12-2022

Advocacy Experiences of Licensed Professional Counselors Who Serve Minor Survivors of Abuse and Neglect

Earniesha S. Lott-Kennebrew

University of New Orleans, New Orleans, elott@uno.edu

Follow this and additional works at: https://scholarworks.uno.edu/td

Part of the Counseling Commons

Recommended Citation

This Dissertation is protected by copyright and/or related rights. It has been brought to you by ScholarWorks@UNO with permission from the rights-holder(s). You are free to use this Dissertation in any way that is permitted by the copyright and related rights legislation that applies to your use. For other uses you need to obtain permission from the rights-holder(s) directly, unless additional rights are indicated by a Creative Commons license in the record and/or on the work itself.

This Dissertation has been accepted for inclusion in University of New Orleans Theses and Dissertations by an authorized administrator of ScholarWorks@UNO. For more information, please contact scholarworks@uno.edu.
Advocacy Experiences of Licensed Professional Counselors Who Serve
Minor Survivors of Abuse and Neglect

A Dissertation

Submitted to the Graduate Faculty of the
University of the New Orleans
in partial fulfillment of the
requirements for the degree of

Doctor of Philosophy

in

Counselor Education

by

Earniesha Sherell Lott

B.A., Southeastern Louisiana University, 2006
M.Ed., University of New Orleans, 2011

December 2022
Copyright 2022, Earniesha Lott-Kennebrew
This dissertation is dedicated to my deceased grandparents and great grandparents, Beatrice and Willie Williams, Willie and Talmadge Hart, Earnest Lott Sr., Henrietta Dillard, and Sammie Carter. For them it was never about titles, status, or accolades. Their focus was love, honesty, compassion, and hard work. They built the foundation on which I stand. I am forever indebted to them for the life they lived before me, the love they poured into me, and their light that still shines to light my path.
Acknowledgements

I would like to acknowledge a few individuals who made an impactful difference throughout this process. My outpouring of gratitude begins with God. My faith in God has kept me grounded, framed my identity, and given me strength to persevere. The scriptures remind me that I can do all things through Christ, and I believe that He has great plans for my life.

Acknowledgements are extended to my parents. You have demonstrated the epitome of love and support. Your relentless and unconditional love since birth instilled in me an unwavering level of confidence and purpose. To this very day I cannot recall a time when you did not come through. Your consistent support never fails! Thank you for giving me life, loving me deeply, and being great examples of compassion and diligence.

I would also like to acknowledge my heart in human form, my amazing husband. I am grateful for your encouragement, prayers, presence, and all the snacks you provided while I was in the trenches of writing my dissertation. Thank you for helping me get back on track during moments of frustration. Thank you for participating in the random dance breaks when I needed to reenergize and get my thoughts flowing again. You never questioned my decision and you have been my biggest cheerleader. I promise to do the same for you as you finish your doctoral degree. From the bottom of my heart, I thank you!

My family overall has been a great inspiration. I am, because they are! We are Hart strong, and this degree is for all of us.

Lastly, I would like to thank my committee members, the faculty, and staff of this great program. Thank you to Dr. Watson for asking me as a master student if I was going to consider the doctoral program. Obtaining a Ph.D. was not a thought, but that simple question opened my mind to this great possibility. Thank you to Dr. Dufrene for your patience and expertise. The
process was rigorous but well worth it. Dr. Belser, you stepped just in time to help me to the finish line. Thank you for your quick responses and the encouragement at the beginning of each of your emails. Dr. Wade, you are appreciated! You also stepped in during a time of shifting. I could not have done this without your help.
# Table of Contents

List of Figures .................................................................................................................. x
List of Tables ..................................................................................................................... xi
Abstract .............................................................................................................................. xii
Chapter I .............................................................................................................................. 1
  Introduction ......................................................................................................................... 1
  Overview .............................................................................................................................. 1
Purpose of Study ................................................................................................................... 4
Significance of the Study ..................................................................................................... 4
Conceptual Framework ....................................................................................................... 5
Problem Statement ............................................................................................................. 8
Overview of Methods and Research Questions ................................................................. 8
  Central Question ................................................................................................................. 9
Limitations and Delimitations .............................................................................................. 9
Assumptions of the Study ..................................................................................................... 10
Definitions of Terms .......................................................................................................... 10
Chapter Summary .............................................................................................................. 13
Chapter II ............................................................................................................................ 14
  Literature Review .............................................................................................................. 14
  Children ............................................................................................................................... 14
Childhood Abuse and Neglect ............................................................................................. 15
  Rates and Trends of Abuse and Neglect ......................................................................... 16
  Results of Abuse and Neglect: Trauma ........................................................................ 21
Mandatory Reporters of Abuse and Neglect ..................................................................... 27
  Education and Training .................................................................................................... 28
Counselors, Law, and Ethics ................................................................................................. 29
  Confidentiality .................................................................................................................... 29
  Privileged Communication ............................................................................................... 32
Advocacy .............................................................................................................................. 33
  Definitions of Advocacy .................................................................................................... 34
  Components of Advocacy ................................................................................................. 35
  Professional Counseling and ACA’s Code of Ethics ....................................................... 37
Advocacy Competency Domains ......................................................................................... 38
Figure 1 Conceptual Framework ......................................................................................... 39
Credibility ................................................................................................................................. 64
Dependability .......................................................................................................................... 65
Chapter Summary ...................................................................................................................... 65
CHAPTER 4 ................................................................................................................................ 66
RESULTS ..................................................................................................................................... 66
Data Analysis Procedures .......................................................................................................... 66
Table 1 ......................................................................................................................................... 67
Master Themes ............................................................................................................................. 67
  Fundamentals of Advocacy ........................................................................................................ 67
  Advocacy Defined ..................................................................................................................... 68
  Advocacy Experiences .............................................................................................................. 71
Utilized Resources ....................................................................................................................... 75
  Advocacy Models ..................................................................................................................... 75
  Code of Ethics ........................................................................................................................... 76
  Assessments and Screenings ...................................................................................................... 77
  Consultations ............................................................................................................................. 77
Aspects of Collaboration ............................................................................................................. 78
  Professionals and Systems ......................................................................................................... 78
Influences on Advocacy Preparedness ....................................................................................... 87
  Academic Experiences ............................................................................................................ 87
  Course Content ......................................................................................................................... 87
  Professors’ Expertise ............................................................................................................... 91
  Supervisory Experiences ......................................................................................................... 92
  Professional Experiences ......................................................................................................... 94
  Clinical Experiences ............................................................................................................... 94
Professional Resources ........................................................................................................... 96
  Advocacy Models .................................................................................................................. 98
  Consults ................................................................................................................................... 98
  Trainings .................................................................................................................................. 99
  Psychoeducation Tools .......................................................................................................... 100
Considerations for Advocacy Competency and Preparedness ............................................. 100
  Academic Enhancement ......................................................................................................... 101
  Trauma Informed Supervision ............................................................................................... 103
Advocacy Challenges ........................................................................................................... 103
Continued Education ......................................................................................................... 105
Legislative Change ............................................................................................................. 105
Chapter Summary ............................................................................................................. 106
CHAPTER 5 ......................................................................................................................... 107
DISCUSSION ....................................................................................................................... 107
Purpose ............................................................................................................................... 107
Summary of Methods ......................................................................................................... 107
Discussion of Results ......................................................................................................... 108
Fundamentals of Advocacy ............................................................................................... 108
    Aspects of Collaboration .............................................................................................. 111
Influences on Advocacy Preparedness .............................................................................. 115
Considerations for Advocacy Competency and Preparedness ......................................... 118
Implications and Recommendations ............................................................................... 120
    Implications for Counselor Education Programs ....................................................... 120
    Implications for Counselor Practice and Policy ......................................................... 121
    Implications From the Child and Caregiver Perspective ........................................... 122
Limitations .......................................................................................................................... 122
Recommendations for Future Research .......................................................................... 123
Personal Reflections .......................................................................................................... 124
References ......................................................................................................................... 125
Appendix A .......................................................................................................................... 145
Appendix B .......................................................................................................................... 147
Appendix C .......................................................................................................................... 149
Appendix D .......................................................................................................................... 150
Appendix E .......................................................................................................................... 153
Vita ........................................................................................................................................ 154
List of Figures

Figure 1 Conceptual Framework ........................................................................39
List of Tables

Table 1 Participant Demographic Information .....................................................55
Abstract

LPCs in Louisiana operate in multiple professional roles and maintain various responsibilities, including advocacy for clients. Although numerous advocacy opportunities occur when counselors are working with children, a minimal amount of research exists regarding advocacy training, as well as the associated intricacies and responsibilities of advocacy. Lack of awareness of advocacy issues is a prominent barrier to advocacy involvement and it is suggested that counselor education programs are infusing advocacy education into courses but are not necessarily teaching specific constructs of advocacy. Thus, relevant and existing advocacy literature is sparse.

The purpose of my qualitative phenomenological research is to understand advocacy experiences of LPCs who work with minors who are survivors of child abuse and neglect. I will explore LPCs’ experiences regarding advocacy in the following areas: (a) education, training, and competence; (b) collaboration with various professionals; and (c) difficulties and benefits of advocating for minors who are survivors of child abuse and neglect. The outcome of this research is important as it may uncover advocacy areas in need of further research, gaps in education and training, and a reflection of clinical competency related to advocacy experiences of Louisiana counselors who serve minor survivors of abuse and neglect. Improved actions of advocacy for this population may result in prevention of further traumatic experiences, access to needed resources, lack of gaps in services and improved self-advocacy. Knowledge produced by the research could also lead to more competent practices for clinicians, improved education and training, and improved collaboration with professionals.

Key Words: Advocacy, Licensed Professional Counselors, Abuse and Neglect
Chapter I

Introduction

Chapter I entails an overview of my qualitative phenomenological research, which includes a synopsis of the concept of advocacy and the factors that can impact the advocacy experiences of Licensed Professional Counselors (LPCs) serving minors who are survivors of child abuse and neglect. In Chapter I, I present the purpose and significance of the study, conceptual framework, and statement of the problem followed by an overview of the research methods and research questions. The chapter concludes with an explanation of the limitations and delimitations, assumptions of the study, definitions of key terms, and a summary.

Overview

The advocacy literature includes descriptions of advocacy for individuals living with mental illness, various advocacy definitions related to mental health, descriptions of professional advocacy responsibilities, challenges faced by counselors who advocate for clients, and multidisciplinary approaches that require collaboration of various professionals. When mental health counselors do not understand how to properly advocate, they face challenges and barriers to advocating for their clients (Lyons et al., 2015). Because advocacy is an area of competency that is required within and across helping professions, professional counselors should be knowledgeable in how to advocate effectively (American Counseling Association, ACA, 2014; Barnett, 2004; Crenshaw, 2011).

Although a plethora of advocacy definitions are included in the mental health literature, Ramirez-Steg et al. (2017) suggested the need for clarity in the meaning and operationalization of various advocacy terms. Variations in advocacy perspectives exist across the helping professions, including professional concepts, advocacy terms, and differences in definitions.
(Lating et al., 2009; Lyons et al., 2015; Ramirez et al., 2017). In ACA’s *Code of Ethics*’ (2014) the definition of advocacy at the micro (e.g., individual client) and macro (e.g., counseling profession) levels exist, whereas in the definition by Lewis and Bradley (1999) only a macro-level view is included in their definition. They described advocacy as “taking action” and/or “speaking for” clients to foster environmental advances including social justice and changes in laws that will positively benefit clients (p. 11). ACA’s *Code of Ethics*’ (2014) advocacy definition promotes “the well-being of individuals, groups, and the counseling profession within systems and organizations. Advocacy seeks to remove barriers and obstacles that inhibit access, growth and development” (p. 20). Other organizations, such as the Council for Accreditation of Counseling and Related Programs (CACREP, 2001), define advocacy as an “action taken on behalf of clients and or the counseling profession and to support appropriate policies and standards for the counseling profession and promote individual human worth, dignity, and potential and to oppose or work to change policies and procedures, systemic barriers, long-standing traditions, or preconceived notions that stifle human development” (p. 65). CACREP’s (2001) definition of advocacy pertains the collaboration of professionals for the best interest of minors who are survivors of child abuse and neglect. Eriksen (1997) provided a more simplified view of advocacy as the point at which conflict resolution, public relations, and public policy intersect. Although definitions of advocacy from these authors and professional organizations include common themes of positive change and well-being, definitions, like Lewis and Bradley’s (1999), are more inclusive and detailed than others.

According to CACREP (2016), counseling programs must teach advocacy standards to counseling students. Additionally, counseling practicum and internship students, Louisiana Provisional Licensed Professional Counselors (PLPC) and LPCs have a responsibility to follow
state laws, and anyone who is a member of LCA and ACA must follow ACA’s *Code of Ethics* (2014). The ethical code includes but is not limited to information regarding the process of ethical complaints, ethical obligations, professional considerations and responsibilities, expectations of professional conduct, and support of ACA’s mission. One of the many expectations of ACA’s (2014) ethics code and the “primary responsibility” of counselors is to encourage the welfare and uphold the dignity of clients (p. 4). No matter the professional role in which counselors practice (i.e., practicum or internship student, PLPC, or LPC), their responsibilities for each professional role include upholding the ethics of advocacy at the macro-level to promote environmental change and at the micro-level to support individual clients (ACA, 2014).

When counseling minors who are survivors of child abuse and neglect, counselors’ knowledge of advocacy is required. However, counselors may not know how to advocate for survivors, and they may experience professional difficulties when working with survivors. Difficulties may involve confidentiality issues (Fotheringham, Dunbar, & Hensley, 2013; Fine et al., 2012; Hall & Lin, 1995; Swenson & Spratt, 1999), high-conflict custody cases (Stacer, 2008), legal involvement and court testimony (Bratton & Wallace, 2013; Crenshaw, 2011), role conflict (Cross et al., 2012), and multidisciplinary collaboration (Fran, 2014). Wheeler & Bertram (2015), who served as a licensed attorney and consultant for the risk management department of ACA, stated that a lack of collaboration can create difficulties in client health concerns, civil malpractice lawsuits, client dissatisfaction, and complaints to licensing boards.

Multiple factors are necessary for effective advocacy efforts including: (a) collaboration in professional relationships, (b) persistence during challenging situations, and (c) recognition and actions on opportunities when initially presented with a situation that requires advocacy
(Fran, 2014). Solid collaborations can further assist in advocacy efforts of counselors when building coalitions and engaging effective liaisons who can address policymakers and create relationships with higher level professionals and officials. Advocacy recommendations are especially useful to counselors working with minors who are survivors of child abuse and neglect. Considering the variations in advocacy definitions, ethical responsibilities, legal obligations, and difficulties surrounding advocacy; it is imperative that counselors learn to effectively advocate and collaborate with other professionals for clients, especially most vulnerable minors who have been abused or neglected (Stylianos & Kehyayan, 2012). Effective advocacy also requires consideration for each client’s case.

**Purpose of Study**

The purpose of my qualitative phenomenological research was to understand advocacy experiences of LPCs who work with minors who are survivors of child abuse and neglect. I explored LPCs’ experiences regarding advocacy in the following areas: (a) education, training, and competency; (b) collaboration with various professionals; and (c) difficulties and benefits of advocating for minors who are survivors of child abuse and neglect.

**Significance of the Study**

LPCs in Louisiana operate in multiple professional roles and maintain various responsibilities including advocacy for clients. These professional roles and responsibilities are identified and regulated in the ACA Code of Ethics that was adopted by the Licensed Professional Counseling Board Louisiana (ACA, 2014; Cross et al., 2012). LPCs are legally required to follow the licensing laws of their state (Wheeler & Bertram, 2015), which requires knowledge of the advocacy process and a corresponding ability to advocate competently for their clients. LaFortune and Carpenter (1998) pointed out that counselors may need additional training
in advocacy, especially when treating specialized populations such as children. Areas of advocacy in research include social justice, public policy, and multidisciplinary collaboration (Barnett, 2004; Damashek et al., 2011; Elmquist et al., 2015; Fox, 2008).

Although numerous advocacy opportunities occur when counselors are working with children, a minimal amount of research exists regarding advocacy training, as well as the associated intricacies and responsibilities of advocacy. Lyons et al. (2015) stated that the “lack of awareness of advocacy issues is a prominent barrier to advocacy involvement” (p. 409). Lating et al. (2009) suggested that counselor education programs are infusing advocacy education into courses but are not necessarily teaching specific constructs of advocacy. Thus, relevant and existing advocacy literature is sparse. In my research, I explored LPCs’ experiences with advocacy on behalf of minors who are survivors of child abuse and neglect.

**Conceptual Framework**

A significant factor when conducting research is the conceptual or theoretical framework. Merriam (2009) described a theoretical framework as the “underlying structure, the scaffolding or frame of your research” (p. 66). Failure to use a framework can result in a poorly designed research study with insufficient connections between existing literature, methodology, and research questions (Bloomberg & Volpe, 2012). A theoretical framework influences all aspects of a research study and draws “upon the concepts, terms, definitions, models, and theories of a particular literature base and disciplinary orientation” (Merriam, 2009, p. 67).

As the conceptual framework for my research, I used the Advocacy Competency Domains (ACD) by Lewis et al (2003) which was updated by Toporek and Daniels (2018). The ACD framework is a unique comprehensive guide that includes three levels of intervention (i.e., Client/Student, School/Community, and Public Arena), with six advocacy domains (i.e.,
Client/Student Empowerment, Client/Student Advocacy, Community Collaboration, Systems Advocacy, Collective Action (Public Information), and Social/Political Advocacy). Each level of the ACD framework differs in advocacy actions with and on behalf of a client or student (Lewis et al., 2003). The ACD figure that depicts the ACD framework was updated in 2018 and uses the term Collective Action in place of Public Information (Toporek & Daniels, 2018).

At the Client/Student level of intervention, a client or student acts for his or her own advocacy purposes. Counselors can empower a client (i.e., Client/Student Empowerment domain) or advocate on behalf of a client (i.e., Client/Student Advocacy domain; Ratts et al., 2010). In the Client/Student Empowerment domain, counselors seek to educate a client and facilitate strategies and skills that will allow a client to advocate for him or herself. On this same level, in the Client/Student advocacy domain, counselors determine if the advocacy situation requires direct intervention on behalf of a client, which usually occurs when the counselor has access to resources and can overcome barriers that prevent a client from self-advocating (Ratts et al., 2007).

The School/Community level of intervention focuses on matters that are greater than an individual, which includes the Community Collaboration and System Advocacy domains. Ratts et al. (2007) used the term “client community” to refer to the group of individuals experiencing the injustice (p. 15). In the Community Collaboration domain, counselors and clients work together in the community to create an advocacy plan. In the Systems Advocacy domain, counselors identify systemic problems and collect information from the group of individuals to advocate within the system (Lewis et al., 2003; Ratts et al., 2010). Although the Systems domain may involve client experiences, advocacy does not require a client’s involvement.
The Public Arena level of intervention includes the Collective Action, previously identified as Public Information, and Social/Political Advocacy domains. The Collective Action level of intervention differs from the other two levels (i.e., Client/Student and School/Community) in that intervention occurs on a macrolevel, which involves human dignity issues, whereas the other two domains focus on micro level issues (Lewis et al., 2003; Ratts et al., 2010). In the Collective Action domain, counselors collaborate with a client or client community to inform the public of human dignity issues. In addition, counselors advocate by bringing awareness to the macrolevel by publicizing advocacy issues in relevant organizations and media sources. The Social/Political Advocacy domain focuses on recognizing when a client or client community is experiencing issues that require attention at a legislative and policy level.

ACD is an inclusive framework that provides guidelines for advocacy opportunities at the micro and macrolevels. Although minimal research exists on advocacy frameworks related to survivors of child abuse and neglect, the major concepts of the ACD framework promote and facilitate the awareness of advocacy issues that can be utilized with this population. Key components of the ACD framework are empowerment, collaboration, awareness, and education (Lewis et al., 2010; Ratts et al., 2007). Counselors working with child survivors of abuse and neglect can use various approaches for advocacy that can be derived from the ACD framework. All three of ACD’s lower-level domains (i.e., Client/Student Advocacy, Systems Advocacy, and Social/Political Advocacy) entail considerations for clients who are not able to advocate for themselves, such as children with social, emotional, relational, and self-concept developmental issues.
Problem Statement

In 2021, the American Society for the Positive Care of Children revealed that 4.4 million maltreatment reports involved 7.9 million children, which suggest that counselors, especially those working with children, will likely work with children who have experienced some type of physical, sexual, or emotional abuse. Impacts of child abuse and neglect are complex and can lead to a multiplicity of issues including but not limited to attachment issues, post-traumatic stress disorder, early death, health challenges, and social, emotional, and cognitive impairment (Pekarsky, 2020; Spinazzola, 2005; Toth & Manly, 2019; and Van Nieuwenhove et al., 2019). Due to the prevalence of these issues mental health counselors who serve children will likely find themselves addressing these matters and advocating for these survivors of child abuse and neglect. ACA’s Code of Ethics (2014) requires counselor competency regarding advocacy. Counselors who lack advocacy competencies may not be successful in navigating collaboration and advocacy with other professionals and state agencies (Lating & Barnett, 2009; Meyers, 2014; Swenson & Spratt, 2000). Without sufficient knowledge of how to advocate effectively, counselors may make errors and act unethically, such as making professional claims outside of their professional purview or breach confidentiality in an effort to advocate for minors (Lating et al., 2009; Swenson & Spratt, 2000).

Overview of Methods and Research Questions

Qualitative research seeks to understand and interpret experiences of participants by giving voice to and empowering participants to share their stories (Creswell, 2013; Merriam, 2009). Additional features of qualitative research include the use of the researcher as the main instrument to collect and analyze data and use multiple data collection methods within natural settings (Creswell, 2013; Merriam, 2009). Characteristics, such as the focus of the research,
problem types, and analysis strategies differentiate various qualitative research approaches. In a qualitative phenomenological approach to research, data is reduced to a common phenomenon that reveals a clear understanding of participants’ experiences. The phenomenological methodology includes four major steps: bracketing, intuiting, analyzing, and describing. Bracketing is the process by which the researcher’s assumptions concerning the phenomenon are contained to produce data in the purest form. Intuiting is where the researcher focuses on the meaning if the phenomenon and provides the variance of the data until a common understanding derives. The researcher accomplishes analyzing through coding which requires categorizing the data to make sense of the meaning. Analyzing through coding leads to the emergence of essence and universal themes. The final step of describing requires the researcher to define the phenomenon based on the comprehension produced through previous steps (Moustakas, 1994; Polkinghorne, 1989). The essence of phenomenology is the “grasp of the very nature of the thing” (Van Manen, 1990, p. 177). A phenomenological approach is most suitable for answering my research questions as I seek to capture the essence of my participants’ advocacy experiences.

Central Question
What are the advocacy experiences of Louisiana LPCs who work with minors who are survivors of child abuse and neglect?

Limitations and Delimitations
In the current research, I explored the advocacy experiences of Louisiana LPCs working with minors who are survivors of child abuse and neglect. In phenomenological research, one limitation is that the data analysis process depends heavily on the researcher, which can involve personal interpretations, biases, and assumptions (Creswell, 2013; Merriam, 2009). A second limitation is that participants may hold certain biases that can limit their perspectives about
working with minors who are survivors of child abuse and neglect. Volpe (2012) identifies a small sample size as a limitation however Goodman-Scott & Cholewa (2021) argue that sample size is not an inherent limitation of qualitative research but rather a function of it to gain a more in-depth account. Sample size would only be a limitation if you fail to get enough participants as recommended by qualitative researchers.

A delimitation of my study is the sample of participants who will be LPCs from Louisiana. The specific sampling pool of LPCs in Louisiana excludes opportunities to explore advocacy experiences of counselors who practice outside of Louisiana.

**Assumptions of the Study**

In the present research, four assumptions will exist regarding the experiences of Louisiana LPCs working with minors who are survivors of child abuse and neglect: (a) participants’ abilities to advocate effectively depends on the quality of their training and educational experience; (b) participants’ failure to collaborate with other professionals involved in a case may lead to a disservice to a client; (c) participants will be honest with their answers; (d) phenomenological design is the best design to answer the research questions.

