

Counseling Sexually Abused Children in the Philippines: A Survey of Practices, Beliefs and Activities

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CHILD abuse remains one of the serious problems confronting Filipino children. Based on the number of cases served by the Department of Social Welfare and Development (DSWD) in 2006, child sexual abuse (CSA) accounted for 35.8% of the total cases (2,803 of 7,066). These figures paint an alarming situation specifically for girl children, as sexual abuse comprised 52% of the cases of girls handled by the DSWD. The data still do not include those cases lodged with different private institutions and non-governmental organizations (NGOs) throughout the country.

Considerable attention has been placed on the study of the nature, contributory factors to victimization or healing, and impacts of sexual abuse on Filipino children and families (Ladion, 2007; Tarroja et al, 2007; Bautista et al, 2001; Carandang, 1996;). Very few have focused on studies of interventions. An extensive literature review noted that child abuse interventions in the Philippines, including those for CSA, were largely eclectic, characterized by exploration and experimentation which are largely atheoretical, and if theory-driven, usually involved strategies and techniques imported from the West (Dela Cruz et al, 2000). Furthermore, the approaches are generally designed for individual sessions which places a heavy burden on the already overworked child care workers,

In other countries like the United States, counseling was found to be a positive, useful and effective intervention across the full range of issues confronting children and young people, including sexual abuse (Pattison & Harris, 2006). In the Philippines, counseling was recognized as the primary tool among child care workers (Dela Cruz et al, 2000). Unfortunately, there were very few studies that attempted to describe the practice and status of counseling in the Philippines. Two of the most relevant were done by Clemeña (1993) and Villar (1997). While the first looked into the history, practice, education and training of counselors, the second compared the status of counseling practice in the Philippines alongside the more dominant Western approaches. Both studies, however, focused on education graduates who are not trained to handle the more serious problems such as child abuse.

Another survey was done by Teh (2003), which investigated the practice and status of psychotherapy in the Philippines. This preliminary investigation sampled 48 psychotherapists who were mostly psychologists, psychiatrists, and guidance counselors. However, it was found that the respondents primarily dealt with adult client who bring to therapy issues such as marital and family problems. Problems that involved children usually were school-related, e.g. poor grades, underachievement, learning disabilities, hyperactivity. Sexual abuse of children was not reported by the respondents.

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Monthly Features Page

It seems that social workers are the ones tasked to handle sexual abuse and other related problems. However, there has been no systematic investigation on the practice of counseling child sexual abuse to date. This present study was conducted in order to provide a preliminary look into the status and practice of counseling sexually abused children in the Philippines. More specifically, it seeks to provide information on the following:

1. profile of counselors working with CSA clients and the organizations they belong to;
2. description of the intervention process including the initial contact and intake; interaction with clients, supervision, case documentation;
3. counselors' beliefs regarding sexual abuse and self reported efficacy in counseling
4. training received related to CSA

METHOD

Measure

An 11-page questionnaire was constructed to obtain information on a wide range of items related to personal and professional characteristics. Sample characteristics consisted of age, gender, civil status, religion, birthplace, highest educational attainment, current organization, years in current profession.

Questions about the services offered included information on the following: caseload (e.g., number and types of cases handled); and types of services, administrative and professional support. Questions related to professional activities inquired about trainings received, references on child sexual abuse available to the respondent.

Another major section involved an assessment of the practitioner's own capability in providing different counseling skills. The next section presented 13 cases and asked respondents to indicate if they have ever encountered a particular case in their career and to briefly describe the action they have taken in response to the situation. The last part consisted of 20 items that looked into: beliefs about the nature of child sexual abuse; attitudes towards their work as a counselor; and beliefs about their efficacy as counselors.

Procedure

CPTCSA prepared an initial list of organizations known for counseling services for children victim-survivors of sexual abuse. This list is drawn from the pool of participants who have participated in the trainings that CPTCSA has conducted over the years government and non government organizations who are known to CPTCSA as providing services to sexually abused children. A total of 135 questionnaires were sent out to 108 organizations. However, only 60 questionnaires were returned, yielding only a 44.4% return rate.

Data Analysis

Descriptive statistical procedures were mainly used to summarize the survey responses: frequency counts and percentage computations were used to determine patterns of counseling practices while means were computed for the attitude and belief items.

RESULTS AND DISCUSSION

Sample Characteristics

A total of 60 counselors responded to the survey. However, not all of the respondents provided complete information, one of the major artifacts of a mailed questionnaire. Females dominated the sample (52 of 55 or 94.5%), a figure that may correspond to a gender disparity in the profession.

Table 1. Number of participants by sex and location.

