Promoting Resilience in Children Who Have Been Sexually Abused: A Relational Approach

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An overview of research and practice findings to promote resilience in children who have been sexually abused: a relational approach.

Course Objectives

Upon completion, readers will:

1. Understand current research and practice findings in social work assessment and intervention that support resilience in sexually abused children.

2. Critically evaluate stigma associated with child sexual abuse (CSA) in two ways:
   - First, in terms of its historical foundations, and how stigma has influenced social policies in child welfare.
   - Second, how stigma contributes to assessment and intervention that tends to omit the importance and the impact of the betrayal of caregiver relationships when a child is sexually abused.

3. Appreciate the significance of assessment and intervention that address the relationship violations that characterize CSA.

4. Apply research and practice findings that differentiate the developmental etiologies of relational trauma associated with CSA, from the etiologies of childhood disorders with similar presentations

5. Assess and understand differences in the behavioral manifestations of relational trauma, especially in terms of children’s and adolescents’ externalizing, sexual behaviors.

Introduction and Overview

The Consequences of Childhood Sexual Abuse

When our practice with children and teens in psychotherapy, or in medical and other practice areas, reveals a history of childhood sexual abuse, we often find it is challenging to know how to proceed. What are we to look for in terms of the impact of abuse? Often, the history of child sexual abuse (CSA) is eclipsed by the acute presentation. These presenting problems are usually variations on trauma symptoms such as inattention, hyper-vigilance, impulsivity, easy frustration, poor social skills, and other emotional, social and cognitive concerns (Finkelhor, 2009). Although these are trauma-related problems, too often, they are not conceptualized as the sequelae of trauma. Instead, the presenting problems among children who experience sexual trauma are often diagnosed as ‘externalizing disorders’.

The externalizing disorders are characterized by disruptive behaviors and include Attention Deficit-Hyperactivity Disorder, Oppositional Defiant Disorder, and Conduct Disorder, among others, to include sexual behaviors. Sexual behaviors stigmatize children and adolescents because childhood and sexuality are antithetical in the minds of most adults. Adults are, understandably, uncomfortable with children engaging in sexual behaviors and this is amplified if the child has been sexually abused because it raises the spectre of children as sexually offending. Social workers are expected to conduct a preliminary assessment of sexualized behavior, but are often unprepared to do so (Finkelhor, et al., 2010). Because child sexual behaviors are often viewed as the *sin qua non* of sexual abuse,
but few social workers are familiar with how to assess these, this training will conclude with guidelines for the assessment of sexual behaviors in children and teens.

While externalizing behaviors are disproportionately noted, to a lesser extent, children with a sexual abuse history are diagnosed with ‘Internalizing disorders’ such as depression and anxiety (Finkelhor, et al., 2010; McLeer, Callagham, Henry & Wallen, 1994; Wonderlich, 1996) or learning disabilities (Ollendick & King, 1994; Williams & Pojula, 2002). Although it is often believed girls are more likely to ‘internalize’ distress in response to CSA, this is not supported in empirical studies (ibid). Both internalizing and externalizing problems are best understood in the context of affective, cognitive, and most importantly, the relational manifestations of child sexual abuse.

**Social Work Assessment and Intervention: From Abuse Reactions to Behavior Control**

Although most social workers are aware of these connections, there tends to be a drift away from conceptualizing the child in terms of sexual abuse and trauma, toward managing the behavioral manifestations of it. In school settings, where most child referrals are generated (Sedlack, et al. 2010) these affective and cognitive problems are frequently diagnosed as one or more of the externalizing disorders (Schore, 2001), especially Attention Deficit, Hyperactivity Disorder (ADHD; American Psychiatric Association, 2000; McLeer, Callagham, Henry & Wallen, 1994). This diagnosis means an intervention in the schools will most likely include academic support services (Pfiﬀner, Barkley & DuPaul, 2006). Outside of school, there will most likely be an evaluation and prescription for psychopharmacology, which is largely ineffective with trauma (Connor, Glatt, Lopez, Jackson, Melloni, 2002) and various forms of psychotherapy to reduce behavioral problems (Friedrich, 2002). These, and other supports, are routinely implemented to promote the child’s self-regulation and improve academic performance (Pfiﬀner, et al., 2006).

