseling profession differs significantly from these other related mental health fields; therefore, counseling needs a set of competencies specific to the role and practice of counselors. Most researchers also focused mainly on facilitating the mandated reporting process for professionals and clients (Alvarez et al., 2010; Brown, 2006; Damashek et al., 2011). Many of the suggestions for competencies discussed above were pulled from non-counseling literature and grouped with the needs of counselors in mind. This lack of research could explain why training competencies have not already been established for the counseling profession.

Current climate of training. Training for mental health professionals, including counselors, is currently inconsistent across graduate training programs. Authors have highlighted a deficit in which most psychologists rated their graduate training in child abuse as poor and lacking in adequate preparation for working with this legal mandate (Pope & Feldman-Summers, 1992). A significant percentage (45%) of new professionals

rate their preparation in working with crises related to abuse and neglect as minimal to none (Wachter Morris & Barrio Minton, 2012).

In a survey of CACREP counseling programs on their course offerings for child sexual abuse, 69% of programs reported that they did not offer a course of sexual abuse; however, 41% indicated that they addressed it in other courses (Kitzrow, 2002). In a similar study, Priest and Nishimura (1995) found that 25% of programs surveyed offered a course on child sexual abuse, and 42% of programs indicated that they offered a course that mentioned child sexual victimization.

Comparable to the research done on psychology programs, the inconsistency of other professional programs covering these important topics is concerning. In a survey of graduate school psychology programs, 27% of programs reported that child maltreatment was a major focus of training, 52% reported that it was a minor focus, and 22% offered training informally (Sigel & Silovsky, 2011). Sigel and Silovsky (2011) also found that most psychology graduate programs offered some form of training on treatment of child maltreatment. In a survey of medical professionals, Anderst and Dowd (2010) discovered that many medical professionals desired a more specified training for their specialties on the management of child abuse. Much like in the medical field, counselors too have specializations and may benefit from understanding their role in child maltreatment in context of their specialization.

Despite rating their preparation in graduate programs as poor, in a survey that Pope and Feldman-Summers (1992) conducted with clinical and counseling psychologists on their competence to work with abuse victims, most of the surveyed

professionals rated themselves as moderately competent. These self-assessments are concerning; currently, and during the time that the investigation was conducted, specific competencies had not been established. Since the aim of professional counseling programs is to train competent counselors, the need for a more focused, standardized curriculum for child maltreatment risk assessment and management is clear. With inadequate training, counselors are still expected to develop the competence necessary to be able to work with clients, even though they may not be competent enough to assess and manage the concerns that clients who suffer from child maltreatment present.

Delphi Method

So far, this literature review has documented surrounding competencies, family resilience, child maltreatment, mandated reporting, management, and training. This section outlines the proposed method to be used to build the competencies for child maltreatment risk assessment and management. This section reviews the definition of the Delphi method and details a brief history of the method.

Definition of the Delphi method

Fairly new to social science research, the questions of this study were answered using a Delphi method. According to (Crotty, 1998), it is imperative to select a method of research based on the research question being asked. Considered a consensus method, Hasson, Keeney, and McKenna (2000) discussed the use of a Delphi method when the decisions at hand are dependent on group involvement. Linstone and Turoff (2002) defined the Delphi method as “a method for structuring a group communication process so that the process is effective in allowing a group of individuals, as a whole, to deal with

a complex problem” (pg. 3). Hasson, and colleagues (2000) added transforming opinion into group consensus to their definition of the Delphi method. Traditionally, the process of the Delphi is done through a series of questionnaires that incorporates controlled feedback to participants (Linstone & Turoff, 2002). As the literature presented in this review evidences, building training competencies for counselors is a difficult, complex task that needs to utilize many experts presenting their worldviews and experiences in working with clients.

History of the Delphi Method

The concept of the Delphi originated in a Rand Corporation study termed “Project Delphi” in the 1950s (Linstone & Turoff, 2002). Through a series of questionnaires and feedback, the goal was to achieve an agreement of opinion from a panel of experts (Dalkey & Helmer, 1963; Linstone & Turoff, 2002). The original Delphi was designed to utilize multiple expert opinions to design a target system in the midst of the Cold War (Linstone & Turoff, 2002). The Delphi method came to the attention of the public in 1963 through the publication of the forecasting article (Linstone & Turoff, 2002). The Delphi method is historically used mainly for technological forecasting; however, its current uses are growing in the medical and social sciences fields (Linstone & Turoff, 2002).

Dalkey and Helmer (1963) published the process of the first Delphi. This paragraph provides a brief summary of the first Delphi process as Dalkey and Helmer described it. Consensus of the seven participants recognized as experts in their field was reached after three rounds of questionnaires (Dalkey & Helmer, 1963). In the first round,

participants were presented a scenario, asked to complete a survey, and then interviewed about their answers for the survey (Dalkey & Helmer, 1963). In the second round, participants were asked to complete another questionnaire that was created using the data from the first round (Dalkey & Helmer, 1963). This survey included an open-ended question with which the participants could write their general comments, and this step produced narrative data to be analyzed (Dalkey & Helmer, 1963). The narrative data, along with the answers to the second survey, were again compiled into a final survey, which asked the participants to re-evaluate their initial statements (Dalkey & Helmer, 1963). Consensus was reached through computing the medians from all the surveys (Dalkey & Helmer, 1963). An additional two rounds were completed to clarify and revise the earlier consensus, during which participants were asked to review their answers to previous surveys and revise them as needed. Some critiques that Dalkey and Helmer offered about their process included leading the participants and the recognition that responses were not completely independent of each other. Additionally, they recognized that the wording of questions led to data that did not aid in the computation of the consensus, and they did not have a firm theoretical foundation on the final responses (Dalkey & Helmer, 1963).

The Delphi method has grown into a more reliable and efficient method since its inception. Businesses began adopting the process in the 1960s for forecasting (Rieger, 1986). With the use of this method becoming more popular in the 1960s and 1970s, the process began to be refined, and its rigor was recognized (Gupta & Clarke, 1996; Linstone & Turoff, 2002; Rieger, 1986). Currently, the utilization of the Delphi method

has increased and is now used in most academic and professional fields (Gupta & Clarke, 1996).

The Delphi method has been used to create competencies in other fields, including health care, student affairs, and teaching. Establishing competencies in any given field is a complex task that requires access to experts and professionals without requiring them to be in the same location (Burkard, Cole, Ott, Stoflet, & Cole, 2004). Many of these studies justified the use of the Delphi due to their needs to use a time-efficient, rigorous, and comprehensive method (Burkard et al., 2004; Chen et al., 2013; Smith & Simpson, 1995; Witt & Almeida, 2008). Most notably, Chen and colleagues (2013) used the Delphi method to develop competencies for health care professionals for child abuse educational programming. Their use of the Delphi allowed them “to reach a consensus on the content and priorities for educational programs” (Chen, et al., 2013, p. 169) using expert opinions in an empirical way. The use of the Delphi method in this study hoped to produce empirical data that identifies and analyzes competencies of child maltreatment.

Conclusion

The purpose of this literature review was to present literature that supports the development of domains and competencies for master’s-level counselors for child maltreatment risk assessment and management. Per the information in this review, child maltreatment is a widespread epidemic that many counselors must face in their work with clients. Through the exploration of the literature, it is clear that these competencies are both needed and necessary for preparing counselors to work with clients regardless of the

setting. While many studies have touched on different requirements of training, there are currently no standards established. The goal of this study was to fill this gap through the use of the Delphi method.

CHAPTER III

METHODOLOGY

In the previous chapters, I presented the history and current context of counselors' role in child maltreatment risk assessment and management. I conducted a review of the literature, which provided evidence that more research is needed on training counselors to better assess and manage the risk of child maltreatment in their clients. The purpose of this study was to help narrow this gap in training by developing competencies for master's level counselor educators in training programs. I used a Delphi study to fulfill this purpose. The Delphi method delivers valuable empirical data on difficult issues allowing the identification and assimilations of experts' opinions about important variables, like the building of professional competencies (Chen, et al., 2013).

I used a mixed methods exploratory sequential design, a type of Delphi study, in this research. In a mixed methods exploratory sequential design, the researcher engages in a progressive process of collecting and analyzing qualitative and quantitative data (Creswell & Plano Clark, 2007). This design was relevant to developing competencies in this study because, through the Delphi process, a qualitative survey initiated the discussion on the scope of counselor education on child maltreatment, and the quantitative surveys integrated expert opinion into consensus on the content and priorities for counselor education programs.

The questions that guided this study follow:

- Q1. How is a counselor's role in child maltreatment risk assessment and risk management defined?
- Q2. What are the domains of competence for counselors working with individuals and families experiencing child maltreatment?
- Q3. What are the necessary competencies for counselors to identify child abuse and neglect, to fulfill the mandate to report child abuse and neglect, and to work with clients after a report of child abuse and neglect?

According to (Crotty, 1998), the four basic elements of a research process are epistemology, theoretical perspective, methodology, and methods. These components apply to development of a mixed methods exploratory sequential design study. In this chapter, these four elements are presented in three sections. First, this chapter begins with the epistemological and theoretical assumptions that guided this study, followed by the methodology and the methods that encompass the techniques used to gather and analyze the data.

Epistemology and Theoretical Perspective

In the process of developing a research study, specifically a study that includes both qualitative and quantitative methods like a Delphi study does, it is imperative to begin by describing the general assumptions central to the study, and the theoretical perspective that shapes the study (Creswell, 2007). Epistemology deals with the nature of knowledge, whereas the theoretical perspective describes the way knowledge is formed (Crotty, 1998). Epistemology is described as the “broadest, most philosophical stance in the research process” (Creswell & Plano Clark, 2007, p. 23), whereas a theoretical perspective provides context for the process and grounds the methodology's logic and

criteria (Crotty, 1998). In this section, the epistemology and the underlying theoretical perspectives that guided the study are discussed.

Epistemology

Constructionism asserts that individuals construct meanings as they engage in the world they are interpreting (Crotty, 1998). Crotty (1998) defined this concept as “the theory of knowledge embedded in the theoretical perspective and thereby in the methodology” (p. 3).” This study used constructionism as the epistemological lens. The purpose of this study was to build competencies using different expert opinions, with the goal of reaching consensus among the expert panel. Constructionism is one type of epistemology that rejects the idea that truth exists as an independent reality. Truth is subjective in a constructionist viewpoint, and it depends on the individual perspective of what is already there (Crotty, 1998). It proposes that individuals construct truth and meaning as they engage in the world they are interpreting (Crotty, 1998).

Constructionism focuses on the individual and posits that individual’s best gain knowledge through the active construction of objects (Crotty, 1998) and “includes the collective generation (and transmission) of meaning” (Crotty, 1998, p. 58).

In order to understand constructivism, one should delineate it from the concepts of constructivism and social constructionism. Constructivism posits the individual construct’s meaning rather than discovers it (Schwandt, 1994) and focuses on the individual mind (Crotty, 1998). Constructionism differs from constructivism in that the former focuses on the individual or a group’s construction of artifacts, while the latter centers on the distinct learning of the individual that takes place because of the

interactions with the world (Crotty, 1998). According to Creswell and Plano Clark (2007), most researchers have chosen to adopt a constructionist paradigm when implementing exploratory designs, like the Delphi method (Creswell & Plano Clark, 2007). This study adopts a constructionist viewpoint, as it accounts for each individual's contribution to the construction of reality.

Competence is defined as the knowledge, skills, and professional behaviors required for master's level counselors to assess and manage the risk of child maltreatment with their clients. In this study, it is unlikely that there is one best way of working with clients affected by child maltreatment, meaning the search for a conclusive reality would be fruitless. Instead, professional competencies are the agreed-upon level of competence necessary to ensure counselors are practicing within their scope of practice. In this study, these were created through the consensus of a group, using the group's knowledge and experience to construct the reality of these competencies.

Theoretical Perspective

The theoretical perspective “narrows the worldview to a particular theoretical lens” (Creswell & Plano Clark, 2007, p. 23). In this study, the worldview has been narrowed down to two theoretical lenses—family resilience framework and social constructivism. These theories serve distinct purposes. The first—family resilience framework—provides a foundational understanding of the complexity of the topic, whereas the second—social constructivism—guides the research design. In this section, family resilience framework is described, followed by social constructivism.

Family resilience framework. The theoretical perspective provides context for the process and grounds the methodology's logic and criteria (Crotty, 1998). In this study, the use of the Family Resilience Framework is providing context and grounding in two ways: (1) by providing a strengths-based lens in which the literature was synthesized and interpreted and (2) by guiding the development of language to communicate with and provide feedback to participants. An examination and application of the Family Resilience Framework can be found in the previous chapter. As stated in Chapter 1, with the increase of strengths-based, family focused interventions from CPS, it is imperative counselors consider a family systems, strengths-based framework to best work with CPS and its clients. The role of counselors in the child protection system is dependent on the practices of the child welfare system as a whole. Along with the legislation, many state child welfare systems are moving toward strengths-based approaches with families (National Technical Assistance and Evaluation Center for Systems of Care, 2008). According to Epley and associates (2010), family-centered practice—which the researchers define as the practice of providing family choice, focusing on the family unit, and focusing on family strengths—has become increasingly common. Building off the concepts of family-centered practice, Walsh (1996) developed the theory of family resilience: the ability for a family system to survive and recover from disruptive life challenges. This section describes how this strengths-based family systems approach was used in the research design for this study.

Family Resilience Framework can be defined as “characteristics, dimensions, and properties of families which help families to be resilient to disruption in the face of

change and adaptive in the face of crisis situations” (McCubbin, & McCubbin, 1988, p. 247). Some basic assumptions of the framework are (1) individuals function as part of a family system; (2) family systems have strengths and coping abilities; and (3) families have the ability to overcome stressful events and crises (Walsh, 2003). These assumptions guided my communication with the participants, the development of the questions in the surveys, and the wording of the feedback given to the participants.

As part of the Delphi method, I conducted a generative round consisting of open-ended questions and used controlled feedback during the remaining rounds to collect qualitative data from the participants. I used concepts from the Family Resilience Framework to guide development of this communication. The language I used was strengths-based and focused specifically on the empowerment of clients and on the family system rather than on the individual. I requested that the expert- participants focus on encouraging family resilience, rather than on separating the individuals from their family systems.

Social constructivism. Often related as part of constructionism, social constructivism is that knowledge developed through a process of negotiation within a community and affected by cultural and historical contexts (Crotty, 1998; Prawat & Floden, 1994). Social constructivism takes into account each individual’s contribution to the creation of reality (Lincoln & Guba, 1985) and accounts for the creation of culture (Berger & Luckmann, 1991). Child maltreatment, and the prevention and interventions involved with child maltreatment, are socially constructed. Therefore, while child maltreatment is an epidemic that spans across world cultures, the historical and cultural

context of child maltreatment in the United States— specifically the systems involved in protecting children—makes the creation of specific competencies for counselors in the United States necessary. In the context of a Delphi method, social constructivism acknowledges the contribution of each participating expert. Through the theoretical lens of social constructivism, each participating member has equal input in the negotiation of the construction of the training competencies. In this study, each of the expert-participants used their unique expertise to provide their opinions, which were combined through the systematic process of the Delphi to construct the competencies necessary for counselors to assess and manage the risk of child maltreatment in their clients.

Methodology

Methodology describes the central assumptions and philosophical framework that relates to the entire process of research (Creswell & Plano Clark, 2007). Also referred to as a set of strategies, methodology is considered the link between these strategies and the desired outcomes (Creswell, 2003; Crotty, 1998). When beginning to discuss the methodology of a study, it is important to differentiate this term from the research methods. In a research study, the methods describe the actual techniques of data collection and analysis (Creswell and Plano Clark, 2007), and linking the methods to the assumptions of the study is the research design (Creswell, 2003; Crotty, 1998). The methodology of this study is mixed methods, with an exploratory sequential research design, utilizing a Delphi as the method of data collection and analysis.

To best understand the use of a mixed methodology in this study, a brief overview of the methodology is presented. A mixed methodology is the combination of qualitative

and quantitative inquiry approaches (Creswell & Plano Clark, 2007). According to (Jennifer C. Greene, 2005), mixed methods research seeks a deeper comprehensive understanding of a phenomenon. The underlying assumption of using a mixed method is that the combination of qualitative and quantitative approaches will provide a better understanding of the problem than will using either approach on its own (Creswell & Plano Clark, 2007). Through the combination of qualitative and quantitative data, a more thorough representation of the problem is obtainable, especially when a qualitative design can be enhanced by quantitative data (Creswell & Plano Clark, 2007) as seen in the Delphi method.

Exploratory Sequential Design

An exploratory sequential design, which informs the development of the Delphi method, was used in this study. The intent of this design is that the outcomes of the qualitative portion can help develop the quantitative portion (Greene, Caracelli, & Graham, 1989). Greene, and associates described this as a developmental design, where the goal of the research is “to seek to use the results from one method to help develop or inform the other method, where development is broadly construed to include sampling and implementation, as well as measurement decisions” (p. 259).

A Delphi method was used to guide the design of the sequencing of the data collection in this study. In this model, the qualitative phase resulted in an emergent theory of the domains of competence for assessing and managing the risk of child maltreatment in clients. The purpose of this particular Delphi study was to help expert- participants

reach consensus on the emergent theory of counseling training competencies for child maltreatment.

Below is a representation of a mixed methods exploratory sequential design (see Figure 1) described by Creswell and Plano Clark (2007). In order to indicate where the emphasis of the study is, Creswell and Plano Clark used capital letters.

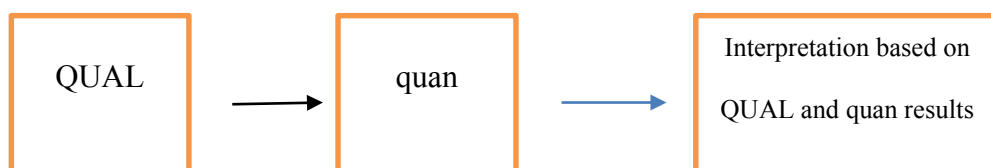


Figure 1: Mixed Methods Exploratory Sequential Design (Creswell & Plano Clark, 2007).

There are some challenges in using an exploratory design. Creswell and Plano Clark (2007) identified the time commitment, specifying procedures for the quantitative portion of the study for IRB approval, and deciding whether participants would be in both the qualitative and quantitative phases. The Delphi method accounts for these specific challenges, as the participants are the ones to decide relevance to the qualitative findings. While this method can be time consuming for both participants and researchers, the interactions can be through remote means, reducing the need for specific scheduling (Hasson et al., 2000).

Method

According to Creswell and Plano Clark (2007), the next step in developing a research study is the development of a strategy to answer the research questions. The methods describe the plan of data collection and analysis (Creswell, 2003). In this section, a description of the proposed participants is provided, followed by a proposed

plan for data collection and analysis using the Delphi Method that is grounded in the exploratory sequential design.

Participants

Prior to collecting data, it is imperative to define who will be researched (Trusty, 2011). In a Delphi study, the “who” are often experts in the field of the topic being studied (Hasson et al., 2000). The following section describes the selection criteria for experts included in this study, followed by the strategy by which the experts were recruited, and finally the justification for the target sample size.

Selection criteria. According to Hasson, and associates (2000), in the Delphi method, the researcher identifies and utilizes individuals who have specific knowledge on the topic being investigated. The selection of these experts is a difficult task, as the definition of what constitutes an expert has been criticized (Strauss & Zeigler, 1975). (Goodman, 1987) discussed finding individuals with enough interest to participate fully in the multiple rounds of the Delphi, but with not so much interest that their professional judgment is clouded by their own bias. Due to this, participants were selected based off of specific criterion; therefore, representativeness found when sampling is done at random would not be guaranteed (Hasson et al., 2000).

Many authors of Delphi studies use rank, education, research experience, and clinical experience to define expertise (Chen et al., 2013; Neimeyer & Diamond, 2001; Norcross, Hedges, & Prochaska, 2002). In a meta-analysis of Delphi studies, (Baker, Lovell, & Harris, 2006) found the common criteria for experts include knowledge, experience, and policy influence. Knowledge, experience, and policy influence are

defined through area of specialization, which can include treating children, families, or perpetrators of child maltreatment; through their publication record (e.g., the number and impact of articles published in the area of child maltreatment); or through their teaching or clinical specialization, either in child maltreatment or crisis and trauma.

To be considered an expert in this study, a participant needed to meet one or more of the three following conditions: (1) be an expert with a clear research agenda that has advanced the field of counseling in child maltreatment (e.g., Bryant & Baldwin, 2010; Henderson, 2013), (2) be a counselor education expert with a specialty in training counselors in one of the following: children and adolescents, ethics, child maltreatment, or crisis and trauma, or (3) be a clinical expert who specializes in working with children and families, or in working with perpetrators of child maltreatment for a minimum period of five years.

To select these individuals, I considered that the combination of experts needs to be defined in context of a comprehensive perspective on child maltreatment and the ability of the experts to apply their expertise specifically to training master's level counselors. In a similar study, Chen and associates (2013) chose a multidisciplinary approach, selecting experts from different disciplines in child protection and focusing them toward their specific specialty (Chen et al, 2013). This approach is supported by Feng, Fetzer, Chen, Yeh, and Huang (2010), who found care quality for victims and their families was enhanced by the collaboration across disciplines. It is important to balance this viewpoint with the very common trend in counseling research of defaulting to other disciplines to study and formulate conclusions for child maltreatment.

The purpose of including professionals from outside of the counseling profession is to help center in on the counselor's role during this process through the gaining of the perspective of those who collaborate with or engage in other aspects of work with children and families. The purpose of the involvement of these non-counseling professionals is not to differentiate between the counselor and other mental health professional roles; instead, the purpose is to provide a more in-depth understanding of the impact of the work of counselors on their clients from a multi-disciplinary perspective.

I chose experts outside the counseling profession from the social work, medical, legal, and education fields, and selections were based on the following conditions: (1) The expert has at least five years' experience in the field of child protection working with counselors on child maltreatment cases; (2) The expert practices counseling and specializes in working with children and families, or in working with perpetrators of child maltreatment for a minimum period of five years; (3) The expert has a clear research agenda that advances the field of child maltreatment; (4) The expert serves in a role of training master's level counselors in working with children and adolescents, perpetrators, counseling ethics, or crisis and trauma.

Sample size. The number of experts needed for a sample in a Delphi study depends on the goal and topic of the Delphi (Linstone & Turoff, 2002; Hasson, et al., 2000; Chen et al, 2013). According to Linstone and Turoff (2002), an expert panel consisting of between 10 and 50 individuals is appropriate. In similar studies developing competencies using a Delphi method, researchers used as many as 105 panel members (Witt & Almeida, 2008) and as few as 25 (Chen et al., 2013).

The target sample for the study was 25 (see Figures 2 and 3).

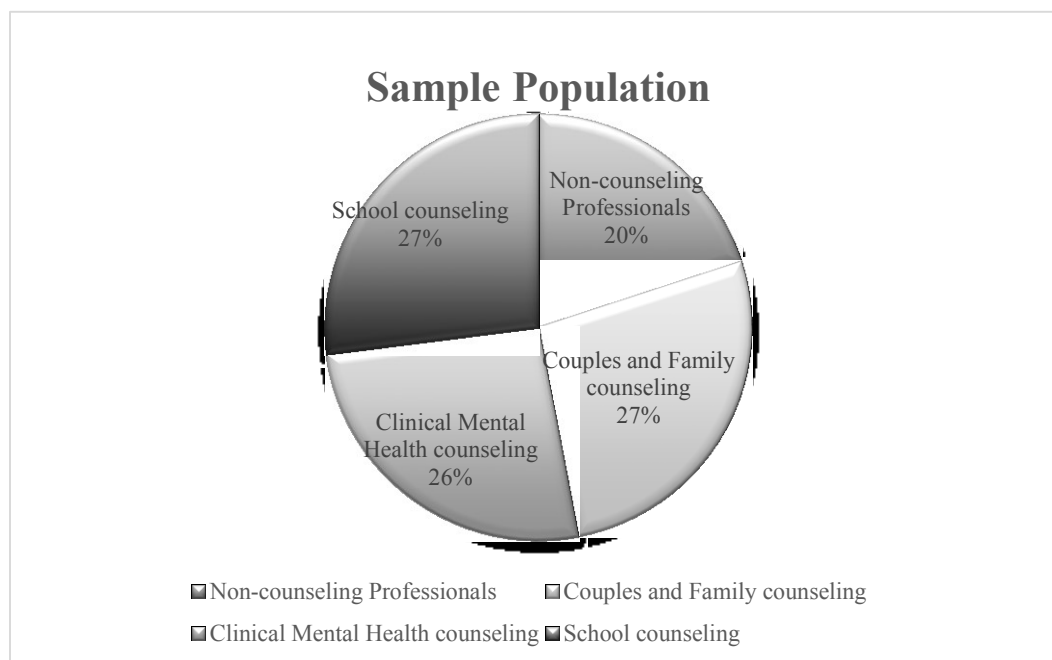


Figure 2: Sample Population. Percentage estimates (+/- 10%), 80% of total expert-participants are counseling professionals; 20% are non-counseling professionals.



