Some Resources for Parents & Caregivers

Your Body Belongs to You, by Teri Weidner (Illustrator), Cornelia Maude Spleman, and Cornelia Maude Spelman. Albert Whitman & Co, 2000. (This book is for parents and teachers of young children, and more focused on prevention.)


The Traumatized Child

This video series, created by Cavalcade Productions, features Dr. Margaret Blaustein and three of her colleagues. All have years of experience as therapists with abused children and their caregivers, and as trainers of therapists doing this work. There are three videos in the series, which can be purchased or rented individually or as a set: Understanding the Traumatized Child, Parenting the Traumatized Child, and Teaching the Traumatized Child.

On the prevention of sexual abuse, here are four books that parents can read to and discuss with their 4 to 8 year old children: My Body Is Private, Your Body Belongs to You, Those are MY Private Parts, and The Right Touch.

If you are the parent or caregiver of a child or teen with sexual behavior problems, Stop It Now publishes an excellent newsletter, PARENTtalk. It is written by and for parents of children and teens with sexual behavior problems, and offers "an opportunity to break the isolation surrounding this issue and offer support to each other through personal stories." All issues are free online.

See also Helping Traumatized Children: A Brief Overview for Caregivers, by Dr. Bruce Perry, Director of the ChildTrauma Academy.
Additional Resources

WEB SITES

Childhelp USA's National Child Abuse Hotline
1-800-422-4453
(1-800-4ACHILD)

If you need immediate information about and/or connection to resources in your own community in the United States, here are three 24-hour toll-free hotlines that you can call:

Childhelp USA is a non-profit organization "dedicated to meeting the physical, emotional, educational, and spiritual needs of abused and neglected children." Its programs and services include this hotline, which children can call with complete anonymity and confidentiality. To know what to expect when you call, see How We Help. From the site: "The Childhelp USA® National Child Abuse Hotline is open 7 days a week, 24 hours a day. Don't be afraid to call. No one is silly or unimportant to us. If something is bothering you or you want information, CALL!" To learn more about reporting child abuse or neglect in your state, see Report Child Abuse.

Rape Abuse & Incest National Network
1-800-656-4673 (HOPE)

RAINN is a national network of rape crisis centers. This is an automated service that links callers to the nearest rape crisis center automatically. Rape crisis centers are staffed with trained volunteers and paid staff members who also have knowledge of sexual abuse issues and services (though sometimes they are not adequately prepared to refer male survivors). All calls are confidential, and callers may remain anonymous if they wish.

National Domestic Violence/Abuse Hotline
1-800-799-SAFE
1-800-799-7233
1-800-787-3224 TDD

This is a 24-hour-a-day hotline, staffed by trained volunteers who are ready to connect people with emergency help in their own communities, including emergency services and shelters. The staff can also provide information and referrals for a variety of non-emergency services, including counseling for adults and children, and assistance in reporting abuse. They have an extensive database of domestic violence treatment providers in all US states and territories. Many staff members speak languages besides English, and they have 24-hour access to translators for approximately 150 languages. For the hearing impaired, there is a TDD number. This is a good resource for people who are experiencing or have experienced domestic violence or abuse, or who suspect that someone they know is being abused (though
it is not perfect, and may not have the best number in your area). All calls to the hotline are confidential, and callers may remain anonymous if they wish.

**BOOKS**


This book was written by an incest survivor, and provides step-by-step guidance for sexually abused teenagers. It has a great deal of knowledge and resources to help teenagers understand what they are going through and overcome feelings of isolation, confusion, and self-doubt to truly heal.


This workbook is written for teenagers, and has effective exercises help them learn about the different aspects of trauma, clarify their own ideas and beliefs, and explore new ways of feeling and relating. The author is a psychologist who works with sexually abused teens on a daily basis. His approach is very positive. The exercises focus on gaining the strength and confidence needed to reshape one’s self-image, connect with others in healthy ways, and develop the skills needed to realize one’s full potential.


If you want to start learning and practicing the self-regulation skills essential to recovering from the effects of child abuse, or to build on progress you are already making, particularly if you struggle with dissociation, I recommend this book. To learn more about the book and/or order it directly from the publisher (for a higher price than Amazon), go to the [Growing Beyond Survival](https://www.sidran.org/bookstore/119) page of the Sidran Press catalog.

*Trauma and Recovery*, by Judith L. Herman.

I still believe this is the best book on psychological trauma and recovery, particularly extreme child abuse. Herman integrates a great deal of research with decades of clinical wisdom and some thought-provoking historical and political perspectives. *Trauma and Recovery* is appropriate for survivors of child abuse and other interpersonal traumas, as well as clinicians and the general reader.

I especially recommend this book to students and others just beginning to learn about child abuse and how people recover from these experiences. Though a lot has been learned since Herman wrote this book (e.g., the widely available treatment [EMDR](https://www.emdr.com) has been proven to be an effective and efficient treatment for posttraumatic stress disorder), this book has easily stood the test of time.

You can learn more about the book (critical acclaim, contents, brief excerpts) from the Web page: *Trauma and Recovery - Judith Herman's Landmark Book on Child Abuse & Other Traumas*.

The following two books offer a wealth of helpful information, including explanations of post-traumatic stress disorder and related problems, and many great techniques for managing trauma-related emotions, memories and various other symptoms and problems commonly struggled with by people who were abused as children.
If you are looking for books and/or articles on the sexual abuse of males, please see the Recommended Books and Articles section of my page, Sexual Abuse of Males: Prevalence, Lasting Effects, and Resources. There's a lengthy listing of books and articles. Some are reviewed, and some can be ordered.

If you are looking for books on recovered memories of sexual abuse, please see the Books on Recovered & Traumatic Memories section of my page, Recovered Memories of Sexual Abuse: Scientific Research & Scholarly Resources.

If you are looking for statistics on child abuse in other countries, I recommend the World Health Organization's 2002 study, World Report on Violence and Health. The entire report, a 372-page and 2.4-megabyte PDF, is available in English, French, Russian or Spanish. A 54-page (600 KB) summary is available in Arabic, English, French, German, and Spanish. Chapter 3, Child Abuse and Neglect by Parents and Other Caregivers, is 30 pages (177 KB) and can be downloaded in English, French, or Russian. Chapter 3 reviews and provides references for many academic studies on rates of abuse in a variety of countries (though it is not comprehensive).

For international statistics there is also a 1994 paper by sociologist David Finkelhor, an internationally recognized expert on research on the incidence and prevalence of child sexual abuse, and Director of the Crimes Against Children Research Center. The countries covered in the paper: Australia, Austria, Belgium, Canada, Costa Rica, Denmark, Dominican Republic, Finland, France, Germany, Greece, Great Britain, Ireland, Netherlands, New Zealand, Norway, South Africa, Spain, Sweden, Switzerland, and the United States. Please note: Because this is a 1994 publication, and this is a growing field of research, additional studies for some of these countries and other countries have been published by now. Here's the citation and abstract:


Abstract: "Surveys of child sexual abuse in large nonclinical populations of adults have been conducted in at least 19 countries in addition to the United States and Canada, including 10 national probability samples. All studies have found rates in line with comparable North American research, ranging from 7% to 36% for women and 3% to 29% for men. Most studies found females to be abused at 1.5 to 3 times the rate for males. Few comparisons among countries are possible because of methodological and definitional differences. However, they clearly confirm sexual abuse to be an international problem."

There are numerous Web sites with content addressing child abuse and
recovery issues in addition to those already mentioned on this page. Below is a sampling.

Please note:

If reading material on these issues may upset you, remember to take care of yourself, and that you can always create a favorite/bookmark and come back to this page or any of the links below when you feel prepared.

Center for Sex Offender Management
This is a Project of the U.S. Department of Justice's Office of Justice Programs. "Established in June 1997, the Center for Sex Offender Management's (CSOM) goal is to enhance public safety by preventing further victimization through improving the management of adult and juvenile sex offenders who are in the community." CSOM's goals are carried out through three activity areas, including information exchange. In addition to an "Ask COSM" feature, their Documents section has a wealth of informative html and pdf materials, including "Myths and Facts About Sex Offenders" in html and pdf formats, and "Recidivism of Sex Offenders," also in html and pdf. Finally, their Reference Library has a searchable documents database and a topically organized list of National Resource Group Recommended Readings. Finally,

FaithTrust Institute
"FaithTrust Institute is an international, multifaith organization working to end sexual and domestic violence. We provide communities and advocates with the tools and knowledge they need to address the religious and cultural issues related to abuse. FaithTrust Institute works with many communities, including Asian and Pacific Islander, Buddhist, Jewish, Latino/a, Muslim, Black, Anglo, Indigenous, Protestant and Roman Catholic." Their site has a number of resources on the issue of Sexual Abuse by Clergy.

Childhelp USA
Childhelp USA is a non-profit organization "dedicated to meeting the physical, emotional, educational, and spiritual needs of abused and neglected children." Its programs and services include a hotline (800-422-4453) that children can call with complete anonymity and confidentiality. To know what to expect when you call, see How We Help. From the site: "The Childhelp USA® National Child Abuse Hotline is open 7 days a week, 24 hours a day. Don't be afraid to call. No one is silly or unimportant to us. If something is bothering you or you want information, CALL!" To learn more about reporting child abuse or neglect in your state, see Report Child Abuse.

ChildTrauma Academy
This organization, Directed by Dr. Bruce Perry, "focuses on service, training and research in the area of child maltreatment." The site has a number of articles by Dr. Perry, including explanations of child abuse effects and Helping Traumatized Children: A Brief Overview for Caregivers.

Child Abuse - Article in online Microsoft® Encarta® Online Encyclopedia
An informative article by researcher pioneering researcher and author,
Richard Gelles, Ph.D. Broadly and topically covers the following issues: Types, Prevalence, Causes, Effects on Children, Protecting Children.

**Child Abuse Legislation Study Project**
"A non-profit organization dedicated to tracking bills, laws, and legislative action on child abuse, incest, and domestic violence."

**Child Welfare**
This site has a wealth of scholarly resources, including an online journal, *Child Welfare Review*, and information about the Oxford University Press Series in Child Welfare Practice, Policy and Research.

**Common Responses to Trauma - And Coping Responses**
This two-page handout, by Dr. Patti Levin, provides excellent and helpful information and suggestions. Dr. Levin's site has other helpful handouts and excellent information on how to choose a therapist. (The above link is to a PDF file, and it's also available as a web page.)

**Court Appointed Special Advocates (CASA)**
"Volunteer Court Appointed Special Advocates (CASA) are everyday people who are appointed by judges to advocate for the best interests of abused and neglected children. A CASA volunteer stays with each child until he or she is placed into a safe, permanent and nurturing home." More than 900 CASA programs are in operation across the United States, with 52,000 women and men serving as CASA volunteers. This website of National CASA explains what CASA's do, how to become one, etc.

**Crimes Against Children Research Center**
"The mission of the Crimes against Children Research Center (CCRC) is to combat crimes against children by providing high quality research and statistics to the public, policy makers, law enforcement personnel, and other child welfare practitioners." The center is directed by Dr. David Finkelhor, a sociologist and internationally recognized expert on child victimization, including child sexual abuse. The site has many good resources, including a Publications section with the paper, *The Decline in Child Sexual Abuse Cases*, a classic 1993 scholarly review paper, *The impact of sexual abuse on children: A review and synthesis of recent empirical studies*, and an excellent Fact Sheet with facts and statistics compiled from a variety of sources.

**David Baldwin's Trauma Info Pages**
These pages are loaded with scholarly resources and references to work on Posttraumatic Stress Disorder, especially from neuropsychological and cognitive-behavioral perspectives.

**EMDR Institute**
Eye Movement Desensitization and Reprocessing (EMDR) has been proven to be an effective and efficient treatment for posttraumatic stress disorder (PTSD), which can be an effect of childhood abuse. It can be particularly helpful at transforming intrusive and upsetting memories of abuse, and does not require one to talk about what happened in detail (for those avoiding therapy for this reason). In recent years, therapists have learned how to use EMDR with children. The EMDR Institute provides referrals to EMDR-trained therapists around the country (by
You can also find EMDR therapists through the Find a Therapist service of the EMDR International Association, whose primary objective is to "establish, maintain and promote the highest standards of excellence and integrity in Eye Movement Desensitization and Reprocessing (EMDR) practice, research and education."

Jennifer J. Freyd's Trauma, Memory, and Betrayal Trauma Research
This page has links to reviews of Dr. Freyd's books and web pages on which she discusses several clarifying perspectives on these issues, including her theory of why it is adaptive for some children not to remember childhood abuse experiences.

Healing from Childhood Sexual Abuse: Book Reviews
Scott Abraham reviews eight books for men who were sexually abused in childhood. Good review, very helpful. If you're considering buying a book, read this first.

isurvive.org - Abuse Survivors Learning to Thrive
This volunteer-run web site and non-profit organization has many great resources – the most valuable being the people who help each other by sharing their experiences, struggles and hard-earned wisdom. There are online chats and forums for survivors of child abuse, including those struggling with addiction and abusing others, as well as friends and family members. It also has a great resources page with many not listed here.

Legal Resources for Victims of Sexual Abuse
This section of Attorney Susan Smith's web site has extensive resources on remedies for victims, statutes of limitations, and mandatory child abuse reporting laws in most states of the U.S.

Lost in the Void
This book is self-published by Lana Walker, an American citizen who has been through a nightmare in the British courts – not only losing custody of her children, but any and all contact with them. She has written this book to alert parents, both mothers and fathers, who marry citizens of other countries and live in those countries with their children, about how vulnerable they and their children are to terrible injustices committed by another country's laws and courts.

Making Daughters Safe Again
This organization and its web site, founded and directed by a graduate student in clinical psychology, provide "support for survivors of mother-daughter sexual abuse."

MaleSurvivor: National Organization against Male Sexual Victimization
Their mission: "We are committed to preventing, healing, and eliminating all forms of sexual victimization of boys and men through treatment, research, education, advocacy, and activism." Their site has many helpful resources.

Pat McClendon's Clinical Social Work Home Page
These are general mental health pages with a focus on abuse and trauma resources, especially those related to dissociation.
**National Child Protection Clearinghouse (NCPC)**
Great official Australian site with an exceptional Publications section, including full-text articles on child abuse, its effects, and how to prevent it - some quite in-depth, sophisticated, and scholarly. For help with accessing NCPC statistical information, see above, Official Statistics: Australia.

**National Child Traumatic Stress Network (NCTS)**
This network of treatment centers was created by an initiative of the US Congress just a few years ago. Their mission is "To raise the standard of care and improve access to services for traumatized children, their families and communities throughout the United States." The site has many great resources, including for parents, caregivers, and school personnel.

**National Clearinghouse on Child Abuse and Neglect (NCCAN)**

**National Clearinghouse on Family Violence (NCFV)**
Official Canadian site with several "fact sheets," an extensive Publications section addressing Child Abuse and Neglect, Child Sexual Abuse, and Family Violence, Intimate Partner Abuse Against Men, Intimate Partner Abuse Against Women, and Preventing Family Violence, a collection of videos for the general public and professionals. For help with accessing NCFV statistical information, see above, Official Statistics: Canada.

**Partners and Allies of Sexual Assault Survivors Resource List**
This page by Kerry Cater, M.S.W., at The Wounded Healer Journal provides a comprehensive list of resources, from Internet mailing lists and newsgroups to newsletters and books, some of which can be ordered online.

**Psychological Trauma and Substance Abuse in Women**
This site, by Barbara Hilliard, M.Ed., has some excellent resources on psychological trauma, posttraumatic stress disorder and substance abuse for women struggling with these issues and those who treat them. In addition to links to various organizations and informative articles, including Barbara's Getting Sober While Staying Sane.

**Publicizing Child Molester's Prison Release**
This site belongs to Mark Welch, a California lawyer who has publicized the release from prison of his brother, who has admitted to sexually abusing him in childhood. This is clearly a very controversial issue. Mr. Welch provides a thoughtful essay on publicizing the release of one's perpetrator, including various ethical considerations.

**Safer Society Foundation**
The Safer Society Foundation, Inc. (SSF) is a nonprofit agency and national research, advocacy, and referral center for the prevention and treatment of sexual abuse. The SSF provides training and consultation to individuals, agencies, states
and organizations. Their Web site has a list of Safer Society Press books and videos. For information about their "Treatment Referrals Program" for sexual abuse perpetrators, see their Contact Us page.

**The Sexual Assault Information Page**
This site is now only available in archive format (last version of October 2001, but is still very useful with its over 400 links to information and resources on child abuse and neglect, as well as the sexual assault of adults.

**Sidran Foundation Online Resources**
This is a national non-profit organization that offers services to people who have experienced trauma and/or suffer from dissociative disorders, and those who provide services to them. There are many excellent resources here, including a Traumatic Memories Brochure and pages with Resources for Survivors and Information for Students.

**Silent Edge**
This page has links to several resources addressing sexual abuse and exploitation by coaches, particularly of figure skaters.

**STOP IT NOW!**
"STOP IT NOW!'s mission is to call on all abusers and potential abusers to stop and seek help, to educate adults about the ways to stop sexual abuse, and to increase public awareness of the trauma of child sexual abuse."

**SNAP - Survivors Network of those Abused by Priests**
"SNAP is a national self-help organization of men and women who were sexually abused by Catholic priests (brothers, nuns, deacons, teachers, etc). Members find healing and empowerment by joining with other survivors."

**The Trauma Center**
The Trauma Center, founded by Bessel van der Kolk, an leading expert in the field of traumatic stress studies, is a clinic affiliated with the Boston University School of Medicine. The site includes pages on the work of Dr. van der Kolk, including links to his articles on the web and psychological trauma assessment instruments.

**VOICES In Action, Inc.**
Victims of Incest Can Emerge Survivors - "VOICES in Action, Inc. is an international organization to provide assistance to victims of incest and child sexual abuse in becoming survivors and to generate public awareness of the prevalence of incest.

**What's Your Fear? - For Abuse Survivors and Their Dentists**
As indicated by its name, this page at Dental Fear Central was written for abuse survivors and their dentists, and has some helpful advice on dealing with many of the issues and difficulties that can arise.

**The Wounded Healer Journal**
"Points of Departure for Psychotherapists and Other Survivors of Abuse." This site, maintained by Linda Chapman, L.C.S.W., has a great wealth of pages and links, including Partners and Allies of Sexual Assault Survivors Resource List.
Children Survivors of Child Abuse/Sexually Reactive Children

- **The Color of Secrets: Encouraging Children to Talk About Abuse**  
  Kimberly Steward, Illustrated by Donovan Foote  
  Doghouse Press / October 2005
- **The Kindness of Strangers**  
  Katrina Kittle  
  William Morrow / February 2006
- **Kids Helping Kids: Break the Silence of Sexual Abuse**  
  Linda Lee Foltz  
  Lighthouse Point Press / March 2003
- **I Told My Secret: A Book for Kids Who Were Abused**  
  Eliana Gil  
  Launch Press / November 1986
- **Spread Your Wings & Fly: Inspired by Actual Events**  
  Rebecca Engle Smith  
  Agreka Books / July 2000
- **I Can't Talk About It: A Child's Book About Sexual Abuse**  
  Doris Sanford  
  Multnomah Publishers/ February 1988
- **My Very Own Book About Me: A Personal Safety Book**  
  Jo Stowell, Mary Dietzel  
  ACT for Kids / January 2000
- **The Me Nobody Knows: A Guide for Teen Survivors**  
  Barbara Bean, Shari Bennett  
  Jossey-Bass / September 1998
- **How Long Does It Hurt: A Guide to Recovering from Incest and Sexual Abuse for Teenagers, Their Friends and Their Families**  
  Cynthia Mather, Kristina E. Debye  
  Jossey-Bass / September 1994
- **When Your Child Has Been Molested : A Parent's Guide to Healing and Recovery**  
  Kathryn B. Hagans, Joyce Case  
- **It Happens to Boys Too**  
  Russell Bradway, Roberta Russell, Pat A. Bradway, Jane A. Satullo  
  Elizabeth Freeman Center / May 1987
Cognitive Behavioral Therapy for Child Sexual Abuse (CBT-CSA)
Selective, Indicated

Brief Program Description

Cognitive Behavioral Therapy for Child Sexual Abuse (CBT-CSA) is a treatment approach designed to help children and adolescents who have suffered sexual abuse overcome posttraumatic stress disorder (PTSD), depression, and other behavioral and emotional difficulties. The program helps children to:

- Learn about child sexual abuse as well as healthy sexuality
- Therapeutically process traumatic memories
- Overcome problematic thoughts, feelings, and behaviors
- Develop effective coping and body safety skills

The program emphasizes the support and involvement of nonoffending parents or primary caretakers and encourages effective parent-child communication. Cognitive behavioral methods are used to help parents learn to cope with their own distress and respond effectively to their children's behavioral difficulties. This CBT approach is suitable for all clinical and community-based mental health settings and its effectiveness has been documented for both individual and group therapy formats.

