

Topic: Assessment and Treatment of Sexually Abusive Children

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Assessment and Treatment of Sexually Abusive Children

- This session will focus on the various components of the assessment and treatment protocols for children with sexually abusive behaviors in specialized psychiatric units in inpatient mental health. These children often have co-existing psychiatric disorders that need to be addressed concurrently. Children with sexually abusive behaviors often have a history of trauma and often have difficulty formulating healthy attachments.

Assessment and Treatment of Sexually Abusive Children – Continued

- This session will include case studies of children that may have a history of trauma, attachment issues, along with sexually abusive behaviors in the inpatient child psychiatric setting.

Case Studies – Patient 1

- Zina is a 9-year-old Caucasian Female whose parents are seeking inpatient treatment for sexually abusive behaviors. Last Friday night, her stepmother entered her room due to noises and saw Zina lying over her 5-year-old sister, Amy, with pants pulled down humping her. Amy said Zina had done this at least 5 times since she came to live with them 3 months ago and told Amy she would hurt her if she told. Zina was currently suspended from school subsequent to throwing a desk at her teacher after being told to raise her hand before talking.

Case Studies – Patient 1 Continued

- Following entering treatment Zina initially stated Amy deserved it because her stepmother loves Amy more than her and because Amy does not mind the sexual behaviors. Zina did disclose sexual abuse by mother's ex boyfriend's son who babysat her when she was 6 years old. However, she was evasive when the topic came up. She was diagnosed concurrently with PTSD and began trauma focused CBT, in addition to treatment for the sexually abusive behaviors, and improved emotional regulation skills.

Case Studies – Patient 2

- Patient Case 2
- Jerome is a 7-year-boy whose his parents are seeking inpatient treatment for frequently getting caught at school with his hands in his pants, and the school will not allow him to return to school until he gets help.

Case Studies – Patient 3

- Alex is a 12-year-old Caucasian female, from a small town somewhere in Northwestern Oklahoma, whose parents were seeking inpatient treatment for her sexually abusive behaviors. They reported she has been having her 5-year-old younger brother and 6-year-old little sister engage in oral sex and object penetration with her for an unknown length of time. Alex would take the children into the storm shelter by their barn when the parents left her to babysit.

Case Studies – Patient 3 continued

- Alex would dress in a Halloween princess outfit and would tell them she was the princess and they were her servants, and that they had to obey. Alex then swore them to secrecy. Alex's sister disclosed this information to her teacher, after being caught touching a female peer. The teacher then called Alex's parents and the DHS hotline. In school, Alex was well behaved, had friends and loved to volunteer to babysit.

Case Studies – Patient 3 continued

- Following initiation of treatment Alex disclosed abusing at least 18 additional child victims all of whom she manipulated into “playing” this game. These victims included neighbor kids, kids she babysat and younger family members over the last 3 years.

Assessment of Child/Adolescent With Sexually Abusive Behaviors:

- Sexually Abusive Behaviors Defined:
 - Definition: Initiation of sexual behavior that is manipulative, coercive, aggressive or all the above.

Assessment of Child/Adolescent With Sexually Abusive Behaviors: Continued

- Examples of sexually abusive behaviors: Anal and vaginal penetration, object insertion, oral-genital contact, genital to genital contact without penetration, bestiality, exposing genitals, grabbing other's private parts, and frottage (sexual gratification from rubbing against non-consenting person)

Assessment of Child/Adolescent With Sexually Abusive Behaviors: Continued

- Age Appropriate Sex Play
 - Masturbation
 - Limited to looking, undressing and touching
 - Activities such as playing house and playing doctor
 - Between same age/size and cognitive level peers without coercion or manipulation
 - Child stops the behavior when redirected by parent/caregiver

Assessment of Child/Adolescent With Sexually Abusive Behaviors: Continued

- Abusive Dynamics
 - Power Differential – age, size, physical ability, developmental level, intellectual functioning, position (put “in charge” by parent etc)
 - Status or Authority
 - Baby sitter
 - Popular kids
 - Class officer at school