Figure 3: Non-Counseling Professionals. 20% of overall expert- participants (+/- 10%), percentage of non-counseling expert- participants broken down by field.

Sampling procedures. I selected experts through purposive sampling (Onwuegbuzie & Leech, 2007) and snowball sampling (Creswell, 2007). A purposive sample is one that is based on the knowledge of a population and the purpose of the study. Snowball sampling involves the identification of participants through the recommendations of others (Creswell, 2007). To begin sampling, I selected a comprehensive list of initial candidates for participation in this study, developed and guided by a balance of expertise presented in Figures 2 and 3. Through purposive and snowball sampling, I selected counselors, counselor educators, counseling researchers, and non-counselor experts, each handpicked from recently published literature on child maltreatment. Second, I conducted a comprehensive search on the American Counseling Association, the Association of Counselor Education and Supervision, the American Mental Health Counselors Association, and various child welfare association websites in order to identify experts that met the criteria identified above. Third, I recruited expert-participants through professional counselor education and supervision listservs by inviting experts to self-identify. Fourth, I included professionals suggested by committee members, as well as personal acquaintances, who met the criteria listed above for experts. Since experts in the field often know others who are appropriate, available, and willing to participate in this type of experience as well, I asked those who were selected to participate for names of others who might be able to add to the development of these counseling competencies. I included any suggested individuals on the list of potential experts to be contacted. Prior to beginning data collection, the potential participant pool was crosschecked by an auditor to ensure that each met the criteria for inclusion.

Once I compiled a comprehensive list, I sorted the list first by profession, then by specialty area, and finally by eligibility criteria. For every five counselors selected, I selected one non-counseling professional. This ratio of experts was to keep the perspective on the counseling field and to balance out the multi-disciplinary perspective on the role of counselors. I selected counseling professionals by rank, based on the following criteria: Individuals that met two of the three criteria from each of the counseling specializations (e.g., clinical/mental health, counselor education, school, marriage and family) were ranked first (see Table 1). Participants that met the minimum requirements were ranked second. An equal number of experts was selected across the different specializations to ensure the representativeness of the sample (see Figure 2).

I purposely selected non-counseling professionals to ensure that their perspective was added to the development of these competencies (see Figure 3). I sorted the individuals by profession and then ranked them. Instead of an equal sample across professions, I chose five of the non-counseling experts from the social work field to ensure that individuals working within the system or those with experience researching the system had a chance to contribute to building these competencies. The remaining four experts I selected consisted of a legal professional for victims, a legal professional for perpetrators, a teacher, and a medical professional.

Table 1

Expertise Requirements for Participants

Expertise Requirements	
Requirements	# of requirements to qualify
Counseling Professionals (80% of total sample)	
1. Clear research agenda that has advanced the field of counseling in child maltreatment	
2. Counselor educators with a specialty in training counselors in children and adolescents, ethics, child maltreatment, or crisis and trauma	2
3. Counselors with a specialization in working with children and families, or in working with perpetrators of child maltreatment for a minimum period of five years	
Non-Counseling Professionals (20% of total sample)	
1. Experience in the field of child protection and working with counselors on child maltreatment cases for a minimum period of five years	
2. Practicing as a counselor specializing in working with children, and families, or in working with perpetrators of child maltreatment for a minimum period of five years	1
3. Clear research agenda that advances the field of child maltreatment	
4. Has a role of training master's level counselors in working with children and adolescents, perpetrators, counseling ethics, or crisis and trauma	

After approval from the UNC Institutional Review Board, I contacted potential participating experts by phone and email. According to Smith & Simpson (1995),

communication with experts is essential and needs to be done before and during a study. Hasson, and colleagues (2000) found the more explicit the expectations of the study during the recruitment of the experts, the more likely the experts are to see the process through to completion. Smith and Simpson (1995) discussed the need to build rapport prior to starting recruitment for participation. For this study, I individually contacted expert- participants either by phone or by email, and explained the purpose of the study prior to asking for commitment to participate. During this eligibility interview, I asked potential expert- participants to verify their appropriateness for the study based on the selection criteria. This information is reported as demographic data in Chapter IV. In order to increase response rates, I explained the process of the Delphi in order to highlight the time commitment being asked of the expert- participants. Finally, I asked the expert- participants to identify any other experts in the field that may have been appropriate for this study.

Data Collection and Analysis

As discussed previously, the design of this study is an exploratory sequential design, and the specific method is the Delphi. Hasson, and associates (2000) described the steps of the Delphi method, which follow: (1) A qualitative round is conducted to collect participant comments; (2) Qualitative data from step 1 are analyzed and compiled into a second quantitative questionnaire; (3) A quantitative questionnaire is then collected from participants; (4) Quantitative data are analyzed and compiled into third questionnaire; (5) The process is continued until consensus is reached. In many Delphi studies, consensus is usually reached after three to five rounds of quantitative data

collection (Chen et al., 2013; Hasson et al., 2000). Controlled feedback is provided to participants with the quantitative rounds to help participants understand the current status of their collective opinion (Goodman, 1987), and this can assist in reaching consensus. In this study, three rounds of surveys were necessary to reach consensus. In order to maximize the response rate, I sent expert- participants an email reminder every week. Also, for the final two rounds, I gave the first five expert- participants to complete their surveys per round a \$5 Starbucks gift card. For the final round, I sent a reminder email that offered those who completed the survey that day a \$5 Starbucks gift card. The process of the Delphi is explained in the following section, and an example of these rounds can be seen in Figure 4.

Generative round.

Data collection. As I discussed previously in this chapter, the first round of the Delphi is traditionally a collection of participant comments on the phenomenon (Hasson, et al., 2000; Linstone & Turoff, 2002). The specific goal of the generative round is to provide an initial forum for participants to generate ideas, provide their unique opinions, and identify issues surrounding counseling competencies for child maltreatment risk assessment and management (Hasson, et al., 2000). In this study, I asked expert- participants to complete an open-ended survey, where the expert- participants were able to respond freely (Gupta & Clarke, 1996; Hasson et al., 2000). The expert- participants were invited to provide as many opinions as possible to maximize the chance of covering the most important opinions and issues (Hasson, et al., 2000). Development of the questions, including phrasing, needs to be careful and deliberate to ensure that it is definitive

(Hasson, et al., 2000). This questionnaire was built into Qualtrics, a survey program. The expert- participants were emailed an invitation with a link to the Qualtrics survey, asking them to complete the survey.

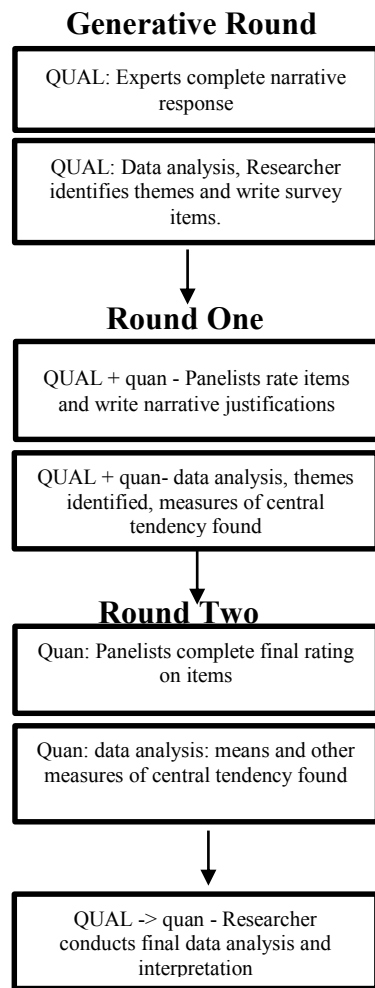


Figure 4: Visual Display of Steps of the Delphi

The family resilience model, along with the theoretical perspective of social constructivism, informed the wording and structuring of the first questionnaire. In order to provide an open forum to begin discussion of the domains, the questions were open-ended and broad. The questionnaire consisted of five open-ended questions, each directly

connected to the research questions (see Appendix C). I first asked the expert-participants to describe a counselor's role in child maltreatment risk assessment and management. Then, I asked them to identify how counselors can empower the client during and after this process. This question was meant to evoke a strengths-based approach that is vital to working within a strengths-oriented CPS system, as was described in Chapter I. Next, I asked the panel to describe the broad domains of competencies for counselors when assessing and managing the risk of child maltreatment, and when working with individuals and families experiencing child maltreatment. Finally, I asked the expert-participants to provide any other information they felt was important to building training competencies for master's level counselors.

Data analysis. The goal of the initial analysis was to create a list of themes using the expert-participants' own words. This list was then used to develop a quantitative survey that I distributed back to the expert-participants (Hasson, et al., 2000). From these responses, I analyzed the qualitative data through categorizing the data, which I then compiled into themes. Hasson, and associates (2000) suggest using content analysis techniques during the process of analysis of the qualitative data. This is done through grouping similar items together through identification of similar terms used to describe the same phenomenon (Hasson, et al., 2000).

I grouped the items together using content analysis; however, the language used by the expert-participants was kept intact in order to avoid researcher bias and to allow the expert-participants to judge the items in terms of quality during the next round

(Hasson, et al., 2000). These groupings were considered the initial domains, and this list was sent back to the expert- participants to begin round one.

Round one.

Data collection. During the generative round, I identified initial domains through the analysis of expert comments. The purpose of this round was to present the identified domains back to the expert- participants to begin refining, adding, and reducing the domains to those that are most relevant to master's level counselors. For this first quantitative round, I emailed the expert- participants a link to complete the survey in Qualtrics. Along with the link to the survey, I provided and asked the expert- participants to read three research articles prior to completing the survey. I also provided definitions for the study that were requested by the expert- participants during round one. According to Hasson, and associates (2000), providing additional materials to be considered during the process can help structure the debate and move the group toward consensus. The three research articles provided were (1) Chen and associates (2013). Healthcare professionals' priorities for child abuse educational programming: A Delphi study. (2) Damashek and associates (2011). Training competent psychologists in the field of child maltreatment. (3) Rudd, Cukrowicz, and Bryan (2008). Core competencies in suicide risk assessment and management: Implications for supervision (See Appendix D for copies of the articles). Each of these articles was meant to provide the expert- participants with equal information to consider when completing and narrowing the domains of competence in child maltreatment. The first two articles, as discussed in previous chapters, provide competencies for working with clients involved in child maltreatment

for non-counseling professionals. The third article, Rudd, Cukrowicz, and Bryan (2008), is meant to provide an example of competencies established for risk assessment and management of a similar difficult counseling topic—suicide.

After reading the articles, I asked the expert- participants to complete the survey by judging each item and rating it in terms of importance and appropriateness for child maltreatment education for counselors (Chen et al., 2013; Hasson et al., 2000; Linstone & Turoff, 2002). I then provided the expert- participants the opportunity to comment on the importance, language and placement of each of the competencies. The additional qualitative data collection provided insight into the decisions of the expert- participants, which led to additional items being added to the quantitative instrument for the following round. Each item was ranked using a 7-point Likert scale, ranging from 1= very inappropriate/unimportant to 7= very appropriate/important (Chen et al, 2013). After each domain, I provided the expert- participants the opportunity to comment on the language, placement, and appropriateness of the competency, as well as ample space for the expert- participants to comment freely on the competencies and domains.

Data analysis. I used descriptive statistics to analyze the rankings provided by the expert- participants (Chen et al, 2013; Hasson, et al., 2000). Consensus is considered reached when a mean importance over 6 on the 7-point scale is met and retained (Cantrill, Sibbald, & Buetow, 1998; Chen et al., 2013). I found the mean of each item, and the expert- participants reached consensus for most of the competencies (mean ≥ 6). I conducted a content analysis, like that in the generative round, on the comments of the expert- participants. While consensus was reached for each of the competencies, the

expert- participants suggested changes to the language and placement of these competencies. Based on the results of Round 1 responses, I categorized, revised, and added items (Chen et al. 2013).

Round 2. The purpose of these rounds was to finalize language and placement of the domains and competencies found in the previous round. For those competencies for which the expert- participants suggested changes to the language and placement, I presented the initial domain or competency, asked the expert- participants to review the comments from the other expert- participants, and then presented the new competency (Chen et al., 2013). I asked the expert- participants to either agree or disagree with the proposed changes and provided them the opportunity to comment on their responses. I provided competencies for those for which consensus was reached in the first round with no suggested changes to language or placement for the participants' reference. The majority of the expert- participants (70%) had to agree to consider the changes as accepted.

Validity

In mixed method research, validity is “the ability of the researcher to draw meaningful and accurate conclusions from all of the data in the study (Creswell & Plano Clarke, 2007, p. 146).” This task becomes complex when utilizing a mixed method design, as validity needs to be discussed within the context of both qualitative and quantitative research, and needs to be discussed from the view of the whole mixed method design (Creswell & Plano Clarke, 2007). In this section, I discuss the strategies I used to address the potential threats to validity. I first present the validity from the overall

standpoint of the exploratory sequential design, followed by the validity for the Delphi. I then discuss validity relative to the qualitative portion of the study, and finally, I discuss the validity for the quantitative portion of the study. In this section, I discuss strategies to address the potential threats to validity. In the discussion (Chapter V), I will further discuss the limitations to the design of this study.

Exploratory sequential design. There are several potential threats to validity in using an exploratory sequential design. In using this design, the potential threats in this study included not addressing validity issues in the qualitative and quantitative rounds, and choosing weak qualitative findings to follow up on quantitatively (Creswell & Plano Clarke, 2007). To address this first threat, I considered potential threats to both the qualitative and quantitative research portions of this study. To address the second threat, I followed the guidelines presented in Hasson, and associates (2000), and consolidated the expert comments into competencies. I created a new competency for each new theme, and I presented these back to the expert- participants. Through this process, the expert- participants, not I, the researcher, were judging and eliminating the domains.

Delphi method. The Delphi method has specific threats to validity associated with the process. Considering validity in a Delphi method, researchers assume safety in numbers, meaning a decision made by multiple individuals will be less likely to be wrong than a decision made by one individual (Hasson, et al., 2000). Some common threats to validity in the Delphi method include the pressure for the convergence of predictions (K. Q. Hill & Fowles, 1975) and response rates (Hasson, et al., 2000). I attempted to control attrition and threats to response rates by thoroughly explaining the time commitment to

the expert- participants during the initial contact and asked them for their commitment to complete the study. As recommended by Hasson, and associates (2000), communication with the expert- participants was consistent throughout the process, with clear expectations for when responses were due, and when the expert- participants should expect the next round. Also, I sent reminder emails to the expert- participants reminding them of the importance of the study and their participation. For the other threat to validity—the pressure for convergence—I attempted to minimize the threat through the language I used to introduce the study and by restating the purpose of the presentation of the quantitative data back to the expert- participants.

Qualitative. In addition to addressing the specific threats to validity inherent in the Delphi method, I addressed the validity in qualitative research, known commonly as trustworthiness. There are four main criteria that account for trustworthiness in qualitative research: credibility (or internal consistency); dependability (external consistency); confirmability (assumption of subjectivity); and transferability (generalizability) (Lincoln & Guba, 1985). In this study, I achieved this through the process of feedback used in the Delphi method. The surveys allowed members to check and recheck their answers and the answers of the group. In addition to member checks, in order to ensure credibility, I needed to check my own beliefs on child maltreatment and counselor training. In the following researcher stance, I discuss my biases so that I may bracket them while interpreting the qualitative data.

Researcher stance. Since this study combines both qualitative and quantitative analysis, trustworthiness needs to be addressed to clarify my own bias. During a

qualitative study, bracketing is imperative in order for the researcher to set aside his or her beliefs, feelings and perceptions to be open to the phenomenon (Merriam, 2009). In this section, I present my background and beliefs as they relate to the study of child maltreatment. As a counselor and past social worker, it is important that I bracket my own experiences and expectations to better prepare to understand the experiences and worldviews of the expert- participants. For the purpose of transparency, the following are personal reflections and biases I hold about the training of counselors in the assessment and management of child maltreatment: (1) Prior to becoming a counselor, I worked for eight years as a CPS child abuse investigator at several different county agencies; (2) I received training on mandated reporting from my master's program after my experiences working for CPS and found the training to be inadequate, (3) I have had several post-graduate counselors ask me to explain how to handle the mandated reporting requirement; (4) In my experience as a caseworker, counselors often refused to speak with me in fear of breaching confidentiality, despite having the verbal consent from the client, and a signed informed consent document.

Through my experiences as both a counselor and a social worker, it is my belief that the current training is not adequate, and potentially creates and instills the fear experienced by counselors facing clients impacting child maltreatment. While facing this fear, I believe counselors fall back on their specific training, or lack of training, on mandated reporting, and may forget to use their therapeutic skills. I also believe that counselors do not fully understand their role in assessing and managing child maltreatment and will create their own personal rules on how to handle these situations. I

feel that developing their own rules without proper education to back them up can lead to poor decision-making and potential negative consequences for the client. With a training based on competencies that are strengths-based and address the full scope of assessing and managing child maltreatment, I believe counselors will have a reduced fear response and will therefore be able to use their therapeutic skills to help support clients through the process of dealing with CPS. I also believe counselors will be better able to help clients access their personal and family strengths to overcome child maltreatment.

In order to best bracket my own personal bias, it is also important for me to be transparent in my beliefs on the requirements for training counselors. I believe counselors need to be exposed to child maltreatment risk assessment and management early in their programs, prior to any practicum experiences, and that they should be exposed often. I believe the more exposure to this topic, the easier it will be for counselors-in-training to perform in an ethical and professional manner when the time comes. Training should begin with addressing a counselor's own personal bias toward both perpetrators and victims of child maltreatment, and toward child protective services.

Through this personal awareness, counselors can begin to understand how their own reactions will impact the client. Training should also include exposure to the federal and state laws and definitions of child maltreatment, and counselors should know how to access these definitions. Training should emphasize the ever-changing nature of CPS, the laws, and the definitions, and counselors should know how to access these definitions and laws to ensure they are assessing risk adequately. An additional training topic should be language and the role of the client. Role-plays and case examples should be used to help

counselors-in-training gain the skills to speak with their clients about child maltreatment using strengths-based language.

Assessing risk is only half of the responsibility counselors have to their clients. I believe counselors should be trained on how to work through client emotions during and after the risk assessment process. With the complexity of this topic, it is important for counselors to be trained by counselor educators. This is important for two reasons—one, to maintain the counseling perspective during the process, and two, to minimize the fear associated with reporting. When the education of counselors on this topic is left to non-counseling professionals, counselors-in-training may believe their role should be passive. I believe counselors should be trained to become advocates and supports for their clients during this process.

Trustworthiness. Due to my bias and closeness with the subject of child maltreatment, it was important for me to bracket my experiences and biases to allow for the voices of the expert- participants to inform and create the competencies needed for counselors to assess and manage child maltreatment (Creswell, 2007). In addition to bracketing, I kept an audit trail, a researcher journal documenting my actions (Onwuegbuzie & Leech, 2007). By documenting my actions, I was able to keep track of my own thoughts and feelings during the analysis of the qualitative data. I documented any contact with the expert- participants, including personal notes, reflexive journals, and expectations. This helped me to bracket my own expectations and ensure the experiences of the expert- participants were being accurately reported.

Another form of trustworthiness addresses confirmability—the act of establishing that the data and interpretations of the data are not the machinations of the researcher (Schwandt, 1994). This form of validity is naturally inherent in the design of the Delphi method. Even though the qualitative data were grouped into themes, the list of themes using the expert- participants' own words was a natural triangulation of the data (Creswell & Plano Clark, 2007). This form of validation is built from a combination of themes from several individuals, rather than from one individual (Creswell, 2007), and the expert- participants made the decisions to retain domains through their rankings and adjustment of language.

Quantitative. In this section thus far, I have presented threats to validity for an exploratory sequential design followed by threats to validity associated with the Delphi, and the threats to trustworthiness for the qualitative portion of this study. There were also potential internal and external threats to validity of the quantitative portion of this study. Potential internal threats to validity are selection bias, researcher bias, and compensatory rivalry. Due to the purposeful selection of the expert- participants, this study may not cover the wide variety of counseling professionals with expertise in this area. To reduce this threat to external validity, I utilized multiple avenues to identify the expert- participants and enlisted an auditor to ensure that the sample was meeting the criteria of an expert as set forth previously in this chapter and that the proportions of the sample were consistent across counseling participants.

Researcher bias was another potential threat to internal validity in this study. As discussed above in the researcher stance, my personal opinions and bias could affect my

feedback to the expert- participants. This could unintentionally impact the responses of the expert- participants. I managed this by monitoring the controlled feedback provided to the expert- participants. In this study, I chose three research articles instead of a literature review to reduce potential bias from me, the researcher. Also, I limited my comments to asking the expert- participants to reflect on other participant comments, and I avoided discussing any single domain.

A final threat to internal validity is compensatory rivalry among the expert- participants. Compensatory rivalry can be described as the social competition among the expert- participants to attempt to reverse or reduce the effects of the desirable treatment levels (Heppner, Kivlighan, & Wampold, 1999). A lack of movement in group means toward consensus could be evidence of this type of threat. In order to reduce this potential threat, I provided controlled feedback, such as exposure to descriptive statistics, reminders of the purpose of the study, and exposure to literature to the expert- participants to encourage group consensus. I set specific cut-off levels for domains, which aided in the elimination of domains under contention.

Two potential threats to external validity are population and reactive effects of experimental arrangements. The potential threat to population validity is the representativeness of the sample to the population at large. This could occur if I failed to adequately select a sample of the expert- participants to best represent counselor needs in assessing and managing the risk of child maltreatment. Similar to controlling for the sample selection, I managed this through the use of an external auditor to ensure the sample selected met the criteria for an expert as defined above. The second threat to

external validity, reactive effects of experimental arrangements, refers to participants knowing they are participating in an experiment. The reactive effects that are potentially demonstrated in this study are the expert- participants' unwillingness to shift their opinions to aid in the movement toward consensus—or the opposite—the expert- participants shifting their opinions, even if their opinions are important in order to reach consensus more quickly. To control for this potential threat, I provided the expert- participants with a thorough explanation of the purpose of this study. I also emphasized the importance of the expert- participants' role in reaching consensus at the beginning of the study. I then exposed the expert- participants to the group comments as they related to the agreement on domains, and asked them to continue to consider both their own opinions and the goal of consensus.

Conclusion

In conclusion, this chapter presents the methodology and procedures of this study. The purpose of this study was to fill the gap in counseling research for the training needs of counselors on child maltreatment risk assessment and management. In the previous chapter, I outlined this gap through a review of the literature. In similar studies, researchers have used a Delphi method to create counseling competencies. These competencies are meant to set a standard for counselors to assess and manage the risk of child maltreatment with any child or adult client, including victims and perpetrators of child maltreatment. In this chapter, I detailed the plan I used to fill this gap using a Delphi methodology.

CHAPTER IV

RESULTS

The purpose of this study is to develop competencies that can be used by master's level counselor training programs to prepare counselors-in-training to better assess and manage the risk of child maltreatment in their clients. This chapter delivers the results from the current study. Utilizing a Delphi methodology, I surveyed a panel of experts to gather their opinions and beliefs regarding the necessary competencies counselors-in-training need to work with clients affected by child maltreatment. Qualitative data were categorized and grouped into themes, descriptive statistics were used to analyze the ranking provided by the expert- participants to determine consensus. In this chapter, first a description of the participants and the procedures are provided, followed by the results of this study. In each of the domains, I report the results of the three rounds of data collection.

Participants

The expert panel was comprised of two types of participants: counseling professionals and non-counseling professionals. The criteria for expertise are described fully in chapter III but in summary the expert- participants were selected based on their knowledge, experience, and specialization in treating children, families, or perpetrators of child maltreatment. Sixty-three experts were identified through purposive sampling, snowballing, and advertisement on counseling professional email listservs. An external

auditor reviewed each of the experts to ensure they met the inclusion criteria. All of the non-counseling experts were recruited through purposive sampling. Fifty-three of the experts were counseling professionals; the remaining 10 were non-counseling professionals. Fourteen of them were males, 39 were females. All were invited to participate in the study.