Recognition

Model Program: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services

Program Background

CBT-CSA was developed following a series of assessment studies that documented the wide array of emotional and behavioral difficulties exhibited by children who have experienced sexual abuse. These studies indicated that while some children suffer minimal difficulties following sexual abuse, others experience serious psychiatric disorders, with one of the most common disorders being PTSD. In addition, assessment research has clearly revealed the important role nonoffending parents play in the recovery process. Thus, a treatment program was developed for abused children and their nonoffending parents specifically designed to improve PTSD and other abuse-related difficulties (e.g., age-inappropriate sexual behaviors, depression, acting-out behaviors,
etc.). To date, seven treatment outcome studies (two pre- and posttest designs and five randomized control trials) have documented the efficacy of this treatment approach.

Dr. Deblinger and her colleagues, Dr. Judith Cohen, and Anthony Mannarino, Ph.D., from Allegheny General Hospital, are currently completing a multisite treatment outcome investigation for children who have suffered sexual abuse and collaborating on a manual for children exposed to other forms of traumatic stress. Melissa Runyon, Ph.D., and Felicia Neubauer, L.C.S.W., from the University of Medicine and Dentistry of New Jersey-School of Osteopathic Medicine, are also collaborating with Dr. Deblinger on the development of modified treatment programs for children who have suffered physical abuse and/or domestic violence.

**Protective Factors**

**Protective Factors to Increase**

**Individual**

- Emotional expression skills
- Relaxation skills
- Cognitive coping skills
- Personal safety skills
- Self-esteem

**Family**

- Parent emotional stability and support
- Sharing of praise and positive feedback
- Effective discipline and limit setting
- Parent-child communication skills
- Cohesive family interactions

**Peer**

- Positive peer relations
- Assertiveness skills

**Society**

- Public education about child sexual abuse
Multidisciplinary team approach

Risk Factors

Risk Factors to Decrease

Individual

- Emotional and behavioral difficulties
- Avoidance and social isolation
- Shame and self-blame regarding abuse

Family

- Lack of parental support
- Parental emotional difficulties
- Ineffective parenting skills
- Problematic family interactions

Society

- Lack of access to specialized treatmentservices
- Ineffective system response to allegations

Target Population

CBT-CSA is designed for children and adolescents 3 through 18 years old who have experienced sexual abuse and are exhibiting posttraumatic stress, depression, and other abuse-related difficulties (e.g., age-inappropriate sexual behaviors, problematic fears, social isolation). Children are generally referred for treatment following an investigation conducted by child protection or law enforcement personnel in which allegations of sexual abuse are found to be credible. Whenever possible, a nonoffending caregiver or parent is encouraged to participate along with the child. The program may be utilized in private and/or public clinics and has demonstrated success with Black/African American, Hispanic/Latino, and White children from all socioeconomic backgrounds. The research participants were primarily seen at a public clinic on a medical school campus, but therapists in community settings, including child protection offices in urban, suburban, and rural settings, have also delivered the treatment program.

Evaluation Design and Outcomes
Evaluation Design

In a series of randomized control trials, this CBT approach led to significant reductions in parental emotional distress, as well as significant improvements with respect to PTSD, depression, behavior problems, and personal safety skills in children. Research examining the impact of the parent and child components of this treatment demonstrated the significant value of parental participation in treating children's acting-out behaviors and depression. The findings also suggested the critical importance of the CBT child interventions in effectively treating PTSD in the population. A recent followup study has documented the maintenance of children's improvements with respect to PTSD, depression, and behavior problems over a 2-year period. The results of a recent study comparing group CBT-CSA to a support group approach suggest that cognitive behavioral strategies are significantly more effective in enhancing children's personal safety skills and reducing parents' abuse-specific distress. Program results have been reported in journal articles published in the *Journal of the Academy of Child and Adolescent Psychiatry*, *Child Maltreatment*, and *Child Abuse & Neglect: the International Journal*.

Research funding that has contributed to the development and evaluation of this treatment program has been provided by the Foundation of the University of Medicine and Dentistry of New Jersey and the U.S. Department of Health and Human Services' National Center on Child Abuse and Neglect and National Institute of Mental Health. Victims of Crime Act grants, grants and contracts administered by the New Jersey Division of Youth and Family Services, and private and corporate donations have also funded individual and group therapy services provided at the center.

Outcomes

Children who participated in CBT-CSA with their nonoffending parents demonstrated greater improvements with respect to PTSD, depression, and acting out behaviors as compared to children assigned to the community control condition. As compared to parents who participated in a support group, parents who participated in a CBT-CSA group showed greater improvement with respect to emotional distress and intrusive thoughts related to their children's sexual abuse.

Benefits

In the aftermath of child sexual abuse, CBT-CSA:

- Helps children talk about their experiences and cope with their feelings and concerns
- Assists parents in coping with abuse-specific distress and responding effectively to their children's emotional and behavioral problems
• Improves parent-child communication and interactions

Training Schedule

Please contact the Program Developer for information on training.

Program Fidelity

Please contact the Program Developer for information on fidelity.

How It Works

The treatment program consists of parallel sessions with the child and his or her nonoffending parent(s), as well as joint parent-child sessions in the later stages of therapy. The treatment approach can be effectively implemented in 12 sessions and has been applied to both individual and group therapy formats. The specific components of treatment for both the child and parent include:

- Education about child sexual abuse and healthy sexuality
- Coping skills training, including relaxation, emotional expression, and cognitive coping
- Gradual exposure and processing of traumatic memories and reminders
- Personal body safety skills training

Parents are also provided with behavioral management training to strengthen children's positive behaviors while minimizing behavioral difficulties. Joint parent-child sessions are designed to help parents and children practice and utilize the skills learned, while also fostering more effective parent-child communication about the abuse and related issues.

A detailed description of CBT-CSA is provided by Esther Deblinger, Ph.D., and Anne Heflin, Ph.D., in their professional book titled Treating Sexually Abused Children and Their Non-offending Parents: A Cognitive Behavioral Approach.

A children’s book, Let’s Talk About Taking Care of You: An Educational Book About Body Safety, by Lori Stauffer, Ph.D., and Dr. Deblinger, is also recommended for use with children 5 to 10 years of age. Information on how to obtain the children’s book is located at www.hope4families.com.
Offenders and Victims: Interactions and Impact
Understand the interactions between sex offenders and victims with an emphasis on incest. Learn how sex offenders get into the heads of their victims and the impact of the behavior. The effect of explicit and implicit denial on victims is addressed along with malevolent competition and emotional visibility/invisibility. Supervised visitation, apology sessions, unsupervised visitation and reunification issues and procedures are discussed. Anna Salter, PhD

Institute

Sexualized Children and Children who Molest: Causality and Response
Police and social services report an increase in the number of children with sexual behavior problems. Learn how to differentiate between “normal sexual play” and abusive sexual activity. Learn how to make hypotheses about causality. Understand family dynamics that may contribute to the problem, and learn ways to provide external controls and community accountability. Treatment methods are reviewed. Eliana Gil, PhD

Pre Conference

Advanced Training Institutes

Beyond our Beliefs—Sensory-Based Techniques to Treat Sexually Abused Children
This session provides you with techniques to treat children from a sensory-base—encouraging rehabilitation while appreciating how trauma triggers are manifested into the child’s adulthood. Learn about the importance of understanding memory management in sexually abused children and how therapy needs to prepare them for how their sexual abuse will be remembered for the rest of their lives. Jan Hindman, MS, LPC

Institute

Trauma-Focused Cognitive-Behavioral Treatment for Traumatized Children and their Families
Learn about cognitive-behavioral therapy for traumatized children and their families, including strategies for intervening with both the children and their parents. The rationale for this treatment model is presented along with a description of the treatment procedures which are stress management, psycho-education, gradual exposure, cognitive processing, and parental interventions. Anthony P. Mannarino, PhD

Institute

Relational Issues and Risk Management in Treating Complex Trauma: Boundaries and Repair
Individuals who suffered chronic trauma during their early developmental years often present with multiple and complex symptoms. Learn why relational treatment is effective with clients who have been traumatized by their caretakers. Understand how transference, countertransference, and vicarious traumatization can affect the therapeutic process. Learn how to avoid boundary violations as well as self-care strategies. This workshop is both didactic and experiential. Christine A. Courtois, PhD

www.dcs.wisc.edu/pda/hhi/eastern

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Thursday, March 23 9:00-10:00 am
Culture, Class and Consent in Sexual Exploitation and Trafficking
Child sexual exploitation is the most underreported form of child abuse. Internet child pornography cases reveal that more than half the images posted on the web are made by the victim’s family. Recent data on the 1700+ arreststo date for child pornography possession reveal more than a 50% rate of dual offenses—possession as
well as histories of child sexual abuse offenses. This presentation provides evidence of media influence on the normalization of what is a serious threat to the well-being of children and youth. Sharon Cooper, MD

10:30-12:00 pm Workshop 6 Risk Assessment: Putting it all Together Workshop focuses on integrating the actuarials into a comprehensive assessment and on testifying to the results of the assessment in court. The impact of the offender’s age on risk assessment is addressed as well as other factors that affect risk but may not be represented fully in the actuarials. Anna Salter, PhD

Family Play Therapy Working with families with young children requires creativity, patience, and an interest in bridging gaps so young children can actively participate in treatment. Workshop offers a rationale for incorporating play therapy into traditional verbal therapy and provides a demonstration of some user-friendly techniques. Eliana Gil, PhD

The Health Impact of Sexual Trauma: Treatment and Prevention The health impact of sexual trauma must be understood for treatment and prevention to be effective. Learn about the research on the specific health risks of sexual trauma to women. A sexual abuse screening instrument is presented that can help coordinate health-care services for women. Screening mothers for sexual abuse trauma can help prevent prolonged postpartum depression and chronic health problems related to sexual abuse. Karen A. Duncan, MA, LSW, LMFT

Group Therapy for Adolescent Sexual Abuse Survivors Learn why group therapy for adolescent sexual abuse survivors is effective and how to implement these groups. The emphasis is on treatment goals, group member screening, format, assessment tools, and group techniques. Sarah Briggs, LPC

Interventions with the Non-Offending but Often Offensive Spouse in Incestuous Families The debate between the family system and the victim advocacy models to treat incestuous families can impede efforts to heal victims who have been abused by a father figure but unsupported by the non-offending mother. Learn how to help these mothers develop a protective role. Restitution therapy is emphasized in this skill-based program which deals with mothers who do not seem able to protect their children. Jan Hindman, MS, LPC

Beyond Leading Questions: Complexities of Interviewing Children Interviewers are advised to use open-ended questions with children whom may have been sexually abused and to obtain narrative accounts from them. Although sound advice, such techniques do not consider the spectrum of children who have been sexually abused. The presenters provide guidance for forensic interviewers based upon a review of the research on questioning techniques, the research on the interview process, knowledge about disclosures of sexual abuse, and their years of experience interviewing children who may have been sexually abused. Kathleen Faller, PhD

Antisocial Attitudes and Beliefs: What to Do About Them Many sex offenders have other criminal offenses and hold antisocial attitudes and beliefs. Learn about theories
of antisocial attitudes, how to treat them, and the role they play in sexual assaults. Anna Salter, PhD

Workshop

Post-Traumatic Processing in Children: An Integrated Approach

Workshop presents an integrated approach to help children after traumatic experiences. Trauma theory provides the context for understanding how to approach and assist young children. Facilitating and responding to post-traumatic play, and using cognitive-behavioral and sensory strategies are discussed. The importance of family work is highlighted. Eliana Gil, PhD

Eastern Conference on Child Sexual Abuse Treatment Workshops 6-11 Welcome and Plenary Session Workshops 12-17 www.dcs.wisc.edu/pda/hhi/eastern3

Communications in Forensic Interviewing—Part 1

An issue in interviewing children about possible abuse is whether to limit the child’s communication to only verbal, or also to allow the child to communicate through demonstrations. Demonstrative communication modes include anatomical dolls, anatomical drawings, freedrawings, dollhouses, and other media. Presenter will critically review a body of analogue and real world research on demonstrative communication in forensic interviews and offer guidelines about when and how to use demonstrative communication methods. Participants should also attend Part 2—Workshop #20. Kathleen Faller, PhD

Best Practices to Treat Abused Children and Their Families—Why Don’t We Use Them?—Part 1

Implementing best practices to treat abused children and their families is difficult. The results of two projects are presented and four “best practice” treatments are described. Learn how to implement evidence-based practice in trauma treatment settings. Participants should also attend Part 2—Workshop #21. Benjamin Saunders, PhD

War and Peace—Family Violence and the Military Family—Part 1

Prior to the war on terror, “military family” referred to an installation based culture associated with career personnel and support services. Although military children have increased risks of family violence, the support services on military installations often surpass those in the community. Since the war on terror, the term military family has expanded to include not only those on military installations, but also National Guard and Reserve families. These families may not have the same support services that are available on military installations. The presentation reviews contemporary military family dynamics in stateside and overseas assignments. Learn about family violence prevention programs, stages of deployment and the associated stresses, the mental health impact for returning military personnel, and the associated risks for child abuse and neglect. Participants should also attend Part 2—Workshop #22. Sharon Cooper, MD

Reactive Attachment Disorder: Dispelling the Myths—Part 1

This presentation includes a brief overview of the normal course of attachment, and a discussion of behaviors believed to indicate attachment disorders. Controversial treatment techniques, and the need for empirically-based treatment strategies are discussed. Participants should also attend Part 2—Workshop #23. Rochelle Hanson, PhD

Workshop

3:00-4:30 pm Workshop 18 Childhood Sexual
Abuse, Eating Disorders and Substance Abuse: Assessment and Group Treatment for Adolescent Girls

Childhood sexual abuse is an underlying cause of substance abuse and eating disorders in adolescent girls. Learn about a group approach with adolescent girls to treat the underlying trauma of sexual abuse and the co-occurring eating and substance use disorders. Prevention education to interrupt the traumatic pathway to other lifetime traumas is discussed.

Karen A. Duncan, MA, LSW, LMFT

Workshop

Female Sex Offenders

This advanced session explores the unique dynamics of juvenile and adult female sex offenders. Learn about offender typology and the differences between male and female offenders. Female sexual development and myths and misconceptions about female offenders are addressed, including problems with intervention, and with society’s attitudes.

Jan Hindman, MS, LPC

Workshop 20

Demonstrative Communication in Forensic Interviewing — Part 2

This a continuation of Workshop #14 is only for those who attend Part 1.

Kathleen Faller, PhD

Workshop 21

Best Practices to Treat Abused Children and Their Families — Why Don’t We Use Them? — Part 2

This continuation of Workshop #15 is only for those who attended Part 1.

Benjamin Saunders, PhD

Workshop 22

War and Peace — Family Violence and the Military Family — Part 2

This continuation of Workshop #16 is only for those who attended Part 1.

Sharon Cooper, MD

Workshop 23

Reactive Attachment Disorder: Dispelling the Myths — Part 2

This continuation of Workshop #17 is only for those who attended Part 1.

Rochelle Hanson, PhD

Eastern Conference on Child Sexual Abuse Treatment Workshops 18-23

www.dcs.wisc.edu/pda/hhi/eastern

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Friday, March 24

9:00-10:30 am

Workshop 24

Assessment of Psychological Trauma

Numerous screening and assessment instruments have been developed in the past decade to evaluate symptoms and to diagnose disorders. This workshop provides an overview of the relevant issues that arise in assessing individuals with a history of trauma. Learn about assessment instruments and how they can be used in both an assessment and a clinical setting.

Christine A. Courtois, PhD

Jean Gearon, PhD

Workshop 25

Sibling Incest — Assessment and Treatment

Understand the literature and the clinical features of sibling incest. Topics include separation of victim and offender, joint interviews with victim and offender, and roles of key service providers (police, protective services, probation, mental health). Learn the importance of full family participation. Case examples demonstrate a working model to address issues of safety, loyalty, engagement, and minimization.

Geraldine Crisci, MSW

Workshop 26

Strong at the Broken Places — Resiliency in Survivors

The myth, “once damaged goods, always damaged goods,” implies survivors of trauma are destined to continue patterns of abuse—against themselves or others. To the contrary, MOST survivors go on to lead healthy and fulfilling lives. Many derive their greatest strengths in the very areas where they’ve been hurt the most. This session includes the documentary short “Strong at the Broken Places,” produced by the Oscar-winning Cambridge Documentary Films. After a brief discussion of the film, Linda presents Aaron Antonovsky’s “salutogenic” approach, and the characteristics that help survivors prevail over trauma. The resiliency of the practitioner is also addressed.