	NCR	Luzon	Visayas	Mindanao	TOTAL
Females	22	4	17	11	52
Males	2	0	1	0	3
TOTAL	24	4	18	11	55

Almost half of the respondents (43.6%) came from the National Capital Region (NCR). About 32.7% came from the Visayas. Only 20% came from Mindanao, while only four respondents came from other parts of Luzon. If these figures accurately represent the actual population of practitioners then this clearly shows that child sexual abuse counselors have a tendency to practice mostly in Metro Manila.

The mean age of the respondents was 36.9 years (SD = 10.7), indicating a young set of practitioners. Male and female respondents have almost equivalent mean ages (Age *females* = 35.9 vs Age *males* = 36.7). For the 56 respondents who provided information on their civil status, majority are either single (51.8%) or married (42.9%). About 3.6% are widowed and 1.8% reported to be cohabiting with a partner. Among the respondents, 86.7% (52) reported some type of religious affiliation, with Catholics as the majority (75% or 39 of the 52 respondents). Some 17.3% self-identified as Christians while only three respondents are Protestants. There was only one Muslim participant in the sample.

Majority of the respondents hold a bachelor's degree in Social Work (42 of 56 or 75%) and obtained these degrees in private colleges and universities (40 of 56 or 76.9%). There were only 6 respondents who have psychology baccalaureate degrees.

Meanwhile, only 16 (30.7%) indicated the master's level as the highest degrees. Of this number, about 37.5% were degrees in social work and 18.75% were in psychology. However, it is interesting that a few respondents (%?) received advanced degrees that are remotely related to counseling practice (e.g., public administration).

Institutional Affiliation

Majority of the respondents are affiliated with non-governmental organizations (62.1%) while the rest work in the Department of Social Welfare and Development (DSWD). Usually, the respondents are deployed in shelters or centers as social workers (in the case of NGOs) or social welfare officers (in DSWD run shelters). On average, the respondents reported 4.5 years practicing as counselors, reflecting a very young set of respondents. However, it is also important to note that about 11 of the respondents have been in their profession for about ten years or more.

Caseload

It was found that majority of the respondents belonged to organizations that do not solely cater to child sexual abuse cases. This is basically true for social workers from the DSWD which is tasked to respond to a variety of children in need of special protection (e.g., victims of trafficking, children in situations of sexual exploitation, street children).

The respondents reported that, on the average, their agencies have about five staff members who handle child sexual abuse cases. However, the respondents reported personally taking charge of an average of 28 cases. About 21 of these are sexual abuse cases. Meanwhile, respondents from government agencies have a heavier CSA caseload than those working for private agencies and NGOs (Mean caseload_{Gov} = 28.25 vs Mean caseload_{NGO} = 16.17). Only eight out of 57 respondents handle solely child sexual abuse cases while four respondents are handling solely non-CSA cases.

About 46.7% respondents also revealed that they are given flexibility in determining which cases to handle. Others who are not afforded that flexibility (38.3%) explain that they are the only ones in the organization who are available or capable to take on the case. Unfortunately, only 30% of the counselors are able to determine their case load. This is especially true among social workers in government institutions.

Services Offered for Sexually Abused Children

On the average, the respondents reported that their respective organizations have been providing services for sexually abused children for about 11.8 years (SD = 8.8). This implies that some organizations have been working on this problem for almost 20 years while some have been in operation for a little over three years.

What services are rendered? As reported by the respondents, counseling for the child victim-survivor (91.7%) topped the list of services offered by their agencies. Other services within the domain of counseling also were high on the list: counseling of the family (80.0%) and group counseling/therapy (70.0%). These results confirm and reaffirm that counseling is one of the primary interventions given to victims of child sexual abuse.

It was also interesting that other services, not essentially counseling-related but integral to the healing process, were reported to being offered by a majority of the agencies that the respondents belong to. One set of services are what may be called as

emergency or immediate services, such as provision of medical assistance (e.g., medico-legal examinations, treatment of injuries, etc.) and temporary shelter. The other set includes services which may aid rehabilitation such as provision of legal assistance when children have decided to file charges against their perpetrators, or those that would develop the children’s knowledge and skills (provision of education).

The other services were more specialized and thus may not be readily offered by most organizations. These include: psychological assessment and psychiatric evaluation, and police reporting. The low number of staff trained in psychology may partly explain why psychological services are usually not part of the organization’s menu of services. Meanwhile, foster care and residential care are usually offered by either government-supported agencies or those funded by international donors or church organizations.

