



**203-9**  
**Managing the Sexually Abused Child**

**A Training Outline**

**Developed by**  
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**For the**  
**Pennsylvania Child Welfare**  
**Training Program**

**University of Pittsburgh**  
**Pittsburgh, PA**

# **203: Managing the Sexually Abused Child**

## **An Overview of the Curriculum**

### **Rationale:**

Working with children and families that have experienced child sexual abuse can be difficult for a variety of reasons. However, it is imperative that we learn ways to be more knowledgeable and supportive. Many times making the proper referral or implementing the necessary intervention can change frustration and hostility to hope for a better future.

### **Learning Objectives:**

1. Classify at least five (5) effects of sexual abuse.
2. Demonstrate the interrelationship between thoughts, feelings, and behaviors of sexually abused children.
3. Assist caretakers/caregivers in strengthening their relationships with sexually abused children.
4. Demonstrate techniques and strategies that reduce inappropriate or destructive behaviors.

### **Competency:**

**203-9:** The Child Welfare Professional is aware of the frequent developmental and psychological consequences of sexual abuse on the victim (i.e. depression, anger, mistrust, and pseudo maturity); can assess their impact on the child, and can refer the child for supportive and therapeutic services.

### **Length of Workshop:**

6 Hours

### **Materials Needed to Present Workshop:**

The Following materials are needed to present the workshop:

- √ Color Markers
- √ Name Tents
- √ Overhead Projector/Screen
- √ Easel/Flip Chart
- √ Curriculum with Transparencies
- √ Handouts for Participants

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### **An Overview of the Curriculum (continued)**

#### **Target Audience:**

Child Welfare Caseworkers and Supervisors

#### **Calendar Summary:**

The workshop is designed to assist Child Welfare Professionals in recognizing the difficulties children experience when they have been sexually abused. Participants will examine each of the possible effects the children may face and will discuss how these stages impact treatment and the healing process.

#### **Expectations of the Trainer:**

The trainer should be knowledgeable about sexually abused children, their behaviors and the impact abuse has on families dealing with issues of sexual abuse to be able to effectively train this outline.

## **203: Managing the Sexually Abused Child**

### **Agenda for a Full-Day Curriculum on Managing the Sexually Abused Child**

<b><u>Section</u></b>	<b><u>Content</u></b>
<b>I</b>	<b>Welcome</b>
<b>II</b>	<b>The Subjectifying Experience of Sexual Abuse</b>
<b>III</b>	<b>Sexual Abuse and the Possible Effects on Children</b> <ul style="list-style-type: none"><li>- Fear &amp; Anxiety</li><li>- Self-Blame</li><li>- Powerlessness</li><li>- Betrayal &amp; Loss</li><li>- Stigmatization</li><li>- Destructiveness</li><li>- Dissociation</li><li>- Attachment</li><li>- Traumatic Sexualization</li></ul>
<b>IV</b>	<b>Treatment Goals and A Cognitive-Behavioral Response to Promote Healing</b> <ul style="list-style-type: none"><li>- Interrelationships Between Thoughts, Feelings, &amp; Behavior</li><li>- Strengthen Relationships with Caregivers</li><li>- Manage Individual Inappropriate, Negative and/or Harmful Behavior</li><li>- Reduce Excessive and Unrealistic Self-Preoccupations and Increase Understanding and Acceptance of Self</li><li>- Fortify Defenses that are Weak and Ease Others that are Rigid</li></ul>
<b>V</b>	<b>Conclusion</b> <ul style="list-style-type: none"><li>- Question &amp; Answer Period</li><li>- Transfer of Learning Exercise</li><li>- Evaluations</li></ul>

## **203: Managing the Sexually Abused Child**

### **Section I: Welcome**

#### **Estimated Length of Time:**

15 minutes

#### **Learning Objectives:**

Discuss the workshop, the rationale, learning objectives, and agenda  
Become familiar with other participants

#### **Method of Presentation:**

Small and large group activity

#### **Materials Needed:**

Name tents and markers  
Handout # 1

#### **Resources Used:**

## **203: Managing the Sexually Abused Child**

### **Section I: Welcome**

#### **Outline of the Presentation:**

##### **Step 1:**

The trainer introduces the workshop by reviewing the agenda and learning objectives for the day.

##### **Step 2:**

The participants should introduce themselves to each other. The trainer should then introduce self and list professional credentials that would be applicable to the participants and/or the training.

##### **Step 3:**

The trainer should distribute **Handout # 1: What if I Find Difficulty in Working with Sexually Abused Children**, and ask participants to write down three (3) issues that they confront when working with sexually abused children. The participants are asked to share these issues in a small group setting and formulate a group list.

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### **Section II: The Subjectifying Experience Of Sexual Abuse**

**Estimated Length of Time:**

30 minutes

**Learning Objectives:**

Discuss the cognitive and behavioral impact of sexual abuse on children

**Method of Presentation:**

Lecture and large group discussion

**Materials Needed:**

Overheads # 10 - 13

**Resources Used:**

Browne, A. & Finkelhor, D. (1986). Impact of Child Sexual Abuse: A Review of the research. *Psychological Bulletin*, Vol. 99, 66-77.

Marinarino, A., Cohen, J. & Moore-Motily, S. (1991). Six and Twelve-Month Follow-up of Sexually Abused Girls. *Journal of Interpersonal Violence*, Vol.6, 494-511.