Linda T. Sanford, LICSW

Workshop 27

What Should We Treat in Sex Offender Treatment? Answers from the Research — Part 1

Sex offender treatment has
typically addressed empathy deficits, cognitive distortions, denial, and offenders’ own histories of victimization. Recent research suggests that some of these issues may be unrelated to recidivism risk. This session reviews these findings and suggests which areas should be covered in sex offender treatment. Participants should also attend Part 2—Workshop #33. Lloyd Sinclair, LCSW Workshop 28 Narrative Therapy Approaches for Sexual Abuse and Compulsivity—Part 1 In this practical and advanced two-part workshop, learn how Narrative Therapy is used with sexual abuse, compulsivity, depression, and other problems. Learn new ideas and skills for working with chronic, multi-problem clients. Video-tapes of individual and family therapy, case examples and demonstrations complement the lecture. If time permits, examples of non-pathologizing therapy planning and insurance authorization requests are shared. You should also attend Part 2—Workshop #34. Walter Bera, PhD, LP, LMFT Eastern Conference on Child Sexual Abuse Treatment Workshops 24-29 Workshop 29 Creative Interventions for Abused and Traumatized Children—Part 1 Learn creative, structured interventions to assess and treat abused and traumatized children. Activities for individual and group treatment settings with children of all ages are outlined. You will come away with many new and innovative play therapy techniques. Participants should also attend Part 2—Workshop #35. Liana Lowenstein, MSW, RSW, CPT-S10:45-12:15 am Workshop 30 Sexual Meaning for Children and Youth: Sorting through the Good, the Bad and the Confusing Explore the importance of prevention efforts that use education to help adults discern healthy from harmful sexual behaviors. Learn how to help children make meaning of sex and sexuality in their lives against the backdrop of many sexual toxins. Cordelia Anderson, MA Workshop 31 Child Sexual Abuse Treatment: Five Essential Ingredients Through client interviews over the past twelve years, we have learned what clients are saying about the process of change. Learn about the essential ingredients for successful treatment outcomes as reported by your consumers. You will also explore ideas of how to integrate these elements into your practice. Mary Jo Barrett, MSW Workshops 30-35 www.dcs.wisc.edu/pda/hhi/eastern5

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Workshop 32 Relational Healing of Complex Trauma Complex trauma usually results from experiencing trauma throughout critical developmental periods. Victimization within the family is the most common cause that makes the child susceptible to other victimizations across the lifespan. The capacity to trust others and to form close interpersonal bonds is often compromised. Learn about criteria for the diagnostic conceptualization of Complex PTSD (CPTSD)/Disorders of Extreme Stress Not Otherwise Specified (DESNOS). Learn about attachment-based interventions. Christine A. Courtois, PhD Workshop 33 What Should We Treat in Sex Offender Treatment? Answers from the Research—Part 2 This is a continuation of Workshop #27 and is only for those who attended Part 1. Lloyd Sinclair, LCSW Workshop 34 Narrative Therapy Approaches for Sexual Abuse and Compulsivity—Part 2 This is a continuation of Workshop #28 and is only for those who attended Part 1. Walter Bera, PhD, LP, LMFT Workshop 35 Creative Interventions for Abused and Traumatized Children—Part 2 This is a continuation of Workshop #29 and is only for those who attended Part 1. Liana Lowenstein, MSW, RSW, CPT-S1 3:00 pm Workshop 36 Healing as Adults from Incest and Sexual Traumas Examine the results of
childhood sexual assault that bring adults into treatment: self-blame, intrusivememories, dissociation, sexualdysfunction, abuse of food and substances, and self-mutilation. Learn how individual, group, family, and family of origin work can help clients rediscover aspects and move beyond survival. Interventions are explored and a treatment model is presented that uses a feminist and societally sensitive approach. Mary Jo Barrett, MSW

Workshop 37 Assessing and Treating Sexualized Behavior Problems in Children Under Age 12

The number of children under age 12 with inappropriate sexualized behavior has increased and presents a challenge to parents, practitioners, schools and communities. Learn how to treat these behaviors starting with proper assessment and within a developmental context. Learn how to use a comprehensive approach which includes milieu interventions and outpatient methods. Geraldine Crisci, MSW

Eastern Conference on Child Sexual Abuse Treatment Workshop 38 Engaging Resistant Clients in Counseling

Many children have difficulty verbalizing their issues because they are reluctant to self-disclose and because they are anxious about the therapeutic process. Learn how play-based and creative activities can engage resistant children and help them express their thoughts and feelings. Lecture, demonstrations, and audiovisuals provide techniques to engage resistant children and youth in counseling. Liana Lowenstein, MSW, RSW, CPT

Workshop 39 Adolescent Sexual Violence Prevention

Stopping adolescent sexual violence involves switching the responsibility from expecting victims to stop the harm, to expecting those that perpetrate to stop the behavior. This session includes online and in-person issues and the role of adults and bystanders in prevention. It includes tools that are used with students and adults such as the “Sexual Behavior Continuum” and “Circles”. Cordelia Anderson, MA

Workshop 40 Shame: I Am Bad So I Do Bad

Shame is a common sequel to trauma. It is an underlying cause of many behaviors that bring people to the attention of helping professionals. This workshop explores the role shame plays in criminal, abusive, addictive and self-destructive behaviors. Implications for interview-ing and treatment approaches are covered as well as the challenges to countertransference management represented by shame. Linda T. Sanford, LICSW

Workshops 36-40

www.dcs.wisc.edu/pda/hhi/eastern
In this two-part article, Toni Cavanagh Johnson introduces a discussion on concerns relating to inappropriate and abusive sexual behavior amongst children and young people in care.

Understanding the Sexual behavior of Children

If one were to ask a group of teachers, school counselors, or social workers, "Do you think children today express more sexual behaviors than they did a generation ago?", most of them would probably say "Yes". Documenting such an increase, however, would be impossible, because, until recently there has been no reliable collection of data about the number and types of sexual behaviors in which children engage; even now, such research is in its infancy.

Nonetheless, all of us can point to certain sociological factors that may be contributing to changes in sexual behaviors, including children's access to wider television programming, adult videos, and communications facilities that provide on-line and telephone sexual experiences for callers. Without an established base of research, however, how are parents, teachers, and counselors able to determine when children's sexual behaviors fall within an acceptable range of sexual behaviors, or when they may require intervention and treatment?

Some professionals continue to argue that intervention around sexual issues is never required for children — that all sexual behaviors of children are, by their very nature, benign and uncomplicated. However; a growing body of research, largely based on two specific populations — children who have been sexually abused and children who have used some kind of coercion or pressure to force other children into sexual behaviors — is causing many professionals to rethink that argument.

Most professionals who work with children are aware of contemporary studies that suggest that increased sexual behaviors may be an indication that a child is being, or has been, sexually molested. Increasing evidence also points to the fact that it is important to evaluate young children who are coercing other children into unwanted sexual behaviors; research on adult offenders has revealed that many offenders began their coercive sexual behaviors in elementary school and increased the number and violence of their sexual behaviors during adolescence. Such findings indicate that there may be danger in just hoping that children will grow out of coercive sexual behaviors.

On the other hand, overreacting to children's sexual behaviors can also have negative consequences; it could cause them to feel ashamed and self-conscious about a natural and healthy interest in their bodies and sexuality.

It is also important to note that adults who work with children often assume that they "just know" whether a child's sexual behavior is natural and healthy. However, what they are generally using in making their evaluations are just sets of internal — and largely unconscious — intuitive guidelines, which have been drawn from their own sexual experiences as children, their parents' attitudes, their religious beliefs, and other aspects of their personal histories and cultures.

Such preformed guidelines may actually reveal more about the adult evaluator than the child in question. Individual standards for evaluation, not surprisingly, vary widely: some adults think that any behavior of a young child relating to sexuality is unacceptable, while others accept a wide range of sexual behaviors among children. Professionals who work with children need practical data-based guidelines to determine when a child's sexual behaviors are within acceptable limits and when they are causes for concern.

Some general guidelines
While research data on childhood sexuality is still in the pioneering stages, there is enough information to establish some important observations about the sexual behaviors of children 12 years of age and younger. In looking at the continuum of sexual behaviors presented in this article, it is important to remember that:

1. There is no single standard for determining *normal* sexual behaviors in all children, since there are individual differences due to the development level of the child and due to the amount of exposure the child has had to adult sexuality, nudity, explicit television, and videos. Parental and societal attitudes and values, as well as the child’s peer group and living conditions, exert additional influences on the types and range of the child’s behaviors. A set of guidelines, nonetheless, may provide a base-line by which children’s sexual behaviors can be somewhat objectively evaluated at this time, and may help target potential problems.

2. The sexual behaviors of a child represent only one part of their total being. Sexual behaviors should not be used as the sole criteria for determining whether a child has a significant problem. (See section on Initial Assessment.)

**A continuum of sexual behaviors**

Professionals who work with children need to have perspectives on the full spectrum of childhood sexual behaviors, from the wide variety of what are perceived to be age-appropriate healthy activities to patterns that may be unhealthy or pathological and may require attention and/or treatment.

After analyzing extensive evaluations of hundreds of children, and their families, who were referred to the author due to the child’s sexual behaviors, four definable clusters or groups of children have begun to emerge on a continuum of behaviors:

- **Group 1** includes children engaged in natural and healthy childhood sexual exploration;
- **Group II** is comprised of sexually-reactive children;
- **Group III** includes children who mutually engage in a full range of adult sexual behaviors; and
- **Group IV** includes children who molest other children.

This continuum of sexual behaviors applies only to boys and girls, aged 12 and under; who have intact reality testing and are not developmentally disabled.

Each group includes a broad range of children, some are on the borderline between the groups, and some move between the groups over a period of time.

**The initial assessment**

The initial assessment, to determine where on the continuum the child may fall, includes:

1. An evaluation of the number and types of sexual behaviors of the child.
2. A history of the child’s sexual behaviors.
3. Whether the child engages in sexual activities alone or with others.
4. The motivations for the child’s sexual behaviors.
5. Other children’s descriptions, responses, and feelings in regard to the child’s sexual behaviors.
6. The child’s emotional, psychological, and social relationship to the other children involved.
7. Whether trickery, bribery, physical or emotional coercion is involved.
8. The affect (levels of feelings) of the child regarding sexuality.
10. Access and careful reading of protective services’ reports, court reports, and probation documents (if applicable).
11. An assessment of the child’s school behaviors, peer relations, behaviors at home, and behaviors when participating in out-of-home activities, such as day care or recreational programs.
12. A history of each family member; the overall family history, and an evaluation of the emotional and sexual climate of the home.

Assessment of these areas helps to determine whether the child falls into Group I, II, III, or IV.

If the child falls into Groups II, III or IV, a thorough evaluation to assess the treatment needs of the child, and the family, will be necessary. It is recommended that assessments should be completed by a mental health professional who specializes in child sexual abuse. While the child may not have been sexually abused, the sexual behaviors demonstrated in these groups may be indicative of previous or current sexual abuse.

**Group I: Natural and Healthy Sexual Play**

Normal childhood sexual play is an information gathering process. Children explore — visually and through touch — each other’s bodies (for example, play doctor), as well as try out gender roles and behaviors (e.g., play house). Children involved in such explorations are of similar age and size, are generally of mixed gender; are friends rather than siblings, and participate on a voluntary basis (“I’ll show you mine if you show me yours!”). The typical feeling level of these children, in regard to sexually-related behaviors, is light-hearted and spontaneous. In natural sexual play or exploration, children often are excited, and they feel and act silly and giggly.

While some children in Group I may feel some confusion and guilt, they do not experience feelings of shame, fear, or anxiety.

The sexual behaviors of children who are engaged in the natural process of childhood exploration are balanced with curiosity about other parts of their universe as well. They want to know how babies are made and why the sun disappears; they want to explore the physical differences between males and females and figure out how to get their homework done more quickly, so they can go out and play. If children are discovered while engaged in sexual play and are instructed to stop, their sexual behavior may, to all appearances, diminish or cease, but it generally arises again during another period of the child’s sexual development.

The range of sexual behaviors in which children engage is broad; however, not all children engage in all behaviors: some may engage in none, and some may only engage in a few. The sexual behaviors engaged in may include: self-stimulation and self-exploration, kissing, hugging, peeking, touching, and/or the exposure of one’s genitals to other children, and, perhaps, simulating intercourse, (a small percentage of children, 12 or younger, engage in sexual intercourse.) Because of this broad range of possible sexual behaviors, diagnosing a child on sole basis of their sexual behaviors can be misleading. Although children who have sexual problems usually manifest more varied and extensive sexual behaviors than Group I children, their behaviors may, in some cases, vary only in degree.

**Group II: Sexually-Reactive behaviors**
Group II children display more sexual behaviors than the same-age children in Group I; their focus on sexuality is out of balance in relationship to their peer group's; and they often feel shame, guilt, and anxiety about sexuality.

Many children in Group II have been sexually abused; some have been exposed to explicit sexual materials; and some have lived in households where there has been too much overt sexuality. Young children, who watch excessive amounts of soap operas or television and videos, and who live in sexually explicit environments, may display a multitude of sexual behaviors. Some parents, who themselves may have been sexually and/or physically victimized, express their sexual needs and discuss their sexual problems openly with their young children. This can over-stimulate and/or confuse their children. Some children are not able to integrate these experiences in a meaningful way. This can result in the child acting out his or her confusion in the form of more advanced or more frequent sexual behaviors, or heightened interest and/or knowledge beyond that expected for a child of that age. The sexual behaviors of these children often represent a repetition compulsion or a recapitulation (often unconscious) of previously over-stimulated sexuality or sexual victimization. The time between the sexual over-stimulation and the sexual behaviors is close, and often overlaps or is contiguous.

Behaviors of Group II children include: excessive or public masturbation, overt sexual behaviors with adults, insertion of objects into their own or other's genital, and talking about sexual acts.

Such sexualized behavior may be the way the child works through his or her confusion around sexuality. After being told that their sexual behaviors need to be altered, Group II children generally acknowledge the need to stop the behaviors and welcome help.

The sexual behaviors of this group of children are often fairly easy to stop, as they do not represent a long pattern of secret, manipulative, and highly charged behaviors, such as those seen among child perpetrators (as will be seen in Group IV).

_In next month’s concluding article Dr Toni Cavanagh Johnson will deal with the more worrying Group III and Group IV sexual behaviors._

_SEXUALITY_

In this two-part article (concluded this month) Toni Cavanagh Johnson has introduced a discussion on concerns about inappropriate and abusive sexual behaviour amongst children and young people in care.
Understanding the Sexual Behaviour of Children - II

In Part I of this article we discussed Group I (Natural and Healthy Sexual Play) and Group II (Sexually-Reactive Behaviours). This month we will continue with Groups III and IV.

**Group III: Extensive Mutual Sexual Behaviours**

Group III children have far more pervasive and focused sexual behaviour patterns than Group II children, and they are much less responsive to treatment. They participate in a full spectrum of adult sexual behaviours, generally with other children in the same age range, (oral and anal intercourse, for example), and they conspire together to keep their sexual behaviours secret. While these children use persuasion, they usually do not force or use physical or emotional coercion to gain other children's participation in sexual acts. Some of these children however, move between Groups III and IV, i.e. between mutually engaging in sexual behaviours and forcing or coercing other children into sexual behaviours.

One of the striking differences between Group III children and the children in other groups, is their affect or emotional level -- or more precisely, their lack of affect -- around sexuality. Group III children do not have the light-hearted spontaneity of sexually healthy children, the shame and anxiety of sexually-reactive children, or the anger and aggression typical of child perpetrators. Instead, they display a blasé, matter-of-fact attitude toward sexual behaviours with other children -- as one explained, “This is just the way we play”.

It might be more accurate to say that sexual interaction is the way Group III children try to relate to their peers. As for relating to grownups, most Group III children expect only abuse and abandonment from adults.

Other Group III children have been sexually abused, in a group, by one or more adults, and continue the sexual behaviours experienced with the other children after the abuse by the adults has stopped. Other children in Group III are siblings who mutually engage in extensive sexual behaviours as a way of coping in their highly dysfunctional families.

All Group III children have been sexually and/or physically abused and/or have lived in highly chaotic and sexually charged environments. Through these experiences their understanding of relationships has become skewed; distrustful of adults, chronically hurt and abandoned, and lacking in academic or social success. These boys and girls use sexuality as a way to make another child a friend – even briefly. Few of these children report any need or drive for sexual
pleasure or orgasm, and although their “What’s the big deal?” attitude may have the appearance of sophistication, it conceals significant emotional vulnerability. Their sexual activities appear to be their attempts to make some kind of human connection in a world which is chaotic, dangerous, and unfriendly.

**Group IV: Molestation Behaviour**

Many professionals involved with the care and protection of children find it difficult to believe that children 12 years and younger can molest other children. Evidence that they can, and do, is found not only in a growing group of studies and journal articles, but in FBI reports and newspaper clippings. In one recent case, a fourth grader was sexually assaulted by several students in the bathroom of her local public school. The incident occurred at a small country school in Vermont which serves just 150 children, from kindergarten through fourth grade. The perpetrators of the sexual assault against the little girl were all her age or younger. Two 10-year-old boys from the girl’s class initiated the attempted rape, and three other boys watched or helped to hold the struggling victim while her attackers tried to penetrate her. One of these boys was eight years old and the other two were six years old.

This small town incident is just one example of a nationwide increase in reports of sexual offences by prepubescent children that have taken the system by surprise. Last year, in the state of New York, “juvenile court prosecutors handled 270 cases of sexual crimes involving children 12 years old and younger – more cases than in the 13- to 1 5-year-old range. Commenting on the statistics, Peter Reinharz, supervisor of the sexual crimes prosecution unit, noted that the age drop meant that the unit was dealing with “eight, nine, ten-year-olds committing rape (and) sodomy. The identified victims are usually other children.

Only a few treatment programmes have been established for these child perpetrators, but preliminary findings on children in Group IV have been published. As a group, they have behaviour problems at home, and at school, few outside interests, and almost no friends. These children lack problem-solving and coping skills, and demonstrate Little impulse control. Often, they are physically and sexually aggressive. In preliminary findings on child perpetrators, no one – parents, teachers, or peers -- described any member of the group as an average child.

The sexual behaviours of Group IV children go far beyond developmentally appropriate childhood explorations or sexual play. Like the children in Group III, their thoughts and actions are often pervaded with sexuality. Typical behaviours of these children may include (but are not limited to) oral copulation, vaginal intercourse, anal intercourse and/or forcibly penetrating vagina or anus of another child with fingers, sticks and/or other objects. These children’s sexual behaviours continue and increase over time, and are part of a consistent pattern of behaviours rather than isolated incidents. Even if their activities are discovered, they do not, and cannot, stop without intensive and specialized treatment.

A distinctive aspect of Group IV children is their attitudes toward sexuality. The shared decision making and lighthearted curiosity evident in the sexual play of children in Group I is absent; instead, there is an impulsive, compulsive, and aggressive quality to their behaviours. These children often link sexual acting out to feelings of anger (or even rage), loneliness, or fear. In one case, four girls held a frightened, fighting and crying 18-month-old child while another girl fellated him. The girls (all age six to eight) each took a turn. The little boy required extensive medical attention as a result of penile injuries.

While most of the case studies in this group are not physically violent, coercion is always a factor. Child perpetrators seek out children who are easy to fool, bribe, or force into sexual activities with them. The child victim does not get to choose what the sexual behaviours will be, nor when they will end. Often the child victim is younger and sometimes the age difference is as great as 12
years, since some of these children molest infants. On the other hand, some child perpetrators molest children who are age-mates or older. In sibling incest with boy perpetrators, the victim is typically the favourite child of the parents. In other cases, the child is selected due to special vulnerabilities, including age, intellectual impairment, extreme loneliness, repression, social isolation, or emotional neediness. Child perpetrators often use social and emotional threats to keep their victims quiet: "I won't play with you ever again, if you tell"; this is a powerful reason to keep quiet if the child victim already feels lonely, isolated or even abandoned at home and at school.

Even the bathroom games sometimes seen in Group I children are markedly different from the disturbed toileting behaviours common in Group IV. Some children who molest other children habitually urinate and defecate outside the toilet (on the floor, in their beds, outdoors, etc.) While many Group I children may mildly resist changing underwear, some children in Group IV will wear soiled underpants for more than a week or two and adamantly refuse to change. Some constantly sniff underwear. Many of the children regularly use excessive amounts of toilet paper (some relate wiping and cleaning themselves to masturbation) and stuff the toilet until it overflows day after day. The children continue these disturbed toileting patterns even if their families have severely punished them for their behaviour. While Group IV children often obsessively focus on toileting and sexual activities, the natural and healthy sexual curiosity and delight of young children is absent. Instead, they express a great deal of anxiety and confusion about sexuality. Many Group IV children say they act out sexually when they feel jumpy, funny, mad (angry) or bad. Yet, after engaging in sexual behaviours, most report that they feel worse.

Most child perpetrators who have been studied have been victims of sexual abuse themselves, although the sexual abuse generally has occurred years before the children began molesting other children. All of the girl perpetrators (females represent about 25% of child perpetrators) and about 60% to 70% of the boy perpetrators have been molested. All of the children live in home environments marked by sexual stimulation and lack of boundaries, and almost all of the children have witnessed extreme physical violence between their primary caretakers. Most parents of Group IV children also have sexual abuse in their family histories, as well as physical and substance abuse.

This group of children is at the highest risk for continuing, and escalating, their patterns of sexually abusive behaviours, unless they receive specialized treatment specifically targeting their acting out. Unfortunately, there are only a handful of any type of treatment programmes specifically targeted for children who molest other children. A jury in New York City took just two months to convict a ten-year-old boy of raping a seven-year-old girl, but two years to find a treatment resource for him.