Counseling Professional Participants

Of the 53 counseling professionals invited to participate, 51%, (n=26) accepted the invitation. Fifteen percent (n=4) of the counseling professionals were male, 85% (n=23) were female. Nineteen of the counseling expert- participants (73%) met two or more of the criteria, the remaining eight (27%) identified as meeting only the criteria for clinical expert. Thirty-eight percent (n=10) of the expert- participants were counselor educators, 27% (n=7) were school counselors or school counselor educators, and 31% were practicing clinical counselors. Twelve of the expert- participants (46%) were from the Western region of the United States, nine of the expert- participants (35%) were from the southern region, four of the expert- participants (15%) were from the Midwestern region, and one participant (4%) was from the northeast region of the United States.

Non-Counseling Participants

Of the 10 non-counseling professionals invited to participate, five expert- participants (50 percent) accepted the invitation. Two of the expert- participants were male, three were female. Three of the expert- participants were social workers (60 percent), one was an attorney that specializes in family law (20 percent), and one (20

percent) was a medical doctor that specializes in child maltreatment. All of the non-counseling professionals were from the western region of the United States.

Summary of Participants

Sixty-three eligible professionals were invited to participate in the study. Thirty-one expert- participants initially accepted the invitation to participate. Only 25 expert- participants, 20 counseling expert- participants (80%), and five non-counseling expert- participants (20%), completed the first survey. This proportion of counseling to non-counseling expert- participants was consistent with the original plan. All 25 expert- participants were invited to complete the second survey, 14 expert- participants completed the survey, one participant indicated they did not wish to participate in the second survey, and 10 expert- participants did not respond to the second invitation to participate. Eleven of the expert- participants who completed the second survey were counseling expert- participants; three of the expert- participants were non-counseling participants. All 25 of the expert- participants were invited to complete the third survey. Thirteen expert- participants completed the final survey, one participant withdrew from the survey, and one participant answered the first four questions, 10 expert- participants did not respond to the third invitation to participate. Eleven of the expert- participants who completed the third survey were counseling expert- participants; two of the expert- participants were non-counseling professionals. A total of 25 expert- participants completed the first survey, 60% (n=15) completed the second survey, and 52% (n=13) completed the final survey.

Procedures

The three rounds of data were collected via online survey software over a period of twenty-one weeks. After the generative round, expert- participants generated 43 competencies and four domains. In the final two rounds, expert- participants reached consensus and solidified the language, definitions, and placement of each of the competencies and domains. This section provides the procedures and analyses used in each round.

Generative Round

The first survey (Appendix E) asked expert- participants a series of five questions to elicit their opinions and beliefs on what domains and competencies counselors need to effectively work with clients affected by child maltreatment. The survey was open for 24 days. I reminded expert- participants to complete the survey every seven days and I closed round one based on reaching the desired target sample size (25 of 31 participants), and the passage of time.

The data collected from the generative round were exposed to a content analysis. Similar items were grouped together, through identification of similar terms used to describe the same phenomenon. For example, I grouped "child maltreatment definitions," "prevalence of child maltreatment," and "risk factors of child maltreatment" together and named the competency "Child Abuse and Neglect (e.g., Definitions, prevalence, risk factors, types of perpetrators, types of violence, symptomology)". Once I grouped all participant responses into categories, I combined those categories further into domains. Since the expert participants did not provide any specific domains, I

continued the content analysis on the competencies. I grouped those competencies that dealt with the knowledge and skills needed to assess abuse and neglect into the risk assessment domain. I then grouped those competencies that focused on the knowledge and skills needed during and after a report is made into management. I then separated both risk assessment and management into knowledge, and skills. For example, I grouped together " Child Abuse and Neglect (e.g., Definitions, prevalence, risk factors, types of perpetrators, types of violence, symptomology " and " Legal Requirements (e.g., Knowledge of federal and state laws)" along with twelve similar competencies and named the domain "Child Maltreatment Risk Assessment: Knowledge." After all the competencies were categorized into their initial domains, I created a definition for these domains (e.g. This domain covers all of the knowledge counselors need prior to seeing clients in order to identify clients at risk for child maltreatment and report suspicions of abuse to child protective services).

There were some responses from expert- participants that were not included in the building of the competencies. I did not include comments that did not answer the questions presented. For example, the first question asked expert- participants to describe a counselor's role in child maltreatment risk assessment and management. I did not include comments such as "It is pivotal," "The counselor's role is crucial" or "depends on who the client is... this question is unclear... is the client the child, the perpetrator, parents, etc.? I do not have enough information to answer the question." Based on some of these comments, I developed a list of definitions to clarify terms in the study, and shared it with the expert- participants in the next round.

In order to reduce my researcher bias, I documented any contact with the expert-participants, including personal notes, reflexive journals and expectations. This helped me to bracket my own expectations and ensure the experiences of the expert- participants were being accurately reported. Also, I maintained the language of the expert-participants in the wording of the competencies, and created a competency for any new concept presented in the responses of the expert- participants. The Delphi method allows for a natural triangulation of the data, where the expert- participants own words are used to create the list of themes.

Round One

The second survey (appendix G) presented the forty-three competencies and four domains to expert- participants. The expert- participants took 32 days to respond to the second round. Once every seven days, I sent emails reminding them to complete the survey. The response rate did not reach the desired 70% response rate, however, the decision to close was based on the passage of time and the response rate.

Prior to taking the survey, I asked the expert- participants to read three articles that I selected to provide examples of established competencies from other professions, and other topics, along with the definitions for the study that were requested by the expert- participants during round one (Appendices G and H) prior to responding to the survey. The purpose of these articles was to provide the expert- participants with samples of established competencies to guide them toward reaching consensus.

The second survey asked the expert- participants to rank the level of importance of each domain and competency, and provided the expert- participants the option to

comment on the placement and language of each. Data analysis for the second round calculated the means to each question to determine if the expert- participants reached consensus. Similar to other Delphi studies, including Chen and colleagues (2013), consensus was considered reached when a mean importance over six on the seven point scale is met and retained (Cantrill, et al., 1998). The expert- participants reached consensus for all competencies during the second round. On the majority of competencies, the expert- participants made suggestions for placement (e.g. " 'Prevention' stood out to me as not really fitting with knowledge. I am wondering if this wouldn't be a better fit in a domain such as 'Skills' ") and language ("Prevention: I wanted to add more here ... Thinking about victim's rights and then services and care for the abuser as well....").

The expert- participants also suggested changes on the definitions of the domains (e.g. "This one sounds like the other domain... Maybe using the words applying their knowledge into the field or something more interactive would be a better use of the definition.") On those items that had suggestions, I incorporated the suggested changes into the wording of the competency.

Round Two

The third survey presented the twenty-one competencies and four domains that the expert- participants suggested changes to in round one. The expert- participants took fourteen days to respond to the second round. I sent a reminder email seven days after the survey was open. Items that reached consensus without comments were included in the

subsequent round only for the expert- participants to use for reference. Of the remaining 15 expert- participants, 14 responded, therefore, I decided to close the round.

For each of the competencies and domains with suggested changes, the survey first provided the expert- participants with the original wording of the competency/ domain, then asked the expert- participants to review comments on the identified competencies, and finally asked the expert- participants to either agree or disagree with the proposed changes made to the wording and placement. The expert- participants were able to provide final comments on the competencies. For this round, the expert- participants reached consensus if 70 percent or more of them approved of the change.

For those competencies that did not reach consensus, I took into account the comments of the expert- participants and incorporated these suggestions into the final wording. Also, some of the expert- participants requested small changes to some of the competencies. For those suggestions that added to the clarification of the competencies (e.g. Perhaps it should be general knowledge of school policies), I incorporated those changes into the final language.

Results

After three rounds of surveys, expert- participants created and agreed upon forty-six competencies and four domains. Expert- participants generated four overarching domains: (1). Child Maltreatment Risk Assessment: Knowledge, (2). Child Maltreatment Risk Assessment: Practical Skills (3). Child Maltreatment Impact Management: Knowledge (4). Child Maltreatment Impact Management: Practical Skills. In this section, I present each of the four domains and their associated competencies. In order to show

the progression toward the final competencies, I describe the results from each of the rounds, and then present a table of the final competencies included in that domain. For a full list of competencies, please see Appendix H.

Child Maltreatment Risk Assessment Domain 1 of 2: Knowledge

Generative round. From the content analysis, I grouped fourteen competencies under the domain "Child Maltreatment Risk Assessment domain 1 of 2: Knowledge". The overall theme of these fourteen competencies was knowledge counselors need to have to assess for child maltreatment. The definition for this domain that emerged was: "This domain covers all of the knowledge counselors need prior to seeing clients in order to identify clients at risk for child maltreatment and report suspicions of abuse to child protective services." See Table 2 for a list of competencies for this domain.

First round. The second survey prompted expert- participants to rate the level of importance of the fourteen competencies in this domain using a 7-point Likert scale, ranging from 1=very inappropriate/unimportant to 7= very appropriate/ important (Chen et al., 2013). The expert- participants reached consensus (mean ≥ 6) as to the importance for all of the competencies. The survey also asked expert- participants to comment on the wording and placement of each of the competencies into their correct domain. Expert- participants approved of six of the fourteen competencies without comments. Of the remaining eight, seven had minor suggestions to language. The competencies with minor suggestions on language are listed, examples of the suggestions can be found in the paragraph below:

- Legal Requirements (e.g., Knowledge of federal and state laws)
- Understanding of programs and organizations related to child welfare (e.g., knowledge of child welfare system, reporting requirements, current language trends, agency processes and role of CPS workers.)
- Understanding how to integrate the role of the counselor and the role of reporter in such circumstances.
- Understanding potential therapeutic relationship issues for client/therapist around child maltreatment.
- Understand the difference between Risk and Safety
- Training on Other non-trauma related treatment modalities such as substance abuse
- Prevention

I incorporated participant suggestions into the final wording of the competencies.

For example, for the competency on “Legal Requirements (e.g., Knowledge of federal and state laws)”, the second round of questions yielded two suggested changes (1) to add “school district policies” for school counselors, and (2) to add “agency requirements. To accommodate these suggestions, the competency changed to “Legal Requirements (e.g., knowledge of federal and state laws, school district policies, and agency requirements)”.

Expert- participants suggested three of the initial 14 competencies either be moved or duplicated to other domains. Expert- participants suggested, “Crisis intervention models (how to discuss crisis with clients, ability to identify concerning behaviors that indicate client is in crisis, suicide assessments)”, be duplicated into Child Maltreatment Impact Management: Knowledge. Expert- participants also requested “Prevention” be moved to a different domain. They did not make a suggestion as to where this competency belonged. Finally, expert- participants suggested “training on non-trauma related modalities such as substance abuse” be moved to Child Maltreatment Impact Management Domain 1 of 2: Knowledge.

Expert- participants were also asked to comment on the importance and wording of the domain name and definition. Expert- participants reached consensus (mean= 6.57) as to the importance of this domain. Expert- participants commented on using wording like “all the knowledge” and “seeing”. Expert- participants were concerned counselors could never have all of the knowledge needed, and suggested using language that was more inclusive. Expert- participants also suggested changing “seeing” to “working with”. I incorporated these changes into the definition, and presented them to expert- participants in the final survey.

Second round. In this final round, the survey asked expert- participants to approve of the changes to the definition of this domain. Ninety-three percent of the expert- participants agreed to the new wording of the definition as: Child Maltreatment Risk Assessment Knowledge: This domain covers important knowledge counselors need prior to counseling clients in order to identify clients at risk for child maltreatment and report suspicions of abuse to child protective services. Eight questions asked expert- participants to approve of the language and placement changes suggested for the competencies in the first domain. The expert- participants reached consensus ($\geq 70\%$) on all of the suggested changes to language for the competencies.

For the three competencies with suggested changes, expert- participants reached consensus to move two of the three. The expert- participants agreed to move “training on non-trauma related modalities such as substance abuse” to Child Maltreatment Impact Management Domain 1 of 2: Knowledge. Also, The expert- participants agreed to duplicate “Crisis intervention models (how to discuss crisis with clients, ability to

identify concerning behaviors that indicate client is in crisis, suicide assessments)", into Child Maltreatment Impact Management: Knowledge.

The expert- participants did not reach consensus for the placement of "Prevention". Thirty-one percent of the expert- participants did not agree on moving this competency, 38% of the expert- participants agreed to move this competency to Child Maltreatment Impact Management Domain 1 of 2: Knowledge, 15% agreed to move it to Child Maltreatment Risk Assessment Domain 2 of 2: Skills, and 15% agreed to move it to Child Maltreatment Impact Management Domain 1 of 2: Practical Skills. Since the majority of the expert- participants (69%) agreed the competency belonged in the knowledge domains, this competency was included in both Child Maltreatment Risk Assessment: Domain 1 of 2: Knowledge, and Child Maltreatment Impact Management: Domain 1 of 2: Knowledge. One additional competency, "Training on trauma informed assessment" was added to Child Maltreatment Impact Management: Domain 1 of 2: Knowledge.

Table 2 has the final list of the 14 competencies in this domain, along with their mean of importance from round one, and the percent of approval of the changes to the language from round two. The final name and definition of this domains is

Child Maltreatment Risk Assessment Domain 1 of 2: Knowledge. This domain covers important knowledge that counselors need prior to counseling clients in order to identify clients at risk for child maltreatment and report suspicions of abuse to child protective services.

Table 2

List of Competencies Included in Child Maltreatment Risk Assessment Domain 1 of 2: Knowledge

Competency	Mean	%Approve
1. Legal requirements (e.g., knowledge of federal and state laws, general knowledge of school district policies, and agency requirements)	6.5	85%
2. Ethical requirements (e.g., ethical guidelines, confidentiality, informed consent, and supervision in child maltreatment)	6.8	**
3. Ethical decision-making models	6.1	**
4. Child abuse and neglect (e.g., definitions, prevalence, risk factors, types of perpetrators, types of violence, and symptomology of child abuse and neglect).	6.4	**
5. Role and limits in reporting process (e.g., role in assessing and assuring safety, permitted follow-up, documentation)	6.4	**
6. Normal human development and theory (e.g., ability to identify the difference between age appropriate and concerning behaviors)	6.0	**
7. Socio-cultural competencies, social justice, and advocacy (e.g., cultural implications and context of maltreatment).	6.3	**
8. Programs and organizations related to child welfare (e.g., knowledge of child welfare system, how to make a report, knowledge of current language trends in child welfare, agency processes and role of CPS workers, and knowledge of how to access information on child welfare and related programs)	6.1	85%
9. How to integrate the role of the counselor and their role of reporter once a disclosure of child maltreatment is made (e.g., finding the balance between legal responsibility to report while focusing on the well-being of the client, and understanding the boundaries of reporting)	6.2	90%
10. Potential therapeutic relationship issues for client/therapist around child maltreatment (e.g., client anger, boundaries, transference, and countertransference)	6.3	92%

Table 2 continued

Competency	mean	%Approve
12. Crisis intervention models (e.g., how to assess and discuss potential crisis with clients, ability to identify concerning behaviors that indicate client is in crisis, suicide assessments, and homicide assessments)	6.8	100%
13. Training in trauma-informed assessment	6.3	91%
14. Prevention (e.g., understanding root causes of child abuse and neglect, psycho educational prevention, knowing victims' rights and how to access services, knowing abuser rights, cycle of abuse and services).	6.38	80%

** indicates no changes were made to language after the second round.

Child Maltreatment Risk Assessment Domain 2 of 2: Practical Skills

Generative round. A grouping of eight competencies combined to form the second domain: Child Maltreatment Risk Assessment: Practical Skills. These eight competencies addressed the practical skills counselors need to assess for child maltreatment. The original definition for this domain was “This domain covers all of the practical skills counselors need prior to seeing clients in order to identify clients at risk for child maltreatment and report suspicions of abuse to child protective services”.

First round. From the second round of questions, the expert- participants suggested changes to the language for the definition of the domain. Similar to the first domain, the expert- participants were concerned with the use of “all” in this definition. The expert- participants commented on the need to allow for not obtaining all of the skills needed, for example “Again, be careful with the word all. I think that are so many skills

that a counselor needs to have but will any counselor have ALL the skills needed.”

Another participant suggested to change the repeating of skills in the definition, “What can be used instead of repeating skills...what about saying counselors ability to recognize, determine, and address needs for those clients at risk for child maltreatment...etc.” As a result of these suggestions, the following definition was used in round three, “This domain covers important abilities counselors need to attain prior to working with clients in order to identify clients at risk for child maltreatment and report suspicions of abuse to child protective services.”

All eight of the competencies reached consensus (mean ≥ 6) during the second round of questions. Three of the eight competencies had no changes to the language. The expert- participants suggested changes to the following five competencies, final wording can be found in Table 3:

- Gathering Information (e.g., Training on how to interview a child, knowing how role in process mitigates how much information is gathered)
- Collaboration
- Access supervision/ consultation
- Ability to be transparent with client (e.g., informing and including them in the report)
- Address own beliefs and attitude (e.g., maintain professional boundaries, manage own stress and bias, recognize their own boundaries and issues when addressing children to not allow their own issues to come out in the session or impact the child)

The expert- participants suggested two of the competencies be duplicated into other domains. The expert- participants suggested both “Ability to be transparent with client (e.g., informing and including them in the report)” and “Address own beliefs and attitudes (e.g., maintain professional boundaries, manage own stress and bias, recognize

their own boundaries and issues when addressing client to not allow their own issues to come out in the session or impact the client)” be duplicated in the Child Maltreatment Management: Practical Skills domain.

Second round. In this final round, the survey asked the expert- participants to approve of the changes to the definition of this domain. One participant made a final suggestion to change the language from “important abilities” back to “practical skills”. Since 93 percent of the expert- participants agreed to the changes in language to this domain, the final definition of this domain remains “This domain covers important abilities counselors need to attain prior to working with clients in order to identify clients at risk for child maltreatment and report suspicions of abuse to child protective services.”

Expert- participants were low on consensus for two of competencies as to the changes of the language. For “Gathering Information (e.g., Training on how to interview a child, knowing how role in process mitigates how much information is gathered, Identifying line between enough information and crossing into investigating abuse, knowing when not to gather more information)” 69% of the expert- participants approved the suggested changes in the language from the third round.

The expert- participants had the following comments about this competency:

- I would separate them into 2 - there is gathering information for the purpose of reporting and then distinguishing that from investigating. Using active words like distinguishing could help to clarify. I think it would be important for skills to be learned for both as some graduates may be working within child welfare - as well as those who will be only reporting - knowing both roles would help to minimize the crossing over into gathering too much information.
- Remove "interview the child", this language may imply further investigation - how about - obtaining information needed to make report?

- The only info we need to gather is what is needed to help the child move further along in healing but not any investigation at all.

Based on these comments, the new competency reads as “Gathering Information (e.g., Training on how to obtain enough information needed to report, Identifying line between enough information and crossing into investigating abuse, knowing when not to gather more information).

Only 63% of the expert- participants agreed to changes to “Ability to be transparent (when appropriate - and the ability to know the difference) with client”. The expert- participants provided the following comments on this competency:

- Again, this wording is far too imprecise to be helpful. Undoubtedly those who made these suggestions understand what they were attempting to convey. However, the impreciseness of the new statement is too nebulous to be helpful.
- I think transparency is key all of the time. It also helps in building/ continuing the relationship with the client.

In order to further clarify the competency and its description, the competency now reads as “Ability to be transparent with the client with the process of reporting and include them in the report (when appropriate - and the ability to know the difference)”.

The expert- participants identified two competencies that needed to be duplicated into Child Maltreatment Management: Practical Skills. 77% of the expert- participants agreed to duplicate “Ability to be transparent with the client with the process of reporting and include them in the report (when appropriate - and the ability to know the difference)” and 83% agreed to duplicate “Address own beliefs and attitudes (e.g., maintain professional boundaries, manage own stress and bias, recognize their own

boundaries and issues when addressing client to not allow their own issues to come out in the session or impact the client)".

Table 3 has the final list of the eight competencies in this domain, along with their mean of importance from round one, and the percent of approval of the changes to the language from round two. The final title and definition of this domain is

Child Maltreatment Risk Assessment Domain 2 of 2: Practical Skills. This domain covers important abilities counselors need to attain prior to working with clients in order to identify clients at risk for child maltreatment and report suspicions of abuse to child protective services.

Table 3

List of Competencies Included in Child Maltreatment Risk Assessment Domain 2 of 2: Practical Skills

Competency	mean	% Approval
15. Utilize informed consent (e.g., be able to explain confidentiality to clients; know when to revisit limits to confidentiality).	6.5	**
16. Use basic counseling skills during process (e.g., demonstrate ability to maintain empathy and compassion with clients; offer a positive environment for the child and family to communicate without judgment).	6.6	**
17. Empower the client (e.g., use reframes; strengths-based approaches; understand the importance and means of validating survivors during disclosures and subsequent discussions).	6.8	**
18. Gather information (e.g., training on how to obtain enough information needed to report; identify line between enough information and crossing into investigating abuse; know when not to gather more information).	6.4	69%

Table 3 Continued

Competency	Mean	% Approval
19. Collaborate (with CPS, law enforcement, hospital, other counselors, teachers, etc.)	6.7	100%
20. Access supervision/consultation (e.g., know when to seek supervision/consultation).	6.6	85%
21. Be transparent with the client regarding the process of reporting and include them in the report (when appropriate and the ability to know the difference).	6.5	67%
22. Address own beliefs and attitudes (e.g., maintain professional boundaries; manage own stress and bias; recognize own boundaries and issues when addressing client so that own issues do not come out in the session or impact the client).	6.6	100%

*** indicates no changes were made to language after the second round.*

Child Maltreatment Impact Management Domain 1 of 2: Knowledge

Generative round. A grouping of ten competencies united to form the third domain: Child Maltreatment Management Domain 1 of 2: Knowledge. These ten competencies addressed the knowledge counselors need to promote client welfare during and after a child maltreatment report. The original definition for this domain was "This domain covers all of the knowledge counselors need prior to seeing clients in order to ensure client welfare during and after a child protection report."

Round one. The expert- participants had similar concerns as the Child Maltreatment Risk Assessment Domain 1 of 2: Knowledge for the use of "all" in the definition. Participant comments indicated obtaining "all of the knowledge" is an impossible task, and requested less restrictive language. Also, the expert- participants

suggested using "ensuring client welfare" was misleading, and "awkward". One participant proposed to expand this domain from "management" to "impact or resilience management" as "the management of relationship and ongoing wellbeing was beyond risk itself". Therefore, the final name and definition for this domain are as follows: Child Maltreatment Impact Management Domain 1 of 2: Knowledge. Child Maltreatment Impact management: This domain covers important knowledge counselors need prior to working with clients in order to promote client welfare during and after a child protection report.

The expert- participants reached consensus (mean ≥ 6) on all 10 of the competencies identified under this domain. Of the 10 competencies, the expert- participants did not suggest changes for five of the competencies, and five had minor changes to the language. Table 4 displays the final wording of these competencies. The expert- participants suggested one competency, "Training in Trauma informed assessment" be moved to Child maltreatment risk assessment: knowledge.

Four new competencies were added to this domain. The expert- participants added one new competency during this first round, "Understanding of and ability to assess own strengths and needs (e.g., take responsibility to seek training as needed, seek out resources, seek supervision and consultation)". Three competencies originated from a different domain:

- Training on other non-trauma related treatment modalities such as substance abuse, domestic violence, socioeconomic bias, and mental illness

- Crisis intervention models (how to discuss crisis with clients, ability to identify concerning behaviors that indicate client is in crisis, suicide assessments)
- Prevention

The expert- participants were low on consensus (mean=5.57) for "Training on other non-trauma related treatment modalities such as substance abuse, domestic violence, socioeconomic bias, and mental illness". Participant comments included moving the competency to a different domain, and adding "domestic violence and mental illness" to the competency. The expert- participants commented further on this competency during the next round.

Round two. In this final round, the survey asked the expert- participants to approve of the changes to the name and definition of this domain. The expert- participants approved of all changes to this domain and definition, resulting in the final definition: Child Maltreatment Impact management: This domain covers important knowledge counselors need prior to working with clients in order to promote client welfare during and after a child protection report.

The expert- participants also approved of all of the changes to the language of the five original competencies. Table 4 displays the final wording of all 14 competencies in this domain. Of the four added competencies, 91% of the expert- participants agreed to duplicating "Crisis intervention models (how to discuss crisis with clients, ability to identify concerning behaviors that indicate client is in crisis, suicide assessments)", and 100% of the expert- participants agreed to duplicating "Training on other non-trauma related treatment modalities such as substance abuse, domestic violence, socioeconomic

bias, and mental illness" with minor language changes into this domain. These two competencies can also be seen listed under Child Maltreatment Risk Assessment Domain 1 of 2: Knowledge.