Table 2. Types of services currently offered for sexually abused children

	<i>%</i>	<i>freq</i>
Counseling of child victim-survivor	91.7	55
Counseling of family	80.0	48
Provision of medical assistance	76.7	44
Temporary shelter	75.0	45
Group counseling/therapy	70.0	42
Provision of legal assistance	70.0	42
Provision of vocational, educational or special education	61.7	37
Police reporting	55.0	33
Psychological assessment	55.0	33
Psychiatric evaluation	33.3	20
Foster care	28.3	17
Residential care	24.0	36

Different Aspects of Interventions for Child Sexual Abuse

We have learned from the preceding section that counseling services count as the major types of interventions given to children who have experienced sexual abuse. This section will provide us an overview of the systems and processes that the organizations adopt in their attempt to provide these services to children. Among those that will be discussed are the following: process of initial contact with the child, including reasons for the contact and the intake process (more specifically, the kind of information taken in the initial contact with the child); the referral system, including the presence of a referral network or a multi-disciplinary response team; and the counseling interventions, including counseling techniques, case monitoring and supervision.

Initial Contact with Child Victim-Survivor. In most cases, contact is almost always done by referral by another organization (43%) or the organization itself makes the contact (40%). There are a few occasions (16.7%) that the child’s family or relatives

brought the child to the organization or that children themselves would personally contact the agencies (11.7%).

Table 3 shows the reasons for initial contact with the children. As expected, a majority of the cases were to provide counseling for the children. The rest of the dominant reasons all involve for emergency and immediate assistance: protective custody (71.7%); admission to residential care (68.3%); provision of legal assistance (63.3%), and medical assistance (58.3%). These may be the reason why these are the services usually offered by most organizations helping children victims of sexual abuse as seen in Table 2, implying that sexual abuse is seen as a problem that needs immediate help and support. It is also important to note that although rescue is an emergency assistance, only government-run agencies are mandated by law to perform the rescue of children.

Table 3. Reasons for Initial Contact

	%	freq
Counseling	76.7	46
Protective custody	71.7	43
Admission to residential care	68.3	41
Provision of legal assistance	63.3	38
Provision of medical assistance	58.3	35
Rescue	50.0	30
Provision of vocational/educational training	45.0	27
Psychological assessment	35.0	21
Foster care	25.0	15
Psychiatric evaluation	23.3	14
Others (e.g., financial assistance)	23.3	14

The other services may not be the primary reasons why children come into contact with organizations because they represent more specialized assistance (e.g., psychological assessment and psychiatric evaluation) or more long-term rehabilitative help (e.g., education).

Based on the data, we could categorize the available services for child sexual abuse victims into two: the basic services (those that focus on safety and emergency forms of assistance, and those that most organizations offer) and the more long-term services (those that are more specialized and focus on mental health services, and therefore, cannot be readily offered by most organizations).

The intervention process. The most common mechanism in the intervention process for children is the intake interview (90%). Other common strategies include referral and case study formulation (both at 83.3%).

The next cluster of activities has something to do with the treatment: from formulation to implementation (78.3%). Interestingly, those activities that have

something to do with more in-depth assessments, monitoring and evaluation are not common processes. Given the high caseload of individual counselors, this finding is also alarming in the sense that it suggests that counselors do not find time to reflect if their strategies are working or not.

Table 4. The Intervention Process

	%	freq
intake interview	90.0	57
referral	83.3	54
case study formulation	83.3	50
treatment goal and treatment plan formulation	78.3	47
treatment implementation	78.3	47
assessment session	76.7	46
evaluation	73.3	44
assessment reformulation	61.7	37

The intake. Of the 57 that reported having an intake interview, only 56 reported using an intake form. What information is collected about the child victim survivor? Table 5 shows the basic features based on the intake form used by CPTCSA and the proportion of respondents who also collect the same information in their intake interviews.

Table 5. The Basic Features of An Intake Form

	%	n
name of child	100.0	56
educational attainment	100.0	56
Sex of child	98.2	55
Age of child	98.2	55
date of birth	98.2	55
family composition	98.2	55
place of birth	90.4	54
religion	88.3	53
nature or circumstance of abuse	85.7	48
child's source of social support	83.9	47
physical or psychological complaints	71.4	40
child's abilities or interests	67.9	38
information on alleged abuser/perpetrator	67.9	38
report of behavioral changes since the abuse	62.5	35
history of family violence, substance abuse or legal problems	60.7	34
experience of reporting the abuse	42.9	24
experience of previous counseling	30.4	17
factors of not returning for another session	19.6	11

We found that a number of socio-demographic information about the child was deemed important: name of the child, age, sex, religion, education, and birth date. Family composition is the only information about the family that is included on the top of the list.

The next cluster of important information includes: place of birth, religion, nature or circumstance of abuse and child’s source of social support. It is surprising that the report on the circumstance of abuse itself is grouped in this cluster and not included as one of the most important information in the intake form.

Not as frequently collected are information on: physical or psychological complaints, child’s abilities or interests, information on alleged abuser/perpetrator, report of behavioral changes since the abuse, and history of family violence, substance abuse or legal problems. Again, these are important information that could guide a counselor in formulating an intervention plan and yet were not as prioritized as the other sets of information.