Even in an age of sharply limited government funds, increasing resources for children who molest other children are vital.

Gene Abel, MD, Director of the Behavioural Medicine Institute in Atlanta, and author of more than 80 articles on sexual offenders, has hypothesized that the average adolescent perpetrator could be expected to commit more than 300 sexual crimes in his lifetime. Abel noted, "We know that many adolescent perpetrators engaged in deviant sexual behaviours as early as five or six years of age. When there is a persistent and consistent pattern of sexually deviant behaviour in young children, early assessment and specific treatment affords the best opportunity to stop the behaviour.

Conclusion: The Need for Practical Guidelines on Child Sexual Behaviours

While thorough evaluation needs to be provided by an expert in child sexual behaviours, it is almost always a nonspecialist who identifies and refers a child for evaluation. The persistent and
consistent pattern of problem sexual behaviours is usually first noticed by parents, caretakers, and front line professionals, including school teachers, nurses, counsellors and social workers. For this reason, all professionals who work with children or families need practical guidelines as to which child sexual behaviours are natural and healthy and which behaviours indicate a need for specialized assessment.

Research on child sexual behaviours also has immediate practical ramifications for anyone teaching sexuality education classes to youngsters.

- First, the families of children in Groups II, III and IV verbally or nonverbally communicate inaccurate information about sexuality, gender, and reproduction. Accurate information, and a forum in which to ask questions about sexuality, are essential for these children.
- Secondly, the increase in reports on child perpetrators underscores the importance of including information on child sexual abuse in sexuality education classes. Children should be aware that no other person (whether that person is an adult or another child) has the right to force or pressure them into unwanted sexual behaviours.

As sexual behaviour raises concern ...

### Signals for Parents and Counsellors

1. The child focuses on sexuality to a greater extent than on other aspects of his or her environment, and/or has more sexual knowledge than similar-age children with similar backgrounds who live in the same area. A child's sexual interests should be in balance with his or her curiosity about, and exploration of, other aspects of his or her life.

2. The child has an ongoing compulsive interest in sexual, or sexually-related activities, and/or is more interested in engaging in sexual behaviours than in playing with friends, going to school, and doing other developmentally-appropriate activities.

3. The child engages in sexual behaviours with those who are much older or younger. Most school-aged children engage in sexual behaviour with children within a year or so of their age. In general, the wider the age range between children engaging in sexual behaviours, the greater the concern.

4. The child continues to ask unfamiliar children, or children who are uninterested, to engage in sexual activities. Healthy and natural sexual play usually occurs between friends and playmates.

5. The child, or a group of children, bribes or emotionally and/or physically forces another child/children of any age into sexual behaviours.

6. The child exhibits confusion or distorted ideas about the rights of others in regard to sexual acts. The child may contend: "She wanted it" or "I can touch him if I want to."

7. The child tries to manipulate children or adults into touching his or her genitals or causes physical harm to his or her own or other’s genitals.

8. Other children repeatedly complain about the child’s sexual behaviours – especially when the
child has already been spoken to by an adult.

9. The child continues to behave in sexual ways in front of adults who say "no", or the child does not seem to comprehend admonitions to curtail overt sexual behaviours in public places.

10. The child appears anxious, tense, angry, or fearful when sexual topics arise in his or her everyday life.

11. The child manifests a number of disturbing toileting behaviours: plays with, smears faeces, urinates outside of the bathroom, uses excessive amounts of toilet paper, stuffs toilet bowls to overflow, sniffs or steals underwear.

12. The child's drawings depict genitals as the predominant feature.

13. The child manually stimulates or has oral or genital contact with animals.

14. The child has painful and/or continuous erections or vaginal discharge.
How to deal with sexual acting-out on the child psychiatric inpatient ward.

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1. Although the management of sexually abused children is not new, a comprehensive approach is often lacking, especially as it pertains to dealing with sexually acting-out children. 2. In addition to the usual social work measures of child protection, a program of developmentally and psychoeducationally based interventions supplemented by behavioral techniques were found to be most effective. 3. Acting-out children often provoke reactions of rage, betrayal, and impotence among the staff. Discussions of interventions must take into account the staff’s own philosophy about how sexuality should be taught to these children. 4. The treatment team leader must decide whether the sexual acting-out among children is due to active solicitation from sexually abused children, delinquent acting-out, or age-appropriate exploration.
Sexually Reactive Children

- Six-year-old Jason has been touching his infant foster sister inappropriately.
- Eight-year-old Alisha undresses younger children on the playground and mimics oral sex.
- Ten-year-old Adam was caught masturbating a same-age, same-sex playmate in the boys' bathroom at school.

All the above children have one thing in common: They are sexually reactive children, which means that they are acting out in sexual ways because they themselves have been sexually abused in the past. It is learned behavior.

These children relate to others in sexual ways because these are behaviors with which they are familiar. They have either watched or participated in sexual acts. Although sexual abuse is a horrible act against anyone, sometimes these young victims don't understand the dynamics or realize the ramifications. Not all perpetrators behave violently with their young victims, and when or if a child has derived pleasure from the act, it's even more confusing for them to understand the nature of abuse.

Without intervention, redirection, and therapy, these children can grow up to be juvenile and adult sex offenders. Some children are erotisized without becoming offenders, so we should be careful to avoid labeling all of these children as perpetrators.

As parents, teachers, ministers, counselors, and childcare providers, how can we distinguish normal sex play from sexually "acting out"? And what do we do about it if we encounter a child who engages in overt and continuous sexual behavior?

Though there is no rigid profile of the sexually reactive child, there are some characteristics that are found most often in these children, and include:

- A history of sexual abuse.
- Acting out with children younger than themselves.
- Has a knowledge of sex that is beyond their age level. (Ex: Vibrators, dildos, condoms, etc).
- Simulates copulation with dolls, toys, other children, and even animals and adults.
- Appears to have little or no age-appropriate fear of strangers.
- Has no sense of boundaries, modesty, or privacy where their personal physical space is concerned.
- Often acts in a flirtatious or promiscuous ways that are not age-appropriate.
- Uses coercion, bribery, or force in what would appear to be otherwise normal sex play with same-age friends.
- Sexual contact with other children appears to be more adult in nature than age-appropriate.
- Demands secrecy, and makes threats of harm if the acts are disclosed.
- Lies or manipulates when confronted with knowledge of the sexual contact.
• Uses objects, violence, or weapons during a sex act.
• Touches children and adults inappropriately, and in public (breasts, vagina, groin, buttocks). Excessive masturbation and exposure.
• Sexualized themes during play and conversations, including drawing, painting, and playing with dolls and dollhouses.

Remember, it is normal for a child to have a healthy curiosity about sex and body parts. Don't be alarmed when same-age children play doctor with one another. Do be alarmed if some or most of the above red flags appear consistently in a child.

Not all sexually reactive children act out because of overt sexual abuse. Some imitate pornography that may belong to a household member. Some mimic what they may spy in their own parents' or teenage sibling's bedroom.

If you encounter a child who you suspect is sexually reactive, you may:

• Bring it to the attention of the parents.
• If the parents dismiss or don't acknowledge concern, inform a social worker, nurse, counselor, or minister.

**Why should we bring it to someone’s attention?**

Because it may be your little boy or girl who encounters the sexually reactive child in the school bathroom or park.

Again, not all sexually abused children grow up to be perpetrators, but a sexually reactive child can and should learn specific skills in recognizing his behavior and redirecting it. These skills can be taught to very young children. Family therapy is often the key to successful intervention and treatment.

Though it's a delicate subject, it's one that needs addressed, because help is available to children who act out sexually. Behavior can be refocused, trauma can be repaired, and lives can be restored.
Treating Child Sexual Abuse: Advice for Parents

Published: February 9, 1999

by: Joan Tabachnick

So many of us are willing to hide from the reality of child sexual abuse, to hope that it won't happen again, and then end up simply waiting until it is too late and another child is hurt. Yet there is hope and help available.

Consider this circumstance: a child is abused at a very young age. As he gets older, he acts out his anger by abusing another child. This child who has abused, was finally placed in a specialized treatment program for adolescents who abuse children, but will soon be released from that residential program not because he has successfully completed treatment but because he will be considered an adult at the age of 18. His parents want him to stay in treatment so that he does not act out again and hurt another child. His parents want him to learn how to control this anger and how to stay safe so that he does not hurt himself or anyone else. But his current program does not treat children over the age of 18. Would you know where to turn?

First, it is important to remember that there is hope. There are others around the country that will take in young men and women who have abused and need help to live in a community again. If the young adult is just turning 18, many youth programs accept them up to the age of 21 if the intake is taken before the age of 18. There are also other residential programs around the country for adults of any age who have sexually abused children. The first step in finding a program near you is to have a complete psychosexual assessment of the youth to determine what he needs at this point in his treatment. If you have already had an assessment, you may want to call the Safer Society Foundation, Inc. in Brandon, Vermont. The Safer Society has the only database of treatment programs in the country and can give you a referral to a treatment program that addresses your needs in your part of the country. If your treatment provider cannot call, you may call
them directly at (802) 247-5141. The referral line is open Monday, Wednesday and Friday from 1:00 to 4:30 PM (EST).

One of the most difficult parts of getting help is to acknowledge the problem. Like other addictions, if you ignore the problem for years, it becomes much more difficult to stop the behaviors and heal. Children and teenagers can benefit most from our willingness to identify a problem and get help for our children.

Research shows that this is a treatable condition, especially when it is identified at an early age. I want to emphasize this point for other parents who see sexual behaviors in their children that are not appropriate to their age. Seeking help at an early age will help the child who is "acting out" and prevent the sexual abuse of another child. If parents have concerns about the sexual behaviors of their children or want to know more about age appropriate sexual behaviors, they can call our organization STOP IT NOW! VERMONT at (802) 247-0105 for an informational brochure "Do Children Sexually Abuse Other Children?" For parents who want to talk to staff confidentially, they can call our toll-free helpline at 1-888-PREVENT on Mondays through Fridays from 1:00 - 5:00 PM (EST).

Researchers agree that in 30-50% of the reported cases of sexual abuse, the abuser was under the age of 18. With national studies showing 700,000 cases of child sexual abuse each year, we know that many of the abusers were children in loving families. One organization working on public policies to ensure that our young people are given a chance at treatment coupled with accountability for the crime is the Association for the Treatment of Sexual Abusers. This national organization provides information and research information about people who sexually abuse others. They can be reached at (503) 643-1023.

At a recent public forum sponsored by STOP IT NOW! a parent explained "My older son sexually abused my younger son. I reported the abuse so we could all get help. We are healthier and closer than we've ever been. I encourage parents to do whatever is necessary to identify and stop the cycle of abuse now." Another mother told us that she wished this parent would write a book about how she had the courage to turn her own 14 year old son into the legal system to get the treatment he needed. We believe it is time to shift the
responsibility of talking about this from our children's' shoulders to our own. It is critical for every adult in the situation to begin speaking about child sexual abuse and breaking the silence. We encourage everyone including adult survivors, recovering sex offenders, parents of victims and the parents of sexually abusing youth to speak out about this issue. In response to parents talking about their isolation, STOP IT NOW! is developing a newsletter for parents of sexually abusing children to share their stories and provide support to each other about how to keep their children and our communities safe. Any parent wanting more information about this newsletter should call the STOP IT NOW! VERMONT office at (802) 247-0105
Mary and Carol travel around the state educating foster parents and staff about working with juvenile sexual offenders. It is critical that all foster parents have some level of education about the complexities of parenting sexual offenders because even those kids who have not been identified as having sexual acting out behaviors may show some behaviors at some point during their placement. We are fortunate to have Mary and Carol join us to discuss sexual acting out children/youth. They will discuss NORMAL vs ABNORMAL SEXUAL BEHAVIORS; how your OWN FAMILY VALUES and attitudes come into play; what "TRIGGERS" or warning signs you should watch for; what "GROOMING" behaviors are; how to "PERP PROOF" your own home, and more. Mary Simon is a licensed Clinical Social Worker with over 16 years experience with juvenile sexual offenders. Mary developed and implemented a juvenile sexual offender program at Sunburst Youth homes in 1989 and became employed with Community Care Resources in 1992. At CCR she has developed and implemented S.T.O.P. programs and currently is the Program Manager there.
Treatment Of Child Sexual Abuse

Treatment of child sexual abuse is a complex process. Orchestration of treatment in the child's best interest is a genuine challenge. Moreover, it is often difficult to know how to proceed because there are so few outcome studies of treatment effectiveness.

In this chapter, case management issues are discussed; a model for understanding why adults sexually abuse children is proposed; treatment modalities are described; and treatment issues are examined. The focus of the discussion is primarily on intrafamilial abuse.

Case Management Considerations

One of the reasons sexual abuse treatment is such a challenge is that it occurs in a larger context of intervention. Therefore, coordination is of utmost importance and ideally is provided by a multidisciplinary team. Treatment issues are then handled by the team as part of overall intervention.

The team usually consists of the various professionals directly involved in the case and their consultants and, as noted earlier, begins its activity at the time of case investigation. The composition and functioning of teams vary by locality, and the level of participation of team members often varies depending on the stage of the intervention. In an intrafamilial case, the members active at the treatment stage will ordinarily include the Child Protective Services (CPS) and/or foster care workers, the therapists treating various family members, professionals providing other services (e.g., homemaker, parenting guidance), a representative from the prosecutor's office, and relevant consultants. The frequency of meetings will depend on the needs of the case and how the team is structured.

The following issues are the most important of those the team should consider at this stage of intervention: separation of the child and/or the offender from the family, the role of the juvenile court, the role of the criminal court, the treatment plan for the family, visitation, and family reunification.

Case management decisions are often provisional; that is, they are based on what information about the family members and their functioning is available when decisions
are made. Treatment is often a diagnostic process. The positive or negative responses of family members to treatment determine future case decisions. Outcomes of court proceedings can impinge upon and alter case management decisions and treatment.

The team meets periodically to assess progress and make future plans. Because of the complexity of case management decisions and the fact that a decision in one realm can have an impact on other aspects of the case, especially on treatment progress and outcome, multidisciplinary decision making is crucial. In the absence of a multidisciplinary team, such decisions should be made in consultation with other relevant professionals.

Before the implementation of the treatment plan, the following case management decisions should be addressed:

- Should the child remain a part of the family?
- Do the courts have a role in the case?
- Is there a question of visitation?

Guidelines for making these decisions will be discussed.

**Should the Child Live With the Family?**

The preferred outcome in cases of sexual abuse, as in other types of child maltreatment, is that after intervention the family will be intact.

Generally at the time of disclosure of the sexual abuse, the offender is not separated from the family. The victim may be removed if the mother is unable or unwilling to protect and support the victim or if the victim wishes to be removed. Many professionals advocate the removal of the offender even in circumstances in which the victim is removed.

After these initial decisions, a longer term plan must be made about whether the child should be a part of the family and, if so, whether or not that family should include both parents. This plan will be based on an assessment of each parent.

Aspects of the functioning of both parents outlined previously in the discussion of risk assessment should be examined in deciding about the child's future living situation. These include the following factors for the offender:

- the extent of the offender's sexually abusive behavior;
- the degree to which the offender takes responsibility for the sexual abuse;
- the number and severity of the offender's other problems, for example;
- substance abuse,
- violent behavior,
- mental illness, and
- mental retardation.

Regarding the nonoffending parent, the following factors should be assessed:

- reaction to knowledge about the sexual abuse,
- quality of relationship with the victim,
- level of dependency on the offender, and
- the number and severity of other problems.

Other possible problems are similar for the nonoffending parent and the offender.

Although these factors are universally useful to consider, in specific cases other factors may be important or even overriding.

Offenders who have engaged in a small number of sexual acts, have taken responsibility for their behavior, and have few other problems are judged to have positive findings in these key areas and are usually treatable. Negative findings in these three areas mean that the prognosis for positive treatment outcome is quite guarded. When mothers are protective of victims when they discover the sexual abuse, have good relationships with victims, are not unduly dependent on the offender, and do not have other significant problems, their treatment prognosis is positive. Again negative findings mean that the treatment prognosis is poor.

These proposed variations in parental functioning suggest four possible combinations: both parents may have positive findings, indicating a good treatment prognosis (case type 1); the nonoffending parent may have positive findings, and the offender negative ones (case type 2); the offender may have positive findings and the nonoffending parent negative ones (case type 3); and finally, both parents may have negative findings (case type 4).110

Different combinations argue for different intervention plans and long-term goals. General strategies are suggested in the decision matrix in Chart 3.

This matrix suggests how professionals hope to be able to make decisions. However, the parents are usually more complex than the matrix suggests. Probably in the majority of cases, the parents present a mixed picture, rather than appearing to have either a very good or bad prognosis. Moreover, as already suggested, there may be gaps in information about the family when treatment planning is undertaken and parental
functioning is not static. Progress or lack of progress in treatment may result in reconsideration of the initial placement and treatment plan. Because of these complexities, most sexually abusive families should and do receive a trial of treatment. This generally entails individual treatment for all parties and the appropriate use of groups. Initial case decisions are periodically evaluated based on treatment outcome and reassessed accordingly. In addition to being useful in placement and treatment planning decisions, the matrix may offer guidance in terms of court intervention. Most professionals would agree that the Juvenile Court should be involved in all four types of cases, perhaps with the exception of a small number of those falling into case type 1. These might be cases in which the offender confesses to his wife or family, the family seeks treatment, and the abuse is then reported to CPS by their therapist.

There is also increasing consensus that criminal charges should be filed, even though the offender appears treatable. Some professionals feel that even treatable offenders should do some jail time, while others see the criminal process as a means of ensuring that the treatable offender will take responsibility for his behavior and/or enter into treatment. However, criminal prosecution is especially important in cases categorized as case types 2 and 4 to offer some protection to both the family and society from the offender.

In addition, factors related to the child should also be considered. These include the child's wishes. To be more precise, if the child does not wish for a reunified family, that desire should be given a great deal of weight. A child's wish for the offender not to leave the home, however, should generally not be granted. In addition, some sexually abused children are so damaged, because of the abuse and other conditions, that they require specialized care outside the home.

The same assumption is made here as in earlier chapters, that there is a single offender, usually a father figure, and a nonoffending parent, usually a mother figure. If that is not the case, and there is more than one offender, especially within the family, prognosis is much poorer. Even more problematic are cases in which both parents are offenders; in such instances, family reunification is extremely unlikely to be in the child's best interest.

**The Role of the Courts**

Two or three courts are potentially involved in a sexual abuse case—the Juvenile Court, responsible for child protection; the Criminal Court, responsible for offender prosecution; and the Divorce Court, if either parent decides to pursue divorce.

Court involvement can be either a help or a hindrance to therapeutic goals. The challenge is to integrate court involvement into the overall intervention. Early decisions about the role of the court can facilitate its role in the therapeutic process.

The court can be helpful in compelling family members, especially offenders, into treatment; in protecting victims and families from offenders; and in effecting alternative
living situations for offenders (or victims, if necessary).

Court involvement can be problematic because legal safeguards for the defendant may prevent certain evidence from being admitted; because the adversarial process may interfere with the therapeutic process, including disruption of offender treatment by incarceration; and because it allows procedural delays that may prevent timely intervention.

Finally, testifying in court may have a positive or negative effect on the child. The effect, in part, depends on its outcome. That is, if the case is won, the impact of court testimony is more likely to be positive.

Victims may gain a sense of mastery over the sexual abuse from testifying. If they are believed, they may derive a degree of vindication when they see that the offender has to pay for what he did. Completing the court process may also engender a sense of closure for the victim.