Assessment of Child/Adolescent With Sexually Abusive Behaviors: Continued

- Manipulation
 - Bribes
 - Threats – against victim, someone victim cares about, or pets
 - Use of force
- Charm, Seduction, Coercion, Guilt induction, Bribery

Assessment of Child/Adolescent With Sexually Abusive Behaviors: Continued

- Interview
 - Child
 - Guardian
 - Collateral Sources (e.g. foster parents, teachers, therapist, DHS or OJA caseworker)

Assessment of Child/Adolescent With Sexually Abusive Behaviors: Continued

- Child Assessment
 - Abuse history – while many children who engage in sexually abusive behaviors do have a history of being sexually abused, it is important to note that 1) most children who were sexually abused do NOT engage in such behaviors and 2) many children who engage in sexually abusive behaviors do not have a history of being directly sexually abused.

Assessment of Child/Adolescent With Sexually Abusive Behaviors: Continued

- Assess for co-existing psychiatric disorders and/or medical issues –
 - Psychiatric (e.g., PTSD, Bipolar Disorder, Depression, ADHD, Intermittent Explosive Disorder, etc.)
 - Physical (e.g., rash, asthma, urinary tract infection, etc.)

Assessment of Child/Adolescent With Sexually Abusive Behaviors: Continued

- Age of child and developmental age (emotional, and intellectual)
- Specifics of the sexual acts – as identified at assessment (often, once in treatment, more such acts will be disclosed)
- Identifiable Triggers
- Number of known incidences

Assessment of Child/Adolescent With Sexually Abusive Behaviors: Continued

- Number of known victims
- Reliability of report
- What is fueling the abusive behaviors (e.g. revenge, hypersexual, bullying, copying, “boys will be boys”, experimentation, exposure to adult sexuality, etc.)

Assessment of Child/Adolescent With Sexually Abusive Behaviors: Continued

- Parent/Guardian/Care-giver Assessment
 - Commitment and willingness to participate in the child's treatment
 - Home environment
 - Involvement of extended family – negative or positive
 - Community Support

Assessment of Child/Adolescent With Sexually Abusive Behaviors: Continued

- Child parent relational problems
- Sibling relationships
- Discipline methods in the home

Assessment of Child/Adolescent With Sexually Abusive Behaviors: Continued

- Safety Assessment
 - Assessing extent of danger to others – home, school, community
 - Supervision plans – home, school, community

Assessment of Child/Adolescent With Sexually Abusive Behaviors: Continued

Ability of current caregiver to maintain safety

- Awareness of the behavior
- Does the caregiver view the behavior as problematic
 - “boys will be boys” attitude
 - “They are just playing” (without recognizing power differential etc.)
- Willingness and ability of caregiver to provide the level of supervision required to keep everyone safe

Assessment of Child/Adolescent With Sexually Abusive Behaviors: Continued

Risks for continuing to engage in sexually abusive behaviors

- The child does not acknowledge the behavior
- The child is not aware that the behavior is wrong
- The child generally non-compliant with authority
- The child is not well-supervised
- The child has co-occurring mental disorders that increase risk of harm to self or others

Assessment of Child/Adolescent With Sexually Abusive Behaviors: Continued

Implementing safety plans in home, school, and community environment while on a waiting list for admission

- Written plan for rules and supervision – specific to the situation Examples of things that might need to be on the plan:
 - No bathing together
 - Doors closed when using bathroom, bathing, dressing, etc

Assessment of Child/Adolescent With Sexually Abusive Behaviors: Continued

- Direct supervision at ALL times when child is around any other child
- Keeping all sexually explicit material out of child's reach
- No sleepovers with other children
- Child sleeps in his or her own room with no other children
- Secure internet access/parental controls at home/school/community

Treatment: Inpatient vs. Outpatient



Treatment of Child/Adolescent With Sexually Abusive Behaviors:

- **TREATMENT:**
- Inpatient versus Outpatient
 - Advantages of each
 - Disadvantages of each