**Child Sexual Abuse as Betrayal Trauma: Why Etiology Matters**

It is fair to ask why the etiology matters if the intervention supports the child in becoming more competent in school. After all, academic engagement is a key characteristic among resilient children (Masten & Coatsworth, 1998). However, the point of assessment is to accurately identify strengths and resources (Saleebey, 2002). Assessment leads to a name for the problem. The name we assign helps the client and social worker focus attention toward particular issues, and away from others. In the vast majority of cases, child sexual abuse is committed by someone a child relies on (Berliner, 2011; Briere & Scott, 2013). Because most children rely on their abuser, there is betrayal of trust. When the abuser and the person who is supposed to provide protection and guidance are the same, the child is in the untenable position of maintaining the relationship and submitting to this abuse of power (Putnam, 1997). These relational dynamics in sexual abuse impact the child in ways that can be misattributed to internalizing or externalizing disorders.

**Etiology of Externalizing Behaviors: Neurobiology in ADHD and CSA**

A longitudinal analysis of the diagnostic reliability of ADHD among children who were sexually abused found that 27% of the clinical sample met DSM-IV-TR criteria for ADHD prior to sexual abuse and 67% did afterward (Taro, Sugiyama & Someya, 2006). Based on these ﬁndings, the authors concur with other researchers in the observation that hyper-vigilance (Glod & Teicher, 1996) and hyperactivity (Bremner, Vythilingam, & Vermetten, 2003) among children who have been sexually abused and those who have ADHD have distinctly different etiologies. These etiological ﬁndings point to different regions of the brain that account for attention problems in children who have experienced CSA and those with ADHD. In CSA the Hippocampal-Pituitary Axis, (Bremnar, et al., 2003) is implicated while cerebellar-prefrontal-striatal dysfunction is found in children with ADHD (Schore, 2001).

This analysis, and others (e.g. McLeer, Callagham, Henry, & Wallen, 1994) propose that cognitive and affective changes that follow childhood sexual abuse mimic those of ADHD. In particular, hyper-vigilance interferes with attention and contributes to hyperactivity (ibid). Likewise, neurological correlates with impulse control problems that were not present prior to sexual abuse have been noted afterward (Merry & Andrews, 1994). Taken together, these studies suggest that internalizing and externalizing behaviors are best understood as problems with self-regulation that result from the overwhelming stress of trauma as betrayal in the context of a relationship with an adult.

Evidently, the etiology of internalizing and externalizing symptoms involve different neuro-pathways. In cases of trauma that result from interpersonal sexual violence, children’s relationships with adults and peers are profoundly impacted because of the exquisitely personal nature of this experience. Failure to differentiate between the behavioral manifestations of sexual abuse and the behavioral manifestations in the form of internalizing or externalizing symptom runs the risk of iatrogenic error. Put another way, it is important to understand and respond to the emotional, cognitive, and physiological dysregulation in the aftermath of child sexual abuse as the sequelae of relational trauma.

Although key principles of interventions that address internalizing and externalizing behavior disorders, such as Collaborative Problem Solving (Greene, 1996) and Multisystemic Treatment (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998) are recommended here, they are chosen because they address not only behavioral problems, but they are also fundamentally interpersonal rather than behavioral. As will be developed in depth in this training, social workers need to understand how to assess...
and intervene when relational trauma is a factor and to make relationship-trauma-informed decisions about intervention. This is easier said than done. In some cases, the full impact of sexual abuse, or the fact that it happened at all may not be realized until years later (Finkelhor, 2008, Herman, 1992) or in some cases until adulthood (Maughan & Cicchetti, 2003, Briere, 1992, Rothschild, 2000).