## **203: Managing the Sexually Abused Child**

### **Section II: The Subjectifying Experience Of Sexual Abuse**

#### **Outline of the Presentation:**

##### **Step 1:**

The trainer should explain that child sexual abuse is a very subjectifying experience. As with the snowflake theory, no two (2) children relate to or are affected by their victimization in the same manner. Even siblings who have been sexually abused by the same perpetrator in a similar fashion can react very differently to the abuse.

Many sexually abused children are left to confront a number of cognitive and behavioral issues. Victimization teaches children that the world operates with different rules, beliefs and experiences than non-abused children. Victimization also impacts on the child's way of thinking, daily functioning and behavioral response to the world. Children can develop internalizing and externalizing problems. Internalizing problems can include depression, low self-esteem, self-destructive behaviors, anxiety, somatic complaints, increased fears, and post-traumatic stress disorder (PTSD) (Browne & Finkelhor, 1986; Rowan & Foy, 1993). Externalizing problems include aggression, delinquency and sexually acting-out behaviors (Mannarino, Cohen, Smith & Moore-Motily, 1991).

Caretakers who work with sexually abused children must recognize that there is no "right" or "wrong" way to heal from victimization. A child must travel down his/her own path at their own pace. Every child must find their own way with our guidance. It is important for staff to remember to focus on the normalcy of the child and not their pathologies. Children who have been victims of sexual abuse are children first and foremost. Their victimization is only a part of who they are and is not defining of the child. (Professionals who have personal histories of victimization should note that the way that they chose to heal from their own victimization is not necessarily the way that a child should heal.)

## **203: Managing the Sexually Abused Child**

### **Section III: Sexual Abuse & The Possible Effects On Children**

#### **Estimated Length of Time:**

2 hours

#### **Learning Objectives:**

Understand the possible effects of sexual abuse on children

Discuss the impact of abuse on daily living

#### **Method of Presentation:**

Lecture and large group discussion

#### **Materials Needed:**

Handout # 2, Overheads # 1-9

#### **Resources Used:**

Lipovsky, J., Saunders, B. & Murphy, S. (1989). Depression, Anxiety, and Behavior Problems Among Victims of Father/Child Sexual Assault and Non-Abused Siblings. *Journal of Interpersonal Violence*, Vol.4, 452-468.

McLeer, S., Deblinger, E., Henry, D., & Orvaschel, H. (1992). Sexually Abused Children at High Risk For Post-Traumatic Stress Disorder. *Journal of the American Academy of Child and Adolescent Psychiatry*, Vol.31, 875-879.

Hoagwood, K. (1990). Blame and Adjustment Among Women Sexually Abused as Children. *Women & Therapy*, Vol.9, 89-109.

Finkelhor, D. & Browne, A. (1988). Assessing the Long-Term Impact of Child Sexual Abuse: A Review and Conceptualization, In L. Walker (Ed.), Handbook on Sexual Abuse of Children. (55-72). NY, Springer Pub.

Conterio, K. & Lader, W., Ph.D. (1998). *Bodily Harm*, Hyperion, NY., Doubleday.

Friedrich, W., Jaworski, T., Huxsahl, J. & Bengtson, B. (1997). Dissociative and Sexual Behaviors in Children and Adolescents with Sexual Abuse and Psychiatric Histories. *Journal of Interpersonal Violence*, Vol.12, #2, 155-171.

Cicchetti, D. & Carlson, V. (Eds.) (1989). Child Maltreatment: Theory and Research on the Causes and Consequences of Child Abuse and Neglect. New York, Cambridge University.

Maier, H. (1994). Attachment Development Is "In". *Journal of Child and Youth Care*, Vol.9, 35-51.

# **203: Managing the Sexually Abused Child**

## **Section III: Sexual Abuse & The Possible Effects On Children**

### **Outline of the Presentation:**

#### **Step 1:**

Trainer distributes **Handout # 2: Effect of Sexual Abuse on Children**, to participants as an introduction to the next section.

#### **Fear & Anxiety**

#### **Step 2:**

Using **Overhead # 1: Fear & Anxiety**, trainer discusses fear & anxiety in children who have been sexually abused. The following are some talking points:

Fear and anxiety are the most common symptoms found in children who have been victims of sexual abuse (Lipovsky, Saunders & Murphy, 1989). Approximately one-third (1/3) of children meet the diagnostic criteria for PTSD (McLeer, Dblinger, Henry and Orvashal, 1992). Sexually abused children are fearful of the consequences of their participation in the sexual abuse, the disclosure process, and possible placement out of the home. Thus, for children in care one of their greatest fears is often confirmed.

Sexually abused children are often described as being “full of anxiety.” They have previously functioned in a world where they have no control over their own destiny. The offender and others who could change the rules at will defined these rules of operation. Chronic victims of sexual abuse often learn that the world is an unsafe place and that their actions or behaviors have little affect on the outcome. Survival becomes the only goal. Some children describe this high state of anxiety as, “walking on eggshells.” Professionals believe that the child’s constant state of hypervigilance regarding their surroundings may be the early markings of PTSD. This high state of arousal is not unique to victims of sexual abuse and can be observed in children who are also victims of physical abuse, children living in alcoholic or drug addicted home or victims of domestic violence.

The behaviors of children living in a high state of anxiety can be displayed as clinging behaviors, inappropriate dependency on others, aggressive behaviors and the development of somatic and nervous complaints. Some children attempt to master their environments by becoming “too good to be true.” These overly compliant children will attempt to excel in everything that they do because they believe that some day they will become “good enough” and the abuse will stop. These children are often difficult to detect since they may be good students, excellent athletes, or high achievers.