**Definitions of Terms**

The following terms are significant to my research, and these definitions provide clarity for context of the terms.

**Advocacy** is the promotion of the well-being of individuals, groups, and counseling professionals within various systems and organizations. Advocacy seeks to remove barriers and obstacles that inhibit access, growth, and development (ACA, 2014).

**Advocacy Competency Domains** is a framework for the competency standards adopted by ACA that applies to advocacy actions for both mental health and school counselors. These
competencies are inclusive of three levels and six comprehensive domains spanning across micro and macrolevels (Lewis et al., 2003).

**Advocate** a mental health professional who engages in the promotion of the well-being of their clients as it relates to safety, education, consultation, and removing of barriers that grant access to growth.

**Age of Majority** is the age at which an individual is considered an adult according to a state law. The age of majority in Louisiana is 18. For those under the age of 18, laws regarding legal age dictate certain rights and responsibilities of minors (Louisiana Civil Code Tit. I, Art. 29, Statelaws.findlaw.com, 2019).

**Child Abuse and Neglect** According to the Centers for Disease Control and Prevention (CDCP, 2018), child abuse and neglect is “any act or series of acts of commission [physical abuse, sexual abuse, and psychological abuse] or omission [physical neglect, emotional neglect, medical and dental neglect, educational neglect, in adequate supervision, and exposure to violent environments] by a parent, caregiver, or other person in a custodial role (e.g., clergy, coach, teacher) that results in harm, potential for harm, or threat of harm to a child. A preventable act” (CDC, 2008). According to the Louisiana Law, abuse is defined by any one of the following acts that physically, mentally, or emotionally endanger a child: (a) the infliction, attempted infliction, or, negligence leading to infliction of physical or mental injury upon the child by a parent or any other person; (b) the exploitation or overwork of a child by a parent or any other person, including but not limited to commercial sexual exploitation of the child; or (c) the involvement of a child in any sexual act including pornographic content, a coerced abortion, female genital mutilation, or any sexual activity constituting a crime under the laws (Louisiana Children’s Code Article 603:2).
**Child on Child Sexual Abuse** is “sexual activity between children that occurs without consent, without equality (mentally, physically, or in age), or as a result of physical or emotional coercion. What this means is that a power difference exists between the two children, whether that is in age, size, or ability” (DefendInnocence.org, 2019).

**Competence** is the “habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served” (Epstein & Hundert, 2002, p. 226).

**Interdisciplinary Team** refers to a group of professionals serving mutual clients. The professionals may not all share the common responsibility of confidentiality (ACA, 2014). Such professionals include but are not limited to counselors, social workers, psychologists, psychiatrists, and child protection workers.

**Maltreatment** is a behavior toward a child that is outside of conduct norms and entails substantial risk of causing physical or emotional harm” (Pekarsky, A. R., 2020, Merk Manuals).

**Role Conflict** is the simultaneous occurrence of two or more role pressures so that the compliance with one role makes it more difficult to comply with the other role (Kahn et al., 1964).

**Survivor** is a term used in the place of victim and for an individual who lived beyond the experience of sexual, physical, or emotional abuse. Survivor implies progression and is an empowering term that honors the strength of the individual who experienced trauma (Kelly, 1988).

**Trauma** is a disturbing or deeply distressing event that leads to an emotional and psychological response (Center for Anxiety and Mood Disorders, 2017; Department of Mental Health, 2019; Perry & Azad, 1999; Pfefferbaum, 1997).
Chapter Summary

In the first chapter, the key components that serve as a foundation for the present research study were described including the overview, purpose of the study, significance of the study, conceptual framework, and statement of the problem. Additionally, an overview of the research methods and questions were provided. The final sections included an explanation of limitations and delimitations of the research study, assumptions of the research study, and definitions of the key terms.
Chapter II

Literature Review

The purpose of Chapter II is to review the existing literature about the advocacy experiences of counselors who serve minors who are survivors of child abuse and neglect. Pertinent topics will include effects, trends, and treatment of child abuse and neglect. The chapter entails the review of mandatory reporters, history of advocacy within the mental health field, definitions of advocacy, and the Advocacy Competency Domains (ACD) framework. The conclusion of the chapter entails major points involving collaboration, legal and ethical considerations for counselors serving minors who are survivors of child abuse and neglect.

Children

According to the Louisiana Civil Code Title I, Article 29, a minor is an individual who has not reached the age of majority, which is 18. However, various rights are considered for minors at certain ages including eligibility of emancipation, ability to sue, and consent to some types of medical treatment (Louisiana Civil Code Title VIII, of Minors, of their Tutorship, Chap. 2 Emancipation, Art. 366; Louisiana Civil Code Tit. VIII, , 2017). In most cases in Louisiana, parents or legal guardians are considered the personal representatives of minors. Personal representatives have many rights regarding minors including access to their medical records.

Additionally, and related to minors’ rights is the Health Insurance Portability and Accountability Act (HIPAA, 1996) that encompasses federally mandated laws to protect individuals’ confidentiality. Included in HIPAA are situations in which the privacy rule prevents parents or guardians from being a minor’s representative. HIPAA complements the Louisiana law regarding children’s rights. For example, Louisiana law 45 C.F.R. 502(g)(3)(i) allows minors to consent to their own treatment for the purposes of pregnancy or childbirth. In cases
when professionals have a reasonable belief of parental abuse, neglect, or endangerment; HIPAA mandates that regardless of state laws, professionals may withhold records from a minor client’s personal representative for the minor client’s best interest (45 C.F.R. 502(g)(5)).

**Childhood Abuse and Neglect**

Detailed specifications explaining the context of child abuse and neglect are included in the literature. According to the Centers for Disease Control and Prevention the definition of child abuse and neglect is “any act or series of acts of commission or omission by a parent, caregiver, or another person in a custodial role [e.g., clergy, coach, teacher] that results in harm, potential for harm, or threat of harm to a child. A preventable act” (CDC, 2021). According to the law in Louisiana, child abuse is defined as by any one of the following acts that physically, mentally, or emotionally endanger a child: (a) the infliction, attempted infliction, or, negligence leading to infliction of physical or mental injury upon the child by a parent or any other person; (b) the exploitation or overwork of a child by a parent or any other person, including but not limited to commercial sexual exploitation of the child; or (c) the involvement of a child in any sexual act including pornographic content, a coerced abortion, female genital mutilation, or any sexual activity constituting a crime under the laws (Louisiana Children’s Code Article 603:2). Additionally, Child abuse and neglect are preventable and Safe, stable, and nurturing relationships and environments are key for prevention (CDC, 2021).

Two phrases associated with the child abuse and neglect definition are acts of commission and act of omission. Mogaddam et al., (2015) described as acts of commission as intentional harming of a child, such as, “the intentional use of physical force;” (p.1). Acts of omission are based on failure of a caregiver to provide life-sustaining resources” (Mogaddam et al., 2015, p. 1). Maltreatment, another term closely related to child abuse and neglect, is defined
as “a behavior toward a child that is outside the norms of conduct and entails substantial risk of causing physical or emotional harm” (Pekarsky, 2018). Also, the definition of maltreatment varies among states and is based on an individual state’s definition of abuse and neglect (DHHS, 2018).

Types of child abuse and neglect include physical, sexual, and emotional (psychological) (Department of Children and Family Services, DCFS, 2018; Perkarsky, 2018). Physical abuse by an adult of a child involves inflicting or attempting to inflict physical harm or putting a child at high risk of physical harm that includes but is not limited to such actions as shaking, dropping, striking, or burning (DCFS, 2018; Perkarsky, 2018). Child sexual abuse is when an adult involves a child in any sexual act for the purpose of sexual gratification, exposes the child to pornography, performs coerced abortion, or female genital mutilation (DCFS, 2018; Louisiana Children’s Code Tit. VI, Art. 603.2, 2019; Perkarsky, 2018). Emotional abuse by an adult, also referred to as psychological abuse, involves the use of words or actions to inflict emotional harm to a child. Common examples of emotional abuse include yelling, berating, and terrorizing (Perkarsky, 2018). Neglect by an adult is failure to provide or meet a child’s basic needs (e.g., food, clothing, shelter, emotional support, affection, education, and appropriate medical treatment). Childhood abuse, neglect, and maltreatment are associated with long-term adverse effects of children, such as fear and stress, as well as impaired psychological development, emotional dysregulation, and delayed school readiness (Gunnar & Donzella, 2002; Rogosch et al., 1995; Skowron et al., 2010).

Rates and Trends of Abuse and Neglect

In 2018, forensic interviewers working in Louisiana Children’s Advocacy Centers (CACs) interviewed 5,679 children. Of those children, 58.3% reported sexual abuse, 20.7%
physical abuse, 4.2% neglect, 9% violence, and 1.3% drug endangerment. Of those children, 4,590 were referred for counseling services (https://www.lacacs.org/learn-more). The children who received counseling often presented with Post-Traumatic Stress Disorder (PTSD) symptoms (Louisiana CACs, 2018). The Child Trends (2019) report, produced by the Children’s Bureau an office of the Administration for Children and Families of the United States Department of Health and Human Services (DHHS), highlighted trends of abuse and neglect in the United States from 1990 to 2017 (Child Trends) Child maltreatment cases in the United States began to significantly drop in 1990 and leveled off from 2005 to 2017. One consistent theme in DHHS’ report was that young children have higher rates of abuse and neglect than older children. In 2017, children younger than the age of 1 were three times more likely to experience abuse and neglect than 16- or 17-year-olds. Statistics across the United States showed that the abuse and neglect rate for children ages 3 years and younger, was 15 in 1,000; 4 to 7 years, 10 in 1,000; 8 to 11 years, 7 in 1,000; 12 to 15 years, 7 in 1,000; and 16 to 17 years, 5 in 1,000. Also reported in the Child Trends (2018) was that 48.6% of child abuse and neglect survivors were male and 51.0% were female. Neglect is the most common form of maltreatment, with physical abuse as the second highest, followed by sexual abuse, and last, psychological or emotional abuse (Administration for Children and Families, ACF, https://www.acf.hhs.gov/cb/resource/child-maltreatment-2018).

In 2018, the National Child and Trauma Stress Network (NCTSN) identified six populations most at risk of childhood trauma and repeated victimization as: (a) youth who engage in substance use and those whose caregivers abuse substances; (b) youth of families experiencing economic stress; (c) youth of military and veteran families; d) youth with intellectual and developmental disabilities; (e) youth who are homeless; and (f) youth who are lesbian, gay, bisexual, transgender, or queer (NCTSN, 2012). Risk factor often occur
simultaneously placing children at a greater risk for child abuse and neglect (Child Welfare Information Gateway, 2021; Vial, van der Put, Stams, Kossakowski, & Assink, 2020). According to Child Welfare Information Gateway (2021) co-occurring factors include family factors, community conditions, and parent and child conditions. Vial et al. (2020) identified significant risk factors as childhood maltreatment of the caregiver, history of domestic violence, and when the caregiver is emotionally absent. However, as described in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5, 2013), experiencing a traumatic event such as abuse and neglect does not always result in traumatization, PTSD, or complex trauma and it is unclear how many children actually develop PTSD as a result of their traumatic experiences (DSM, 2013; NCTSN, 2012; Recognizetrauma.org).

Child abuse and neglect occurs least in Non-Hispanic Asian cultures and most in American Indian, Alaskan Native, and African American cultures. As noted in the child abuse and neglect DCFS (2019) standards, professionals should consider culture when assessing children. For example, in a life-threatening situation, such as a child needing a blood transfusion, parents may have the right to refuse medical treatment due to religious beliefs. Although boundaries between culturally acceptable behaviors and abuse can vary, extreme situations still constitute abuse (e.g., female genital mutilation; DCFS, 2019; Merk Manual, 2018). Another cultural consideration in relation to child abuse and neglect is race and ethnicity. Sedlack et al. (2010) and Zolotor et al. (2011) indicated in their research that black and Hispanic children experience abuse and neglect at a higher rate than the general population. Sedlack et al. (2010) conducted a 3-month national needs assessment on child abuse and neglect in 122 counties across the United States that was comprised of 126 child protection service agencies. The rates of abuse and neglect were significantly higher for Black children than White and Hispanic children.
Sedlack et al. (2010) also found that children with disabilities had lower rates of physical abuse and significantly higher rates of serious injury or harm and emotional neglect.

Living arrangements are a determinant for childhood abuse and neglect. Lack of parental employment and low socioeconomic status contributed to higher rates of abuse and neglect. According to a review of literature by Sedlak et al. (2010), children with unemployed parents experienced abuse and neglect at approximately two times more than children with employed parents. Children in households with incomes less than $15,000 were three times more likely to be abused and seven times more likely to experience neglect than those in higher income homes. Children living in impoverished families are five times more likely to experience abuse and neglect than other children. Also, Sedlak et al. (2010) found that children who are placed in foster care may continue to experience abuse and neglect at the hands of their foster parents, who are burdened with multiple foster children without sufficient financial, emotional, or social support.

In research by Riebschleger, Day, and Damashek (2015), the testimony of 43 individuals between the ages of 15 to 23 who had been in foster care was obtained. Participants reported nine different types of traumatic experiences that occurred while in foster care including child abandonment, sexual abuse, physical abuse, emotional abuse, violence in the home, frequent living arrangement changes, inability to maintain contact with family members, disrupted adoptions, and forced medications. Three themes arose from their research. First, trauma before, during, and after foster care placement included child abandonment, violence in the home, absence of visits with family members, as well as physical, sexual, and emotional abuse. Second, trauma events and chronic situations were described as intense, composite, and cumulative such as rape and murder. Finally, suggestions were to reduce traumatic experiences for children in
foster care that included earlier intervention, better foster home placements, access to caring adults, improved training for foster care parents, increased continuity of relationships, and opportunities for youth participation in leadership activities. Additionally, children in foster care who experience abuse and neglect multiple times are more likely to experience long-term mental, emotional, and behavioral consequences (Berzenski & Yates, 2011; Hazen et al., 2009).

Corporal punishment and physical abuse trends with 3- to 11-year-old children in the United States were analyzed by Zolotor et al. (2011) using the results of four research studies spanning from 1975 to 2002; Theodore et al. (2005), Straus and Gelles (1976a, 1976b), and the Gallup News Service Poll (1995). Theodore et al. (2005) used the anonymous Carolina Survey of Abuse in Family Environments telephone interviews with 1,435 mothers that obtained a response rate of 52%. The Straus and Gelles (1975) study had a sample size of 1,139 parents with a response rate of 65% and the 1985 study had a sample size of 3,360 with a response rate of 84%. The 1975 study included two-parent households, whereas the Straus and Gelles (1985) study included single parent households. The Gallup Poll (1995) study had a sample size of 1,000 parents and the response rate was 81%. The researchers conducted telephone interviews using the Gallup Poll and the National Family Violence Surveys. In all four research studies, the total sample size was 6,934 parents from four cross-sectional populations. From 1975 to 2002, corporal punishment without an object/weapon declined 18% and corporal punishment with an object declined 35%. Actions beyond spanking or slapping was identified as physical abuse, which included kicking, biting, hitting, burning and scalding. Based on the four studies, Zolotor et al (2011) found that despite an overall decrease in corporal punishment, spanking and hitting preschool-aged children remained a part of normal parenting behavior. Later works by Zolotor
(2014) continued to reflect abusive impacts of corporal punishment and the correlation to physical abuse.

**Results of Abuse and Neglect: Trauma**

Child abuse and neglect can result in trauma, which is defined as a disturbing or deeply distressing event that leads to an emotional and psychological response (Center for Anxiety and Mood Disorders, 2017; Perry & Azad, 1999; Pfefferbaum, 1997). Trauma resulting from a single incident is known as acute trauma, whereas repeated and prolonged exposure to trauma (e.g., domestic violence or physical abuse) is known as chronic trauma (The Center for Treatment of Anxiety and Mood Disorders, 2017). And, complex trauma is when an individual experiences repeated exposure to various types of traumas.

The effects of childhood trauma such as abuse and neglect are vast and often carry over into adulthood (Meeker, Connor, Kelly, Hodgeman, Scheel-Jones, & Berbary, 2021; Messina & Grelle, 2006; Sansone et al.; 2011; Van Nieuwenhove et al., 2019). Using semi-structured psychiatric interviews over a six-month period with 68 young adults, Morris et al. (2014) found a direct correlation between childhood trauma and dysfunctional attitudes, maladaptive coping skills, and depressive symptoms. Common emotional and psychological symptoms were flashbacks, dissociation, altered sense of shame, unpredictable emotions, intense feelings of guilt, inability to focus, and feelings of isolation and hopelessness. In another research study, prolonged exposure to interpersonal trauma caused by childhood sexual, physical, and psychological abuse leads to more detrimental psychological effects than non-interpersonal trauma, such as car accidents or natural disasters (Ehring & Quack, 2010).

Childhood traumatic experiences including abuse and neglect affect an individual’s emotional well-being and relation to the world (Hodgdon et al., 2013). Sansone et al. (2011) used
a cross-sectional sample of 250 survivors of childhood trauma and found a positive association between various forms of trauma and a diagnosis of borderline personality disorder. Later in 2019, a case study by Van Nieuwenhove et al. substantiated the impacts of childhood trauma on emotional confidence and the ability of children to develop relationships. They assessed a 26-year-old female with a history of childhood physical and psychological abuse perpetrated by her father while her mother remained a non-protective witness. Emotional challenges caused by her childhood abuse, such as insecurity, fear, anxiety, anger, shame, and emotional dysregulation, impacted her therapeutic and other relationships. The researchers concluded that when treating trauma, dominant interpersonal patterns should be addressed through interpersonal and emotional challenges during the therapeutic process. Meeker et al. (2021) researched the impact of adverse childhood experiences (ACEs), also known as traumatic experiences, on adolescents. In alignment with the studies above the researchers found that multiple ACEs lead to greater likelihood of mental health challenges, substance use, suicidality, and aggression.

In addition to emotional and mental health concerns arising from childhood trauma, survivors may present with medical issues (Harris, 2018; Mulvihill, 2005; Perry & Azad, 1999). Physical effects of childhood trauma caused by abuse and neglect can include stomachaches, headaches, hyperactivity, encopresis, and enuresis (Harris, 2018; Perry & Azad, 1999), which increases the risk of health issues for children related to their brain development, immune system, and hormonal system as well as how their DNA is read and transcribed (Harris, 2018; Meyers, 2014; Sansone & Sansone, 2007; Sansone et al., 2011). A research study conducted by Messina and Grelle (2006), with a convenience sample of 500 incarcerated women who experienced childhood trauma, indicated that abuse and neglect were a risk factor for medical problems during adulthood including high blood pressure, heart issues, and ulcers. A systematic review
and meta-analysis found that individuals with associated with multiple ACES reported increased risks of physical health conditions (Hughes, Bellis, Sethi, Buchart, Mikton, Jones, and Dunne, 2017). Additionally, childhood trauma can lead to adverse experiences such as ischemic heart disease, liver and lung disease, and cancer (Perry & Azad, 1999).

**Abuse and Neglect Treatment**

Multiple modalities have been evaluated for treatment of individuals with trauma resulting from childhood abuse and neglect. An initiative by Kramer et al. (2015) involving more than 2,500 professionals who participated in a trauma-informed training based on best practices led to effective treatment of children, improved networking among agencies, enhanced monitoring of outcomes, and improved referrals and services for children who were exposed to trauma. Limitations of their initiative were that the program evaluations were based on pre-implementation measures, however, follow-up practices were not implemented with fidelity and long-lasting organizational change and strategies were not evaluated.

Leenarts et. al (2013) completed a systemic review of evidenced-based treatment methods for children exposed to abuse and maltreatment. The review involved seven non-randomized control clinical trials and 26 randomized controlled clinical trials. Their research involved various aspects of abuse and maltreatment with considerations for gender, age, and abuse or maltreatment types. The treatment interventions involved in the review included but were not limited to eye movement desensitization and reprocessing (EMDR), trauma focused-cognitive behavioral therapy (TF-CBT), cognitive behavioral therapy (CBT) group therapies, and child-parent psychotherapy. The results suggested that TF-CBT is the best supported treatment for children who have experienced maltreatment. Five of the research studies in Leenarts et. al (2013) review specifically evaluated the use and effectiveness of TF-CBT. The child and a non-
offending caregiver completed eight sessions that involved psychoeducation and creation of a trauma narrative. The use of TF-CBT in this manner effectively reduced abuse-related fear and anxiety. Considering the complexities of clients who experience PTSD and aggressive or violent behavior, the researchers suggested that clinicians consider a phase-oriented approach: (1) stabilization, (2) resolution of traumatic memory, and (3) personality reintegration and rehabilitation (Leenarts et. al, 2013).

TF-CBT encompasses 11 modules that are designed to educate and help children process their trauma. The process involves psycho education for the child and the non-offending caregiver. A major component of the treatment is creating a trauma narrative. Although the target population for TF-CBT is ages 3 to 21, TF-CBT has only been proven effective for ages 3 to 18. TF-CBT has been proven to be effective for both single traumatic incidents and complex trauma (Allen & Johnson, 2011; Allen et al., 2012; Medical University of South Carolina, 2017; NCTSN, 2012).

Another common modality used to treat childhood trauma is play therapy. Play therapy is a systemic, theory-based modality that involves interpersonal processing with a trained play therapist, which allows children to resolve psychosocial, emotional, and behavioral concerns through the therapeutic powers of play (Association of Play Therapy, 1997; Reedy et al., 2005). Landreth (2001) stated that "children communicate their unconscious feelings through play and utilize available toys and materials as symbols to express the feelings of which they may not be aware at that time" (p. 8). Play therapy is most appropriate for children ages 2 to 12 years; however, play therapy has also been used effectively with older clients (Landreth, 2001; Reddy et al., 2005). Post traumatic play therapy, child-centered play therapy, and cognitive behavioral play therapy that involve repetitive play decrease anxiety in children and allows children to take
the therapeutic experience where they need to be, which challenges children’s thoughts (Association for Play Therapy, 1997; Gill, 1991; Landreth, 2002; Terr, 1983).

Child centered play therapy (CCPT) and the use of toys for personal expression is shown to be developmentally appropriate and effective for children who have experienced trauma and adverse childhood experiences. Parker, Smelser and Kelly (2021) completed a meta-analysis to explore the biases across research and gaps in literature regarding significant outcomes utilizing CCPT for children with a history of trauma. The meta-analysis involved the use of 32 between-group design research studies exploring CCPT and children with a history of trauma. The author assessed research quality and biases. The author identified play therapy as evidence-based, a way for children to make meaning of the world, and a method to develop a sense of safety and trust. All of these factors are significant for therapeutic trauma work. A number of studies addressed in this meta-analysis identified a significant decrease of PTSD symptoms as a result of play therapy treatment. The research presented a 64% decrease in externalizing behaviors and a 36% decrease in internalizing behaviors. Parker, Smelser and Kelly, (2021) noted that despite multiple studies noting the effectiveness of CCPT with children who have a history of trauma, play therapy is often excluded from numerous meta-analyses in current literature.

Green and Myrick (2014) developed a phase-based, integrative approach for play therapists when treating complex trauma in adolescents. The first phase involves safety and stabilization, reduction of self-destructive behaviors, psychoeducation to manage symptoms, engagement in self-care, and regulation of stress and destructive impulses. Play-based activities in the first phase involve drawing and hypothetical game questions. The second or trauma processing phase allows children to address their cognitive distortions and misattributions in the form of trauma narratives and non-verbal expressive art. The final phase is the reconnection and
reintegrative phase. The goals in phase three are to enhance positive affect and address more individualized goals, such as identity or spiritual development, which can involve mandalas, board games, music, and competitive yet cooperative play.