Treatment of Child/Adolescent With Sexually Abusive Behaviors: Continued

- Inpatient - Advantages
 - Intensity of treatment –
 - Individual Therapy
 - Family Therapy
 - Master's level process therapy groups
 - Recreational/Expressive therapy
 - Rehab groups
 - Milieu treatment

Treatment of Child/Adolescent With Sexually Abusive Behaviors: Continued

- Increased supervision
- Therapeutic passes – practice what has been learned in treatment
- School provided on-site with improved supervision
- Sleeping arrangement
- Treatment of co-occurring psychiatric needs and other behavior problems

Treatment of Child/Adolescent With Sexually Abusive Behaviors: Continued

- Outpatient - Advantages
 - Child remains in the home with family
 - No disruption in school attendance (staying in the same school)
 - Treatment within the community

Treatment of Child/Adolescent With Sexually Abusive Behaviors: Continued

- Disadvantages
 - Inpatient
 - Disruption of family unit
 - Family may have to travel long distances to be involved in child's treatment
 - Child may learn negative behaviors from other peers in the inpatient setting

Treatment of Child/Adolescent With Sexually Abusive Behaviors: Continued

- Outpatient Disadvantages
 - Potential for the child to continue engaging in sexually abusive behaviors, placing others at risk
 - May not be able to provide treatment for co-occurring disorders in one setting, requiring multiple settings and appointments each week

Treatment of Child/Adolescent With Sexually Abusive Behaviors: Continued

- Outpatient Disadvantages
Continued

- Specialized treatment specific to children with sexually abusive behaviors may not be available within the community
- Less intensive treatment

Treatment of Child/Adolescent With Sexually Abusive Behaviors: Continued

- Decision Tree
 - Severity of the sexually abusive behaviors –
 - How long have the behaviors been occurring
 - How serious are the behaviors
 - How much power and control is being exerted on the victim(s)
 - Are the victims in the home

Treatment of Child/Adolescent With Sexually Abusive Behaviors: Continued

- Extent of co-existing psychiatric and/or other behavior problems
- Risk that the child will continue engaging in sexually abusive behaviors
- Level/quality of supervision available at home, in school, in community
- Availability of outpatient services specific to treating children with sexually abusive behavior problems in the community

Treatment – Inpatient setting

Guiding Principals/Goals in Treatment:

- The child will return home following treatment
 - Exception: if the child is in state custody the child will return to foster care in the same or a different foster home as determined by DHS and the treatment team

Guiding Principals/Goals in Treatment: Continued

- The parent(s) will participate in the child's treatment
 - Attending weekly family therapy sessions
 - Phone calls
 - Visitation
 - Therapeutic passes
 - Preparing the home for the child's return – safety and prevention planning

Guiding Principals/Goals in Treatment: Continued

- Notification to DHS hotline when indicated, for investigation and protection of the victim
 - if the child's sexually abusive behaviors have not already been reported

Guiding Principals/Goals in Treatment: Continued

- Notification of DHS hotline when indicated, for investigation regarding the child's own sexual abuse history that may be disclosed in therapy – if not already reported
 - When in doubt – report
 - Families may not always remember correctly what has or has not been reported
 - Safety issues – is there a perpetrator still out there potentially hurting other children

Guiding Principals/Goals in Treatment: Continued

- Individualized treatment for the child's developmental level
 - Using the same general components, but making sure to address each child at his or her specific developmental level and cognitive ability

Components of Treatment

- Treatment generally falls into the following 7 categories and occurs in individual, family, group, and milieu settings:
 - Accountability
 - Development of Empathy
 - Trauma
 - Relationship Skills
 - Sexuality
 - Safety/Prevention Plan
 - Treatment of co-occurring psychiatric and behavioral problems

Components of Treatment Continued

- Accountability
 - Acknowledging the behavior and taking responsibility
 - Thinking Errors such blaming, minimizing, playing the victim

Components of Treatment Continued

Sexual Behavior Rules

- It is not okay to show other people your private parts.
- It is not okay to touch other people's private parts.
- It is not okay to let other people touch your private parts.
- It is not okay to tease, joke, or harass about sexual things to make other people feel uncomfortable.
- It is okay to touch your own private parts as long as you are alone, you don't take too long, or hurt yourself.

