CLINICAL SOCIAL WORK AND CHILD SEXUAL ABUSE

by

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Abstract

Children and adolescents who experience traumatic life events may develop a wide variety of problems including symptoms of posttraumatic stress disorder (PTSD), depression, and substance use. This report will focus on assessment and treatment of children and youth with PTSD symptoms and a history of sexual abuse. An examination of the impact of sexual abuse on children will be described. A critical analysis of psychotherapy with children and youth who have been sexually abused will be explored. Trauma-focused cognitive behavioural therapy (TF-CBT) will be examined as a therapeutic approach that targets PTSD symptom reduction. This intervention is provided in a community setting. The Sexual Abuse Intervention Program provides services to child victims of sexual abuse that are 18 years of age or younger. In reviewing the literature, sexualized behaviours are the most commonly studied and characteristic symptom of sexual abuse. The following will explore children with sexual behaviours problems.
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Dedication

This report is dedicated in loving memory of my brothers and sister: Allen Vernon Johnson, Randy Robert Johnson, Kenneth Terry “Tawny” Johnson, and Sherry Laura Johnson.

Forever missed
And dearly loved

Always in my heart
Chapter 1: Introduction

This report is an examination of the assessment and treatment of child sexual abuse. It is based on my practicum experience at the North Coast Transition Society in Prince Rupert, British Columbia with the Sexual Abuse Intervention Program (SAIP). The aim was to develop my clinical skills in assessment, treatment planning, and clinical interventions that would enable me to work effectively with children and youth who are survivors of sexual abuse. The purpose of this report is to offer a critical analysis of psychotherapy with child sexual abuse survivors. Trauma-focused cognitive behavioral therapy (TF-CBT) will be examined as a therapeutic approach that targets posttraumatic stress disorder (PTSD) symptom reduction.

Sexual violence is a global problem that has profound impacts. The World Health Organization "estimates that one hundred and fifty million girls and 73 million boys under eighteen have experienced forced sexual intercourse or other forms of sexual violence involving physical contact" (Pinheiro, 2006, p. 54). Sexual violence has significant health consequences, including suicide, stress, mental illnesses, unwanted pregnancy, sexually transmitted infections, HIV/AIDS, self-inflicted injuries, and assuming high-risk behaviours such as multiple partners and substance use (Siegel & McCormick, 2010, p. 19). Sexual violence is the:

Nonconsensual completed or attempted contact between the penis and the vulva or the penis and the anus involving penetration, however slight; nonconsensual contact between the mouth and the penis, vulva, or anus; nonconsensual penetration of the anal or genital opening of another person by a hand, finger, or other object; nonconsensual intentional touching, either directly or through the clothing, of the
genitals, anus, groin, breast, inner thigh, or buttocks; or nonconsensual non-contact of a sexual nature such as voyeurism and verbal or behavioral sexual harassment. All the above acts also qualify as sexual violence if they are committed against someone who is unable to consent or refuse (Basile & Saltzman, 2002, p. 9).

It is estimated that "about one out of every three girls and one in six boys are sexually abused in some way before they turn eighteen" (Lehman, 2005, p. xi). Violence against women and girls is an "act of gender based violence" (Senn, 2010, p. 78). This analysis will be approached from a feminist perspective, which includes being "informed about the gendered nature and the extent and variety of violence perpetrated against women and girls in [today's] culture" (p. 90 & 91). A feminist perspective examines child sexual abuse within its wider social context. Feminist insights of the role and function of patriarchy are invaluable when the users and providers of social work services are predominately women. Feminist analysis links the personal and political. There are five different feminist approaches that offer analyses of the fundamental source of oppression in society: intersectional feminism, liberal feminism, socialist feminists, Marxist feminists, and radical feminism (Damant, Lapierre, Kouraga, Fortin, Hamelin-Brabant, Lavergne, & Lessard, 2008; Mullaly, 1997, p. 132). Please refer to Jagger and Struhl-Rothenberg's (1984), Feminist Frameworks, for a greater understanding of feminist approaches.

This report opens with a description of the practicum setting followed by a conceptual framework of child sexual abuse. Chapter 3 includes a discussion of relevant terms and the traumatic impact of child sexual abuse. Chapter 4 addresses research findings of child sexual abuse in Canada. Chapter 5 focuses on activities completed in the practicum placement. An examination of trauma-focused cognitive behavioral therapy (TF-CBT) will be presented.
Chapter 6 provides a discussion for social policy development. Finally, I conclude with an exploration of vicarious traumatization.

Supporting the recovery of children, youth, and their families is an honour and a challenge. It is exciting to be a clinician working with traumatized children because of the amount of information that is available to guide and shape our practice. There are several evidence-based approaches that show great potential for helping our child clients. It is astounding to observe a child slowly shift his or her view of themselves, others, and the world to a more positive pattern. As a therapist, I am also participating in the healing of the child’s losses and grief. I firmly believe that children can often find natural ways to address their personal injuries if given the proper environment or what is referred to as a “container” (Gil, 2010, p. 46). The recovery process begins with the establishment of safety and security. According to Gil, a child that has “healthy relational interactions with safe and familiar individuals can buffer and heal trauma-related problems” (p. 28). A family’s response to trauma can increase or decrease their child’s anxiety and/or adaptation. As a counsellor, it has been a challenge because of my own emotional reactions. To be a witness to my clients’ pain makes me feel helpless. I acknowledge I have gaps in understanding and I need to be enlightened while preserving my own beliefs. Another difficulty is contending with children’s distrust of adults. Perpetrators destroy the child’s relationships through feelings of isolation, secrecy, and betrayal. My view of “having justice” or efforts to seek justice can be significantly different from my client’s view. The justice system response can be disheartening. The slow pace of the criminal justice process is often overwhelming and can be insensitive to the needs of children and their families. It is perplexing that child sexual abuse continues to occur at a significant rate. It is also the preliminary work that is done by
clinicians that is often difficult. Reading the many stories of abuse I can’t help but think of the hurts I suffered as a child.

It is important that I identify my own location in this work both professionally and culturally. Writing about child sexual abuse has led me to reflect on the transformation over time of my own cultural identities. The interactions between my own cultural identity (including self-identity) and the counselling process have impacted my practice as a First Nations able-bodied heterosexual clinical social worker living in Northern British Columbia. I am Tsimshian from the Laxsgiik (Eagle) clan I grew up off-reserve in Port Edward, British Columbia. In my family I am the second youngest of nine children. I am influenced by a history of colonialism, the Canadian Indian Act, and the harm both have caused Aboriginal people in Canada. I am a feminist, child welfare advocate, structural social worker, and child therapist. I understand that the oppression of others is based on unhealed pain from my own experience of being oppressed. Liberating myself is an on-going process that continues each day by increasing my knowledge of personal loss and de-colonization. An anti-oppressive practice for me takes into account that “... violence is always accompanied by resistance”. Resistance can be in many ways – grand gestures or subtle – that is either any mental or behavioral act that opposes any form of violence or oppression. For me, it can be gentle as shedding tears constitutes resistance (Richardson, 2010, p. 123).

Prior to beginning my practicum, I believed that child sexual abuse is unusual but in fact incest and other forms of sexual abuse are not rare (Bernet, 1997, p. 37S). Childhood sexual abuse is the most underreported crime in North America. In 2012/2013, there were 32,542 victims of crime in which 3,018 (9.3%) were children/youths in BC Prosecution Service – the Criminal Justice Branch of the Ministry of Justice (Ministry of Justice,
2012/2013, p. 15). A total of 2.3% or 1,477 were violent offences (p. 11). The majority of violent offences were sexual assaults with a total of 489 accused persons with one or more child/youth victim(s) (p. 12). Therefore, 24.9% of violent crimes have a child/youth victim. Results for sexual assaults are 278 guilty, 14 peace bonds, 57 not guilty, 135 stayed, and 5 other (p. 13). Close to half of the prosecuting cases concerning children and youth victims involved court proceedings suspended without resolution of guilt or innocence, “other” (accused person either has died or has been found not criminally responsible by reason of a mental disorder), or not guilty (p. 17). Sexual abuse “happens in every social, racial, geographic, cultural, and economic group” (Lehman, 2005, p. xiii). It is estimated that “90 percent of sexual offenders are known and trusted by their victims and about half of offenders are family members”. The majority that do offend are men but there are also female sexual offenders (p. xiii).

This chapter provided a summary of my interest in the treatment of complex traumatic stress disorders. Feminist theory and analysis provide insight into the patriarchal structures that virtually incorporate all social institutions such as the family. There is a basic view that patriarchal society is oppressive (Mullaly, 1997, p. 132). As a First Nations clinician this is important because “Aboriginal people [are] three times more likely than non-Aboriginal people to experience a violent victimization (319 versus 101 incidents per 1,000 population” (Brzozowski, Taylor-Butts, and Johnson, 2006, p. 1). I intend to gain a theoretical basis and practical framework for the conceptualization, assessment, and treatment of complex traumatic stress disorders. The next section will describe my practicum placement at the North Coast Transition Society with the Sexual Abuse Intervention Program.
(SAIP) in Prince Rupert, British Columbia. This will set the stage for an in-depth exploration of child sexual abuse and posttraumatic stress disorder.
Chapter 2: Practicum Setting

This chapter covers a brief history of the North Coast Transition Society and a description of the Sexual Abuse Intervention Program (SAIP). In November, 2009 the BC Society of Transition Houses (BCSTH) conducted a 24-hour census of 119 BC Violence Against Women Services. On that night, 351 women and 133 children were accommodated in BC transitional housing programs. That same day, BCSTH member programs were unable to meet the housing or support needs of 209 women and 313 children and youth through transitional housing (2011, p. 7). According to BCSTH, a focused, comprehensive, and gendered strategy is needed because of the severity and impact of violence against women (p. 9). I will explain the services the agency provides to the community of Prince Rupert, BC and surrounding area. The mandate of SAIP as well as eligibility criteria will be presented. An explanation of practicum objectives will be highlighted. The practicum allowed an opportunity to integrate and expand my knowledge on complex trauma with sexual abuse.

Practicum Objectives

To summarize briefly I have three learning objectives: 1) to gain a current and comprehensive understanding of child sexual abuse; 2) to explore current best practice in assessment and treatment planning in the trauma field; and 3) to study contributing factors to vicarious trauma. A fundamental question that guided my practicum experience was: “how do I develop my practice using a trauma framework for understanding child sexual abuse?” During my practicum I struggled with the question of “should sexually abused children who exhibit no symptoms or subclinical symptoms receive mental health treatment?”

North Coast Transition Society

The North Coast Transition Society is a feminist non-profit organization that has been helping women and children who are survivors of violence for the past 32 years. The Society
was founded in March, 1980. In 1978, a group of local women advocated on behalf of a woman who was assaulted by her husband. This local feminist group became known as *Prince Rupert Options for Women*. The group received support from the community and began taking victims of family violence into their homes at the request of the Royal Canadian Mounted Police and the Prince Rupert Regional Hospital. After one year of graciously operating their own homes as an emergency shelter the group then applied for a grant to study the incidence of wife assault in Prince Rupert, British Columbia. After the study was completed, the Society then approached the City of Prince Rupert and the Ministry of Human Resources for funding. A contract was granted by the Ministry and the City of Prince Rupert provided a house to rent. The “Maude Bevan House” doors were then opened with a staff of four.

Today there are seven programs and a 24-hour crisis line that is offered by the North Coast Transition Society. In 2012/2013 the programs were funded by British Columbia Housing Management Commission, Northern Health Authority, Ministry of Children and Family Development, Ministry of Public Safety and Solicitor General, and Other. The seven programs include: Ravens Keep Transition House, Eagles Landing Second Stage Housing, Supportive Recovery Program, Sexual Abuse Intervention Program, Stopping the Violence Counselling, Women’s Outreach Program, and Housing Outreach Services. Last year all programs moved under one roof into a new high performance green building that will lower operating costs by saving on energy and water.

In March, 2013 the North Coast Transition Society celebrated International Women’s Day by holding an open house so community agency members could view the new facility. There are fifteen individually locked bedrooms in the Ravens Keep Transition
House. The Supportive Recovery Program is designated three of the beds/rooms that are for women who want to address their alcohol and drug use. Women and their children in the Supportive Recovery Program can stay up to ninety days. The Eagles Landing Second Stage Housing has eight units (two are 2 bedroom – with one of the units being fully accessible and six 1 bedroom with one fully accessible).

Sexual Abuse Intervention Program

The Sexual Abuse Intervention Program (SAIP) is a community-based program that is funded by the Ministry of Children and Family Development (MCFD) to deliver 1,352 hours of service in Prince Rupert, British Columbia (MCFD Subsidiary Component Agreement, 2013, p. 5). The North Coast Transition Society receives funding for one clinician to work 26 hours a week in the Sexual Abuse Intervention Program. However the SAIP therapist works 30 hours a week with the additional funding coming from the North Coast Transition Society. The Sexual Abuse Intervention Program was created in 1990 when funds were reallocated to Child and Youth Mental Health (CYMH). At this time CYMH was part of the Ministry of Health. In 1996, CYMH services were transferred to the Ministry of Children and Family Development therefore SAIP contracts are managed by MCFD and are the responsibility of Community Service Managers. There are 49 SAIP agencies in the province of British Columbia (North Coast Transition Society, 2012).

