TRAINER GUIDE

Audience: This training is designed for foster parents. It is designed to highlight common issues for sexually abused children and to present a realistic picture of the types of behaviors that foster parents may encounter in this population.

Organization: The Trainer Guide consists of a training outline with exercises, copies of the Participant Manual for the trainer's use, trainer, and a manual for participants.

Areas to Emphasize: Foster children have developed a number of behaviors and coping mechanisms that enabled them to survive in their families of origin. These behaviors developed over a long period of time. Modifying the behaviors will not be accomplished in a short time frame. Foster parents must have realistic expectations and must work cooperatively as part of the treatment team.

Time:
This training is set up for one hour. There are more exercises included than that time frame allows. Modify according to group size.

Mandated Reporter Training
Sexual Abuse
Trainer Outline

COA Requirements Addressed
❖ **G7.3**

Competencies Addressed
❖ ❖

TIME: **3 Hours (9:00-12:00)**

Workshop Objectives: Participants will

- Understand the scope of child sexual abuse in the United States.
- Know the dynamics of a child molestation.
- Understand the principles of the Child Sexual Abuse Accommodation Syndrome
- Know behaviors frequently exhibited by sexually abused children
- Understand why children may recant a valid disclosure

TRAINER NOTE: Do not pass out the Participant Manual until after the first exercise. The first exercise will not work if participants can just look up the answer in the Participant Manual. Set Handout 1, Child Maltreatment Questionnaire out on the tables and encourage participants to complete it as they come into the classroom.

I. Introductions

A. Trainer to group – briefly introduce yourself and establish your credentials to train the material

B. Cover housekeeping issues – location of break rooms and bathrooms, message boards, etc. Request that participants sign the sign-in sheet in order to get credit. (Do this step only if time allows and the group is relatively small.)

C. Course objectives – cover the course objects quickly. This material is summarized for participants in the Participant Manual which they will receive in a few minutes (page 3).

D. No icebreaker is included as the training session is only an hour.

II. Dynamics of Child Molestation

A. Help the group differentiate between a rape and a molestation (not in the legal sense but in the mechanism of the assault). Teaching points include:

- By far the most children who are victims of sexual abuse are molested.
- These children are seduced into sexual activity by a person they should have been able to trust.
- Most of the abusers are known to the child and in a care-giving position.

B. Stages of molestation

- Direct participants to the page in the manual on stages of a molestation (pages 4 - 6).
- Lead a large group discussion to surface the behaviors that occur at each stage. For example, ask "What do you do o build a child's trust?" Again, in the short time frame, this material may have to be presented as a lecture only.

C. Cover the progression of sexual acts
Discussion Questions:

- Do you think children are getting reported sooner in the process?
- Do all molesters commit all the acts in this progression?

III. Child Sexual Abuse Accommodation Syndrome

A. Poll the group to see if anyone has heard this term.

B. Cover the major principles of the syndrome. Emphasize the detrimental effects on normal attachment and the wrong learning that happens in abusive home. Refer participants to page 7 in the Participant Manual.

C. Point out that some of the accommodation behaviors are common to all types of abuse. Specific accommodations in sexual abuse including learning to value yourself only as a sexual object and learning to relate to adults and to others in a sexualized manner.

IV. Physical and Behavioral Indicators of Sexual Abuse

A. Small group exercise: Behavioral indicators of sexual abuse. The instructions for this exercise are in the trainer resource section. Do try to have this small group exercise.

B. Processing this exercise is really a discussion of ways to handle the sexualized behaviors and other abuse-related behaviors exhibited by foster children. Participants have resources in their manuals on page 8.

V. Recanting

A. Refer participants to the material on recanting.

B. Lead a discussion of the points set out in the material.

VI. Do Children Lie (optional – time dependent)

A. Lead a discussion around the issues set out on the page. See the material in the trainer resource section for additional information.