Considered to be least important are the following: experience of previous counseling, experience of reporting the abuse, and factors of not returning for another session.

The Multidisciplinary Team and the Referral System. Only 66.7% (40) of the respondents stated that their organizations have their own multidisciplinary response team. The usual composition would be a medical doctor, usually a pediatrician or general practitioner (43.9%), psychologist (38.6%), lawyer (36.8%), police representative (29.8%) psychiatrist (28.1%)

While only 54 mentioned referral as part of their intervention process, 57 respondents reported having a referral network. Table 6 lists the services that respondents refer to other agencies. Note that two of the top three services (psychological assessment and psychiatric evaluation) were also those that are not usually offered by the respondents’ agencies, hence requiring referral when necessary.

However, it was interesting that provision of legal and medical assistance were also referred to other agencies, although these were reported as offered by most organizations (Table 2) and considered as basic services for initial contact (Table 3). What would account for this inconsistency? While this lack of confirmation is clearly a limitation of the survey method, we may logically surmise that legal and medical assistance that go beyond those which are offered by the organizations are the ones that are referred to other agencies. For example, most of the organizations that referred medical assistance named general and mental hospitals as receiving agencies.

Table 6. Services that Respondents Refer to Their Network

	%	n
psychological assessment	71.7	43
provision of legal assistance	71.7	43
psychiatric evaluation	70.0	42
provision of medical assistance	68.3	41
temporary shelter	53.3	32
residential care	50.0	30

provision of vocational/educational training	50.0	30
counseling of child victim-survivor	38.3	23
counseling of family	38.3	23
foster care	28.3	17

Individual and Group Counseling. While 55 respondents (91.7%) reported having counseling services for children (Table 2), interestingly 59 (98.3%) mentioned conducting individual counseling. Aside from that, only 48 (80%) mentioned having a separate private room in their organizations for such purposes. This suggests a lack of privacy when conducting individual sessions with the children for some 20% of the respondents, a situation that could limit the efficacy of the sessions.

How frequent are these sessions done? It is alarming that while most of the respondents reported counseling as a core service, *only as the need arises* is the modal response (41.7%). Next would be weekly sessions (20%). On average, the counselors spend a total of 2.7 hours per child in a week.

Meanwhile, about 71.7% (43) reported conducting group sessions with their clients. And like individual counseling, group counseling is conducted *only as the need arises* (23.3%) or weekly (21.7%). On average, the counselors spend about 1.7 hours per weekly group session.

Considering the heavy caseload of most counselors (who not only handle CSA cases), weekly sessions for individual and group counseling sessions would be the most manageable schedule.

Records-Keeping, Case Supervision and Case Conferencing. About 86.7% of the respondents reported their capability of recording their sessions for supervisory purposes while 90% claimed keeping accurate records of their transactions with their clients. On average, they spend about 1.6 hours per case building these records. An interesting follow up study would be an analysis of the case records that these counselors keep.

About 83.3% reported being supervised by a superior (a higher ranked social worker in the case of government run agencies) or the program or executive director (in non-governmental organizations). Supervision is mostly done for administrative purposes (80%), such as monitoring case load, report writing and other administrative concerns; but not so much for emotional and professional support (63.3%) nor educational purposes (56.7%). These sessions are conducted monthly (26.7%) or as the need arises (25%). When they have a problem with a case they are handling, a large proportion (91.7%) seeks their supervisor's help.

Case conferences are reported to be done by 78.3% of the respondents. These conferences are usually done monthly (30%) and last an average of 2.2 hours.

Experiences in Handling Specific Counseling Issues

Given a list of 13 case scenarios, the respondents were asked to indicate which of these they have had experience handling in their career. Incidentally, the top five situations were experienced by more than half of the participants, also indicating the nature of cases most commonly handled by the counselors in the sample.

Table 7. Experiences in Handling Counseling Issues

	%	freq
Multiple sexual abuse	70.0	42
Refusal to disclose	66.7	40
Refusal to file charges	63.3	38
Violence or aggressive behaviors	61.7	37
Suicide ideation	56.7	34
Age inappropriate sexual language	45.0	27
Clients with depression	36.7	22
Disclosures of female masturbation	30.0	18
Run away clients	30.0	18
Age inappropriate sexual play	26.7	16
Children who molest other children	26.7	16
Disclosures of male masturbation	21.7	13
Use of pornography	8.3	5

What were the common strategies in handling these issues? Again, the modal response would be to set up a counseling session with the particular child. This is done especially with problems that the counselor feel either capable of handling or situations that are less severe. One example of such a situation is counseling a child who has experienced multiple sexual violations. Those who are reluctant to disclose or refuse to file charges are re-assured and comforted during counseling sessions. Further study on counseling methods would be warranted.

However, those situations that are beyond the competence or control of the counselor such as suicide ideation would entail referral or help-seeking (e.g., setting up a case conference).