Trust-based relational intervention (TBRI) is a therapeutic model that trains caregivers to provide effective support for at-risk children including those affected by trauma. The three foundational principles of TBRI are empowerment (i.e., attention to physical needs), connection (i.e., attention to attachment needs), and correction (i.e., attention to behavioral needs; Purvis et al., 2013). TBRI has been applied in places such as foster care systems, courts, orphanages, and residential treatment facilities. Although not as effective as TF-CBT, TBRI is appropriate for children and youth of all ages. Howard Parris, Nielsen, Lusk, Bush, Purvis and Cross (2013) completed a preliminary study investigating the effects of implementing TBRI. The researchers reviewed 167 child welfare adoption cases opened between 2011 and 2013. There were 89 participants between ages 4 and 18. These children were also receiving therapy in an outpatient setting. TBRI was taught to the caregivers. Two scales, developed for this study, were used to measure outcomes. The results identified a significant decrease in psychiatric problems for children with implementation, especially for children whose caregivers were more invested. For caregivers, there was a greater decrease in stress problems with parents who were more invested in the implementation of TBRI than those who were not. There was also a greater decrease in stress for parents of children who did not have a history of abuse than those children who had experienced abuse. Lastly, caregivers of children who were younger upon entering adoption had a greater decrease in stress problems. While TBRI is an intervention implemented by the caregiver instead counselor, the intervention is an effective evidence-based tool to help children who have experienced child abuse and neglect.
Mandatory Reporters of Abuse and Neglect

Mandatory reporters of child abuse and neglect include health and social service practitioners, counselors, members of clergy, teachers and childcare providers, law enforcement officials, commercial film and photographic processors, family mediators, individuals who work in youth organizations or activity providers, coaches in sports and school settings (DCFS.louisiana.gov, 2019). In an effort to protect children in Louisiana, the Children’s Code Title VI Article 603 requires mandatory reporters to report infliction or attempted infliction of physical or mental injury and exploitation or overwork of children as well as any form of sexual acts or exposure to pornography. Also, to protect children, coerced abortion, pornographic displays, and female genital mutilation are required to be reported by law. In addition to these forms of abuse, mandatory reporters are required to report neglect that involves a caretaker who refuses or fails to provide a child’s basic needs of food, clothing, shelter, emotional support, affection, education, and appropriate medical treatment. Prenatal neglect is also required to be reported per the mandatory reporting laws (DCFS.louisiana.gov, 2019; DHHS, 2018).

A study conducted by Bryant and Milsom (2005) suggested that most school counselors feel confident about their responsibilities as mandatory reporters; however, they desired more training. The researchers performed a mixed methods nationwide study in which they examined 193 school counselors’ perceptions and experiences of mandatory reporting. Four major themes emerged: (1) concern for the effectiveness of the mandatory reporting process, (2) frustrations of working with child protection agencies (3) specific challenges such as dealing with parents following mandated reports, and (4) frustrations and difficulty of mandatory reports leading to actual investigations. Although many of the school counselors believed mandatory reporting trainings were beneficial, they believed continued training is needed to help children and families
affected by child abuse to identify possible emotional and sexual abuse. There is a need for additional mandatory reporter training for school counselors and LPCs just as there is also a need for education and training on treatment, advocacy, and professional collaboration efforts.

**Education and Training**

Spinazzola et al. (2005) reported that nationally 78% of children on 118 clinicians’ caseloads had been exposed to multiple and prolonged trauma such as abuse and neglect. Considering the probability of exposure to child abuse and neglect and the resulting trauma, counselors must be able to competently treat children who experience trauma (ACA, 2014; Donisch et al., 2016; Kramer et. al, 2015). Counselors serving this population can retraumatize abused or neglected children if they do not have proper training (Cooper et al., 2007).

In 1987 laws were passed requiring LPCs to meet specific requirements including graduate counseling education and supervision. These laws developed as part of the Mental Health Counselor Licensing Act (LPCBoard.org) In Louisiana, LPCs who are licensed through the Louisiana Licensed Professional Board of Examiners, work in various settings such as community agencies and schools. LPC licensure requires a minimum 3,000 hours of post-master’s supervised experience including 1,900 direct client contact hours, 1,000 indirect hours, and 100 face-to-face supervision hours (LPC Board [https://www.lpcboard.org/application](https://www.lpcboard.org/application)). Louisiana school counselors are not required to be licensed but those who work in state schools are required to be certified and must adhere to the standards set by the State Department of Education and the board of Elementary and Secondary Education ([LPC Board](https://www.lpcboard.org/application)).
Counselors, Law, and Ethics

Although counseling is the main role of counselors, they are obligated to uphold a plethora of responsibilities and must do so in the confines of their state and federal laws and their code of ethics. Although, both the ACA’s *Code of Ethics* (2014) and ASCA’s Ethical Standards for School Counselors (2016) are designed to do what is in the best interest of clients, some of the principles such as confidentiality and mandatory reporting may help or hinder advocacy efforts. For example, breaking confidentiality to report child abuse upholds the principal beneficence but violates the principle of autonomy if the child does not want the counselor to report. As advocates, counselors must be willing to reconcile these inner ethical and legal dialogues. Ledyard (1998) stressed that counselors should seek legal consultation when needed because state laws and ethical codes are complex, and these complexities are unwavering (Wheeler and Bertram, 2015). Counselors are obligated to uphold their ethical and legal responsibilities although “for many practicing MHPs and graduate students, the legal system is a foreign and sometimes frightening place” (Wheeler & Bertram, 2015, p. 1). When counselors provide counseling services to minors, ethical and legal challenges can result from issues surrounding confidentiality and privileged communication. Both confidentiality and privileged communication are included in ACA’s (2014) ethical code.

Confidentiality

ACA’s (2014) ethical code clearly indicates confidentiality is a professional obligation of counselors. Confidentiality is part of the informed consent process in which clients are informed of a counselor’s confidential responsibilities. Standard B.1.c. states that “counselors [should] protect the confidential information of perspective and current clients. Counselors [should] disclose information only with appropriate consent or with sound legal or ethical justification”
(p. 7) and Standard B.5.b directs counselors to educate parents or guardians on the role of counselors and the details of confidentiality as well as “…establish as appropriate, collaborative relationships with parents or guardians to best serve [minor] clients” (p. 7). As part of the informed consent process, counselors should inform minors of their confidentiality and privacy rights (ACA, 2014; Dansby-Gile, 2014; Remley & Herlihy, 2014; Taylor & Adelman, 1998). Although the ethical standard regarding confidentiality involves parents or guardians, counselors also have an ethical responsibility to obtain a minor’s permission before releasing information (Herlihy & Corey, 2015; Taylor & Adelman, 1998).

The consideration of confidentiality is complex when working with minors. For example, the ACA Ethical Standards Case Book (2015) contains a case that involves a legal guardian’s request for sexual orientation of a 13-year-old girl. In accordance with ACA Code of Ethics (2014) Standard B.5.a, the counselor consulted with an attorney and subsequently protected the minor client’s confidential information, despite threats from the legal guardian to file complaints. The counselor did not turn over the counseling records with the understanding that the courts could supersede Standard B.2 since the ACA Code of Ethics is not a legal document (Herlihy & Corey, 2015).

The legal rights of minors are separate from those of their parents or legal guardians, which adds to the complexity of laws and ethical codes (Remley & Herlihy, 2014). Counselors who work with minors often feel pulled between responsibilities for their minor clients and the adults involved in these clients’ lives (e.g., parents, teachers, MHPs). For example, counselors who work with teenagers may have concerns related to teenage pregnancy. Herlihy and Corey (2015) presented the case of a school counselor working with a 17-year-old female who was six weeks pregnant and did not want to inform her mother because she was uncertain whether she
wanted to have an abortion. Multiple concerns surfaced as the counselor considered the ethical dilemma as well as his own personal values, the well-being of client, the well-being of the unborn child, and the uncertainty of his ethical and legal obligations to inform the client’s parents. The counselor chose to consult with another counselor at the school that he worked and requested a meeting with the school’s attorney to explore his obligations and options further. As a result, the counselor took necessary precautions and considered risk factors before making any professional decisions regarding the legal rights and ethical disclosures.

Counselors serving minors in schools may face additional complexities regarding confidentiality. School counselors who receive federal funding are governed by privacy laws based on the Family Educational Rights and Privacy Act of 1974 (FERPA). FERPA allows school counselors to “exercise discretion regarding the personal and confidential records released to parents” (Anderson, 1996, p. 34). In cases in which counselors choose to withhold a minor’s confidential information from a parent, FERPA protects counselors except for duty to uphold a school board policy (Anderson, 1996).

Confidentiality is also a part of the informed consent process in which counselors inform clients of their duty to warn. Duty to warn is an ethical responsibility but can also lead to legal issues if informed consent is not handled appropriately (ACA, 2014; Remley & Herlihy, 2014; Wheeler & Bertram, 2015). Although counselors are ethically obligated to maintain protection of client information, protection does not apply in cases of serious and foreseeable harm and legal requirements (ACA, 2014; Taylor & Adelman, 1998). Hendrix (1991) stated that the law supersedes ethical standards in cases of abuse, harm to self, and a plan to do harm to other(s). Another exception to confidentiality is a court order for release of counseling records; if counselors object, they can be found in contempt of court (Salo & Shumate, 1993).
Privileged Communication

Privileged communication protects clients from disclosure of their confidential information by counselors (Hendrix, 1991; Jacob & Powers, 2009). Standard B.2.d. of the ACA Code of Ethics (2014) details specific information on counselors’ responsibilities to seek their clients’ permission and obtain written consent when counselors are court-ordered to release privileged information. Hall and Lin (1995) agreed that privileged communication is a challenge for counselors regarding the rights of children versus their parents or guardians. “Privacy rights are generally seen as an extension of the parents’ rights to privacy; minors do not hold these rights in isolation from their parents” (Salo & Shumate, 1992, p. 28). However, minors have constitutional rights to privacy (Boomer, Hartshorne, & Robertshaw, 1995). Due to a lack of knowledge as well as the complexity surrounding privileged communication, counselors at times unknowingly violate children’s rights, which can negatively affect the counseling relationship and place the counselor at risk for legal ramifications (Hall & Lin, 1995; Wheeler & Bertram, 2015).

Failure of counselors to adhere to ethical and legal professional responsibilities can result in four legal consequences: (a) negligence (i.e., unintentional tort), (b) malpractice, (c) intentional torts, and (d) criminal action. Negligence involves four elements: (a) duty, (b) breach, (c) causation, and (d) damages (Wheeler and Bertram, 2015). Wheeler and Bertam (2015) defined negligence as “the unintentional violation of an obligation one person owes to another… and “failing to follow all requirements of a protective statute” (p. 62). The risk of negligence is reduced when counselors follow sections A (i.e., Counseling Relationship), B (i.e., Confidentiality and Privacy), and C (i.e., Professional Responsibility) of the ACA Code of Ethics (2014). The second legal concern, malpractice. The is when a professional is negligent in that he
or she deviates from the accepted professional standard causing injury or harm to party receiving services (Walker, Shapiro, & Akl, 2020). Malpractice is a term that is often connected to civil suits against professional counselors. Malpractice is regulated by state law and typically only applies within the state where professionals are licensed or certified (Wheeler & Bertram, 2015). The third legal concern, intentional tort can involve the counselor engaging in direct or intentional violation of a person’s legal rights. Examples of intentional torts include but are not limited to assault, battery, infliction of emotional distress, and defamation of character. Finally, although rare, professional counselors can face criminal actions (Remley & Herlihy, 2014; Wheeler & Bertram, 2015), such as not reporting child sexual abuse or neglect, contributing to delinquency of a minor, or committing sexual misconduct or insurance fraud.

In order to avoid legal complications, counselors must practice competently (Corey, Corey, & Callanan, 2015; Wheeler & Bertram, 2015). Corey et al. (2015) stated that “striving for competence is a lifelong endeavor” (p. 304). Wheeler and Bertram (2015) added that competence involves responsibilities such as training, skills, education, consultation, and referrals (Welfel, 2013), which are supported by ACA’s Code of Ethics as well as regulatory boards such as accreditation organizations and licensure boards. While counselors may not be able to avoid frivolous legal claims that are related to competency, counselors can minimize legal ramifications by practicing ethically, maintaining appropriate relationships with clients, and upholding the foundational principles in ACA’s Code of Ethics (2014) such as autonomy, nonmaleficence, beneficence, justice, fidelity, and veracity (Wheeler & Bertram, 2015).

**Advocacy**

In the late 1900s, the concepts of social advocacy and activism emerged. Events such as the Great Depression, Industrial Revolution, Vietnam war and World Wars I and II led to needed
changes in society (Smith et al., 2009b). In 1908, Clifford Beers and Frank Parsons developed the term social justice advocacy (Kiselica & Robinson, 2001). Beers published an autobiography after his personal and horrific experience in a psychiatric hospital. His book paved the way for the mental hygiene movement that raised awareness of mental illness and promoted humane treatment for those with mental illnesses (Tenety & Kiselica, 2000). Other advocacy efforts included actions taken for immigrant families spearheaded by Parsons, the founder of the Boston Vocational Bureau. Kiselica and Robinson’s (2001) extensive timeline depicting significant advocacy efforts that occurred from 1905 to 2000. Each item on the timeline relates to macrolevel issues that involves social change, beginning with the publishing of articles and development of theories to influence policy makers.

An article written by Hays, Green, Orr, and Flowers (2007) identified collaboration as a particularly important element of advocacy in relation to work with female survivors of partner abuse. Additional elements of advocacy include conducting through assessments, encouraging competence of counselors, agencies, community leaders, and systems; and increasing community awareness. Implications for counselor preparation in terms of advocacy include knowledge regarding partner abuse survivors, survivor assessments, and skills to provide partner abuse intervention.

Definitions of Advocacy

Throughout the 1900s, definitions of advocacy evolved and advocacy efforts by influential counselors began. Macro-level advocacy efforts involve general changes that ultimately impact individual clients. The major purposes of macro-level efforts are to advance laws and promote social justice (Ahmedani, 2011; Lewis et al., 2010). Micro-level advocacy differs in that it directly impacts clients. Social advocacy, social justice advocacy, social
advocacy counseling, and public policy advocacy efforts all promote positive change, but differ in scope and are considered macro-level advocacy.

The ACA Code of Ethics (2014) defines advocacy as “promotion of the well-being of individuals, groups, and the counseling profession within systems and organizations. Advocacy seeks to remove barriers and obstacles that inhibit access, growth and development” (p. 20). When referring to advocacy, ACA considers the individual, group, and profession. In contrast, Bradley and Lewis (2000) described advocacy as implementation of environmental change to take action and speak for clients. Erickson (1997) simplified the term of advocacy as the point at which conflict resolution, public relations, and public policy intersect. Barnett (2004) defined advocacy as a process of informing and assisting decision makers, and Myers and Sweeney (2002) defined advocacy as the process or act of arguing or pleading for a cause or proposal to promote social change.

Key actions within advocacy definitions include being aware (Barnett, 2004; Fox, 2008), seeking change for a cause (Myers & Sweeney, 2002), promoting well-being, removing barriers (ACA, 2014), and creating social change (Myers & Sweeney, 2002). These actions and definitions promote client well-being; however, variations among the actions and definitions can cause confusion for professionals. Thus, advocacy can be viewed as “a construct that is broadly conceptualized and open to various interpretations and applications” (Lating et al., 2009, p. 106). “A need [exists] to clearly define and operationalize different types of advocacy and advocating” (Ramirez Steig et al., 2017, p. 196).

Components of Advocacy

The various views and perspectives on advocacy share commonalities. For example, Fran (2014) listed “key ingredients for effective advocacy” that include development of coalitions and
liaisons and involvement of professionals (p. 2). Similarly, Stewart et al. (2009) identified “practical advocacy strategies for psychotherapists,” such as identifying target populations, understanding the problem, setting clear goals, and accessing resources (p. 58). Damashek et al. (2011) included Fran’s key ingredients and Stewart’s strategies in three foundational advocacy components that professionals need; knowledge, skills, and attitudes. Knowledge involves the understanding of professional boundaries and roles, recognition of advocacy opportunities, and identification of target populations including background information and goals for progress. Advocacy skills should be based on collaboration efforts and determination of necessary interventions. The final foundational component, attitudes, considers respect for the profession and other disciplines, willingness to collaborate, and commitment to life-long learning and service (Damashek et al., 2011). Fran (2014) also identified perseverance as essential for a proper advocacy attitude and noted that effective advocacy requires relentlessness and the ability to break through barriers during a sustained period of challenges. In agreement, the ACA Code of Ethics (2014) identified attitudes related to advocacy as an important component that facilitates change.

Counselor advocacy and collaboration extend into counseling practices within school settings. Ratts and Hutchins (2009) explore the necessity for advocacy within the school setting and stated that sometimes the issue is the system and not the individual. The authors further communicate a need for the counseling profession to clarify implementation of social justice advocacy in school settings. During exploration of the ACD framework the authors discuss the importance of collaboration and systems advocacy. In 2016, the American School Counselor Association (ASCA) revised their standards and competencies for school counselors, who are now required to collaborate and share information with other professionals and colleagues.
Collaboration is a major factor of advocacy and is presented across various disciplines. Barnett et al. (2011) highlighted the role of counselors as social justice advocates when addressing child abuse and neglect. They stated that “counselors are ultimately called to collaborate with stakeholders” to ensure that the needs of children who are maltreated are met (Barnett et al., 2011, p. 90). Lambie (2005) developed a four-step model promoting systemic school advocacy interventions and coordination as well as comprehensive responses for support of children and families with varying developmental needs. The collaborative model entails completing an initial assessment, educating school personnel, restructuring family-school interactional patterns, and finally evaluating and accommodating to meet needs.

**Professional Counseling and ACA’s Code of Ethics**

Advocating for clients is one of the many roles and responsibilities of professional counselors (ACA, 2014). Counselors licensed by the Louisiana Board of Professional Counselors are legally obligated to follow the licensing laws ([https://www.lpcboard.org/rules](https://www.lpcboard.org/rules)), and those who are members of LCA and ACA are expected to follow the ACA Code of Ethics (2014). Included in the code is information regarding the process of ethical complaints, ethical obligations, professional considerations and responsibilities, and expectations of professional conduct. In addition, the code requires counselors to advocate for clients when necessary by seeking to “remove barriers and obstacles that inhibit access, growth and development” (ACA, 2014, p. 20). Advocacy involves efforts at the macrolevel for the profession, groups, and organizations and at the micro level for clients. Section A.7 of the ACA Code of Ethics (2014) specifically addresses “Advocacy” and “Confidentiality and Advocacy” (p. 5). The code also addresses other matters related to advocacy efforts including client welfare, court-ordered
disclosure, client and counselor relationships, interdisciplinary teamwork, and ethical obligations.

In 2000, ACA’s president commissioned a task force to seek avenues that would make social justice advocacy an essential part of the counseling profession. This initiative arose from advocacy concerns related to students and environmental problems in society. The goal of the task force was to develop a framework that heightened school counselors’ awareness of the oppression of certain individuals in society. As a result of the task force, an inclusive framework, the Advocacy Competency Domains (Lewis et al., 2002) was developed and in 2018, the figure depicting the ACD framework was updated by Toporek and Daniels. The framework provides both micro and macrolevel tenets that guide advocacy efforts. As a follow-up, at the ACA National Convention in 2003, the Governing Council endorsed the ACD framework.

**Advocacy Competency Domains**

ACD’s framework is a comprehensive and unique guide that includes six advocacy domains: a) Client/Student Empowerment, b) Client/Student Advocacy, c) Community Collaboration, d) Systems Advocacy, e) Collective Action, and f) Social/Political Advocacy, with three levels of intervention: a) Client/Student, b) School/Community, and c) Public Arena. Each level consists of actions taken by counselors with and on behalf of clients or students. As shown in the figure the levels and domains are surrounded by three arrows. The arrow to the left of the figure reflects the extent of client involvement depicting actions taken on behalf of the client for the lower domains and collaboration with the client for the upper domains. The arrow at the bottom of the figure depicts the level of advocacy intervention starting with the microlevel on the left that progresses to the macrolevel on the right. The final arrow found on the right side of the figure depicts the focus of a counselor’s energy with direct system interventions for the
lower domains and support to client or client groups for the upper domains. Figure 1 provides a visual overview of the framework (Toporek & Daniels, 2018).

**Figure 1 Conceptual Framework**

![Conceptual Framework Diagram](image)


**Level 1: Client/Student.** The first level, Client/Student, involves interventions by counselors regarding an individual client in an individual case. Dinkermeyer and Carlson (2006) state that counselors who advocate on behalf of clients often assume the role of a consultant. Counselors may take action that empowers a client in the Client/Student Empowerment domain or on behalf of a client at the Client/Student Advocacy domain. In the Client/Student
Empowerment domain, counselors seek to educate and facilitate strategies and skills that equips clients to advocate for themselves. The process of empowering individuals can advance them to a position of action (Vera & Speight, 2003). In the Client/Student Advocacy domain, counselors determine if the advocacy situation requires direct intervention on behalf of clients. The counselors’ determination usually occurs when they have access to resources and barriers that prevents client self-advocacy (Lewis et al., 2003).

Lewis et al. (2010) identified specific counselor competencies for the two domains within level one. The Client/Student Empowerment domain has seven competencies that “…involves not only systems change interventions but also implementation of empowerment strategies in direct counseling with individuals, families, and groups” (p. 246). The competencies lead counselors to identify strengths and resources as well as social, political, economic, and cultural factors that impact clients. Clients similarly learn how to advocate for themselves. The competencies for the Client/Advocacy domain, though similar to those of the Client/Student Empowerment domain, involve additional actions taken by the counselor on behalf of clients, such as negotiating services, paving access to resources, and creating action plans with allies to overcome barriers for clients.

**Level 2: School/Community.** The School/Community level focuses on matters greater than the individual, and clients may be involved in advocacy based on their experiences. Lewis et al. (2010) used the term “client community” to refer to the group experiencing the injustice (p. 15). In Level 2 are the Community Collaboration domain, in which counselors and groups work together to create an advocacy plan, and the System Advocacy domain, in which counselors identify systemic problems and collect information from a group that is used to advocate at the system level. The two domains within the School/Community level provide a basis for
counselors to navigate advocacy experiences and a rubric to evaluate and compare their experiences.

The competencies in the Community Collaboration domain are advocacy skills that support systemic change in schools and communities. These competencies lead counselors to identify barriers that stifle client development, make others aware of advocacy issues, unite with groups to offer support, understand goals and resources, and ultimately participate in collaboration efforts. The competencies within the Systems Advocacy domain are similar to those of the Community Collaboration domain, but counselors are more involved in carrying out the advocacy actions. In addition to identifying and making barriers known, counselors develop a “step-by-step plan for implementing the change process” and work towards advocacy efforts despite resistance (Lewis et al., 2010, p. 247).

**Level 3: Public Arena.** In the third level, Public Arena, the Collective Action and Social/Political Advocacy domains focus on informing the public of advocacy issues and counselors acting as “change agents” (Lewis et al., 2010, p. 248). Level 3 differs from the first two levels in that it includes macrolevel interventions involving human dignity issues. In the Collective Action domain, counselors collaborate with the client community (i.e., group) to inform the public of human dignity issues and create approaches to advocate for macrolevel problems through relevant organizations and media sources. In the Social/Political Advocacy domain, efforts are focused on recognizing when a client or community is experiencing issues that require attention at the legislative or policy levels. The Collective Action domain has the fewest competencies (four) of all domains, but they encourage counselors to identify “oppression and other barriers to healthy development” and make the issues known to the public by developing and disseminating information through multimedia outlets (Lewis et al., 2010, p.
The Social/Political Advocacy includes competencies that “influence public policy in a large public arena” (Lewis et al., 2010, p. 248). As with the other domains, the competencies in the Social/Political Advocacy domain begin with identifying advocacy issues related to social or political actions. Counselors as advocates seek avenues for change, join and support established allies, construct convincing data, and lobby legislators and policymakers to bring about macrolevel change.