**Family Dynamics in CSA**

Other complications in work with sexual abuse involve family dynamics, which again, are often not understood in the context of the relational trauma that co-exists with sexual abuse. Families are often devastated by fractured relationships and lingering loyalty conflicts. Social workers are bewildered by hidden coalitions, patterns of secrecy, denial and scape-goating because we don’t always understand how these dynamics are connected to the abuse. When these and other family dynamics are assessed and intervened with as sexual abuse-related, there is more opportunity for a coherent case formulation and to collaborate with family members around how to address these patterns (Madsen, 1999).

About 12% of all social workers serve in the area of child welfare, including social work in schools (NASW, 2010). For the majority of social workers in other practice areas, the impact of childhood sexual abuse is not our direct focus. However, given the estimated prevalence of one in five girls and one in eleven boys who are reported to experience sexual abuse of varying degrees (Finkelhor, 2009) social workers who serve children, adolescents and families, inevitably encounter CSA in our work. The assessments and interventions required by federal and state mandate (e.g. through the Department of Children and Families; DCF in Massachusetts) are not the direct focus of this training, although this training is of value to child protection social workers.

**Definitions, Assumptions, and Scope of Training**

A lack of universal definition across treatment settings, among researchers and in the legal community, make it difficult to know exactly what we mean when we say a child has been sexually abused (Bolen & Scannapieco, 1999). The necessary conditions for contact child sexual abuse proposed by Douglas & Finkelhor (2005) will be used here. An age or maturational difference, which usually ranges from three (e.g. Snyder, 2000) to five (e.g. Sedlack, Mettenburg, Basena, Petta, McPherson, Green, & Li 2010) years difference. The abuser is in a position of authority or is a care-taker, and the acts are carried out against the child by using violence or trickery. This training assumes that the perpetrator of abuse is someone the child knows, as is true in about 90% of all cases (Berliner, 2011; Sedlack, 2010). Contact abuse, as the terms implies, differs from non-contact abuse in that there are various forms of physical contact. These and the corresponding impact are outlined in the Assessment section below.

It is also assumed that the incidents of sexual abuse are in the past and that the child is currently safe. Although we can never be certain that a child is safe, the main purpose here is to assist social workers across practice settings to provide effective assessment and trauma-informed intervention following CSA. To this end, this training will provide a brief overview of the historical context of childhood sexual abuse in which the continued secrecy, shame and stigma are identified as likely contributors to the tendency to lose sight of the significance of CSA in assessment and intervention. Social policy or lack thereof will also be discussed as these shape contemporary practices. Resilience theory frames the assessment of risk and protective factors that contribute to the range of outcomes presented. Interventions that promote resilience, or protective factors, and reduce the negative effects of CSA are presented as well.

**PART ONE: Stigma and the Historical Context of Childhood Sexual Abuse**

Child sexual abuse is part of the history of a fair number of children and families. Over time, it seems that the discomfort we have with the idea of sexual abuse of children lead us astray in terms of assessment and intervention. Thus, our thinking about children and families tends to focus on the manifestations of CSA, rather than a holistic perspective that includes and appreciates the profoundly relational aspects of this trauma. There is a good bit of history that precedes our current avoidance. The impact of child sexual abuse and what we do and what we do not know about it, is influenced by the larger social and historical context. Historical antecedents can be found in the case of Sigmund Freud and his contemporaries.

Freud, Janet, Charcot, and others proposed a causal relationship between childhood sexual abuse and subsequent psychiatric impairment, most notably ‘hysteria’ (Kerr, 2012). That Freud or others would suggest sexual impropriety as an etiological factor in hysteria was aggressively rejected by many psychiatrists at the time (ibid). The example of Sigmund Freud, who was ostracized and shamed for his willingness to believe and address the impact of CSA in the case of Dora, serves to illustrate important social dynamics. First, is the profound and pernicious influence of social pressure on what a society will allow itself to know and to learn more about. The social taboo against sexual contact between adults and children does serve to inhibit this behavior. It also serves to limit our willingness to acknowledge that it happens. In turn, our unwillingness to know, creates a climate of secrecy that is a necessary pre-condition for CSA to occur (Douglas & Finkelhor, 2005).