The mandate of the program is to provide clinical services to children and youth who have been sexually abused and to children under the age of twelve with sexual behavior problems (MCFD Subsidiary Component Agreement, 2013, p. 3). Families, who live in the surrounding area such as Port Edward, Metlakatla, Dodge Cove, Kitkatla, Hartley Bay, and Port Simpson, can access services in Prince Rupert (MCFD Subsidiary Component Agreement, 2013, p. 3).
Agreement, 2013, p. 6). SAIP aims to “reduce suffering and restore healthy functioning by providing a range of appropriate, timely, and accessible ... service” to children, youth, and their families (Representative for Children and Youth, 2010, p. 3).

A child or youth must be 0-18 years old and have experienced sexual abuse or sexual exploitation or under the age of twelve with sexual behavior problems related to sexual abuse or sexual exploitation to qualify for SAIP services (Ministry of Children and Family Development, 2008, p. 4). The Standards provide detailed situations when a child is eligible for services such as, if there is ongoing contact with the alleged offender and the child’s safety is assured or, if the child or youth is involved in a case before the courts.

According to the BC Handbook for Action on Child Abuse and Neglect, sexual abuse is when “a child is used (or likely to be used) for the sexual gratification of another person. It includes:

- touching or invitation to touch for sexual purposes
- intercourse (vaginal, oral, or anal)
- menacing or threatening sexual acts, obscene gestures, obscene communication or stalking
- sexual references to the child’s body/behaviour by words/gestures
- requests that the child expose their body for sexual purposes
- deliberate exposure of the child to sexual activity or material, and
- sexual aspects of organized or ritual abuse” (p. 24).

Sexual exploitation is:

a form of sexual abuse that occurs when a child [is] engage[d] in a sexual activity, usually through manipulation or coercion, in exchange for money, drugs, food, shelter
or other considerations. Sexual activity includes performing sexual acts, sexually explicit activity for entertainment, involvement with escort or massage parlour services, and appearing in pornographic images (Ministry of Children and Family Development 2008, p. 6).

Young people who are involved in a street lifestyle are particularly vulnerable to exploitation. In 2006, the McCreary Centre Society conducted a health survey of marginalized and street-involved youth in nine communities across British Columbia. The report examined the experiences of 410 Aboriginal youth. Findings indicated that “one in three survey participants reported sexual exploitation: 30% of males and 23% of females” (Saewyc, Bingham, Brunanski, Smith, Hunt, & Northcott, 2008, p. 42). The North Coast Transition Society reported that 85% of SAIP files are “aboriginal cases” (McEwan, 2006, p. 10).

SAIP provides support to the children and youth and their families by offering assessment and treatment services. According to the Subsidiary Component Agreement, 80% of time would be intervention service, 15% is on risk reduction, and 5% involves capacity building (p. 4). The objectives of intervention services are:

- alleviate psycho-social impairment and/or trauma-related symptoms
- reduce the likelihood of adverse long-term consequences of child abuse trauma (e.g. depression, substance misuse, etc.)
- manage or reduce problematic behaviours including inappropriate sexual behaviours
- provide specialized treatment services to children with special needs (e.g. children with disabilities) who have been sexually abused
• assist non-offending family members and significant others in supporting children/youth who have experienced sexual abuse
• instil knowledge and skills that reduce the likelihood of future incidents of sexual abuse
• assist the child and/or caregivers to develop an understanding of healthy sexuality, and
• [when] resources permit, build capacity to educate the public and the community on the prevention and early detection of child sexual abuse

(Ministry of Children and Family Development 2008, p. 2).

This chapter summarized the practicum setting with the Sexual Abuse Intervention Program. A description of the North Coast Transition Society was presented. SAIP provides clinical services to children and youth who have been sexually abused and to children under the age of twelve with sexual behavior problems in Prince Rupert, BC and surrounding area. The next chapter examines the basic components in developing a conceptual framework for child sexual abuse.
Chapter 3: Conceptual Definitions

This chapter will present a basic conceptual framework for child sexual abuse. Sexual abuse is defined as “the involvement of a child in a sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared, or else that violates the laws or social taboos of society. Children can be sexually abused by both adults and other children who are—by virtue of their age or stage of development—in a position of responsibility, trust, or power over the victim” (Butchart & Harvey, 2006, p. 10). A focus on child sexual abuse and its effects will be discussed. An introduction to sexual abuse and incest will be presented. The two models of the traumatic impact of child sexual abuse will be examined. Each of the traumagenic dynamics will be described. The purpose of chapter three is to provide fundamental concepts needed to understand and conduct trauma intervention.

Children are the most vulnerable citizens in any society and are the most criminally victimized. Crimes against children happen far too often with children being the victims of multiple kinds of victimization or “poly-victimization” (Finkelhor, 2008, p. 34). Poly-victims are “victim[s] who have experienced several victimizations” (p. 35). There are many distinct forms of child victimization such as child abuse and neglect and child exploitation. For the purpose of discussion here, child maltreatment is defined as:

All forms of physical and/or emotional ill-treatment, sexual abuse, neglect, or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child’s health, survival, development or dignity in the context of a relationship of responsibility, trust or power (Butchart & Harvey, 2006, p. 9). There are five types of child maltreatment: physical abuse, sexual abuse, emotional, neglect, and exposure to intimate partner violence (Lefebvre, Van Wert, Fallon, & Trocmé, 2012, p.
Children suffer the same victimizations that adults do but one characteristic that is different in childhood is dependency (Finkelhor, 2008, p. 27). Violence against children is a complex issue. Children and youth often witness domestic violence in the home and are exposed to community violence. These painful situations are often traumatic.

Clinical intervention in child sexual abuse requires a basic understanding of the phenomenon. The dynamics of child sexual abuse differ from those of adult sexual abuse. Children rarely disclose sexual abuse immediately after the event. Disclosure tends to be a process rather than a single episode and is often initiated by a caregiver following a physical complaint or a change in behaviour. When an adult coerces a child into sexual activity it often progresses through a spectrum of sexually abusive behaviours. The sexual abuse of children often becomes more invasive with time. Child sexual abuse typically occurs as repeated episodes and can occur over many weeks or even years (World Health Organization, 2003, p. 75). The following will explain this range of behavior:

1. Nudity: the adult parades nude around the house in front of all or some of the family members.
2. Disrobing: the adult disrobes in front of the child.
3. Genital exposure: the adult exposes his or her genitals to the child. The perpetrator directs the child’s attention to the genitals.
4. Observation of the child: the adult surreptitiously or overtly watches the child undress, bathe, excrete, and/or urinate.
5. Kissing: the adult kisses the child in a lingering and intimate way.
6. Fondling: the adult fondles the child’s breasts, abdomen, genital area, inner thighs, or buttocks. [The adult coerces the child to fondle the adult].
7. Masturbation: the adult masturbates while the child observes; the adult observes the child masturbating; the adult and child observe each other while masturbating themselves; or the adult and child masturbate each other (mutual masturbation).

8. Fellatio: the adult has the child fellate him or the adult will fellate the child. This type of oral-genital contact requires the child to take a male perpetrator’s penis into his or her mouth or the adult to take the male child’s penis into his or her mouth.

9. Cunnilingus: this type of oral-genital contact requires the child to place mouth and tongue on the vulva or in the vaginal area of an adult female or the adult will place his or mouth on the vulva or in the vaginal area of the female child.

10. Digital (finger) penetration of the anus or rectal opening: this involves penetration of the anus or rectal opening by a finger. Perpetrators may thrust inanimate objects such as crayons or pencils inside as well. Preadolescent children often report a fear about “things being inside them” and “broken”.

11. Penile penetration of the anus or rectal opening: this involves penetration of the anus or rectal opening by a male perpetrator’s penis. A child can often be rectally penetrated without injury due to the flexibility of the child’s rectal opening.

12. Digital (finger) penetration of the vagina: this involves penetration of the vagina by a finger. Inanimate objects may also be inserted.

13. Penile penetration of the vagina: this involves penetration of the vagina by a male perpetrator’s penis.

14. “Dry intercourse”: this is a slang term describing an interaction in which the adult rubs his penis against the child’s genital-rectal area or inner thighs or buttocks (Sgroi, Blick, & Porter, 1982, p. 10-12).
Since physical force is rarely involved in cases of child sexual abuse, definitive signs of genital trauma are seldom seen. Coercion occurs more subtly through manipulation of a power position. Perpetrators usually engage the child in a gradual process of sexualizing the relationship over time (i.e. grooming). Definitive evidence of abuse or sexual contact include “sperm or seminal fluid in, or on, the child’s body; positive culture for [gonorrhea or syphilis] (when perinatal and iatrogenic transmission can be ruled out); intentional, blunt penetrating injury to the vaginal or anal orifice” (World Health Organization, 2003, p. 79). During a medical examination, gross trauma to the genital and/or anal area is easier to diagnose but healed or subtle signs of trauma are more difficult to interpret (p. 78). Physical indicators of child sexual abuse include unexplained genital injury, recurrent vulvovaginitis, vaginal or penile discharge, sleep disturbances, bedwetting and fecal soiling beyond the usual age, anal complaints (e.g. fissures, pain, bleeding), pain on urination, urinary tract infection, sexually transmitted infection, pregnancy (diagnostic in a child below the age of consent), and presence of sperm. These indicators must be used with caution, especially in the absence of a disclosure or a diagnostic physical finding (World Health Organization, 2003, p. 78).

What is Incest?

Incest or familial abuse is probably the most common type of sexual abuse (Friedrich, Beilke, & Urquiza, 1987, p. 393). Incest is defined as “any kind of exploitative sexual contact that occurs between relatives”. Incestuous child sexual abuse encompasses any form of sexual activity between a child and a parent or stepparent or extended family member (grandparent, aunt, or uncle) or surrogate parent (common-law spouse or foster parent) (Sgroi, Blick, & Porter, 1982, p. 10). The most frequently reported type of incest is parental, father-daughter, and the most common form of incest is sexual activity among siblings.
Sibling incest is "a sexual interaction between individuals who have one or both parents in common". Sibling incest typically takes the form of brother-sister interactions. Other types of sibling incest interactions are brother-brother and sister-sister (Loredo, 1982, p. 177).

Any type of exploitative sexual activity that occurs between relatives leads to serious effects later in life (Rudd & Herzberger, 1999, p. 917). Retrospective adult reports of childhood sexual abuse frequently cite chronic depression, anhedonia, and inner deadness (Herman, Russell, Trocki, 1986, p. 1293). Women stated that sexual abuse had substantial lasting effects. Women commonly mentioned negative feelings about men, sex, or themselves. Other complaints included “generalized anxiety and distrust, difficulties in forming or maintaining intimate relationships, and sexual problems” (p. 1295). Incest research suggests specific treatment strategies are necessary especially because of the differing characteristics of each type of abuse i.e. father-daughter incest and brother-sister incest (p. 915).

Incest can be addressed in individual and group therapy. Group therapy can be helpful for sexually abused children to counter elements of secrecy, isolation, and the sense of being different (Lowenstein & Freeman, p. 355). Individual therapy has the potential to replicate some aspects of the isolation experienced during the course of the incest but has still helped many. Group psychotherapy encourages children and youth to break the pattern of isolation. The support of the group can counterbalance the feelings of intense shame, anger, and humiliation (Rudd & Herzberger, 1999, p. 926). One study found father-daughter incest averaged 14.7 years and sibling incest averaged 7.9 years. The sibling-abused women claimed the incest was interrupted when the brother, who was older, left the home. While women who were abused by their fathers, it was the women who had to be the one to leave
the home (p. 920). The length of the abuse continued over two or three developmental phases. The secrecy of the abuse often contains a threat that a child lives in fear for an extended period of time (p. 925). Women who have been sexually abused by their brothers may have even more guilt than father-abused women because of the higher incidence of force and injury (p. 926). The adult survivor often feels betrayed and unprotected by both parents. Basic trust is compromised usually due to frequent parental absence, neglect, and physical abuse. The chaotic family situation puts the woman in a sense of continued fear and crisis. Generally, the family appears “normal” and is accepted by the community. The survivor is often confused when comparing her experience with what her family is presenting to the public. This discrepancy creates further reluctance for the survivor to trust her own judgement as well as to build trust with others.

Children who have suffered sexual abuse may experience a wide range of emotional and/or behavioural reactions that can be divided into several general categories. Trauma symptoms refer to behavioural, cognitive, physical, and/or emotional difficulties that are directly related to the traumatic experience (Cohen, Mannarino, & Deblinger, 2006, p. 5). Children typically exhibit symptoms of post-traumatic stress disorder (PTSD). Features that distinguish traumatic events include the following: death or threat to life or body integrity, and/or the subjective feeling of intense terror, horror, or helplessness (American Psychiatric Association, 2000, p. 463). A child’s response will depend on his/her age and developmental level (Cohen et al., 2006, p. 3).

**Impact of Sexual Abuse on Children**

There are a wide variety of symptoms and pathological behaviours in children who have been sexually abused. The two symptoms that have commonly appeared in research are
PTSD and sexualized behaviour. Age and a variety of abuse-related factors can affect both the nature and the severity of symptoms. Some child victims have no apparent symptoms (Kendall-Tackett, Williams, & Finkelhor, 1993, p. 173). The impact of sexual abuse is complicated because it “produces multifaceted effects” (p. 174). The abusive acts themselves and the contribution of familial and environmental conditions play a role in traumatization (p. 175).