B. Acknowledge that the subject of false memories is the material for a workshop in and of itself.

C. The teaching points are set out in the trainer resource section.

VII. Conclusion

Conclude the session by answering any questions (as time allows). Thank participants for coming and spending their time to learn more about this subject.

Ask participants to please evaluate the session and pass out the evaluation forms.

SMALL GROUP ACTIVITY

Purpose

The purpose of this exercise is to highlight the behaviors evidenced by sexually abused children and to develop strategies to modify unacceptable behavior patterns.

Materials

Since this activity is for a very large overall group no materials other than a piece of paper and something to write with are required.

Methodology

1. Divide the group into several smaller groups. If possible, separate couples.

2. Ask each small group to list 3-5 behaviors exhibited by sexually abused children that they have trouble dealing with. The group needs to rank the behaviors, with one being the most problematic.

3. Allow 5-7 minutes. Then, ask the small groups to report back to the larger group. Point out common themes if/as they emerge.

4. Move the discussion into the following areas:

Processing

- Behaviors have developed over time
- Behaviors had survival value for a long time
- Is it abuse or is it just “kid”
- Expect sexual activity
- Structure for safe sex
- Set reasonable limits (depending on behavior and assessment of problems)
- No right or wrong answer
- Work with professionals

Child Sexual Abuse

Parenting the Sexually Abused Child

Participant Manual

U·A·L·R

School of Social Work

CHILD SEXUAL ABUSE
AGENDA

I. Introductions

A. Speaker

B. Course objectives

C. Scope of the problem

II. Dynamics of Child Molestation

A. Molestation vs Rape

B. Stages of molestation

C. Progression of sexual acts

III. Physical and Behavioral Indicators

A. Physical indicators (developmental perspective)

B. Behaviors associated with abused children

D. Discussion

IV. Recanting (If we get there)

A. How frequent

B. Structuring for safety

V. Lying, False Memories and Issues De Jour (If we get there)

A. Lying vs Coaching

B. Lying from a developmental perspective

C. The issue of false memories

COURSE OBJECTIVES

Participants will:

- Understand the scope of child sexual abuse in the United States
- Know the physical indicators of sexual abuse
- Know behaviors frequently exhibited by sexually abused children
- Understand the dynamics of child molestation
- Be familiar with conditions that lead children to recant a valid disclosure
- Be familiar with the controversy around children lying about sexual abuse and around false memories of sexual abuse

SCOPE OF THE PROBLEM

1996: 3,000,000 Reports of Suspected Child Maltreatment to CPS

Slightly more than 1,000,000 were substantiated

Of the 1,000,000:

52% involved neglect

24% involved physical abuse

12% involved sexual abuse

6% involved emotional abuse

3% involved medical neglect

14% involved other types of maltreatment (abandonment, threat of harm, congenital drug addiction, and other situations not specified in the initial report to CPS)

1996: 1,077 children projected to have **died** from physical abuse and/or neglect

Sources

U.S. Department of Health and Human Services, National Center on Child Abuse and Neglect data System. (1998). *Child maltreatment 1996: Reports from the states to the National Center on Child Abuse and Neglect.* Washington, DC: U.S. Government Printing Office.

American Humane Association: http//www.americanhumane.org/children/factsheets

STAGES OF SEXUAL MOLESTATION
INCEST STAGES

Much of child sexual abuse is a molestation rather than a rape or forcible contact (not rape as legally defined in the criminal code).

Child sexual molestation frequently passes through the following stages:

- Engagement
- Sexual Interaction
- Disclosure
- Recanting/Suppression

Some professionals list secrecy as an incest stage. However, for purposes of this discussion secrecy is assumed to be a dynamic that permeates all stages.