On the other hand, victims may experience court testimony as additional trauma. Some are required to confront their abusers, endure lengthy cross-examination, and reveal shameful experiences to an audience. If possible, the courtroom should be cleared during the child's appearance. Testifying in court, which rarely entails a single appearance, may enhance the child's perception of him/herself as a victim, rather than a normal child. Moreover, because the court process tends to be protracted, it may delay resolution of the victim's treatment issues. For more detailed information on the role of the court in child abuse and neglect cases, the reader is referred to another manual in this series entitled Working With the Courts in Child Protection.

**Visitation**

As noted previously, in most cases it is appropriate for the offender to leave the home and for the victim to remain. In other cases, the victim should be removed to protect her/him from further sexual abuse and/or emotional abuse. (In a very small number of cases, it will be appropriate to leave the family intact after disclosure.) Obviously what constitutes visitation will vary depending on the living arrangements.

However, there are some guidelines to be used by the court and the professionals in making decisions about visitation. Many professionals recommend no contact between the victim and the offender, if the child is to appear in court, until after her/his testimony. If the mother and/or other family members are unsupportive of her/his testifying, they may be prohibited from seeing her/him until after her/his testimony.

If the child genuinely does not wish visitation, there should be none. There should be no unsupervised visitation until the child feels she/he will be safe and the offender has been assessed and found not at risk to reoffend. In some cases, the child may want visitation or unsupervised visitation when it is not deemed in her/his interest by the
professionals. In such a circumstance, professional opinion should prevail.

Assuming all parties want visitation, as the offender (and other family members) make progress in treatment, visitation is initiated and becomes progressively more liberal (i.e., more frequent, for longer time periods, and with less supervision). As successive steps are taken to make visitation more liberal, it is important to make sure the victim (and her/his caretaker) want this change. The multidisciplinary team or the child's therapist needs to make these decisions.

**Causal Models of Sexual Abuse**

Before developing a treatment plan, it is important to have an understanding of why the sexual abuse occurs, both generally and in the particular case under consideration.

It is useful to briefly examine the history of causal theories of sexual abuse before a discussion of the current level of professional understanding. Historically there have been two rather separate efforts to understand the phenomenon of sexual abuse, its causes, and its resolution. These can be conceptualized as the family-focused perspective and the offender-focused perspective.

**The Family-Focused Perspective**

Those taking a family perspective focused their attention on incest and developed hypotheses that family dynamics are at the root of sexual abuse. Specifically, clinicians taking this perspective described the collusive mother, who has estranged herself from the father, as the "cornerstone" of the incestuous triad and the victim as a parental child who has replaced her mother as sexual partner to the father.\(^{111}\)

The implications of this model in terms of treatment are that the mother and the daughter must change, but the offender is not necessarily required to take responsibility for his behavior and develop strategies to control it. Most professionals working in the sexual abuse field recognize the limitations of a perspective that focuses purely on family dynamics.

This perspective does not help very much in explaining extrafamilial sexual victimization and, taken to its extreme, represents the offender as the hapless victim of family dynamics. Moreover, recent research, which finds that a substantial proportion of incest offenders begin their sexual victimization as adolescents and experience arousal to children before they become fathers, calls into question assumptions about the pivotal role of family dynamics in incest.\(^{112}\)

**The Offender-Focused Perspective**

Those who work primarily with perpetrators have historically been located in institutions for adjudicated offenders. Most of these clinicians/researchers appreciate that their clientele do not represent the full spectrum of sex offenders. Their focus has
been on understanding the etiology of sexual abuse by examining the physiological and psychological functioning of offenders. They typically do not have access to families to understand any role they might have played in the victimization, nor its impact on the families. Moreover, as these clinicians develop and implement treatment strategies, they may have to do so in a vacuum and in an artificial environment. There are frequently both problems translating what is learned in treatment in the institution to the offender's normal environment and failure to continue needed treatment when the offender returns to the community.

**An Integrated Model**

Efforts to integrate the family and offender perspectives to the causes of sexual abuse began in the mid-1980's. Finkelhor examined the spectrum of clinical literature and research into the causes of sexual abuse and developed a model of causation that incorporates both the family-, and offender-focused perspectives. He posits four preconditions that must obtain for sexual abuse to occur: factors related to the offender's motivation to sexually abuse; factors predisposing the offender to overcoming internal inhibitors; factors predisposing to overcoming external inhibitors (e.g., absence of environmental obstacles); and factors predisposing to overcoming child's resistance (e.g., a vulnerable child or the use of coercion). Finkelhor applied this model on both the individual (case) level and the sociocultural level.

The model presented here is somewhat different and more practice-focused. It proposes that there are some causal factors that are **prerequisites** for sexual abuse and there are others that play a **contributing** role. Prerequisite factors – sexual arousal to children and a propensity to act on arousal – are to be found within the offender, whereas contributing factors may come from the culture, from the family system (including the marital relationship), from his current life situation, from his personality, or from his past life experience.

**An Integrated Model of the Casual Factors of Sexual Abuse**

The presence of the two prerequisite factors (sexual arousal to children and propensity to act on arousal) is both necessary and sufficient to result in sexual abuse. This is not the case for the contributing factors. For example, a man does not sexually abuse his daughter because his marriage is unhappy. More than half of American marriages end in divorce, suggesting that a substantial number of marriages are unhappy. But only a very small number of men in unhappy marriages sexually abuse their children.

Contributing factors may enhance the prerequisite factors or they may, independent of an effect on the prerequisites, increase risk. An example of the former dynamics is found in the role of alcohol abuse. It usually leads to diminished capacity to control behavior, which may increase the propensity to act on sexual arousal to children. (Chemicals are also used by some offenders to cope with guilt related to their abuse behavior.) An example of the latter dynamic is that found in situations of unsupervised access to children. It may enhance risk because it provides opportunity for an offender
who is aroused to children and prone to act on that arousal. This model will be referred to again in the discussion of treatment issues.

**Treatment Modalities**

In this section, the role of various treatment modalities is described. An approach to treatment that addresses prerequisite and contributing causes of sexual abuse and meets the treatment needs of victim, family, and offender must be multimodal. Ideally, individual, dyadic, family, and group treatment modalities should be available, especially if reintegration of the offender and/or the victim into the family is planned. However, therapists and programs without this full spectrum of services can be successful in treatment.

Although group, individual, dyadic, and family modalities should be available, it does not appear to be necessary to have a rigid progression from individual to dyadic to family therapy. However, it is crucial that progress be made in individual and sometimes dyadic therapy before family therapy is indicated and before individuals can benefit from it. The types of treatment and their uses will be discussed as follows:

- **Group therapy** is generally regarded as the treatment of choice for sexual abuse. However, usually groups are offered concurrent with other treatment modalities, and some clients may need individual treatment before they are ready for group therapy. Furthermore, there will be a few clients who are either too disturbed or too disruptive to be in group treatment.

  - Groups are appropriate for victims, siblings of victims, mothers of victims, offenders, and adult survivors of sexual abuse. In addition, “generic” groups that include offenders, parents of victims, and survivors of sexual abuse have been found to be very powerful and effective for all parties involved.

  - Groups may be time-limited, long-term, or open-ended. They may deal with specific issues (e.g., relapse prevention, sex education, or protection from future sexual abuse), or they may deal with a range of issues. Some programs have “orientation” groups for new clients, usually with separate groups for children and adults.

  - Victim's and offender's groups have been brought together for occasional sessions. Models that have concurrent groups for victims or children and their nonoffending parents, where from time to time the two groups join for activities, are very productive.

- **Individual treatment** is appropriate for victim, offender, and mother of victim (as well as for siblings of victims and survivors). As a rule, an initial function and a major one for individual treatment is alliance building. All parties have to learn to trust the therapist and come to believe that change is possible and desirable. The members of this triad may have different levels of commitment to therapy, with the victim usually the most
invested and the offender the least.

- **Dyadic treatment** is used to enhance and/or repair damage to the mother-daughter relationship, the husband-wife relationship, and the father-daughter relationship, as well as to deal with issues initially addressed in individual treatment.

- **Family therapy** is the culmination of the treatment process and is usually not undertaken until there has been a determination that reunification is in the victim's best interest.

- **Multiple therapists** can be very helpful. Such a complex series of interventions can rarely be provided by one individual. If possible, two therapists should be involved, even if it is only one person doing the group work and another the individual, dyadic, and family work. However, because each family member will typically participate in a group as well as other treatment modalities, there are usually several clinicians involved with a single family. Moreover, there are reasons other than logistics for involving several clinicians.

  - Sexually abusive families are very difficult to work with, and therapists need one another's support. Such families are crisis-ridden and multiproblem, making it very difficult for one person to have total responsibility for the family.

  - Assigning a different therapist to the victim and to the offender "recreates," although artificially, a family boundary that was crossed when the sexual abuse occurred. It also enhances a sense of privacy and safety for the victim—two elements violated by the offender.

  - In addition, cotherapy, using both a male and female therapist, has considerable therapeutic advantage. It exposes family members to appropriate role models of both sexes. Cotherapy also enhances the ability of clinicians to effect change because of the leverage it allows, particularly in group therapy.

  - Finally, decisions that must be made in the course of treatment are very difficult ones, and mistakes are potentially devastating. Two or more heads may be better than one. And as noted earlier, ideally clinicians should be guided in their decisions by the input of a multidisciplinary team.

**Treatment Issues**

There are two main objectives in sexual abuse treatment:

- dealing with the effects of sexual abuse, and
- decreasing risk for future sexual abuse.

Victim treatment tends to focus more on the former; mother's treatment issues are fairly evenly split; and the offender's issues are predominantly in the realm of preventing future victimizing behavior, although the initial stage of treatment may focus on the
effects of the abuse disclosure on him/her.

**Treatment Issues for the Victim**

The saliency of treatment issues discussed in this section will vary for each victim, some possibly being irrelevant. Also, there may be additional treatment issues for victims that are not discussed here. The following issues appear to be the most important:

- trust, including patterns in relationships;
- emotional reactions to sexual abuse;
- behavioral reactions to sexual abuse;
- cognitive reactions to sexual abuse; and
- protection from future victimization.

These issues are interrelated. As the following discussion illustrates, the categorization is somewhat artificial.

**Trust**

Being a victim of sexual abuse can have a devastating effect on children's object relations, particularly the ability to trust other people. In intrafamilial sexual abuse, the impact may be pervasive because a caretaker, who should be a protector and a limit-setter, exploits the child and violates the boundaries of acceptable behavior. Furthermore, this damage may be exacerbated by an unsupportive nonoffending parent. Moreover, sexual abuse may not be the only way in which the child's trust is undermined. The victim may experience other maltreatment or traumatic experiences in the family.

However, children sexually molested outside the home may also experience problems with trust. This may come about because the person who victimizes the child is someone to whom the child has been entrusted by the parents, as happens, for example, when the abuser is a child care provider. These victims frequently perceive their parents as having given permission for the exploitation. Alternatively, the offender may be a person in a position of authority over the child and she/he feels compelled to comply. Then children may have considerable difficulty trusting persons in positions of authority in the future.

The challenge to the therapist is to create circumstances in which the child has positive experiences with trustworthy adults in order to ameliorate the damage to the child's ability to trust. This may involve rehabilitating the parents and/or creating opportunities for appropriate relationships with adults, for example, with foster parents, mentors, or other relatives. An admonition to therapists is that they must be honest and dependable
in order to create an atmosphere of trust.

**Emotional Reactions to Sexual Abuse**

Three common emotional consequences of sexual victimization are a sense of somehow being *responsible* and therefore feeling *guilty*, an *altered sense of self* and *self-esteem* because of involvement in sexual abuse, and *fears and anxiety*.

- **Feeling responsible.** An offender may make the victim feel responsible for the sexual abuse, for the offender's well-being, and/or for the consequences of disclosure. Victims may also feel guilty for not having stopped the sexual abuse as well as for any positive aspects of the abuse, such as physical pleasure, the special attention given by the offender, or an opportunity to have control over other family members because of “the secret.”

The role of the clinician is to help the child understand intellectually and accept emotionally that the child was not responsible. The adult sexually abused the child; the child did not sexually abuse the adult. It was the adult’s job – not the child's – to stop or prevent the abuse.

- **Altered sense of self.** Guilt feelings as well as the invasive and intrusive nature of the sexual activity impact negatively on the child's sense of self and self-esteem. As Sgroi puts it, victims suffer from “damaged goods” syndrome. The effect is both physical, in that children have an altered sense of their bodies, and psychological, in that children may see themselves as markedly different from their peers.

The task of the therapist is to make victims feel whole and good about themselves again. Work, mentioned above, that addresses the issue of self-blame is helpful. However, so are interventions that help children view themselves as more than merely victims of sexual abuse. Normalizing and ego-enhancing activities, such as doing well in school, participating in sports, getting involved in scouts, or helping a younger victim, can be very important in victim recovery.

- **Anxiety and fear** to be discussed here are related to the traumatic impact of the abuse *per se* on the child rather than environmental responses to it. The victim develops phobic reactions to the event, the offender, and to other aspects of the abuse. Experiences that evoke recollections of the abuse come to elicit anxiety. In some children this anxiety and phobias become pervasive and crippling because of the level of avoidance they engage in to reduce their stress.

Before treating the child's fears and anxiety, the therapist must be sure the child is not being sexually abused or at risk for sexual abuse. Then the therapist engages the victim in a series of interventions that allow her/him to gradually deal with the abuse and related phobias and anxiety in ways that usually avoid excessive stress and allow mastery. These may include discussions, play therapy, or interventions in the child's environment. For example, the victim may be encouraged to ventilate by talking about the abuse and accompanying feelings, thereby reducing the level of distress related to it. Similarly, a child who is phobic about being left with a babysitter may be left with a relative first for short and then longer time periods, then with a babysitter for brief and
then longer periods and thereby be desensitized to babysitting situations.

- **Additional emotional reactions** may be found. Depending on the circumstances of the victimization and the child's personality, she/he may react with *regression, anger, depression, revulsion, or posttraumatic stress disorder* to sexual abuse. These emotional reactions are likely to manifest themselves in problematic behaviors. These behaviors will be discussed in the next section.

**Behavioral Reactions to Sexual Abuse**

As suggested in the second chapter, behavioral effects of sexual abuse can include sexualized behavior and other behavior problems.

- **Sexualized behavior.** A serious reaction is sexualized behavior. Children who have been sexually victimized may masturbate excessively and openly or sexually interact with other people. Every act of sexualized behavior has the potential for increasing the probability of future acts. Not only is the activity likely to be physically pleasurable, but it may also enhance the child's view of her/himself as a sexually acting out person. Such acts may also stigmatize the child, which has a negative impact on the child's sense of self.

Clinicians should work to diminish and/or eliminate sexualized behavior through teaching behavioral controls. Sexual acting out may be controlled, for example, by teaching the child to masturbate privately. Behavior management techniques, which can involve rewarding "sex-free" days and using "time-out" for sexual acting out, can be taught to the child's caretaker. In addition, the child's energies that might have gone into sexual behavior can be channeled into more age-appropriate activities by having a caretaker monitor the child, interrupt any sexual acting out, and provide opportunities for positive alternative behaviors. These interventions are conducted with the child's caretaker and/or in dyadic work with child and caretaker.

One of the reasons treatment of sexualized behavior is so essential is because of a recently recognized phenomenon called the *victim to offender cycle*. Both male and female victims are at risk for this problem. Many offenders begin as victims, whose response to sexual abuse is to identify with the aggressor and to sexually act out in order to cope with their own sense of vulnerability and trauma. Professionals must recognize the potential danger of allowing sexualized behavior to go untreated, which is that the child then is at risk for becoming first an adolescent offender and eventually an adult offender. The child not only damages him/herself, but also may cause grave harm to many other children over the course of time.

- **Other behavior problems.** Other behavioral reactions to sexual abuse include such problems as *agression* toward people and animals, *running away*, *self-harm* (cutting or burning), *criminal activity*, *substance abuse*, *suicidal behavior*, *hyperactivity*, *sleep problems*, *eating problems*, and *toileting problems*.

Some of these problems, for example, difficulties with sleep, eating, toileting, and being alone, may be acute after disclosure but diminish over time and eventually disappear. Short-term intervention, labeling the behavioral problems as common
reactions, and helping the victim resolve the underlying emotional or cognitive issues is generally helpful. Parents are encouraged to be understanding.

Treatment strategies for all behavioral problems include helping the victim understand the relationship between the behaviors and the sexual abuse and emotional or cognitive reactions to it; helping the child develop insight into the self-destructive nature of some of these behaviors; assisting the victim in more appropriate expression of the emotions, for example, anger; and behavioral interventions to diminish and eliminate problematic behavior. With older children, group therapy is usually very useful in addressing these problems.

**Cognitive Reactions to Sexual Abuse**

An important part of treatment of victims of sexual abuse is to help them understand the meaning of the abuse. This includes learning what appropriate and inappropriate touching entails; what is wrong about sexual activity between adults and children, if they do not know this; why adults or a particular adult was sexual with them; and in some cases, why they were chosen as targets and what that means to them. How these issues are addressed will vary with the child's developmental stage. They may be more adequately dealt with in group treatment than individual therapy, and sometimes having the offender take full responsibility for the abuse in dyadic therapy with the victim is useful.

Moreover, an adequate explanation for a child at a young age may not be sufficient as she/he grows older. Thus, this particular issue will need to be addressed at a more sophisticated level as the child matures. This may be done by a parent but in some cases will need to be done by a therapist.

**Protection From Future Victimization**

Treatment of victimized children needs to include strategies for future protection. Teaching children to say no and tell someone may be useful, especially if the material is presented in a group setting and there are opportunities to role play resisting sexual advances. Specific protective strategies involving family members and helping professionals need to be developed in intrafamilial sexual abuse situations. Additionally, the therapist must appreciate that placing even partial responsibility for self-protection on the victim is potentially an overwhelming burden.

**Treatment Issues for the Mother (Nonoffending Parent)**

Although the discussion that follows refers specifically to mothers as nonoffending parents, much of the material is also applicable to nonoffending fathers. Treatment issues for mothers of victims can be categorized under the following four general headings.
• issues related to the sexual abuse,
• issues related to the mother-victim relationship,
• issues related to the offender (spouse), and
• other personal issues.

These issues are particularly relevant to cases involving mothers in intrafamilial sexual abuse but also can be important when other persons are the abusers. Like victim treatment issues, they are interrelated, and there may be other issues that are salient in a given case. The relationship of the mother's treatment issues to factors to be assessed in making decisions about victim reunification with the family will become apparent.

**Issues Related to the Sexual Abuse**

It is difficult for most people, including mothers of victims, to understand why an adult might want to be sexual with a child. This is often the first issue that the clinician must address with the mother. This may be especially difficult for the mother to understand if the offender is her spouse or another close relative.

The therapist may offer professional understanding into the general causes of sexual abuse or those specific to the case. The parent might also be given material to read. However, group involvement, in either a generic sexual abuse or mothers' group, may be the most effective method for addressing this issue.

A related issue is that of believing the victim's disclosure of sexual abuse. Many parents will try to explain it away. As noted in the discussion of assessment of the nonoffending parent, coming to believe a victim is usually a process, rather than instantaneous.

The therapist may describe what in the child's disclosure makes her/him believe the child or speak generally about the conclusion that children rarely make false allegations and the reasons for that belief. However, group treatment, in which the mother is confronted by others who have also struggled with disbelief, is often the most effective mode for dealing with this issue.

Finally, the therapist will want to help the mother understand her role in the abuse, if she has had one. The nonoffending parent is not to blame for the victimization but in some instances may have contributed to risk of abuse or prolonged abuse, for example, by leaving the child for long periods of time with the offender or by discounting the child's early disclosures.

Interestingly, a good prognosis is suggested when a mother feels very guilty and the therapist must work to alleviate her sense of responsibility. Conversely, a poorer prognosis is indicated when the mother sees herself as absolutely blameless and the therapist has to point out things that the mother might have done differently that could have prevented or minimized the abuse. As with other issues related to the abuse, this
issue may be best dealt with in group therapy.