Thirty-eight percent of the expert- participants agreed to move "Prevention" from Child maltreatment Risk Assessment Domain 1 of 2: Knowledge, to this domain. 85 percent of the expert- participants agreed to the addition of " Understanding of and ability to assess own strengths and needs (e.g., take responsibility to seek training as needed, seek out resources, seek supervision and consultation)" to this domain. Ninety-two percent of the expert- participants agreed to move "Training in trauma informed assessment" to Child Maltreatment Risk Assessment Domain 1 of 2: Knowledge. Table 4 reflects the 14 competencies identified for this domain. The table displays the mean of importance for each from round one, and the percent of approval of the changes to the language from round two. The final title and definition of the domain is

Child Maltreatment Impact Management 1 of 2: Knowledge. This domain covers important knowledge counselors need prior to working with clients in order to promote client welfare during and after a child protection report.

Table 4

List of Competencies included in Child Maltreatment Impact Management Domain 1 of 2: Knowledge

Competency	mean	% Approve
23. Community resources and how to access them	6.43	**
24. Human development knowledge and theory (e.g, how child maltreatment impacts child development; understanding of short- and long-term consequences of abuse; effects of child maltreatment on the brain, behavior and development)	6.54	**
25. Attachment and how it is impacted by child maltreatment	6.29	**
26. Neurobiology and how it is impacted by child maltreatment	6.29	**
27..Basic parenting practices (e.g., how to educate and coach parents to be effective caretakers during recovery; knowing parenting modalities that work)	6.21	**
28. Trauma-informed care that includes awareness of the different trauma treatment modalities (e.g., evidenced-based practices; play therapy; child-focused treatments; trauma focused-CBT filial therapy; ways to work with ongoing trauma experienced by children who are maltreated)	6.14	92%
29.Family systems (e.g., knowing how to engage a family; understanding the systemic impact of child maltreatment; understanding cultural influences and their impact on the family system)	6.57	85%
30. How to work with the child welfare system after the abuse has been reported	6.29	92%
31. Theories of change (knowledge of the change process and how it applies to counseling clients impacted by child maltreatment)	6.00	77%
34. Prevention (understanding root causes of child abuse and neglect; psycho educational prevention; knowing victims' rights and how to access services; knowing abuser rights; cycle of abuse and services).	6.38	78%

Table 4 continued

Competency	mean	% approve
35.. How to assess own strengths and needs (e.g., taking responsibility to seek training as needed; seek out resources; seek supervision and consultation).	n/a	85%

*** indicates no changes were made to language after the second round.*

Child Maltreatment Impact Management Domain 2 of 2: Practical Skills

Generative round. Eleven competencies developed into a domain that addressed the practical skills counselors need to work with clients impacted by child maltreatment. The final domain was named Child Maltreatment Impact management: Practical Skills. The original definition was "This domain covers all of the practical skills counselors need prior to seeing clients in order to ensure client welfare during and after a child protection report".

Round one. From the second round of questions, the expert- participants suggested changes to the language of the title of this domain. Similar to the Child Maltreatment Impact management domain 1 of 2: Knowledge, the expert- participants recommended the addition of "impact" to the name of the domain. Also, the expert- participants were concerned about the use of "ensure" and requested using something less definite. Finally, the expert- participants suggested varying the language in the definition by changing "practical skills". As a result of these suggestions, the following domain name and definition are "Child Maltreatment Impact management: Practical skills: This

domain covers important abilities counselors need to attain prior to working with clients in order to promote client welfare during and after a child protection report.

There were nine competencies initially identified as part of this domain (see Table 5). All nine of the competencies reached consensus (mean ≥ 6) during the second round of questions. Six of the nine competencies had no changes to the language. The remaining three had minor changes to the language, which are reflected in table 5. One additional competency was added to this domain, "Address own beliefs and attitudes (e.g., maintain professional boundaries, manage own stress and bias, recognize their own boundaries and issues when addressing client to not allow their own issues to come out in the session or impact the client)" into this domain.

Round two. All of the expert- participants agreed to the changes to the name and definition of this domain. The final definition is: Child Maltreatment Impact management: Practical skills: This domain covers important abilities counselors need to attain prior to working with clients in order to promote client welfare during and after a child protection report.

The expert- participants approved all of the changes suggested in the previous round. Eighty-six percent of the expert- participants agreed to duplicate "Address own beliefs and attitude (e.g., maintain professional boundaries, manage own stress and bias, recognize their own boundaries and issues when addressing client to not allow their own issues to come out in the session or impact the client)" into this domain. This can also be seen in Child Maltreatment Risk Assessment Domain 2 of 2: Practical Skills. Table 5 reflects all ten competencies in this domain, their mean of importance from round one,

and the percentage of agreement to the changes to the language from round two. The final title and definition of this domain is

Child Maltreatment Impact Management 2 of 2: Practical Skills. This domain covers important abilities counselors need to attain prior to working with clients in order to promote client welfare during and after a child protection report.

Table 5

List of Competencies Included in Child Maltreatment Impact Management Domain 2 of 2: Skills

Competency	mean	% Approval
36. Recognize and repair ruptured relationships (Understand anger is a normal part of the process)	6.64	**
37. Use basic counseling skills with clients	6.50	**
38. Advocate for clients and families	6.64	**
39. Continue assessment for further maltreatment	6.62	**
40. Collaborate with multidisciplinary teams (e.g., participate in group and family meetings; set goals with all teams involved; understand how to help all individuals that have contact with the child to better support the child).	6.50	**
41. Use self-care practices	6.71	**
42. Balance the need for fidelity using evidenced-based models and client's individual needs when treating trauma.	6.14	77%
43. Use a strengths-based approach with children and families (e.g., assess for protective capacity of both offending and non-offending caregivers and how to build it; empower clients during and after report)	6.57	85%

Table 5 continued

Competency	mean	% Approval
44. Recognize beliefs and attitude (e.g., maintain professional boundaries, manage own stress and bias, recognize their own boundaries and issues when addressing client to not allow their own issues to come out in the session or impact the client)	6.64	100%
45. Recognize and utilize effective and supportive supervision/consultation	6.57	92%

*** indicates no changes were made to language after the second round.*

Summary of Findings

Through this Delphi study, I engaged a panel of 25 expert- participants and produced a set of 45 competencies divided into four domains for counselors-in-training to work with clients affected by child maltreatment. The domains were (1). Child Maltreatment Risk Assessment Domain 1 of 2: Knowledge, (2). Child Maltreatment Risk Assessment Domain 2 of 2: Practical Skills, (3). Child Maltreatment Impact Management Domain 1 of 2: Knowledge, (4). Child Maltreatment Impact Management Domain 2 of 2: Practical Skills. In addition, eight to 14 competencies were developed per domain. All competencies reached consensus as to their importance and reached majority approval for changes to placement and language. Appendix I has a full list of domains and competencies.

CHAPTER V

DISCUSSION

The purpose of this study was to determine the competencies that are necessary for counselors to effectively work with clients—both children and adults—before, during, and after a child maltreatment report. This study sought to identify those competencies through a Delphi process. In this chapter, I discuss the findings within the context of the professional literature. I then discuss the limitations of the study, the implications for counselor educators, and directions for future research.

Competencies for Child Maltreatment Risk Assessment and Management

In the past five years, researchers have focused on crisis education for counselors, and have found that training on crisis, including child maltreatment, is lacking and is not preparing counselors to protect client welfare (Milton & Pease- Carter, 2011; Wachter Morris & Barrio Minton, 2012). There is a need to increase the competency of professionals, including counseling professionals, to recognize and respond to child maltreatment. Professionals other than counseling professionals, such as those from the health and psychology fields, have developed competencies for training in the field of child maltreatment (Chen et al., 2013; Damashek, et al., 2011). Competencies from other fields represent an important step toward improving training for mandated professionals. The focus and training of the counselor is different than that of the health or psychology

professional. Counselors tend to be master's level practitioners, whereas most psychology and health professionals tend to have doctoral degrees. Counselors also tend to focus on positive human change and wellness (Duffey & Somody, 2011; Van Hesteren & Ivey, 1990), whereas psychologists and health professionals tend to use a medical model of diagnosis, pathology, and medications (Duffey & Somody, 2011). A gap in the research exists for the training needs of counselors on child maltreatment risk assessment and management.

In this study, a panel of 25 expert- participants created and confirmed a list of 45 competencies across four domains through an iterative process. Expert- participants identified the knowledge and skills counselors need to have in order to work effectively with clients experiencing child maltreatment. The findings highlight the complexity of the counselors' role and the importance of clinical competence in improving services to families experiencing child maltreatment. These findings advance the literature base by providing empirically supported competencies for counselor preparation.

Complex role. The role of the counselor in child maltreatment risk assessment and management is complex (Henderson, 2013). Through the development of these competencies, the expert- participants attempted to help clarify the role of counselors in assessing and managing child maltreatment in their clients. Across four domains, expert- participants detailed that a counselor must take on the role of counselor, advocate, teacher, mandated reporter, and consultant. Similar to the findings in the literature (e.g., Henderson, 2013; Levine, et. al, 1995; Damashek, et al., 2011; Chen, et al., 2013), the panel of expert- participants in this study identified the knowledge and skills counselors

need to fulfill these roles. The four domains that emerged are: (1) Child maltreatment risk assessment: Knowledge; (2) Child maltreatment risk assessment: Practical skills; (3) Child maltreatment impact management: Knowledge; (4) Child maltreatment impact management: Practical skills. In this section, I present each of the four domains and their underlying competencies and contextualize them within the professional literature.

Counselor-specific Domains

Researchers from the health profession and psychology produced training competencies for working within the area of child maltreatment (Damashek, et al., 2011; Chen, et al., 2013). Expert- participants and the researchers found similar domains, such as identifying knowledge and skills necessary for working with clients who are impacted by child maltreatment. Different from these prior studies, the expert- participants in this study separated the competencies into risk assessment and impact management as the two important domains. The expert- participants separated the competencies by chronological order, rather than by grouping by content. For example, Damashek, and colleagues (2011) identified overarching competency areas, such as assessment, research ethics, and treatment, and then broke these down into the knowledge, skills, and attitudes needed to achieve competence. Unlike most studies, this study went beyond mandated reporting and focused on the process of first assessing for the risk and then managing the impact of child maltreatment on the client. This grouping into chronological order may give counselors a better guide for the skills and knowledge needed before, during, and after a report is made.

With these overarching domains, the expert- participants in this study highlighted that counselors need to understand potential impacts on client welfare. This focus was unique to this study, as the non-counseling professionals did not address the working relationship with the client or the need to understand cultural implications of child maltreatment. This different focus may be due to the use of the family resilience framework. The assumptions of the family resilience framework, (1) individuals function as part of a family system; (2) family systems have strengths and coping abilities; and (3) families have the ability to overcome stressful events and crisis (Walsh, 2003) guided my communication with participants, and the development of the first survey. This strength-based focus placed client welfare in the forefront, which potentially influenced the expert-participants in this study to do the same.

Child Maltreatment Risk Assessment

In Chapter I, child maltreatment risk assessment was defined as “identifying if the client is experiencing child maltreatment, gathering enough information to make the decision to report, and reporting to child protective services.” Researchers and the expert-participants in this study agreed that the role of mental health professionals in child maltreatment risk assessment is complex and requires the acquisition of particular knowledge and skills in order to work with clients competently (Damashek, et al., 2011). The expert- participants in this study outlined the knowledge and skills counselors need to assess for child maltreatment. The competencies in this domain present an intricate combination of knowledge and skills a counselor must utilize during the process of child maltreatment risk assessment.

Domain 1 of 2: Knowledge. This domain covers important knowledge for counselors prior to counseling clients to help them identify clients at risk for child maltreatment and report suspicions of abuse to child protective services. Expert-participants identified 14 training competencies under this domain. Table 6 includes the list of competencies included in this domain. These competencies are consistent with the suggestions from the literature.

Table 6

List of Competencies Included in Child Maltreatment Risk Assessment Domain 1 of 2: Knowledge.

Competency
1. Legal requirements (e.g., knowledge of federal and state laws, general knowledge of school district policies, and agency requirements)
2. Ethical requirements (e.g., ethical guidelines, confidentiality, informed consent, and supervision in child maltreatment)
3. Ethical decision-making models
4. Child abuse and neglect (e.g., definitions, prevalence, risk factors, types of perpetrators, types of violence, and symptomology of child abuse and neglect).
5. Role and limits in reporting process (e.g., role in assessing and assuring safety, permitted follow-up, documentation)
6. Normal human development and theory (e.g., ability to identify the difference between age appropriate and concerning behaviors)
7. Socio-cultural competencies, social justice, and advocacy (e.g., cultural implications and context of maltreatment).
8. Programs and organizations related to child welfare (e.g., knowledge of child welfare system, how to make a report, knowledge of current language trends in child welfare, agency processes and role of CPS workers, and knowledge of how to access information on child welfare and related programs)

Table 6 continued

Competency
9. How to integrate the role of the counselor and their role of reporter once a disclosure of child maltreatment is made (e.g., finding the balance between legal responsibility to report while focusing on the well-being of the client, and understanding the boundaries of reporting)
10. Potential therapeutic relationship issues for client/therapist around child maltreatment (e.g., client anger, boundaries, transference, and countertransference)
11. Difference between risk (the likelihood that abuse or neglect will happen in the future) and safety (freedom from current danger, risk, or injury)
12. Crisis intervention models (e.g., how to assess and discuss potential crisis with clients, ability to identify concerning behaviors that indicate client is in crisis, suicide assessments, and homicide assessments)
13. Training in trauma-informed assessment
14. Prevention (e.g., understanding root causes of child abuse and neglect, psycho educational prevention, knowing victims' rights and how to access services, knowing abuser rights, cycle of abuse and services).

Competencies 1, 2, 3: Legal and Ethical. As in the literature, expert-participants in this study expressed the need for counselors to understand their legal and ethical obligations, to accurately identify child maltreatment, and to be prepared to collaborate with outside professionals (Bernstein & Hartsell Jr., 2004; Chen et al., 2013; Damashek et al., 2011; Lambie, 2005; Levine et al., 1995; Remley & Fry, 1993). The literature clearly supports a requirement for counselors to report suspected child abuse and neglect, and highlights their responsibility to know the definitions of each type of maltreatment and to accurately identify each form of abuse and neglect (Henderson, 2013; Levine et al., 1995; Remley & Fry, 1993).

The expert- participants included knowledge of ethical decision-making models. Many researchers have suggested professionals need to understand how to apply ethical decision-making models to the reporting of child maltreatment (Henderson, 2013; Remley & Herlihy, 2010; Tufford, 2012). Henderson (2013), and Remley and Herlihy (2010) both discussed counselors using ethical decision making models as guidance for making a sound decision. These models (e.g., the feminist model and the social constructivism model) assist counselors in assessing the risk for child maltreatment by providing a map for counselors to follow when making the decision to report abuse and neglect. With an ethical decision-making model the counselor can walk through the steps listed in the model. Counselors often rely on ethical decision-making models to provide a framework for comprehensive ethical decision making (Forester- Miller & Davis, 1996). This is important for counselors to apply to the assessment of child maltreatment as following a step-by-step model ensures the decision is not self-serving, and is based on both the legal and ethical guidelines of the counseling profession.

For example, the steps outlined in the feminist model include: recognizing and defining the problem, developing the solution, choosing a solution, reviewing the process, and implementing and evaluating the decision (Hill, Glaser, & Harden, 1998). The following vignette provides a brief overview of how this model might apply to a counselor assessing for child maltreatment. A counselor is working with an adult client experiencing depression. This client discusses suicidal thoughts, and reports struggling to get out of bed in the morning to take care of the children. The counselor would first recognize that the client's depression could be affecting her ability to care for the

children. The counselor would then define the type of child maltreatment suspected (e.g., neglect) by talking more with the client and gathering additional information. The counselor would next begin to develop a solution, one of which could involve calling CPS, the other alternative is not involving CPS as the situation does not rise to the level of reasonable cause to suspect child maltreatment. The counselor would next review his or her decision-making process (possibly with the client) and then would make the call to CPS.

Another model for ethical decision making is social constructivism approach. It is an interactive process between people (Cottone & Claus, 2001). Cottone and Claus (2001) outlined the steps as:

(a) obtain information from those involved, (b) assess the nature of the relationships operating at that moment in time, (c) consult valued colleagues and professional expert opinion (including ethics codes and literature), (d) negotiate when there is a disagreement, and (e) respond in a way that allows for a reasonable consensus as to what should happen or what really occurred (p. 43).

This approach utilizes consultation with colleagues, and the opinion of the client. In contrast, the counselor completes an internal process of decision making in the feminist approach. Applying the social constructivist model to the above scenario, the counselor would consult with the client, CPS and other counselors prior to making the decision to report. This model also allows room for the counselor to negotiate with the client on who actually makes the report to CPS. The feminist and social constructivist models are two ethical decision making models which provide a map that could help guide the counselor to the appropriate decision and help them to document their process throughout (Cottone & Claus, 2000).

Throughout the ethical decision making process, many other competencies from this study are needed. As is evidenced in the above vignette, the counselor applying the ethical decision making model also needed competencies 1, 2, 4, 5, 9, and 10, along with skills included in the subsequent domain. It is important to note that these competencies are not exclusive, they are all important and needed in assessing for the risk of child maltreatment.

Competency 4: Child Abuse and Neglect. The expert- participants found counselors need to know the definitions, prevalence, risk factors, types of perpetrators, types of violence, and symptomology of child abuse and neglect, which is consistent with many findings in the research (Alvarez et al., 2005; Chen et al., 2013; Kalichman, 1999). The *Child Abuse Prevention and Treatment Act (CAPTA) of 2010* provides the federal definition of child maltreatment. Each state defines the specific types of child abuse and neglect (CWIG, 2010). Counselors need to be prepared to look up the definitions in the state where they practice in order to accurately assess whether their concerns rise to the level of reporting to CPS. Often definitions of what legally constitutes child maltreatment is different from state to state, and can add to the difficulty of identifying child maltreatment.

For example, a counselor living in Colorado needs to know that spanking is allowable as long as it is age appropriate and does not leave a mark (CRS 19-1-103(1)(a)(I)). However, this is not true for all states, as some states such as Delaware, prohibit causing any kind of physical pain to a child (DRS 11-5-1100 (5)). With all of these statutory differences, it is imperative that counselors are familiar with their state's

definitions. Counselors can find their state's definitions at the Child Welfare Information Gateway (www.childwelfare.gov). The Child Welfare Information Gateway also provides resources on the prevalence, risk factors, symptomology, types of perpetrators, and violence.

Competencies 5, 9, 11: Counselor's role. The expert- participants also included three competencies dealing with a counselor's role during the reporting process. These competencies were: (5) Understanding role and limits in reporting process (e.g., role in assessing and assuring safety, permitted follow-up, documentation); (9) Understanding how to integrate the role of the counselor with the corresponding role of reporter once a disclosure of child maltreatment is made (e.g., finding the balance between legal responsibility to report while focusing on the well-being of the client and understanding the boundaries of reporting); (11) Understanding the difference between risk (the likelihood that abuse or neglect will happen in the future) and safety (freedom from current danger, risk, or injury).

The expert- participants attempted to clarify the role of the counselor in child maltreatment risk assessment and discussed the fine line between promoting client safety and directly assessing the safety of the child. Some expert- participants discussed determining whether a child is in an environment that is of high risk and should be placed elsewhere. While other expert- participants discussed maintaining the role of the counselor throughout the process, and not overstepping their part, e.g., "the role is not to determine whether or not the maltreatment has occurred." Most researchers and expert- participants suggested that counselors understand that their role is to report when they

suspect abuse is present, not to prove it is happening (Alvarez et al., 2004; Henderson, 2013; Kalichman, 1999; Levine et al., 1995; Renninger et al., 2002).

This clarification of the counselor's role in ensuring client safety is important. Professionals often question the safety of a child (Henderson, 2013; Remley & Herlihy, 2010), which can lead to a desire to take on a more active role in determining safety. DePanfilis and Salus (2003) clarified that the role of CPS and law enforcement is to assess for safety since they have the ability and authority to gain court orders and control for safety in the home. Henderson (2013) suggested that counselors consult with CPS or law enforcement if the concern for safety of the child is imminent or there is a potential threat to the child's welfare. For example, counselors who are worried for their client's safety can call CPS or law enforcement while in session and describe their concerns in order to expedite the safety assessment that CPS professionals are mandated to complete. Often, CPS and law enforcement are able to safety-plan with the family to reduce the risk of child maltreatment in the home. Counselors who choose to safety-plan without consulting with CPS and law enforcement place themselves at risk for legal consequences, and put their clients at-risk of future harm. With these competencies, counselors-in-training may be better prepared to provide a thorough assessment of risk of child maltreatment while maintaining their focus on promoting client welfare.

Counselor-specific risk assessment knowledge. There were similarities in the findings of this study to those found by Damashek, and colleagues (2011) and identified through a Delphi by Chen and Colleagues (2013), such as recognizing child abuse and neglect, understanding the role and appropriate boundaries, knowing legal and ethical

responsibilities, understanding human development, and understanding programs and organizations. The expert- participants in this study highlighted the importance for counselors to understand potential impacts on client welfare, such as gaining awareness of socio-cultural competencies and potential therapeutic relationship issues for client/therapist around child maltreatment.

This focus was unique to this study, as the health care professionals and psychologists did not address the working relationship with the client or the need to understand cultural implications of child maltreatment. This client and relationship focus could be due to the strength-based framework on which this study is structured. Expert- participants were asked to focus on empowering clients, and the results of this study reflect an attitude believing all clients can change. Also, expert- participants were asked to focus on the entire system, including adult and children. This broad focus on clients, regardless of their role in the child maltreatment (e.g. victim or perpetrator) may have directed the expert- participants to focus on client welfare and the therapeutic relationship. Counselors have many different ways of working with clients, many of them may have been exposed to child maltreatment, either as a victim or as a perpetrator. It is important counselors be prepared to work with clients effectively and promote their welfare regardless of their role with child maltreatment.

Domain 2 of 2: Practical Skills. This domain covers important abilities that counselors need to attain prior to working with clients to help them identify clients at risk for child maltreatment and report suspicions of abuse to child protective services. Expert- participants identified eight competencies in this domain. These competencies are

consistent with the recommendations from the literature. Expert- participants and the many researchers agree that professionals need particular skills to assess for child maltreatment. Table 7 contains the list of competencies included in this domain.

Table 7

List of Competencies Included in Child Maltreatment Risk Assessment Domain 2 of 2: Practical Skills

Competency
15. Utilize informed consent (e.g., be able to explain confidentiality to clients; know when to revisit limits to confidentiality).
16. Use basic counseling skills during process (e.g., demonstrate ability to maintain empathy and compassion with clients; offer a positive environment for the child and family to communicate without judgment).
17. Empower the client (e.g., use reframes; strengths-based approaches; understand the importance and means of validating survivors during disclosures and subsequent discussions).
18. Gather information (e.g., training on how to obtain enough information needed to report; identify line between enough information and crossing into investigating abuse; know when not to gather more information).
19. Collaborate (with CPS, law enforcement, hospital, other counselors, teachers, etc.)
20. Access supervision/consultation (e.g., know when to seek supervision/consultation).
21. Be transparent with the client regarding the process of reporting and include them in the report (when appropriate—and the ability to know the difference).
22. Address own beliefs and attitudes (e.g., maintain professional boundaries; manage own stress and bias; recognize own boundaries and issues when addressing client so that own issues don't come out in the session or impact the client).

Competency 15, 16, 17, 21, 22: Counseling relationship. The expert- participants in this study acknowledged the need for counselors to develop skills that

facilitate the counseling relationship when assessing for child maltreatment. Skills, such as informed consent, client empowerment, transparency with the client, and basic counseling skills are important to maintaining the counseling relationship. Researchers have found that clients are more likely to return to treatment after a report is made if there is a strong therapeutic alliance, longevity in treatment, and more explicit consent procedures (Steinberg et al., 1997; Weinstein et al., 2000). Researchers have suggested that informed consent and involving the client in the making of the report influence the outcomes of the report (Henderson, 2013; Levine et al., 1995; Remley & Fry, 1993). Including parents and children in the report can facilitate the continuity of the therapeutic relationship, can reassure parents and children that the counselor is an advocate for the family, and can lay the foundation for future clinical work (Henderson, 2013; Remley & Fry, 1993).