Beliefs on Child Sexual Abuse

Using a five-point Likert scale, we explored the counselor's beliefs on child sexual abuse with eight items dealing with: the nature and circumstance of abuse, reasons for the abuse, impact on children, the role of interventions.

Children tend to be truthful about their reports of sexual abuse. Our data showed that the counselors believe that when children report an incidence of sexual abuse, they are telling the truth ($M = 3.9$, $SD = 1.2$). This belief is consistent with several researches that indicate that children rarely lie about or imagine being sexually abused. In fact, what children often do is to minimize and deny, rather than fabricate what has happened to them (Sjoberg & Lindblad, 2002; Lawson, & Chaffin, 1992).

Children-victims of sexual abuse, without any treatment or intervention, cannot overcome the trauma that they have experienced. The respondents have only moderate agreement with this statement ($M = 3.4$, $SD = 1.4$). This tells us that some of the counselors also believe that children can survive the trauma of child sexual abuse even without any intervention.

I believe that child sexual abusers are sexually attracted to their victims. The respondents somewhat disagreed with this statement ($M = 2.6$, $SD = 1.23$). However, it is also important to point out that a number of our counselors believe in this statement, producing an ambiguous overall position.

Counseling sexually abused children do not require specialized strategies. The respondents strongly disagreed with this statement ($M = 1.8$, $SD = 0.9$), suggesting that child sexual abuse cases should be handled differently from other cases. In fact, these strategies may make the difference between a child's disclosing and not disclosing (Wood & Graven, 2000).

In fact, good rapport-building skills may make the difference between a child's disclosing and not disclosing (Wood & Garven), as "acceptance and validation are crucial to the psychological survival of the victim" (Summit, 1983, p. 53). Requiring specialized strategies, however, would mean that counselors would also need specialized training.

Most abusers are known to their children-victims. The counselors strongly agreed with this statement ($M = 4.0$, $SD = 1.1$), and both research and practice support this belief. For example, the 2000 data from the University of the Philippines Child Protection Unit show that 65% of the perpetrators in all cases were family members, with 23% non-familial, 5% unknown and 7% other undisclosed.

Children who are sexually abused will become abusers as adults. The counselors were somewhat conflicted over this statement ($M = 3.2$, $SD = 1.1$). While there is widespread belief in a "cycle" of child sexual abuse, there is also very little empirical evidence for this belief. The studies that explored this link, found the cycle more likely among male children than among female children. For example, one study looked into clinical case note reviews of 843 subjects attending a specialist forensic psychotherapy center (Glasser et al, 2001). The data support the notion of a victim-to-victim cycle **only** in a minority of male perpetrators **but not** among the female victims studied. Romano & de Luca (1997) found similar trends in their study of male sexual offenders

Incidents of sexual abuse are usually single, violent incidents. Counselors believed that sexual abuse incidents are NOT just single, violent episodes ($M = 2.7$, $SD = 1.2$). Again, as borne out by research, sexual abuse could be multiple episodes.

Counseling Skills and Counselor Self-Efficacy

The following section presents the repertoire of counseling skills which the respondents rated based on a seven point scale that measures their self-reported capability. Of the 17 items on the list, only two items were rated poorly: handling cases of sexually abused boys (M= 3.5, SD=1.6) and gay children (M=3.4, SD= 1.7). The low rating may be attributed to a lack of experience in handling such cases.

Table 8. Mean Self-Ratings of Confidence in Performing Specific Counseling Skills

	Means	SD
Individual counseling with child	5.5	1.2
Networking with other professionals	5.2	1.4
Facilitating group sessions	5.1	1.4
Assessment	5.1	1.3
Handling cases of sexually abused girls	5.1	1.3
Counseling parents or guardians	5.0	1.4
Formulating case management plans	4.9	1.5
Documenting cases	4.9	1.3
Handling cases of adolescents	4.9	1.4
Group counseling	4.7	1.5
Stress management	4.7	1.4
Handling child sexuality	4.7	1.5
Organizing case conferences	4.7	1.5
Handling adolescent sexuality	4.6	1.6
Handling cases of school age children	4.6	1.6
Handling cases of pre-school age children	4.1	1.6
Handling cases of sexually abused boys	3.5	1.6
Handling cases of sexually abused gay children	3.4	1.7

On the other hand, as expected, individual counseling with children was rated as the highest among the skills that counselors felt most capable in doing, a pattern that we have seen to be very consistent. They were also quite confident about managing different types of clients (e.g., girls, adolescents, school-aged children, pre-school children). Last, they also reported being capable in handling the different phases of the intervention process. The counselors also reported being least confident in handling cases of sexually abused boys or gay children.