**Issues Related to the Mother-Victim Relationship**

Treatment of intrafamilial sexual abuse that results in successful reunification of the family rests upon the mother's relationship with the victim. This may be a very problematic relationship at the time of disclosure. The offender may have engaged in manipulations that have alienated mother and victim from one another. The victim may have developed problematic behaviors because of the abuse, which have damaged her relationship with the mother. The consequences of disclosure may be blamed on the victim, or the mother may never have related well to the victim (or other people).

This problem appears to be less severe with boy victims. Mothers are more likely to be supportive of them. In part this is because when boys are sexually abused, the offender is more often, than with girls, someone outside the family. Moreover, when victimized within the family, boys tend to be abused along with their sisters, meaning the mother is less likely to regard a single child as to blame or as the source of her frustrations. However, this phenomenon may also relate to differences in role relationships between mothers and daughters and mothers and sons.

The therapist tries to enhance the mother-victim relationship by assisting the mother in developing empathy for the victim; by facilitating their communication; by helping them resolve ongoing problems in their relationship, such as disputes regarding bedtime or chores; and by helping them develop opportunities for mutually enjoyable experiences. Initial work is usually done in individual treatment with the mother, and later within the mother-child dyad.

Improving the mother-child relationship is generally a prerequisite to assisting the mother in being protective of her child in the future. Although interventions are employed to help the offender control his behavior in the future, the major source of protection for the child is the mother.

Intervention to make the mother more protective is implemented in a variety of ways. If the mother has a more positive relationship with the child, she will be more predisposed to protect the child. Treatment to improve the mother-child communication should enhance the likelihood the child will tell mother. Moreover, the therapist usually works with both the child and the mother to encourage communication specifically about the child's safety.

Especially if the family has not been separated or, if separated, as the family is reunited, specific guidance should be given to the mother regarding safety. For example, she may be instructed not to leave the child alone with the offender, not to let the offender bathe the child, not to allow the offender any control over the child's activities, and/or not to give the offender the responsibility for disciplining the child. How long these protections remain in place will depend on the case.
Finally, the therapist usually helps the mother develop a specific plan in case the offender does reoffend. Her plan is communicated to the victim, the offender, and the rest of the family. It can often involve dissolving the marriage.

**Issues Related to the Offender (Spouse)**

In cases of intrafamilial sexual abuse, the mother must decide whether she wants to **sever her relationship with the offender or try to salvage the relationship.** Some mothers decide at the time of disclosure to terminate the relationship or, alternatively, to work to preserve it. For others, this decision takes time and observation of the offender's progress or lack thereof in treatment. Still others are indecisive and change their minds more than once.

The clinician may have an opinion about what the mother should do. However, it is wise to allow the mother to make her own decision. This does not preclude sharing opinions about the offender's treatability and the likelihood of the victim remaining or returning home should the mother choose to stay with an untreated or untreatable offender.

In cases in which the offender is the mother's partner, regardless of the decision to leave or to stay, the mother will need to address her **relationships with men.** The goal is to help her gain some insight into these relationships, including that with the offender, and to understand their problematic aspects. If she intends to stay with the offender, she must be assisted in changing that relationship. If she leaves him, the goal of insight is to help her in future relationships. Group treatment with other mothers is particularly useful in this work. Of course, if her intention is to preserve the relationship with the offender, dyadic work with the offender is necessary.

Often mothers are very dependent on the men who have abused their children. In most instances, it is important to help her **become less dependent** so that she will be better able to seek what is in her children's and her interest, should there be a conflict between the offender's interest and that of the rest of the family.

Independence may be fostered by involving the mother in activities outside the home, including therapy; enhancing her financial independence; encouraging her to do things without his assistance; and facilitating her assertiveness when they are in conflict. Opportunities for these types of interventions may present themselves quite naturally if the offender must leave the home at the time of disclosure of the sexual abuse. Because of the mother's need to function autonomously in his absence, he may return home to a situation quite different from the one he left.

**Other Personal Issues**

Most mothers must deal with other issues related to current functioning and past experiences in therapy. The most common issue regarding current functioning is **low self-esteem.** However, other issues, such as **substance abuse, experiences of violence,**
dependency, and emotional problems, often need to be addressed as well.

The most common issue in terms of past trauma is having been sexually victimized themselves. Such an experience can have a variety of implications in terms of the mother's ability to deal with her children's sexual abuse. For example, at the time of disclosure, a mother may be so overwhelmed because of her own abuse that she cannot deal with her child's victimization. In such instances, her abuse may have to be addressed first. Her own victimization may have an impact on her willingness to believe the victim, her ability to discern risky situations (she may not note them), and her choices of partners, playing a role in her choosing someone who is sexual with children. In addition, it may cause her to mistakenly believe her children are being victimized.

Treatment Issues for the Father as the Offender

Although the following discussion will refer to the father as the offender, it is equally applicable to cases involving stepfathers and unmarried partners of mothers who are offenders. It is also relevant to some situations involving other intrafamilial offenders. Treatment issues for the offending fathers can be broadly defined as falling into three categories:

- issues related to the father's past sexual victimization of children,
- issues related to the father's possible future victimization of children, and
- other dysfunctional behaviors and problems.

These broad categories tend to be overlapping.

Issues Related to the Father's Past Sexual Abuse of Children

In many cases, the first challenge for the clinician is obtaining a confession of the sexual offenses. Many fathers are too ashamed to admit what they have done. Others are reluctant to disclose their abuse during litigation because they are afraid of its impact on the outcome. They may be more willing once the court case is resolved. Others are ordered into treatment by the court while continuing to protest their innocence.

Operationally, confession means an admission to all of the acts the child has described. However, it is common for the child not to disclose all of the abuse; therefore, it is important for the offender's therapist to stay in touch with the victim's therapist in case there are additional disclosures. (In treating intrafamilial sexual abuse, it is important for each family member to consent to share information with each therapist treating each family member.) To obtain a confession, the therapist actively confronts the father with the information on his offenses provided by the victim and others. In addition, group treatment, in which the father observes others confessing their victimizing
behavior, can facilitate full disclosure.

With confession must come an acceptance of responsibility for the abusive acts. That is, the father must disavow any past excuses, such as his wife was not giving him sex or that he was drunk at the time. He must not minimize the behavior by saying, for example, "it only happened once," "there was no penetration involved," or "I stopped when she asked me to." As is probably apparent, it is extremely difficult to know when the offender has actually accepted responsibility rather than saying what he thinks the therapist wants to hear. Again, the use of group treatment can be especially helpful because other offenders may be more capable of discerning and confronting deception than a therapist.

A related task of treatment is for the father to appreciate the harm the abuse has caused the victim, his partner, and finally himself. There may be others affected as well, for example, siblings of the victim and the extended family. Some sort of communication from the victim and the offender's partner about the effects of the abuse on them can be useful. This may be in the form of a letter, a video or audiotape, or a face-to-face confrontation involving the therapist. Generic groups in which offenders are confronted by adult survivors and mothers of victims, other than the offender's own, can facilitate these insights. Written accounts, by victims, journalists, and professionals, of the impact on victims may be used, and offenders' groups can be the context for this work. As with the issue of responsibility, being sure the father is doing more than saying the right thing is a significant challenge.

At some point in treatment after the offender has confessed, taken responsibility, and come to appreciate the harm he has done, a series of apologies should be made. The offender must apologize to the victim, to his partner, and to the family in intrafamilial cases. There may be others who have been affected and deserve an apology as well. This is a process, not a single act, usually conducted in the context of dyadic or family treatment. The fact that the offender apologizes does not imply that the victim and others need to forgive him. These interventions need to be carefully orchestrated and controlled by the therapist. Only after the offender has completed the process, demonstrating an appreciation of the harm done, should his return home be considered.

A final treatment issue related to past abuse has to do with prevention. In order to prevent future sexual abuse, it is important for the offender and the therapist to understand why the offender sexually abuses children. In this regard, the model presented earlier in this chapter is relevant.

Thus, the treatment process involves coming to understand the offender's arousal pattern and why he acts on the arousal. Then contributing factors are explored.

**Sexual arousal to children.** Arousal patterns vary. They may be conceptualized as follows:

- **Child is the offender's primary sexual object.** Some offenders' sexual preference,
sometimes exclusively, is for children. The term *pedophile* is generally used to refer to this type of offender. Often pedophiles not only prefer children, but children of a particular age and sex. Pedophiles tend to have multiple victims and actively seek opportunities whereby they can have sexual access to children, by choosing vocations and avocations that afford them contact with children. A contributing factor to this type of arousal pattern is often traumatic childhood sexual experience.

- **Child is one of multiple sexual objects.** Other offenders have multiple *paraphilias* or aberrant sexual preferences and sometimes normal sexual preferences as well. The behavior of these offenders is characterized by sexual contact with children but may also include rape of adults, promiscuity with adults, exposure, voyeurism, sadomasochism, group sex, bestiality, and other sexual acts. The term *sexual addict* is often applied to this type of offender. The contributing factors or etiology of this pattern of sexuality appear to be a combination of childhood and adolescent experiences.

- **Child is a situational sexual object.** Finally, there are offenders whose normal sexual orientation is toward peers but who become aroused by children under certain circumstances. Factors that contribute to such arousal may include the absence of other sexual outlets, stresses affecting normal marital and/or peer relations and communications, child pornography, and physical exposure or contact to children that is sexually stimulating. Although initial sexual contact involving this type of offender may be situationally induced, the experience may be very gratifying. Clinical experience indicates this is likely to result in an increased desire for and preference for sex with children.

As may be apparent from the last point, although these three arousal patterns are presented as though they are discrete, they probably are not. For example, it may be inappropriate to classify some offenders as having either a primary orientation to children or to adults.

Understanding the offender's arousal patterns may be done by having the offender describe what he experiences about his victims as arousing, having him discuss in detail his sexually abusive behavior, having him reveal his sexual fantasies, or measuring his erectile responses to various visual and auditory sexual stimuli using the penile plethysmograph.* Treatment prognosis with pedophiles and sexual addicts is much poorer than for those who have situational sexual arousal to children.

**The propensity to act on arousal.** There is research that suggests that a substantial minority of the male population experiences sexual arousal to children. [121] (Comparable research has not been conducted on women.) However, it appears that a great many more men experience these feelings than act on them. The willingness to act on these feelings appears to be related to one or in most cases more than one of the following deficits:

- pervasive superego deficits,
- circumscribed superego deficits,
- cognitive distortions,
- impulse control difficulties, and
- diminished capacity.

Persons whose superego deficits are pervasive have little or no conscience. The term psychopath is often applied to them. This condition is thought to be a result of early traumatic life experiences. Those who have some superego deficits may experience an absence of conscience related specifically to sexual activity or sexual activity with children, or they may generally have a weak or impaired superego. Some combination of early experience, lifestyle, and cultural norms may create this sort of superego. Differing in degree is the offender who has cognitive distortions related to his sexual deviance. He will have persuaded himself that sexual abuse is not bad or not so bad by such rationalizations as "The child won't know what I'm doing so it's not harmful" or "Everyone needs sex; this is my way." After the initial act, distortions may be "The child didn't resist, so she must have liked it," "There was no penetration so it wasn't really sexual abuse," or "It's my wife's fault because she withheld sex from me." Some offenders appreciate that what they do is wrong, but they do it anyway because they have poor impulse control.

Finally, some offenders experience diminished capacity, which enhances propensity to act on arousal. Typically, this is a temporary condition, and its most common cause is substance abuse. Thus, the offender acts on his arousal because alcohol or drugs have decreased his ability to control his behavior. Initial instances of victimization when drunk may occur without a prior plan. However, subsequently, the offender may drink so that he will have an excuse to abuse. Furthermore, after the initial acts, the attraction of the behavior itself may increase and chemicals are less necessary to diminish control. There can be other causes of diminished capacity. Offenders may lack adequate ability in handling stress, depression, anxiety, and/or anger in healthy ways. In addition, some persons suffer from chronic diminished capacity as a result of mental retardation or organic brain syndrome. If they experience arousal to children, it will make them at ongoing risk for sexual abuse.

**Contributing factors.** Some factors that may enhance arousal or increase the propensity to abuse have been described above. There may be other factors that act on these prerequisites and ones that independently contribute to risk for sexual abuse, for example, child behaviors, mother behaviors, and opportunity to sexually abuse.

It is an important part of the treatment process to understand why the offender has sexually abused children so that he can be empowered to gain control over his arousal and propensity to act on arousal. Some of the intervention that addresses contributing factors may be initiated with the offender alone, but much is done in the treatment of other individuals in the family and in dyadic and family work.

**Issues Related to Possible Future Sexual Abuse**

As noted in the previous section, preventing future sexual abuse relies on understanding what made the offender abuse in the first place. In this section, interventions that
address arousal to children and propensity to act on arousal are discussed.

**Sexual arousal to children.** It has already been pointed out that sexual and other trauma during childhood may play a role in later sexual arousal to children. However, understanding the relationship of the offender's previous history to his arousal patterns is probably the least useful in prevention of future sexual abuse. In fact, often offenders manipulate the treatment process so that past history becomes an excuse for their offending. In spite of this risk, for some offenders, understanding the origins of previously incomprehensible behavior can render it manageable. Moreover, realizing that what the offender learned about sex roles as a child was wrong can lead to the development of more appropriate definitions of sex role behavior.

When deviant arousal patterns have been defined, the therapist will attempt to change these patterns. That is, the therapist will endeavor to decrease sexual arousal to children and increase arousal to appropriate sex objects. This is done through a variety of behavioral interventions that rely on both respondent and operant conditioning. These techniques include aversive conditioning, covert sensitization, thought stopping, masturbatory satiation, behavioral rehearsal, systematic desensitization, and masturbatory reconditioning. These techniques are often used in conjunction with social skills training, empathy training, and behavioral assignments.

Behavioral interventions are exacting, and some require a laboratory setting. They also require the full cooperation of the client if they are to be successful. Moreover, the changes they create are not assumed to be permanent (nor are those from other types of intervention), and clients may need booster sessions. Many mental health professionals are untrained in and uncomfortable with behavioral interventions. However, to date they are the only therapeutic techniques that have been found, based on empirical evidence, to decrease sexual arousal. It behooves every clinician treating offenders to be familiar with these techniques and use those that can be suitably employed in his/her agency.

**The propensity to act on arousal.** Two approaches may be used to address propensity to act: techniques that enhance superego functioning by taking responsibility for sexual abuse and relapse prevention. Offenders whose propensity to act is based on pervasive superego deficits will probably not respond to treatment to reduce this propensity. However, those who have circumscribed superego deficits or are engaged in cognitive distortions probably will respond to interventions to address superego deficits. Treatment that is focused on getting the offender to take responsibility for his abusive behavior, to appreciate its harm, to acknowledge the feelings of traumatized parties, and to make amends or reparation is meant to enhance the offender's superego functioning and eliminate cognitive distortions, thus decreasing the probability of his acting on arousal in the future. Making amends or reparation usually involves a physical (e.g., community service) or monetary consequence that may serve to teach empathy and inhibit further abuse. In addition, when an offender lacks a strong internalized superego, the fact that there will be consequences for reoffense, such as prison or his wife leaving him, serves as an external superego. The strength of such interventions is
in their deterrent effect.

In recent years, sex offender therapists have experienced success by using relapse prevention strategies, a technique borrowed from addiction treatment, in their intervention. Relapse prevention addresses propensity to act based on impulse control problems, reduced inhibition, and diminished capacity. Relapse prevention assumes that there are emotional states and behaviors on the offender's part that precede and ultimately precipitate the sexually abusive behavior. Often the offender is unaware of these factors and believes that his behavior is out of his control.

The clinician assists the offender in understanding these precursors and helps him develop a plan to manage such situations so that he does not reoffend. The clinician uses disclosures from the offender and others, including the victim, to obtain an accurate understanding of the circumstances that led to offending. Obviously such an intervention requires a candid and cooperative offender.

With some offenders, particularly those with cognitive limitations and difficulty being introspective, the clinician merely teaches the offender to anticipate, identify, and avoid risky situations. Thus, the offender may be instructed that he cannot assist at summer camp anymore or he cannot be left alone with his daughter.

With other offenders, the clinician helps him understand the chain of events, often seemingly unrelated to the sexual abuse, that precedes the victimization. This might include a series of procedures, such as the grooming process an offender may employ in the seduction of his victim, or acts such as getting upset with his wife and getting drunk after she goes to bed as a prelude to going into the daughter's room to molest her. The therapist then teaches the offender to interrupt the chain of events rather early while he still has control of his behavior. Thus, the pedophile is instructed to avoid driving by playgrounds, and the offender whose abuse is precipitated by drunkenness is instructed to abstain completely. If he has a serious substance abuse problem, he is sent to a substance abuse treatment program, either before treatment of his sexually abusive behavior is begun or in conjunction with sexual abuse treatment.

The relapse prevention plan is usually written out, and the offender carries it with him so he can refer to it when he thinks he is in a high-risk situation.

Interventions with the family mentioned earlier, such as not allowing the offender to be alone with the child or to discipline her, are meant to prevent him from being in high-risk situations. Moreover, there are numerous other ways the family and others can be involved in helping the offender prevent a relapse. Because most offenders experience more than one deficit leading to propensity to act, interventions that focus both on his taking responsibility and on relapse prevention are advised.

**Other dysfunctional behaviors and problems.** The offender may experience many other problems, and often these are contributing factors to the sexual abuse. Examples might be violent behavior, problems with the law, poor parenting skills, marital discord,
poor social skills, low self-esteem, lack of education, and unemployment.

These are appropriate foci of treatment, and indeed it may be necessary to treat them because they increase the risk for future sexual abuse. Nevertheless, it is crucial that the clinician not allow him/herself to become sidetracked into only dealing with these other problems. Distraction can occur more easily than one might think if the offender refuses to admit to the sexual abuse or is reluctant to focus on it in treatment, yet is more than willing to work on his other problems. This pitfall is usually avoided if group therapy, which forces the offender to deal with his abuse, is a major component of the intervention and/or if there are several therapists involved in the case.

* The plethysmograph consists of a gauge attached to the offender's penis that can measure and systematically record tumescence.
Although her stepfather had been sexually molesting her for years, Jenny never told anyone about it because she was afraid what would happen if she did. When she finally did disclose his abuse of her, her mother reacted with angry shock and told her never to say such awful things about her stepfather again.

After that, the only way Jenny could stop the abuse was by running away.

Whether or not it is occurring more often or being reported more often, the incidence of reported sexual abuse of children has increased in America. Studies have shown that one out of four women, and one out of ten men, state they were sexually abused as children.

The stereotypical image of the sexual offender as a stranger lurking in the dark to attack his victim is erroneous. Most sexually abused children have been molested by a member of their own family or someone known to the family. Only 15 to 20 percent of child molesters are unknown to their victims.

Nor is force commonly used in child molestation. Since the offender is often a close relative, the victim usually has a trusting relationship with him. What is so potentially damaging about child sexual abuse is that relationship of trust is deliberately violated by the offender.

It is difficult to detect signs of sexual abuse in a child or adolescent. She may be depressed, anxious, using drugs or alcohol, self mutilating or having times of dissociation in which she "checks out" and doesn't remember what she did. But these behaviors can be caused by other problems as well.

Any sexualized behavior - sexual acting out, talking about sex at too young an age - are signs, however, that there is a good chance the child or adolescent is being abused.

Most victims - over 90 percent according to research - are telling the truth when they reveal what has been happening to them. Usually the victim has no reason to lie about so serious a matter while the alleged offender has every reason to deny it.