Engaging - Key Issues • **Building Trust** • **Favoritism** • **Alienation** • **Boundary Violations** **Sexual Interaction** • **Progression** • **Place** • **Time** • **Bribes, threats, punishment, guilt - to maintain the secret**	**Disclosure** • **Accidental vs. Purposeful** • **Crisis** **Recanting/Suppression** • **System mobilizes to maintain status quo** • **Overt/covert pressure** • **Victimization by "helping" systems**

BEHAVIORS IN THE STAGES of MOLESTATION

List Behaviors

Engagement

- Building trust
- Favoritism
- Alienation
- Boundary violations

Disclosure

- Accidental vs. purposeful
- Generates a family crisis

Sexual Interaction

- Progression of sexual acts (See next page)
- Place
- Time
- Bribes
- Threats
- Guilt

Suppression

- Family system mobilizes to maintain the status quo
- Overt and covert pressure on the victim to retract the disclosure
- Re-victimization by the “helping” systems.

PROGRESSION OF SEXUAL ACTS

Nudity

Disrobing

Genital Exposure

Observation of the child

Kissing - Lingering, Intimate

Fondling

Masturbation

Fellatio

Cunnilingus

Digital Penetration of Anus or Vagina

Dry Intercourse

Vaginal and/or Anal Intercourse

THE WORLD OF THE SEXUALLY ABUSED CHILD: ACCOMMODATION TO an ABNORMAL ENVIRONMENT

(Adapted from Child Sexual Abuse Accommodation Syndrome; R. Summit)

The world of the sexually abused child:

- Secrecy
- Helplessness
- Entrapment
- Delayed disclosure
- Retraction

To Live and Survive the Child Must:

- Keep the secret
- Learn to distrust his/her perceptions
- Accept responsibility for the survival of the family
- Learn an alternative way to be “good”

Behaviors

- Develop over a long period of time (a lifetime)
- Enable survival – emotional and physical
- May mimic ADHD symptoms
- May be what the child falls back on in times of stress

DEALING WITH THE BEHAVIOR
(Pulling, Hair, Gnashing Teeth, Keeping On Keeping On)

Be an Advocate for Assessment/Treatment

- Even if the child is "doing OK"
- Evaluate the need for medication (mimicking symptoms ADHD)
- Treatment if recommended
- Be a pert of the Treatment Team
- Recognize the child may need treatment "boosters"

Deal with Sexual Behaviors

- Recognize they may likely occur
- Work with the treatment provider, FSW and school
- Set reasonable expectations on behaviors
- Explain consequences for failure to comply with "rules of the house"
- Determine rewards for desired behaviors
- Be patient – behavior was a long time in the making

CHOOSING A THERAPIST

(Provided by Karen Worley, Ph.D. and Jan Church, Ph.D.; Family Treatment Program)

The therapist should:

- Be familiar with normal sexual development

- Be willing and able to work well with children, parents (including foster parents)

- Be comfortable opening discussing sexual behaviors with youth and parent/foster parent alike

- Conduct a thorough assessment of therapeutic needs, be flexible and creative, monitor and evaluate treatment and modify if needed

- Have skills in cognitive-behavioral therapy, play therapy, social skills training and self-esteem building

1.

PHYSICAL and BEHAVIORAL INDICATORS OF CHILD SEXUAL ABUSE

Provided by
THE CHESAPEAKE INSTITUTE, INC.

The behaviors listed below are behaviors frequently exhibited by children who are experiencing stress. Certainly, many of the behaviors can be caused by things other than sexual abuse. Some behaviors may be normal at certain developmental stages but at different stages may indicate regression. Behaviors are a clue but rarely prove sexual abuse in the absence of other factors.