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Behaviors exhibited by fearful children may also include clinging behaviors, children who attempt to isolate themselves or avoid the stimuli that remind them of the abusive event(s). For example, some children will connect a certain smell or aroma with the abuse or with a certain room of the house. They will then avoid any situation that triggers that fear or anxiety. Various issues can arise when the child attempts to avoid remembering or revisiting the abuse. Even seemingly unrelated events can often be connected in some manner or fashion to the abuse.

#### **Step 3:**

The trainer should ask each participant to take out a piece of paper and to privately write down one (1) smell, noise, or sound that triggers a positive experience/sensation. The trainer should then ask the participants to think about the origins, of this smell, noise, or sound. Is it from their childhood? Why does this smell, noise, or sound evoke a response for the participant at this time in their life? The trainer should then ask the participants to break into small groups to discuss this exercise. Following the breakout of the small groups, the trainer should bring the participants back into a large group in order to discuss the relevance of the exercise. The trainer should focus on the relationship that exists between the reported smell, noise or sound for the participants and their feelings and

thoughts of a positive experience/sensation. This same relationship exists for sexually abused children, although it is in a negative context.

#### **Self-Blame**

#### **Step 4:**

Trainer shows **Overhead #2: Self Blame**, and discusses with participants self blame in children who have been sexually abused. Below are some talking points:

The issue of self-blame has long been of interest to professionals who work with sexually abused children/adolescents. Some researchers believe that a victim's response of blaming themselves for the abuse is related to their level of adjustment (Hoagwood, 1990; Morrow, 1991). Since adolescents and children are very egocentric, they tend to believe that bad things happen to them because they somehow deserved it or they weren't good enough. Children may state, "I guess I could have told someone." or "I thought that if I just started acting right, he would stop." Adolescents may report, "I must have liked it because I didn't stop her."

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Adolescents and children may feel self-blame because they actively participated in the abuse, they failed to seek help (many children even deny the abuse initially when confronted), they failed to control or stop the abuse, they failed to protect a sibling, or they gained some sense of pleasure (i.e., from the physical touch or the relationship with the offender) (McMillen & Zuravin, 1997).

McMillen & Zuravin's (1997) research examined the effects that self-blame had on children. In their research, children who blamed themselves for the abuse suffered in areas of self-esteem and relationship anxiety. Interestingly, children who blamed no one for their abuse had the highest views of others. This may be one healthy way of children taking charge of the experience and healing from the abuse. The shame that a child feels is not produced by the event, but rather by their reaction to the event. It is this shame that leads to a poor adaptation to the sexual abuse.

#### **Powerlessness**

##### **Step 5:**

The trainer displays **Overhead #3: Powerlessness**, and discusses with participants powerlessness in children who have been sexually abused. Below are some talking points:

Powerlessness can be defined as, "...the process in which the child's will, desires and sense of efficacy are continually contravened" (Finkelhor & Browne, 1988). Children know that their most intimate space, their bodies, has been invaded. They feel that they have little control over their world or what happens to them. This lack of control is only heightened by the fact that most victims of sexual abuse have attempted to stop their abuse in some manner or another, often to little avail. Some children even made repeated attempts to stop the abuse (i.e., telling the offender they are going to tell, saying "No," or displaying a behavioral indicator). When these attempts failed, the powerlessness of the child to control the situation was reinforced.

Powerless children can behave in very destructive ways. Children who believe that their feelings, thoughts or actions are inconsequential to their world can make drastic attempts to empower themselves. For example, powerless children can develop eating disorders because the one (1) element that they can control is what food they do or do not put into their mouths. Powerless children can also become physically or sexually aggressive with other children in an attempt to gain control. Finally, powerless children can harm themselves in order to control their environments and reactions.

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These children are prone to phobias, somatic complaints, depression, disassociation, avoidance behaviors, aggression and offending behaviors (Finkelhor & Browne, 1988). To caretakers for powerless children, many of these behaviors can be viewed as scary, bizarre, or even threatening to the personal safety of the caretaker. Remember that sexually abused children seek the same experiences that healthy children do in relation to empowering their lives.

#### **Betrayal & Loss**

##### **Step 6:**

The trainer displays **Overhead # 4: Betrayal & Loss**, and discusses with participants feelings of betrayal and loss in children, which have been sexually abused. Below are talking points for the trainer to address:

The very adults in their lives who were in charge of their safety have often betrayed sexually abused children. Someone, on whom they were virtually dependent knowingly and without regard, caused them harm. Victimized children understand that a trusted person has manipulated them through lies or misrepresentations.

Betrayal is not only levied against the offender but it may even be more strongly felt in relation to the non-offender or other individuals who were in a position to help the child but did not do so. Often victims of sexual abuse state that they feel the most betrayal and anger not at the offender but at the non-offending parent who they view as failing to protect them from the abuse. In our society, women, especially, are supposed to be adults who represent and provide safety for children. If they do not do so, then they have failed.

Children who are placed in care following the disclosure have also been betrayed by other individuals who were supposed to be their support system. Non-offending parents, extended family members and even friends of the family did not step in to assist the child. Children learn from their victimization that the world is full of adults who should not be trusted. As a result, intimate relationships with others can be confusing and overwhelming to victimized children. It is important to remember that caring for children who were unsuccessfully cared for by previous caretakers requires a long-term plan. Brief interventions are not traditionally very helpful.