Self-efficacy, or more appropriately perceived self-efficacy, is defined as the belief that one is capable of performing in a certain manner to attain certain goals (Ormrod, 2006). In the context of counseling, this would entail the counselor’s perception of his or her competence to conduct counseling. This was explored using seven items measured on a five point Likert scale (see Table 9). For the analysis, negatively stated items were recoded so that higher mean scores suggested higher self-efficacy.

Table 9. Mean Ratings on Items on Counselor Self-Efficacy

	Mean	SD
I feel that I have adequate fundamental knowledge to do effective counseling.	3.7	1.0
I do not feel that I possess a large enough repertoire of techniques to deal with the different problems that	3.0	1.2

sexually abused clients may present.**		
I feel that I am an effective counselor of sexually abused children.	3.0	1.2
In working with sexually abused clients, I may have a difficult time viewing situations from their perspective.**	2.9	1.3
I feel competent regarding my abilities to deal with crisis situations that	2.9	1.2
I am likely to impose my personal values on the sexually abused client during the interview.**	2.8	1.2
I feel that my religious beliefs interfere with my ability to counsel sexually abused children.**	2.2	1.2

** *recoded items*

Considering the high level of confidence given to specific counseling skills in Table 8, it was surprising that the respondents gave very low ratings to most of the self-efficacy statements. Only *possessing adequate knowledge* revealed some degree of confidence among the counselors. A closer look at the data would suggest that many of the counselors feel that they lack the capability of taking the other's perspective, especially when it conflicts with their personal values and religious beliefs. However, one major limitation of this measure is that many of the respondents left most of the items unanswered which may affect the validity of the results.

Attitudes towards Counseling as a Profession

The participants showed very strong positive attitudes towards their current profession as shown in Table 10. This is an important finding as this would signal the respondents' current level of satisfaction with the work that they do and also in some way predict openness to more training and desire to provide more quality service.

Table 10. Items on Attitudes towards Counseling as a Profession

	Mean	SD
If I had all the money I needed without working, I would probably still continue in my professional discipline.	3.9	1.1
If I could go into a different profession that paid the same, I would do it.	2.7	1.2
If I could do it all over again, I would not choose to work in my professional discipline.	2.1	1.0
I definitely want a career for myself in the professional discipline I am currently in.	2.9	1.3

Counselor Continuing Education and Access to Information

Only 9 respondents (15%) reported never having undergone any training, seminar or workshop on sexually abused children. About 73.3% participated in a training seminar within the last six months of the time the survey was conducted. The topics of

the workshops and seminars may be divided into the following areas: child abuse; counseling and therapy; interventions regarding child sexual abuse.

Only 43 (%) respondents mentioned being interested in receiving further training related to child sexual abuse. They are most interested in the following domains: 1) theories and perspectives on child abuse, including current trends in research and practice; 2) approaches, methods and techniques in handling child sexual abuse; and 3) skills for a more effective intervention process. A complete list can be found in Appendix 1.

Table 11. Ideal Number of Days for a Training Seminar on Child Sexual Abuse

	%	freq
1-3	39.5	17
4-7	46.5	20
8 and more	14.0	6
TOTAL	100.0	43

What reference materials are at hand for the counselors in their respective organizations? Basing our analysis on reference materials available to the respondents, we could say that a more general information on children’s rights but not much access to more specific information on child sexual abuse.

Table 12. Reference Materials Available to Respondents

	%	freq
Books or manuscripts on children’s rights	81.7	49
Copies of local laws relevant to child sexual abuse	70.0	42
Books on child sexual abuse	58.3	34
Training modules on identifying and managing child sexual abuse	53.3	32
Research on child sexual abuse	25.0	15

SUMMARY AND CONCLUSIONS

The study confirms that those who provide the counseling interventions for sexually abused children are mostly social workers. The sample reflects a very young set of practitioners, in terms of age and experience. Very few have advanced degrees in social work or related disciplines.

The respondents have an average of about 28 cases they are personally handling. While a major bulk of their caseload focuses on child sexual abuse, the respondents are also expected to cater to other child abuse cases. Case workers in government agencies handle more cases than those in private institutions and NGOs.

As expected, counseling was reported as the most common intervention offered to CSA clients. Other services offered by the organizations include more emergency-related services such as medico-legal assistance, and other rehabilitative services such as provision of education or economic assistance. The range of services provided by many of the organizations suggests an attempt to be more holistic in the interventions provided for the children. Since most of the organizations are more equipped to provide counseling services, other interventions, especially those that are more specialized, such as psychological or psychiatric assessment, are usually referred to other agencies. A referral network becomes a necessary and integral aspect of working with and helping sexually abused children. While most of the respondents reported having such a network in place, only a few have a multidisciplinary team in place in their own locales of operation. It was also unclear as to how these systems operate since this is beyond the scope of the present instrument. These questions on systems and processes may be captured by more in-depth investigations using interviews and actual observation.