The major concepts included in the ACD framework promote the well-being of clients or client communities and awareness of issues within each of the three levels that facilitate advocacy. Rubel and Ratts (2007) referred to the ACD framework as a social change agent for K-12 schools. Ratts et al. (2007) discussed support of the ACD framework for schools and how the framework compliments the ASCA’s National Model (2005). School counselors can apply the ACD framework across various populations (e.g., queer, impoverished, female, religious, and spiritual) in schools. Four basic tenets within the ACD levels that support schools are empowerment, collaboration, awareness, and education. In schools, advocacy actions can differ across the levels such as advocating on behalf or with minors who are survivors of child abuse and neglect. Each of the domains in the ACD framework are unique and serve a specific purpose in the advocacy roles of counselors. Like Fran (2014), Lewis et al. (2003) believed that competent mental health professionals (MHPs) should develop and execute an advocacy strategy as well as promote multidisciplinary alliances. The ACD comprehensive framework gives guidelines for each of the actions noted by Lewis et al. (2003).

**Collaboration and the ACD Framework**

When various professional disciplines fail to collaborate, clients suffer (Fran, 2014; Stylianos & Kehyayan, 2012a, 2012b; Swenson & Spratt, 1999; Trossman, 2011). Thus,
multidisciplinary collaboration is important and benefits clients and communities. When collaborating on cases with other disciplines, counselors should ethically assist with the discovery and management of barriers to clients’ well-being (Elmquist et al., 2015) and operate with the intent to protect client well-being (ACA, 2014). Both the well-being of clients and the barriers that they face are foundational components involved in multidisciplinary collaboration efforts.

Although not every domain in the ACD framework specifically includes collaboration, certain competencies within each of the six domains apply to collaborative, multidisciplinary, and advocacy approaches. In the first level, at the Client/Student Empowerment domain, collaboration is required to identify needed resources for clients and external barriers that clients experience (Lewis et al., 2010). In the Client/Student Advocacy domain, collaboration is required when counselors negotiate with various professionals and agencies for relevant client services and identify allies to overcome barriers faced by clients.

At the second level, in the Community Collaboration domain, collaborative competencies require counselors to identify environmental factors, alert professionals to client issues, develop alliances with advocacy groups, acknowledge and communicate strengths of professionals involved and resources needed for clients, and use and offer counseling skills needed in collaboration. The Systems Advocacy domain includes collaborative competencies that lead counselors to recognize environmental factors that are barriers, create a vision to guide change and collaboration with other stakeholders, examine the sources of political power and social influence with the system, and address resistance upon recognition (Lewis et al., 2010).

The two domains in the third level involve informing the general public of human dignity issues and facilitating change. In the third level, at the Collective Action or Public Information
domain, the professionals must ethically communicate information to the media about oppressive issues and barriers that clients experience. At the Social/Political Advocacy domain, counselors must collaborate with and support allies that bring about change, produce persuasive content that promotes advocacy, and lobby for legislative and policy changes (Lewis et al., 2010). Each domain within the ACD framework highlights an aspect of advocacy that aligns with a multi-disciplinary and collaborative approach. The framework reflects counselors’ responsibilities to operate in a collaborative and multi-disciplinary manner, assist clients with a plan of action, advocate for themselves or counselors, and act on behalf of clients.

Benefits of Collaboration and Advocacy

Collaboration and advocacy lead to multiple benefits for clients and counselors, including coalitions with professionals and agencies, advancements in policies, improvement in services, elimination of gaps in services, prevention of ethical misconduct and potential lawsuits, and creation of fairness and social justice for specialized populations (Fran, 2014; Swenson & Spratt, 1999; Trossman, 2011; Wheeler and Bertram, 2015). Cultivating collaboration requires supporting instrumental relationships, persevering advocacy efforts, and acting on opportunities when they are initially presented that lessens gaps in services and missed opportunities that benefit clients (Fran, 2014).

Benefits for Clients

Collaboration proves benefits across various professions including mental health and medical fields (Swenson & Spratt, 1999; Trossman, 2011). Coalitions, liaisons, and stakes with higher-level professionals and officials resulting from strong collaborations benefit clients by creating opportunities and removing barriers (Fran, 2014). Also, interdisciplinary collaboration efforts often lead to positive outcomes for clients with disabilities who often do not have the
knowledge or ability to advocate for themselves (Meyers, 2014). Similarly, Kelleher and Rickert (1994) stated that interdisciplinary collaboration assures that all client areas of care receive attention. For example, Meyers (2014) stressed the importance that all school professionals understand the role of counselors in school settings to ultimately benefit students. A historical review proved that collaboration leads to positive progress for individuals, professionals, and all humanity. Kieselica and Robinson (2001) pointed out that international collaborations between professors and leaders result in educational advancement and provision of counseling services for refugees. Professional coalitions have led to fairness and social justice for specialized populations (i.e., lesbian, gay, bisexual, and transgender individuals, refugees, and youth; Kieselica & Robinson, 2001). In general, collaboration and advocacy lead to benefits for client care and advancements for the mental health field.

**Benefits for Professionals**

Various professions, including mental health, medical, education, and law enforcement, acknowledge the value of collaboration in relation to advocacy (Fran, 2014; Lating et al., 2009; Meyers, 2014; Swenson & Spratt, 1999; Stewart et al., 2009; Trossman, 2011). Collaboration is a significant aspect of advocacy and can involve interdisciplinary and/or multidisciplinary efforts (Meyers, 2014; Swenson & Spratt, 1999; Trossman, 2011). When implemented effectively, collaboration aids in positive outcomes for professionals and clients. The benefits of collaboration for the medical field and counseling profession have been recognized and addressed by the implementation of programs supported by organizations such as the Substance Abuse and Mental Health Services Administration Services (SAMHSA) and National Alliance on Mental Illness (Trossman, 2011).
Swenson and Spratt (1999) stated that collaboration between medical professionals, such as doctors and nurses and MHPs, such as counselors, psychologists, and social workers allows for sharing of expertise leading to improved job performance. For example, it is especially important that medical professionals, often the first to see survivors of child abuse and neglect, share medical observations with MHPs who may not otherwise have access to this information. MHPs benefit by ensuring that all areas of the family receive services and follow-up for completion of services, which aligns with an element of Herzberg’s two-factor theory of motivation. Herzberg (1987) suggested that a sense of achievement is satisfying and leads to motivation. Additionally, mental health and medical professionals each possess specialized strengths and skills that when shared among disciplines ultimately benefit clients involved in child abuse cases (Swenson & Spratt, 1999). Kelleher and Rickert (1994) added that collaborations between mental health and medical professionals account for inclusive care for children and their families, again leading to satisfaction for the professional (Herzberg, 1987; Lamb & Ogle, 2019). For effective collaboration to occur, the authors added that professionals across disciplines should be competent and maintain positive relationships with other professionals who work in agencies such as the court system, child protection services, and law enforcement.

One example of collaboration across disciplines was efforts made by Kramer et al. (2015) to collaborate with various disciplines on a state-wide level that involved agencies such as CACs and Child Protection as well as MHPs who provided services to minors who reportedly experienced child abuse or neglect. The method by which they promoted collaboration was specialized training to MHPs and online reporting tools. Although well-trained professionals and online databases were beneficial, the fact that they evaluated measures of success prior to
implementation versus post-implementation created a limitation in their research. Ultimately the results of the study revealed the use of technology as a benefit to professionals for collaboration purposes.

**Challenges of Collaboration and Advocacy**

Trossman (2001) reported a lack of professional collaboration between psychiatric nurses and psychotherapists. Fran (2014) and Gonzales et al. (2017) agreed that failure to collaborate can lead to challenges and lack of coordination. Such failures can subsequently result in health concerns, civil malpractice lawsuits, client dissatisfaction, and complaints to licensing boards. In addition to issues with professional collaboration the literature provided more challenges faced by counselors while serving minors who are survivors of child abuse and neglect. The challenges included role conflict and navigation of professional roles (Bratton, 2013; Cross et al., 2102; Fine, 2014; LaFortune & Carpenter, 1998; Stacer, 2008).

Grimes, Haskins, and Paisley (2013) conducted a phenomenological study to explore rural school counselors acting as social justice advocates. After interviewing seven school counselors, the authors extracted five themes that improved or interfered with the ability to advocate, which included “stability of place” which highlights the impacts of generational support and reputation within the community, “community promise” which refers to indicators of success held by the community, “mutual reliance” focusing on the relationships between schools and community organizations, “professional and personal integration” developing courage and determination to meet the needs, and “a focus on individuals” meaning seeing each person as an individual with individualized needs and developing individual relationships with community resources (p. 40). The essence of the phenomenon of the rural school counselors
acting as social justice advocates “is made meaningful by deep community connections …” despite limitations and socio-economic loss (p. 47).

**Role Conflict**

Counseling, consulting, collaborating, testifying, and advocating are a few of the many actions taken by counselors when serving minors who are survivors of abuse (ACA, 2014; Bratton & Wallace, 2013; Crenshaw, 2011; Cross et al., 2012). “Role conflict has been an issue in the intervention of child abuse cases since the beginning of the alliance drawn between the legal and mental health professions” (Goldstein, 2012, p. 240). Challenges for counselors who are involved in cases of child sexual abuse and neglect include counselors’ ability to remain unbiased, understand their role as counselors, and operate within their professional boundaries (Cross et al., 2012, Fine et. al., 2014; Goldstein, 2012). Additionally, while advocating and collaborating with other professionals, counselors encounter the challenge of protecting client confidential information (Jacob & Powers, 2009; Knapp & Vander Creek, 1983). In an effort to advocate for children, counselors often collaborate with law enforcement and testify in court (Bratton & Wallace, 2013). In such cases, Melton and Kimbrough-Melton (2006) argued that MHPs’ roles were compromised when participating in duties such as forensic interviewing and gathering evidence to aid in the prosecution of cases. School counselors face similar challenges with regard to role conflict when serving minors who are survivors of child abuse and neglect (Barnett et al., 2011; Huey, 2011).

**Role Navigation**

Stacer (2008) noted that MHPs play various roles like evaluator, mediator, or counselor in situations such as custody. Challenges experienced by many counselors entail when they are placed in dual roles of advocate and custody evaluator. Authorities believe that counselors who
act as both advocate and custody evaluator are in violation of custody guidelines. Added to the challenges with various roles, Stacer (2008) reported that 75 to 90% of high-conflict custody cases involve a parent who has a personality disorder, personality deficits disorder or substance abuse addiction. She argued that parents with such diagnoses are more likely to behave in ways that cause ongoing conflict that counselors would encounter in their professional roles. Sexual abuse allegations often further complicate high-conflict custody cases adding a legal element to consider (Francella et al., 2002). Counselors acting as evaluators, mediators, or therapists are challenged to best serve their clients competently and without bias in such cases.

The key to counselors avoiding challenges and practicing competently involves understanding the laws and rules governing custody cases, participating in proper training and supervision, considering confidentiality issues, knowing ex-parte communications, and understanding ethical and professional boundaries (LaFortune & Carpenter, 1998; Patel & Jones, 2008). Just as Lyons et al. (2015) promoted counselor competency through knowledge, Dunbar and Hensley (2013) stressed that counselors need additional education and professional development regarding custody cases. They stressed that children in high-conflict custody cases should be able to have a voice in their living arrangements. For example, these researchers recommended that a trauma counselor and an attorney make decisions in high-conflict custody cases to ensure the best interest of the children involved, to include overall safety for children; ensuring that children’s perspectives, wants, and needs are heard; and preventing further victimization of children during decision-making in court. Counselors who navigate professional roles should be knowledgeable of the various considerations that must be made in custody cases.
Chapter Summary

This chapter contains specifics regarding the history, challenges, and benefits of advocacy, minor survivors of abuse and neglect, and education and training of counselors who serve this population (Ahmedani, 2011; Dunbar & Hensley, 2013; Lewis et al., 2010; Trossman, 2011; Wheeler & Bertram, 2015). A significant portion of this literature review entails discussion of the ACD framework, which encompasses key constructs regarding advocacy. With regard to the specialized population of minors who are survivors of child abuse and neglect, the definition of minors, mandatory reporting, specialized training, and professional education and training were explored (Damashek et al., 2011; Lyon et al., 2015). The final section of this chapter entails explanations of Louisiana LPCs and school counselors. Although some research exists on the afore mentioned topics including counselors’ roles as mandatory reporters and advocates, there is little to no research about how the role as an advocate translates into advocacy work with minor survivors of abuse and neglect.
Chapter III
Methodology
Introduction

Chapter 3 includes the research question, research design, and methodology utilized to guide the present research. In addition, the following sections are included: (a) research questions, (b) participants, (c) data collection methods, (d) role of the researcher, (e) data analysis, (f) validation procedures; and (g) summary.

The purpose of my qualitative, phenomenological research is to understand the advocacy experiences of Louisiana LPCs serving minors who are survivors of child abuse and neglect. I propose to interview LPCs about their advocacy experiences in the following areas: (a) education and training, (b) collaboration with professionals of various disciplines, and (c) challenges and benefits of advocacy.

Research Questions

Corbin and Strauss (2008) stated that qualitative research questions are broad in nature and allow for in-depth exploration by the researcher. Typically, researchers use an overarching question as the central question followed by several sub-questions (Creswell, 2007). For my research, I have one central research question.

Central Research Question

What are the advocacy experiences of Louisiana LPCs who work with minors who are survivors of child abuse and neglect?
Research Design

Qualitative research seeks to understand and interpret the experiences of individuals (Creswell, 2013; Merriam, 2009). It also gives voice to and empowers participants to share their stories (Creswell, 2013). Merriam (2009) stated that “qualitative researchers are interested in understanding how people interpret their experiences, how they construct their worlds, and what meaning they attribute to their experiences” (p. 5). Additional features of qualitative research include use of the researcher as the main instrument to collect and analyze data and the use of multiple data collection methods within natural settings (Creswell, 2013; Merriam, 2009).

Various approaches to qualitative research are differentiated by characteristics such as the focus, problem type, and analysis strategy. Phenomenological research reduces data to a common phenomenon that reveals a clear understanding of participants’ experiences. Moustakas (1994) referred to the common phenomenon as the “essence” (p. 84). Van Manen (1990) explained that the essence of phenomenology is “a grasp of the very nature of the thing” being studied (p. 177). For my research, I used a phenomenological approach to explore the advocacy experiences of Louisiana LPCs to best capture the essence of these experiences.

Interpretive Phenomenological Analysis (IPA) is a method of analysis that seeks to examine participants’ lived experiences and how they make sense of their experiences (Smith, 2004). IPA has been described as hermeneutic, idiographic, inductive, and interrogative in nature (Smith, 2004). Smith further described IPA as a double hermeneutic method because the participant and researcher are both trying to make sense of their personal and social world. My quest to understand LPCs’ advocacy experiences while counseling minors who are survivors of child abuse and neglect and the phenomenological nature of my research led to my decision to
use IPA. The characteristics of IPA align heavily with my plan to understand the meaning of my participants’ experiences and the methods to carry out my data analysis.

Participants

Quantitative research often requires a large sample; however, qualitative research can utilize a small sample of participants (Miles et al., 2014). Although Polkinghorne (1989) recommended five to 25 participants, IPA is ideographic in nature in which cases are individually examined in great detail and themes are identified through the process of cross-analysis, allowing for a small sample size of six to nine participants (Smith et al., 2009a). In my research, participants will be LPCs who practice counseling in the state of Louisiana and graduated from a Council of Accreditation for Counseling Related Education Program (CACREP)-accredited program. There will be two participants from the following settings: school, private practice, or CAC.

Sample Size and Criteria

As suggested by Smith (2004), I included six to nine participants in my study. As suggested by Creswell (2013), I began with six participants and increase the number of participants if necessary to reach saturation, which involves having “enough information to fully develop the model” (p. 89). In my research, the criteria for participation are the following: (a) have a current LPC license; (b) work in a school, (b) private practice, or Children’s Advocacy Centers, and (c) be a graduate of a counseling program accredited by CACREP.

Description of Participants

This section introduces each of the six participants and describes their advocacy preparation and advocacy related experiences as clinicians. Participants chose pseudonyms however two were very similar therefore those two pseudonyms were changed to eliminate any
potential confusion. The six participants attended CACREP-accredited universities in Southern Louisiana with four being master level and the remaining two being doctoral level. All six obtained their LPC credential from the Louisiana State Board of Licensed Professional Counselors. Five of the participants responded to the email solicitation and one was gained from snowball sampling. There was an individual who responded to the solicitation and completed the first interview however the interview was never recorded. While she agreed to re-record and continue in the study, she did not provide a new interview date and stopped responding to communications. Her content is not included in this research study.

The participants graduated from three different universities: Ricky, Lithie, and JC attended the same university; Jane and Katie attended the same university; and PJ was the only participant from her university. Only two of the three universities have doctoral counselor education programs. No male participants responded to the email and all who participated identify as female. Two participants are black and four are white. In terms of age, the participants ranged from thirty-three to forty-five. The demographic of each participant is detailed below if Table 1.

<table>
<thead>
<tr>
<th>Participant Pseudonym</th>
<th>Race</th>
<th>Age</th>
<th>Gender</th>
<th>Setting</th>
<th>Years as an LPC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ricky</td>
<td>Black</td>
<td>42</td>
<td>Female</td>
<td>School</td>
<td>14</td>
</tr>
<tr>
<td>Lithie</td>
<td>White</td>
<td>41</td>
<td>Female</td>
<td>School</td>
<td>1.5</td>
</tr>
<tr>
<td>Jane</td>
<td>White</td>
<td>43</td>
<td>Female</td>
<td>Private Practice</td>
<td>1 week</td>
</tr>
<tr>
<td>PJ</td>
<td>Black</td>
<td>36</td>
<td>Female</td>
<td>Private Practice</td>
<td>11</td>
</tr>
<tr>
<td>JC</td>
<td>White</td>
<td>45</td>
<td>Female</td>
<td>CAC</td>
<td>10</td>
</tr>
<tr>
<td>Katie</td>
<td>White</td>
<td>33</td>
<td>Female</td>
<td>CAC</td>
<td>2</td>
</tr>
</tbody>
</table>

Table 1.

Participant Demographic Information
**Ricky**

Ricky is a 42-year-old black female. She is one of the doctoral level participants and has been a LPC for 14 years. In addition to being a registered play therapist (RPT), and nationally certified counselor (NCC), Ricky has appraisal privileges and is approved to offer telehealth counseling. She completed the school track in her masters program and has worked in three school settings. The schools included elementary and middle school aged clients and one of the three schools was a private religious school. Currently, Ricky serves as a professor of a counselor education program at a public university.

**Lithie**

Lithie is a 41-year-old white female. She graduated from a Southern Louisiana university and this particular university does have a doctoral counselor education program. During her masters program, Lithie completed the school track. She has held her LPC credential for one and a half years and is also a NCC. Lithie has worked in a private practice setting and served at elementary and middle schools as a school counselor.

**Jane**

Jane is a 43-year-old white female who represents the private practice setting. Jane gained her masters degree from a Southern Louisiana university and she has been licensed as an LPC for one week. In addition, she is a NCC, and holds multiple certificates including certified clinical trauma professional (CCTP) and TF-CBT. Prior to her 3 years working in a private practice setting, Jane worked in a medication treatment facility and at an agency. Jane currently serves children, teens, and adults providing services for trauma and general issues.
**PJ**

PJ is a 36-year-old black female who represents the private practice setting. She is the other doctoral level participant and she graduated from a CACREP-accredited university in Southern Louisiana that also has a doctoral counselor education program. PJ completed the marriage and family track in her masters program and prior to private practice she gained experiences in an agency and a school setting. PJ provides serves to both children and adults at her private practice. PJ has been licensed for 11 years and also holds the supervision credential making her a LPC-S.

**JC**

JC is a 45-year-old white female who completed her masters counselor education program at a Southern Louisiana university that also has a doctoral counselor education program. JC has been an LPC for 9 years. JC represents the CAC setting. She is technically employed by a separate agency that is contracted to provide services at the CAC. In addition to providing counseling, she serves as a clinical supervisor to other counselors at her site. Prior to working at the CAC, JC worked at a few different agencies where she gained experience in providing services to children and adults.

**Katie**

Katie is a 33-year-old white female who also represents the CAC setting. She obtained her masters degree at a Southern Louisiana university and has been licensed for two years. Katie is a NCC and holds certifications; one in trauma focused-behavioral therapy (TF-CBT) and the other parent-child interaction therapy (PCIT). Prior to working at the CAC for two and a half years, Katie worked in an agency setting where she served children, teens, and adults. Katie also served as a victim advocate for a period of time at the CAC.
Data Collection Methods

IPA aligns well with semi-structured interviews (Roberts, 2013), allowing for detailed first-person reports (Smith et al., 2009a). In a semi-structured interview, the interviewer asks open ended questions allowing discussion rather than a simple question and answer format. Schaeffer et al. (2010) successfully completed a phenomenological research study focusing on advocacy and utilized semi-structured interviews to answer their research questions. Grimes et al. (2013) also utilized semi-structured interviews in a phenomenological research study to answer research questions related to social justice advocacy research. The previous examples of phenomenological studies on advocacy successfully used semi-structured interviews and this supports my use of semi-structured interviews for data collection within my research. In addition, IPA has been used effectively to gain lived experiences of participants in multiple phenomenological studies in other areas of research (Roberts, 2013; Smith, 2011; Etough & Smith, 2017).

Sampling Procedures

Purposeful sampling allows the researcher to solicit participants who can “purposefully inform an understanding of the research problem and central phenomena in the study” (Creswell, 2013, p. 156). Rubin and Rubin (2005) added that with purposeful sampling, “researchers talk to those who have knowledge of or experience with the problem of interest” (p. 3). With purposeful sampling, the researcher selects a sample from which they can learn the most about the explored phenomena (Merriam, 2009). Purposeful sampling aligns best with the nature of my phenomenological research because I seek to understand the experiences of a specific group, namely, LPCs working in CACs, S, or PP in Louisiana.
Before beginning my research, I obtained approval from the University of New Orleans’ Institutional Review Board (IRB). The informed consent addressed confidentiality by the following: (a) allowing each participant to choose a pseudonym to disguise his or her identity, (b) storing all information in a computer program that will be secured with password protection, (c) maintaining informed consent and all other written information in a locked file cabinet in a locked office, (d) storing all audio recordings in the same locked file cabinet office, (e) explaining potential risks and benefits to each participant, and (f) offering voluntary participation (see Appendix A).

My sampling procedures began with a recruitment by email and solicitation to LPCs working in CACs, Ss, or PPs in Louisiana (see Appendix B). One participants was gained through snowball sampling. I obtained email lists or contacts of professional counseling organizations. I obtained electronic mailing lists for counseling doctoral programs of Louisiana universities and CAC websites. Appendix B is the recruitment email/phone solicitation document that explains the participant criteria. I chose the three work settings because participants who counsel children in these settings are more likely to engage in some form of advocacy. I selected participants from the three settings that allowed me to be more inclusive of participants’ array of experiences within the phenomenon of advocacy experiences of minors who are survivors of child abuse and neglect. I began with six participants, two from each setting, and I did not need to increase the number of participants as saturation was reached.

Once a potential participant responded to my recruitment email or phone solicitation, a follow-up email including my interview protocol, interview questions, and informed consent will be emailed to the participant (see Appendices A, C, and D). In the follow-up email to each participant, a time and place for the interview was arranged. Each of the participants chose the
HIPPA compliant virtual video option for their confidential interviews. The informed consents were signed prior to the initial meetings.

I conducted each individual, face-to-face or virtual, semi-structured, in-depth interview to guide my data collection process. My interviews involved methods identified by Creswell (2013), Merriam (2009), and Smith et al. (2009a) and use closed and open-ended questions to allow for flexibility during the interview process. I began the interview with the informed consent process as stated in Appendix A (i.e., explaining the informed consent and confidentiality agreement) and followed with the interview questions. The initial interviews lasted no longer than 90 minutes. Each interview was digitally reordered for transcription purposes. Also, I asked participants to identify and provide documents (e.g., clinical assessment forms, confidentiality agreements with clients and other organizations that a client is receiving services from, law material, advocacy documentation) used to assist them when they provide services to their child clients. No one provided physical documents however some mentioned specific resources they used.