Sexually abused children have often experienced a great number of losses in their short lives. They may have lost significant individuals in their lives (i.e., parents, extended family), the warmth and caring of vital family members, their homes and security. All victims of sexual abuse have been robbed of their innocence and their childhood.

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These are losses that can never be recovered no matter how hard the child or other individuals work. (This is probably one of the most frustrating and saddest aspects of working with victimized children.) Children who present with such overwhelming losses often feel angry or vindictive toward the individuals that they view as responsible for their losses. Thus, they may blame the system for the losses and strike out while in care or they may become clinically depressed believing that they can never recover. Children need a chance to mourn their losses and to grieve a childhood that was not as it should have been and to which they were entitled.

#### **Step 7:**

The trainer should purchase a total of five (5) helium filled balloons prior to the training and write the following words on each balloon in permanent magic marker. One (1) word is placed on each balloon: family, friends, school, home and hope. The trainer should tie one (1) balloon to the back of five (5) chairs. (The balloon with the word “hope” should be tied to a chair in the back of the room.) Following the discussion regarding loss issues the trainer should direct the participants attention to the balloons in the room. Using a straight pin and warning the participants of the loud noise that will soon incur, the trainer should break the balloons one-by-one. As the trainer progresses around the room s/he should discuss how sexually abused children are at risk of losing one (1) or all of these items as a result of their victimization. The trainer should then move to the back of the room where the balloon marked “hope” is left. The trainer should discuss how “hope” is an issue that many sexually abused children struggle with due to their cumulative losses. The trainer should emphasize that “hope,” however, can never be demolished when we are working with sexually abused children. Thus, “hope” remains and the trainer leaves this balloon intact throughout the training day. (If the trainer would like to provide the balloon to a participant at the end of the day, s/he can offer the balloon to the one (1) participant who offered a statement of “hope” for the day.)

#### **Stigmatization**

#### **Step 8:**

The trainer displays **Overhead #5: Stigmatization**, and discusses with participants the reasons for stigmatization may occur. Below are talking points for the trainer to discuss with participants:

Children who have been victims of sexual abuse are keenly aware of the negative connotations that surround their experience(s).

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#### **Step 8: continued**

They know that other individuals look at them and label the abuse and sometime the children as “bad,” “shameful,” or guilty of the abuse. Even very young children become aware of the “look” that others give them and know that they are being evaluated first as a victim and secondly as a child. The stigmatization of the experience is reinforced after the disclosure by the reaction and shock of others. If this reaction is negative, the child confirms his greatest fear - the fear of the abandonment by those who proclaim to love or care for him/her. Thus, the label of victimization is a strong and powerful one.

The degree to which a child is stigmatized often depends on the environment from which the child came and their current environment. The child’s family, offender, community and ecological surroundings all impact on the child’s knowledge and response to the abuse. In addition to these factors, the child’s religion, culture, moral standards and basic beliefs either contributed to or decreased the impact of the stigmatization. For example, in some cultures children who have been victims of sexual abuse, as well as women who have been raped, are viewed by the community as “tainted” or “damaged.” These children and women will be second-class citizens within their environment. This belief system certainly contributes to the stigmatization that the child feels.

The danger with the stigmatization process is that children begin to incorporate internally what others say or believe about them. This incorporation process can greatly affect their self-esteem and self-worth. In other words, the child comes to believe what the offender and others have told them all along - they are worthless or are only of value by meeting someone else’s needs. Children who feel very stigmatized as a result of their sexual abuse experiences can engage in very isolating behaviors, participate in alcohol or drug usage, involve themselves in criminal behavior, self-mutilate their bodies or attempt or complete suicide. They expect others to be repulsed by what has happened to them or what they allowed to occur. They expect professionals to choose to be with the “better” kids. We must show these children that we care deeply for who they are and not what happened to them. This unconditional affection may be confusing for some children.

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### **Destructiveness**

#### **Step 9:**

The trainer displays **Overhead #6: Destructiveness**, and discusses with participants reasons for destructive behaviors. Children who have been victimized may take their anger out on themselves or on others. Angry children, an emotion that they typically were not allowed to display during the abuse, have a need to control. They may become physically or sexually abusive with other children. They have a need to “one up” other children or caretakers. These are children who have faced a lifetime of failed efforts. Their response to failure is often immediate and intense. Sometimes they can appear overwhelmed by this intensity and out of control.

These children can also be destructive toward themselves. Approximately 1.4% of children and adults engage in some form of self-injury (Conterior & Lader, 1998). These behaviors include: cutting of the skin; hitting oneself; extracting hair to excess; head banging; scratching to excess; head banging; biting oneself; burning oneself; interfering with the healing of wounds; breaking bones; chewing the lips, tongue, or fingers; eye enucleation (removal); amputation of limbs, breast, digits, genitals; facial skinning; and/or the ingestion of sharp or toxic objects (Conterior & Lader, 1998). Approximately seventy-five (75)% of these children and adults engage in more than one method of self-injury. The typical self-mutilator is Caucasian, middle class, displays low self-esteem, is depressed and has above average intelligence. These behaviors appear uncontrollable to the child and become a more concerning problem in time, as the child often needs to move to more destructive behaviors to achieve the desired effect. It is important to remember that self-mutilators are typically not suicidal individuals. In fact, the irony is that they are engaging in these behaviors as an attempt to sustain their lives. Self-mutilating behavior can become a coping mechanism. Of all the concerning or problematic behaviors exhibited by sexually abused children, destructive behaviors can be some of the most bizarre or scariest for caretakers to manage.