Because of the realistic fears of disclosure - the shame, criminal prosecution and possible break-up of the family - sexual abuse can go on for years before it is discovered. The pressures on the victim not to disclose are enormous. Often, she has been repeatedly warned by the offender not to tell and she is afraid of what
might happen to him and her family if she does.

If the disclosure of the sexual abuse is handled calmly and properly and if treatment is provided, the abuse will not necessarily permanently traumatize a victim. But without proper handling and treatment, the effects to the victim can include life-long depression, guilt, self-concept problems, unresolved anger, sexual dysfunctions or hypersexuality and difficulty trusting other people.

Whenever a youth, like Jenny, says she is being sexually victimized, the best strategy is to believe her. She must also be reassured that she has done the right thing by disclosing and that she is in no way responsible for the abuse. Her chances of recovering from the molestation are much greater if she is supported in these ways.

If you suspect that sexual abuse is occurring, you must report it to your local Child Protective Services. The abuse must be stopped as soon as possible, and the only way this can be guaranteed is by notifying the proper authorities. Regardless of what happens to the offender, the protection and safety of the child must be the first priority.

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About The Author / Credits: J. Bailey Molineux, a psychologist with Adult and Child Counseling, has incorporated many of his articles in a book, Loving Isn’t Easy, ISBN 1587410419, sold through bookstores everywhere or available directly from Selfhelpbooks.com. Copyright 2002, J. Bailey Molineux and Selfhelpbooks.com, all rights reserved. This article may be reprinted but must include authors copyright and website hyperlinks.
PTSD in Children and Adolescents

A National Center for PTSD Fact Sheet

By Jessica Hamblen, Ph.D.

The diagnosis of Posttraumatic Stress Disorder (PTSD) was formally recognized as a psychiatric diagnosis in 1980. At that time, little was known about what PTSD looked like in children and adolescents. Today, we know children and adolescents are susceptible to developing PTSD, and we know that PTSD has different age-specific features. In addition, we are beginning to develop child-focused interventions. This fact sheet provides information regarding what events cause PTSD in children, how many children develop PTSD, risk factors associated with PTSD, what PTSD looks like in children, other effects of trauma on children, treatment for PTSD, and what you can do for your child.

What events cause PTSD in children?

A diagnosis of PTSD means that an individual experienced an event that involved a threat to one’s own or another’s life or physical integrity and that this person responded with intense fear, helplessness, or horror. There are a number of traumatic events that have been shown to cause PTSD in children and adolescents. Children and adolescents may be diagnosed with PTSD if they have survived natural and man made disasters such as floods; violent crimes such as kidnapping, rape or murder of a parent, sniper fire, and school shootings; motor vehicle accidents such as automobile and plane crashes; severe burns; exposure to community violence; war; peer suicide; and sexual and physical abuse.

How many children develop PTSD?

A few studies of the general population have been conducted that examine rates of exposure and PTSD in children and adolescents. Results from these studies indicate that 15 to 43% of girls and 14 to 43% of boys have experienced at least one traumatic event in their lifetime. Of those children and adolescents who have experienced a trauma, 3 to 15% of girls and 1 to 6% of boys could be diagnosed with PTSD.

Rates of PTSD are much higher in children and adolescents recruited from at-risk samples. The rates of PTSD in these at-risk children and adolescents vary from 3 to 100%. For example, studies have shown that as many as 100% of children who witness a parental homicide or sexual assault develop PTSD. Similarly, 90% of sexually abused children, 77% of children exposed to a school shooting, and 35% of urban youth exposed to community violence develop PTSD.
What are the risk factors for PTSD?

There are three factors that have been shown to increase the likelihood that children will develop PTSD. These factors include the severity of the traumatic event, the parental reaction to the traumatic event, and the physical proximity to the traumatic event. In general, most studies find that children and adolescents who report experiencing the most severe traumas also report the highest levels of PTSD symptoms. Family support and parental coping have also been shown to affect PTSD symptoms in children. Studies show that children and adolescents with greater family support and less parental distress have lower levels of PTSD symptoms. Finally, children and adolescents who are farther away from the traumatic event report less distress.

There are several other factors that affect the occurrence and severity of PTSD. Research suggests that interpersonal traumas such as rape and assault are more likely to result in PTSD than other types of traumas. Additionally, if an individual has experienced a number of traumatic events in the past, those experiences increase the risk of developing PTSD. In terms of gender, several studies suggest that girls are more likely than boys to develop PTSD. A few studies have examined the connection between ethnicity and PTSD. While some studies find that minorities report higher levels of PTSD symptoms, researchers have shown that this is due to other factors such as differences in levels of exposure. It is not clear how a child's age at the time of exposure to a traumatic event impacts the occurrence or severity of PTSD. While some studies find a relationship, others do not. Differences that do occur may be due to differences in the way PTSD is expressed in children and adolescents of different ages or developmental levels (see next section).

What does PTSD look like in children?

Researchers and clinicians are beginning to recognize that PTSD may not present itself in children the same way it does in adults (see What is PTSD? below). Criteria for PTSD now include age-specific features for some symptoms.

Very young children may present with few PTSD symptoms. This may be because eight of the PTSD symptoms require a verbal description of one's feelings and experiences. Instead, young children may report more generalized fears such as stranger or separation anxiety, avoidance of situations that may or may not be related to the trauma, sleep disturbances, and a preoccupation with words or symbols that may or may not be related to the trauma. These children may also display posttraumatic play in which they repeat themes of the trauma. In addition, children may lose an acquired developmental skill (such as toilet training) as a result of experiencing a traumatic event.

Clinical reports suggest that elementary school-aged children may not experience visual flashbacks or amnesia for aspects of the trauma. However, they do experience "time skew" and "omen formation," which are not typically seen in adults. Time skew refers to a child mis-sequencing trauma related events when recalling the memory. Omen formation is a belief that there were warning signs that predicted the trauma. As a result,
children often believe that if they are alert enough, they will recognize warning signs and avoid future traumas. School-aged children also reportedly exhibit posttraumatic play or reenactment of the trauma in play, drawings, or verbalizations. Posttraumatic play is different from reenactment in that posttraumatic play is a literal representation of the trauma, involves compulsively repeating some aspect of the trauma, and does not tend to relieve anxiety. An example of posttraumatic play is an increase in shooting games after exposure to a school shooting. Posttraumatic reenactment, on the other hand, is more flexible and involves behaviorally recreating aspects of the trauma (e.g., carrying a weapon after exposure to violence).

PTSD in adolescents may begin to more closely resemble PTSD in adults. However, there are a few features that have been shown to differ. As discussed above, children may engage in traumatic play following a trauma. Adolescents are more likely to engage in traumatic reenactment, in which they incorporate aspects of the trauma into their daily lives. In addition, adolescents are more likely than younger children or adults to exhibit impulsive and aggressive behaviors.

**Besides PTSD, what are the other effects of trauma on children?**

Besides PTSD, children and adolescents who have experienced traumatic events often exhibit other types of problems. Perhaps the best information available on the effects of traumas on children comes from a review of the literature on the effects of child sexual abuse. In this review, it was shown that sexually abused children often have problems with fear, anxiety, depression, anger and hostility, aggression, sexually inappropriate behavior, self-destructive behavior, feelings of isolation and stigma, poor self-esteem, difficulty in trusting others, and substance abuse. These problems are often seen in children and adolescents who have experienced other types of traumas as well. Children who have experienced traumas also often have relationship problems with peers and family members, problems with acting out, and problems with school performance.

Along with associated symptoms, there are a number of psychiatric disorders that are commonly found in children and adolescents who have been traumatized. One commonly co-occurring disorder is major depression. Other disorders include substance abuse; other anxiety disorders such as separation anxiety, panic disorder, and generalized anxiety disorder; and externalizing disorders such as attention-deficit/hyperactivity disorder, oppositional defiant disorder, and conduct disorder.

**How is PTSD treated in children and adolescents?**

Although some children show a natural remission in PTSD symptoms over a period of a few months, a significant number of children continue to exhibit symptoms for years if untreated. Few treatment studies have examined which treatments are most effective for children and adolescents. A review of the adult treatment studies of PTSD shows that Cognitive-Behavioral Therapy (CBT) is the most effective approach. CBT for children generally includes the child directly discussing the traumatic event (exposure), anxiety management techniques such as relaxation and assertiveness training, and correction of
inaccurate or distorted trauma related thoughts. Although there is some controversy regarding exposing children to the events that scare them, exposure-based treatments seem to be most relevant when memories or reminders of the trauma distress the child. Children can be exposed gradually and taught relaxation so that they can learn to relax while recalling their experiences. Through this procedure, they learn that they do not have to be afraid of their memories. CBT also involves challenging children's false beliefs such as, "the world is totally unsafe." The majority of studies have found that it is safe and effective to use CBT for children with PTSD.

CBT is often accompanied by psycho-education and parental involvement. Psycho-education is education about PTSD symptoms and their effects. It is as important for parents and caregivers to understand the effects of PTSD as it is for children. Research shows that the better parents cope with the trauma, and the more they support their children, the better their children will function. Therefore, it is important for parents to seek treatment for themselves in order to develop the necessary coping skills that will help their children.

Several other types of therapy have been suggested for PTSD in children and adolescents. Play therapy can be used to treat young children with PTSD who are not able to deal with the trauma more directly. The therapist uses games, drawings, and other techniques to help the children process their traumatic memories. Psychological first aid has been prescribed for children exposed to community violence and can be used in schools and traditional settings. Psychological first aid involves clarifying trauma related facts, normalizing the children's PTSD reactions, encouraging the expression of feelings, teaching problem solving skills, and referring the most symptomatic children for additional treatment. Twelve Step approaches have been prescribed for adolescents with substance abuse problems and PTSD. Another therapy, Eye Movement Desensitization and Reprocessing (EMDR), combines cognitive therapy with directed eye movements. While EMDR has been shown to be effective in treating both children and adults with PTSD, studies indicate that it is the cognitive intervention rather than the eye movements that accounts for the change. Medications have also been prescribed for some children with PTSD. However, due to the lack of research in this area, it is too early to evaluate the effectiveness of medication therapy.

Finally, specialized interventions may be necessary for children exhibiting particularly problematic behaviors or PTSD symptoms. For example, a specialized intervention might be required for inappropriate sexual behavior or extreme behavioral problems.

**What can I do to help my child?**

Reading this fact sheet is a first step toward helping your child. Gather information on PTSD and pay attention to how your child is functioning. Watch for warning signs such as sleep problems, irritability, avoidance, changes in school performance, and problems with peers. It may be necessary to seek help for your child. Consider having your child evaluated by a mental-health professional who has experience treating PTSD in children and adolescents. Many therapists with this experience are members of the International
Society for Traumatic Stress Studies, which has a membership directory containing a geographical listing of therapists who treat children and adolescents. Ask how the therapist typically treats PTSD, and choose a practitioner with whom you and your child feel comfortable. Consider whether you might also benefit from talking to someone individually. The most important thing you can do now is to support your child.

Related Fact Sheets

Children and community violence
A summary of the specific effects of community violence on children and adolescents

Children and disasters
Answers the questions: How do children respond to trauma, how should you talk to your child, and what can parents do?

Seeking help
A general overview of the nature of PTSD and the resources available to individuals suffering from PTSD

Talking with children about war
How do children understand what war means? How can adults best address the concerns of children?

What is PTSD?
Answers basic questions about the signs and symptoms of PTSD, who gets it, how common it is, and what treatments are available

Web Links

TF-CBTWeb: Course for Trauma-Focused Cognitive Behavioral Therapy for abused and traumatized children

TF-CBTWeb, is a web-based, distance learning course for Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) for for abused and traumatized children who have symptoms of posttraumatic stress. It was developed and tested in multiple clinical trials by Drs. Esther Deblinger, Judy Cohen, and Anthony Mannarino. Sponsored by he National Crime Victims Research and Treatment Center at the Medical University of South Carolina and the National Child Traumatic Stress Network.
Sexual Abuse of Preadolescent Children: Symptoms and Treatment

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Symptoms

Gender Differences

Long-term Effects

Mediating Factors that influence severity and presentation of symptoms

Treatment

Conclusions

Symptoms:

- Wide range of symptom patterns – no one symptom or pattern of symptoms characterizes the majority of victims.
- Most frequently cited symptoms: depression, aggression/hostility, sexually inappropriate behavior, fear/anxiety, and school/academic problems
- Other common problems include: anger, social withdrawal, psychosomatic complaints, behavior problems and acting out, moodiness, regression in behavior, changing in eating and/or sleeping habits, nightmares, poor self-esteem, and social difficulties.
- Sexualized behavior is more frequent in sexually abused children than in other clinical populations. Reports range from in 7 – 41% of all sexually abused children display sexually inappropriate behaviors.

Gender Differences:

- Few differences have been found between males’ and females’ symptoms.
- Males tend to display more externalizing behaviors (i.e. aggression, acting out, antisocial behavior, limit testing)
- Females tend to display more internalizing behaviors (i.e. fear, social withdrawal, depression, inhibition)
- Males show a greater degree of sexualized behavior
Males may feel a greater sense of shame due to cultural stereotypes about males, machismo, and victim status – have a sense that masculinity is undermined ("sissy").

Males experience more concern about sexual orientation.

**Long-term Effects:**

- Both males and females experience depression, self-destructive behavior, anxiety, feelings of isolation and stigma, poor self esteem, difficulty trusting others, substance abuse, impaired relationships, sexual problems, dissociation
- Females also have a tendency toward re-victimization
- Males also experience anger; hostility; suicidal ideation and behavior; attempts to prove masculinity through multiple partners, victimizing others, and engaging in dangerous or violent behavior; confusion about gender and sexual identity; sense of being inadequate as a man; sense of a loss of power and control; homophobia; and fear that the abuse will make them homosexual.

**Mediating factors that influence the severity and presentation of symptoms:**

- Nature of the act itself, frequency, duration, relationship to perpetrator, age and developmental level of the child, parental reaction and support, response of family and others to the disclosure, parental depression, and the victims outlook and perspective all influence the severity and presentation of symptoms
- Use of force, penetration, father figure as perpetrator, and maternal depression are associated with more severe symptoms
- Factors that impact recovery include: maternal support, family support, parents involvement in treatment, parent’s emotion distress, and nature of criminal court involvement for the child

**Treatment:**

- Better outcomes are associated with early intervention and treatment, combination of group and individual therapy, parental involvement in therapy, and therapy that is structured, abuse-specific, and psycho-educational.
- Externalizing behaviors, aggressiveness, and inappropriate sexual behaviors are resistant to change
- Much of the literature recommends time-limited (8-16 sessions), structured, abuse- specific group therapy that covers a specific topic or issues each week.
Groups should be small (4-8 children) and homogenous in regards to the gender of members. Only two authors recommend long-term treatment (8 mos.)

- Recommend male and female co-facilitators for the group.

**Most Commonly Used Goals/Issues for Group Therapy:**

- Decrease social isolation, shame, and stigmatization; identify and express difficult feelings (including feelings toward perpetrator and non-offending parent(s); provide safe environment; prevent re-victimization and enhance safety skills; provide appropriate adult role models (male and female co-facilitators); build peer relationships and support; support child through court proceedings; sexual education
- Important issues include: denial, repression, and retraction; illogical beliefs, guilt and responsibility; separation and abandonment anxiety; sexual acting out; sexual knowledge; assertiveness; good touch/bad touch; secrecy and sharing; anger; powerlessness and empowerment
- One goal mentioned specifically for males – reduce externalizing behaviors.
- For boys setting limits is an important part of the therapy session

**Activities for Group Therapy:**

- Role plays, books, videos, art work, drawing, clay, dramatic scripts, puppets, communication board games (The Ungame, Talking, Feeling, Doing Game, the Self-Esteem Game, The Rainbow Game, and Let’s Talk About Touching Game), animal assisted therapy sessions

**Conclusions:**

- Family support and involvement in therapy is very important for the prognosis of treatment
- Prognosis for males may be poorer than that for females since externalizing behaviors and sexualized behaviors are more resistant to change. These are the symptoms where a gender difference is consistently found.
- Group treatment has many benefits for treating the effects of sexual abuse, but it is only one part of a multidimensional treatment plan.
- More research on treatment for males is necessary. In comparison to that for females, there is little research or literature addressing treatment issues and outcome measures specifically for boys. This is particularly important since males who have been sexually abused are more likely, as adults, to victimize others.
Practice Improvement Protocol 13
CHILDREN AND ADOLESCENTS WHO ACT OUT SEXUALLY
Developed by the
Arizona Department of Health Services
Division of Behavioral Health Services
Effective March 7, 2005

ISSUE:
Sexually inappropriate behavior often results in tragic consequences for those who are victimized by such behavior and for the child or adolescent involved in such behavior. Children and adolescents who act out sexually or display sexually inappropriate behaviors are frequently involved with multiple agencies that must approach interventions with coordinated perspectives and consistent goals and outcomes. A collaborative and integrated approach to care, with values, priorities and expectations agreed upon by all child-serving systems, can promote improved treatment outcomes.

PURPOSE:
To establish protocols for behavioral health interventions for children and adolescents who display sexually inappropriate behavior that effectively serve their psychosexual and behavioral health needs, that are consistent with the Twelve Arizona Principles, that increase safety for all, and that complement and reinforce the interventions of other child serving agencies.

TARGET POPULATIONS:
All Title XIX and Title XXI eligible children and adolescents who are enrolled in Arizona’s public behavioral health system and who
Exhibit developmentally or socially inappropriate sexual behaviors or preoccupations; or
Have initiated and engaged in sexual behavior that was illegal, coercive, forced, or otherwise non-consensual; or
Have initiated and engaged in sexual behavior that was aggressive, threatening or violent in nature, or resulted in physical injury to another person.

BACKGROUND:
ADHS is committed to the provision of services through family focused practice in the context of Child and Family Teams (CFTs). In order to extend this commitment to children and adolescents with sexually inappropriate behavior, service provision and planning should:
Explore and document the strengths and needs of the child or adolescent and family;
Establish and prioritize service goals;
Identify the most appropriate services and supports necessary to meet those goals;
Ensure that the services provided are of sufficient intensity to accomplish identified service goals;
Describe a course of action encompassed in a written service plan developed by team members, with input from all involved agencies;
Monitor the accomplishments of the child and family; and
Determine the responsibilities of all team members involved in these efforts.

CHILD AND FAMILY TEAMS:
All assessments, service planning and service provision should occur within the context of the CFT process. When out of home services are used, the providers should ensure the continuation of a child’s CFT during transitions into and out of their facilities, or the establishment of a CFT for children admitted without a functioning team. Child and Family Teams should include a broad representation by both professionals and community members, as described in the ADHS/DBHS Child and Family Team Practice Improvement Protocol. Representatives from Child Protective Services (CPS), Arizona Department of Juvenile Corrections (ADJC), Department of Developmental Disabilities (DDD), the Juvenile Probation Officer (JPO), local schools, etc. should participate in CFT meetings and their schedules considered in the planning of all team meetings. Even when their representatives cannot directly participate with the CFT, their input into the CFT process should always be solicited, and their perspectives should be given consideration in all decisions made. The CFT should strive to provide agencies with behavioral health expertise and with any relevant information that would help inform their decision-making processes.
The CFT must fully respect the mandates of each involved system (e.g. conditions of probation, court orders, no contact orders) and strive to implement them in the most appropriate and clinically sound manner.
Victim participation on a CFT must always be voluntary and not coerced. The willingness and ability of a victim to effectively and beneficially participate must be cautiously considered and weighed against potential personal trauma. The victim should be provided a thorough understanding of the benefits and risks.