After each interview was transcribed, I emailed each participant a copy of her transcript. In the email, I requested a 30-minute second meeting to discuss the transcript, themes, and any additional information or data analysis the participant wanted to discuss or share about her advocacy experiences. While none of the participants had any questions regarding their transcripts, I did ask a few questions of clarity during the follow-up interview.

Role of the Researcher

In qualitative research, the researcher is the tool used for data collection (Creswell, 2007; Merriam, 2009) and “just as the artist is the primary instrument in painting, the researcher is the primary instrument in qualitative investigation” (McCaslin & Scott, 2003, p. 453). Merriam
(2009) and Corbin and Strauss (2008) shared the importance of being aware of biases that can interfere with the research. In my research study, I was the human instrument used to collect and analyze the data on advocacy experiences of LPCs.

My interest in this topic developed from my personal experiences working in a setting in which I counseled minors who are survivors of child abuse and neglect. My role in that setting involved collaborations with my LPC-Supervisor, a multi-disciplinary team (e.g., LPCs, law enforcement, attorneys, forensic interviewers, and social workers), various professionals from other disciplines during court testimony (e.g., court mediators, and custody evaluators), and parents. I often participated in advocacy efforts regarding minor clients. Although my LPC-Supervisor provided information to assist me during my experiences, I gained knowledge through trial and error. The ACA Code of Ethics (2014) states that advocacy is one of the responsibilities of professional counselors. Considering my advocacy experiences, particularly during the first five years of my career, and the ethical code of the ACA regarding advocacy, I became interested in the advocacy experiences of other counselors working with the specialized population of survivors of childhood abuse and neglect. After reviewing empirical research and the literature on advocacy, I found minimal information regarding direct advocacy actions by counselors for these vulnerable minors.

I had three major biases going into my research. The first bias is that counselor preparation programs, particularly those accredited by CACREP, may not be providing the appropriate advocacy education needed to work with a specialized population such as children who have been abused and neglected. I believe that without knowledge of how to advocate, counselors may cross boundaries, divulge confidential information, or act beyond their professional scope of practice that could lead to negative ramifications. My second bias is that I
believe advocacy training should be a part of clinical supervision when working with and counseling clients and during the licensure and supervision processes. I believe that more education and training on advocacy will better prepare counselors to navigate advocacy efforts, especially court testimony. My final bias is that I find collaboration among professionals to be challenging yet necessary to yield the biggest benefits to clients.

I relied on three particular methods to prevent my biases: (a) debriefing by my dissertation committee (b) reflexive journaling, and (c) bracketing. As Creswell (2012) suggested, a peer debriefer can assist me in diminishing my personal biases by challenging my thought processes and values, asking thought-provoking questions, and engaging in dialogue that may interfere with my data analysis and eliminate or bracket any preconceptions that I may have. Lincoln and Guba (1985) also stated that a peer debriefer helps to separate personal bias from the research process. Second, I used a separate reflexive journal during the interview and data analysis process that will include my thoughts, notes, and feelings that arise during my research process. Lincoln and Guba (1985) referred to a journal as a diary-like tool that can be used daily or as needed to keep a record about the researcher’s thoughts about the research. The third method I used is bracketing, which involves identifying and removing prejudices, preconceived assumptions, and personal viewpoints. The researcher attends to the meaning provided by the participants as well as the awareness of the researcher’s personal biases to maintain confidence of the research (Creswell, 2013). I used bracketing to identify and remove personal prejudices, assumptions, and viewpoints from my research.

**Data Analysis**

Without trustworthy methods and valid data, research results are not credible (Merriam, 2009). I used IPA analysis techniques that extract personal accounts of participants’ experiences
through in-depth, semi-structured interviews (Smith, 2011). In IPA, the researcher points out meaning units, textural descriptions such as “participants’ experience,” and structural descriptions that are the context of the participants’ experiences (Creswell, 2013, p. 80). The researcher also identifies significant statements and extracts themes in the data that produce meaning and capture the essence of participants’ experiences. According to Smith (2009a), each case is examined one after the other. IPA is becoming more commonly used to address research questions related to counselor training (Miller, Chan, & Farmer, 2018).

**Method of Analysis**

For my research, I used the six-step process developed by Smith et al. (2009a) to complete my data analysis. Before the analysis process, all data collected from each participant will be transcribed by myself or a hired transcriptionist. Purposeful sampling typically relies on the concept of saturation (Guest, Bunce, & Johnson, 2006). I analyzed each case individually to the point of saturation, which Creswell (2007) described as the point at which the researcher gathers enough information necessary for understanding the data. As the interviewer I was able to detect when the interviews are no longer yielding new information thus identifying the point of saturation. The analysis process was completed serially for each participant’s transcript and not concurrently.

**Six-Step Process**

In step one of the analysis, I immersed myself in the data by reading the first transcript three times, underlining important concepts, phrases, and words, and then annotating in the left-hand margin of the transcript. The left margin notes included summaries of content, initial ideas, observations, and significant phrases. Smith et al. (2009a) stated that the researcher should maintain an open mind and take note of any information that adds to the understanding of a
participant’s views and use of language. Bracketing, also known as the epoche technique, is the process of setting aside biases, personal experiences, and preconceived notions. I used bracketing throughout the analysis process to identify and remove any prejudices, preconceived assumptions, and personal viewpoints that I may have. I gave attention to the meaning provided by each participant and be aware of my personal biases to maintain confidence in my research.

The second step involved a second and third reading through the annotation in the left margin making connections to identify abstract emergent themes and noting them in the right-hand margin. Emergent themes are more abstract concepts developed from the raw data and can be viewed as the basic building block of the analysis process.

In step three, I searched for connections in the list of emergent themes creating clusters that will develop into superordinate themes. Superordinate themes are more dominate ideas developed from specific emergent themes and allow for connections within the data. In the fourth step, I assembled the superordinate themes in an Excel document. The purpose of the excel document is to organize data for the cross-analysis process. According to Smith et al. (2009a), similarities and differences produced in the data highlight patterns that reveal the meaning of participants’ experiences. The essence is sorted from the data through sifting out the essence of the research through extracting themes and bracketing. This process leads to phenomenological reduction (Beech, 1999; Gearing, 2004; Speigelberg, 1973). As also suggested by Smith et al. (2009a), I maintained a journal during the data analysis process to track my thoughts and emotions and how I came to the emergent theme commonalities that resulted in the superordinate themes.

The fifth step involved completing steps one through four for the remaining transcripts. The superordinate themes and categories from the transcripts were added to the Excel document
in preparations for the final and sixth step. Identification of convergences and divergences across the transcripts is important (Smith and Osborne, 2008). The sixth step involved development of master level themes. Master level themes involve organizing developed themes across all transcripts creating a theoretical comprehensive narrative. Smith and Dunworth (2003, p.608) identify this analysis process as “moving from the particular to the general”.

**Validation Procedures**

Validation procedures are extremely significant to a research study in that the procedures account for accuracy of the research (Creswell, 2007). Lincoln and Guba (1985) stated that qualitative validation procedures determine if a research study is “…worth paying attention to…” and include three measures of trustworthiness: confirmability, credibility, and transferability (p. 290). Bloomberg and Volpe (2016) agreed that components of confirmability, credibility, and dependability support trustworthiness of data.

**Confirmability**

The six-step analysis process I used accounted for the confirmability in my research. Guba (1981) described confirmability as the process of making certain that the research results clearly relate to the conclusions of the researcher and the research can be replicated. Following the six-step analysis process that I used for my data analysis allows for replication of my research. Additionally, journaling throughout my data analysis will assist me along my decision trail and allow for confirmability of my research.

**Credibility**

Lincoln and Guba (1985) used “confidence” and “truth” to describe credibility (p. 218). King and Horrocks (2010) described credibility as participants’ endorsement in the interpretation of the research. Merriam (2009) stated that participants recognize their experiences in data
interpretation as a measure of credibility. I used three strategies recommended by Creswell (2009) to account for credibility; member checking, peer debriefing, and triangulation. In my research, member checking involved a meeting with each participant to review her transcript and the emergent themes and superordinate themes that I extracted from each interview. In addition, I met with my dissertation chair to ensure elimination of any biases and to ensure that research findings are accurate. Third, used triangulation to compare my data analysis to my journal notes, and transcripts. Each of the three measures ensured credibility in my research.

**Dependability**

Dependability measures trustworthiness and is the ability to track the collection of data and analysis procedures (Lincoln & Guba, 1985; Volpe, 2012). I used margin notes and extraction of themes from the data as mentioned by Huberman and Miles (1994) and Wolcott (1994). Volpe (2012) described measures such as margin notes and extraction of themes as an “audit trail” (p. 113). I used a six-step method that includes transcript checking, journaling, and an auditor. My dissertation chair and methodologist carefully considered my collection methods and data analysis process to ensure that dependability was maintained.

**Chapter Summary**

The purpose of my qualitative phenomenological research was to understand the advocacy experiences of Louisiana LPCs who counsel minors who are survivors of child abuse and neglect. Participants were solicited from CACs, Ss, and PPs in Louisiana. I used IPA and semi-structured interviews to gather the data. A six-step data analysis process was conducted and used to answer my research questions. Validation procedures were used.
CHAPTER 4

RESULTS

When counseling minors who are survivors of child abuse and neglect, counselors’ knowledge of advocacy is required. When mental health counselors do not understand how to properly advocate, they face challenges and barriers to advocating for their clients (Lyons et al., 2015). Because advocacy is an area of competence that is required within and across helping professions, professional counselors should be knowledgeable in how to advocate effectively (American Counseling Association, ACA, 2014; Barnett, 2004; Crenshaw, 2011).

The purpose of my qualitative phenomenological research is to understand advocacy experiences of LPCs who work with minors who are survivors of child abuse and neglect. I explored LPCs’ experiences regarding advocacy in the following areas: (a) education, training, and competence; (b) collaboration with various professionals; and (c) difficulties and benefits of advocating for minors who are survivors of child abuse and neglect.

The intent of the study was to describe the lived advocacy experiences of licensed professional counselors who serve minor survivors of abuse and neglect. The findings are organized in four master themes: fundamentals of advocacy, aspects of collaboration, influences on advocacy preparedness, and considerations for advocacy competency and preparedness. The categories of super-ordinate themes and emergent themes are also discussed.

Data Analysis Procedures

Data analysis began after obtaining a detailed account through an initial semi-structured interview and follow-up clarifying interview of the six participants. The data analysis process involved a cyclical approach of reading the transcripts three times then underlining important concepts, words, and phrases. Annotations were documented in the left margins then reviewed to
identify abstract emergent themes. Connections and patterns within the emergent themes developed clusters and were organized into super-ordinate themes. Once this process was completed for each of the transcripts, cross-analysis began by making connections between the super-ordinate theme categories. These connections were then organized and relabeled resulting in master themes. Demographic information for all participants is displayed in the table below.

**Table 1.**

*Participant Demographic Information*

<table>
<thead>
<tr>
<th>Participant Pseudonym</th>
<th>Race</th>
<th>Age</th>
<th>Gender</th>
<th>Setting</th>
<th>Years as an LPC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ricky</td>
<td>Black</td>
<td>42</td>
<td>Female</td>
<td>School</td>
<td>14</td>
</tr>
<tr>
<td>Lithie</td>
<td>White</td>
<td>41</td>
<td>Female</td>
<td>School</td>
<td>1.5</td>
</tr>
<tr>
<td>Jane</td>
<td>White</td>
<td>43</td>
<td>Female</td>
<td>Private Practice</td>
<td>1 week</td>
</tr>
<tr>
<td>PJ</td>
<td>Black</td>
<td>36</td>
<td>Female</td>
<td>Private Practice</td>
<td>11</td>
</tr>
<tr>
<td>JC</td>
<td>White</td>
<td>45</td>
<td>Female</td>
<td>CAC</td>
<td>10</td>
</tr>
<tr>
<td>Katie</td>
<td>White</td>
<td>33</td>
<td>Female</td>
<td>CAC</td>
<td>2</td>
</tr>
</tbody>
</table>

**Master Themes**

The participants reflected on various aspects of their training and professional advocacy experiences. Though the participants represented three different settings their experiences could be attributed to: fundamentals of advocacy, aspects of advocacy collaboration, influences on advocacy preparedness, and considerations for advocacy competency and preparedness. Emergent themes and superordinate themes are further developed within each master theme and are supported by extracts and quotes from participants.

**Fundamentals of Advocacy**

The participants shared content highlighting their perspectives regarding the essentials and experiences of advocacy while operating in the following settings: private practice, schools,
and CACs. Three superordinate themes presented within this master theme: advocacy defined, advocacy experiences, and utilized resources.

**Advocacy Defined**

The lens through which participants defined advocacy centered around three core principles: support, educate, and collaborate.

**Support**

Participants spoke of support being an essential component of advocacy. Supportive aspects presented in the data through the context of fighting for, helping, and representation. PJ identified support through being there to “help navigate and guide [clients] through a process”. PJ pointed out the importance of being “consistent” and at times “encouraging” when offering support. JC shared similar sentiments adding that advocacy involves helping children and families through various “hardships” and “navigating challenges”. Katie expanded on the aspect of advocacy as support through listening and understanding to ensure that the “child feels heard” and their feelings are identified. Lithie added to the aspect of support of children through “protecting the child’s privacy”.

While defining advocacy Lithie and Jane both used the language “fighting for”. Jane stated that advocacy is “fighting for those who can’t fight for themselves” and Lithie added that advocacy is “fighting for children and helping them get what they need”. Much like the two previous statements, Ricky informed that advocacy requires support through “speaking up for others”. In addition to “fighting for” and “speaking up” Jane added that advocacy requires “sometimes really being willing to stick my neck out to try and help in the best way possible.”

Lastly the supportive aspect of advocacy emerged in the concept of representation. This aspect was presented in the context of community outreach and professional offices. Ricky stated
that advocacy is “being able to use your position for individuals who may have been
disenfranchised”. Ricky went on to add that advocacy might include “running for an office or
increasing visibility about the profession …eradicating some of these myths about working with
vulnerable populations.” Katie and JC spoke of representation in the context of being a member
of the multi-discipline team (MDT) which allows the opportunity to share and advocate in a
setting amongst other professionals. Katie spoke of influences of her representation and spoke of
advocacy as:

“… advocating for a child in an MDT by sharing information or if I don’t think
something is fair. Speaking up for the family and saying this family really needs our help.
Can we create another meeting separately from this MDT so we can help this family?”

Educate

In addition to support, all six of the participants spoke of education as a component of
advocacy. This aspect presented in the context of educating oneself as a professional and
educating others. Knowledge of resources was mentioned by four of the participants. PJ spoke of
knowing resources to help guide and navigate clients through challenges. This view was similar
to JC’s comment about knowledge being required to link clients to resources during advocacy.
She stated that “advocacy is awareness of resources”. Katie added that advocacy involves
“connecting to resources” which involves the professional educating themselves.

“Educating others” was a specific characteristic of advocacy pointed out by Lithie. Jane
highlighted the importance of being educated on world and client issues related to trauma. Jane
stated:
I think the biggest and most important piece of it is maintaining education and awareness around issues that pertain to our world and reality and also potential issues that clients can come in with ranging from socio economic stuff to abuse, and education.

The participants spoke of experiences where they advocated for their minor clients by educating parents, professionals, and the community. Ricky mentioned advocating through “eradicating myths about working with vulnerable populations” which further speaks to education as an aspect of advocacy.

**Collaborate**

Collaboration presented as a third major defining characteristic of advocacy. This involved collaborating with professionals, parents, and systems. Katie and JC spoke of collaborating with law enforcement to provide additional details on cases, social workers associated with child protection, and doctors. The aspect of collaborating with parents presented in the context of “mediating communication” as described by Ricky, providing psychoeducation, and collaborating with parents as they supported their child through the forensic interview process.

According to the participants, advocacy involved working with systems such as schools. As a school counselor, Lithie spoke of advocating by working with the school system including teachers, administrator, and principals. The experiences involved “educating teachers about the impacts of trauma” and teaching them that “behavior is not just a choice but a symptom”. Lithie added that advocacy within the system required “navigating sticky situations” but ultimately “doing the right thing even if it goes against the system”. JC spoke of working with a system of professionals to advocate regarding individualized educational plans. Another system the
participants spoke of was child protection. As mandatory reporters they all mentioned the responsibility of making reports even when other professionals did not agree.

**Advocacy Experiences**

Another superordinate theme that emerged from the data is aspects and experiences. All six of the participants reported a variety of advocacy experiences including feelings and views about the experiences.

**Mandatory Reporting**

Each of the participants spoke of mandatory reporting during practice and it was identified as an ethical requirement and an aspect of advocacy. When speaking on mandatory reporting Katie and JC reported experiences that were at times challenging. When working in a CAC setting there is often a previous report that has led the client to receive services. One of the complications is getting clear about what was previously reported versus new content that surfaces during counseling. New abuse or neglect disclosures would then need to be reported to the proper professionals. Katie stated, “it just gets really complicated” after speaking about the complexities of knowing who is “on the case” and “not knowing what information was previously disclosed”.

The two school counselors reported the most content about experiences of mandatory reporting. Lithie spoke of navigating “sticky situations” surrounding mandatory reporting in the school system. She added that executing professional responsibilities of mandatory reporting was at times uncomfortable because it was more “discouraged” than encourage by administrators. It was suggested by administrators and staff that mandatory reports reflect poorly on the school. Though resistance from staff was at times an issue, Lithie stated that she had to “do the right thing even if it goes against the system”. Ricky reported similar experiences where she was
encouraged not to report even when there was suspected abuse and bruising. Ricky reported being told, “you’re going to tear this black family apart and put the child in the system.” In another situation Ricky was told, “you don’t want that smoke” referring to a family of wealth and power. The comment was an attempt to prevent reporting. Ricky spoke of educating the staff and moving forward with her ethical and legal obligations. Lithie added that it was “challenging to find the words” to inform superiors that you would be going against their wishes. In all necessary cases, the participants reported that going against superiors and the system was “intimidating”. At times they sought support and confirmation from professional peers and supervisors.

**Educating**

**Clients**

Educating clients, parents, other professionals, and educating in community-based settings are aspects in which participants reported advocating through educating others. The two school-based participants spoke of providing psycho education to clients in individual and group settings. Clients are educated on matters such as impacts of trauma, coping with trauma, reporting, and prevention. Some of the prevention education tools Ricky reported using included: Speak Up, Be Safe, Gator Academy, and Play it Safe. Ricky added that some of the resources she utilized were recommended by the mental health wellness team of the school and some provided by outside consultants. Participants across settings each reported educating caregivers. Katie, JC, PJ, and Ricky spoke of informing parents of the reporting and forensic interview process. This also involved educating caregivers on “the next steps” and what to expect. Every participant mentioned educating parents in the context of helping them understand what their child is attempting to communicate. Jane stated,
I have advocated for those clients in a very basic way sometimes and sometimes in a very complex way. Basic would-be kind of acting as a translator of sorts and helping parents and foster parents and trying things a different way to best help the child.

In addition to educating caregivers to better understand their child, JC also informed of providing education to parents about how their actions impact their child. JC stated:

There are times when I am advocating with and times I am advocating just on behalf of the child because the caretaker is emotionally not present or the caretake doesn’t realize that there is harm being done.

Professionals

Educating professionals was another common aspect the participants reported experiencing. PJ and Ricky spoke of presenting on advocacy and trauma at professional conferences to educate professional counselors and social workers. As a professor, Ricky also spoke of educating future professionals through, “being a professor who is able to train students on how to work with this population.” Katie and JC both spoke of educating the multidisciplinary team members about impacts of trauma, trauma research, and cultural considerations as they navigated cases. Jane, Katie, and JC reported experiences of educating attorneys, and mediators on their scope of practice as counselors and how utilizing a client’s records for court purposes could put the minor client’s confidentiality at risk. Jane stated:

There are situations where I have sometimes had to advocate in an indirect way for clients with court systems, custody evaluators, professional providers, schools, …and where I see a place that was within my scope of practice and within my ability to try and help them in some way.
Lithe and Ricky spoke of educating teachers, administrators, and other school staff regarding student challenges, impacts of trauma on emotions and behavior, and mandatory reporting. In reference to educating professionals about her responsibility as a mandatory reporter, she stated:

I will bring in the relevant codes and talk about how I am a mandated reporter and that I abide by these things. … I would have to talk about my limitations to confidentiality, but I would also point out how I would have to adhere those five basic principles along with the preamble.

Consulting

Participants spoke of their advocacy experiences involving consulting to gain knowledge and to share knowledge. While each of the participants mentioned utilizing their peers and supervisors for the purpose of gaining clarity and obtaining confirmation. Lithe and JC, who work in collaboration with the CAC, spoke of consulting with nurses, doctors, and an onsite psychologist. Ricky spoke of obtaining support through consulting with her professors while in her doctoral program. Ricky shared of a specific experience where she consulted with a professor when a system was pressuring her not to follow-through with an ethical and legal obligation. A few of the participants spoke of instances in which they consulted for the purpose of providing knowledge. At times this involved providing information to other counselors, mediators, attorneys, teachers, administrators, and caregivers.

Community Involvement

Ricky also spoke of one additional area in which she offered education and that was in community settings. She reported offering education within the community in direct and indirect ways. Ricky stated:
...So for me when I think about advocacy it could be when you’re just trying to influence decisions, tabling for different events, even running for an office, or increasing visibility about the profession or what we do and eradicating some of these myths about working with vulnerable populations.

Lastly, Ricky spoke of educating in the community by offering knowledge in faith-based. She added, “I am talking about these things not just in the classroom but also in my faith-based community. So that will be ways that I’ve advocated for them.”

The main context in which the participants spoke of community involvement was related to getting acquainted with resources. Katie reported of the significance by stating “advocacy is awareness of resources”. JC spoke of using community resources to share with clients, caregivers, and also other professionals. Ricky highlighted the other two ways she and other counselors engage in community involvement. They hold official positions and participating on committees. Ricky identified involvement in the community by “running for office” and “using position for the disenfranchised”. She added that community involvement “increases visibility for the profession”. Tabling for events and being on committees within the community were identified as community involvement and advocacy experiences by Ricky and PJ.

**Utilized Resources**

The final super-ordinate theme that presented as a fundamental of advocacy was utilized resources. The participants spoke of the use or absence of advocacy models, code of ethics, assessments, screenings, and consultations.

**Advocacy Models**

Ricky was the only participant who identified specific advocacy models used during practice. The models she listed included the ACA Advocacy Competencies, Social Justice
Competencies, Child Welfare reporting forms, ASCA Position statement, Legislative Advocacy Models, the Advocate Model. While others did not identify any specific models or sets of rules they followed during practice, the participants each spoke of mandated reporting which involved the use of child welfare documents. Three of the participants spoke of developing an advocacy strategy as situations arose. Jane stated that her experiences involved, “moving on instinct and doing what is right.” PJ informed that although there is no specific model she uses, she does what is “best suited at that time” and develops “individualized and personalized plans”. Very similar to the approach of PJ, Lithie informed that her plans for advocacy “develops organically based on the situation”. Lithie added her “number one resource” when developing a plan and advocating was her Provisionally Licensed Professional Counselor supervisor who had extensive experience with the population. Multiple participants mentioned the need for advocacy models to utilize when serving children who have experienced abuse or neglect.

**Code of Ethics**

The participants reported utilization of the *Code of Ethics* during advocacy practices, however none of them could identify any specific codes that focus on advocacy. Elements of the code highlighted by Ricky included mandatory reporting and compliance to the code even when professionals within the school systems disagreed. Ricky spoke of a situation in which she honored the *Code of Ethics* even when “the rules and standards differed substantially”. This ultimately resulted in Ricky leaving that job and choosing not to renew her contract. Lithie’s main focus on the *Code of Ethics* as it relates to advocacy was “protecting privacy”. Along those same lines, Jane highlighted parental legal rights, documentation, and confidentiality as aspect of the Code she leaned on associating with advocacy. PJ shared the following as it relates for her use of the Code in connection with advocacy:
I’m definitely mindful of what’s ethical and what’s not with minor. Especially, because it’s such a fine line with them. There’s a level of protection with any client so there’s definitely a level of protection with minor people that are under a certain age. Specific codes I use? I don’t remember off the top of my head.