Sexualized behaviour in sexually abused children is difficult to determine. The concept when studied has sometimes been called “inappropriate sexual behaviour”, “sexual acting out”, or “intrusive sexual behaviours” (Kendall-Tackett, Williams, & Finkelhor, 1993, p. 173). Sexualization is not a symptom that occurs only in sexually abused children. Physically abused children also exhibited sexually inappropriate behaviour (p. 173). Nonsexually abused children may also be sexualized. A large number of children engage in sexual activities prior to puberty and these experiences are often with those who are in close contact with one another such as with brothers and sisters (Finkelhor, 1980, p. 172). Children with sexual behavior problems (SBP) “can range widely in their degree of severity and potential harm to other children”. Children with SBP are at low risk to commit future sex offenses if provided with appropriate treatment. In fact, “children with SBP may be at equal or greater risk for becoming future sexual abuse victims as sexual abuse perpetrators” (Chaffin, Berliner, Block, Johnson, Friedrich, Louis, Lyon, Page, Prescott, Silovsky, & Madden, 2008, p. 200).

Many children may suffer symptoms that are explained by the PTSD model however PTSD is not universal to sexual abuse (Kendall-Tackett et al., 1993, p. 174). A conceptual model of the traumatic impact of child sexual abuse called the Traumagenic Dynamics
Model of Child Sexual Abuse is complex with a variety of different mechanisms posited. There has been little research to confirm the model due to the difficulty of clearly delineating and measuring the variety of different dynamics (p. 175).

**Traumatic Impact of Child Sexual Abuse**

This section examines the two models of the traumatic impact of child sexual abuse: the Posttraumatic Stress Disorder and the Four Traumagenic Dynamics Model. According to Finkelhor (1987) there are limitations in using the PTSD formulation for sexual abuse. A PTSD formulation “does not adequately account for all the symptoms ... it accurately applies only to some of the victims ... and it does not truly present a theory that explains how the dynamics of sexual abuse lead to the symptoms noted” (p. 350).

In May, 2013 the American Psychiatric Association released the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorder* (5). There were changes made to the diagnostic criteria of Posttraumatic Stress Disorder. Diagnostic criteria for PTSD explicitly states how an individual experiences a traumatic event: “exposure to actual or threatened death, serious injury, or sexual violence” in Criterion A. There are now four symptom clusters and two distinct clusters of intrusive symptoms, with avoidance of stimuli associated with the traumatic event(s). A new category is negative alterations in cognitions and mood. A separate criteria for children age 6 years or younger has been added. The DSM-IV diagnostic criteria for PTSD was scrutinized because it was designed for adults. Assessment of young children needs to take into account their limited verbal skills and different ways of reacting to stress. Children may not be able to express signs of numbing and withdrawal. Flashbacks or intrusive thoughts can be in the form of play re-enactment (Balaban, 2009, p. 63). Please refer to Appendix 1 for diagnostic criteria for posttraumatic stress disorder.
The Traumagenic Dynamics Model suggests sexual abuse traumatizes children through four distinctive types of mechanisms: 1) traumatic sexualization; 2) betrayal; 3) powerlessness; and 4) stigmatization. A traumagenic dynamic "is an experience that alters a child's cognitive or emotional orientation to the world and causes trauma by distorting the child's self-concept, worldview, or affective capacities (p. 354). Traumatic sexualization refers "to the conditions in sexual abuse under which a child's sexuality is shaped in developmentally inappropriate and interpersonally dysfunctional ways" (Finkelhor, 1987, p. 355). In the second dynamic, "children discover that someone on whom they were vitally dependent has caused them or wishes to cause them harm." (p. 356). A child realizes he or she was betrayed by being tricked into a sexual activity through the use of lies or misrepresentations. The closeness of the relationship between the offender and the child is a main component of betrayal. Another element is "how taken-in the child feels by the offender regardless of who the offender is." (p. 356). Please refer to Appendix 2 for a detailed description of the traumatic dynamics in the impact of child sexual abuse.

The article, "The Making of a Whore" by Diana H. Russell (1995) describes the range of symptomatic behaviour of an incest survivor who was abused by her grandfather between the ages of four and twelve when her family would visit her grandparents during holidays two or three times a year for two weeks at a time. The article is a personal account of "Lara", a 23-year old who was groomed by her grandfather for this role: "I've been trained to be a whore. I know all the tricks of the trade ... my grandfather made me pose in seductive poses. It's like being a circus animal. If you train them hard enough, they'll remember what they have to do" (p. 87). The incestuous acts taken upon Lara would occur every day or every
second day -- and sometimes twice a day with a break of one year when her grandfather moved.

The sodomy was the most painful thing he did. I think the vaginal penetration was only partial while he did full anal penetration, which is why it hurt so much more. I remember quite a lot of blood. (p. 78). I remember the burning sensation ... I used to have vaginal infections (p.84). When I was about five years old, I had an operation that my mom subsequently told me was to have my urethra widened. I thought - and still do - that my grandfather had hurt me so badly that the doctors had to repair my vagina (p. 79).

Children’s self-concept, worldview, and affective capacities are distorted from the sexual abuse trauma (Finkelhor, 1987, p. 348). Incest victims often internalize the beliefs that they are dirty, “spoiled goods”, and/or worthless and that they are responsible for the abuse (Russell, 1995, p. 95).

But the real me inside thinks it was my fault. I have a feeling of guilt, of being naughty. It must have been something about me — something about the way I sat, something I did — that made my grandfather rape and abuse me (p. 92).

Several distinct processes combine to contribute to traumatic sexualization.

1. Sexually abused children are often rewarded, by offenders, for sexual behavior that is inappropriate to their level of development.

2. Because of the rewards, sexually abused children learn to use sexual behavior, appropriate or inappropriate, as a strategy for manipulating others to get their needs met.
3. Because of the attention they receive, certain parts of sexually abused children’s anatomy becomes fetishized and given distorted importance and meaning.

4. Children become confused and acquire outright misconceptions about sexual behavior and sexual morality as a result of things that offenders tell them or ways that offenders behave.

5. Finally, a child’s sexuality can become traumatized when frightening and unpleasant memories become associated in the child’s mind with sexual activity (p. 355 & 356).

This affirms the child’s feelings of “badness”. The incestuous abuse impacted Lara’s relationship with her mother:

… All my feelings center around my mother. I hate her more than I hate my grandfather (p. 88) … I think my mother does believe me, but she doesn’t want to believe me because she absolutely worshipped her father (p. 84). So even though what he did to me was so revolting – and this is where I have a lot of conflict – I started liking it. He made me feel good in some ways and bad in others (p. 81).

Another notable resource that helped to develop my conceptual tools was Liza Potvin’s (1992) book, White Lies (for my mother). It is a non-fiction book about memories of sexual abuse by her father and grandfather. The author explores memories using a diary style format of how the abuse impacted her relationship with her mother. It is crucially important to understand the problem of sexual abuse and its traumatic basis. It is essential that the type, nature, and duration of trauma be assessed in children. Traumatized children have high rates of comorbidity. Assessing children requires input from several informants. Careful screening and assessment need to consider the interpersonal, social, and cultural contexts in which child assessments take place (Balaban, 2009, p. 77).
Guidelines for Child Sexual Abuse

The following are guidelines that underlie best practice treatment decisions with cases of child sexual abuse:

1. Child sexual abuse is a historical event in a child’s life, not a disorder to be treated.
2. The term child sexual abuse encompasses a highly diverse set of sexual victimization experiences that carry varying levels of risk for different mental health problems.
3. Child sexual abuse victims may exhibit problems that vary widely in their nature and intensity from victim to victim.
4. A history of child sexual abuse increases the risk of the victim developing certain serious mental health problems.
5. The increase in risk can be low, moderate or large depending on the abuse situation and the mental health outcome.
6. Specific victim, sexual assault incident, and family and community response characteristics are associated with a greater likelihood of various mental health disorders.
7. A large proportion of sexually abused children also have experienced other types of serious victimizations, violence, and traumatic life events.
8. Older sexually abused children are more likely to have a history of polyvictimization.
9. Sexually abused children often have comorbid mental health problems.
10. Children who have experienced multiple types of victimization, violence, and trauma are more likely to have comorbid mental health problems.
11. Because of the prevalence of polyvictimization, children should not be labeled by the emergent report of sexual abuse.
12. Because of the prevalence of polyvictimization and other possible etiological factors, mental health problems should not automatically be attributed to sexual abuse.

13. Case formulation and subsequent treatment should incorporate the child’s complete history and presentation and not focus exclusively on sexual abuse.

14. Most sexually abused children need effective, evidence-based mental health services to treat and/or prevent the development of serious mental health problems.


16. Some sexually abuse children are highly resilient and will not develop clinically meaningful mental health problems.

17. Some children will initially develop problems related to sexual abuse, but will recover in a timely manner using their own coping abilities and support from family and friends.

18. Some children do not improve and a small proportion will get worse even when best practice treatment is used.

19. The personal, familial, social, and financial costs need to be considered, as well as the potential clinical benefits and risks when recommending mental health treatment for sexually abused children (Saunders, 2012, p. 181 & 182).

Practice Principles for Treating Children with Posttraumatic Stress Disorder

Ford and Cloitre (2009) suggest several practical, therapeutic, and ethical considerations when working clinically with children with complex traumatic stress disorders. The seven protocols that need selection, adaptation, and successful deployment are:

1. Identifying and addressing threats to the child’s or family’s safety and stability.
2. A relational bridge must be developed to engage, retain, and maximally benefit the child and caregiver(s).

3. Diagnosis, treatment planning, and outcome monitoring are always relational.

4. Diagnosis, treatment planning, and outcome monitoring are always strength-based.

5. All phases of treatment should aim to enhance self-regulation competencies.
   a. Emotion regulation
   b. Attention, memory, decision making (information processing)
   c. Self-regulation of consciousness and motivation.
   e. Relational self-regulation

6. Determining with whom, when, and how to address traumatic memories.

7. Preventing and managing relational discontinuities and psychosocial crises (p. 67-77).

This chapter presented the two models of the traumatic impact of child sexual abuse: Posttraumatic Stress Disorder and the Four Traumagenic Dynamics Model. This section oriented the reader to the basic conceptual framework for child sexual abuse. Sexual victimization has been shown to contribute to significant immediate and long-term psychological distress and functional impairment. Chapter 4 introduces complex trauma and clinical considerations when conducting a thorough assessment with children who have been sexually abused and children with sexual behaviour problems.
Chapter 4: Literature Review

In this section, an examination of the incidence of reported child maltreatment will be presented. According to the Canadian Incidence Study of Reported Child Abuse and Neglect (CIS-2008) there were 10,173 allegations of sexual abuse in 2008. Some of these children will have experienced symptoms of post-traumatic stress disorder (PTSD) but occasionally the traumatic impact is often greater. Children who have experienced multiple forms of trauma or who have long-term trauma histories are then exposed to complex trauma. A description of complex trauma will be presented. The following will provide one of the components of conducting a thorough assessment: completing standardized assessment measures. The use of standardized assessment measures helps the clinician gather information about specific domains from different reporters’ perspectives (Chadwick Center for Children and Families, 2009, p. 21). An exploration of children with sexual behaviour problems will be discussed. This chapter contains details of the Child Sexual Behavior Inventory (CSBI).

Sexual Abuse of Children in Canada

The 2008 Canadian Incidence Study of Reported Child Abuse and Neglect (CIS-2008) is the third nation-wide study to examine the incidence of reported child maltreatment and the characteristics of the children and families investigated by child welfare. The Public Health Agency of Canada (PHAC) oversees the CIS program in conjunction with other national programs such as unintentional injury, perinatal health, and chronic and infectious diseases. All thirteen provinces and territories participated in the study. The first and second CIS was released in 1998 and 2003. In 1998, the CIS used a sample of 7,672 and in 2003 the sample size was 14,200 of child maltreatment investigations. The CIS-2008 tracked 15,980
child maltreatment investigations conducted in a representative sample of 112 Child Welfare Service organizations across Canada in the fall of 2008. The age range of children included in the sample is children between newborn and 15 years of age (p. 50). In Canada, there were an estimated 174,411 maltreatment investigations conducted in 2008; of these investigations 10,173 focused on an allegation of sexual abuse as the primary form of maltreatment.

For maltreatment investigations, information was collected regarding the primary form of maltreatment investigated as well as the level of substantiation for that maltreatment. Thirty-two forms of maltreatment were listed on the data collection instrument, and these were collapsed into five broad categories of physical abuse, sexual abuse, neglect, emotional maltreatment, and exposure to intimate partner violence (Lefebvre, Van Wert, Fallon, & Trocme, 2012, p. 1).

The Canadian Incidence Study states sexual abuse is when a “child has been sexually molested or sexually exploited this includes oral, vaginal or anal sexual activity, attempted sexual activity, sexual touching or fondling, exposure, voyeurism, involvement in prostitution or pornography, and verbal sexual harassment” (p. 65).