Competency 18: Gathering information. Expert- participants also addressed the difficult role that counselors play when gathering information to make a report. Expert- participants in this study identified a line between gathering enough information and crossing into investigating abuse. Bernstein and Hartsell (2004) and Brown, Brack, and Mullis (2008) indicated that it is important that counselors understand their role in the investigation/potential court processes so they do not interfere or influence the child's statement. The statements from the expert- participants also reflected the difficulty of determining when enough information has been gathered. Some expert- participants expressed the need to gather as much information as they can about it and pass this information on to CPS workers, while others identified limits to how much they are to

gather. One participant said, “I think it’s important to teach counselors when NOT to talk to children any longer. They are not the investigator.... this is critical for them to know so they don't think it's their job to investigate an allegation. It is only to see it and report it.” All expert- participants agreed on the importance of knowing the limit to how much information is necessary to gather and which information is relevant to assessing for child maltreatment. An understanding of the law, child maltreatment and the counselors role in the reporting process (competencies 1, 4, 5, 9) can help guide counselors in how much information to gather. For example, Colorado law states a mandated reporter is required to report when they have “reasonable cause to know or suspect that a child has been subjected to abuse or neglect (C.R.S 19-3-304).” The amount of information for counselor’s to gather to report child maltreatment in Colorado is only as much as they need to have “reasonable cause.” This gray area can be confusing to many counselors and counselors should seek consultation and utilize ethical decision-making models (competencies # 19, 3) to help them decide how much information is enough.

Counseling-specific skills for risk assessment. Similar to the results of the current study, researchers from psychology and health suggested that professionals need to demonstrate the ability to assess for and respond to child maltreatment and to collaborate with professionals from other disciplines (Damashek, et al., 2011; Chen et al, 2013). The competencies for health care professionals also included addressing professional attitudes, such as bias for the abused family, and counter-transference, along with the need for professionals to learn interviewing skills (Chen et al., 2013). The expert- participants in the current study also identified addressing the counselors’ own

beliefs and attitudes as an important competency for assessing for the risk of child maltreatment. Counselors need to assess their own beliefs about child maltreatment, including what it means to be a victim, and what type of people they believe are capable of abusing and neglect. A counselor's bias can impact how they assess for child maltreatment, and oftentimes counselors may confuse poor parenting for child maltreatment (Levine, et al, 1995).

Child Maltreatment Impact Management

The first two domains and their associated competencies identified by the expert-participants were the knowledge and skills that are important to assessing for the risk of child maltreatment. Assessing for risk is only part of the counselor's role in working with a client affected by child maltreatment. Once the counselor has made the decision that a report is necessary, the counselor's role then turns to helping manage the impact of the report on the client (Abrahams et al., 1992; Alvarez et al., 2005; Bavolek, 1983; Baxter & Beer, 1990; Champion et al., 2003; Levine et al., 1995; Pollak & Levy, 1989; Reiniger et al., 1995). In this study, child maltreatment risk management is defined as advocating for the client during and after the risk assessment and continuing a working relationship with the client once the risk assessment is completed. Similar to the domains for child maltreatment risk assessment, the expert- participants who were surveyed in this study outlined the knowledge and skills counselors need in order to complete this task. Compared to defining the role of counselors in assessing for the risk of child maltreatment, expert- participants were able to define the role of the counselor much more clearly. One participant remarked, "These seems to be the most solid set of

competencies for any of the domains thus far! I really appreciate these...” The competencies in these domains are more consistent with the traditional counseling role. In this section, I provide the competencies for the two domains of child maltreatment impact management and compare them to the professional literature.

The competencies in these next two domains align with the recommendations of the literature base. Most researchers have suggested ways to improve the training of counselors to minimize the impact of mandated reporting on the client and the therapeutic relationship (Alvarez et al., 2004; Bromley & Riolo, 1989; Luthar et al., 2000; Steinberg et al., 1997). This study provides empirical support to these recommendations, and extends the existing literature by specifically defining the knowledge and skills the counselor needs in order to promote client welfare during and after reporting.

Domain 1 of 2: Knowledge. This domain covers important knowledge counselors need prior to working with clients in order to promote client welfare during and after a child protection report. Expert- participants identified 14 competencies for this domain. Table 8 displays the list of competencies included in this domain.

Table 8

List of competencies included in child maltreatment impact management Domain 1 of 2: Knowledge.

Competency
23. Community resources and how to access them
24. Human development knowledge and theory (e.g, how child maltreatment impacts child development; understanding of short- and long-term consequences of abuse; effects of child maltreatment on the brain, behavior and development)
25. Attachment and how it is impacted by child maltreatment

Table 8 continued

Competency
26. Neurobiology and how it is impacted by child maltreatment
27. Basic parenting practices (e.g., how to educate and coach parents to be effective caretakers during recovery; knowing parenting modalities that work)
28. Trauma-informed care that includes awareness of the different trauma treatment modalities (e.g., evidenced-based practices; play therapy; child-focused treatments; trauma focused-CBT filial therapy; ways to work with ongoing trauma experienced by children who are maltreated)
29. Family systems (e.g., knowing how to engage a family; understanding the systemic impact of child maltreatment; understanding cultural influences and their impact on the family system)
30. How to work with the child welfare system after the abuse has been reported
31. Theories of change (knowledge of the change process and how it applies to counseling clients impacted by child maltreatment)
32. Crisis intervention models (how to discuss crisis with clients; ability to identify concerning behaviors that indicate client is in crisis; suicide assessments; homicide assessments)
33. Other trauma-related treatment modalities such as substance abuse, domestic violence, socioeconomic bias, and mental illness
34. Prevention (understanding root causes of child abuse and neglect; psycho educational prevention; knowing victims' rights and how to access services; knowing abuser rights; cycle of abuse and services).
35. How to assess own strengths and needs (e.g., taking responsibility to seek training as needed; seek out resources; seek supervision and consultation).

Competencies 23, 25, 26: Human Development, Attachment, and

Neurobiology. Three of the items in this domain relate to managing the impact of the consequences of child maltreatment on the client and their family system. As I discussed

in Chapter 2, there are short- and long-term consequences across the different types of child maltreatment. Researchers have linked child maltreatment to many mental health disorders (Johnson et al., 2000), social problems (Chu & Dill, 1990; Kaplan et al., 1999), and health issues (Moeller et al., 1993). Child maltreatment has also been shown to impact daily functioning in both children and adults (Hildyard & Wolfe, 2002; Parker & Herrera, 1996; Trickett & McBride-Chang, 1995; Waite & Shewokis, 2012). The expert-participants in this study believed counselors gaining knowledge in human development, attachment, and neurobiology can help counselors manage the impact of child maltreatment on clients.

Competencies 28, 31, 32, 33: Treatment. The expert- participants also stated that knowledge of different types of treatment and practices may help manage the impact of child maltreatment on clients. Similar to the competencies for psychologists (Damashek, et al., 2011), the expert panel described a need for counselors to be aware of different trauma treatment modalities, such as evidenced-based practices and play therapy. Some expert- participants expressed concern with strictly adhering to evidenced-based practices. One panelist said,

I would caution strict adherence to a specific model; while utilizing evidence-based treatment is important, ‘evidence’ is not a well-defined construct and the research often differs. I would focus on the ability to effectively evaluate the efficacy of a specific treatment modality and make necessary changes based on the need of the client.

This attitude toward evidence-based practices is common in counselor education (Patel, Hagedorn, & Bai, 2013). Patel, and associates found that counselor educators were not familiar with how to integrate evidence-based practices into counselor education

curricula, and the inclusion of evidence-based practice was not consistent across CACREP training programs. This may account for the panel's hesitancy to use evidenced-based practices as training competency for counselors-in-training.

Competency 27, 29: Basic parenting skills and family system. Comparable to the competencies for health care professionals (Chen, et al. 2013), expert- participants agreed counselors need an understanding of family systems and basic parenting practices. Expert- participants in Chen and colleagues (2013) research ranked working with the family as less important than working with the identified child experiencing the child maltreatment. In this study, expert- participants rated these as equally important. The counseling and related mental health literature present similar results. Much of the mental health research focus has been on the family system (Charlow, 2001; Dempsey et al., 2013; Fergusson et al., 2008; Garbarino et al., 1997; Klorman et al., 2003; Wolfe & McIsaac, 2011). Individuals exist within a system, and their ability to overcome trauma depends on their connection to caring adults in either their family or their community (Masten & Coatsworth, 1998). The expert- participants in this study and the literature agree that managing the impact of child maltreatment includes both the individual and the family.

Competency 35: Assessing own strengths. One competency, understanding of and ability to assess own strengths and needs, was added to this list of competencies. One participant commented,

Assessment of needs and strengths would be beneficial, and understanding the need to take responsibility to become trained seems more realistic than expecting all these levels of knowledge at the time the counselor is working with a client—seeking out resources, getting supervision and consultation, etc.

This competency is unique to the counseling competencies. Damashek, and colleagues (2011) and Chen and associates (2013) suggested attitudes that professionals could develop that could enhance their work with clients experiencing child maltreatment. The expert- participants in this study, however, presented the idea of ongoing training on concepts related to child maltreatment that may not be covered by these competencies; such ongoing training may leave counselors-in-training with the expectation that training and awareness do not end after the master's program.

Domain 2 of 2: Practical Skills. This domain covers important abilities counselors need to attain prior to working with clients in order to promote client welfare during and after a child protection report. Expert- participants identified ten competencies for this domain. Table 9 contains a list of these competencies.

Table 9

List of Competencies for the Child Maltreatment Impact Management Domain 2 of 2: Practical Skills

Competency
36. Recognize and repair ruptured relationships (Understand anger is a normal part of the process)
37. Use basic counseling skills with clients
38. Advocate for clients and families
39. Continue assessment for further maltreatment
40. Collaborate with multidisciplinary teams (e.g., participate in group and family meetings; set goals with all teams involved; understand how to help all individuals that have contact with the child to better support the child).
41. Use self-care practices

Table 9 Continued

Competency
42. Balance the need for fidelity using evidenced-based models and client's individual needs when treating trauma.
43. Use a strengths-based approach with children and families (e.g., assess for protective capacity of both offending and non-offending caregivers and how to build it; empower clients during and after report)
44. Recognize beliefs and attitude (e.g., maintain professional boundaries, manage own stress and bias, recognize their own boundaries and issues when addressing client to not allow their own issues to come out in the session or impact the client)
45. Recognize and utilize effective and supportive supervision/consultation

Competencies 36, 37, 38: Therapeutic relationship. The majority of these competencies focused on the therapeutic relationship between the counselor and the client. According to Grencavage, and Norcross (1990), the relationship between client and counselor is the most common factor across all theories that impacts client outcomes. Researchers found that therapists fear disrupting the therapeutic relationship by addressing and reporting child maltreatment (Bean et al., 2011; Watson & Levine, 1989; Weinstein et al., 2000). Based on the competencies they developed, the expert-participants in this study believe the therapeutic relationship plays a large role in managing the impact of child maltreatment on clients. The literature supports the finding that counselors should be prepared to address relationship problems and modify their approach to meet the clients' current needs (Grosse Holtforth & Castonguay, 2005; Safran et al., 2001). An active demonstration of empathy, unconditional positive regard,

and warmth can help maintain and strengthen the therapeutic relationship (Levine et al., 1995; Weinstein et al., 2000).

Competencies 41, 45. Self-care and supervision. Expert- participants in this study identified competencies related to self-care and supervision as necessary components to managing the impact of child maltreatment on clients. This is a new concept that the psychology and health care professionals did not include. The counseling profession promotes counselors to seek supervision continuously and regularly throughout their practice. The ACA code of ethics (2014) includes the expectation for counselors to seek supervision and consultation to evaluate their effectiveness as a counselor. A search for the term supervision in the ACA code of ethics (2014) yielded 37 instances where supervision is discussed, with the majority referring to counselors' requirement to seek supervision. Comparatively, a similar search in the APA code of ethics (2010), yielded seven instances where supervision is discussed. This difference distinguishes these two similar professional fields, and their focus on self-assessment.

In this section, I presented the four domains and 43 competencies found in this study, and their relationship with the professional literature. The panel of expert-participants surveyed in this study identified the knowledge and skills necessary for counselors to work with clients affected by child maltreatment. The majority of the competencies were consistent with the suggestions from the literature and other professions. This consistency strengthens these competencies through the support of expert opinion with the findings in the literature. In the next section, I will discuss the implications of this study for counselor education.

Implications

Embedded in the discussion of each domain and competency are examples on using these competencies in training programs. The purpose of this implication section is to move from discussing specific domain and competencies in the context of the literature to applying the findings to training competent counselors in prevention and response to child maltreatment. Further, this section provides guidance on how to incorporate the domains and competencies into counselor supervision and gatekeeping practices.

Many researchers have studied mandated reporting, child maltreatment, and treatment of clients affected by child maltreatment. As a result of these studies, researchers have made many suggestions as to the training of professionals to better care for clients affected by child maltreatment (Alvarez et al., 2005; Donohue et al., 2002; Pollak & Levy, 1989). Currently, the CACREP 2009 standards do not specify training on child maltreatment as a requirement for counseling programs. The 2009 CACREP standards do require mental health counselors to gain knowledge, and skills around "the impact of crises, disasters, and other trauma-causing events on people " (p.29), as well as "principles of crisis intervention for people during crises..." (p. 30). In the school counseling program requirements, the standards do include "Understands the influence of multiple factors (e.g., abuse, violence, eating disorders, attention deficit hyperactivity disorder, childhood depression) that may affect the personal, social, and academic functioning of students" (CACREP, 2009); p. 41). The 2009 CACREP standards do not clearly delineate child maltreatment apart from crisis and trauma. This study presents a

set of standards to provide guidance for the training of counselors on how to work specifically with clients experiencing child maltreatment.

Many of the identified competencies are central to counselor training in general (e.g., ethical decision making, use of supervision and self-care, knowledge of development). The findings suggest these general knowledge and skills already present in counselor education are imperative for working with clients impacted by child maltreatment. While present in curriculum, these knowledge and skills may not be directly applied to working with clients impacted by child maltreatment. As discussed in Chapter II, many researchers have found professionals, including counselors, struggle working with clients impacted by child maltreatment, as their role in assessment and management are unclear (Alvarez et al., 2004; Horton & Cruise, 2001; Kalichman et al., 1988; Levine et al., 1995). The findings suggest certain knowledge and skills, (e.g., ethical decision-making, human development, and attachment) should be intentionally connected to child maltreatment, so as counselor educators are confirming counselors-in-training are prepared to assess and manage the impact of child maltreatment with future clients.

With these competencies as guidance, counselor educators can begin to incorporate the necessary knowledge and skills identified in this study into their curricula. Researchers have evaluated core competency training for increasing counselor readiness and found it was effective for increasing clinician's confidence (Oordt, Jobes, Fonseca, & Schmidt, 2009). Many of the competencies in this study, such as knowledge of human development, and attachment, and the ability to use basic counseling skills, are

topics and skills that are already being taught in counseling programs. Counselor educators can incorporate child maltreatment when discussing these topics, and can allow counselors-in-training to practice these skills. Researchers have suggested active learning techniques, such as role-playing, can help students develop competence (Falender & Shafranske, 2007; Rudd et al., 2008).

One way counselor educators can utilize these competencies is make programmatic decisions as to where each competency is best addressed within a course sequence. The following example illustrates integrating competency numbers 6, 24, 25, and 22 into a human development course. Counselor educators can intentionally incorporate these competencies while they are introducing the different developmental stages and discuss abnormal development due to child maltreatment. Counselor educators can also guide a discussion on student beliefs and attitudes about child maltreatment victims and perpetrators. As part of their role-plays, counselor educators can integrate scenarios that indicate impaired development, so counselors-in-training gain the experience assessing for the risk of child maltreatment.

In a practical skills course, a counselor educator can select different competency combinations such as competency numbers 2, 3, 5, 9, 18, and 21. The counselor educator can create a role play that addresses these specific competencies. Counselors-in-training can practice gathering enough information (i.e., competency #2, 3, 18), while balancing the role of the reporter (i.e., competency #5, 9), and discussing the possibility of reporting with their client (i.e., competency #21). The counselor educator can then highlight these

competencies during feedback to students, and address any worries or concerns students have while practicing.

Counselor educators can also use these competencies as part of their supervision with counselors. Researchers have supported competency-based supervision as an effective way of promoting confidence (Oordt et al., 2009; Rudd et al., 2008). Expert-participants in this study highlighted the need for supervision and consultation through both risk assessment and impact management. Often, counselors, both those in training and established counselors, feel fear when they are faced with a client affected by child maltreatment (Anderson et al., 1993; Donohue et al., 2002; Hawkins & McCallum, 2001; McCauley et al., 2003; Pollak & Levy, 1989; Reiniger et al., 1995). Supervisors can help address this fear by focusing on enhancing these competencies in their supervisees. Supervisors can use these competencies to direct feedback and promote self-assessment in order to enrich learning and skill development in counselors (Falender & Shafranske, 2007).

Supervisors can focus on building and enhancing child maltreatment risk assessment and impact management knowledge and skills during supervision. Prior to meeting with clients, supervisors can focus on certain competencies, such as informed consent, information gathering, understanding role and limits in reporting process, and addressing own beliefs and attitudes. Supervisors can role-play different client scenarios, helping the counselor to practice these competencies. When supervisees are faced with assessing for child maltreatment, supervisors can help the supervisee utilize a decision making model in determining whether a report should be made to CPS (i.e., Ethical

decision making). A supervisor can also focus on helping the supervisee determine how much information to gather, and maintaining their use of basic counseling skills with a client during the assessment process (i.e., competency #16). After the report is made, a supervisor can focus on impact management with the supervisee, by promoting the counselor to assess their relationship with the client, encouraging them to acknowledge any relationship ruptures with the client, helping them to identify ways to advocate for the client (#38), and helping them to collaborate with CPS (if possible; competency #8 and #40).

These competencies can also be used to assess readiness of counselors-in-training to work with clients. According to Lumadue and Duffey (1999), counselor educators are responsible for monitoring the competency of student counselors, including their academic ability and clinical skills. Expert- participants in this study identified both knowledge and skill-based competencies that counselor educators can use to evaluate counselors-in training. Falender and Shafranske (2007) found performance outcomes such as evidence-based competencies can be used as criteria for evaluating learners and training programs. Counselor educators can use these competencies as a guide to assess students, and provide students with clear expectations on how to work with clients.

Limitations of the Study

The discussion of the competencies was sequenced as a detailed review of the domain and competency-specific discussion, followed by a discussion for implementing the competencies in the field of counselor education. While the development of counselor competencies for working with child maltreatment offers benefits to counselor education,

there were several limitations to this study. The limitations of this study relate to the exploratory nature of the Delphi, recruiting, survey development and analysis, consensus, and attrition. In this section, I discuss each of these limitations.

Delphi Method

The first limitation to this study is the method I chose, the Delphi. The Delphi method is a multi-stage process that changes opinion into group consensus (Hasson et al., 2000). The Delphi method functions as an exploratory, knowledge- building tool. The exploratory nature of the Delphi method is a limitation to this study because of the group opinion. The expert- participants generated these competencies without support from the literature. Therefore, the validity of this study is dependent on the representativeness of the sample. This study acts as a first step toward developing empirically based competencies for the training of counselors on child maltreatment.

Recruiting

In this study, there were limitations related to recruiting. Sixty-three professionals were initially identified as meeting the study criteria, 31 agreed to participate, and only 25 engaged. This is a limitation because of the representativeness of the sample. According to Hasson, and associates (2000), the lack of random selection reduces the representativeness of the sample. Some researchers suggest increasing the sample size in order to counter this concern (Hasson, et al., 2000). With the smaller sample size in this study, the expert- participants may not have been a comprehensive representation of the available experts in the content area, and consensus may have been different with more expert- participants.

Limitations for Survey Development and Analysis

In addition to recruitment, there were limitations related to the development of the survey. One of the criticisms of the Delphi method is the lack of direction as to the development of the surveys (Hasson, et al., 2000). The Delphi method has been used to develop competencies in other professions (Burkard et al., 2004; Chen et al., 2013). Similar to this study, researchers typically use three rounds of surveys to reach consensus (Burkard, et al., 2005; Chen, et. al, 2013). In this section, I discuss the limitations of each round of survey development.

Generative round. My development of the questions for the generative round may have influenced participant response. Some researchers, like Burkard and associates (2004), use open-ended questions to elicit expert opinions on the topic, and then converge these opinions into competencies. Chen and colleagues (2013) chose to present common recommendations from the literature and asked expert- participants to rank them in order of importance for the first round. In this study, I chose to elicit expert opinions in the generative round, similar to Burkard and associates (2004). With this qualitative inquiry, expert- participants may have been influenced by my choice of wording the questions. Many of the participant responses used “risk assessment” and “management” in their responses, suggesting that the presentation of these concepts during the generative round influenced their responses.

Another limitation for this round was the broadness of these questions and lack of directions and definitions. Several expert- participants refused to answer the questions due to the broad scope of the questions they were being asked. For example, as a

response to “What are the domains of competence for counselors working with individuals and families experiencing child maltreatment?” one participant commented, “This is too demanding for a casual response. If you listed options, I could check them off, but I don't have this much time to devote to your research.” Other expert-participants were confused by the question, and responded, “I do not understand what they are asking. Can they rephrase this for better understanding?”

A limitation for this round may have also been my naming and defining the domains. Despite the question asking expert- participants to name the domains, expert-participants only discussed competencies in their responses in the generative round, leaving me to group them together to form domains. While I presented the name and definition for the domain to be checked by the expert- participants, my bias in the language of the domain is clear. I grouped the domains into assessment and management, similar to what I predicted them to be. Given different guidance, expert- participants may have grouped the domains differently.

First and second round. The limitations of these two rounds included reaching consensus too early, and the low response rate for the first survey. First, expert-participants reached consensus for all competencies during the first round, despite setting a high level of consensus, a mean of 6 out of 7. While reaching consensus is a goal of the Delphi, reaching it too soon suggests consensus was forced (Hasson, et al., 2000). In this study, expert- participants may have responded favorably due to enthusiasm for the topic. During the second round, a participant commented,

assessment of needs and strengths would be beneficial and understanding the need to take responsibility to become trained seems more realistic than expecting all these levels of knowledge at the time the counselor is working with a client—seeking out resources, getting supervision and consultation etc.

This suggests expert- participants may have responded favorably to the competencies because, in an ideal world, counselors-in-training would possess all of this knowledge and all of these skills. However, realistically, as evidenced by the above comment, the expert- participants may be expecting too much with these competencies. Responses may have been different if a focus group, rather than a survey, had elicited the initial competencies, allowing expert- participants to explain and defend their positions, and creating an argument (Hasson, et al., 2000).

Attrition is another limitation to this study. Sumison (1998) suggested a response rate of 70% for each round in order to maintain rigor of the Delphi method. Round one only had a 60% response rate. This lack of response for this round may have impacted the results. The Delphi method is dependent on the expert- participants' ongoing discussion of the content (Sumison, 1998). Based on this lower response rate, it is possible that expert- participants reached consensus on a competency that would other expert- participants would have eliminated had the response rate been higher.

Directions of Future Research

Through this investigation, I have identified several future research opportunities. Expert- participants in this study created domains and competencies to guide the training of counselors in working with clients affected by child maltreatment. In order to strengthen these competencies, a possible next step for this research would be to hold an in-person focus group, where experts could discuss each of the domains and

competencies to further explain and evaluate their positions and to create an argument (Hasson et al., 2000). After an in-person focus group were held, I could then distribute the competencies to more expert- participants. According to Hasson and associates (2000), the larger the sample size, the stronger the generation of data. With more expert- participants, perhaps some of the competencies would be ranked differently, which could generate a deeper debate on the needs of counselors-in-training prior to their working with clients affected by child maltreatment.

Another next step for this research line would be to evaluate current counseling programs across the competencies. As with other professional competencies, counselor educators can use these competencies to gage the current curriculum and identify the areas requiring improvement. In order to evaluate the training gap, researchers could use these competencies to gather student perception of preparedness across the competencies. Counselor educators and researchers could also use these competencies to evaluate counselor readiness in working with clients impacted by child maltreatment.

Conclusion

This study was the first step toward creating training competencies for child maltreatment risk assessment and management. These competencies contribute to filling a gap in counselor education for the training needs of counselors on child maltreatment risk assessment and management. Unlike most studies, this study went beyond mandated reporting, and focused on the process of assessing for the risk, and then managing the impact of child maltreatment on the client. These 45 competencies represent the knowledge and skills counselors-in-training need to provide the best care to clients

impacted by child maltreatment. Counseling training programs can begin to incorporate these competencies as a way to address the current lack of training on child maltreatment. In this way, programs can produce competent counselors in which clients can depend.