**Assessments and Screenings**

The participants spoke of their use of screenings and assessments as resources during the advocacy process. Some spoke of formal evidence-based tools whereas other utilized the intake process and observations as a screening tool. JC spoke of the Structured Trauma-Related Experiences & Symptoms Screener (STRESS) tool which is” a grief and trauma intervention screener- tool developed after Hurricane Katrina”. PJ mentioned the use of verbal reports and visual observations as a “base assessment” to determine if formal assessments were needed. Ricky reported use of Adverse Childhood Experience (ACE) screening, intake content, and websites to utilize appropriate tools.

**Consultations**

Consulting with professionals and peers was reported to be a significant utilized resource during advocacy experiences. JC reported consulting with staff, supervisors, attending peer consultations, and group case conceptualizations. The other participants mentioned the same supports however Ricky also utilizes direction from her higher power, the Bible, and her husband. Ricky was careful to mention ensuring confidentiality while consulting with her husband. Lithie added that her “go- to source” was her registered play therapy supervisor who possessed extensive expertise with the population of study. The participants spoke of consulting with professionals and peers in-person, via email, phone, social media and video. During and after the Covid pandemic, the non-contact methods were primarily utilized.
Aspects of Collaboration

The second superordinate theme that emerged from the data is aspects of collaboration. The participants spoke of various collaborative experiences that involved working with professionals and systems, caregivers, and sources of support. Lastly, the participants discussed navigating challenges during collaborative advocacy experiences.

Professionals and Systems

School Systems

Due to their professional setting, Lithie and Ricky reported the most details of collaborative experiences with the school system. Other participants also shared their experiences including collaborating with teachers, administrators, school counselors and after school programs.

Benefits

One benefit of collaboration occurred through being a voice of change leading to special accommodations for minor survivors of abuse and neglect. JC, Katie, Ricky each mentioned collaborating for the purpose of developing 504 and Individualized Education Plans. Another reported benefit of advocacy collaboration was possibly decreasing prevalence and improving reporting through prevention measures. Jane and Katie spoke of offering recommendations and “filling in the teachers about the children’s needs” which is a benefit of advocacy. JC, Ricky, and PJ each mentioned providing prevention education in the school system both with students and staff. Providing prevention education to staff also aided in better outcomes and considerations for the students. Lithie specifically reported collaborating with teachers and administrators to help them better understand the impacts of trauma. She stated:
…it was talking to the teachers and helping them understand that the behavior they see in the classroom is because a traumatic experience happened to them. It’s not just because they are choosing to act out. So, teachers were really my primary target to help them understand why the child was behaving in a certain way. And then I worked with administrators because they also saw misbehavior as a choice. So, I tried to help them understand where this is coming from.

Challenges

While most collaborative efforts lead to beneficial change, the participants shared of challenges encountered during the process. Lithie stated, “When you’re dealing with parents or guardian, and teachers and sometimes you get in these very sticky situations, in the school setting itself.” The most discussed challenge reported by the participants when collaborating in the school system involved mandatory reporting. Lithie and Ricky specifically talked about school officials discouraging mandatory reporting. Lithie reported that these adversities challenged her professionally and emotionally. Lithie stated:

On the emotional level it was hard knowing that you’re doing something that other adults didn’t approve of, my superiors didn’t approve of. And I felt like one, I had to remind myself why am I doing that. Again, getting help from the supervisor and getting that support and confirmation. And being firm and grounded in that knowing and trying to communicate that to my administration. This is why I am doing this. You may not like it but this is what I have to do. So, it challenged me to also find the right words to explain what I’m doing. Why I’m doing this. And remind myself that this is part of my job. Not to get intimidated. Emotionally it was a little hard to find that place where I can really feel grounded and confident.”
Ricky spoke of being discouraged to refrain from filing a mandatory report in both private school and public-school settings. She stated:

For example, the private school I worked at, certain families, we were told “you don’t want that smoke”. And then when we worked in the school, on the other side of the coin, I remember someone was trying to make the argument, it was actually another mental health provider. It wasn’t a school counselor, but they made the argument that this was going to tear the black family apart and put the child in the system.

Navigating such challenges put participants in a position to advocate for themselves and the students they served. Ricky shared the following regarding her experience:

I will bring in the relevant [ACA] codes and talk about how I am a mandated reporter and that I abide by these things. Sometimes the state and the school district I’m working in may supersede my code of ethics and I would have to talk about my limitations to confidentiality, but I would also point out how I would have to adhere those five basic principles along with the preamble. That’s where I usually start.

Ricky reported how discouragement from administrators and self-advocacy led to choosing to release that position and finding another place of employment. Ricky stated, “the rules and standards differed substantially” which resulted in Ricky leaving one position and choosing not to renew her contract. Jane stated was determined to “sustain ethical adherence”. These experiences led to feeling a “wave of disappointment, sadness, defeat and weathered”.

Protecting confidentiality was another challenge the participants experienced while collaborating with school professionals. Lithie discussed how she navigated the challenge when educating teachers about the impacts of trauma without discussing the trauma. Lithie stated:
When advocating with teachers and administrators, I would try to keep the privacy of the child as much as possible. I would try to communicate the reason for the behavior in more general terms rather than specifically what happened or might have happened to the child. Really trying to get them to understand their emotional need. The difficulty or the pain, but not necessarily the facts of what happened. That’s what comes to my mind when you ask that question.

Ricky reported navigating the challenge of protecting confidentiality with administrator by requesting that only specific individuals had access to records. Ricky stated:

Ethical challenges may have been in terms of making sure the agency, the school counseling staff, when it came to storage and proper storage of records and as far as who needed to be involved. That was a challenge—where when I made a report it needed to be filed in the school counseling file cabinet yet, let’s say, the school secretary wanted to know what was happening when really needed to be between at the school answering office maybe the principal and related administrators. There were some challenges we had in terms of it being a small-town area.

PJ added that she has collaborated with the school social worker or school counselor instead of teacher due to the challenge of reaching the teachers. She stated:

If a school social worker or the school counselor is present that’s probably the easiest person to connect to because sometimes teachers can be hard to reach because of their school. School counselors are more flexible and more readily available to handle those types of problems, so they are more readily available to have conversations versus with the teacher in the middle of the day, when they’re in class.
Advocacy collaboration within school systems proved beneficial and at times challenging. The school counselors in particular had plenty to share regarding their experiences.

**Multidisciplinary Teams**

The two clinicians who represented the CAC, Katie, and JC, reported benefits and challenges of collaborating with the MDT team. This team included professionals such as: counselors, forensic interviewers, police, representatives from the district attorney’s office and child protection. Activities of collaboration involved providing significant updates regarding counseling services, abuse disclosures, psychoeducation, multi-cultural and diversity considerations, and resources accommodations.

Two challenges the participants addressed involved providing correct information especially when opinion or personal views may have been shared regarding cases. JC spoke of providing research content to dispute opinions. JC stated the following:

> It gets a little tricky cause there’s a lot of people in the MDT meetings and room. And I always try to provide knowledge and education and not opinions and keep opinions out. Sometimes other people might add their opinions and I’m like we have to stick to research.

Katie reported the challenge of collaboration for the purpose of reporting additional details and clarity in terms of what aspects of the abuse have been reported and what has not. Katie feared sharing unreported abuse details with the non-offending caregiver as if they already knew. Katie also spoke of the pressure of understanding that unreported additional details could impact the extent of charges to the alleged offender. Katie stated:

> So sometimes I’m not sure what was disclosed in the forensic interview and then if I should be reporting more details. I wonder if they’re sharing more with me that wasn’t
shared in the interview. So then I’m just like, what do I do? What if I share this with the caregiver and the caregiver didn’t know any of this… Like the abuser also forced her to more… I’m like oh my gosh what do I even do. Then, it’s like a dilemma but I can call the detective and ask detective did you share everything with the caregiver and does the caregiver know. It just gets really complicated.

**Child Protection**

Reporting to child protection potentially resulted in benefits of preventing further child abuse or neglect. Each of the participants reported filing a report at some point during their career. Ricky spoke of a challenge involving reporting to child protection and a breach of confidentiality. Ricky reported how this issue led her to go against and spiritual belief and tell a lie to protect her safety. She stated:

I did experience a breach of confidentiality issue when reporting and someone disclosed to the family and I don’t like to lie but I had to deny that I made the report because there could’ve been a threat of violence.

Katie reported the challenge of reaching child protection for consultations and follow-up meetings.

**Legal Professionals**

Challenges experienced by the participants relating to legal collaborations included navigating consultations, records requests, and subpoenas. The other common theme was fear regarding the possibility of testifying in court. JC reported navigating requests for records and seeking support from her supervisor. On one occasion her records were subpoenaed but nothing was found to use for court. Katie reported that she was subpoenaed for court once but did not have to attend. Katie stated that she would need “heavy support” from her supervisor should she
ever have to testify. Lithie reported similar sentiment stating that she would need to prepare emotionally and professionally for court testimony. PJ, Ricky and Jane reported feelings or nervousness should they have to testify however they felt they could get through it. Jane stated, “I think I would of course do the proper consulting and probably very closely review my chart but I think I would survive it OK.”

**Caregivers**

PJ reported working with caregivers as her biggest source of collaboration while some reported working with caregivers as challenging and at times frustrating. An aspect of collaborative work with caregivers for PJ included acting as a “middle person and advocate” specifically regarding communication challenges between caregivers and teens. Jane spoke of similar collaborative work with caregivers stating that she has acted as a “translator” and assisted in relaying information to help parents with better understand their children. Sharing resources, referrals and providing psychoeducation to caregivers are common collaborative experiences. Katie shared of her collaborative advocacy experiences stating:

> Advocating for the child so the parents can know what we’re working on in session and also how to help continue those skills outside of session. So, if it’s just identifying feelings. So, I’m advocating for the child to be heard.

JC spoke of educating parents about the impact of their actions on their children while Jane reported helping caregivers who are not sensitive to their children’s emotional needs.

Challenges that arose while collaborating with caregivers involved parental involvement and confidentiality. Jane stated the following when speaking of the challenges of collaborating with caregivers:
I also think that there could be like a whole other elective course and then some create it with how to work with the parents of children because sometimes that could be the more frustrating part of working with children. Being able to see how we can help this child but how do we get the parents to make changes and get on board with really embracing it to get the results that they want.

PJ noted that teens are in a difficult developmental stage and identified challenges when working with caregivers and their teens. PJ stated:

Sometimes teenagers and parents have really strained relationships and so often times I act as that middle person, or that advocate in the middle to help them understand like, he’s trying to say and this is what she’s trying to convey. Kind of illustrating it in a more positive way. Sometimes parents or caregivers in that spot can be so frustrated of so overwhelmed. So, they only kind of see what is negative or was there. And when you have a therapeutic relationship with a client, especially with a teenager or you build a rapport, you learn a lot about them really in depth. And so really being able to say mom, dad, caregiver, whoever it is, it may seem this way from this perspective, but I’ve seen this side, and I think you may benefit from you know, maybe changing some about the conversation, or change some of the language, or reframing it this way, to develop a healthier relationship or better communication. So, that’s one of the major ways I would say, it's really with their own caregiver. The people they are in the environment.

JC also expressed a collaborative challenge regarding emotionally unavailable caregivers and the impact on the minor client’s therapeutic progress. JC stated:
There are times when I am advocating with and times I am advocating just on behalf of the child because the caretaker is emotionally not present or the caretaker doesn’t realize that there is harm being done.

Two participants reported collaborative challenges with caregivers in relation to confidentiality. Katie referenced consulting with caregivers about their children’s’ counseling without disclosing confidential information. Katie stated, “Staying in touch with parents, not sharing details of the counseling sessions but for the advocacy and to keep the children safe”. Lithie mentioned the challenge of navigating confidentiality with caregivers as well stating, “When you’re dealing with parents or guardian, and teachers and sometimes you get in these very sticky situations, in the school setting itself”.

Sources of Support

While navigating collaborative advocacy experiences participants consulted with resources to seek confirmation and obtain assistance with challenges. The resources included but were not limited to supervisors, peer clinicians, and professional social media networks. Each of the six participants reported utilizing either their site supervisor or credential supervisor as a main resource. Lithie and Jane reported feeling well supported by their supervisors who specialized in trauma work with minor survivors of abuse or neglect. Lithie stated that the supervisor was her, “number one resource”. When speaking about consultations with her supervisor Jane stated, “I don’t think I’ve ever asked a question and have been unable to get a clear answer that helped steer me.” Peer clinicians including counselors, social workers, and even medical professionals at times were also identified as consultants. PJ stated:

I have a network of clinicians that I piggyback things off, ask questions. Also, there’s a really good Facebook group that provides really insightful answers. So just utilizing
social media groups, close network of people, professionals in the field. I also can email professors if I needed to.

In addition to other resources Ricky added that she utilizes her “higher power, the bible, and her husband” at times for support when navigating challenges.

**Influences on Advocacy Preparedness**

The third master theme that emerged from the data is influences on advocacy preparedness. The influences are presented in three specific categories: academic experiences, supervisory experiences, and professional experiences. Although the participants spoke of beneficial influences that aided in their competency and advocacy preparedness, they also identified inadequacies within their CACREP graduate programs.

**Academic Experiences**

All six participants noted their academic experiences as a major influence of advocacy preparedness. PJ and Ricky spoke positively about the inclusiveness of advocacy preparation within their academic curriculums and reported the content being presented throughout the courses. However, four of the six participants reported significant advocacy inadequacies within their master level graduate programs. Two aspects of academic experiences discussed by the participants included advocacy content offered in the program and the expertise of the professors.

**Course Content**

PJ and Ricky spoke specifically about the inclusiveness of advocacy content within their graduate programs. The two participants who reported adequate preparation in their programs both graduated at the doctoral level. PJ stated, “I feel like it was constantly embedded in some part of the course work throughout the semesters.” Ricky added, “I would say it [advocacy
preparation] was very fluid and present throughout my masters and doctorate program”. While all participants provided recommendations on how programs might better prepare counselors to advocate for children who have experienced abuse or neglect, the master level participants communicated more of a need in those areas. Jane stated, “I think that there certainly could stand to be more of an academic focus in the programs that prepare us for this career.” JC added, “I feel like I learned things at [my university] but I feel like I learned more after just being in the role”. She reported feeling more prepared by her experiences in the field. Katie further explained that there was a heavy focus on theory and perhaps not enough clarity on advocacy teachings. Katie stated, “I know they talked about it [advocacy] on a macro level but I don’t know if we really understood what that meant or if I understood what that meant, cause it’s so theory heavy.”

Multiple courses were mentioned when the participants spoke of advocacy preparation and their curriculum. Each of the six participants mentioned their ethics course and the advocacy detail identified by the experience of this course was mandatory reporting. Katie stated, “I think they definitely emphasize mandated reporting in mainly the ethics class. I think the ethics class mainly focused on advocating.” In agreement, Jane stated, “A lot of that has come from of course academics with a heavy stress on the ethics of that.” A collection of courses that influenced advocacy preparation identified by the participants are child and adolescent related courses. This includes play therapy and school counseling classes. When explaining advocacy preparation in curriculum Ricky stated, “I had a very lovely counseling and children’s and adolescence professor and introductory to school counseling professor.” While Ricky recounted positive experiences and felt prepared by child and adolescent related courses, Jane communicate the need for more preparation regarding advocacy for children, stating, “Particularly, advocacy
for children because they don’t have the full ability to advocate for themselves more so than adult may or may not have that ability.”

Ricky expressed the most detail on how extensive the advocacy preparation was in her curriculum stating:

Also, my intro to multicultural class, my advanced multicultural, my supervision course, the group work course, matter of fact it was throughout the curriculum. I remember it even in interventions and crisis. The professors even had guest speakers come in. We even had a POP group Promoting our Own Profession. And then our chapter of Chi Sig also did some presentations, and they even had their seminar series and some workshops too. I would say it was a very fluid and present throughout my masters and doctorate program.

The data presented a deficit in the area of legal advocacy preparation within the participant’s graduate programs. Only one participant spoke of a strength in this area while the other five cringed at the idea of advocating legally such as in a court room or speaking with an attorney or law enforcement. The one participant who spoke positively about this area was PJ, a doctoral participant, and had a professor with a counseling and law background. PJ stated, “… one of my professors he was a lawyer as well as a therapist, so the go to know the legal side.”

Lithie reported feeling that more training would have been helpful stating, “with any novel situation, like dealing law enforcement I didn’t feel that prepared.” She also added:

I feel like grad school it was very general guidelines of what the law requires us to do and ethical principles. So, it was very general understanding, but there wasn’t a particular model we discussed or particular steps that we take- not that I can recall. Maybe there was something, but I just don’t remember that. And I don’t recall spending a whole lot of
time on that piece. Like we didn’t study that in dept. It was something we went over just have a general understanding and foundation.

Multiple participants reported a need to consult if presented with legal inquiries. I subpoenaed to testify, Jane stated, “I think I would of course do the proper consulting and probably very closely review my chart, but I think I would survive it OK.” Katie reported seeking guidance from another employee after being subpoenaed for court, stating:

I got subpoenaed once and I didn’t end up having to share anything with that attorney.

So, if the attorneys subpoena us or one our records we can rely heavily on the support of a supervisor. [She] helps a lot with that if that came up. I really haven’t dealt with that quite yet but I know it’s coming.

When speaking of future possibilities of being subpoenaed to court, Lithie added:

I feel like I’d really have to learn more about it. Maybe consult with someone who has done that just to see what that’s like. Both to prepare emotionally and to prepare- what to say and what not to say in that setting

Lastly, JC spoke of a complicated legal situation in which she leaned on the support of a supervisor to navigate the situation, JC stated:

There was one incident where an attorney that had reached out when I was working …. and it was more of like custody and the conversation got recorded and things got twisted and that was a big learning curve for me. You know, so then also just, so gaining the knowledge and like being told different things by supervisors and talking through it and peer consultations. Things like that.

The participants reported different levels of influence based on advocacy preparation presented in their graduate programs.
Another aspect of academic influence identified by the participants is the expertise of their professors. Some of the participants reported feeling more prepared and confident when educated by professors who not only knew the information but who had experience in working with the specific population. PJ spoke specifically about the level of competency gained from a professor who held degrees in law and counseling. Due to the professor’s expertise PJ reported receiving greater insight. PJ reported:

I think one thing that I also took away from each experience is that each professor had a different nugget of knowledge that they would pass on in terms of how to navigate the system. For example, in my program I had one of my professors who was a lawyer as well as a therapist, so he knew the legal side. So, he often would share the legal and ethical side of how it would look in court. He also got to share the therapist side. So, it was just each experience that I received from each professor that allowed me to take this information or knowledge and say OK this is maybe what I’ll retain if I’m ever in a situation. So, I think not only giving you like what it is in black-and-white and terms of what is the proper protocol but also, going by people’s experiences, people’s knowledge, and people’s expertise on who’s been in the field for a long time. It’s also really helpful in learning how to properly advocate for your client as well.

While Katie spoke of a deficit in advocacy training within her academic program, she reported receiving advocacy guidance from an outside professor within another university stating:

and works with families who are all referred by child protection and with children under six.
Lastly, Ricky spoke of an enriching experience with a professor who taught the children and adolescent course. Ricky stated, “I had a very lovely counseling and children’s and adolescence professor and introductory to school counseling professor”. Three of the six participants spoke of the impact and influences of their professors’ expertise on their advocacy preparation within their academic experience.

**Supervisory Experiences**

When considering the influences supervision had on the advocacy preparation of the participants it is important to note that there was supervisory experience during the graduate program and post-graduation. The participants spoke of the benefits of both. The participants identified their supervisors’ expertise, guidance, and support as beneficial influences on advocacy preparation.

Ricky spoke of utilizing the support of her university supervisor in her master’s program. An ethical dilemma regarding mandatory reporting arose at her internship site. When the site supervisor suggested that Ricky did not have to report she turned to her university supervisor for support. Ricky stated:

I had a supervision within supervision situation. I had something arise and that particular professor helped me walk through that process because it was a particular site where the site was not conducive to report. It was the administrative supervisor who was like “you really don’t have to do this”. It was a weekend, and the person was going out of town and the university person backed me up. They were like, the student was going to report, and the university supervisor was going to report. They backed me up.

Lithie and Katie both spoke of circumstances in which they gained advocacy support from their registered play therapy supervisor (RPT-S) and provisionally licensed professional counselor
(PLPC) supervisor. Lithie stated, “I think supervision one was that one piece that really helped me understand what advocacy means for me to do for the kids.” Lithie added, “That [my RPT supervisor] was my number one resource. I worked with my PLPC supervisor. I had two, and my play therapy supervisor.

Jane reported on the benefits of having a site supervisor who was trauma informed and a registered play therapist at the private practice. Jane stated:

I have plenty resources that I might seek for the support depending on the situation. As a relates to primarily working with children in my current work setting, I seek that support usually from the owner [site supervisor] who has knowledge on just about all of it. I don’t think I’ve ever asked a question and have been unable to get a clear answer that helped steer me.

PJ added:

I had a lot of support in terms of supervision and consultation on how to actually do this and what are the proper steps. …. Not from my PLPC supervisor. Maybe my site administrative supervisor at the particular agency I was talking about that works with children. They were really good at connecting the dots form you and answering the hard questions and helping you understand the resources in the community. I think part of advocacy is awareness and understanding what’s out there, what’s around, what can you utilize, and who can you utilize. I think is a big part of advocacy as well.

Katie identified multiple ways in which her site supervisor provided advocacy and competency support. Katie reported that her supervisor encouraged communication with outside resources, guidance on collaborating with parents, communication with school leaders, safety and mandatory reporting. Katie stated that she did not get to training on legal advocacy. JC also
reported of advocacy support through a specific community agency supervisor who was experienced with the population and who provided good insight and direction.

**Professional Experiences**

The third and final theme of advocacy influence produced from the data is professional experiences. The aspects of professional experiences are clinical experiences and professional resources. The clinical experiences involved aspects such as on the job training and consultation whereas the professional resources involved benefits of past professions, advocacy models, psychoeducation tools, the ACA *Code of Ethics*, and peer consultation.

**Clinical Experiences**

The participants felt that most of the specialized preparation needed to competently serve and advocate for this population developed during clinical experiences. While the two participants representing the CAC setting described experiences of providing trauma therapy, psychoeducation, collaborating with other professionals, and participating in MDT meetings as aspects of their current roles, they each spoke of prior clinical experiences. JC reported gaining experience at her practicum and internship site, the department of juvenile services. Following graduation, she was employed by an agency where she provided in-home services to youth ages five to seventeen.

PJ and Jane represent the school setting and reported that clinical experiences had a positive influence on their advocacy preparation. PJ completed the marriage and family tract in her graduate program and although she originally wanted to work with couples, she landed a job working with children. For roughly six years PJ served children ages five to seventeen. PJ went on to serve as a school counselor for two years prior to starting her private practice. During her time in the school setting PJ provided six-week trauma therapy groups. PJ shared They were
really good at connecting the dots form you and answering the hard questions and helping you understand the resources in the community. PJ shared following about her clinical experiences of working with a supervisor, “They were really good at connecting the dots … and answering the hard questions and helping you understand the resources in the community”.

Prior to working in private practice, Jane had the opportunity to work at a medication treatment facility for substance abuse and completed her practicum at a district attorney’s office. During her two and half years of working in private practice Jane has provided services to individuals ages three to sixty for various issues including trauma, abuse, and neglect. Experiences that have further prepared Jane for advocacy work include acting as a translator of sorts, helping parents and foster parents to best help their child, making reports to child protection, and being a voice for the children. Jane reported:

I have sometimes had to advocate in an indirect way for clients with court systems, custody evaluators, professional providers, schools, kind of whatever comes up where I see a place that was within my scope of practice and within my ability to try and help them in some way.