Infants

A. Types of Physical Evidence
   1. Observation of sexual abuse by a third party (witness)
   2. Physical injury
      a. Genital bruising or bruising caused by restraint of child's mouth, wrists, or legs
      b. Lacerations around genitalia
      c. Fissures - small cracks around anal opening - may be visible in sodomy cases
      d. Skin tags - flaps of skin around anal area - caused by repeated rectal penetration - sphincter muscles become damaged and stretched
      e. Bite marks - may be visible around breast or genital area
   3. Suspicious stains, blood or semen are noted on child's diapers, clothing or body
   4. Presence of sexually transmitted disease
   5. Difficulty urinating (burning, frequent urination or retention) or excreting (pain when excreting or retention of feces)

B. Behavioral Indicators:
   1. Excessive crying
   2. Fretful behavior - agitation
   3. Somatic symptoms such as feeding problems, bowel problems
   4. Failure to thrive

Toddlers

A. Types of Physical Evidence:
   1. Observation of sexual abuse by a third party (witness)
   2. Verbal statement (2-5 years) from child
   3. Physical injury
      a. Genital bruising or bruising caused by restraint of child's mouth, wrist, or legs
      b. Lacerations around genitalia
      c. Fissures - small cracks around anal opening - may be visible in sodomy cases
      d. Skin tags - flaps or skin around anal area - caused by repeated rectal penetration - sphincter muscles become damaged and stretched
      e. Bite marks - may be visible around breasts or genital area
   4. Suspicious stains, blood or semen are noted on child's underwear, clothing, or body
   5. Presence of sexually transmitted disease in the child
   6. Difficulty urinating (burning frequent urination or retention), problems with bowel movement, pain when excreting or retention of feces.

B. Behavioral Indicators:
   1. Regression - thumb sucking, bed wetting and/or soiling, baby talk, clinging to adult, fretful behavior, sleeping with previously discarded toy
   2. Fear of dark
   3. Intensified sex play with peers, dolls, toys, animals
   4. Nightmares
   5. Excessive masturbation - may cause genital irritation, consistent behavior in public

School Age Children

A. Types of Physical Evidence:
   1. Verbal statement, planned disclosure
   2. Observation of sexual abuse by a third party (witness)
   3. Physical injury
      a. Genital bruising
      b. Lacerations around genitalia
      c. Fissures - small cracks around anal opening - may be visible in sodomy cases
      d. Skin tags - flaps or skin around anal area - caused by repeated rectal penetration - sphincter muscles become damaged and stretched
      e. Bite marks - may be visible around breasts or genital area
   4. Suspicious stains, blood or semen are noted on child's underwear, clothing, or body
   5. Presence of sexually transmitted disease
   6. Early unexplained pregnancy

7. Difficulty urinating (burning, retention, frequent urination) or problems with bowel movement, pain when excreting or retention of feces.

B. Behavioral Indicators:
   1. No affect (emotions) to dramatic display of affect
   2. May exhibit regressive behavior (acts younger than chronological age)
   3. Sleep disturbances
   4. School problems
      a. School phobia (fear of school may indicate victimization from a school employee or offender who approaches child on way to school)
      b. Arriving early to school, leaving late (resistance to going home)
      c. Multiple absences from school
      d. Inability to concentrate or perform academically (distracted, may be trying to find a solution to their victimization)
      e. Sudden, noticeable fluctuation in school performance (may mark onset of victimization or change in extensiveness of victimization)
   5. Withdrawal from peers - secrecy isolates victim from meaningful relationships, due to trauma victim feels older than peers
   6. Withdrawal from recreational activities - victims have a negative or distorted body image
   7. Poor body image/poor self-esteem - victim perceives self in a negative way and body image as distorted
   8. Advanced sexual knowledge
   9. Prevailing lack of trust
   10. Stylized sexual behavior - learned seductive behavior
   11. Depression - may lead to suicide attempts
   12. Aggressive behavior - verbal or physical fights with others
   13. Enticing other child into sexual play or acting out sexual behavior with dolls, toys or animals
   14. Enuresis - bed wetting
   15. Running away
   16. Eating problem
      a. Anorexia - refusal or inability to eat, severely underweight which may lead to hospitalization
      b. Bulimia - eating excessively and vomiting
   17. Wearing layered clothing, hoping it will provide protection or make self unappealing
   18. Acquires expensive or inordinate amount of gifts from one individual