### **Dissociation**

#### **Step 10:**

The trainer displays **Overhead #7: Disassociation**, Dissociation is the, “separation of mental processes that are normally integrated” (Spiegel & Cardena, 1991). Dissociation is a numbing process that shields the child from re-experiencing the abuse through intrusive thoughts (Sanders, 1991). Children “play possum” in order to detach from their bodies, numb their responses or/and build walls to protect themselves. Children dissociate emotionally and mentally when physical escape is not possible.

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Often children who have learned to disassociate may report that they are forgetful, notice attention shifts and have difficulty in establishing a sense of identity. Adolescents may report that they feel unreal and detached from their own experiences or history.

Children and adolescents may be unaware that they are dissociating and may not be able to accurately report their condition. Thus, caretakers of children must be keenly aware of what behaviors may be observed in these children. Dissociative behaviors include forgetfulness, staring blankly, and sudden shifts in mood or behavior (Friedrich, Jaworski, Huxsahl & Bengtson, 1997). The essential features of dissociation in children are amnesic periods and/or trance-like states and marked changes in behavior and functioning (Friedrich, et al, 1997). Dissociation can run the continuum of daydreaming to the extreme form of Dissociative Identity Disorder (DID). (This used to be termed, Multiple Personality Disorder). It is important to note that even though the child may have attempted to push the abuse out of his/her awareness, the abuse can still influence their thoughts, emotions and behaviors.

#### **Attachment**

##### **Step 11:**

The trainer displays **Overhead #8: Attachment**, and explains Although the attachment process continues throughout one's lifetime, the attachment of a child to a primary caretaker should occur between the ages of six (6) to twelve (12) months (Pearce & Pezzot-Pearce, 1994). As Bronfenbrenno proposed, "Every child needs someone who is crazy about him or her" (Maier, 1987). (Trainer can display this on a flip chart.) Children should learn that the adults in their lives are there to provide comfort, security and warmth. Maltreated children are less likely to develop these secure attachments. Insecure attachments are a risk factor for psychopathology in later childhood, which includes difficulties in the cognitive realm poor social skills, dysfunctional relationships and low self-esteem (Cicchetti & Carlson, 1989).

Children who are removed from their homes present with additional attachment issues. It is well documented that maternal support is one important factor in the healing process of victimized children. Children who have been placed in care may have little, if any, support from their maternal or extended family members. In fact forty (40%) to seventy-three (73%) of children with post-disclosures have been removed from their homes (Jaudes & Morris, 1990). The secondary trauma of removal and placement in care may have produced even a greater effect on the child than the original abusive incident(s).

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Attachment develops through attachment behavior. Children who do not know how to respond to appropriate relationships must be taught. Children who do not have the skills or resources to develop attachment must be provided with them. Children whose world has reigned with inconsistency and unreliability must be provided with consistency and order. Most troubled children can learn how to respond and form healthier relationships once someone has taken the first step in re-establishing a safe and appropriate relationship. Caretakers for these children must be the guides through this process.

#### **Traumatic Sexualization**

##### **Step 12:**

The trainer displays **Overhead #9: Traumatic Sexualization** and explains, Averaged across different age groups, sexualized behavior is one of only two symptoms found most frequently in sexually abused children compared to non-abused children who received clinical services (Pithers, Gray, Busconi, & Houchens, 1998). (The other symptom was PTSD). Traumatic sexualization is, “the process by which a child’s sexuality is shaped in developmentally inappropriate and interpersonally dysfunctional ways (Finkelhor & Browne, 1988). Victimization has taught the child that s/he will be rewarded for their inappropriate sexual behavior and they learn that their victimization is a strategy for manipulating others and getting their developmental needs met. The child develops confusion and misconceptions about his/her sexual behavior and morality.

Some children may engage in developmentally precocious behaviors such as masturbating in public, being overly sexualized with other children and adults, prostitution, promiscuity or engaging in sexual relationships with others. Typically these behaviors do not involve the use of force or implied force or planning. The intention of the child is not to harm another child but to work out its own issues of victimization. Dr. Toni Cavnagh Johnson identifies these children as “sexually reactive children” (1993).

Other children engage in coercive sexual behavior. They may involve younger or less sophisticated children in a variety of sexual acts, which typically involve force, or threat of force and planning. The purpose of these children’s behavior is to gain the submission of the other child. In some clinical environments, these children can be identified as juvenile sex offenders.

## **203: Managing the Sexually Abused Child**

### **Section IV: Treatment Goals and a Cognitive-Behavioral Response to Promote Healing**

**Estimated Length of Time:**

3 hours

**Learning Objectives:**

Discuss setting appropriate treatment goals  
Identify behaviors to address with sexually abused children  
Assess intervention techniques to manage inappropriate behavior

**Method of Presentation:**

Lecture, individual, small group, large group

**Materials Needed:**

Handouts # 3-6, Overheads 10-13

**Resources Used:**

Maier, H. (1994). Attachment Development Is "In". *Journal of Child and Youth Care*, Vol.9, 35-51.

Deblinger, E. & Heflin, A. (1996). Treating Sexually Abused Children and Their Non-offending Parents. Thousand Oaks, CA., Sage Pub.

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### **Section IV: Treatment Goals and a Cognitive-Behavioral Response to Promote Healing**

#### **Outline of the Presentation:**

##### **Step 1:**

The trainer explains the healing process for children should center on altering their more chronic maladaptive emotional and behavioral patterns, reducing their levels of stress and replacing maladaptive behaviors with more appropriate ones.