Components of Treatment Continued

Sexual Behavior Rules Continued:

- The child will identify what sexual behavior rule(s) he or she has broken and with whom
- The child will identify both internal and external triggers to engaging in sexual behaviors

Components of Treatment Continued

- The child will identify positive coping skills to use to keep from engaging in additional sexually abusive behaviors when triggered
 - Relaxation Technique
 - Turtle Technique
 - Journaling
 - Art work
 - Physical Activity

Components of Treatment Continued

- Development of Empathy
 - Letter of apology
 - “Conversation with the Victim”
 - Draw your own/victim faces
 - How Would You Feel if

Components of Treatment Continued

- Trauma
 - Education about what trauma is and how it impacts thinking, emotions, and behaviors
 - Use of trauma workbook
 - Processing the child's personal trauma history
 - Trauma Timeline/Life Story
 - Who Is Responsible
 - Identifying how the child's behavior is causing trauma for his or her victims

Components of Treatment Continued

- Relationship Skills
 - Anger management
 - Trust development
 - What Makes a Friend
 - Teaching healthy and appropriate boundaries

Components of Treatment Continued

- Sexuality
 - Body Respect
- Treatment of co-occurring psychiatric and behavioral problems and the role of psychiatric medications

Components of Treatment Continued

- Safety/Prevention Plan
 - Prior to passes and discharge (e.g., increased supervision, privacy rules, boundaries, triggers)

FAMILY/PARENT/CAREGIVER:

- Education – the parent or caregiver is educated about parenting a child with sexually abusive behaviors
- The potential need for concurrent outpatient family and individual therapies for family members and/or victim

FAMILY/PARENT/CAREGIVER: Continued

- The parent or caregiver receives the same information as the child regarding
 - Sexual behavior rules
 - Safety/Prevention Planning
 - For passes and at discharge
 - The importance of increased supervision on passes and at discharge

FAMILY/PARENT/CAREGIVER: Continued

- Personal Responsibility
- Criteria and therapeutic work to be done while the child is on a pass
- Aftercare – outpatient follow-up services for the child and family
- What to do if the child engages in additional sexually abusive behaviors following discharge

FAMILY/PARENT/CAREGIVER: Continued

- How to encourage and prompt the child to use the positive coping skills learned
- Family communication – Active Listening Skills
- Age-Appropriate discipline/Parenting Skills
- Treatment of co-morbid psychiatric disorders and/or behavior problems

Prognosis

- Extent of success hinges on:
- Active participation of child in all aspects of treatment including:
 - Owning the sexually abusive behaviors
 - A sense of remorse
 - Developing healthy social/interpersonal skills
 - Development of empathy
 - Education about sexually abusive behaviors and trauma
 - Use of positive coping skills learned in treatment

Prognosis - Continued

- Active participation of parent(s) and/or other caregivers during inpatient treatment
- Co-existing mental illness stabilization
- Active participation and consistency in participation and all aspects of after-care plan, including outpatient appointments and use of the comprehensive safety/prevention plan developed while the child is participating in inpatient care.
- Supportive home and community environment, including extended family members when possible



References and Resources

- References and Resources:
- Treating Children With Sexually Abusive Behavior Problems, Jan Ellen Burton, Lucinda Rasmussen, Julie Bradshaw, Barbara Christopherson, and Steven Huke, 1998 The Haworth Maltreatment and Trauma Press
- Where Did I Come From? by P. Mayle, 1973. Lyle Stuart, Inc.
- Types of Touch – A Very Touching Book...for Little People and Big People, Jan Hindman, Alexandria Assoc (July 1983)

References and Resources Continued

- **National Center on Sexual Behavior of Youth (NCSBY) <http://www.ncsby.org/>**
- **Cognitive-Behavioral Group Therapy for Children with Sexual Behavior Problems
<http://ncsby.org/pages/publications/CSBP%20Cognitive-behavioral%20child.pdf>**
- **American Academy of Child and Adolescent Psychiatry <http://www.aacap.org/>**
- **Center for Child Abuse and Neglect at the O.U. Health Sciences Center
<http://www.oumedicine.com/body.cfm?id=4532>**