Adolescents

A. Types of Physical Evidence:
   1. Verbal statement, planned disclosure
   2. Observation of sexual abuse by a third party (witness)
   3. Physical injury to genital area
      a. Genital bruising
      b. Lacerations around genitalia
      c. Fissures - small cracks around anal opening - may be visible in sodomy cases

d. Skin tags - flaps of skin around anal area - caused by repeated rectal penetration, sphincter muscles become damaged and stretched
e. Bite marks - may be visible around breasts or genital area

4. Presence of infection or sexually transmitted disease
5. Pregnancy one or more times at an early age
6. Complaints of gastrointestinal problems (nausea, stomach aches)
7. Burning on urination or frequency of urination

B. Behavioral Indicators:

1. Prevailing lack of trust
2. Poor peer relationships
3. Poor body image and poor self-esteem (victim perceives self in a negative way, sees body as distorted)
4. Running away
5. No affect (emotions)
6. Sleep disorders - nightmares, restless sleep, excessive sleep or inability to sleep
7. Observe either:
   a. Overly compliant adolescent (adolescent says what he/she thinks you want to hear) or
   b. Aggressive acting out behavior, fights with peers (verbally or physically)
8. School problems
9. Pseudo maturity (acts older than years, adult like)
10. Substance abuse (alcohol or drugs)
11. Multiple sexual contacts, has negative reputation
12. Fear of males/females
13. Confusion over sexual identity and fear further sexual encounters
14. Clinical depression - requiring mental health treatment, medication or hospitalization
15. Depersonalization, or multiple personality disorder
16. Suicide - threats, gestures or accomplishment
17. Desire for pregnancy - love object, wants to get pregnant, engages in sex and refuses to use birth control
18. Eating problems:
    a. Anorexia - refusal or inability to eat, severely underweight which may lead to hospitalization
    b. Bulimia - eating excessively and vomiting
19. Wearing layered clothing, hoping it will provide protection or make self unappealing
20. Acquires expensive or inordinate amount of gifts from one individual

*Note the behavioral indicators show signs of stress in children. Some of the behaviors listed are normal at a given stage of child development. You are looking for excessive behaviors or regression (behaviors a child has outgrown and reverts back to).

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WHEN THE CHILD RECANTS

Life in the Home
- Secrecy
- Helplessness
- Learning to live with it: betrayal, objectification, distrust of own perceptions, self-blame, learning how to "be good," protection of the family

How Children Tell
- Small percentage actively disclose – clear, purposeful decision to tell someone
- Greater % tell in bits and pieces
- Developmental considerations
- Some never tell or do not tell until adulthood

Reasons to Recant a Valid Disclosure
- Pressure from the perpetrator
- Pressure (overt or covert) from the family
- Negative personal consequences
- Negative consequences for the perpetrator
- System influences – multiple interviews by different interviewers, multiple courts, quality of the interaction with system personnel

Implications for Intervention
- Recanting should not equal automatic disbelief of original disclosure – how good was the original interview(s) and investigation
- Deserves careful evaluation

Structuring for Safety (physical and Emotional)
-
-
-

DO CHILDREN LIE ABOUT SEXUAL ABUSE?

Considerations

- Differentiate lying from mistakes, misinterpretations of innocent acts and or coaching

- Developmental perspective on lying
  1. Why would a child lie about sexual abuse (motivation)?

  2. What do you have to do to make up a good lie (making it believable)?

  3. Are children cognitively able?

IS IT A FALSE MEMORY?

- Could be a workshop by itself
- How good was the interviewer?
- How many times was the child interviewed?
- What is the pattern of the child's information over several interviews?

HANDOUT 1

CHILD SEXUAL ABUSE QUESTIONNAIRE

How many children will be sexually abused in the United States?

Which is more frequent – rape or molestation?

Do children lie about sexual abuse?

Do you believe that YOU can make a difference for sexually abused children? Why or why not?