#### **Interrelationships Between Thoughts, Feelings, and Behavior**

##### **Step 2:**

Trainer should display this quote on **Overhead #10: Tobin 1991**, “Troubled children do not conceal their emotions well. They have a raw and disconcerting honesty. Perhaps that’s why we call them difficult.” (Tobin, 1991). The trainer should ask for examples from the group of a child, which had been labeled due to a lack of information. The following are talking points to be addressed with the group.

Sexually abused children need to identify, understand, and appropriately display their world of feelings. Children need to know that there is no right or wrong way to feel regarding what has happened to them. Children also need to know that it is helpful to share their feelings with others and that others, especially adults, can help children facilitate their expression of feelings. The first stage in the expression of feelings is to identify the feelings. Sexually abused children experience the same emotions that non-abused children do; however, they lack the past experience of identifying and labeling these feelings. (Distribute **Overhead #11: Feelings Workshop, Handout #3: Feelings Workshop**). Professionals may help children by asking them to express their feelings through words, song, artwork, or other creative means. (Distribute **Handout #4: Facilitating Children’s Expression of Feelings**).

##### **Step 3:**

Prior to the training, the trainer should purchase a large piece of paper and write the words “Feeling Wall” on the paper. The trainer should place this paper on a wall in the back of the training room. During the training, the trainer should direct the participants to think about what feelings sexually abused children struggle to deal with. Participants should be provided with an index card to write down this feeling on and place their cards on a “Feeling Wall.”

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The “Feeling Wall” will list several of these feelings as reported by the participants. The trainer should comment on the clusters displayed by the various participants at the training and discuss how this tool may be effective both as an individual and/or group strategy to minimize the isolation and stigmatization of sexual abuse, as well as promoting the identification and labeling of feelings.

Healing is the recognition of the experience(s), the identification and labeling of the child’s feelings and the integration of the experience. Deblinger & Heflin (1996) have developed a triangle that shows the interaction between the child’s thoughts, feelings and behaviors. (Trainer should display **Overhead # 12: Thoughts, Feelings, Behaviors**). This triangle can assist professionals in visualizing the mind and body connection while discussing their inter-relationship. Once victimized children have identified and labeled their feelings they often do not understand how their feelings and thoughts impact their behavior. They view their behavior as something that just happens and over which they have very little control. They need to understand that powerlessness in the past, is not powerlessness now. This model can help professionals discuss with children and adolescents the ability that every child has to control their behaviors. The ultimate goal surrounding this issue is that children learn to make the “head” to “heart” connection within their bodies just as healthy children do.

#### **Step 4:**

##### **Strengthen Relationships with Caregivers**

Trainer should explain that sexually abused children need to be cared for. This caring involves helping children to feel comfortable in a physical sense within their environments and developing “rhythmicity” (Maier, 1987). Rhythmicity is helping to create order and fostering togetherness.

Rhythmicity forms naturally in a caring environment. All children need consistency in their routines and a sense of order. This order produces a sense of security. Since, sexually abused children often come from chaotic environments where they do not know the value of order. These children may not know how to keep their personal belongings together, respect other’s property or function in a group setting. Caretakers may need to teach very basic skills. We also should encourage activities and exercises that promote a sense of belonging.

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Attachment to others promotes a faith in the future. Once children and adolescents become more comfortable with their relationships and see that other adults can be trusted and counted on, they begin to branch out and take more risks. Mistakes no longer are devastating to their self-esteem and they can learn from them. One of the major issues that confronts victimized children is, "Who and what should I tell everyone about what has happened to me?" Obviously, it is important that some individuals are aware of the child's history. In fact, it is vital that anyone that the child forms a significant bond with be well aware of the child's past since it has an effect on the child's current functioning. The victimization is a part of the child. It is not necessary, however, for everyone to be privileged to this information nor is it necessary for attached individuals to know all the details of the victimization. It might be wise to think of this sharing of information and letting "others in" (attachment) as deciding who is beneficial to the healing process and who is harmful. Beverly James has designed a technique entitled, "The Circle Of Telling" which allows children to visualize supportive and caring individuals in their lives. This helps children to filter out those adults, which are beneficial to their healing from those adults who are not. This is a fluid process that will have individuals entering and exiting the circle over a lengthy period of time. For young children it may be helpful to draw this circle of a large piece of flip-chart paper so that they can visualize these relationships. (Trainer can draw a "Circle of Telling" on the flip chart.)

#### **Step 5:**

The trainer should ask each participant individually to take a blank sheet of paper and write down the four (4) most important or valuable relationships in their current or past. The trainer should then direct the participants to write down at least one lesson or valuable piece of knowledge that they gained from each of these relationships. In other words, what did the participant gain from having being involved in each relationship? Next the trainer should ask the participants to consider how each lesson carried over or impacted on their current relationship(s). The trainer should facilitate a large group discussion with several participants offering up examples of their relationships. The trainer should draw the connection between historical relationship(s) impact on current functioning relationship(s). The correlation also exists for sexually abused children.

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#### **Manage Individual Inappropriate, Negative and/or Harmful Behavior(s)**

##### **Step 6:**

The trainer should read the following statement to the group or present it on a poster-board to give to a participant at the conclusion of the training. The quote reads, "Behavior management must be more than just devising techniques to make children do what we want them to do. We can do that; we have all the rewards and consequences and techniques. But do they meet the child's needs? Do they treat the child with dignity? A troubled child will answer these questions for you. You will know quickly and clearly whether you have met a need or only managed a behavior for a time" (Tobin, 1991, p. 40).