The outcomes of maltreatment investigations are classified into three levels of substantiation: 1) substantiated (the balance of evidence indicates abuse or neglect has occurred); 2) suspected (insufficient evidence to substantiate abuse or neglect, but maltreatment cannot be ruled out; 3) unfounded (the balance of evidence indicates that abuse or neglect has not occurred. Unfounded does not mean that a referral was inappropriate or malicious; it simply indicates that the worker determined that the child has not been maltreated (p. 24).
Findings indicate that 26% of sexual abuse investigations (2,607) were substantiated, 14% were suspected (1,452), and 60% were unfounded (6,114). The primary form of investigated sexual abuse by level of substantiation is: an estimated 524 investigations involved allegations of penetration (53% of these investigations were substantiated, 12% suspected, and 35% unfounded); an estimated 304 investigations for oral sex (42% were substantiated); an estimated 3,713 investigations were for fondling (34% of these cases were substantiated, 9% were suspected, and 57% were unfounded); an estimated 441 investigations of sex talk or images (33% substantiated) and other sexual abuse involved 3,772 investigations with 9% of investigations substantiated (Lefebvre, Van Wert, Fallon, & Trocmé, 2012, p. 2).

**Defining and Understanding Complex Trauma**

A clear definition of psychological trauma has been difficult to define in the trauma field. The word trauma originates from the ancient Greek word for “injury” or “wound” (Ford & Courtois, 2009, p. 14). A traumatic event is identified as one in which an individual experiences a threat (actual or perceived) of death or serious injury to self or others, with a response of “intense fear, helplessness or horror.” It is not the event itself, but the meaning it has for the individual that makes it traumatic. The closer the relationship between the perpetrator(s) and victim(s) and their group memberships (e.g. in a family, religion, gender), the more likely they are to face conditions of divided loyalty. As a self-protective strategy some groups might join in silencing, secrecy, and denial. As a result, victims do not receive the help they expect and need when the victimization is disclosed. This is referred to as the second injury or betrayal trauma (p. 18). A lack of response, protection, or victim blaming is betrayal of the victim’s trust. Young children exposed to betrayal trauma by caregivers often develop a “disorganized/dissociative” attachment style in childhood and an adult attachment style described as “fearful/avoidant/dissociative” (p. 18).
Survivors of complex trauma are likely to experience the following problems: affect dysregulation, structural dissociation, somatic dysregulation, impaired self-development, and disorganized attachment patterns (Ford & Courtois, 2009, p. 13). Complex traumatic stress disorder is associated with histories of multiple traumatic stressors and experiences, along with severe disturbances in primary caregiver relationships (Ford & Courtois, 2009, p. 18).

There are two types of traumatic events. Type I is single-incident trauma (e.g. an event that is "out of the blue" and thus unexpected, such as a traumatic accident or a natural disaster, a terrorist attack, a single episode of abuse or assault, witnessing violence) and Type II is complex or repetitive trauma (e.g. ongoing abuse, domestic violence, community violence, war, or genocide) (Ford & Courtois, 2009, p. 15).

Ford and Courtois (2009) define complex psychological trauma as "exposure to severe stressors that 1) are repetitive or prolonged; 2) involve harm or abandonment by caregivers or other ostensibly responsible adults; 3) occur at developmentally vulnerable times in the victim’s life, such as early childhood or adolescence" (p. 13). Complex traumatic stress disorders also routinely include a combination of other Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) Axis I and Axis II disorders and symptoms (p. 18). The DSM-5 has changed the recording of conditions by using one list for all mental disorders instead of having a multi-axial system. The five axes have been eliminated. The format is a single level of recording procedure (American Psychiatric Association, 2013).

**Standardized Instruments**

A review of the literature suggests having a broader understanding of the child’s life. Therapists can utilize a standardized format that investigates a wide variety of childhood traumatic experiences (Cohen et al., 2006, p. 20). A brief description of two instruments is
presented. The first is a self-report measure for children. The Trauma Symptom Checklist for Children (TSCC) evaluates “children who have experienced traumatic events, including childhood physical and sexual abuse, victimization by peers (physical or sexual assault), major losses, the witnessing of violence done to others, and natural disasters” (Briere, 1996, p. 1). The TSCC evaluates symptoms in children ages 8-16 years old. The full TSCC is a 54-item test that includes 10 items on sexual symptoms and preoccupation. It has two validity scales (Underresponse and Hyperresponse) and six clinical scales: Anxiety, Depression, Anger, Posttraumatic Stress, Sexual Concerns (with two subscales), and Dissociation (with two subscales) (Briere & Spinazzola, 2009, p. 109). A child writes his or her response in a test booklet.

The child is presented with a list of thoughts, feelings, and behaviours, and asked to mark how often each of these things happens to him or her. Each item is rated on a 4-point scale anchored at 0 (never) and 3 (almost all of the time). The full TSCC requires 15 to 20 minutes to complete for most children and can be scored and profiled in approximately 5 to 10 minutes (Briere, 1996, p. 3).

The Trauma Symptom Checklist for Young Children (TSCYC) is a parent/caretaker report of trauma symptoms in children ages 3 to 12 years (Briere & Spinazzola, 2009, p. 109). There are two parent report validity scales: 1) Response Level (RL) and 2) Atypical Response (ATR) and an item evaluating how many hours a week the parent/caretaker spends with the child (Briere, 1996, p. 5). There are 90-items that are normed separately for males and females and in three age groups: 1) 3-4 years, 2) 5-9 years, and 3) 10-12 years. Parents rate each symptom on a 4-point scale according to how often it has occurred in the previous month (p. 4).
According to Foa, Keane, Friedman, and Cohen (2009), there are several clinical considerations therapists need in deciding the course of treatment for PTSD. The therapist must decide what are the goals for therapy. Some treatments “target PTSD symptom reduction … [others] emphasize the capacity to enrich the therapeutic process rather than the ability to improve directly PTSD symptoms … [and some] emphasize functional improvement, with or without reduction of PTSD symptoms” (p. 8). Good clinical practice assesses and monitors both PTSD and comorbid symptoms. Some comorbid disorders such as substance abuse can complicate treatment and in some cases exacerbate PTSD. A careful evaluation of current suicidal ideation and past history of suicidal attempts are segments of clinical management. Children and youth differ greatly in “… symptom severity, chronicity, complexity, comorbidity, associated symptoms, and functional impairment” (p. 8-10). These differences affect both choice of treatment and clinical goals.

**Children with Sexual Behaviour Problems**

Sexual behaviour problems are a set of behaviors outside of acceptable societal limits. Intrusive or coercive sexual behaviours are persistent and developmentally atypical (Letourneau, Chapman, & Schoenwald, 2008, p. 134). Children with sexual behavior problems are children ages 12 and younger “… who demonstrate developmentally inappropriate or aggressive sexual behavior” (Friedrich, 2007, p. 9). Sexual intrusiveness is defined as “violation of another person’s sexual privacy” (Friedrich, 1997, p. 1). Intrusive sexual behavior refers to “behavior that involves others, including animals, other children, or adults” (Friedrich, 2007, p. 9). The intentions or motivations for these behaviors may be related to curiosity, anxiety, imitation, attention seeking, self-calming, or other reasons. These behaviours may or may not be related to sexual gratification or sexual stimulation.
Children with sexual behavior problems often initiate behaviors involving sexual body parts (i.e. genitals, anus, buttocks, or breasts) that are developmentally inappropriate or potentially harmful to themselves or others" (Chaffin et al, 2008, p. 200). Sexual behaviour problems “occur with unexpected frequency, occur in coercive contexts or between older and younger children, have been resistant to caregiver intervention, interfered with the child’s development and/or were associated with emotional distress by the child” (Letourneau et al, 2008, p. 134).

Normal childhood sexual play and exploration is “behavior that occurs spontaneously, intermittently, is mutual and non coercive when it involves other children” (Chaffin et al., 2008, p. 2001). Johnson (2002) has identified a continuum of sexual behaviours in children. There are four groups of children along this continuum of sexual behaviours. One group consists of children who engage in natural and healthy sexual behaviours and the other three groups consist of children with sexual behaviour problems. The three groups of children with sexual behaviour problems are: 1) sexually-reactive children; 2) children who engage in extensive, mutual sexual behaviours; and 3) children who molest other children (p. 91-102). Each group will be defined.

A greater understanding can distinguish when the sexual behaviour is abusive and when it is less serious and not intended to harm. This will assist in a more accurate assessment and treatment planning (p. 84). There have been numerous misconceptions about children twelve years and younger who molested other children. It was previously believed that the primary etiological factor for molesting behaviour was the child has been sexually abused and that it was likely that he/she will go on to molest others (p. 85).
It is important to counteract this belief in professionals, as some may influence children who molest to make a disclosure of sexual abuse where there has been none. Children may believe that there is only one acceptable explanation for their molesting behavior and move to satisfy the belief of the therapist by fabricating a history of sexual abuse. It is also important that children themselves do not believe that, if they were molested, this is the sole reason for their molesting behavior (p. 86).

Children with sexual behaviour problems might feel less competent to stop from engaging in sexually intrusive behaviours because they might think this is the only reason why they have sexually aggressive feelings and behaviours. Research indicates that the majority of sexually abused children do not engage in worrisome sexual behaviors and sexually abusive behaviors (p. 88).

Children involved in healthy sexual play are of similar age, size, and developmental status. Children participate on a voluntary basis of sexual exploration. Children gather information by exploring each other’s bodies by looking and touching as well as exploring gender roles and behaviours. Most sexual play is “between children who have an ongoing, mutually enjoyable play and/or school friendship”. Healthy sexual exploration is limited in type and frequency. Sexual behaviours are balanced by curiosity about other aspects of a young person’s life. It occurs at several periods which may result in embarrassment “... but does not usually result in deep feelings of anger, shame, fear, or anxiety”.

Children’s feelings regarding their sexual behavior are generally light-hearted and spontaneous. Children usually experience pleasurable sensations from genital touching. Some children experience sexual arousal while some children experience
orgasm. Sexual arousal and orgasm are reported more frequently in older children entering puberty (Johnson, 2002, p. 92).

Sexually-reactive children exhibit self-stimulating and/or sexual behaviours with other children and sometimes with adults. These children do not coerce others into sexual behaviours. There is no intent to hurt others. The sexual behaviour is "a response to environmental cues that are overly stimulating or reminiscent of previous abuse or to feelings that reawaken other traumatic or painful memories". Most of these children have not been guarded from adult or adolescent sexuality. These children live in sexually overwhelming environments, which causes confusion and anxiety. Engaging in sexual behaviour is a way of coping with overwhelming feelings. Behaviours may be compulsive so tension can be released and often it is not within the full conscious control of the child. Children who display sexually-reactive behaviour are "... trying to make sense of something sexual done to them by doing it to someone else" (Johnson, 2002, p. 92). Many of these children do not understand their own or others' rights to privacy or physical space (p. 93). They also do not receive clear messages about unacceptable sexual contact. Another factor that may encourage this behaviour is repressed sexual abuse (p. 95).

Almost all of these children have been sexually and emotionally abused and neglected. They relate best to other children by connecting with similarly lonely children who will engage in sexual behaviors with them. These children look to other children to help meet their emotional needs and their need for physical contact. Children who engage in extensive, mutual sexual behaviours use "sex as a way to cope with their feelings of abandonment, hurt, sadness, anxiety, and often despair". Children in this group were previously sexually-reactive children. They become confused and overwhelmed by the overt
and covert sexuality to which they are exposed and use sex as a coping mechanism. These children are often distrustful. The pain, despair, disillusionment, and lack of adult attachment figures causes them to use sexual behaviour as a way of coping with their feelings (Johnson, 2002, p. 98).

Children who have inappropriate or aggressive sexual behavior use some type of coercion such as bribery, trickery, manipulation, or emotional or physical intimidation to get other children to participate in sexual behaviours. Aggressive sexual behaviors are “forcing other children to engage in sex acts, planning how to touch other children sexually, persisting in sexual behavior after being told not to, and inserting a finger or objects into another child’s vagina or rectum” (Friedrich, 2007, p. 10). Please refer to the Child Sexual Behavior Inventory for more information. Sexual behaviours are frequent and pervasive with an impulsive and aggressive quality. The victims can be younger, the same age, or older. They are selected due to vulnerabilities, including developmental delays, social isolation, and emotional neediness. There is an intense sexual confusion of children in this category due to the many adversities in their lives. Children who have aggressive sexual behavior have a history of abuse and neglect. Emotional, physical, and sexual violence is associated with all aspects of the child’s family life (Johnson, 2002, p. 100).

Child Sexual Behavior Inventory (CSBI)

According to Johnson (2006) it is important to assess family boundaries as possible contributors to the development of problematic sexual behaviours in children (p. 113). An instrument that can assist the clinician in determining if boundary problems are present is the Child Sexual Behavior Inventory (CSBI) (Briere & Spinazzola, 2009, p.110). The CSBI-3 is a 38-item behavior checklist assessing sexual behaviors in children two to twelve years old.
during the past six months. The first two versions of the CSBI were developed in 1991 and 1993. Both versions demonstrated adequate reliability and validity.