References and Resources Continued

- Treatment Centers in Oklahoma:
- Center on Child Abuse and Neglect
- <http://www.oumedicine.com/body.cfm?id=4532>
- INTEGRIS Health-Spencer, Inpatient Residential Treatment for child and adolescents (ages 5-14)
<http://www.integrish-health.com> scroll down through Services to “Mental Health” and click on “STAR” for more information

References and Resources Continued

- Saint Anthony Hospital, Positive Outcomes (ages 13-17), Oklahoma City
- Shadow Mountain Hospital, Threshold Unit (ages 12-17)
- <http://www.psolutions.com/facilities/shadowmtn/serve.html>

Steps to Taking Personal Responsibility for My Actions:

- STEP #1: Admit my behavior (Tell it like it is)
- STEP #2: Accept the consequences for my behavior without arguing or pouting
- STEP #3: Identify the trigger (What was I thinking, feeling, or telling myself that made it OK to do the behavior?)

Steps to Personal Responsibility Continued

- STEP #4: Identify how my behavior was harmful
 - To myself
 - To others
 - To property
- STEP #5: Make a plan (What can I tell myself or what positive coping skill can I use to keep from doing that behavior the next time?)
- STEP #6: Do it – WORK THAT PLAN! (Use the plan you made. If you need to say, “I’m safe now” say it. If you need to use the Turtle Technique, your “Safe Place” or some other relaxation skill, use it)

Steps to Personal Responsibility Continued

- The children are taught to use this 6-step process to work through a variety of behaviors, not just sexual behaviors. If the child can dissect his or her behavior in this way, it helps point to where an intervention might be most effective. This is a difficult process for very young children, but can be simplified depending on the age and developmental level of the child.

Common Thinking Errors and Corrections

- **Common Thinking Errors and Corrections:**
- Blaming Acknowledge your behavior
- Dishonesty Tell the truth – all of it
- Playing the Victim Identify strengths and
responsibility for change
- Avoiding Face it

Common Thinking Errors and Corrections Continued

- Changing the subject Stay on task
- Minimizing Honestly acknowledge what you did – in full
- Assuming Make sure you know the truth
- Anger Violence is not okay –
Positive alternatives
- Wearing a mask Be genuine
- Making Excuses Identify your choices

Letter of Apology

- **Information about writing a Letter to the victim –**
This is not necessarily a letter that will be sent to or read by the victim. Whether or not the letter is ever sent to or read to the victim is a decision that must be made with all the parties providing input regarding the victim's readiness to hear an apology. If the victim's healing will not be helped or will be hindered by reading such a letter, then the letter should still be written, but not sent.

Letter of Apology Continued

- Initially the child should NOT be told what kind of things should or should not be in the letter, only asked to write an apology letter. Writing a letter of apology is primarily an exercise to help the child develop empathy by identifying what he or she did to harm another person, accepting that he or she was totally responsible for those actions, apologizing for those actions, and identifying what he or she is now doing to be sure the actions are not repeated.

Letter of Apology Continued

- The apology letter will take on a somewhat different look depending on the age and developmental level of the child writing it. It often requires a number of drafts or attempts before the letter is completed. There are some important “do’s and don’ts” in writing such a letter.

Letter of Apology Continued

- The child should apologize – “I am sorry that I touched you in sexual ways”
- The child should make a clear statement acknowledging responsibility without blaming or making excuses – “What I did was wrong and it was my responsibility, not yours”. It is important that the child not say things like – “but I would not have done it if you had kept the bathroom door closed” or “I only did it because that is what happened to me” or other such blame-shifting statements.

Letter of Apology Continued

- The child should make a clear statement that it was not the fault of the victim -- “What I did was wrong and it was my responsibility, not yours”.