These are a few talking points to discuss with participants. As previously stated, sexually abused children can develop and exhibit a whole host of inappropriate or harmful behaviors. The development of these behaviors probably served a purpose for the child during the abuse. It may have made the child feel safer, more comfortable or in control of themselves. The behavior may also be an attempt to get their developmental needs met. Basic needs of the child are often disrupted by the trauma. These basic needs include: safety for self and others, trust in self or others, control of self or others, esteem for self or others and intimacy of self and others. Children should not be held responsible for what they did to survive or deal with the consequences of the abuse. Children must be taught that all of their feelings are valid, but that it is not appropriate to act on feelings that are detrimental to themselves or others. For example, sexually abused children probably are often angry about their victimization but, it is not okay for them to be aggressive with someone else. Teaching these children problem-solving skills, anger management and impulse control skills is essential.

##### **Step 7:**

It is important to remember that no process is full proof and that adjustments must be tailored to fit the child's developmental and individual needs. Any intervention must come from security and empathy. Successful intervention usually combines both a cognitive and a behavioral component to managing harmful behaviors. (Trainer should display **Overhead #13: Managing Inappropriate, Negative, or Harmful Behaviors** and **distribute Handout #5: Managing Inappropriate, Negative, or Harmful Behaviors**).

The trainer should at this point walk participants through each step of successful intervention, providing examples of from past experiences. Also giving participants the opportunity to share examples as a way of validating the information being covered in this section of the curriculum.

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#### **Step 7: (continued)**

The steps include:

- Separate the behavior from the child.
- Pick your battles. Behaviors need to be prioritized to determine their importance. (This is a very difficult step for parents/caretakers.)
- Children who exhibit a negative behavior should be encouraged to elicit a positive behavior.
- Identify and establish standards of behavior that the child can understand and fulfill.
- Adults should model and/or demonstrate appropriate behavior.
- Develop cues or signals to help the child remember the “new” behavior.
- Identifying and establish standards of performance that are understood by the child.
- Set the child up to succeed.

Some children may need someone to set physical boundaries on their behaviors. For example, children who engage in fire-setting behaviors must function in environments where they do not have access to fire-setting materials. Other children who display the behavior of defecating in the corner of a room may need someone who can physically walk them to the bathroom and support the child’s efforts to use the toilet. It is important to remember that caretakers may need to appeal to all of the child’s senses, and not rely on just the verbal world. Many sexually abused children have become numb to words and attach little meaning to them. Thus caretakers may need to be creative in developing ways to re-parent the child. We must be willing to offer up options or alternatives to the child to replace these behaviors. We are often quick to take something away from a child, without giving them something to replace it. Remember that inappropriate and harmful behaviors developed for a reason, to cope with the abuse. If we snatch away an inappropriate behavior away from the child, then often the child will develop another harmful behavior in its place.

#### **Step 8:**

Participants are asked to return to their small groups with Handout #5. In a small group the participants are asked to identify one potential problematic behavior of a sexually abused child and apply the eight (8) steps for managing the behavior.

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The group should discuss both a cognitive approach, such as listing statements that should be made to the child to re-structure inappropriate cognitive statements and to cite behavioral responses to the problematic behavior. This plan of action should be well thought out and detailed.

#### **Reduce Excessive and Unrealistic Self-Preoccupations and Increase Understanding and Acceptance of Self**

##### **Step 9:**

Victimized children want their problematic or traumatized childhood to be erased and for someone to provide them with a second chance to live the childhood to which all children are entitled. Sexually abused children have been robbed of their innocence, safety and security, and their childhood. For some children this pre-occupation with payback becomes a mission. Victimized children need to have an opportunity to mourn these losses while at the same time understanding that they can't get even or seek revenge in order to heal. Caretakers must dedicate both time and effort to allow children to honor their losses, losses for which no one can provide adequate compensation. Some children need to move through forgiveness with the offender or other involved individuals so that the child can engage in the healing process. In some religious communities (i.e., Roman Catholic Church), forgiveness is a necessary part of healing. Children should never move to work on forgiveness unless it is for the benefit of the child, NOT the offender or non-offender. It is vital to remember that forgiveness is NOT something that the offender requests; s/he is not entitled to it. Rather, the child offers up forgiveness because it is in her/his best interest. For some children offering forgiveness may allow the child to move on and not become stuck in their anger.

Sexually abused children and their caretakers must learn the appropriate use of boundaries in every aspect of the child's functioning. Many victimized children possess little ability to set limits on their physical or emotional self. Through the sexual abuse, the offender has taught the child that they do not have the right to set limits on their own bodies and what little boundaries are in place, can be violated when and if the offender chooses. It is important that children be taught what appropriate boundaries are in relation to their own body spaces, their right to privacy, and respect. They must be able to actively take steps to remove themselves from situations where they feel uncomfortable. For example, children may need to physically take one (1) or two (2) steps back from someone else if they feel uncomfortable with their bodies in relation to others. Children may also need to learn how to keep their hands to themselves.

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Establishing a sense of body integrity is necessary for victimized children. Trauma is experienced by children and adults within their psychological and physical realms. Healing involves helping children to learn to appreciate their bodies and to feel comfortable with their developing bodies. Unlike adults, children and adolescents are in the midst of an ever-changing physical state. The feelings of confusion, embarrassment and even disgust that some children feel about their bodies are heightened by sexual abuse. Caretakers have to teach body awareness and comfort as basic steps in learning to love and appreciate one's body.