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APPENDIX A**IRB APPROVAL LETTER**

UNIVERSITY of
NORTHERN COLORADO



Institutional Review Board

DATE: June 4, 2014

TO: Janessa Parra, MA

FROM: University of Northern Colorado (UNCO) IRB

PROJECT TITLE: [609675-1] Counseling Competencies for Child Maltreatment Risk Assessment and Management

SUBMISSION TYPE: New Project

ACTION: APPROVAL/VERIFICATION OF EXEMPT STATUS

DECISION DATE: June 3, 2014

Thank you for your submission of New Project materials for this project. The University of Northern Colorado (UNCO) IRB approves this project and verifies its status as EXEMPT according to federal IRB regulations.

Janessa -

Hello and thank you for your patience with the IRB process. Your application was incredibly thorough and your research appears relevant and interesting.

Your inclusion of phone and email recruitment scripts was much appreciated.

Please make one small addition to your consent form before use in data collection; add your advisor's name and contact information to the heading under your name and contact information. You do not need to submit this revision for subsequent review.

Best wishes with your dissertation research. Please don't hesitate to contact me with any IRB-related questions or concerns.

Sincerely,

Dr. Megan Stellino, UNC IRB Co-Chair

We will retain a copy of this correspondence within our records for a duration of 4 years.

If you have any questions, please contact Sherry May at 970-351-1910 or Sherry.May@unco.edu. Please include your project title and reference number in all correspondence with this committee.

This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within University of Northern Colorado (UNCO) IRB's records.



Institutional Review Board

DATE: June 17, 2014

TO: Janessa Parra, MA

FROM: University of Northern Colorado (UNCO) IRB

PROJECT TITLE: [609675-2] Counseling Competencies for Child Maltreatment Risk Assessment and Management

SUBMISSION TYPE: Amendment/Modification

ACTION: APPROVAL/VERIFICATION OF EXEMPT STATUS

DECISION DATE: June 17, 2014

Thank you for your submission of Amendment/Modification materials for this project. The University of Northern Colorado (UNCO) IRB approves this project and verifies its status as EXEMPT according to federal IRB regulations.

Thank you for providing your additional recruitment materials.

Best wishes with your research.

Sincerely,

Dr. Megan Stellino, UNC IRB Co-Chair

We will retain a copy of this correspondence within our records for a duration of 4 years.

If you have any questions, please contact Sherry May at 970-351-1910 or Sherry.May@unco.edu. Please include your project title and reference number in all correspondence with this committee.

This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within University of Northern Colorado (UNCO) IRB's records.

APPENDIX B

EMAIL TO PARTICIPANTS

Good (Morning, Afternoon, Evening) Insert name here.

You have been recommended/ selected to participate in a Dissertation study regarding the building of counseling competencies for child maltreatment risk assessment and management. The purpose of this study is to begin to fill a gap in training by establishing competencies that provide guidance for counselor preparation programs in training counselors to work with clients impacted by child maltreatment. You have been selected to participate due to your unique knowledge and contributions to the counseling and child maltreatment field.

You will be asked to participate in several rounds of surveys that will collect your opinion of the necessary components needed for Masters level counselors to assess and manage the risk of child maltreatment in their clients. Child maltreatment is a widespread epidemic that many counselors must face in their work with clients. It is imperative that counselors entering the field have the skills to not only assess for the risk of child maltreatment and make a report to CPS but also to continue to manage client welfare during and after a report is made. Consequently, the counseling field needs to establish training standards in order to prepare competent counselors for working in the real world. The goal of this study is to reach consensus among yourself and the other selected experts to create the domains and the specific competencies required to work with clients.

This study employs a Delphi method, which typically consists of 3 to 5 rounds of both open and closed ended surveys. Emails will be sent to you with a link to complete the survey online. Each survey may take up to 45 minutes to an hour to complete, may

require you to read material prior to completing the survey, and may ask you to consider statistics of group consensus when you are completing the survey. You will have one week to respond to each survey, and the first 5 participants to complete each survey will receive a \$5 Starbucks card for the prompt completion of the survey. If you chose to participate in this survey, it will be very important that you commit to participating in the full process, as your opinion is valuable to this study.

Please respond if you are interested in participating in this study, and provide a phone number for you to be contacted. I will contact you shortly by phone to answer any questions you may have about the study, or the details of your participation.

Thank you so much for your consideration,

Janessa Parra, M.A.

Doctoral Student

Counselor Education and Supervision

University of Northern Colorado

772-812-9735

Janessa.parra@unco.edu

APPENDIX C
PHONE SCRIPT

The following information will be included in the initial phone conversation with participants:

- Confirming qualification for study
- Demographic data, such as credentials, current work experience, and number of publications.
- Explaining process of study.
- Discuss their availability, time frames, and structure of study
- Explaining the goal of the study, specifically, of the first round, which is to provide an initial forum for participants to generate ideas, provide their unique opinion, and identify issues surrounding counseling competencies for child maltreatment risk assessment and management.
- Explain the goal is to start broad and then narrow down.
- Discuss the focus of the study, and why need to start broad.
 - o Ask them to consider first round as a brainstorming session
 - o Set the expectation is for broad, and multiple opinion
 - o Set expectation that opinions do not need to be fully formed, just as many as you possibly can provide.

APPENDIX D**HUMAN RESEARCH CONSENT FORM**

CONSENT FORM FOR HUMAN PARTICIPANTS IN RESEARCH

University of Northern Colorado

Project Title: Counselor Competencies for Child Maltreatment Risk Assessment and Management

Researcher: Janessa Parra, M.A. Counselor Education and Supervision

Phone Number: (772) 812-9735

Email: janessa.parra@unco.edu

Research Advisor: Elysia Clemens, Ph.D. Email: Elysia.clemens@unco.edu

The purpose of this study is to begin to fill a gap in training by establishing competencies that provide guidance for counselor preparation programs in training counselors to work with clients impacted by child maltreatment. You have been selected to participate due to your unique knowledge and contributions to the counseling and child maltreatment field. You will be asked to participate in several rounds of surveys that will collect your opinion of the necessary components needed for Masters level counselors to assess and manage the risk of child maltreatment in their clients. The goal of this study is to reach consensus among yourself and the other selected experts to create the domains and the specific competencies required to work with clients. This study employs a Delphi method, which typically consists of 3 to 5 rounds of both open and closed ended surveys. Each survey may take up to 45 minutes to an hour complete, may require you to read material prior to completing the survey, and may ask you to consider statistics of group consensus when you are completing the survey.

You will be asked to provide your name, your email address and your telephone number. I will do everything possible to keep your information and answers private and confidential. However, I cannot guarantee anonymity because I will collect data directly from you or use other mechanisms such as the Internet and sometimes this can be traced back to individuals. A unique ID will be assigned to you, and all materials collected from you will be attached to that ID. All collected material will be kept on a file, on a personal computer that will both be password protected. Anything that identifies you will be removed from your responses. Only this researcher will have access to your personal information.

Possible risks in this project are minimal. Reflecting on your professional experiences with child maltreatment may be upsetting, however the questions will not elicit any self-reflection beyond what is expected of you during your normal work environment. To thank you for your time and commitment, the first five participants of each round to complete the survey will receive a \$5 Starbucks gift card.

Participation is voluntary. You may decide not to participate in this study and if you begin participation you may still decide to stop and withdraw at any time. Your decision will be respected and will not result in loss of benefits to which you are otherwise entitled. Having read the above and having had an opportunity to ask any questions, please consent to participate and continue on to the survey. If you have any concerns about your selection or treatment as a research participant, please contact the Office of Sponsored Programs, Kepner Hall, University of Northern Colorado Greeley, CO 80639; 970-351-2161.

APPENDIX E
GENERATIVE ROUND QUESTIONS

Generative Round Questions

Describe a counselor's role in child maltreatment risk assessment and management?

How can counselors empower their clients before, during and after the reporting process?

What are the broad domains of competencies for counselors specific to child maltreatment risk assessment and management?

What are the domains of competence for counselors working with individuals and families experiencing child maltreatment?

What other information, opinion, or thoughts do you have about building training competencies for counselors to assess the risk and manage clients involved with child maltreatment?

APPENDIX F**CITATIONS FOR ROUND ONE**

- Chen, Y. W., Fetzer, S., Lin, C. L., Huang, J. J., & Feng, J. Y. (2013). Healthcare professionals' priorities for child abuse educational programming: A Delphi study. *Children and Youth Services Review*, 35(1), 168-173.
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APPENDIX G
ROUND ONE SURVEY

Thank you for completing the first survey! We accomplished developing a list of competencies. This next step is a survey to further develop the competencies through adding, changing or deleting the competencies as necessary. This survey also hopes to group the competencies into domains and to establish names for these domains.

This survey will take approximately one hour to complete. If you have any questions, feel free to contact me at janessa.parra@unco.edu. The first 5 individuals to complete the survey will receive a \$5 gift card to Starbucks. You will be notified via email if you were one of the first five. Participation in this survey is confidential and voluntary.

To continue your participation and complete the survey, please click continue. If you no longer wish to participate, you may mark "no thanks" to be taken to the end of the survey.

- Continue
- No, thanks

Definitions:

The following definitions are being provided based on feedback from round 1.

Child Abuse and Neglect (Maltreatment): CAPTA defines child abuse and neglect as “Any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation, or an act or failure to act which presents an imminent risk of serious harm” (CAPTA, 2010, p. 6).

Child Maltreatment Risk Assessment: For the purposes of this study, risk assessment will be defined as the skills and actions required of counselors to identify clients at risk for child maltreatment and report suspicions of abuse to Child Protective Services.

Child Maltreatment Risk Management: For the scope of this study, child maltreatment management is defined as the skills and actions required of the counselor to ensure client welfare during and after a child protection report.

Client: For the purposes of this study, a client is any individual, child or adult, entering into a counseling relationship. This includes but is not limited to individuals or families being seen in community, private, or school settings, individuals that are mandated or voluntary clients, and they can be perpetrators or victims of the maltreatment.

Competencies: In counseling, competency statements refer to the minimum skills, behaviors, and professional disposition needed to perform effectively when working with specific client populations.

Domain: A domain of competence is a specified sphere of activity or knowledge.

Child Maltreatment Risk Assessment Domain 1 of 2: Knowledge

This domain covers all of the knowledge counselors need prior to seeing clients in order to identify clients at risk for child maltreatment and report suspicions of abuse to child protective services.

1. Rate competencies based on their importance for masters level counselors
2. Provide feedback on competencies through
 - a. minor edits in text box under competencies

Open ended response items that follow the rating scale.

[illegible]

	Not at all important	Very unimportant	Somewhat Important	Neither Important nor Unimportant	Somewhat Important	Very Important	Extremely Important
Understanding how to integrate the role of the counselor and the role of reporter in such circumstances <input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Crisis Intervention models (e.g., how to discuss crisis with clients, ability to identify triggers, suicide assessments) <input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Prevention <input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Understand potential Therapeutic Relationship issues for client/therapist around child maltreatment. <input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Normal Human Development Knowledge and Theory (e.g., identify the difference between age appropriate and not age appropriate) <input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Understand the difference between Risk and Safety <input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Awareness of socio-cultural competencies, social justice, and advocacy (e.g., cultural implications, considering the cultural context of the abuse, ways to advocate for the family) <input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Training on Other non-trauma related treatment modalities such as substance abuse. <input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please use the space below to indicate any changes, additions, or deletions to the competencies listed above. Please include comments on the title and definition of the Domain.

	Not at all important	Very Unimportant	Somewhat Unimportant	Neither Important nor Unimportant	Somewhat Important	Very Important	Extremely Important
based approaches, understanding the importance and means of validating survivors during disclosures and subsequent discussions)							
<input type="text"/>							
Address own beliefs and attitude (e.g., maintain professional boundaries, manage own stress and bias, recognize their own boundaries and issues when addressing children to not allow their own issues to come out in the session or impact the child)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="text"/>							
Collaboration	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="text"/>							
Access supervision/ consultation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="text"/>							

Please use the space below to indicate any changes, additions, or deletions to the competencies listed above. Please include comments on the title and definition of the Domain.

Please indicate any competencies you feel belong in a different domain and which domain it would be better suited for.

Please use this space to discuss any competencies you rated “Not at all important,” “very unimportant,” “Somewhat unimportant,” or “Neither important or unimportant.”

Child Maltreatment Management Domain 1 of 2: Knowledge

This domain covers all of the knowledge counselors need to ensure client welfare during and after a child protection report.

1. Rate competencies based on their importance for masters level counselors
2. Provide feedback on competencies through
 - a. minor edits in text box under competencies
 - b. Open ended response items that follow the rating scale.

	Not at all important	Very Unimportant	Somewhat Unimportant	Neither Important nor Unimportant	Somewhat Important	Very Important	Extremely Important
Understanding of different Trauma treatment modalities (e.g., Evidenced based practices, play therapy, child-focused treatments, TF-CBT, filial therapy, ways to work with on-going trauma experienced by children who are maltreated)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="text"/>							
Understanding of Family Systems (e.g., knowing how to engage a family, understand the systemic impact of child maltreatment)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="text"/>							
Knowledge of different community resources and how to access them	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="text"/>							
Knowledge of basic parenting practices (e.g., knowledge on how to educate and coach parents to be effective caretakers during recovery, knowing parenting modalities that work)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="text"/>							
Training in Trauma informed Assessment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="text"/>							
Understanding of Human Development knowledge and theory (e.g., how child maltreatment impacts child development, understanding of short and long term consequences of abuse, effects of child maltreatment on the brain, behavior and development)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="text"/>							
Knowledge of how to work with the system after the abuse has been reported	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="text"/>							

	Not at all important	Very Unimportant	Somewhat Unimportant	Neither Important nor Unimportant	Somewhat Important	Very Important	Extremely Important
Ability to use basic counseling skills with clients <input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ability to advocate for clients and families <input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Continued assessment for further maltreatment <input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Collaboration with multidisciplinary teams (e.g., participate in group and family meetings, setting goals with all teams involved, understand how helping all individuals that have contact with the child to better support the child). <input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Utilize supervision/ Consultation <input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Understand and apply self-care practices <input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A demonstrated ability to maintain fidelity to evidenced based models to treat trauma <input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ability to apply a strength based approach with children and families (e.g., assess for protective capacity of caregivers and how to build it, empower clients during and after report, Applying solution focused methods) <input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please use the space below to indicate any changes, additions, or deletions to the competencies listed above. Please include comments on the title and definition of the Domain.

Please indicate any competencies you feel belong in a different domain and which domain it would be better suited for.

Please use this space to discuss any competencies you rated “Not at all important,” “very unimportant,” “Somewhat unimportant,” or “Neither important or unimportant.”

Below, you will find the list of the Domain Names. You will first be asked to rate the importance of the domain, and then you will be given the opportunity to change the name, or the description of the domain.

Please rate the importance of the following Domain.

	not at all important	Very Unimportant	Somewhat Unimportant	Neither Important nor Unimportant	Somewhat Important	Very Important	Extremely Important
Child Maltreatment Risk Assessment Knowledge: This domain covers all of the knowledge counselors need prior to seeing clients in order to identify clients at risk for child maltreatment and report suspicions of abuse to child protective services.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please comment on the wording and definition of the following Domain:

Child Maltreatment Risk Assessment Knowledge: This domain covers all of the knowledge counselors need prior to seeing clients in order to identify clients at risk for child maltreatment and report suspicions of abuse to child protective services.

	not at all important	Very Unimportant	Somewhat Unimportant	Neither Important nor Unimportant	Somewhat Important	Very Important	Extremely Important
Child Maltreatment Risk Assessment Practical Skills: This domain covers all of the practical skills counselors need prior to seeing clients in order to identify clients at risk for child maltreatment and report suspicions of abuse to child protective services.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please comment on the wording and definition of the following Domain:

Child Maltreatment Risk Assessment Practical Skills: This domain covers all of the practical skills counselors need prior to seeing clients in order to identify clients at risk for child maltreatment and report suspicions of abuse to child protective services.

	not at all important	Very Unimportant	Somewhat Unimportant	Neither Important nor Unimportant	Somewhat Important	Very Important	Extremely Important
Child Maltreatment Risk Management Knowledge: This domain covers all of the knowledge counselors need prior to seeing clients in order to ensure client welfare during and after a child protection report.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please comment on the wording and definition of the following Domain:

Child Maltreatment Risk Management Knowledge: This domain covers all of the knowledge counselors need prior to seeing clients in order to ensure client welfare during and after a child protection report.

	not at all important	Very Unimportant	Somewhat Unimportant	Neither Important nor Unimportant	Somewhat Important	Very Important	Extremely Important
Child Maltreatment Risk Management practical skills: This domain covers all of the practical skills counselors need prior to seeing clients in order to ensure client welfare during and after a child protection report.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please comment on the wording and definition of the following Domain:

Child Maltreatment Risk Management practical skills: This domain covers all of the practical skills counselors need prior to seeing clients in order to ensure client welfare during and after a child protection report.

APPENDIX H
ROUND TWO SURVEY

Thank you for completing the second survey! We have reached consensus as to the importance of the competencies that were found in the first survey. This final survey will finalize the language and placement of these competencies into their appropriate domains. This survey should take approximately 10 to 15 minutes to complete.

To continue your participation and complete the survey, please click continue. If you no longer wish to participate, you may mark "no thanks" to be taken to the end of the survey.

- ☐ Continue
- ☐ No thanks

In this section, you will be asked to approve of the suggested changes to the domain names and definitions. You will be provided with the original definition of the domain, and the new definition. Please indicate whether you agree or disagree with these changes. The suggested changes are highlighted.

1. Original Definition: Child Maltreatment Risk Assessment Knowledge: This domain covers all of the knowledge counselors need prior to seeing clients in order to identify clients at risk for child maltreatment and report suspicions of abuse to child protective services.

New Definition: Child Maltreatment Risk Assessment Knowledge: This domain covers important knowledge counselors need prior to counseling clients in order to identify clients at risk for child maltreatment and report suspicions of abuse to child protective services.

- ☐ Agree
- ☐ Disagree

1a. Please discuss why you disagree with the above changes, and indicate any additional changes needed.

2. Original Definition: Child Maltreatment Risk Assessment Practical Skills: This domain covers all of the practical skills counselors need prior to seeing clients in order to identify clients at risk for child maltreatment and report suspicions of abuse to child protective services.

New Definition: This domain covers important abilities counselors need to attain prior to

working with clients in order to identify clients at risk for child maltreatment and report suspicions of abuse to child protective services.

- ☐ Agree
- ☐ Disagree

2a. Please discuss why you disagree with the above changes, and indicate any additional changes needed.

3. Original Definition: Child Maltreatment Management Knowledge: This domain covers all of the knowledge counselors need prior to seeing clients in order to ensure client welfare during and after a child protection report.

New Definition: Child Maltreatment Impact management: This domain covers important knowledge counselors need prior to working with clients in order to promote client welfare during and after a child protection report.

- ☐ Agree
- ☐ Disagree

3a. Please discuss why you disagree with the above changes, and indicate any additional changes needed.

4. Original Definition: Child Maltreatment Management: Practical skills: This domain covers all of the practical skills counselors need prior to seeing clients in order to ensure client welfare during and after a child protection report.

New Definition: Child Maltreatment Impact management: Practical skills: This domain covers important abilities counselors need to attain prior to working with clients in order to promote client welfare during and after a child protection report.

- ☐ Agree
- ☐ Disagree

4a. Please discuss why you disagree with the above changes, and indicate any additional changes needed.

Child Maltreatment Risk Assessment Domain 1 of 2: Knowledge

This domain covers important knowledge counselors need prior to working with clients in order to identify clients at risk for child maltreatment and report suspicions of abuse to child protective services.

There were 14 competencies found for this domain, all of which have reached consensus (mean >4). Of the 14 competencies, six had no suggested changes, seven had minor changes to the language, and two suggested to be added or moved to a different section.

- You will first be provided with the list of the six competencies that were not changed. These are listed for your reference.

- Next, you will be presented with the eight competencies that require changes. Please review the changes suggested for the competency and then either agree or disagree with the proposed changes. You will be provided the comments that prompted the changes to help in your decision.

Below you will find a list of the competencies under Child Maltreatment Risk Assessment Domain 1 of 2: Knowledge. These are being provided for your reference.

1. Knowledge of Ethical Requirements (e.g., Ethical guidelines/ confidentiality/ informed consent/ and supervision in child maltreatment)
2. Knowledge of Ethical Decision Making models
3. Knowledge of Child Abuse and Neglect (e.g., Definitions, prevalence, risk factors, types of perpetrators, types of violence, symptomology of child abuse and neglect).
4. Understanding role and limits in reporting process (e.g., role in assessing and assuring safety, permitted follow-up, documentation)
5. Normal Human Development Knowledge and Theory (e.g., identify the difference between age appropriate and concerning behaviors)
6. Awareness of socio-cultural competencies, social justice, and advocacy (e.g., cultural implications, and context of maltreatment).

In this section, please review the changes suggested for each competency and then either agree or disagree with the proposed changes. You will be provided the comments that prompted the changes to help in your decision.

5. Original Competency:

Legal Requirements (e.g., Knowledge of federal and state laws)

Comments: Add "school district policies" for school counselors, Add Agency Requirements

New Competency: Legal Requirements (e.g., knowledge of federal and state laws, school district policies, and agency requirements)

☐ Agree

☐ Disagree

- ☐ I would like to comment on this competency

5a. Please indicate your comments on this competency

6. Original Competency:

Understanding of programs and organizations related to child welfare (e.g., knowledge of child welfare system, reporting requirements, current language trends, agency processes and role of CPS workers.)

Comments: I would focus on ability to access this information

- For reporting requirements - that could be clarified to help clearly distinguish them from federal/state requirements

New Competency: Understanding of programs and organizations related to child welfare (e.g., knowledge of child welfare system, how to make a report, current language trends, agency processes and role of CPS workers, knowledge of how to access this information)

- ☐ Agree
☐ Disagree

- ☐ I would like to comment on this competency

6a. Please indicate your comments on this competency

7. Original Competency:

Understanding how to integrate the role of the counselor and the role of reporter in such circumstances.

Comments: Circumstances such as? I am not sure I understand what this competency is referring to

- It is important to be aware of state and federal laws, but the primary focus should be on the well-being of the client regardless of the laws. Other than determining credibility, I don't feel it is critical to develop a role or interaction with the reporter, unless further information is needed or unless the reporter is critical to involvement in safety planning and ongoing treatment

New Competency: Understanding how to integrate the role of the counselor and the role of reporter once a disclosure of child maltreatment is made (e.g., finding the balance between legal responsibilities to report while focusing on the well-being of the client)

- ☐ Agree
☐ Disagree

- ☐ I would like to comment on this competency

7a. Please indicate your comments on this competency

8. Original Competency:

Understanding potential therapeutic relationship issues for client/therapist around child maltreatment.

Comments:-what specific issues? boundaries? Countertransference

New Competency: Understand potential therapeutic relationship issues for client/therapist around child maltreatment (e.g., client anger, boundaries, transference, and countertransference)

☐ Agree

☐ Disagree

☐ I would like to comment on this competency

8a. Please indicate your comments on this competency

9. Original Competency:

-Understand the difference between Risk and Safety

Comments:

- Have the ability to access this information

- This may benefit from clarification within this specific context

New Competency: Understand the difference between Risk (the likelihood that abuse or neglect will happen in the future) and Safety (freedom from current danger, risk, or injury)

☐ Agree

☐ Disagree

☐ I would like to comment on this competency

9a. Please indicate your comments on this competency

10. A suggestion was made to include this competency in a different domain.

Please review the changes suggested for the competency and then either agree or disagree with the proposed changes. (Please mark all that apply)

Original Competency:

-Crisis intervention models (e.g., how to discuss crisis with clients, ability to identify triggers, suicide assessments)

Comments:

-triggers?

- This competency should also be included in Child Maltreatment Risk management: knowledge domain.

New Competency: Crisis intervention models (e.g., how to discuss crisis with clients, ability to identify concerning behaviors that indicate client is in crisis, suicide assessments)

- ☐ I agree to the changes to the language
- ☐ I disagree to the changes to the language
- ☐ I agree with including this in Domain: Child Maltreatment Management: Knowledge
- ☐ I disagree with including this in Domain: Child Maltreatment Management: Knowledge
- ☐ I would like to comment on this competency

10a. Please indicate why you chose to disapprove the changes to the competency, along with any comments you have.