The two participants who represent the school setting, Lithie and Ricky, practiced mainly in school settings. Lithie completed her practicum and internships in the school setting and became employed by an elementary school following graduation. Lithie recently began serving in a private practice setting though most of her professional experiences occurred in schools. Lithie reported that she was not prepared for advocacy work in the beginning of her career however experiences led to preparation. Lithie reported that she learned to consult and ask questions which eventually led to a sense of being prepared.
Ricky reported having experience in three school setting prior to her current position as a professor. The school included both private and public middle and elementary schools. Some roles besides counseling sessions included but was not limited to community networking, providing psychoeducation, and mandatory reporting. Ricky reported a few negative experiences that led her to consult and research to competently navigate the circumstances. In doing so Ricky gained more knowledge for advocacy preparation. Some of the challenges involved confidentiality. Rick reported:

Making sure the agency, the school counseling staff, when it came to storage and proper storage of records and as far as who needed to be involved. That was a challenge- where when I made a report it needed to be filed in the school counseling file cabinet yet, let’s say, the school secretary wanted to know what was happening when really needed to be between at the school answering office maybe the principal and related administrators. There were some challenges we had in terms of it being a small-town area.”

These were circumstances that lead to greater advocacy preparation for future experiences.

Professional Resources

Past Professions

Two participants spoke of previous profession or role as a resource that positively influenced their advocacy preparation. Katie spoke of her experiences as a victim advocate where she developed knowledge to assist with sharing of resources, outside referrals, mandatory reporting, and collaboration with other professionals such as medical doctors, law enforcement, and child protection. Jane informed that her past legal experience in the legal field provided knowledge and confidence to advocate more effectively. Jane stated:
It has given me some background with sometimes getting creative with ways that I can advocate and gaining a certain confidence and boldness which sometimes just being able to go in and get the point in a very direct and professional away. To say this is what I’m saying that my client needs, how are you able to help me? Rather than waiting for waiting for solutions to appear.

*Code of Ethics*

Each of the six participants mentioned the ACA *Code of Ethics* as a tool and resource used to aid in practice. When referencing the code, the participants mainly spoke of aspects of confidentiality and mandate reporting. PJ stated:

I’m definitely mindful of what’s ethical and what’s not with minor. Especially, because it’s such a fine line with them. There’s a level of protection with any client so there’s definitely a level of protection with minor people that are under a certain age. Specific codes I use? I don’t remember off the top of my head…. So if there is something I’m unclear about or just making sure I’m up to ethical standard I’ll look it up. Also. Because I supervise as well, I also sometimes will just refresh just to tell a PLPC this is what you cannot do, and this is what you can do. I refer to it when I need to.

When speaking of implementation of the code of ethics Ricky stated:

So, for me when it comes to specific advocacy, cause what I try to do is bring in not only a copy of the various competencies but also the 2014 ACA code of ethics and prior to that 2005 code of ethics. I will bring in the relevant codes and talk about how I am a mandated reporter and that I abide by these things. Sometimes the state and the school district I’m working in may supersede my code of ethics and I would have to talk about
my limitations to confidentiality, but I would also point out how I would have to adhere to those five basic principles along with the preamble. That’s where I usually start.

**Advocacy Models**

Ricky was the only participant who reported using advocacy models as a resource that aided in preparedness while others reported that they did not learn of any or did not use any advocacy models. Ricky identified the following models: ACA Advocacy Competencies, Social Just Competencies, Child Welfare Reporting forms, ASCA Position Statement, Legislative Advocacy Model, The advocate Model. She added that these models aided in advocacy efforts when navigating systems and during community collaboration. While JC did not have a specific advocacy model of use, she reported feeling mostly prepared. In reference to preparations, she stated:

Most of the time but not 100% of the time. But letting my client know that it’s something that is important to me then we figure it our together or I do research and figure it out on my own and figure out how we are going to do this with the parent, the client, or whatever family member. Cause I am not the expert all the time and don’t have all the answers.

**Consults**

Each of the six participants spoke of utilizing consultations and this often served as an influence of advocacy preparedness. The resources mainly included supervisors and peer professionals. PJ stated, “I have a network of clinicians that I piggyback things off, ask questions. Also, there’s a really good Facebook group that provides really insightful answers. So just utilizing social media groups, close network of people, professionals”.


JC spoke of consulting with staff, other clinicians, and supervisors and Lithie added that her “go-to source” is her supervisor who specializes in trauma work with children and adolescents. Katie shared similar resources such as:

... other licensed counselors who are friends and old colleagues. One is a registered play therapist so I can ask her play therapy questions. I will consult with the social workers here. They are usually out of grad school so we have different experiences and backgrounds but since they are more in the mix with the nurses and the doctors maybe they can tell me a little bit about advocacy since there they have more routine over there...

Jane concluded,

I have plenty resources that I might seek for the support depending on the situation. As a relates to primarily working with children in my current work setting, I seek that support usually from the owner who has knowledge on just about all of it. I don’t think I’ve ever asked a question and have been unable to get a clear answer that helped steer me. And the second part was how often?

**Trainings**

Continued education is a requirement to maintain licensure and some of the participants spoke of training as an influence on advocacy preparedness. JC spoke of being in the process of gaining a certification for trauma focused- cognitive behavioral therapy. She stated:

So, today will be my last case consultation call for TF-CBT. So, then I’ll take the test and get TF-CBT certified, even though you can practice once you do all of the trainings, I’ve done the trainings a couple of times, but I’ll actually be certified.
JC also reported recently attending a training to gain more competence on multiculturalism. JC and Katie reported participating in “peer reviews for mental health professionals” and “trainings that come up and topics that we discuss and challenges”. Jane spoke of immersing herself on extensive continued education and reported:

“I am a certified clinical trauma professional. I have a brief counseling certification and I am also and consulting hypnotherapist. I’ve had training in EMDR, brain spotting, and many many other things also.”

*Psychoeducation Tools*

Ricky and Katie spoke of psychoeducation resources they used during advocacy work and these resources added to advocacy preparedness. Ricky spoke of using evidence-based prevention resources such as; Darkness to Light, Play It Safe, Gator Academy, and Speak up Be Safe. Katie spoke of a program called Teen, Sex and the Law which educated you on law related to sexual contact.

Content of courses and the expertise proved to be a positive influence on advocacy preparation, however more than half of the participants reported a greater need for advocacy preparation within their graduate programs.

*Considerations for Advocacy Competency and Preparedness*

The final master theme is considerations for advocacy competency and preparedness. Each of the six participants provided recommendations as to how professional counselors might be better prepared to treat and advocate for children who have experienced abuse or neglect. The main categories entailed academic enhancement, trauma informed supervision, continued education, and legislative change.
**Academic Enhancement**

Five of the six participants mentioned the need for improvements in the academic setting. Lithie stated, “Definitely more training is needed in the academic setting”. PJ reported the need for more advocacy content be offered as a course or be infused into the curriculum stating:

I think it would be beneficial to have a specific class about advocacy and how to navigate it because it can be kind of overwhelming and intimidating, especially to a new counselor. I think adding that to a program curriculum or a as course could be beneficial. PJ further explained that adding a course could be difficult based on accreditation requirements and she provided ideas as to how content might be infused to existing courses. She added:

… sometimes adding a course can be really difficult, depending on the CACREP accreditation, maybe just having like, almost like you take play therapy classes in order to get a certification it’s something like a course or a CEU opportunity.

Jane added that there is a need for “focus on advocacy specifically for children”. Four of the participants specifically spoke of a need for specialized electives focusing trauma work, neurobiology, advocacy challenges, working with caregivers and families, and secondary trauma prevention. Ricky stated, “I would recommend having an additional course that’s all related to serving this population.” She further elaborated on the benefits of education on instruments and role play stating:

I am appreciative of when I was in class when we got to do role-plays using those instruments with peers and being able to take some of the self-scoring but it was a little different in the field because what I found was that with some of the instruments they’re not uniformed when it comes to open responses, especially with the semi structured interviews so you could be left to your own devices or falling on deaf and ears when
working in those settings. And also, what I recommend is using more tools as a relates to burn out and compassion fatigue.

In reference to course work and specialized electives Jane spoke of the need for education on childhood neurobiology and brain development related to trauma, adding:

I think that it will be more helpful if of course there is some more human development involved in coursework in this profession. I think it would be helpful to have some coursework that looked at the neurobiology of childhood development. Specifically, today with how a child’s brain may function differently if they have autism or any variety of diagnoses. I feel like that would be helpful.

Both Jane and Katie reported a need for academic preparation when working with caregivers and families of children who have experienced abuse or neglect. Jane stated:

I also think that there could be like a whole other elective course and then some create it with how to work with the parents of children because sometimes that could be the more frustrating part of working with children. Being able to see how we can help this child but how do we get the parents to make changes and get on board with really embracing it, to get the results that they want.

When speaking of being prepared to work with families and caregivers Katie added,

The only reason I felt slightly prepared was because I did a year-long internship at the child and family counseling clinic … and so I learned a lot there. Then I worked in the school, but I don’t think that really prepared me to work because the child the family counseling clinic was more with little ones and family work. Like caregiver work and caregiver trainings.
**Trauma Informed Supervision**

Another recommendation for competency through academic preparation was trauma informed supervision. Ricky stated that there was a need for trauma informed supervision. In agreement, Lithie spoke of how having a trauma informed supervisor was a great benefit. Lithie stated:

My go-to is my supervisor and also because I know that she has worked in the field of abuse and advocacy, so I know she has a lot of knowledge in that area. This is my go-to source for information, for support, for better understanding of how to help these kids.

**Advocacy Challenges**

Participants spoke of the need for specialized education and training due to the intricacies involved in serving this population. Some of these challenges are the same as those that emerged during collaboration as the collaborative efforts were for the purpose of advocacy. PJ pointed out that, “advocacy can be overwhelming and intimidating, especially for new counselors”. Multiple participants shared at various points within their interview the realization that advocacy is broader than they realized. Lithie stated:

You know as I was working with kids it took me a long time to even realizing that part of what I was doing was advocating for them. Because advocacy sounds like such a fancy word, like oh, I’m advocating, and I never thought in terms of my job until later on. I guess thought more about it and maybe I was faced with more challenging situations. So, it’s not a term I used to define my work early on.

PJ stated similar sentiments, “I never really thought about many of my actions as advocacy and how much advocacy is a part of our work.” PJ then added, “we really don’t talk about it
[advocacy], especially if you don’t work with children.” When speaking of professional efforts and the topic of advocacy, JC added. “I don’t always think of it [actions] like that [advocacy].” Lithie later highlighted the importance of understanding advocacy and challenges for new and upcoming counselors. Lithie stated:

As a new professional you go into the field and you have this general knowledge floating around your head but when you’re confronted with a certain situation, you’re kind of at a loss as to where do you start and what do you do. So, it would be very helpful to have either step-by-step things or guidelines, resources, models maybes- to have access to so you know what to do.:  

Five of the six participants reported that they did not have a specific advocacy model to help them navigate advocacy matters. Ricky was the only participant who identified models she used. PJ spoke of creating personalized plans, stating:

No, there’s not an actual model I find. I think everything is individualized or personalized to the person. So, whatever I see, I don’t mind researching and asking the questions or consulting to figure out, hey this is what I thinks is going on. I need more information. I would like to know more. I would like to understand more to better help this person. So, it’ kind of what I feel like will be best suited for that client at that particular time.

Similar to PJ, when asked if there was a specific advocacy model Jane stated, “Other than instinct of what feels right for the situation, no.” While JC and Katie did not provide much detail, they both indicated not having a specific advocacy model to refer to. Considering the complications that may arise while advocating for children who have experienced abuse or neglect academic knowledge or continued education on advocacy models may prove helpful for preparedness and competency.
Continued Education

JC’s main recommendation for advocacy competency and preparedness was continued education. JC specifically spoke of education related to considerations for various backgrounds and resources. When identifying topics of continued education JC stated, “I think being aware of backgrounds of the families so we can be better informed of the needs of the family too.” This included religious beliefs, morals, and values. Katie added that continued education could be helpful in the context of specific certification such as Parent Child Interaction Therapy (PCIT), Child-Parent Relationship Therapy (CPRT), and Trust Based Relational Intervention (TBRI). JC and PJ identified knowledge of resources as a recommendation for preparedness. JC reported how a lack of resources might prevent clients from receiving the mental health service they need. JC added, “If they are homeless then it’s not quite possible to do counseling if they are not stable. We must meet the biggest need first.” Meeting the need happens through knowledge of resources and connecting to resources. PJ stated, “I think part of advocacy is awareness and understanding what’s out there, what’s around, what can you utilize, and who can you utilize.” Continued education in these areas were reported to be considerations for preparedness and competency.

Legislative Change

Lastly Jane added a recommendation to produce legislative change on federal and state levels. Jane stated:

I think it probably has more to do with the level of permissions that we as clinicians are granted and the things that we can and cannot do to advocate for our clients. Accepting confidentiality and that ethical considerations but unfortunately sometimes our hands are tied beyond, Okay, I tried to talk to the school, the schools not getting back to me, I made
a DCFS report they were not elected to do anything, I really can’t help this child any further.

The participants each made recommendations to promote competency and preparedness of counseling students and practicing counselors in order to best serve minor clients of abuse and neglect.

Chapter Summary

Chapter four encompassed a brief introduction and explanation of the purpose of the study. A brief summary of the data analysis procedures was explained followed by findings produced by the data analysis. The finding across and within cases was presented through four master themes: fundamentals of advocacy, aspects of collaboration, influences on advocacy preparedness, and considerations for advocacy competency and preparedness. In the final chapter the findings are discussed in relation to current literature followed by implications of the study. Lastly, the limitations of the study are presented and the recommendations for future research are shared.
CHAPTER 5
DISCUSSION

This chapter entails a restatement of the purpose of the study and a summary of the research methods. Discussion of the results in relation to current literature is followed by discussion of limitations, and recommendations for future research. The chapter concludes with my personal reflections about the research process.

Purpose

The purpose of my qualitative phenomenological research is to understand advocacy experiences of LPCs who work with minor survivors of child abuse and neglect. I explored LPCs’ experiences regarding advocacy in the following areas: (a) education, training, and competency; (b) collaboration with various professionals; and (c) difficulties and benefits of advocating for minors who are survivors of child abuse and neglect.

Summary of Methods

I used interpretive phenomenological analysis to individually examine details and identify themes within the data produced by the phenomenological study. Purposeful sampling aligned best with seeking to understand the experiences of the participants. LPCs who practice counseling in the state of Louisiana and graduated from a CACREP accredited program were solicited via email. Two were selected from each of the following settings: schools, private practices, and Children’s Advocacy Centers. My sampling procedures began with recruitment by email. I conducted individual virtual semi-structured, in-depth interviews to guide my data collection process. I used closed and open-ended questions to allow for flexibility during the interview process. The findings presented four master themes which derived from emergent and super-ordinate themes.
Discussion of Results

The findings produced by this study are the essence of the participants’ experiences as LPCs serving minor survivors of abuse and neglect. The participants’ experiences involved benefits, challenges and could be attributed to the following four master themes: fundamentals of advocacy, aspects of collaboration, influences of preparedness, and considerations for advocacy competency. The conceptual framework I used is the (ACD) by Lewis et al (2003) which was updated by Toporek and Daniels (2018). The ACD framework is a unique comprehensive guide that includes three levels of intervention (i.e., Client/Student, School/Community, and Public Arena), with six advocacy domains (i.e., Client/Student Empowerment, Client/Student Advocacy, Community Collaboration, Systems Advocacy, Collective Action (Public Information), and Social/Political Advocacy). Each level of the ACD framework differs in advocacy actions with and on behalf of a client or student (Lewis et al., 2003). The finding of this research study suggests that counselors may need more advocacy preparation during their graduate level counselor education programs and pre and post graduate supervision from supervisors who specialize in serving minors who have survived abuse and neglect.

Fundamentals of Advocacy

Variations in advocacy perspectives exist across the helping professions, including professional concepts, advocacy terms, and differences in definitions (Lating et al., 2009; Lyons et al., 2015; Ramirez et al., 2017). In ACA’s Code of Ethics’ (2014) the definition of advocacy involves the micro (e.g., individual client) and macro (e.g., counseling profession) levels, whereas in the definition by Lewis and Bradley (1999) only a macro-level view is included. Fran (2014) suggested that multiple factors are necessary for effective advocacy efforts including: (a) collaboration in professional relationships, (b) persistence during challenging situations, and (c)
recognition and actions on opportunities when initially presented with a situation that requires advocacy. The results reflected fundamentals of advocacy involving the participants definitions of advocacy, experiences, and utilized resources.

As reflected in the literature, the participants included a variety of terms while defining advocacy. Ramirez and Steg et al. (2017) described advocacy as “taking action” and/or “speaking for” clients to foster environmental advances including social justice and changes in laws that will positively benefit clients (p. 11). While this definition is rooted in social justice and changes in laws, the participants highlighted the same details of “taking action” and “speaking for” but in the context of direct action for the client. Jane reported that advocacy is “fighting for those who can’t fight for themselves” and Lithie identified advocacy as, “fighting for children and helping them get what they need”. Ricky also used parts of the same language as Ramirez and Steg et al. (2017) stating that advocacy requires “speaking up for others”. Terms within the ACA’s Code of Ethics’ (2014) advocacy definition, such as, “well being and “remove barriers and obstacles” was also referenced by the participants when defining advocacy. Statements made by the participants that referenced the client’s well-being included “protecting the child’s privacy” ensuring that the “child feels heard, and “being consistent”. Aspect of removing barriers and obstacles included, “fighting for those who can’t fight for themselves”, helping children and families through various “hardships” and “navigating challenges”. Jane added advocacy requires “sometimes really being willing to stick my neck out to try and help in the best way possible.” There were some commonalities between definitions in the literature, however difference remain in regard to micro and macro-level efforts and variation in terms. As suggested by Ramirez-Steg et al. (2017) there is a need for clarity in the meaning and operationalization of various advocacy terms.
In addition to defining advocacy, another aspect of the first master theme is the experiences involved in advocacy work. These presented in the form of mandatory reporting and educating. The literature highlighted the responsibility of mandatory reporting as identified by the Department of Children and Family Services and the law, which is indicated in the Louisiana Children’s Code Title VI Article 603 (DCFS.louisiana.gov, 2019; DHHS, 2018). While each of the six participants understood their duty to report and upheld the responsibility, they communicated some challenges involved in the process. The reported challenges involved dealing with the adversity of other professionals in the school system who discouraged reporting, not always knowing what was previously reported in cases of the CAC and educating others on mandatory reporting. As mentioned by Fran (2014) the participants utilized “persistence during challenging situations” to reach positive outcomes during advocacy efforts. While some of these specific issues were not noted in the literature, a study conducted by Bryant and Milsom (2005) suggested that most school counselors feel confident about their responsibilities as mandatory reporters; however, they desired more training. The aspect of educating came through the experiences of educating oneself and educating others such as clients and professionals and in the context of consultations and community involvement. The experiences are inclusive of each level of the ACD framework (2018) ranging from micro to macro levels of advocacy work with the individual client, the community, and the public arena.

The final aspect of the first theme, fundamentals of advocacy, is utilized resources. While only one participant identified the use of an advocacy model during practice, each of the participants reported relying of the ACA Code of Ethics, consultations, screenings, and assessments. Ricky, a doctoral level participant, stated that she uses the ACA Advocacy Competencies, Social Justice Competencies, Child Welfare reporting forms, ASCA Position
statement, Legislative Advocacy Models, the Advocate Model. While others reported that they
do not use a specific model, they reported referring to the code of ethics when needed.
Counselors are obligated to uphold a plethora of responsibilities and must do so in the confines
of their state and federal laws and their code of ethics. The ACA’s Code of Ethics (2014) and
ASCA’s Ethical Standards for School Counselors (2016) are designed to do what is in the best
interest of clients. When discussing avoiding challenges, LaFortune & Carpenter, 1998; Patel &
Jones, 2008 highlighted the importance of supervision and other factors. Each of the six
participants reported relying on supervisors and consultation with professional peers during
advocacy experiences, specifically those that involved challenges. One of the keys to counselors
avoiding challenges and practicing competently is participating in proper training and
supervision (LaFortune & Carpenter, 1998; Patel & Jones, 2008).

Aspects of Collaboration

The second master theme produced by the study is aspects of collaboration. The topic is
discussed in the literature and was extensively discussed by the participants. The aspects of
collaboration involved working with professionals and systems, such as schools,
multidisciplinary teams, and child protection. Collaborative aspects also involved legal
caregivers and supportive resources.

Childhood abuse, neglect, and maltreatment are associated with long-term adverse effects of
children, such as fear and stress, as well as impaired psychological development, emotional
dysregulation, and delayed school readiness (Gunnar & Donzella, 2002; Rogosch et al., 1995;
Skowron et al., 2010). The study suggested that school counselors understand the impacts of
trauma and their role to advocate for these clients. Literature and results of the study reflect that
counselors often act as a voice of change by collaborating with teachers and administrators to
better understand the children’s behaviors and needs. As suggested in the study conducted by Bryant and Milsom (2005) the results show that counselors feel confident about their role as mandated reporters. However, the results of my research suggest that school counselors face adversity from school systems when reporting and are sometimes discouraged to report. As discussed in a study by Kramer et al. (2015) counselors in CACs do collaborate with child protection as well as counselors in other settings. The results of the study also reflect that navigating collaborations with professionals and systems produce benefits and challenges.

Ledyard (1998) stressed that counselors should seek legal consultation when needed because state laws and ethical codes are complex, and these complexities are unwavering (Wheeler and Bertram, 2015). Although the results suggest that counselors are willing to testify, if necessary, they may need extensive support and guidance. In circumstances where there was communication with attorneys, counselors reported heavily relying on supervisors and professional peers. Counselors are obligated to uphold their ethical and legal responsibilities although “for many practicing MHPs and graduate students, the legal system is a foreign and sometimes frightening place” (Wheeler & Bertram, 2015, p. 1). The results aligned with this piece of literature as there was a common theme fear regarding the possibility of testifying in court. When counselors provide counseling services to minors, ethical and legal challenges can result from issues surrounding confidentiality and privileged communication. Legal challenges produced by the study related to navigating consultations, records requests, and subpoenas. The results show that there is a need for more training in this area. In order to avoid legal complications, counselors must practice competently (Corey et al., 2015; Wheeler & Bertram, 2015). The literature and results are of one accord as it relates to advocacy experiences involving legalities.
The results of the study show that counselors in all three settings experience collaborative efforts with caregivers. Experiences with caregivers while serving this population might involve assisting in effective communication between minor clients and caregivers, sharing resources, providing psychoeducation, and providing education on the use of client records. The results also show that counselors might experience challenges across settings while collaborating with caregivers. Challenges involve confidentiality and a lack of emotional availability from caregivers. Aspects of these experiences are discussed in the ACA Code of Ethics (2014). Standard B.1.c. states that “counselors protect the confidential information of perspective and current clients. Counselors disclose information only with appropriate consent or with sound legal or ethical justification” (p. 7) and Standard B.5.b directs counselors to educate parents or guardians on the role of counselors and the details of confidentiality as well as “…establish as appropriate, collaborative relationships with parents or guardians to best serve [minor] clients” (p. 7). Two particular domains of the ACD model applies to these experiences. When counselors empower minor clients to have healthy conversations with their caregiver the counselor is acting within the Client/Student Empowerment domain. When counselors act on behalf of their minor clients but educating caregivers and sharing resources, counselors are acting within the Client/Student Advocacy.

Sources of support is the final focus of the second theme. Results of the study show that counselors serving minor survivors of abuse and neglect often access sources of support during advocacy collaboration. Counselors may access sources such as supervisors, peer clinicians, and professional social media networks. Each of the six participants reported utilizing either their site supervisor or credential supervisor as a main resource. While some counselors may also utilize
sources such as a higher power or family member, most counselors seem to feel best supported by supervisors who have experience in serving minor survivors of abuse and neglect.