The CSBI-3 contained 22 of the CSBI-2 items, and all remaining items were reworded for easier readability (e.g. Item 18 was changed from “inserts or tries to insert objects in vagina/anus to “puts objects in vagina or rectum”) and greater specificity and clarity (e.g. “touches people’s sex (private) parts” to “touches another child’s sex (private) parts” and “touches an adult’s sex (private) parts”) (Friedrich, Fisher, Dittner, Acton, Berliner, Butler, Damon, Davies, Gray, & Wright, 2001, p. 38).

The CSBI-3 is a reliable and valid indicator of sexual behavior that can be used during sexual abuse evaluations (Friedrich et al., 2001, p. 46). It should never be used in isolation. This instrument measures nine domains that are associated with childhood sexual abuse: boundary problems, exhibitionism, gender role behaviour, self-stimulation, sexual anxiety, sexual interest, sexual intrusiveness, sexual knowledge, and voyeuristic behaviour. The CSBI yields a total score and two scale scores: Developmentally Related Sexual Behaviour which reflects the level of age and gender-appropriate sexual behaviour and Sexual Abuse-Specific Items which comprises items that have been empirically related to a history of sexual abuse (Briere & Spinazzola, 2009, p. 110).

This chapter discussed the use of standardized assessment measures for child sexual abuse assessments. A description of three standardized assessments was included: the Trauma Symptom Checklist for Children, the Trauma Symptom Checklist for Young Children, and the Child Sexual Behavior Inventory. The CIS-2008 provided an understanding of reported child sexual abuse that is investigated by child welfare agencies in Canada. In
Chapter 5 I highlight the main activities during my practicum experience. I strived to create a system of the most beneficial assessment measures for the program. I focused on conducting structured in-depth interviews and using components of trauma-focused cognitive behavioral therapy.
Chapter 5: Practicum Activities

This section deals with current best practices in treatment of children and youth with symptoms associated with trauma exposure. A description of what clinical social work will be provided. A description of trauma-focused cognitive behavioral therapy (TF-CBT) will be included. There are ten components of TF-CBT. I will provide a brief account of the psychoeducation component.

Clinical Social Work

The social work practicum offers a unique opportunity to expand knowledge and develop skills as a clinical social worker. Clinical social work is:

the professional application of social work theory and methods to the treatment and prevention of psychosocial dysfunction, disability, or impairment, including emotional and mental disorders (Barker, 2003, p. 76).

Social workers offer a critical link between the client and the mental health team. The practitioner has familiarity with the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (American Psychiatric Association, 2013). Clinical social workers create psychosocial assessments, formulate goals, and provide psychotherapeutic interventions or treatment. The work a clinical social worker does is called psychotherapy. It is defined as the "specialized formal interaction between social worker or other mental health professional and a client (an individual, couple, family, or group) in which a therapeutic relationship is established to help resolve symptoms of mental disorder, psychosocial stress, relationship problems, and difficulties in coping in the social environment". An example of a specific type of psychotherapy is cognitive therapy (Barker, 2003, p. 349). Cognitive theory has been combined with behavioural approaches, which then became cognitive behavioural therapy.
I obtained a copy of the Prince George SAIP - Surpassing Our Survival (S.O.S Society) intake assessment form. I analyzed three clinical practice guidelines developed by the American Academy of Child and Adolescent Psychiatry: *Posttraumatic Stress Disorder, Forensic Evaluation for Children and Adolescents Who May Have Been Physically or Sexually Abused, and Children and Adolescents Who Are Sexually Abusive of Others*. I reviewed and adapted the S.O.S intake assessment form to fit the Prince Rupert SAIP office. The existing SAIP forms were included in the new format. I expanded on the information that is needed for a comprehensive assessment. I also included additional items for the clinical interview that would help with case conceptualization and treatment planning. The purpose of the revised assessment forms is to aid and guide the clinician in the interview process and to document information. The result was an intake/referral/assessment form that can be used as a guideline for completing assessments. Please refer to Appendix 3 for Assessment Template.

I used components of the Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) model with clients of the Sexual Abuse Intervention Program. For the duration of the practicum I worked with three adolescent female clients. I began working with my first client on March 20, 2013. A total of 24 hours were documented with six hours being direct service. There were five sessions documented with each being one hour either in the school or in the community. The majority of time was spent obtaining collateral information by interviewing other professionals that had current or past involvement with the client. My last session with this client was on May 28, 2013. Sessions stopped due to the client being accepted to a youth treatment centre for substance abuse. Subsequently the file was closed. I met with the second client on March 27, 2013 at her school. I had one home visit with her mother. I saw this
client weekly for ten sessions for a total of 18.5 direct service hours and 20 hours in total. I started working with my third client on April 13, 2013. I met with the client and caregiver at the Raven Keep Transition House “quiet room” on Saturdays. Sessions averaged 2.5 hours with the last session on May 25, 2013. For the entire practicum I spent a total of 60 hours and 40.5 hours were direct service hours with clients.

Other activities included attending three days of Infant Mental Health training, two days completing a First Aid course, 10 hours completing the Domestic Violence Safety Planning online course, one day of Technology Training, half-day in Terrace, BC at Dr. Matè’s presentation on “Biology of Loss”, completing Foundations in Violence online course which included a three day workshop at the Crest Hotel in Prince Rupert, BC. I also attended a webinar titled, “Prevention and Treatment Interventions for Traumatized Children: Restoring Capacities for Self-Regulation”, presented by Julian Ford, PhD. I completed the web-based learning course, TF-CBT Web, by the National Child Traumatic Stress Network and used the book: “Treating Trauma and Traumatic Grief in Children and Adolescents” by Judith A. Cohen, Anthony P. Mannarino, and Esther Deblinger (2006) as a guide/manual during my work with clients.

Activities I observed during my practicum included the North Coast Transition Society Open House, workshop presented at the high school titled “Understanding Consent”, two program and staff meetings, and three Sexual Assault Protocol sub-committee meetings. I also had a meeting with the Community-based Victim Support Services worker. On April 15, 2013 and May 27, 2013, I was present for two court hearings to observe court proceedings and I also participated in eight clinical supervision sessions. Discussions during
supervision comprised of how “accurate and timely assessment of posttraumatic stress disorder symptoms in children is important” (Balaban, 2009, p. 62).

**Assessment**

A comprehensive assessment incorporates use of standardized assessment instruments such as *Trauma Symptom Checklist for Young Children* (Briere, 1996) and *Trauma Symptom Checklist for Children* (Briere, 1996) and interviews from a number of sources (Sands, 2001, p. 83). I administered the TSCC and hand-scored two answer sheets. I became familiar with and used the Trauma Symptom Checklist for Children and Child Sexual Behavior Inventory.

**Trauma-Focused Cognitive Behavioral Therapy**

The following will describe the use of trauma-focused cognitive behavioral therapy (TF-CBT) with children who experienced sexual abuse. TF-CBT is an evidence-based treatment approach that integrates elements from cognitive, behavioral, and family therapy, and attachment, humanistic, and empowerment models. It is a components-based model of psychotherapy with “individual sessions for the child and for the parents or caregiver, as well as joint parent-child sessions” (National Child Traumatic Stress Network, 2004, p. 8). Each session is designed to build the therapeutic relationship while providing education, skills, and a safe environment to address and process traumatic memories.

TF-CBT is a model of psychotherapy that combines trauma-sensitive interventions with cognitive behavioural therapy. TF-CBT is an individual treatment approach appropriate for children ages 3 to 18 that have experienced a traumatic life event. The event may be singular or multiple traumas. It is used with both male and female clients. TF-CBT is designed to be short-term treatment typically 12 to 16 sessions or once a week for 12 to 16 weeks. Each session is between 60 to 90 minutes. Treatment can be provided for longer
periods depending on the needs of the child and family. This model can be used with children with challenging clinical presentations and complex family situations such as significant behavioural or emotional problems. TF-CBT is not appropriate for children and adolescents who have a history of running away, serious cutting behaviours, or engaging in other parasuicidal behaviour. TF-CBT is contraindicated for children who are acutely suicidal or who actively abuse substances. Interventions aimed at enhancing affective regulation and stress reduction are recommended until the child has become more stabilized. Creating the trauma narrative may worsen suicidal ideation in children that are particularly fragile (Cohen, Mannarino, & Deblinger, 2006, p. 22). Children with significant conduct problems that existed prior to the trauma may respond better to an approach that focuses on the primary behavioural problem (Child Welfare Information Gateway, 2012, p. 6).

It is recommended that therapists take the free TF-CBT online training course available at www.musc.edu/tfcbt (Cohen, Mannarino, & Deblinger, 2006, p. ix). After completing the 10-hour online training therapists receive a printable certificate of completion worth 10 Continuing Education Unit (CEU) credits. Judith Cohen, Anthony Mannarino, and Esther Deblinger (2006) developed a treatment manual in the form of a book titled: Treating Trauma and Traumatic Grief in Children and Adolescents that describes the 10 specific components of TF-CBT.

The concepts and components of TF-CBT will be introduced. There are six core values of TF-CBT model. It can be summarized by the acronym CRAFTS:

- **Components based**
- **Respectful of cultural values**
- **Adaptable and flexible**
• Family focused

• Therapeutic relationship is central

• Self-efficacy is emphasized

The components-based treatment include psychoeducation, parenting skills, relaxation, affective expression and modulation, cognitive coping and processing I, trauma narrative, cognitive coping and processing II (processing the traumatic experience), in vivo mastery, conjoint child-parent sessions, and enhancing future safety (Cohen, Mannarino, & Deblinger, 2006, p. xiv & xv). TF-CBT components can be summarized by the acronym PRACTICE. Components are interrelated by emphasizing a set of skills that progressively build on previously consolidated skills. Therapists work with the child and parent in deciding the best way to implement the core components for their family. In implementing the core components adaptability is crucial. To work effectively it is essential to have respect for individual, family, religious, community, and cultural values. In this approach the therapist’s clinical judgment and creativity is highly valued. The most important feature is having family involvement in treatment. TF-CBT incorporates individual child and parent sessions as well as conjoint sessions (p. 35). Traumatized children need to develop and maintain a trusting, accepting, and empathic relationship with their therapist. The therapeutic relationship is central to restoring trust, optimism, and self-esteem in traumatized children. A sensitive reflective approach throughout the assessment and treatment phase is important to both client and practitioner. It is vital to develop a trusting compassionate relationship. TF-CBT aims to provide children, parents, and families with skills so they continue to grow long after therapy has ended. Self-efficacy skills include self-regulation of affect, behaviour, and cognitions (p. 33).
Psychoeducation is a major component of TF-CBT. It is introduced at the outset of treatment and continues throughout the therapy process with both the child and parent. There are two goals of psychoeducation:

1. To normalize both the child’s and parent’s response to the sexual abuse; and
2. To reinforce accurate cognitions about what occurred.

Psychoeducation begins at the initial intake telephone call. According to SAIP Standards (2008) all referrals “... are screened for the purposes of determining eligibility, the nature and severity of presenting problems, and the urgency of service need” (p. 13). Intake procedures in a community setting such as SAIP may include a trauma screen such as the UCLA PTSD Index to the usual intake process (National Child Traumatic Stress Network, 2004, p. 28). As the parent or caretaker describes the traumatic event/sexual abuse, the child’s reaction to the sexual abuse, and his/her own responses, the clinician will be supportive and normalize both the child’s and parent’s responses. It is reassuring for a parent to learn that their child’s response to a traumatic event is not unusual when the child may be behaving in a way that is not typical for him/her (Cohen et al, 2006, p. 59).

The initial step is to provide general information to both the child and parent about sexual abuse. It is recommended to provide information sheets with information “as how many children are sexually abused by the age of 18, what are the different types of sexual abuse, who molests children, and why many children do not tell others about the sexual abuse”. The intent is to dispel many myths about sexual abuse and for the child and parent to learn “facts”. Misinformation is dispelled so families do not feel alone in the difficult challenge ahead of having several different agencies involved such as RCMP and a child protection social worker (Cohen et al., 2006, p. 60). The National Child Traumatic Stress
Network provides a resource kit that has tools to help parents support children who have been victims of sexual abuse. The kit, *Caring for Kids: What parents need to know about sexual abuse*, contains information and fact sheets for parents, caregivers, and adolescents on “the importance of talking to children and youth about body safety, and guidance on how to respond when children disclose sexual abuse. Also included is advice on how to cope with the shock of intrafamilial abuse and with the emotional impact of legal involvement in sexual abuse cases” (National Child Traumatic Stress Network Child Sexual Abuse Committee, 2009). The Child Development Institute (2006) developed a similar resource for parents in Canada titled: *Understanding child sexual abuse: A guide for parents and caregivers*.

This booklet defines sexual abuse, outlines disclosures and reporting, and the investigation. The booklet was intended for citizens of Ontario where families would be working with a Children’s Aid Society. A helpful section of the booklet provides information on the *Criminal Code of Canada* that defines the age of consent to sexual activity. However, the information requires updating. On May 01, 2008 the age of consent for sexual activity was raised from 14 years to 16 years by the *Tackling Violent Crime Act*.