11. A suggestion was made to move this competency to domain: Child maltreatment Risk Management: knowledge.

Please review the changes suggested for the competency and then either agree or disagree with the proposed changes (Please mark all that apply)

Original Competency:

- Training on Other non-trauma related treatment modalities such as substance abuse

Comments:

-domestic violence and mental illness (and socioeconomic bias)

- I believe that other non-trauma modalities may best fall under management

New Competency: Training on Other non-trauma related treatment modalities such as substance abuse, domestic violence, socioeconomic bias, and mental illness

- ☐ I agree with the changes to language for this competency
- ☐ I disagree with the changes to the language for this competency
- ☐ I agree to move this competency to Child Maltreatment Management: Knowledge
- ☐ I disagree with moving this competency to Child Maltreatment Management: Knowledge
- ☐ I would like to comment on this competency

11a. Please indicate your comments on this competency.

12. Suggestions were made to move this competency to a different domain.

Please review the changes suggested for the competency and then either agree or disagree with the proposed changes. Please also mark the domain you feel it would best fit.

Original Competency:

-Prevention

Comments:

-Most will only find out after the fact and little can be done for prevention but should also be basic common sense stuff.

- Prevention should be more specific - psychoeducational prevention, understanding the root causes of CAN etc.

- Prevention: I wanted to add more here but wasn't sure what exactly. Thinking about victim's rights and then services and care for the abuser as well....doesn't really fit with prevention
- "Prevention" stood out to me as not really fitting with knowledge. I am wondering if this wouldn't be a better fit in a domain such as "Skills"
- Prevention may go best under Child Risk Management.
- I believe that prevention may best fall under management

New Competency:

- Prevention(understanding root causes of Child abuse and Neglect, psycho educational prevention, knowing victims' rights and how to access services, knowing abuser rights, cycle of abuse and services)

- ☐ I agree with the changes to language for this competency
- ☐ I disagree with the changes to the language for this competency
- ☐ This best fits in Child Maltreatment Risk Assessment: Knowledge
- ☐ This best fits in Child Maltreatment Risk Assessment: Skills
- ☐ This best fits in Child Maltreatment Management: Knowledge
- ☐ This best fits in Child Maltreatment Management Skills
- ☐ I would like to comment on this competency

12a. Please indicate your comments on this competency.

Child Maltreatment Risk Assessment Domain 2 of 2: Practical Skills

This domain covers important abilities counselors need to attain prior to working with clients in order to identify clients at risk for child maltreatment and report suspicions of abuse to child protective services.

There were 8 competencies found for this domain, all of which have reached consensus (mean >4). Of the 8 competencies, three had no suggested changes, five had minor changes to the language, and two were suggested to be added to a different domain.

- You will first be provided with the list of the three competencies that were not changed. These are listed for your reference.

- Next, you will be presented with the five competencies that require changes. Please review the changes suggested for the competency and then either agree or disagree with the proposed changes. You will be provided the comments that prompted the changes to help in your decision.

Below you will find a list of the competencies under Child Maltreatment Risk Assessment Domain 1 of 2: Knowledge. These are being provided for your reference.

1. Informed Consent (e.g., Ability to explain confidentiality to clients, knowing when to revisit limits to confidentiality)
2. Ability to use Basic counseling skills during process (e.g., Demonstrate ability to maintain empathy and compassion with clients, offer a positive environment for the child and family to communicate without judgment)
3. Ability to empower the client (e.g., use reframes, strength-based approaches, understanding the importance and means of validating survivors during disclosures and subsequent discussions)

In this section, please review the changes suggested for each competency and then either agree or disagree with the proposed changes. You will be provided the comments that prompted the changes to help in your decision.

13. Original Competency:

-Gathering Information (e.g., Training on how to interview a child, knowing how role in process mitigates how much information is gathered)

Comments:

- As a therapist, it is not our job to gather the information but it is important for therapists to know that and what that process is so that we can help the family to understand the process.

- I think its important to teach counselors when NOT to talk to children further. They are not the investigator.... that's critical for them to know so they don't think it's their job to investigate an allegation. It is only to see it and report it.

New Competency:

Gathering Information (e.g., Training on how to interview a child, knowing how role in process mitigates how much information is gathered, Identifying line between enough information and crossing into investigating abuse, knowing when not to gather more information)

- ☐ Agree
- ☐ Disagree

- ☐ I would like to comment on this competency

13a. Please indicate your comments on this competency.

14. Original Competency:

-Collaboration

Comments:- Need more information

-Perhaps this could be more specific; collaboration with CPS, Law enforcement, etc

New Competency: Collaboration(e.g., with CPS, law enforcement, hospital, other counselors etc)

- ☐ Agree

☐ Disagree

☐ I would like to comment on this competency

14a. Please indicate your comments on this competency.

15. Original Competency:

-Access supervision/ consultation

Comments:

- include knowing when to seek

New Competency:

-Access supervision/ consultation(e.g., knowing when to seek supervision/ consultation).

☐ Agree

☐ Disagree

☐ I would like to comment on this competency

15a. Please indicate your comments on this competency.

16. A suggestion was made to include this in Child maltreatment management: Practical Skills, as well as change the language. Please approve/disapprove of the suggested changes to both the language and the location.

Original Competency:

-Ability to be transparent with client (e.g., informing and including them in the report)

Comments:

- be transparent (when appropriate - and ability to know the difference) with client

-Some of these, such as being transparent, can go into the Management practical skills as well.

New Competency:

-Ability to be transparent (when appropriate - and the ability to know the difference) with client

☐ I approve of the changes to the language for this competency

☐ I disapprove of the changes to the language for this competency

☐ I approve of including this in the Child Maltreatment Risk Management: Practical Skills Domain

☐ I disapprove of including this in the Child Maltreatment Risk Management: Practical Skills Domain

☐ I would like to comment on this competency

16a. Please indicate your comments on this competency.

17. A suggestion was made to include this in Child maltreatment Risk management: Practical Skills, as well as change the language. Please approve/disapprove of the suggested changes to both the language and the location.

Original Competency:

-Address own beliefs and attitude (e.g., maintain professional boundaries, manage own stress and bias, recognize their own boundaries and issues when addressing children to not allow their own issues to come out in the session or impact the child)

Comments:

- This e.g., insinuates that the client is a child... the client could be an adult
 -Some of these, addressing own beliefs and attitudes, can go into the Management practical skills as well.

New Competency:

-Address own beliefs and attitude (e.g., maintain professional boundaries, manage own stress and bias, recognize their own boundaries and issues when addressing client to not allow their own issues to come out in the session or impact the client)

- ☐ I approve of the changes to the language for this competency
- ☐ I disapprove of the changes to the language for this competency
- ☐ I approve of including this in the Child Maltreatment Risk Management: Practical Skills Domain
- ☐ I disapprove of including this in the Child Maltreatment Risk Management: Practical Skills Domain
- ☐ I would like to comment on this competency

17a. Please indicate your comments on this competency.

Child Maltreatment Impact Management Domain 1 of 2: Knowledge

This domain covers important knowledge counselors need prior to working with clients in order to promote client welfare during and after a child protection report.

There were 10 competencies found for this domain, all of which have reached consensus (mean >4). Of the 10 competencies, five had no suggested changes, five had minor changes to the language, and one was suggested to be moved to a different domain.

- You will first be provided with the list of the five competencies that were not changed. These are listed for your reference.
- Next, you will be presented with the five competencies that require changes. Please review the changes suggested for the competency and then either agree or disagree with the proposed changes. You will be provided the comments that prompted the changes to help in your decision.

Below you will find a list of the competencies under Child Maltreatment Impact Management Domain 1 of 2: Knowledge. These are being provided for your reference.

1. Understanding of Family Systems (e.g., knowing how to engage a family, understand the systemic impact of child maltreatment)
2. Knowledge of different community resources and how to access them
3. Understanding of Human Development knowledge and theory (e.g., how child maltreatment impacts child development, understanding of short and long term consequences of abuse, effects of child maltreatment on the brain, behavior and development)
4. Understanding Attachment and how it is impacted by child maltreatment
5. Understanding of neurobiology and how it is impacted by child maltreatment.

18. Original Competency:

-Understanding of different Trauma treatment modalities (e.g., Evidenced based practices, play therapy, child-focused treatments, TF-CBT, filial therapy, ways to work with on-going trauma experienced by children who are maltreated)

Comments:

- and really just the basis of trauma informed care that underlies all of these

New Competency:

-Understanding of trauma informed care which includes awareness of the different trauma treatment modalities (e.g., Evidenced based practices, play therapy, child-focused treatments, TF-CBT, filial therapy, ways to work with on-going trauma experienced by children who are maltreated)

☐ Agree

☐ Disagree

☐ I would like to comment on this competency

18a. Please indicate your comments on this competency.

19. Original Competency:

-Understanding of Family Systems (e.g., knowing how to engage a family, understand the systemic impact of child maltreatment)

Comments:

- cultural

New Competency:

-Understanding of Family Systems (e.g., knowing how to engage a family, understand the systemic impact of child maltreatment, understanding cultural influences and their impact on the family system)

☐ Agree

☐ Disagree

☐ I would like to comment on this competency

19a. Please indicate your comments on this competency.

20. It was suggested this competency be moved to Domain Child Maltreatment Risk Assessment: Knowledge.

Original Competency:

-Training in Trauma informed Assessment

Comments:

this one would go under assessment knowledge and skills a bit better i believe
Please indicate if you agree or disagree with moving this competency to a different domain.

☐ I agree this competency should be moved to Child Maltreatment Risk Assessment: Knowledge

☐ I disagree with this competency being moved to different domain.

☐ I would like to comment on this competency

20 a. Please indicate your comments on this competency.

21. Original Competency:

-Knowledge of how to work with the system after the abuse has been reported

Comments:

- may want to distinguish this from the family system above

New Competency:

-Knowledge of how to work with the child welfare system after the abuse has been reported

☐ Approve

☐ Disapprove

☐ I would like to comment on this competency

21 a. Please indicate your comments on this competency.

22. Original Competency:

-Understanding theories of change.

Comments:

- This is too vague for me - not sure what theories are being addressed here.

- I am just not really understanding how theories of change fit into this except perhaps with regard to working with parents and noting their readiness

New Competency:

- Theories of Change (knowledge of the change process and how it applies to counseling clients impacted by child maltreatment)

☐ Approve

- ☐ Disapprove
- ☐ I would like to comment on this competency

22a. Please indicate your comments on this competency

23. The following competency was suggested to be added to this domain. Child Maltreatment Management: Knowledge. Please indicate whether you agree/ or disagree with this addition.

New competency: Ability to assess own strengths and needs (e.g., take responsibility to seek training as needed, seek out resources, seek supervision and consultation).

Comments: -assessment of needs and strengths would be beneficial and understanding the need to take responsibility to become trained seems more realistic then expecting all these levels of knowledge at the time the counselor is working with a client - seeking out resources, getting supervision and consultation etc.

- ☐ I agree to add this competency to the Child Maltreatment Management: Knowledge Domain.
- ☐ I do not agree to add this competency to the Child Maltreatment Management: Knowledge Domain.
- ☒ I believe this competency belongs in a different domain (please indicate which domain)
- ☐ I would like to comment on this competency

23a. Please indicate your comments on this competency

Child Maltreatment Impact Management Domain 2 of 2: Practical Skills

This domain covers important abilities counselors need prior to working with clients in order to promote client welfare during and after a child protection report. There were 9 competencies found for this domain, all of which have reached consensus (mean >4). Of the 9 competencies, six had no suggested changes, five had minor changes to the language, and one was suggested to be moved to a different domain.

- You will first be provided with the list of the six competencies that were not changed. These are listed for your reference.
- Next, you will be presented with the three competencies that require changes. Please review the changes suggested for the competency and then either agree or disagree with the proposed changes. You will be provided the comments that prompted the changes to help in your decision.

Below you will find a list of the competencies under Child Maltreatment Management Domain 2 of 2: Practical Skills. These are being provided for your reference.

1. Ability to recognize and repair ruptured relationships (Understand anger is a normal part of the process)

2. Ability to use basic counseling skills with clients
3. Ability to advocate for clients and families
4. Continued assessment for further maltreatment
5. Collaboration with multidisciplinary teams (e.g., participate in group and family meetings, setting goals with all teams involved, understand how helping all individuals that have contact with the child to better support the child).
6. Understand and apply self-care practices

23. Original Competency:

-Utilize supervision/ Consultation

Comments:

I feel like in the supervision and consultation perhaps a caveat noting effective or supportive supervision and consultation..it can exist but not be helpful.

New Competency: Ability to recognize and utilize effective and supportive supervision/ Consultation

- ☐ Approve
- ☐ Disapprove
- ☐ I would like to comment on this competency

23a. Please indicate your comments on this competency

24. Original Competency:

-A demonstrated ability to maintain fidelity to evidenced based models to treat trauma

Comments:

- I would caution strict adherence to a specific model - while utilizing evidence-based

New Competency:

-A demonstrated ability to balance the need for fidelity to evidenced based models and clients individual needs when treating trauma.

- ☐ Approve
- ☐ Disapprove
- ☐ I would like to comment on this competency

24a. Please indicate your comments on this competency

25. Original Competency:

-Ability to apply a strength based approach with children and families (e.g., assess for protective capacity of caregivers and how to build it, empower clients during and after report, Applying solution focused methods)

Comments:

-I think this one had too many components - does it have to include solution focused

-working with the offending "parent"

New Competency:

-Ability to apply a strength based approach with children and families (e.g., assess for protective capacity of both offending and non-offending caregivers and how to build it, empower clients during and after report)

- ☐ Approve
- ☐ Disapprove
- ☐ I would like to comment on this competency

25a. Please indicate your comments on this competency

APPENDIX I**LIST OF DOMAINS AND COMPETENCIES**

Child Maltreatment Risk Assessment Domain 1 of 2: Knowledge

This domain covers important knowledge counselors need prior to counseling clients in order to identify clients at risk for child maltreatment and report suspicions of abuse to child protective services.

Competency

1. Legal requirements (e.g., knowledge of federal and state laws, general knowledge of school district policies, and agency requirements)
2. Ethical requirements (e.g., ethical guidelines, confidentiality, informed consent, and supervision in child maltreatment)
3. Ethical decision-making models
4. Child abuse and neglect (e.g., definitions, prevalence, risk factors, types of perpetrators, types of violence, and symptomology of child abuse and neglect).
5. Role and limits in reporting process (e.g., role in assessing and assuring safety, permitted follow-up, documentation)
6. Normal human development and theory (e.g., ability to identify the difference between age appropriate and concerning behaviors)
7. Socio-cultural competencies, social justice, and advocacy (e.g., cultural implications and context of maltreatment).
8. Programs and organizations related to child welfare (e.g., knowledge of child welfare system, how to make a report, knowledge of current language trends in child welfare, agency processes and role of CPS workers, and knowledge of how to access information on child welfare and related programs)
9. How to integrate the role of the counselor and their role of reporter once a disclosure of child maltreatment is made (e.g., finding the balance between legal responsibility to report while focusing on the well-being of the client, and understanding the boundaries of reporting)
10. Potential therapeutic relationship issues for client/therapist around child maltreatment (e.g., client anger, boundaries, transference, and countertransference)
11. Difference between risk (the likelihood that abuse or neglect will happen in the future) and safety (freedom from current danger, risk, or injury)

12. Crisis intervention models (e.g., how to assess and discuss potential crisis with clients, ability to identify concerning behaviors that indicate client is in crisis, suicide assessments, and homicide assessments)

13. Training in trauma-informed assessment

14. Prevention (e.g., understanding root causes of child abuse and neglect, psycho educational prevention, knowing victims' rights and how to access services, knowing abuser rights, cycle of abuse and services).

Child Maltreatment Risk Assessment Domain 2 of 2: Practical Skills

This domain covers important abilities counselors need to attain prior to working with clients in order to identify clients at risk for child maltreatment and report suspicions of abuse to child protective services.

Competency

15. Utilize informed consent (e.g., be able to explain confidentiality to clients; know when to revisit limits to confidentiality).

16. Use basic counseling skills during process (e.g., demonstrate ability to maintain empathy and compassion with clients; offer a positive environment for the child and family to communicate without judgment).

17. Empower the client (e.g., use reframes; strengths-based approaches; understand the importance and means of validating survivors during disclosures and subsequent discussions).

18. Gather information (e.g., training on how to obtain enough information needed to report; identify line between enough information and crossing into investigating abuse; know when not to gather more information).

19. Collaborate (with CPS, law enforcement, hospital, other counselors, teachers, etc.)

20. Access supervision/consultation (e.g., know when to seek supervision/consultation).

21. Be transparent with the client regarding the process of reporting and include them in the **report** (when appropriate—and the ability to know the difference).

22. Address own beliefs and attitudes (e.g., maintain professional boundaries; manage own stress and bias; recognize own boundaries and issues when addressing client so that own issues don't come out in the session or impact the client).

Child Maltreatment Impact Management 1 of 2: Knowledge

This domain covers important knowledge counselors need prior to working with clients in order to promote client welfare during and after a child protection report.

Competency

23. Community resources and how to access them
24. Human development knowledge and theory (e.g., how child maltreatment impacts child development; understanding of short- and long-term consequences of abuse; effects of child maltreatment on the brain, behavior and development)
25. Attachment and how it is impacted by child maltreatment
26. Neurobiology and how it is impacted by child maltreatment
27. Basic parenting practices (e.g., how to educate and coach parents to be effective caretakers during recovery; knowing parenting modalities that work)
28. Trauma-informed care that includes awareness of the different trauma treatment modalities (e.g., evidenced-based practices; play therapy; child-focused treatments; trauma focused-CBT filial therapy; ways to work with ongoing trauma experienced by children who are maltreated)
29. Family systems (e.g., knowing how to engage a family; understanding the systemic impact of child maltreatment; understanding cultural influences and their impact on the family system)
30. How to work with the child welfare system after the abuse has been reported
31. Theories of change (knowledge of the change process and how it applies to counseling clients impacted by child maltreatment)
32. Crisis intervention models (how to discuss crisis with clients; ability to identify concerning behaviors that indicate client is in crisis; suicide assessments; homicide assessments)
33. Other trauma-related treatment modalities such as substance abuse, domestic violence, socioeconomic bias, and mental illness
34. Prevention (understanding root causes of child abuse and neglect; psycho educational prevention; knowing victims' rights and how to access services; knowing abuser rights; cycle of abuse and services).
35. How to assess own strengths and needs (e.g., taking responsibility to seek training as needed; seek out resources; seek supervision and consultation).

Child Maltreatment Impact Management 2 of 2: Practical Skills

This domain covers important abilities counselors need to attain prior to working with clients in order to promote client welfare during and after a child protection report.

Competency

- 36. Recognize and repair ruptured relationships (Understand anger is a normal part of the process)
- 37. Use basic counseling skills with clients
- 38. Advocate for clients and families
- 39. Continue assessment for further maltreatment
- 40. Collaborate with multidisciplinary teams (e.g., participate in group and family meetings; set goals with all teams involved; understand how to help all individuals that have contact with the child to better support the child).
- 41. Use self-care practices
- 42. Balance the need for fidelity using evidenced-based models and client's individual needs when treating trauma.
- 43. Use a strengths-based approach with children and families (e.g., assess for protective capacity of both offending and non-offending caregivers and how to build it; empower clients during and after report)
- 44. Recognize beliefs and attitude (e.g., maintain professional boundaries, manage own stress and bias, recognize their own boundaries and issues when addressing client to not allow their own issues to come out in the session or impact the client)
- 45. Recognize and utilize effective and supportive supervision/consultation

APPENDIX J

MANUSCRIPT FOR PUBLICATION

Counseling Competencies for Child Maltreatment

Risk Assessment and Management

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Abstract

Child maltreatment is a widespread epidemic that has relevance to the work of counselors (Alvarez et al., 2005). The purpose of this Delphi study was to discover the domains and competencies necessary to prepare master's-level counselors to assess and manage the risk of child maltreatment with clients. Twenty counseling and five non-counseling experts provided their opinions through a series of three structured surveys. Experts detailed the necessary knowledge and skills required to assess the risk and manage the impact of child maltreatment in their clients. Counseling training programs can begin to incorporate these competencies into their programs as a way to address the current lack of training on child maltreatment.

Counseling Competencies for Child Maltreatment Risk Assessment and Management

In 2011, Child Protection agencies in the United States received an estimated 3.4 million referrals involving approximately 6.2 million children (United States Department of Health and Human Services, [USDHHS], 2012). The statistics describing the number of referral reports likely do not fully capture the prevalence of child abuse and neglect. According to Child Protective Services (CPS) surveys, reports to CPS may underestimate the true occurrence of child abuse and neglect (Finkelhor, Turner, Ormrod, & Hamby, 2009). Studies have shown that professionals in the mental health fields underreport child maltreatment for a variety of reasons despite the potential consequences to children and themselves (Hinson & Fossey, 2000; Alvarez et al., 2005).

Oftentimes, counseling professionals lack the confidence and the competence on how to manage this legal mandate (Anderson, Levine, Sharma, Ferretti, Steinburg, & Wallach, 1993; Alvarez, et al., 2005). These issues of confidence and competence may contribute to findings such as those mental health providers make relatively few of the reports among required professionals—4.6% of the 57.6% (USDHHS, 2012). Many researchers have established the need for increasing competence and confidence through training (Alvarez, et al., 2005; Donohue, et al., 2002; Pollack & Levy, 1989). Although many mental health programs may incorporate some form of training on mandated

reporting or child abuse and neglect (Champion et al., 2005; CACREP, 2009), the counseling profession has not yet established a set of standards that provide comprehensive guidance on how to work with clients experiencing child abuse and neglect. Considering the low percentage of reports mental health professionals made to CPS compared to other disclosing groups, coupled with evidence indicating many unreported cases of child abuse and neglect, there is a need to increase the competency of mental health professionals to recognize and respond to child maltreatment. The purpose of this study is to establish the competencies counselors need to assess and manage the risk of child maltreatment risk with clients.

Suggestions from the Research

Many researchers have studied the barriers counselors have to reporting child maltreatment, and have made suggestions for counselors over coming them. The main themes found in the literature are content knowledge, the counselor role with the system, the counselor role with the client, addressing countertransference, collaboration with Child Protective Services, and management. Taken in combination, these themes provide insight in to why it is important to take a comprehensive approach to identifying the child maltreatment risk assessment and management competencies. Further the literature on barriers may inform how to implement the competencies within training programs.

Content knowledge. One suggestion within the literature toward the attainment of competence is building content knowledge of child maltreatment and the mandated reporting process. This content knowledge includes training on legal requirements, child maltreatment definitions, indicators of abuse, and the process of child protective services.

Knowing and understanding the legal requirements is key to having competence in working with this population. A strong knowledge base in reporting laws, including the philosophy underlying the laws, what constitutes reportable abuse in the current state, the types of perpetrators who must be reported, and the statute of limitations on reports, are recommendations of what to include in professional preparation (Renninger, et al., 2002; Steinberg, Levine, & Doueck, 1997). In addition to understanding the legal expectation to report, researchers have suggested training professionals on the legal consequences for failing to report (Alvarez, et al., 2005; Levine, et al., 1995). Students need to know that failure to report can lead to criminal charges and civil suits from the victims or their families (Alvarez, et al., 2005). Overall, students need to learn to document any decisions to report or not report in order to avoid legal ramifications (Besharov, 1990).

Defining and identifying abuse represent other content knowledge areas for counselors to reach competence. Kalichman (1999) supported the need for counselors to understand the definitions and the indicators of abuse. Individual definitions of the different forms of child maltreatment were presented earlier in this literature review. Each state has its own definition of child maltreatment and the subsequent forms of abuse. Counselors need to be prepared to look up the definitions in the state where they practice in order to accurately assess whether their concerns rise to the level of reporting to CPS. The identification of child maltreatment can be extremely difficult, and it depends on the state in which the counselor lives. For example, a counselor living in Colorado needs to know that spanking is allowable as long as it is age appropriate and does not leave a mark (Colorado Children's Code, n.d.). However, this permission is not

true for all states, as some states like Delaware prohibit causing any kind of physical pain to a child (*Title 11: Crimes and Criminal Procedure, Delaware Criminal Code*, n.d.).

Becoming competent working with clients also includes an understanding of CPS and its role with clients. An understanding of the CPS system will ease the reporting process for professionals, as it will address any preconceived notions the professional might have about the system and will help clarify the caseworker's role in preventing abuse (Delaronde, et al., 2000). Donohue and colleagues (2002) discussed the importance of sharing knowledge of the CPS investigatory process with the client as a way to maintain a working relationship. Knowing the system of CPS and what happens to families once a report is made is an important training point to help mitigate the negative attitude toward CPS caseworkers and the system (Alvarez, et al., 2005). Alvarez, and colleagues (2005) and Zellman (1990) suggested that training methods surrounding the process and caseloads of the CPS workers should alleviate some of the animosity felt toward making reports. Knowing what is going to happen to the client will help the counselor feel competent and confidently share with the client that the aim of the report is to strengthen the client's family.