What is the nature of counseling sessions? We found that although counseling was reported to be the core of the services given to CSA clients, most of the time this was reported as being done only as the need arises. We surmised that this is due to the heavy caseload assigned to each case worker. If conducted, individual counseling sessions last for an average of 2.7 hours while group counseling sessions take about 1.7 hours. Surprisingly, 20% of the respondents reported not having a separate room for conducting counseling sessions.

Not all respondents reported keeping records of their transactions with their clients. Those who do keep records spend about 1.7 hours building the records per case. The respondents also reported being subjected to monthly supervision usually by their immediate supervisors. However, supervision is mostly for administrative purposes. This is unfortunate since supervision has the important role of supporting counselors who directly confront the trauma of sexual abuse and may also become traumatized in the process (Etherington, 2000). Meanwhile, case conferences are usually done once a month.

Of the 13 example cases, only five were reported as being encountered by more than half of the respondents. These include: multiple sexual abuse; refusal to disclose; refusal to file charges; violence or aggressive behaviors; and suicide ideation. These cases are usually the most common clusters of behaviors and situations associated with CSA victims. The counselors' familiarity with these cases may help bolster their ability to handle these situations in the future since experience was found to positively affect the sense of self-efficacy (Ormrod, 2006). On the other hand, the lack of familiarity with the remaining eight cases may also negatively impact their confidence in handling similar cases in the future. For example, since very few cases of sexual abuse cases involved boys, the respondents also reported low confidence in counseling boys (and gay children) who experienced sexual abuse. Thus, it becomes imperative that education and training institutions for social workers include adequate discussions of the range of possible situations associated with childhood sexual abuse.

We found that the respondents have considerable confidence in handling specific counseling scenarios. While they reported possessing adequate fundamental knowledge in counseling, they are unsure of their ability to take the other's

perspective, especially when it conflicts with their personal values and religious beliefs.

We also tested the respondents' beliefs about child sexual abuse. We found that respondents' beliefs coincide with research evidence for only three of the eight items: children are truthful about their disclosures of abuse; most abusers are known to the victims; and sexual abuse is not just a single episode. For the remaining five items, the respondents seem to hold opposing beliefs. It does not bode well that most of the respondents have admitted to having only a basic knowledge of child sexual abuse, and not having access to current information on child sexual abuse.

Based on these findings, we propose three lines of recommendations: a) future research; b) training and continuing education; and c) standards of practice.

Future research

This present investigation provided a highly descriptive account of some aspects of counseling practice related to child sexual abuse. A number of limitations of the study's methodology warrant a follow up research: incomplete information provided by the respondents; and the small sample size and the lack of representativeness (since the total number of counselors working with CSA clients is currently unknown) severely limit the results' validity and reliability. Other questions about the counseling process were left unexplored (eg., How is counseling actually done? What is the quality of records-keeping for CSA cases?), since these are more amenable to other methods like in-depth interviews, observations, and document analysis.

Training and continuing education

We feel that an undergraduate degree does not provide an adequate grasp of the complexity of childhood sexual abuse, and a more advanced and specialized training on child sexual abuse should be encouraged for practitioners in the field. These may come in the form of a formal degree or an equivalent series of continuing education. We recommend that supervisors allow their counselors some time off to receive the necessary training in order for them to be equipped with the adequate knowledge, skills and attitudes to provide quality care for children. Supervisors and counselors need to be reminded that training and education is a lifelong process of updating, retooling, and reflecting.

Training content should focus not only in strategies and techniques, but also most especially in correcting possible misconceptions and helping counselors adopt an orientation more suited to working with children in this situation. It is also important for counselors to keep abreast with the current developments in the research and practice regarding child sexual abuse.

Standard of practice

We found several aspects of the intervention process that may negatively impact on the quality of service being offered to CSA clients. Foremost is the heavy caseload

carried by each counselor. A heavy caseload results in shorter interactions with each child, leads to a lack of or poor documentation of cases, and contributes to the possible burnout of even the most dedicated case worker.

It is also important that systems and processes support the rendering of quality service for CSA clients. For example, the interventions should ensure that the child is not traumatized by repetitive interviews and procedures (Dela Cruz et al, 2000). These include an adequate tool for intake and monitoring, the provision of a private (and safe) space for counseling and other related purposes, close supervision that is not just done for administrative purposes, a working and reliable referral system, and if possible, a competent and sensitive multi-disciplinary team.

There may be a need for all those involved in the practice of helping sexually abused children to come together and seriously and actively discuss the issues that affect their work with these children. The establishment of a national network of individuals and organizations that provide CSA services and intervention may not only facilitate the monitoring and regulation of the practice of counseling for sexually abused children but also provide the much needed support among practitioners themselves.