The age of consent, also known as the “age of protection”, refers to the age at which a young person can legally consent to sexual activity. All sexual activity without consent, regardless of age, is a criminal offence. However, the age of consent is 18 years where the sexual activity “exploits” the young person – when it involves prostitution, pornography, or occurs in a relationship of authority, trust or dependency. Sexual activity can also be considered exploitative based on the nature and circumstances of the relationship and how the partner may have controlled or influenced the young person (Department of Justice, 2013).
There are exceptions in the *Criminal Code*: “close in age” and “peer group”. For children 12 and 13 years old there is a “close-in-age” exception, which means the child can consent to sexual activity with another younger person who is less than two years older and there is no relationship of trust, authority, or dependency or other exploitation of the young person. A 14 or 15 year old can consent to sexual activity with a partner as long as the partner is less than five years older and there is no relationship of trust, authority, or dependency or any other exploitation of the young person (Department of Justice, 2013).

Next the social worker provides, common emotional and behavioural responses to both the child and parent. A way to provide information on common reactions is to utilize children’s books such as *Please Tell: A child’s story about sexual abuse* by Jessie Ottenweller. Psychoeducation also involves specific information about symptoms and diagnosis. If a child has PTSD, the clinician can provide the information in a straightforward manner that is easily comprehended. For example:

The reexperiencing symptoms can be described as painful reminders of the trauma and the avoidant symptoms as a way for the child to try to obtain relief from this emotional pain. For the hyperarousal symptoms (e.g. distractibility, difficulty sleeping, irritability), the child and parent can be told that these are ways that the brain and/or body indicate that the traumatic event has overwhelmed the child’s physical ability to cope (Cohen et al., 2006, p. 61).

The next step in psychoeducation is giving a description of treatment (p. 61). There are many effective trauma-specific therapy models that share common components. Examples include child-parent psychotherapy, parent-child interaction therapy, Life Skills/Life Story model, Seeking Safety, Structured psychotherapy for adolescents responding to chronic stress.
(SPARCS), Trauma systems therapy, and the Trauma Affect Regulation: Guide for education and therapy (TARGET). TF-CBT is the best-validated psychotherapy approach for sexually abused children with PTSD. It is an “evidence-based treatment shown to help children, adolescents and their caregivers overcome trauma-related difficulties” (Child Welfare Information Gateway, 2012, 1).

This section described practicum activities in which a main venture was learning trauma-focused cognitive behavioral therapy. I described activities of developing an assessment form and providing components of TF-CBT as a treatment intervention. The next section outlines policy considerations in the area of SAIP Standards and program evaluation.
Chapter 6: Critical Review

The following is a critical review of the SAIP Standards and program evaluation. The SAIP Standards were “intended to ensure a consistent level of access to, and quality of, SAIP services across the province and to facilitate accountability” (MCFD, 2008, p. 1). An internal review of SAIP was conducted in 2006 by an independent contractor (the McEwan Review).

A recommendation by Dr. Kimberly McEwan remains unclear. A key finding from the McEwan Review suggests “the provincial mandate and standards need to be strengthened with flexibility at the regional and local levels” (Representative for Children and Youth, 2010, p. 4). In March 2008, SAIP Standards were revised featuring specific information on ten “Standards”: 1) Eligibility 2) Reporting Requirements 3) Release of Information 4) Screening and Assessment 5) Treatment Planning and Interventions 6) Collaborative Service Planning 7) Counsellor Competencies and Qualifications 8) Documentation and Electronic Records 9) Clinical Supervision and Consultation and 10) Professional Conduct. Neither the Standards nor the Subsidiary Component Agreement (SCA) specify how SAIP will work “… with flexibility at the regional and local levels”.

The Ministry of Children and Family Development is divided into thirteen service delivery areas with the Prince Rupert SAIP office located in the Northwest (Haida Gwaii/Terrace/Kitimat/Bulkley/Stikine). There are two Sexual Abuse Intervention Programs in the Northwest: Prince Rupert and Smithers. These are the only two programs in the northwest that are specifically funded by MCFD to treat sexually abused children. Children living in a community where there is no SAIP will then have to access services from a Child and Youth Mental Health office. Therefore, this is a tremendous gap in services for children and families living in communities such as Haida Gwaii, Terrace, and the Nass Valley.
There is a concern by the Representative regarding eligibility requirements for children over 12 years not charged with sexual offences.

Under the revised 2008 Standards, children over 12 charged with sexual offences under the Youth Criminal Justice Act fall within the mandate of the Youth Sexual Offence Program within Youth Forensic Psychiatric Services (YFPS). However, the Representative's assessment found youths under age 15 were often not getting service from this program because they are usually not charged. It is unclear where these children receive services if they are not eligible under SAIP or YFPS (Representative for Children and Youth, 2010, p. 7).

The Representative recommends “MCFD review the mandate and eligibility of the Youth Sexual Offence Program for children over 12 years not charged with sexual offences. SAIP services should be offered to children over 12 years not charged with sexual offences if they do not meet the mandate under the Youth Sexual Offence Program” (Representative for Children and Youth, 2010, p. 7). I do not agree with this recommendation. The Youth Sexual Offence Treatment Program is available on an outpatient basis at eight clinics in the province: Burnaby, Langley, Vancouver, Victoria, Kamloops, Kelowna, and Prince George. Referrals must be accompanied by a court-order requiring attendance for treatment. Youth charged with and/or convicted of sexual or sexually related offences are in a program that is highly structured. It provides assessment and treatment in a standardized approach (MCFD Specialized Treatment Programs, 2013). SAIP is a voluntary program and to have youth aged 13, 14, or 15 with sexualized behaviour problems is inconceivable. SAIP is already stretched to its limits. This is another illustration of a gap in services for youth. Youth will need to be willing to seek counselling at a Child and Youth Mental Health office.
SAIP providers have identified under-funding as a major issue due to population growth and inflation (McEwan, 2006, p. 23). The last time ministry funding for SAIP increased was in 2010/11. In 2008/09 SAIP funding was $4.5 million; there was a small increase to $4.9 million (Representative for Children and Youth, 2010, p. 7). Funding for clinical resources and prevention services continue to be of concern. As Dr. Friedrich (1991) stated “working with sexually abused children can be terribly isolating” (p. xi). Support from other clinicians may not be easily available. According to the McEwan Review, SAIP clinicians expressed “feelings of isolation and being disconnected from peers”. A solution suggested by SAIP clinicians was having a provincial network or an association. This will help in meeting training needs and improve communication as well as meet aspects of program delivery (McEwan, 2006, p. 20). It is extremely vital that SAIP clinicians feel supported when treating traumatic stress in children and adolescents. Families often experience many layers of stress. Clinicians are often working within a larger helping system that want quick convenient fixes for children “… who have been given no personal sense of value, whose basic needs have been ignored, and who have been consistently attacked and misused emotionally, physically, and/or sexually”. Typically, parents are often re-enacting their own history of abuse that has come from multigenerational dysfunction that causes them to be unavailable, unpredictable, and/or out of control, creating a chaotic environment (Dhaese, 2011, p. 75). Cases where there is chaos and unpredictability in the home will cause the clinician to feel a sense of inadequacy and a lack of direction. Clinicians need a network of peer support teams (Friedrich, Luecke, Beilke & Place, 1992, p. 407).

It is recommended at referral that SAIP offer a “package” of services to families. It is possible with the support of MCFD that SAIP can offer a “multiple impact model of therapy”
(Bander, Fein, & Bishop, 1982, p. 352). This model includes multiple modalities of therapy that will allow the team to enter the family system in a variety of ways. This model will integrate more than two distinct theories and fields of study or assimilated psychodynamic psychotherapy integration (Gil, 2009, 252). Assimilative integration retains allegiance to a single theoretical school. The clinician introduces techniques drawn from other approaches in a seamless way. The working relationship between the Child and Youth Mental Health team and SAIP will be highly integrated. The manner in which they work will be dependent on the child, youth, and family needs.

Multiple therapists or a team of therapists will allow more effective crisis management. Team treatment will include a therapist for the parent and a therapist for the child. A component of the treatment can include consulting with a psychiatrist. Telehealth services are available through BC Children’s Hospital if needed for SAIP clients. In addition to the treatment team, a multidisciplinary team of consultants comprising of a police officer, crown counsel, a community-based victim service worker, a MCFD Child Protection social worker and a pediatrician will be available to the therapist. Team consultants will include a Child and Youth Mental Health clinician and a Team Leader. The team will meet regularly at biweekly reviews of selected cases to provide information and facilitate coordination with the justice system, health care, and law enforcement system to maximize utilization of available resources within the community. The model will operate in the following manner:

- Following the disclosure of the sexual abuse and referral to SAIP, a therapist will be assigned for the child and for the parent of each family.
- The therapist will begin gathering information.
• At the end of the assessment period a team meeting will be held to plan the treatment strategy.

• Treatment planning will be based upon SAIP assessment as well as the legal justice status of the case. SAIP therapists will work closely with Child Protection Social Workers in determining the safety of the child if needed.

• To develop a plan to determine which modality - individual, group, or family therapy - to use and when to use them (Bander, Fein, & Bishop, 1982, p.352 & 353).

Program Evaluation

All SAIP contracts include reporting requirements (Representative for Children and Youth, 2010, p. 18). The Representative recommends that “MCFD ensure[s] that all SAIP providers use consistent data collection and that SAIP program information is used to make decisions about program funding, direction and effectiveness”. Most SAIP agencies will do monthly, quarterly, and annual reports either to their organization or MCFD. There are several fundamental questions about client characteristics that remain unclear such as the classification by type of child sexual abuse (i.e. intrafamilial intercourse, intrafamilial sexual contact, extrafamilial intercourse, or extrafamilial sexual contact) and demographic characteristics (i.e. age of victim, sex of victim, ethnic background, parental marital status, religion, income, geographic residence). Other useful information include: referral source, relationship of perpetrator to child victim, and history of the sexual abuse (Bander, Fein, Bishop, 1982, pp. 354-361). It is essential that the type, nature, duration of trauma be assessed in children and youth (Balaban, 2009, p. 72).
The UCLA PTSD Index is a standardized format that investigates a wide variety of childhood traumatic experiences. It can be used either as an interview or a self or parent-report. It asks children to identify and rate the severity of each traumatic event they have experienced and to select the one that was most upsetting to them. This event is then used as the index trauma for rating trauma-related symptoms (Cohen, Mannarino, & Deblinger, 2006, p. 20 & 21). There is no clinical cut-off; this is a trauma screen to measure exposure to trauma symptoms. The Child PTSD Symptoms Scale (CPSS) has a clinical cut-off of 12. The youth form is for children between eight and eighteen years old. It comprises of 17 questions that assess the frequency of symptoms of PTSD in the previous month and seven additional questions that assess daily functioning (Balaban, 2009, p. 69). This is a free online resource at the Harborview Medical Center: Center for Sexual Assault & Traumatic Stress: http://depts.washington.edu/hcsats/. This can be used at intake and then again during the termination phase.

Northern and Remote Practice

Understanding the context of practice is an essential component of social work in northern and remote settings. In northern and remote practice, the context strongly influences the choice of practice methods. Practitioners deal with issues of distance, low population, scarce resources, and a lack of service choice. Northern and remote social workers take "more of a community focus than their counterparts and are more generalist than specialist in their skills and approaches" (Green, Gregory, & Mason, 2009, p. 414). According to Green et al. (2009) contextual practice is "... practice both with and within context ... this mode of practice means that we work reflectively with whole contexts [both] simultaneously within and outside those contexts" (p. 415). This is also referred to as contextual fluidity where
“construct, knowledge, and practice are dynamic rather than fixed in their nature” (p. 416). A contextual fluidity perspective states “the person is perceived as being inseparable from their environment” (p. 416). This framework is useful because it promotes critical analysis and self-reflection. This will challenge the practitioner to explore the impact of context as it applies to the analysis of the service user, the practitioner and the agency. This model will be helpful during clinical supervision and debriefing. Clinicians need to maintain a greater self-awareness and attention to emotional reactions when working with sexual abuse trauma.

This chapter highlighted areas that need additional attention by policy makers within the Ministry of Children and Family Development. A closer look at SAIP Standards was presented which has implications for clinicians that use a trauma-informed practice in both contracted community-based services such as SAIP and Child and Youth Mental Health office across Northern British Columbia. Chapter seven provides a description of vicarious trauma.
Chapter 7: Implications for Personal/Professional Practice

The following is a description of vicarious trauma. The need for practitioner self-care is a requirement when working with traumatized children and youth. The impact of the work can be distressing and difficult so it is very important. On-going consultation and supervision is necessary when doing trauma work.

Vicarious Trauma

According to Pearlman and Caringi (2009) vicarious trauma is “the negative transformation in the helper that results from empathic engagement with trauma survivors and their trauma material, combined with a commitment or responsibility to help them” (p. 202 & 203). Vicarious trauma differentiates from countertransference, burnout, and compassion fatigue. Vicarious trauma refers to the negative changes that can take place in trauma workers across time, whereas countertransference describes the therapist’s responses to a single client, whether trauma is involved or not. Countertransference focuses primarily on the therapist’s role in that process, whereas burnout focuses on the situation, the gap between what the helper is expected to do and what he or she is able to do (p. 204).