Letter of Apology Continued

- The child should express some empathy for the pain caused – “I think that you might have been really scared and angry when I touched you. It is probably going to be really hard for you to trust me again”. (The child must be careful to say what he or she thinks the other person may have felt and not be as presumptuous as to declare how the other person felt or to tell that person what to feel.)

Letter of Apology Continued

- The child should describe how he or she set up the incident and how he or she attempted to cover it up – “I gave you candy so that you would do what I wanted and so that you would not tell”.

Letter of Apology Continued

- The child should also explain what he or she is doing to be sure that it never happens again – “I am learning how to live by the sexual behavior rules. I am learning what triggers me to act in that way and how to change my focus. I am learning positive coping skills to use to replace those behaviors. I am working hard and am going to do my best to be sure I never engage in those hurtful sexual behaviors again”

Letter of Apology Continued

- The child should encourage the other child to tell if the child ever feels unsafe.
- The child **SHOULD NOT** ask the other child to forgive him or her. The other child may not be ready to forgive and may feel “put on the spot” to “forgive” even when not ready, which will likely then impede his or her healing process.

Sample: Safety and Prevention Plan

Behavior	Trigger	Place	Safety Team Member	Replacement Activity/Behavior
Sexual behaviors	Talking about sexual things	Home	Outpatient therapist, My DHS worker, foster parents	Talk to a safety team member; go to the park; Play with remote control car
	Movies or television with sexual content	Home	Outpatient therapist, My DHS worker, foster parents	Change channel; Walk away; talk to safety team member; Safe place
	Seeing pictures of sexual things	Home or School	Outpatient therapist, my DHS worker, foster parents, teacher, principal, school counselor	Walk away; talk to a safety team member; go clean room; safe place
	Seeing peers pretend to have sex	School or Home	Outpatient therapist, my DHS worker, foster parents, teacher, principal, school counselor	Walk away; talk to a safety team member; safe place; school work
Violence or Defiance	Being in trouble	Home, School, Community	Foster parents, outpatient therapist, My DHS worker, teacher, school counselor, principal	Safe place; change self-talk; talk to a safety team member
	Not getting what I want	Home, School, Community	Foster parents, outpatient therapist, My DHS worker, teacher, school counselor, principal	Safe place; change self-talk; talk to a safety team member

Safety and Prevention Plan Continued

- “Johnny” should not be with other children unsupervised and should not be placed in a position of authority over other children (NO BABYSITTING, no bathing or changing of diapers).
- All family members need to be sure the bathroom door is completely closed when using the bathroom, bathing, or changing clothes.
- All family members need to be sure bedroom doors are completely closed when changing clothes.
- “Johnny” should not be allowed to be in any room alone with any other children without direct adult supervision by trusted adults who know “Johnny’s” history
- In school, “Johnny” is also to be closely monitored and should pay special attention to avoid risky situations like reading cubbies or secluded places on the playground
- If “Johnny” rides a school bus she should be seated in direct line of vision of the driver or monitor

Safety and Prevention Plan Continued

- “Johnny” is not to engage in such activities as a “sleep-over” for a minimum of 6 months, at which time this should be revisited/reviewed with the family therapist
- “Johnny” is to have his own room and should not be sleeping in a room with any other children
- ALL adults and children in the home should maintain modesty at all times – changing clothes in a bedroom or bathroom with the door closed, doors closed when using the bathroom or bathing, etc.
- “Johnny’s” television/movie watching and video game playing should be closely monitored. “Johnny” is not to watch any movies or television or play any video games with questionable content or rated more than PG. Be aware that some PG rated movies have content that may be a trigger...these are also to be avoided
- All adults in the home need to be aware of these rules and be willing to follow them.
- It is important to stay in constant contact with the outpatient therapist and to fully engage in family therapy, as well as, individual therapy.

Safety and Prevention Plan Continued

- Adult matters should be kept private and foster parents will need to monitor all adults in the home to be sure they are appropriate and that they behave appropriately around “Johnny”. All adults in the home need to be aware of this safety plan and willing to adhere to it.
- The family needs to stay in close contact with the outpatient therapist and immediately address any new or ongoing issues.