REFERENCES:

- Bautista, V.; Roldan, A. & Garces-Bacsal, M. (2001). *Working with Abused Children from the Lenses of Resilience and Contextualization*. Quezon City: Save the Children UK - Philippines and UP Center for Integrative and Development Studies Psychosocial Trauma and Human Rights Program.
- Carandang, M.L. (1996). *Listen to Their Inner Voice: Street Children Speak Through Their Drawings and Metaphors*. Manila: UNICEF.
- Clemeña, R.S. (1993). *Counseling psychology in the Philippines: Research and practice*. Manila, Philippines: De La Salle University Press.
- Dela Cruz, T.; Protacio-Marcelino, E.; Balanon, F.; Camacho, A. & Yacat, J. (2000). *Child Abuse in the Philippines: Integrated Review of the Literature and Annotated Bibliography*. Quezon City: Plan International Philippines and UP Center for Integrative and Development Studies Psychosocial Trauma and Human Rights Program.
- Department of Social Welfare and Development. (2006). MFOs 2 & 3.
- Etherington, K. (2000). Supervising counselors who work with survivors of childhood sexual abuse. *Counseling Psychology Quarterly*, 13(4); 377-389.
- Glasser M. ; Kolvin I.; Campbell D.; Glasser A.; et al. (2001). Cycle of child sexual abuse: links between being a victim and becoming a perpetrator. *British Journal of Psychiatry*, 179; 482-497.
- Ladion, F. (2007). Kiss of heaven: Recovering from the trauma of child sexual abuse among Evangelical Christians. *Philippine Journal of Psychology*, 40(2); 58-87.
- Lawson, L., & Chaffin, M. (1992). False negatives in sexual abuse disclosure interviews. *Journal of Interpersonal Violence*, 7, 532-542.
- Ormrod, J. E. (2006). *Educational Psychology: Developing Learners* (5th ed.), N.J., Merrill: Upper Saddle River (companion website).
- Pattison, S. & Harris, B. (2006). Counselling children and young people: A review of the evidence for its effectiveness. *Counselling and Psychotherapy Research*; 6(4); 233-237.
- Romano, E. & De Luca, R.V. (1997). Exploring the relationship between childhood sexual abuse and adult sexual perpetration. *Journal of Family Violence*, 12 (1); 85-98.
- Sjoberg, R. L., & Lindblad, F. (2002). Limited disclosure of sexual abuse in children whose experiences were documented by videotape. *American Journal of Psychiatry*, 159; 312-314.

- Summit, R. (1983). The child sexual abuse accommodation syndrome. *Child Abuse and Neglect*, 7, 177-192.
- Tarroja, M.C.; Balajadia-Alcala, M.A. & Co, S.A. (2007). The impact of family composition and last incident of abuse on the psychosocial well-being of abused children. *Philippine Journal of Psychology*, 40(2), pp. 111-136.
- Teh, L. (2003). A survey on the practice and status of psychotherapy in the Philippines. *Philippine Journal of Psychology*, 36(1); 112-133.
- Villar, I. (1997). *Western approach to counseling in the Philippines*. Manila, Philippines: De La Salle University Press.
- Wood, J. M., & Garven, S. (2000). How sexual abuse interviews go astray: Implications for prosecutors, police, and child protection services. *Child Maltreatment*, 5, 109-118.

Appendix 1

Theories, Perspectives and Information	Approaches, Methods and Techniques	Intervention Processes
<ul style="list-style-type: none"> • qualitative research on CSA • Updated Data Banking on CNSP • dynamics of a sexually abused child • determinants of a child sexual abuse victim, • trends on helping Child abuse cases, , • abused kids that have developed behavior problems as a result of the abuse, multi-personality • how to handle sexual abuse child • problem as means to cope with the abused • impact of child sexual abuse • laws relevant to sexual abuse • Sexuality in Church and State 	<ul style="list-style-type: none"> • gender sensitive approach • creative and indigenous methods of intervention • Group therapy sessions with CSA victim survivors • behavior modification for children • art therapies for CNSP • handling child sexual abuse victim • family therapy • play therapy • therapeutic activities for sexually abused children • treating sexually abused children that were institutionalized • counseling on child sexual abuse • handling traumas, physical massage training • therapy on CSA • how to handle indiv counsel/SA • training for house parents • how to conduct individual/group counselling • therapy to rape victims • techniques/approaches in handling SA cases • management of dysfunctional family/client • handling adolescent sexuality • Simplified Activities to Reform Child Young Sexual Offenders • treatment of sexually abuse children including the implementation of the after care program 	<ul style="list-style-type: none"> • treatment plan formulation & implementation • measuring impact of intervention • documenting counselling sessions • effective documentation of therapy/counseling, supervision • intake, interview and consultations • management of cases with sexual manifestation • how to be a good/effective counselor to sexual abuse children • case management

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