Research with trauma therapists has found different patterns of reactions to trauma work (Pearlman & Caringi, 2009, p. 203). The term “trauma work” describes “working with clients who have experienced traumatic events (both physical and psychological) and have subsequent psychological difficulties (Sabin-Farrell & Turpin, 2003, p. 451). Trauma therapists describe having common posttraumatic signs, symptoms, and relational adaptations that parallel victims’ and survivors’ (Pearlman & Caringi, 2009, p. 203). The following symptoms have been identified as a part of vicarious trauma: “disturbances in cognitive schemas; symptoms of posttraumatic stress, such as avoidance, hyperarousal, and numbing; relational adaptations, such as aggression, re-enactments, and difficulty with
boundary management; as well as psychological stress” (p. 203). Therapists have also reported “dissociation and depersonalization during sessions, intimacy and sexual difficulties, somatisation, social isolation, and loss of meaning and hope” (p. 203).

Research suggests that “most therapists experience negative transformation of their personal frame of reference (spirituality, worldview, and identity), relationships, ability to self-regulate emotional states, judgment or decision-making abilities, and/or bodily experiences” (Pearlman & Caringi, 2009, p.205). Neither clients nor therapists are responsible for vicarious traumatization it is an occupational hazard. It requires the therapist “... to maintain self-awareness and attention to emotional reactions and behaviours, while remaining attuned to the client’s needs” (p. 202). Vicarious trauma can result because of the therapist’s “empathetic engagement with the client” (p. 205). The therapist’s responses are not adequately processed which can increase the risk to the helper of personal distress or empathy.

Personal distress arises when one imagines personally experiencing the traumatic event, resulting in negative feelings. Empathy arises from imagining what the client experienced and results in compassion for the other and prosocial behavior (Pearlman & Caringi, 2009, p. 205).

Empathic responses and personal distress can lead to vicarious trauma. Other contributing factors of vicarious trauma include aspects of work, aspects of the helper, and sociocultural context. Aspects of work refer to the “horrific experiences that many complex trauma survivors disclose and discuss” (p. 206). Pearlman and Caringi (2009) state “there are effects of working with survivors of complex psychological trauma that increase the likelihood of vicarious trauma in any helper” such as the survivor’s adaptations of disrupted self-
capacities, disrupted psychological needs, disrupted frame of reference, disrupted memory system, and bodily responses (p. 207-210). For an explanation of each of the contributing factors of aspects of work and aspects of the social-cultural context please refer to Pearlman and Caringi (2009). The following will focus on two aspects of the helper that may contribute to or protect against experiencing vicarious trauma: 1) personal trauma history and 2) an avoidant interpersonal style.

Research examining the role of the therapist’s personal trauma history in the development of vicarious trauma has produced mixed findings because of the different ways both personal trauma history and vicarious trauma are assessed. Therapists with personal trauma history bring depth of understanding and an ability to identify. These unique responses require self-awareness so that the “... survivor therapist will not over identify, then respond to clients’ experiences in ways that are counter therapeutic and potentially hazardous for them” (Pearlman & Caringi, p. 211). Motivation also has a role in determining whether a therapist experiences vicarious trauma. A therapist seeking personal healing through the work instead of through his or her own growth and change processes is more susceptible to vicarious trauma. Therapists with the “most disrupted cognitive schemas” were less likely to be receiving clinical supervision (p. 211). All therapists doing trauma work will benefit from ongoing consultation and/or supervision (and personal therapy, as needed) (p. 212).

Therapists that respond persistently with avoidance of clients’ pain often are less able to process the pain, fear, sorrow, frustration, anger, and resentment that may build over time. This also contributes to vicarious trauma. Another factor is the therapist’s attachment style. Those with an insecure attachment style reported more symptoms of vicarious trauma than therapists with secure attachments. Therapists with insecure attachment style “… may have
experienced negative self-worth and/or negative view of others, interpersonal difficulties in close relationships, and discomfort with intense emotions, may hinder the therapeutic process and provide a disservice to trauma survivors" (p. 212). An examination of the contributing factors related to vicarious trauma assists the therapist in increasing awareness and his/her ability in addressing it. Transforming vicarious trauma requires self-care, social support, consultation, and spiritual renewal (p. 214).

The main emphasis of this chapter was to demonstrate that vicarious trauma is the negative changes that can take place in trauma workers across time. This transformation can be personal frame of reference such as spirituality, worldview, and identity. Therapists are not responsible for vicarious traumatization – it is an occupational hazard. Therapist will need support from their colleagues and supervisors.
Chapter 8: Conclusion

In this report, my goal was to provide a critical review of the various models of the traumatic impact of child sexual abuse. A fundamental question that confronted me as a First Nations clinician who treats children who are sexual abuse victims was “How do I develop my practice using a trauma framework for understanding child sexual abuse?” In developing my approach it required self-knowledge, self-healing, and self-reflection so I could create a safe place for clients to begin to heal. I utilized the trauma model as a primary theoretical orientation with a cognitive-behavioural approach. The theoretical model is the conceptualization of trauma and its impact. My goal was to learn about assessment techniques and the different treatment phases. I was hoping to get a glimpse of what it is like for clinicians working with traumatized sexually abused children. Each chapter identified conceptual considerations that will help in developing a clinical framework. Chapter 2 reviewed the practicum setting at the North Coast Transition Society. Chapter 3 provided an overview of child sexual abuse and the traumatic impacts. It explored guidelines for child sexual abuse and practice principles that are invaluable for clinical social workers when approaching assessment and treatment. Chapter 4 elaborated on the research findings of child sexual abuse in Canada and a review of children with sexual behaviour problems. Chapter 5 focused on activities completed in the practicum placement. An examination of trauma-focused cognitive behavioral therapy was presented. Chapter 6 provided a discussion for social policy development. Chapter 7 focused on the clinician by examining the nature of vicarious traumatization in relation to clients with complex trauma. Developing clinical competencies involves a clinical strategy of selecting and deploying an evidence-based
treatment approach and defining parameters of psychotherapy that promote relational healing of traumatized children and youth (Kinsler, Courtois, & Frankel, 2009, p. 183).

Sharing of clinical insights is useful for novice therapists. Supporting the recovery of children and youth with complex trauma requires skill, patience, and awareness. Adequate training, consultation, and/or supervision help prevent and mitigate vicarious trauma for therapists. In addition it is important that leaders at the policy level understand and are aware of the difficult nature of trauma work and the potential impact of vicarious trauma. Most cases usually involve long-term treatment. Sexual abuse is not a syndrome that is characterized by a typical set of symptoms (Friedrich, Luecke, Beilke & Place, 1992, p. 406).

Connection both inside and outside the workplace is necessary even more so in northern and remote communities. Connection in the community offers social support by creating personal and professional networks. Peer support teams will help break isolation and broaden clinical identity as a social worker and therapist. Strengthening the Sexual Abuse Intervention Program in Prince Rupert, as described in Chapter 6, will benefit all clinicians in the community. Working together will allow innovation in clinical conceptualization, assessment, and treatment. There will be opportunities for in-service training and clinical discussion that will foster growth.

The McEwan Review revealed that “many programs conveyed apprehension regarding a ‘fold-in’ of SAIP into CYMH and were adamant that this would not serve the interests of clients”. Therapists felt “… sexual abuse intervention represents a specialized field and believe that CYMH clinicians do not understand [the] complexity of cases nor the interplay between counselling services, child protection, and the judicial system”. Interviewees noted “…that many families are ‘system wary’ and would only access treatment
services for their children if available in community settings – outside government offices”.

Furthermore, providers are uneasy about incorporating sexual abuse into a mental illness framework. There are concerns of diagnostic labeling and stigmatization (McEwan, 2006, p.18). Research is following the direction for broadening current diagnostic conceptualizations for victimized children so there is not a necessity of multiple comorbid diagnoses which can lead to both under-treatment and overtreatment (D’Andrea, Ford, Stolbach, Spinazzola, & van der Kolk, 2012, p. 187). Psychiatric diagnoses guide the development of interventions. D’Andrea and colleagues argue:

“the continued practice of applying multiple distinct comorbid diagnoses to traumatized children defies the cardinal rule of parsimony, obscures etiological clarity, and runs the danger of relegating trauma-informed treatment to only one disorder (PTSD) that is experienced by only a small fraction of traumatized children who are in psychiatric treatment (p. 194).

To reduce confusion it is proposed that research needs to develop a construct. The construct of developmental posttraumatic adaptation is recommended for further research (p. 195). This finding will be better understood with advanced training that is consistent with a complex trauma framework. To advance clinical work the Justice Institute of British Columbia (JIBC) offers training for practitioners with an undergraduate or graduate degree who are working with child, adolescent, and/or adult survivors of complex trauma and child sexual abuse with a blend of online, face-to-face and self-directed study. The program, “Graduate Certificate in Complex Trauma and Child Sexual Abuse Intervention” can be taken individually or as part of the certificate. The total cost to complete the 30-day (15 credit) program is approximately $5,700.00 (JIBC, 2013).
A challenge for clinical social workers is to practice within *Value 6: Competence in Professional Practice* of the Code of Ethics (2005):

Social workers respect a client's right to competent social worker services. Social workers analyze the nature of social needs and problems, and encourage innovative, effective strategies and techniques to meet both new and existing needs and, where possible, contribute to the knowledge base of the profession. Social workers have a responsibility to maintain professional proficiency, to continually strive to increase their professional knowledge and skills, and to apply new knowledge in practice commensurate with their level of professional education, skill and competency, seeking consultation and supervision as appropriate (p. 8).

My therapeutic skills will continue to be developed by having a greater understanding of complex trauma histories while using an attachment developmental framework that promotes resilience and strengthens child-caregiver relationships. Healing for a child with multiple traumas is a lifelong journey (Dhaese, 2011, p. 92).
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Appendix 1: Diagnostic Criteria for Posttraumatic Stress Disorder

**Note:** The following criteria apply to adults, adolescents, and children older than 6 years. For children 6 years and younger, see corresponding criteria below.

A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more of the following ways:

1. Directly experiencing the traumatic event(s).
2. Witnessing, in person, the event(s) as it occurred to others.
3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g. first responder collecting human remains; police officers repeatedly exposed to details of child abuse).

**Note:** Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:

1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).

**Note:** In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.

2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).

**Note:** In children, there may be frightening dreams without recognizable content.

3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.)

**Note:** In children, trauma-specific reenactment may occur in play.

4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
C. Persistent avoidance of stimuli associated with the trauma event(s), beginning after the traumatic event(s) occurred as evidence by one or both of the following:

1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).
2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., “I am bad,” “No one can be trusted,” “The world is completely dangerous,” “My whole nervous system is permanently ruined”).
3. Persistent distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame him/herself or others.
4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).
5. Markedly diminished interest or participation in significant activities.
6. Feelings of detachment or estrangement from others.
7. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.
2. Reckless or self-destructive behavior.
3. Hypervigilance.
4. Exaggerated startle response.
5. Problems with concentration.
6. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).

F. Duration of the disturbance (Criteria B, C, D, and E) is more than 1 month.

G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

H. The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.
Posttraumatic Stress Disorder for Children 6 Years and Younger

A. In children 6 years and younger, exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

1. Directly experiencing the traumatic event(s).
2. Witnessing, in person, the event(s) as it occurred to others, especially primary caregivers.

Note: witnessing does not include events that are witnessed only in electronic media, television, movies, or pictures.

3. Learning that the traumatic event(s) occurred to a parent or caregiving figure.

B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:

1. Recurrent involuntary and intrusive distressing memories of the traumatic event(s).
2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).
3. Dissociative reactions (e.g., flashbacks) in which the child feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings). Such trauma-specific re-enactment may occur in play.
4. Intense or prolonged psychological distress at exposure to internal and external cues that symbolize or resemble an aspect of the traumatic event(s).
5. Marked physiological reactions to reminders of the traumatic event(s).

C. One (or more) of the following symptoms, representing either persistent avoidance of stimuli associated with the traumatic event(s) or negative alterations in cognitions and mood associated with the traumatic event(s), must be present, beginning after the event(s) or worsening after the event(s):

Persistent Avoidance of Stimuli

1. Avoidance of or efforts to avoid activities, places, or physical reminders that arouse recollections of the traumatic event(s).
2. Avoidance of or efforts to avoid people, conversations, or interpersonal situations that arouse recollections of the traumatic event(s).
**Negative Alterations in Cognitions**

3. Substantially increased frequency of negative emotional states (e.g. fear, guilt, sadness, shame, confusion).
4. Markedly diminished or participation in significant activities, including constriction of play.
5. Socially withdrawn behavior.
6. Persistent reduction in expression of positive emotions.

D. Alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Irritable behavior and angry outburst (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects (including extreme temper tantrums).
2. Hypervigilance.
3. Exaggerated startle response.
4. Problem with concentration.
5. Sleep disturbance (e.g. difficulty falling or staying asleep or restless sleep).

E. The duration of the disturbance is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in relationships with parents, siblings, peers, or other caregivers or with school behavior.