Counselor role with the system. Knowledge-based training is only one of many components in reaching competency. Building on their knowledge base, counselors should be able to understand their roles in the process of assessing and reporting suspicions of child maltreatment. According to researchers, a counselor's role includes gathering information and advocating for the client. A difficult role, the process of gathering information is to collect enough information to make a report without crossing

the line into investigation (Renninger, et al., 2002; Levine, et al., 1995; Kalichman, 1999). According to Alvarez and associates (2005), training should emphasize that professionals are only required to report suspicion of abuse, not prove that abuse occurred. For many counselors, this fine line can be confusing and difficult to recognize.

Becoming a client advocate is another role a counselor must take. Steinberg, Levine, and Doueck (1997) suggested that training should include discussions around the value of informed consent procedures. According to the ACA code of ethics (2014) “Clients have the freedom to choose whether to enter into or remain in a counseling relationship... Informed consent is an ongoing part of the counseling process...” (p. 4). In order to build counselor competence in working with clients involved with child maltreatment, training should focus on how a counselor can include discussions of informed consent with the client when assessing for child maltreatment.

Counselor role with the client. A counselor’s primary responsibility is to “respect the dignity and promote the welfare of clients” (ACA, 2014, p. 4). When considering the prospect of training competent counselors in working with clients affected by child maltreatment, this responsibility continues throughout the reporting process. Researchers have found that while current improvements in child abuse training for professionals help raise awareness, it sometimes falls short in affecting clinical performance (Khan, et al., 2005). Clinical performance for counselors is of the utmost importance when considering protecting client welfare.

Researchers suggest that counselors should be prepared to inform the client about the report in a way that minimizes anger and to continue working with the client in the

aftermath of a mandated report (Steinberg, et al., 1997). In 2013, Chen and associates provided a set of training competencies recommended for medical professionals. Similar to the aim of the present study, the authors argued that medical professionals ought to be trained to address the needs of abused children and their families, which goes beyond training on mandated reporting (Chen, et al., 2013). The focus on parents or perpetrators of abuse was rated low in importance (Chen, et al., 2013).

Addressing countertransference. Building competence in counselors goes beyond focusing on the emotional impact of reporting for the client; training should also concentrate on the counselor's personal reactions and stability during and after the process. Many counselors report using mandated reporting to manipulate the relationship with the client (Pollack & Levy, 1989). To help counselors recognize their own values, some authors suggested assessing personal fears and attitudes toward reporting as part of training (Pollack & Levy, 1989; Anderson, et al., 1993). Most of the training programs evaluated and studied have focused on increasing confidence in making a report to CPS (McCauley, Jenckes, & McNutt, 2003; Hawkins; Donohue, et al., 2002). This confidence in reporting is important, as clients can perceive a counselor's hesitation and discomfort when discussing the probability of reporting.

Beyond increasing self-efficacy, practicing with and expecting client anger is an important component of addressing counselor countertransference. Many counselors fear client anger; therefore, Alvarez and colleagues (2005) suggested that training on anger management and self-protection strategies should be included during training programs as a way to ease this fear. Providing students with opportunities to practice, as Renninger,

and associates (2002) advocated, is an important addition to training, as it helps counselors in training balance the need to make a report, the need to maintain the therapeutic relationship, and the fear that comes with these requirements.

The concept of self-care is an additional training component to help counselors develop competency in addressing their own reactions to the client involved with child maltreatment. Sommer (2008) discussed the ethical obligation for counselor educators to prepare counselors to work with trauma victims and be able to cope with vicarious trauma. Many researchers have suggested that trauma education should include helping counselors recognize their own emotional reactions to clients (Salston & Figley, 2003; Elwood, et al., 2011) and normalizing the secondary trauma as a response to working with survivors (Elwood, et al., 2011). Students should be encouraged to seek supervision when working with this population to help them manage and identify their own secondary trauma reactions (Elwood, et al., 2011).

Collaboration with child protective services. Some studies have moved beyond content and practice as the only strategies to build competence. A few investigators have encouraged counselors to build a collaborative relationship with social services (Alvarez, et al., 2005). Training can guide counselors in forming these relationships and working within the system in order to support client welfare (Alvarez, et al., 2005). Alvarez and colleagues (2005) also suggested that collaborative relationships may help professionals understand the process for the client, which may alleviate some of the negative feelings they may have toward CPS. Some researchers included the possibility of inviting guest speakers from CPS into training as a way to address some of the adversity professionals

feel toward the system (Chen, et al., 2013). Building relationships with outside agencies such as CPS can also help counselors recognize their part in the system rather than feeling apart from the system.

Management. Competence in working with child maltreatment extends past a child maltreatment. The counseling field has conducted some research on training for counselors working with survivors of child maltreatment (Priest & Nishimura, 1995; Alvarez, Donohue, Carpenter, Romero, Allen, & Cross, 2010; Bryant & Baldwin, 2010). Most of these studies focused on training for counselors to be prepared to identify and report child maltreatment (Alvarez, et al., 2010; Bryant & Baldwin, 2010). The suggestions in these studies mirror the research already presented above, identifying a need for training on specific challenges of counselors, the legal consequences, and identifying child maltreatment. While this helps counselors prepare for the risk assessment part of their responsibility to clients, counselors still need to be prepared to work with survivors of child maltreatment.

In psychology programs, the focus for treating survivors of child maltreatment is training on evidence-based treatments (EBT) (Allen & Crosby, 2014; Sigel & Silvosky, 2011). These EBTs are often manualized, and they require the clinician to follow a specified structure regardless of the specific needs of the client (Allen & Crosby, 2014). According to Allen and Crosby (2014), most clinicians preferred nondirective approaches to treating children who experienced trauma in spite the focus in training programs on EBTs. This difference in attitude and training suggests that despite the push toward EBT

during graduate training, clinicians still hold the belief that survivors should be allowed to discuss their trauma on their own time.

The purpose of this Delphi study was to expand beyond the suggestions of the literature in order to identify child abuse and neglect, to fulfill the mandate to report child abuse and neglect, and to work with clients after a report of child abuse and neglect.

Method

This study used a Delphi method to survey a panel of experts to produce empirical data that identified and analyzed competencies of child maltreatment. Linstone and Turoff (2002) defined the Delphi method as “a method for structuring a group communication process so that the process is effective in allowing a group of individuals, as a whole, to deal with a complex problem” (pg. 3). Hasson, and associates (2000) added transforming opinion into group consensus to their definition of the Delphi method. Hasson, and colleagues (2000) described the steps of the Delphi method, which follow: (1) A qualitative round is conducted to collect participant comments; (2) Qualitative data from step 1 are analyzed and compiled into a second quantitative questionnaire; (3) A quantitative questionnaire is then collected from participants; (4) Quantitative data are analyzed and compiled into third questionnaire; (5) The process is continued until consensus is reached.

In many Delphi studies, consensus is usually reached after three to five rounds of quantitative data collection (Hasson, et al., 2000; Chen et al., 2013). Controlled feedback is provided to participants with the quantitative rounds to help participants understand the

current status of their collective opinion (Goodman, 1987), and this can assist in reaching consensus. In this study, three rounds of surveys were necessary to reach consensus.

Selection of Experts

The expert panel was comprised of two types of experts: counseling professionals and non-counseling professionals. Experts were selected based on their knowledge, experience, and specialization in treating children, families, or perpetrators of child maltreatment. Sixty-three experts were identified through purposive sampling, snowballing, and advertisement on counseling professional email listservs. An external auditor reviewed each of the experts to ensure they met the inclusion criteria. All of the non-counseling experts were recruited through purposive sampling. Fifty-three of the experts were counseling professionals; the remaining 10 were non-counseling professionals. Fourteen of them were males, 39 were females. All were invited to participate in the study.

Sixty-three eligible professionals were invited to participate in the study. Thirty-one expert- participants initially accepted the invitation to participate. Only 25 expert- participants, 20 counseling experts (80%), five non-counseling experts (20%), completed the first survey. All 25 expert- participants were invited to complete the second survey, 14 expert- participants completed the survey, one participant indicated they did not wish to participate in the second survey, and 10 expert- participants did not respond to the second invitation to participate. Eleven of the expert- participants who completed the second survey were counseling experts; three of the participants were non-counseling experts.

All 25 of the expert- participants were invited to complete the third survey. Thirteen expert- participants completed the final survey, one participant withdrew from the survey, and one participant answered the first four questions, 10 expert- participants did not respond to the third invitation to participate. Eleven of the expert- participants who completed the third survey were counseling experts; two of the expert- participants were non-counseling professionals. A total of 25 expert- participants completed the first survey, 60% (n=15) completed the second survey, and 52% (n=13) completed the final survey.

Procedures

The three rounds of data were collected via online survey software over a period of twenty-one weeks. After the generative round, expert- participants generated 43 competencies and four domains. In the final two rounds, expert- participants reached consensus and solidified the language, definitions, and placement of each of the competencies and domains.

Generative round. The first survey asked expert- participants a series of five questions to elicit their opinions and beliefs on what counselors need to work with clients affected by child maltreatment. The data collected from the generative round were exposed to a content analysis. Similar items were grouped together, through identification of similar terms used to describe the same phenomenon. Once I grouped all participant responses into categories, I combined those categories further into domains. After all the competencies were categorized into their initial domains, I created a definition for these domains (e.g. This domain covers all of the knowledge counselors need prior to seeing

clients in order to identify clients at risk for child maltreatment and report suspicions of abuse to child protective services.)

Round one. The second survey presented the forty-three competencies and four domains to expert- participants. Prior to taking the survey, I asked expert- participants to read three articles that I selected to provide examples of established competencies, along with the definitions for the study that were requested by the expert- participants during round one prior to responding to the survey. The purpose of these articles were to provide expert- participants with samples of established competencies to guide them in towards reaching consensus.

The second survey asked expert- participants to rank the level of importance of each domain and competency, and provided expert- participants the option to comment on the placement and language of each. Data analysis for the second round calculated the means to each question to determine if expert- participants reached consensus ($\text{mean} \geq 6$). Expert- participants reached consensus for all competencies during the second round. On the majority of competencies, expert- participants made suggestions for placement and language. On those items that had suggestions, I incorporated the suggested changes into the wording of the competency.

Round two. The third survey presented the twenty-one competencies and four domains that expert- participants suggested changes to in round one. For each of the competencies and domains with suggested changes, the survey first provided expert- participants with the original wording of the competency/domain, then asked expert- participants to review comments on the identified competencies, and finally asked expert-

participants to either agree or disagree with the proposed changes made to the wording and placement. Expert- participants were able to provide final comments on the competencies.

For this round, expert- participants reached consensus if 70 percent or more of the expert- participants approved of the change. For those competencies that did not reach consensus, I took into account the comments of the expert- participants and incorporated these suggestions into the final wording. Also, some of the expert- participants requested small changes to some of the competencies. For those suggestions that added to the clarification of the competencies (e.g. Perhaps it should be general knowledge of school policies), I incorporated those changes into the final language.

Results

Through this Delphi study, panel of 25 experts produced a set of 45 competencies divided into four domains for counselors in training to work with clients affected by child maltreatment. All competencies reached consensus as to their importance and reached majority approval for changes to placement and language. The four domains that emerged are: (1) Child maltreatment risk assessment: Knowledge; (2) Child maltreatment risk assessment: Practical skills; (3) Child maltreatment impact management: Knowledge; (4) Child maltreatment impact management: Practical skills.

Child Maltreatment Risk Assessment Domain 1 of 2: Knowledge

From the content analysis, I grouped fourteen competencies under the domain "Child Maltreatment Risk Assessment domain 1 of 2: Knowledge". The overall theme of these fourteen competencies was knowledge counselors need to have to assess for child

maltreatment. Expert- participants agreed the definition for this domain was “this domain covers important knowledge that counselors need prior to counseling clients in order to identify clients at risk for child maltreatment and report suspicions of abuse to child protective services.” All competencies reached consensus during the second round. The 14 competencies that emerged were:

1. Legal requirements (e.g., knowledge of federal and state laws, general knowledge of school district policies, and agency requirements)
2. Ethical requirements (e.g., ethical guidelines, confidentiality, informed consent, and supervision in child maltreatment)
3. Ethical decision-making models
4. Child abuse and neglect (e.g., definitions, prevalence, risk factors, types of perpetrators, types of violence, and symptomology of child abuse and neglect).
5. Role and limits in reporting process (e.g., role in assessing and assuring safety, permitted follow-up, documentation)
6. Normal human development and theory (e.g., ability to identify the difference between age appropriate and concerning behaviors)
7. Socio-cultural competencies, social justice, and advocacy (e.g., cultural implications and context of maltreatment).
8. Programs and organizations related to child welfare (e.g., knowledge of child welfare system, how to make a report, knowledge of current language trends in child welfare, agency processes and role of CPS workers, and knowledge of how to access information on child welfare and related programs)

9. How to integrate the role of the counselor and their role of reporter once a disclosure of child maltreatment is made (e.g., finding the balance between legal responsibility to report while focusing on the well-being of the client, and understanding the boundaries of reporting)
10. Potential therapeutic relationship issues for client/therapist around child maltreatment (e.g., client anger, boundaries, transference, and countertransference)
11. Difference between risk (the likelihood that abuse or neglect will happen in the future) and safety (freedom from current danger, risk, or injury)
12. Crisis intervention models (e.g., how to assess and discuss potential crisis with clients, ability to identify concerning behaviors that indicate client is in crisis, suicide assessments, and homicide assessments)
13. Training in trauma-informed assessment
14. Prevention (e.g., understanding root causes of child abuse and neglect, psycho educational prevention, knowing victims' rights and how to access services, knowing abuser rights, cycle of abuse and services).

Child Maltreatment Risk Assessment Domain 2 of 2: Practical Skills

A grouping of eight competencies combined to form the second domain: Child Maltreatment Risk Assessment: Practical Skills. These eight competencies addressed the practical skills counselors need to assess for child maltreatment. The definition for this domain was “This domain covers important abilities counselors need to attain prior to working with clients in order to identify clients at risk for child maltreatment and report

suspensions of abuse to child protective services.” The eight competencies in this domain are:

15. Utilize informed consent (e.g., be able to explain confidentiality to clients; know when to revisit limits to confidentiality).
16. Use basic counseling skills during process (e.g., demonstrate ability to maintain empathy and compassion with clients; offer a positive environment for the child and family to communicate without judgment).
17. Empower the client (e.g., use reframes; strengths-based approaches; understand the importance and means of validating survivors during disclosures and subsequent discussions).
18. Gather information (e.g., training on how to obtain enough information needed to report; identify line between enough information and crossing into investigating abuse; know when not to gather more information).
19. Collaborate (with CPS, law enforcement, hospital, other counselors, teachers, etc.)
20. Access supervision/consultation (e.g., know when to seek supervision/consultation).
21. Be transparent with the client regarding the process of reporting and include them in the report (when appropriate—and the ability to know the difference).
22. Address own beliefs and attitudes (e.g., maintain professional boundaries; manage own stress and bias; recognize own boundaries and issues when addressing client so that own issues don’t come out in the session or impact the client).

Child Maltreatment Impact Management 1 of 2: Knowledge

A grouping of ten competencies united to form the third domain: Child Maltreatment Management Domain 1 of 2: Knowledge. These ten competencies addressed the knowledge counselors need to promote client welfare during and after a child maltreatment report. The definition for this domain was “this domain covers important knowledge counselors need prior to working with clients in order to promote client welfare during and after a child protection report. The competencies in this domain are:

23. Community resources and how to access them
24. Human development knowledge and theory (e.g, how child maltreatment impacts child development; understanding of short- and long-term consequences of abuse; effects of child maltreatment on the brain, behavior and development)
25. Attachment and how it is impacted by child maltreatment
26. Neurobiology and how it is impacted by child maltreatment
27. Basic parenting practices (e.g., how to educate and coach parents to be effective caretakers during recovery; knowing parenting modalities that work)
28. Trauma-informed care that includes awareness of the different trauma treatment modalities (e.g., evidenced-based practices; play therapy; child-focused treatments; trauma focused-CBT filial therapy; ways to work with ongoing trauma experienced by children who are maltreated)

- 29. Family systems (e.g., knowing how to engage a family; understanding the systemic impact of child maltreatment; understanding cultural influences and their impact on the family system)
- 30. How to work with the child welfare system after the abuse has been reported
- 31. Theories of change (knowledge of the change process and how it applies to counseling clients impacted by child maltreatment)
- 32. Crisis intervention models (how to discuss crisis with clients; ability to identify concerning behaviors that indicate client is in crisis; suicide assessments; homicide assessments)
- 33. Other trauma-related treatment modalities such as substance abuse, domestic violence, socioeconomic bias, and mental illness
- 34. Prevention (understanding root causes of child abuse and neglect; psycho educational prevention; knowing victims' rights and how to access services; knowing abuser rights; cycle of abuse and services).
- 35. How to assess own strengths and needs (e.g., taking responsibility to seek training as needed; seek out resources; seek supervision and consultation).

Child Maltreatment Impact Management 2 of 2: Practical Skills

Eleven competencies developed into a domain that addressed the practical skills counselors need to work with clients impacted by child maltreatment. The final domain was named Child Maltreatment Impact management: Practical Skills. The definition for this domain is “this domain covers important abilities counselors need to attain prior to

working with clients in order to promote client welfare during and after a child protection report.” The competencies in this domain are:

36. Recognize and repair ruptured relationships (Understand anger is a normal part of the process)
37. Use basic counseling skills with clients
38. Advocate for clients and families
39. Continue assessment for further maltreatment
40. Collaborate with multidisciplinary teams (e.g., participate in group and family meetings; set goals with all teams involved; understand how to help all individuals that have contact with the child to better support the child).
41. Use self-care practices
42. Balance the need for fidelity using evidenced-based models and client’s individual needs when treating trauma.
43. Use a strengths-based approach with children and families (e.g., assess for protective capacity of both offending and non-offending caregivers and how to build it; empower clients during and after report)
44. Recognize beliefs and attitude (e.g., maintain professional boundaries, manage own stress and bias, recognize their own boundaries and issues when addressing client to not allow their own issues to come out in the session or impact the client)
45. Recognize and utilize effective and supportive supervision/consultation

Discussion

In this study, a panel of 25 experts created a list of 45 competencies across four domains. The findings highlight the complexity of the role counselor's play and the importance of clinical competence in improving services to families experiencing child maltreatment. These findings advance the literature base by providing empirically supported competencies for counselor preparation.

Complex Role

The role of the counselor in child maltreatment risk assessment and management is complex (Henderson, 2013). Through the development of these competencies, this study attempted to help clarify the role of counselors in assessing and managing child maltreatment in their clients. Across four domains, expert- participants detailed that a counselor must take on the role of counselor, advocate, teacher, mandated reporter, and consultant. Similar to the findings in the literature (e.g., Henderson, 2013; Levine, et. al, 1995; Damashek, Balachova, & Bonner, 2011; Chen, et al., 2013), the panel of expert- participants in this study identified the knowledge and skills counselors need to fulfill these roles.

Counselor-specific Domains.

Health professionals and psychologists produced training competencies for working with the area of child maltreatment (Damashek, et al., 2011; Chen, et al., 2013). Panelists and the researchers found similar domains such as identifying knowledge and skills necessary for working with clients impacted by child maltreatment. Different from these studies, the expert- participants separated the competencies into risk assessment and

impact management as the two important domains. The expert- participants separated the competencies by chronological order, rather than by grouping by content. For example, Damashek, and colleagues (2011) identified overarching competency areas, such as assessment, research ethics and treatment, and then broke those down into the knowledge, skills and attitudes needed to achieve competence. Unlike most studies, this study went beyond mandated reporting, and focused on the process of assessing for the risk, and then managing the impact of child maltreatment on the client. This grouping into chronological order may give counselors a better guide for the skills and knowledge needed before, during and after a report is made.

With these overarching domains, the experts in this study highlighted counselors need to understand potential impacts on client welfare. This focus was unique to this study, as the health care professionals and psychologists did not address the working relationship with the client, or the need to understand cultural implications of child maltreatment. This may be due to the nature of the counseling profession, which is most concerned with positive human change (Van Hesteren & Ivey, 1990), and its focus on wellness (Duffey & Somody, 2011).

Implications

Currently, the CACREP 2009 standards do not specify training on child maltreatment as a requirement for counseling programs. The 2009 CACREP standards do require mental health counselors to gain knowledge, and skills around "the impact of crises, disasters, and other trauma-causing events on people" (p.29), as well as "principles of crisis intervention for people during crises..." (p. 30). In the school counseling

program requirements, the standards do include "Understands the influence of multiple factors (e.g., abuse, violence, eating disorders, attention deficit hyperactivity disorder, childhood depression) that may affect the personal, social, and academic functioning of students" (CACREP, 2009); p. 41). As is clear, the 2009 CACREP standards do not clearly delineate child maltreatment apart from crisis and trauma. This study presents a set of standards to provide guidance for the training of counselors on how to work with clients experiencing child maltreatment.

With these competencies as guidance, counselor educators can begin to incorporate the necessary knowledge and skills identified in this study into their curricula. One way counselor educators can utilize these competencies is make programmatic decisions as to where each competency is best addressed within a course sequence. The following example illustrates integrating competency numbers 6, 24, 25, and 22 into a human development course. Counselor educators can intentionally incorporate these competencies while they are introducing the different developmental stages and discuss abnormal development due to child maltreatment. Counselor educators can also guide a discussion on student beliefs and attitudes about child maltreatment victims and perpetrators. As part of their role-plays, counselor educators can integrate scenarios that indicate impaired development, so counselors-in-training gain the experience assessing for the risk of child maltreatment.

Counselor educators can also use these competencies as part of their supervision with counselors. Researchers have supported competency-based supervision as an effective way of promoting confidence (Rudd, et al., 2008; Oordt, Jobes, Fonseca, and

Schmidt, 2009). Supervisors can focus on building and enhancing child maltreatment risk assessment and impact management knowledge and skills during supervision. Prior to meeting with clients, supervisors can focus on certain competencies, such as informed consent, information gathering, understanding role and limits in reporting process, and addressing own beliefs and attitudes. Supervisors can role-play different client scenarios, helping the counselor to practice these competencies. When supervisees are faced with assessing for child maltreatment, supervisors can help the supervisee utilize a decision making model in determining whether a report should be made to CPS (i.e., Ethical decision making). A supervisor can also focus on helping the supervisee determine how much information to gather, and maintaining their use of basic counseling skills with a client during the assessment process (i.e., competency #16). After the report is made, a supervisor can focus on impact management with the supervisee, by promoting the counselor to assess their relationship with the client, encouraging them to acknowledge any relationship ruptures with the client, helping them to identify ways to advocate for the client (#38), and helping them to collaborate with CPS (if possible; competency #8 and #40).

Limitations

The limitations of this study relate to the exploratory nature of the Delphi, and recruiting. The first limitation to this study is the Delphi method. The Delphi method is a multi-stage process that changes opinion into group consensus (Hasson, et al., 2000). The Delphi method functions as an exploratory, knowledge building tool. The exploratory nature of the Delphi method is a limitation to this study because of the group opinion.

The expert- participants generated these competencies without support from the literature. Therefore, the validity of this study is dependent on the representativeness of the sample. This study acts as a first step towards developing empirically based competencies for the training of counselors on child maltreatment.

In this study, there were limitations related to recruiting. Sixty three professionals were initially identified as meeting the study criteria, 31 agreed to participate, and only 25 engaged. This is a limitation because of the representativeness of the sample. According to Hasson, and associates (2000), the lack of random selection reduces the representativeness of the sample. Some researchers suggest increasing the sample size in order to counter this concern (Hasson, et al., 2000). With the smaller sample size in this study, the expert- participants may not have been a comprehensive representation of the available experts in the content area, and consensus may have been different with more expert- participants.

Conclusion

This study was the first step toward create training competencies for child maltreatment risk assessment and management. These competencies contribute to filling a gap in counselor education for the training needs of counselors on child maltreatment risk assessment and management. Unlike most studies, this study went beyond mandated reporting, and focused on the process of assessing for the risk, and then managing them impact of child maltreatment on the client. These 43 competencies represent the knowledge and skills counselors in training need to provide the best care to clients

impacted by child maltreatment. Counseling training programs can begin to incorporate these competencies into their programs as a way to address the current lack of training on child maltreatment.

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