ASSESSMENTS:
The assessment and service planning processes must be carefully tailored to the individual. The assessment of all children and adolescents should begin with the ADHS/DBHS assessment process and a thorough review of already existing documents and historical information. All relevant life domains should be explored to the depth necessary to determine the next appropriate service and the level of current risk of danger to self or others. Referrals prompted by specific concerns about sexually aggressive behavior, and by affirmative answers to questions in the Abuse/Sexual Risk Behavior section should trigger deeper explorations of any concerning behavior; of the
child’s depth of awareness, understanding and perceptions of those behaviors; and of associated risk factors (e.g. the level of anger and impulse control, the presence of pervasive emotional or developmental deficits, the presence of academic problems, the presence of substance abuse issues).

The behavioral health assessment should explore the quality of family relationships, the child’s social skills, the extent of his/her own trauma, his/her attitudes towards sex and relationships, and the level of accountability for inappropriate sexual behavior. If not explored fully at the initial assessment, these domains should be explored by the Clinical Liaison during an ongoing assessment process, and in ongoing clinical interviews with the child and other family. Ongoing assessment should explore the thoughts, feelings, and historical precipitants that lead to inappropriate sexual behavior, and the level of victim empathy present. Past behavioral health, medical, school, police or investigational records, and, when applicable, victim statements and juvenile court records should always be reviewed.

Before a diagnosis is made, or an assessment concludes that a child is exhibiting inappropriate sexual behavior, the Clinical Liaison must carefully consider the wide spectrum of developmentally congruous presentations of sexuality. Prematurely and improperly defining a child as sexually inappropriate, or as a sexual perpetrator, can be unnecessarily stigmatizing and have long-term adverse effects on the child’s stability including school placements, treatment setting options and overall stability and societal acceptance. At the same time, the absence of a particular diagnosis or distinct clinical presentation must not preclude the implementation of specific assessment processes that can enhance the understanding of a child’s needs or underlying condition, nor aspects of a service plan that can successfully resolve problematic behaviors.

Family interviews must be done with a well-developed understanding of and sensitivity to the family’s culture and their cultural needs. Interviews should explore possible contributing family issues, the family’s beliefs regarding the child or adolescent’s sexual behavior, their knowledge of the sexual exposure the youth has had, their attitudes towards the sexual acting out, their potential contribution to or hindrance of assessment and treatment, and their sense of the service approaches most likely to be successful. The Clinical Liaison must recognize that effective service plans for children and adolescents are built on explorations of individual, family and community strengths, skills and resources, not only on an understanding of deficits and limitations. These areas should be explored during the initial assessment and during the Strengths, Needs and Culture Discovery process that is a part of it.

The Clinical Liaison should carefully consider whether formal testing is indicated, whenever possible with input from the full CFT. Psychological testing (including intelligence testing, personality inventories, and, when specifically indicated, neuropsychological testing) can be useful in combination with other assessment procedures to create a clinical picture of the child, to identify target areas for clinical intervention, and to determine the most appropriate treatment modality. Psychological
testing can help identify previously undiagnosed conditions such as Attention Deficit Hyperactivity Disorder (ADHD), Bipolar Disorder, Conduct Disorder, Post Traumatic Stress Disorder (PTSD), Affective Disorder, or Learning Disabilities that may coexist, and can identify service determinants relating to intellectual, neurological, and personality functioning. Psychological testing should be used in situations where less intrusive assessment processes like psychiatric evaluations need to be enhanced or expanded upon in order to secure a diagnosis or clinical formulation, when clinical needs can be clearly articulated, and when testing outcomes will likely lead to more effective service plans.

Psychosexual testing includes specific tools like the Multiphasic Sex Inventory II (Juvenile), the Abel Assessment for Sexual Interest, the Abel and Becker Card Sort and other specialized testing tools that assess an individual’s sexual interests, sexual behavior analyses, level of sexual preoccupation and deviant arousal patterns, and risk of sexually offending. They can enhance the clinician’s understanding of the most pertinent underlying concerns and aid in the development of individualized service plans. Psychosexual testing must only be undertaken and interpreted by clinicians with specialized expertise and training in their use.

Decisions to secure or avoid psychological or psychosexual testing should be made in the context of the CFT process and in consultation with a well-informed Clinical Liaison. Consultation with a clinician experienced in psychological and/or psychosexual testing is advised.

Polygraphy focuses on the honesty of the individual about sexual history. It has been increasingly used in the assessment of adjudicated offenders for the purpose of facilitating more complete disclosures of sexually inappropriate behaviors and for maintaining and monitoring compliance with treatment. Polygraphy should require the full informed consent of the youth, parent or guardian and must only be administered by practitioners qualified in its use. As polygraphy is not a covered behavioral health service; its utilization requires coordination with agencies that can access it.

Neither penile plethysmography nor vaginal photoplethysmography should be utilized to identify sexual arousal patterns as they lack reliability and validity for use with this population, and present significant ethical dilemmas.

**TREATMENT OVERVIEW:**
Comprehensive service plans must be based on an awareness that behaviors are founded on the child’s needs, strengths, history, culture, developmental stage, environment and emotional makeup as described by the comprehensive assessment. The presence or absence of early abuse, the age and gender of the child, the presence of developmental delays, etc. should lead the provider towards specific and well-considered strategic approaches and away from others. These factors should not preclude the provision of services to any distinctive population. This holds particularly true for young people with developmental disabilities or delays, whose limitations should not interfere with the delivery of interventions tailored to their unique needs.

While the overall purpose of treatment is to help children and adolescents gain control over problematic sexual behavior, it cannot ignore likely coexisting and contributing
factors. Service plans should include services offered by family members, community supports, and agency representatives as well as by trained, experienced professionals, and should address the following objectives:

1. **Facilitation of disclosure and acceptance of responsibility for behaviors.** Denial is an issue for most sexually aggressive or sexually inappropriate youth. Providers should be aware of the level of denial specific to the individuals and families they serve. Reducing denial is often a starting point, as well as a gradual but ongoing process during treatment. The purposeful functions of denial (e.g. protection from shame and stigma, protection from rejection by family, protection from legal sanctions or other consequences) need to be understood and resolved through relationship building, support for accurate disclosure, and progressive confrontation. The existence of denial should not preclude a child from treatment. Persistent denial may become a factor in making placement decisions. Community based treatment may be inappropriate for a child or adolescent who is in complete denial, especially those who have been adjudicated for sexual offenses.

2. **Re-education and resocialization.** Antisocial and sexually aberrant thoughts and behaviors need to be replaced with prosocial ones. The child or adolescent must be helped to acquire a positive self-concept and improved attitudes and self-expectations. Vocational and living skills training, assistance with academics, the development of prosocial relationships with peers, dating skills, and sex education are examples of replacements to be considered. In addition, the service plan should include specific strength-based interventions adapted to the individual strengths, resources and interests of the child or adolescent.

3. **Gaining and exercising control.** Treatment should assist the child or adolescent in learning to intervene in or interrupt his/her own aggressive patterns and to call upon specific tools, methods, and procedures to suppress, control, manage or stop problematic behaviors.

4. **Assistance with co-occurring medical and behavioral health disorders, deficits and disabilities.** Although there is insufficient evidence to identify substance abuse as a causative factor in the development of sexually aggressive behavior, it is clear that substance abuse has a disinhibiting potential. Issues such as poor impulse control, problem solving difficulties, and poor social skills are often exacerbated by even small quantities of drugs or alcohol and may consequently increase the risk of inappropriate sexual behavior. Service plans should address appropriate substance abuse interventions in addition
to those targeting sexual behavior. **Treatment** of coexisting mental health disorders such as depression, anxiety, conduct disorders, PTSD, and ADHD should also be provided with interventions commonly accepted as appropriate for those diagnoses, along with services targeting sexual behavior. Comprehensive service plans should also define interventions that target the child’s academic and vocational needs, as well as any intellectual and cognitive impairment. **Children** and adolescents with developmental disabilities should be assessed and treated in a manner that accommodates their particular limitations and capabilities and, when appropriate, referred to DDD for additional supportive services. **Treatment** of coexisting medical disorders should be coordinated with primary care providers. Referral for Early Periodic Screening, Diagnosis and **Treatment** (EPSDT) services should be included in the service plan when appropriate.

5. *For those who have been victimized themselves, resolution of the effects of personal victimization experiences.* It is current best practice to target an individual’s problematic sexual behavior before attempting to resolve issues relating to their own victimization experiences. Occasionally, however, **sexually** aggressive **children** and adolescents may be unable to fully acknowledge responsibility for harming others until they are effectively able to discard self-blame and guilt over their own victimization.

The timing and prioritization of **treatment** strategies must therefore be carefully considered for each individual. Eventually, efforts need to be made to provide victimized **children** and adolescents with group and/or individual counseling related to their own victimization as early as indicated in their **treatment** process. At the same time, both providers and families must be cautious not to overreact to a child’s victimization and adversely impact outcomes of **treatment** by condoning, justifying or minimizing a child’s problematic behavior.

6. *Resolution of dysfunctional values and attitudes.* **Children** and adolescents who have displayed inappropriate sexual behavior are frequently confused about how to relate to others **sexually**. Distorted or unattainable gender stereotypes, devaluing gender stereotypes, values about masturbation, and confusion about the difference between mutually-consenting and victimizing sexual behavior can be approached by exercises that clarify values and attitudes, by clinical challenges to cognitive distortions, by sex education, and by counseling to promote the development of positive sexual identities. Interventions should also be directed toward the development of an awareness, appreciation and respect for the experience and feelings of the child or adolescent’s victims.

7.
Resolution of family problems and impaired sibling relationships. If family dynamics are not compromised before a child or adolescent’s problematic sexual behaviors are identified, the confusion, disappointments, anger, shame, embarrassment and fear that result frequently lead to significant family difficulties. **Children** and adolescents in **treatment** have the best opportunity to recover when they are supported, encouraged and embraced by family, even while being challenged to change their inappropriate behaviors. Family members should be included in the **treatment** process whenever possible, and contributing or resulting family dynamics explored and resolved. At the same time, the feelings of victims within the family must always be respected, and their safety always secured.

8. **Inter-agency Collaboration.** **Children** and adolescents exhibiting **sexually aggressive** behavior should be held accountable for their actions. To accomplish this, collaboration among all agencies and individuals responsible for initiating and implementing effective **treatment** and supervision is essential. All parties should share a clear set of operational expectations, in order to minimize the child or adolescent’s ability to circumvent **treatment**, accountability, or goals of supervision. Collaborative efforts must extend beyond simple case management associations. Behavioral health representatives must work closely with supervising agencies (e.g. probation) and all others involved with enforcement and the management of services (e.g. law enforcement officers, defense attorneys, judges, prosecutors, school

9. **Avoidance of relapse.** This includes teaching **children** and adolescents, and their supervising adults, to understand the cycle of thoughts, feelings and events that are antecedent to **acting out sexually**, identifying environmental circumstances and thought patterns that should be avoided due to increased risk of inappropriate behavior, and identifying and practicing coping and self control skills necessary for managing their own behavior.

10. **Service provision in the least restrictive and most appropriate setting.** The Arizona Vision clearly articulates a core value that services are provided in the most appropriate, least restrictive environment, and whenever possible, in the child’s home and community. These values apply equally to **children** and adolescents who act **out sexually**. Although careful consideration must be given to the safety of the community and to others living in the home, all resources required to meet service needs in the child’s home or community
must be explored before other options are considered. Inter-agency collaboration and joint service planning can assist in this endeavor. In order to meet the complex service needs of all sexually inappropriate children, providers working with them should have training and expertise specific to the unique service needs identified, be knowledgeable about issues of victimization, and have a strong interest in and a commitment to working with this population.

**SERVICE PLANNING:**
The Clinical Liaison assigned to a Child and Family Team is responsible for outlining and advising the CFT of all clinical options, assisting the CFT in determining who can best provide identified clinical and supportive needs, and providing clinical guidance to the development of the service plan. Clinical Liaisons working with this population should therefore have specialized training and demonstrated expertise in the evaluative and treatment aspects specific to this population.

1. **Strengths, Needs and Options:** With the assistance of the Clinical Liaison, the CFT should begin by defining the child or adolescent’s unique strengths and needs rather than the specific services they feel may meet those needs. This will support the Clinical Liaison’s ability to provide appropriate consultation to the CFT about the various intervention strategies and service options that will lead to desired outcomes.

The CFT should incorporate into the service plan the input, recommendations, and system mandates of participants from all involved systems. Participants should advise the CFT on issues germane to their systems (court orders and legal responsibilities within which treatment must operate from juvenile probation officers; safety, well-being and permanency needs from CPS; educational needs from schools).

The behavioral health representative on the CFT is responsible for securing all services agreed upon by the CFT (consistent with the ADHS/DBHS Child and Family Team Practice Improvement Protocol). If the CFT, with input from the Clinical Liaison, requests services from a provider with specialized expertise in the treatment of sexually inappropriate behavior, then those services should be secured through the Tribal or Regional Behavioral Health Authority (T/RBHA).

2. **Safety Plans:** Community-based treatment of children and adolescents considered at risk of offending or exercising sexually inappropriate behavior requires a thorough and detailed safety plan with input from all involved agencies. Community safety, consideration of victims’ needs, feelings and security (whether they reside in the home or in the community), and the avoidance of provocative situations, environments and experiences should be considered and ensured in all safety plans.
Crisis Plans: The CFT should develop crisis plans so that all parties understand and accept their role if the clinical picture worsens. Detailed plans (e.g. which next steps will be followed, who will be called, where the child or adolescent will be taken, by whom) should be worked out carefully in advance. In this way, an organized, coordinated interagency response to a potential crisis (with the behavioral health agency planning its response to the behavioral health needs of the child, supervising agencies determining their response to the needs for public protection, CPS assessing the child’s welfare needs, etc.) will be in place well before the predicted crisis might occur. There will usually be significant overlap in the content of crisis and safety plans.

4. Transition Plans: Transitions from restrictive environments to community-based services require a high level of coordination and planning for continuity of care. Communication between service providers, sharing of successful (and less successful) intervention strategies, continuity of service plans, assurance of timely service provision, follow up and monitoring approaches should be a part of every transition plan, and should be carefully documented well in advance of the change in placement. Attempts should always be made to assure continuity of service providers.

At the time of transition, careful consideration should be given to the level of risk the individual poses to re-offend or relapse (based on the historical level of sexually deviant behavior, the level of impact of treatment to date, clinical judgment and, when indicated, appropriate clinical instruments). When making decisions about placement options, always balance the risk with the most normalized, community-integrated placement possible.

For children approaching the age of majority, continuity of care poses unique challenges. Ongoing care must be arranged with providers who work with young adults. Whenever possible, the continuation of the CFT should be

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promoted and encouraged. Children reaching the age of 17 with functional impairments indicative of a serious mental illness should be referred for SMI determination (see the ADHS/DBHS Transitioning to Adult Services Practice Improvement Protocol).

CLINICAL SUPERVISION:
Given the complexity of issues that surface during the treatment of children who act out sexually, all care providers require sound clinical supervision by professionals experienced with this population. Unconscious prejudices, information gaps, emotional blind spots, and subliminal or unspoken expectations or feelings about individual clients can all interfere with good clinical judgment. Without the provision of regularly scheduled, formal and high-quality clinical supervision, these barriers can remain unrecognized and compromise services provided. Therapists, case managers, support staff and all other care providers should be provided with regularly scheduled, dependable clinical supervision.
Sexually Reactive Youth Program

Hope and healing for children with sexualized behaviors and their families

Lutheran Community Services Northwest has been a recognized leader in the state of Washington since 1991 in the provision of quality preventative care to children who are sexually reactive.

The SRY program is a children’s mental health program that provides service to child victims of sexual abuse /assault and their families. The program provides service to children ages 13 and under who exhibit sexually acting out behaviors that put themselves and others at risk. Acting out behavior is often related to a child’s own victimization and positive intervention and support can provide necessary change and redirection toward positive coping skills.

Please note: The program does not provide service to adjudicated youth or youth charged with a sexual offense. The program is an intervention program with intensive efforts aimed at promoting behavioral change.

Services for Children and Their Families

**Individual Counseling:** Individual counseling aimed at reduction of sexually acting out behavior.

**30-Day Assessment:** In office assessment of SRY behavioral risks and support needs.

**90-Day Assessment:** Comprehensive assessment initiated through referrals from the Department of Children and Family Services.

**Group Counseling:** Aimed at behavioral support, behavioral reduction, and relapse prevention planning.

**Attachment Focused Family Support:** Aimed at supporting primary relationships while completing treatment program.

**After-Hours Crisis Support:** Available after-hours and week-ends

**Family Education and Support Services:**

- 12 Week SRY - Curriculum based support program
- Case management and referral services
- Individualized Tailored Care Teams
- Parent and child Group support
- In-home support specialist
- Community Education

**What is SRY behavior?**
When a child touches other children in a sexual way that is not age-appropriate.

- Shows excessive interest/curiosity in sex that overrides other activities.
- When a child continues to have sexual behaviors even after being re-directed by an adult.
- Talks excessively about sexuality, or has inappropriate knowledge of sexuality for their age.
- Harms or touches animals in a sexual way.
- Exchanges gifts or shows affection to others in order to have sexual contact, either to other children or adults.
- Touches a child 3 years younger or someone from a vulnerable population by displaying more power & control.
- Excessive masturbation.

Myths & Facts:

**Myth:** Young kids are just curious.

**Fact:** When children force or coerce others or are unable to stop sexual behaviors, this is a sign of a sexual behavior problem.

**Myth:** Children will grow out of it.

**Fact:** Relying on this hope jeopardizes the safety of your child and others.

**Myth:** My child would never force another to do anything sexual.

**Fact:** Force can include words, coercion, pressure, bribes, or tricks.

**Myth:** My child was not abused.

**Fact:** Children can be exposed to sex without being sexually abused physically. Exposure to pornography or witnessing adult sexuality can affect a child’s behavior.

**Myth:** My child does exactly what I say and this will never happen again.

**Fact:** Parental control is important but is not the simple answer. Kids need to learn new beliefs and skills so they can cope when a parent is not available to guide them.

Reasons Kids Have SRY Behaviors:

Sexually Reactive Behaviors may occur when a child has been exposed to sexually explicit material, environments or has been victimized, and is attempting to cope with his or her own overwhelming feelings. This behavior can put the child and others at risk. Please read below to see examples of circumstances that may initiate or support reactive behavior.

The following are only a few examples:
Confusion based on what they see on TV, videos, video games, internet, or magazines.
- Have been sexually abused by direct physical contact or subject to witnessing sexual abuse.
- Live in sexually explicit environments in which sex has been witnessed and related in a negative manner.
- Witness to Domestic Violence.
- Exposure to pornography or being used by an older person for pornography.

**Other Behaviors Your Child May Display:**

- Aggressive behaviors
- Problems following rules
- Poor physical boundaries in general
- Problems understanding the feeling of others or empathizing with them
- Problems at school, home, or with friends.

Sexually Aggressive Behaviors may occur when a child begins to pair sexual behaviors with threats, coercion, or physical harm, he or she could be considered sexually aggressive.

**Reasons to Get Help**

If your child is a victim of child sexual abuse and is acting out sexually, he or she can learn new coping skills.

- Some sexual exploration between same-age children is normal. If you are worried that your child has sexually reactive or sexually aggressive behaviors you can get help to determine whether the behaviors are within normal limits.
- Children who have sexual behavior problems are not adult sex offenders. Early evaluation and treatment will help eliminate inappropriate sexual behaviors.
- Sexually reactive children are often victims who need to learn new coping skills and behaviors.
- Parents need support and help understanding what is happening with their child and/or in their family.
- SRY behaviors rarely happen only once.
- Children who do not get help are at risk to be re-victimized and/or to re-offend.
- Counseling increases the chances of having healthier happier adult relationships.

**HOW TO CONTACT US**

*If you would like additional information on the Sexually Reactive Youth Program, or any of our Child Welfare Programs, please contact us at 509-343-5035.*