Results of the study show that collaboration produces beneficial outcomes for the clients and professionals. However, as mentioned in the literature collaborative efforts also present challenges. Wheeler (2014), who served as a licensed attorney and consultant for the risk management department of ACA, stated that a lack of collaboration can create difficulties in client health concerns, civil malpractice lawsuits, client dissatisfaction, and complaints to licensing boards.

Collaboration is a significant aspect of advocacy and can involve interdisciplinary and/or multidisciplinary efforts (Meyers, 2014; Swenson & Spratt, 1999; Trossman, 2011). When considering aspects of collaboration when serving minor survivors of abuse and neglect the results of the study reflect that there are various factors involved including working with other professionals, systems, and caregivers. In addition, there are legal considerations and reliance on sources to make informed decisions for the best interest of the client. When implemented effectively, collaboration aids in positive outcomes for professionals and clients. Collaboration proves beneficial across various professions including mental health and medical fields (Swenson & Spratt, 1999; Trossman, 2011). The results reflected that collaborative experiences benefit clients by creating opportunities and removing barriers as mentioned by Fran (2014). Similarly, Kelleher and Rickert (1994) stated that interdisciplinary collaboration assures that all client areas of care receive attention. This was affirmed by data reported by those in CAC settings who work directly with multidisciplinary teams. Aspects of this were proven by the study as counselors shared positive outcomes as a result of their collaborative work.
Influences on Advocacy Preparedness

The third master theme that emerged from the data is influences on advocacy preparedness. The influences are presented in three specific categories: academic experiences, supervisory experiences, and professional experiences. Because advocacy is an area of competency that is required within and across helping professions, professional counselors should be knowledgeable in how to advocate effectively (American Counseling Association, ACA, 2014; Barnett, 2004; Crenshaw, 2011). Failure of counselors to adhere to ethical and legal professional responsibilities can result in four legal consequences: (a) negligence (i.e., unintentional tort), (b) malpractice, (c) intentional torts, and (d) criminal action. Negligence involves four elements: (a) duty, (b) breach, (c) causation, and (d) damages.

According to CACREP (2016), counseling programs must teach advocacy standards to counseling students. Additionally, counseling practicum and internship students, Louisiana Provisional Licensed Professional Counselors (PLPC) and LPCs have a responsibility to follow state laws, and anyone who is a member of LCA and ACA must follow ACA’s Code of Ethics (2014). The ethical code includes, but is not limited to, information regarding the process of ethical complaints, ethical obligations, professional considerations and responsibilities, expectations of professional conduct, and support of ACA’s mission. One of the many expectations of ACA’s (2014) ethics code and the “primary responsibility” of counselors is to encourage the welfare and uphold the dignity of clients (p. 4). No matter the professional role in which counselors practice (i.e., practicum or internship student, PLPC, or LPC), their responsibilities for each professional role include upholding the ethics of advocacy at the macro-level to promote environmental change and at the micro-level to support individual clients (ACA, 2014).
Based on the results, course content addresses some topics needed to serve minor survivors of abuse and neglect. The findings suggest that those who go on to complete their Ph.D. in counselor education feel more prepared to best serve and navigate challenges that arise when serving this population. This may be the result of a greater number of years in practice, expertise gained through providing supervision, and perhaps more education and training. While master level students may acknowledge, and value course content related to counseling skills, ethics, and theory they may not feel adequately prepared to serve their clients.

The study suggests that there is deficit in the area of legal advocacy preparation within counselor education programs with the rare exception that faculty have both a counseling and legal background. Counselors may feel unprepared when navigating situations like communications with law enforcement, legal inquiries, responding to subpoenas and court testimony. The expertise held by faculty in areas specific to serving this population may have a significant impact on the level of preparedness experienced by counselors serving this population. The curriculum of CACREP accredited programs is mindfully considered and while the content of the curriculum provides foundational knowledge, the results of this study suggest that more may be required.

Another important result of the study suggests that the expertise of supervisors may have a significant impact on advocacy preparedness. The expertise of supervisors during academic and post-graduation credentialing experiences was in some cases identified as the primary source of preparedness while navigating this advocacy work. Having access to supervisors with expertise in the areas of trauma, play therapy, and advocacy work seemed to eliminate some fears and produce positive outcomes for clients. This is important because counselors can
retraumatize abused or neglected children if they do not have proper training (Cooper et al., 2007).

Clinical experiences and professional resources may be additional influences on advocacy preparedness according to the study. The clinical experiences that prove beneficial may involve on the job training, consultations, providing trauma therapy, psychoeducation, collaborating with other professionals, and participating in MDT, making mandated reports to child protection, and being a voice for the children. Clinical experiences may require direct and an indirect advocacy effort as reflected in the ACD framework. For example, the Client/Student level of intervention involves direct impact to the individual whereas, the School/Community level focuses on matters greater than the individual. (Toporek & Daniels, 2018). While some counselors may not feel fully prepared at the beginning of their career, professional experiences could lead to feeling prepared.

Professional resources that may have an influence on advocacy preparedness. According to the study these resources include previous professions, consultations, trainings and psychoeducation tools. Previous professions or roles may serve as a resource that positively influences advocacy work. For example, knowledge gained during past experiences in the legal field can serve as a resource when dealing with legalities while serving in a counseling role. It appears that the ACA Code of Ethics (2014) serves as a common tool and resource that influences advocacy preparedness, specifically related to confidentiality and mandated reporting. Ledyard (1998) stressed that counselors should seek legal consultation when needed because state laws and ethical codes are complex, and these complexities are unwavering (Wheeler and Bertram, 2015). With the rare exception of one participant, advocacy models may not typically be used as a professional resource. Additional professional resources that impact advocacy
preparedness include utilizing consultations with professional peers, trainings and psychoeducation and prevention tools.

**Considerations for Advocacy Competency and Preparedness**

The final master theme is considerations for advocacy competency and preparedness. Results of this section of the study present recommendations as to how professional counselors might be better prepared to serve and advocate for children who have experienced abuse or neglect. The main categories entailed academic enhancement, trauma informed supervision, continued education, and legislative change.

The results of the study indicate that counselors believe there is need for enhancement in counselor educator programs. Areas of improvement entail infusion of more advocacy and trauma-based content into curriculums and implementation of trauma-informed supervision. This could be in the context of offering more academic content pertaining to the specific needs of children, trauma-based electives, child brain development and trauma, working with caregivers and families, and secondary trauma prevention. More advocacy education can aid in prevention of further effects of abuse. Effects of childhood trauma caused by abuse and neglect is extensive and can include stomachaches, headaches, hyperactivity, encopresis, and enuresis (Harris, 2018; Perry & Azad, 1999). These physical impacts can increase the risk of health issues for children related to their brain development, immune system, and hormonal system as well as how their DNA is read and transcribed (Harris, 2018 and Meyers, 2014). Lack of advocacy knowledge and advocacy models has led to missed advocacy opportunities leading counselors to operate based on instinct and feel uncertain about advocacy efforts. Providing more knowledge proves helpful for advocacy preparedness and competency. Counselors reported that trauma-informed supervision may be most beneficial for counseling students and those seeking licensure.
Advocacy work can be overwhelming and intimidating, especially for new counselors. Having a supervisor that is knowledgeable in these areas may benefit counselor and clients.

This research reveals that counselors might feel a need for improvement related to continued education, laws, and policies. While counselors may not be able to avoid frivolous legal claims that are related to competency, counselors can minimize legal ramifications by practicing ethically, maintaining appropriate relationships with clients, and upholding the foundational principles in ACA’s *Code of Ethics* (2014) such as autonomy, nonmaleficence, beneficence, justice, fidelity, and veracity (Wheeler & Bertram, 2015). Even with these considerations, more education and training may be necessary. Counselors who serve this population may benefit from continued education related to considerations for various backgrounds, and useful resources. Continued education opportunities leading to certification in specialized areas such as attachment trauma, child and parent interactions, and trauma-work is another potential recommendation for preparedness. The final consideration for advocacy competency is legislative change that would lead to removal of barriers, more detailed specifications surrounding confidentiality and privileged communication.

Multiple factors are necessary for effective advocacy efforts including: (a) collaboration in professional relationships, (b) persistence during challenging situations, and (c) recognition and actions on opportunities when initially presented with a situation that requires advocacy (Fran, 2014). The results related to considerations for advocacy competency is in alignment with factors listed above and beyond. The considerations and recommendation, when implemented, could lead to efforts that fall into each of the domains of the ACD model.
Implications and Recommendations

Implications and recommendations as a result of this study involve considerations for academic curriculums and policies. The significant results of this study can be used to inform the design of counselor education programs, specifically those that prepare counselors to work with minors. Though mental health, counseling techniques, and ethics are foundational principles needed to practice, designers of academic programs may consider that counselors who serve minor survivors of abuse and neglect must be prepared as counselors, advocates, teachers, communication mediators, and collaborative professionals. Counselors serving this population also encounter experiences involving court testimony and conversations with attorneys.

Implications for Counselor Education Programs

Recommendations for counselor education programs that would prepare counselors to work more competently with minor survivors of abuse and neglect involve faculty, course content, and field experiences. Programs might consider hiring trauma-informed faculty with counseling expertise in working with minor survivors as well as faculty with a background in law and counseling.

In terms of course content, programs might offer in-depth education on ethics pertaining to confidentiality and privileged communication, additional education and professional development regarding navigating custody cases, and specific education on documentation and record keeping to avoid ethical and legal complications that might surface when serving this population. In addition, graduate counselor education programs might engage students in exploring case studies on minors and situations in which laws and ethics are challenged and provide a knowledge base that informs counseling students on how to maintain positive relationships with other professionals who work in agencies such as the court system, child
protection services, and law enforcement. The final recommendations regarding course content include providing clear knowledge on the concept of advocacy and the ways in which counselors serving this population might have opportunities to advocate, educate students on advocacy models and role play implementation of the models and programs are recommended to remain knowledgeable on current trends and practices utilized to competently serve minor survivors of child abuse and neglect.

One recommendation related to field experience is to invite guest speakers who can provide guidance on specific laws and legal experiences that pertain to counseling work, advocacy, and collaboration for minor survivors of abuse and neglect. Also, I recommend that programs pair counseling students who have interest in working with this population with site and doctoral supervisors who are trauma informed. Lastly, I recommend that counseling students receive support and guidance to choose practicum and internship sites that allow for a well-rounded experience in working with this population.

**Implications for Counselor Practice and Policy**

The results of this study could also offer insight to improve continued education, post-graduate supervision, and professional policies for counselors. Continued education is required to maintain licensure and could be used to promote competency and in specialized areas such as those serving minor survivors of abuse and neglect. Much like continued education, supervision is required by the state board to obtain licensure, therefore selection of a supervisor who is trauma informed might prove beneficial to these counselors and the population they serve.

One of the recommendations regarding continued education and post graduate supervision is to ensure there is substantial numbers of trauma-based, board approved trainings and workshops available to counselors who serve minor survivors of abuse and neglect. Another
recommendation regarding continued education and supervision is to ensure that board approved training involving laws and ethics including aspects that are relevant to counselors serving this specialized population. Lastly, the licensing board could consider providing support in paring counselors with supervisors who are most experienced and knowledgeable in serving this population.

Two recommendations are made regarding professional policies. They are to develop policies and procedures to further protect the confidentiality of minor clients and to remove barriers that interfere with legal rights and optimal outcomes for minors.

**Implications From the Child and Caregiver Perspective**

The last set of implications focuses on the child and caregiver perspective. The competency level of counselors can have a direct impact on the child and caregiver therefore, elements of these implications are reflected in the study. The implications include receiving subpar counseling services, failure to receive proper referrals and resources, and potential breach of ethical practices.

**Limitations**

One limitation of the study is that the IPA data analysis process depends heavily on the researcher, which can involve personal interpretations, biases, and assumptions (Creswell, 2013; Merriam, 2009). All interview questions were discussed with my dissertation chair and methodologist prior to the interviews to eliminate potential bias related to my own personal advocacy experiences. I also tried to mitigate potential researcher bias by member checking, use of reflexive journaling, and bracketing. A second limitation is that participants may hold certain biases that can limit their perspectives about working with minors who are survivors of child abuse and neglect. A third limitation is the small geographical areas in which graduated and
practiced. Each of the participants graduated and practiced in Southern Louisiana. Expanding the geographic area might have allowed for more variations in experiences and additional details in the data. The final limitation of the study is the variation in time of licensure and academic training. The participants’ time of licensure ranged from one week to fourteen years. The doctoral level students experienced four or more additional years of graduate level academic training than the master level students. These variations may have produced differing results.

**Recommendations for Future Research**

Though the results of this study may be significant to the field, counselors who serve minor survivors of abuse and neglect, and counselor education programs there are some recommendations for future research. The use of a larger sample size including counselors across the nation may produce a broader view of advocacy experiences, more details, and diverse results on factors such as competence related to years in practice, academic graduate levels, quality of supervision received, or other factors not yet considered. Expanding the study could possibly be implemented as quantitative research utilizing surveys or as qualitative research with inclusion of more participants.

Another recommendation for future research is replicating the study with participants who have been practicing in the field an equal amount of time. This could present a more accurate view of counselor advocacy experiences and levels of competency. Making this adjustment could also produces details regarding the point at which counselors serving this population feel competent and confident about their responsibilities.

The final recommendation for future research is comparing experiences of those who had trauma informed supervision versus those who experienced non-trauma informed supervision. Supervisors seem to be the main go-to source when counselors need guidance or encounter
challenges, therefore the expertise of the supervisor may play a significant role in how counselors advocate for this population and navigate challenges.

**Personal Reflections**

Choosing to undertake this process was intended for the purpose of academic advancement and to show others in my community that obtaining this goal is within reach. The experience produced those results but also resulted in unexpected significant personal growth. This doctoral journey and dissertation experience expanded my professional knowledge base, built resilience and developed patience. I learned things about myself that produced a greater sense of humility and thankfulness. I am deeply grateful for the individuals who participated in the process by giving of themselves and their time to make this goal possible. These individuals include my six participants who were willing to share their experiences, my dissertation committee members who were supportive, patient, and encouraging, and my peers who normalized my experiences and took the journey with me.

Engaging in this research study helped me to realize that advocacy work is part of my identity. The process of thinking and writing reminded me that I have been an advocate all my life, so it was only natural to end up in a helping field and now be here further exploring the concept through dissertation work. I also realize that other counselors who serve this population are just as caring even though some may not realize that their efforts are actually advocacy work. My hope is that the results of this research and other research efforts, lead to improved education, training, and resources to better meet the needs of this population and to better prepare those who serve this population.
References


ChildTrends https://www.childtrends.org/indicators/child-maltreatment 2019


Council for the Accreditation of Counseling and Related Educational Programs (2016).
https://www.cacrep.org/for-programs/2016-cacrep-standards/


Department of Children and Family Services.gov 2019
http://www.dcfs.louisiana.gov/page/reporting-child-abuse-neglect#definitions


doi:10.1177/1525822X05279903


Houghton Mifflin Harcourt.


Louisiana Professionals Counseling Board. (2021, November 3) Application Process https://www.lpcboard.org/application

Louisiana Professional Counseling Board. (2021, November 3). Rules https://www.lpcboard.org/rules


134

Medical University of South Carolina. (2017). *TF-CBT Web 2.0: A course for trauma-focused cognitive behavioral therapy*. https://tfcbt2.musc.edu/


Mental health.gov https://www.mentalhealth.gov/

Mental Health Connection of Tarrant County, (2021) recognizetrauma.org


M. Mogaddam, I. Kamal, L. Merdad, N. Alamoudi, O El Meligy, D. El-derwi
Prevalence of child abuse in Saudi Arabia from 2000 to 2015: a review of the literature


Pluristic Psychology- [https://pluralisticpsych.wordpress.com/interpretative-phenomenological-analysis/](https://pluralisticpsych.wordpress.com/interpretative-phenomenological-analysis/) (couldn’t find the author on the website)


*Training and Education in Professional Psychology, 1* (3) 190-197.


Appendix A

Letter of Consent

Date: _____________________
Dear: _____________________.

I am a doctoral candidate under the direction Dr. Christopher Belser in the Department of Educational Leadership, Counseling and Foundations at the University of New Orleans. I am conducting a qualitative research study to understand the advocacy experiences of licensed counselors who work with minor survivors of abuse.

I am requesting your participation, which will involve an interview held in-person or via HIPPA Zoom which will last approximately one hour. Your participation in this study is voluntary and there are no foreseeable risks for participating. If you choose not to participate or to withdraw from the study at any time, there will be no penalty. The results of the study will be used for my dissertation and may be published and used for conference presentations, however, your name will not be used.

Although there may be no direct benefit to you, the possible benefit of your participation is a better understanding of advocacy experiences from the perspective of licensed counselors, which could possibly lead to changes or improvements to the academic and supervision process.

If you have any questions concerning the research study, please contact me at 985-960-7293 or The dissertation chair, Dr. Christopher Belser at 504-280-5684.

Sincerely,
Earniesha S Lott-Kennebrew, M.Ed., LPC-S, RPT-S, NCC, CCTP
Doctoral Candidate in Counselor Education
Department of Educational Leadership, Counseling, and Foundations
University of New Orleans

By signing below, you are giving consent to participate in the above study.

_________________________________  _______________________________  ______
Print                                   Sign                                   Date

If you have any questions about your rights as a subject/participant in this research, or if you feel
you have been placed at risk, please contact Dr. Roberto Refinetti at the University of New
Orleans
at 504-280-3990.
Appendix B

Recruitment Email / Phone Solicitation

Dear Licensed Counselor,

I am a doctoral candidate in the Counselor Education Program at the University of New Orleans. Dr. Christopher Belser is my dissertation chair. I am conducting a qualitative research study on the advocacy experiences of Licensed Professional Counselors who counsel minors who are survivors of child abuse and neglect. The research study that you are being invited to participate in is entitled *Advocacy Experiences of Licensed Professional Counselors Who Work with Minors Who are Survivors of Child Abuse and Neglect.*

If you choose to participate in my research, you must affirm that you meet the following participant criteria:

(a) Licensed Professional Counselor in Louisiana;

(b) Graduate of a Masters program endorsed by the Council of Accreditation for Counseling Related Education Programs (CACREP);

(c) Counsel children who have experienced abuse or neglect;

(d) Counsel in a school setting, private practice, or Children’s Advocacy Center within Louisiana.

(e) Agree that I can confidentially use your information in my research study.
If you are interested in participating in my research study, we will need to set a time to meet in person or virtually through HIPPA Zoom so that I can interview you and review the paperwork. Please provide two dates and multiple times that are convenient for you.

Listed is my contact information for your reference:

Earniesha S Lott- Kennebrew, M.Ed., LPC-S, NCC, RPT-S, CCTP
Doctoral Candidate
University of New Orleans
(985)960-7293, e-mail: elott@uno.edu

Please ask questions if any information is unclear. Thank you for your consideration and time.

Sincerely,

Earniesha S Lott- Kennebrew, M.Ed., LPC-S, NCC, RPT-S, CCTP
Appendix C

Follow-Up Email

Dear Research Participant,

Thank you for your participation thus far in my research regarding LPC advocacy experiences. I am contacting you to schedule the follow-up meeting that was mentioned in the initial email and interview meeting. The second meeting is estimated to last 30 minutes. I have attached your transcript for you to review. The transcript is password protected and the password will be provided via phone. If you have any questions, we can discuss them during our meeting. During our meeting time, we will review the emergent themes and superordinate themes that I extracted during my data analysis process. You will be able to ask questions for clarity and provide feedback.

Please let me know when and where you are available to meet and if you prefer to meet virtually via a HIPPA Zoom. We can meet at the same location as before or another private location of your choosing for your convenience. Please ask questions if any information is unclear. Thank you for your time!

Listed below is my contact information for your reference:

Earniesha S. Lott- Kennebrew, M.Ed., LPC-S, NCC, RPT CCTP
Doctoral Candidate
University of New Orleans
(985)960-7293, e-mail: elott@uno.edu

Sincerely,

Earniesha S Lott- Kennebrew, M.Ed., LPC-S, NCC, RPT-S, CCTP
Appendix D

Interview Protocol

Participant Pseudonym: _____________________________ Date: ____________________

Demographic Questions

1. How long have you been a Licensed Professional Counselor?

2. What other licenses do you hold (e.g., LMFT)?

3. How long have you been counseling children who have been or may have been abused or neglected?

4. What setting(s) have you or are you providing counseling to children who have been or may have been abused or neglected?

5. Identify and provide clinical assessment forms, advocacy instructions or documents, and law material that assist you in providing services to your clients.

6. What are your professional certificates (e.g., NCC, RPT etc.)?

7. In what capacity do you serve at your current place of employment?

8. Before becoming an LPC did you work with children in any professional capacity? If so, what was your role?

9. What is your gender?

10. What is your age?

11. What is your ethnicity?
Overview of Interview Questions

12. How do you define advocacy?

13. In what ways have you participated in advocacy on behalf of minor clients who have experienced or possibly experienced abuse or neglect?

14. In what situations have you collaborated with other professionals for the purpose of advocacy for minor clients who have experienced or possibly experienced abuse or neglect?

15. What were your experience(s) like if you provided testimony in court or spoke to attorneys regarding your minor clients who have experienced or possibly experienced abuse or neglect?

16. What were any confidentiality or other ethical issues you faced while advocating or attempting to advocate for your minor clients who have experienced or possibly experienced abuse or neglect?

17. When participating in advocacy efforts, did you feel prepared?

18. What was your educational preparation like regarding advocacy for your minor clients who have experienced or possibly experienced abuse or neglect?

19. What specific information/training did you receive in your graduate program related to advocacy for minor survivors of child abuse and neglect?

20. What specific information/training did you receive in your supervisory experience related to advocacy for minor survivors of child abuse and neglect?

21. How do you implement the specific ethical codes in the 2014 ACA Code of Ethics that refer to serving minors and your role as advocate?
22. With whom you seek consultation/support for advocacy purposes, and how helpful do you find that support?

23. How do you seek consultation/support for advocacy purposes, and how helpful do you find that support?
Appendix E

Institutional Review Board Approval Letter

THE UNIVERSITY of NEW ORLEANS
INSTITUTIONAL REVIEW BOARD

Memorandum

Principal Investigator: Christopher Todd Belser
Co-Principal Investigator: Eamiesha S Lott
Date: March 17, 2022
Protocol Title: Advocacy Experiences of Licensed Professional Counselors Serving Minor Survivors of Abuse and Neglect
IRB Number: 03Feb22

The Institutional Review Board for the Protection of Human Subjects in Research (IRB) has deemed that the research and procedures of the above-named protocol are compliant with the University of New Orleans and federal guidelines and meet the standard for expedited IRB review according to:

A. Research activities that (1) present no more than minimal risk to human subjects, and (2) involve only procedures listed in one or more of the following categories, may be reviewed by the IRB through the expedited review procedure authorized by 45 CFR 46.110 and 21 CFR 56.110. […]

6. Collection of data from voice, video, digital, or image recordings made for research purposes.

7. Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

Review of the submitted protocol indicated that all procedures are in compliance with 45 CFR 46. Any changes to the procedures must be reviewed and approved by the IRB prior to implementation.

I wish you much success with your research project. If you have any questions, please do not hesitate to contact me at 280-7481.

Sincerely,

Roberto Refinetti, PhD
IRB Chair
The author was raised in Folsom, Louisiana and spent most of her life in Folsom and Covington, Louisiana. She received her bachelor’s degree in Psychology from Southeastern Louisiana University in 2006 and her master’s degree in Counselor Education at the University of New Orleans in 2011. She has worked in St Tammany Parish as a counselor providing trauma informed counseling and play therapy. She is credentialed as a Licensed Professional Counselor-Supervisor and Registered Play Therapy-Supervisor. She has expanded her private practice over the last four years where she provides counseling and supervises professional counselors to aid in their academic and post graduate training and education. She currently resides with her husband spending much of her time in Georgia.