G. The disturbance is not attributable to the physiological effects of a substance (e.g. medication or alcohol) or another medical condition (American Psychiatric Association, 2013, pp. 271-274).
Appendix 2: Traumagenic Dynamics in the Impact of Child Sexual Abuse

**TRAUMATIC SEXUALIZATION**

Dynamics

- Child rewarded for sexual behaviour inappropriate to developmental level
- Offender exchanges attention and affection for sex
- Sexual parts of child fetishized
- Offender transmits misconceptions about sexual behaviour and sexual morality
- Conditioning of sexual activity with negative emotions and memories

Psychological Impact

- Increased salience of sexual issues
- Confusion about sexual identity
- Confusion about sexual norms
- Confusion of sex with love and care getting/care giving
- Negative association to sexual activities and arousal sensations
- Aversion to sex intimacy

Behavioural Manifestations

- Sexual preoccupations and compulsive sexual behaviours
- Precocious sexual activity
- Aggressive sexual behaviours
- Promiscuity
- Prostitution
- Sexual dysfunctions; flashbacks, difficult in arousal, orgasm
- Avoidance of or phobic reaction to sexual intimacy
- Inappropriate sexualisation of parenting

**STIGMATIZATION**

Dynamics

- Offender blames, denigrates victim
- Offender and others pressure child for secrecy
- Child infers attitudes of shame about activities
- Others have shocked reaction to disclosure
- Others blame child for events
- Victim is stereotyped as damaged good
Psychological Impact

- Guilt, shame
- Lowered self-esteem
- Sense of differentness from others

Behavioral Manifestations

- Isolation
- Drug or alcohol abuse
- Criminal involvement
- Self-mutilation
- Suicide

**BETRAYAL**

Dynamics

- Trust and vulnerability manipulated
- Violation of expectation that others will provide care and protection
- Child's well-being disregarded
- Lack of support and protection from parents(s)

Psychological Impact

- Grief, depression
- Extreme dependency
- Impaired ability to judge trustworthiness of others
- Mistrust; particularly of men
- Anger, hostility

Behavioral Manifestations

- Clinging
- Vulnerability to subsequent abuse and exploitation
- Allowing own children to be victimized
- Isolation
- Discomfort in intimate relationships
- Marital problems
- Aggressive behaviour
- Delinquency

**POWERLESSNESS**

Dynamics
Body territory invaded against the child’s wishes
Vulnerability to invasion continues over time
Offender uses force or trickery to involve child
Child feels unable to protect self and halt abuse
Repeated experience of fear
Child is unable to make others believe

Psychological Impact

Anxiety, fear
Lowered sense of efficacy
Perception of self as victims
Need to control
Identification with the aggressor

Behavioral Manifestation

Nightmares
Phobias
Somatic complaints; eating and sleeping disorders
Depression
Disassociation
Running away
School problems; truancy
Employment problems
Vulnerability to subsequent victimization
Aggressive behaviour, bullying
Delinquency
Becoming an abuser (Finkelhor, 1987, p. 359 & 360).
### Appendix 3: Assessment Template

**Today's Date:** ________________

#### PART A

<table>
<thead>
<tr>
<th>Child's Full Name:</th>
<th>____________________________________________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex: Female/Male</td>
<td>Date of Birth: ________________</td>
</tr>
<tr>
<td>Race:</td>
<td>Age: ________________</td>
</tr>
<tr>
<td>Address:</td>
<td>Telephone Number: ________________ Cell #: ________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mother's Name:</th>
<th>____________________________________________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father's Name:</td>
<td>Parents/Caregiver Address: ___________________________________________________________________</td>
</tr>
<tr>
<td></td>
<td>Telephone Number: ________________ Cell #: ________________</td>
</tr>
</tbody>
</table>

| Guardian/Caregiver Name: | ___________________________________________________________________ |
|                         | Telephone Number: ________________ Cell #: ________________ |
Alternate Address: 

Telephone Number: ___________________ Cell #: ___________________

School: ______________________________ ______________________________ 

Teacher’s Name: ______________________ Grade: ___________________

Referred by: ________________________ Agency: _______________________

Reason for Referral:

Description of Current Problem(s)

What happened? Where? When? Describe child’s behaviors. Describe child’s statements. Are there other details? What was the precipitating stimulus for the disclosure?

Symptoms:

___ Avoidance (thoughts, people, places, or situations) ___ Substance abuse
___ Dissociation (emotional numbing) ___ Self-injury
___ Sexualized behaviors ___ Oppositional
___ Inappropriate sexual behavior ___ Mood changes
___ Promiscuity ___ Diminished self-esteem
___ Fear ___ Aggressive behaviors
__ Depression  __ Guilt  __ Feelings of worthlessness  
__ Anger  __ Shame  __ Suicidal thoughts  
__ Insomnia  __ Nightmares  __ Suicide attempt  
__ Anxiety  __ Running away  __ Soiling/wetting bed and/or clothes  
__ Poor self-esteem  __ Behavior problems  __ School/learning difficulties  
__ Withdrawn  __ Somatic complaints  __ Regression/immaturity  

Are both parents aware of referral to Sexual Abuse Intervention Program? ___ (Y) ___ (N)  

If applicable, what are the custody, guardianship, access, and visitation arrangements?  

__________________________________________________________  

__________________________________________________________  

PART B  
Disclosure of sexual abuse (purposeful/intended or accidental/not intended?)  

1. Who did child disclosed sexual abuse to?  
   ____________________________________________________________  
   ____________________________________________________________  
   ____________________________________________________________  

2. What happened? When and where the sexual abuse took place?  
   ____________________________________________________________  
   ____________________________________________________________  
   ____________________________________________________________  
   ____________________________________________________________  
   ____________________________________________________________  
   ____________________________________________________________  

3. Date of disclosure? _________________________________________  

4. How was it handled by the recipients of the information?  
   • Were they angry?  
   • Did they shame or blame the child?  
   • Did they express or imply fear?
• Did they fall apart at the disclosure versus a calm acceptance?
• What questions were asked?
• What words were used?

* Do NOT read the following items to child. Check as applies to each incident.

☐ Perpetrator at least five years older than child
☐ Force or violence used by perpetrator in sexual contact
☐ Touched child’s genitals
☐ Oral-genital contact (perpetrator to child)
☐ Oral-genital contact (child to perpetrator)
☐ Digital penetration of vagina/anus
☐ Intercourse (specify: anal/vaginal ________________ )
☐ Pornographic photography, filming, or activity
☐ Prostitution of child/teenager
☐ Other (describe: ____________________________ )

How old was child when this first happened? AGE ________________
When this most recently happened? AGE ________________

Duration of sexual abuse (How long has the sexual abuse been going on?):

How often has this happened?
___ once ___ one or two times a month ___ several time a week
___ once or twice ___ about once a week ___ daily

Did this happen to you any other times with someone else?

Incident A:
Incident B:

_____________________________________________________________________________________

Incident C:

_____________________________________________________________________________________

Medical treatment required ______ Yes ______ No

Family Physician:

_____________________________________________________________________________________

Telephone #:

_____________________________________________________________________________________

Physician/nurse physically examined child as part of the investigation ______ Yes ______ No

Physical findings:

____ Normal and non-specific vaginal findings (hymenal bumps, ridges and tags; v-shaped notches located superior and lateral to the hymen, not extending to base of the hymen; vulvovaginitis; labial agglutination).

____ Normal and non-specific anal changes (erythema; fissures; midline skin tags or folds; venous congestion; minor anal dilatation; lichen sclerosis).

____ Findings suggestive of abuse (acute abrasions, lacerations or bruising of the labia, perihymenal tissues, penis, scrotum or perineum; hymenal notch/cleft extending through more than 50% of the width of the hymenal rim; scarring or fresh laceration of the posterior fourchette not involving the hymen (but unintentional trauma must be ruled out); condyloma in children over the age of 2 years; significant anal dilatation or scarring.

____ Findings that are definitive evidence of abuse or sexual contact (finding sperm or seminal fluid in, or on, the child’s body; pregnancy; positive cultures for gonorrhea, evidence of syphilis or HIV infection (outside perinatal transmission and or transmission via blood products or contaminated needles); clear evidence of blunt force or penetrating trauma to the hymenal area (without history); clear videotape or photograph of abuse or eye-witness of abuse.
PART C

Alleged Perpetrator(s)

Name: ___________________________________ DOB: ___________ Age: ___
Name: ___________________________________ DOB: ___________ Age: ___
Name: ___________________________________ DOB: ___________ Age: ___
Name: ___________________________________ DOB: ___________ Age: ___

Any current contact or risk to the child? _____ Yes _____ No

If yes, what are the circumstances?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Prior Abuse (other maltreatment child has experienced)

___ Physical abuse       ___ Emotional abuse       ___ Emotional neglect
___ Physical neglect     ___ Domestic Violence    ___ Community Violence

Who is living in the home and what are their ages?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Child’s sibling(s)

Name________________________________________          Age___________
Name________________________________________          Age___________
Name________________________________________          Age___________
Name________________________________________          Age___________
Name________________________________________          Age___________
Name ____________________________________________ Age ____________

Family History

___ Alcohol and/or Drug abuse ____________________________________________

___ Mental Illness _______________________________________________________

___ Sexual Violence _____________________________________________________

___ Domestic Violence ___________________________________________________

___ Past Child Protection Ministry of Children and Family Development Involvement

___ Other _______________________________________________________________

OTHER TRAUMAS/STRESSORS (Have there been events or circumstances that have been traumatic for the child; that is, death of a sibling or parent, multiple caretakers, abrupt separations?)

_____________________________________________________________________

_____________________________________________________________________

______________________________________________________________

PART D

Legal Status at Intake

___ Not yet reported  ___ Not enough evidence to proceed

___ Alleged offender under 12 years of age

___ Alleged offender has been charged with ________________________________

___ Alleged offender is pleading ___ not guilty ___ guilty

___ During court proceedings: ____________________________________________

___ Post court date: ___________________ Verdict _________________________

___ Alleged offender passed polygraph test (no further investigation)
Legal Proceedings
Police File # ____________________________
Court File # ____________________________
Crown Counsel ____________________________

Upcoming Court Appearance and Hearings

<table>
<thead>
<tr>
<th>Date:</th>
<th>Reason:</th>
<th>Outcome:</th>
</tr>
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<tbody>
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</tbody>
</table>

Referral to Community-based Victim Services ___ Y ___ N

PART E

ASSESSMENT IN THE CONTEXT OF CHILD SEXUAL ABUSE

DESCRIPTION OF CURRENT PROBLEM/FUNCTIONING

• Onset
• Frequency
• Intensity
• Previous treatment

FAMILY BACKGROUND

• Socio-economic status
• Culture
• Family constellation and relationships (family rules/roles/boundaries – rigid, diffuse, or maligned)
• Family emotional/medical history
• Changes/stressors
• Violence

DEVELOPMENTAL HISTORY

• Pregnancy, Birth, and Delivery (Were there any problems or concerns that would affect the child now?)
• Are developmental milestones on target?

MEDICAL HISTORY/PROBLEMS

Have there been any medical problems that may affect the child’s current status or the child’s reaction to genital touch (for example, repeated exams for urinary tract infections, multiple enemas)?

Medications ____________________________________________________________

Allergies ______________________________________________________________

Illness _________________________________________________________________

Other _________________________________________________________________

Has the child been assessed for a mental health issue? ___ Yes ___ No

Psychiatrist / Psychologist _______________________________________________

Diagnosis ______________________________________________________________

PARENTING PRACTICE

• Discipline techniques
• Child-rearing attitudes
• Parenting style
• Caregiver’s roles
• Caregiver’s childhood (history of sexual abuse, neglect, family violence, childhood separation or loss of own parents)

SCHOOL FUNCTIONING

• Achievement
SOCIAL RELATEDNESS

• Peers, family members, adults

ATTACHMENT/SEPARATION HISTORY

• Parent-child relationship quality

• What is the nature of the parent’s relationship with the child?

BEHAVIORAL ASSESSMENT (documenting changes or unusual variations in behavior)

• Sleep problems
• Play quality
• Toileting
• Fears/phobias
• Compulsive behaviors
• Separation problems

LEGAL ISSUES

SEXUAL HISTORY

• What exposure has the child had to sexuality?

• What sexual activity has the child seen: hugging, kissing, foreplay, intercourse, pornography - on screen or in print?

• Is child sexually active?

PRIOR COPING

• Substance abuse
• Self-harm

• What was working, what family/youth tried to manage or change the problem?

INTERESTS, HOBBIES, TALENTS
STRENGTHS

• Child
• Family
• Caregiver

OTHER PROFESSIONAL/AGENCIES CURRENTLY INVOLVED WITH CLIENT

INFORMATION GATHERING ACTIVITIES

PART F

Mental Status Examination

a) Physical appearance

b) Manner relating to clinician and parents, including ease of separation

c) Child’s reaction to interviewer and reaction to setting of assessment

d) Mood and affect

e) Orientation to time, place, and person

f) Motor behavior including activity level, coordination, and presence of unusual motor patterns (i.e. tics)

g) Form and content of thinking and perception, including presence of hallucinations, delusions, thought disorder

h) Speech and language, including reading and writing

i) Attention and concentration

j) Memory

k) Judgment and insight

l) Preferred modes of communication (e.g. play, drawing, direct discourse)
Assessment Instruments

PARENT QUESTIONNAIRES

Trauma Screen – Caregiver Completed

SELF-REPORT QUESTIONNAIRES

Child PTSD Symptom Scale (CPSS) – 7-17 years

Suicide Risk Assessment

FORMULATIONS AND IMPRESSIONS

Provisional Diagnosis