Information concerning the basic anatomy of males and females is often necessary, as well as detailed and accurate information regarding healthy sexuality for adolescents. Helping the child or adolescent move from a negative to a positive attitude toward their body integrity can be emphasized with several strategies or activities. For example, children might be encouraged to involve themselves in movement with music, sports, and even martial arts. (For children with destructive or sexually acting out behaviors these activities should be considered in relation to the safety of the child and/or other children.)

#### **Step 10:**

The trainer should ask the participants to take a blank piece of paper and fold it in half horizontally. On the outside each participant should be asked to draw a picture of what they look like on the outside. The trainer should then ask the participants to draw a picture of what they look like on the inside. If time permits the trainer may ask that several participants share with the group their "outside" picture. The "inside" picture should be kept confidential.

Older children or adolescents may also struggle with the physiological body responses to the sexual abuse. Children or adolescent's bodies respond physically to touch, contact and human closeness. Some of these children's bodies responded to the physical touch and displayed sexual arousal. This arousal may add to the child's feelings of shame or guilt over the abuse. These children must be helped to understand that their body's response was "normal" and that it does not mean that they "wanted" or "asked for" the abuse. Professionals should not contribute to the belief system of some children or adolescents that their bodies betrayed them and worked against them.

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#### **Fortify Defenses that are Weak and Ease Others that are Rigid**

##### **Step 11:**

The trainer should explain that, many children and adolescents develop a number of coping techniques to deal with the abuse. Some of these techniques are helpful and some of them are harmful to the child. Some of the harmful coping techniques are listed below (Distribute **Handout #6: Coping Techniques**)

- \*Hurry Up and Get It Over With
- \* A Child Will Forget
- \*They Learned Their Lesson`
- \* It's Not Really That Bad
- \* The "Onlys"
- \* They Said They Were Sorry

Trainer should use these talking points. Each of these coping techniques prevents or disrupts the child from moving through the healing process. These techniques do little to empower the child, which is the goal of a healthy coping technique. Unhealthy coping techniques do not allow the child to change his/her basic beliefs about themselves. A child's basic beliefs about him/herself are altered due to the sexual abuse. The thoughts and feelings that are the reaction to the situation are formed through and after the victimization. We need to help children pay attention to the facts of the situation and identify their beliefs through which they screen the facts. For example, many children develop "stinking thinking" about themselves. They use words or phrases like, "I can't", "I'm a jerk", "I hate everybody" or "I can't do good in school". After these negative beliefs are identified then professionals can help children replace their statements, and ultimately their belief systems, with more positive statements and beliefs. Professionals can assist in changing these negatives by avoiding generalities, avoiding negative predictions, allowing the child to specify their concerns and encouraging positive self-statements.

##### **Step 12:**

One strategy that professionals can use with children ages eight (8) and up is to engage in "thought Ping-Pong" (Shapiro, 1997). "Thought Ping-Pong" is a game that pits optimistic thoughts directly against pessimistic ones. The trainer should develop an overhead or flip-chart paper with several "stinking thinking" statements provided by the participants. The trainer should also have several Ping-Pong balls available at the training, so that s/he can throw the balls into the group and ask a particular participant to re-direct the negative statement. The large group should be asked to come up with the positive statement that contradicts the negative one. Remember that a positive comment must be realistic and "do-able" by the child. "Thought Ping-Pong" does not involve general or cheerleading type of statements. The participants should be able to effectively re-directing the child's "stinking thinking."

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#### **Step 12: (continued)**

There are several adult behaviors that are known to discourage or stimulate moral maturity in children. Some of the behaviors that discourage moral maturity are: cold, punishing, rejecting, hostile, rigid, belittling, critical, incepting, neglecting, authoritarian, nagging, overprotective, over-indulgent, rewarding of fearful behavior, suspicious, paying attention to immature behavior, discouraging independence, encouraging extreme conformity, and discouraging a positive self-concept. Some of the behaviors that encourage moral maturity in children include: showing affection, showing acceptance encouraging autonomy, encouraging courage, encouraging achievement, encouraging social interaction, reinforcing good habits, listening reflectively, understanding, relaxed, respecting self and others, minimizing mistakes, separating the child from the punishment, teaching skillfully, consistency, and modeling positive expected behaviors. Adults who can build this environment for the child are helping the children to help themselves and to think of others.

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### **Section V: Conclusion**

#### **Estimated Length of Time:**

15 minutes

#### **Learning Objectives:**

Provide closure to the training

Evaluate the workshop

#### **Materials Needed:**

Evaluation forms

#### **Resources Used:**

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### **Section V: Conclusion**

#### **Outline of the Presentation:**

##### **Step 1:**

The trainer should summarize the theme of working with difficult children is that our efforts are often genuine but sometimes misguided. The healing process for these children often comes slowly and in steps and stages. We must stand together as professionals who are willing to comfort the child's victimization and serve as a guide for the child through the healing process (Distribute Bibliography).

##### **Step 2:**

The trainer should allow time for a Question and Answer Period to give participants time to clarify any information obtained in this workshop.

##### **Step 3:**

The trainer should thank participants for attending the workshop and distribute the evaluations to be completed by each participant. Then the trainer should allow the participants some space or appoint a spot for all evaluations to be placed before exiting the room, in order to not make participants feel uncomfortable with recording their thoughts and feelings about the experience.

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