For social workers today, as was the case for Freud, stigma exerts subtle influence but is evidenced in our tendency to formulate the sequelae of CSA in terms of its’ behavioral or social manifestations. There are fascinating parallels between the social processes that silenced Freud, and those that may silence us. Perhaps talking about a child’s behavior as related to sexual abuse is more
uncomfortable than talking about reducing ‘acting out behaviors’ or increasing socially appropriate emotional expression.

More important for the child, there are parallels between Freud’s recantation of CSA as the etiology of hysteria because he was not believed, and the experience of the child who recants disclosure of abuse because (s) he is not believed. Freud recanted sexual abuse as the etiology of hysteria. In this revision, he proposed infantile longings for the opposite-sex parent, which he termed the Oedipus (for boys) and Electra (for girls) complexes (Herman, 1989). In this formulation, the child wants to have a sexual relationship with the parent, but abuse experiences are imagined gratification of this longing.

Subsequent to Freud and his colleagues recantation of CSA, history is largely silent on the topic. An ethos of shame and secrecy that kept CSA out of public discourse gradually diminished during the 1980’s and into the 1990’s. I attribute this partly to the subversive powerhouse known as Oprah Winfrey, whose televised chats with sexual abuse survivors introduced this previously forbidden subject into mainstream conversation. This public conversation is most often attributed to the feminist movement, to shifts in our views of the rights of children, and to the enactment of these views through social policy. To sketch out a more complete sense of the current social policy context, this training will briefly highlight select historical events that directly influenced child welfare policy.

The Social Policy Context of Child Sexual Abuse

Child welfare policy is the means through which a society expresses and implements beliefs about parental rights and beliefs about the rights and needs of children. U.S. child welfare policies prescribe the scope and the types of surveillance and intervention child protection agencies are to provide (Lipsky, 2010). From a socio-historical perspective, a consensus about childhood as a protected and separate period of human development is a relatively recent development. To illustrate, consider works of art from specific historical eras and cultures, such as Victorian England, in which sexual interaction between adults and children are depicted. Today, such images would be cause for imprisonment.

The Case of Mary Ellen Wilson: There Ought to be a Law!

In more recent U.S. history, the need for a social policy to enact our values regarding child protection was driven by the sensational story of Mary Ellen Wilson. In 1872, Mary Ellen’s neighbors gave vivid accounts of their observations of her appalling home life. According to their testimony, she was brutally beaten and rarely allowed out of the apartment she shared with her guardians. In some anecdotally recorded accounts, there was also sexual abuse (Nelson, 1984) but public record is silent on this allegation. There was public outcry when the case was prosecuted by the Society for the Prevention of Cruelty to Animals (SPCA) under animal cruelty statutes. The absurdity of an organization whose purpose was to safeguard animal rights championing the cause of Mary Ellen highlighted two social issues. First, is the glaring absence of an agency to safeguard children’s safety. Second, is the absence of any laws to prosecute child maltreatment, despite the existence of both an animal protection agency and legal statutes against animal cruelty. Mary Ellen’s case provoked a social momentum that led to the establishment of the Association for the Prevention of Cruelty to Children (ASPCA) in December of 1874 and legal statutes to prosecute child maltreatment (ibid).

The Child Abuse and Prevention Treatment Act of 1974

The Social Security Act of 1962 mandated child protection services at the state level. The most significant piece of social policy legislation in recent history is the Child Abuse Prevention and Treatment Act of 1974 (CAPTA). Leroy Pelton (1978) objected to ‘the myth of classlessness’, on which CAPTA was established. He proposed that child maltreatment is an economic, or social class issue because child abuse reflects the oppressive living conditions of the adults who, in turn, inflict these conditions on their children in the form of coercion and violence. These patterns of domination and subordination were said to mirror the gross inequalities of U.S. society. Accordingly, Pelton cautioned against the prevailing medical, or psychiatric explanations for child maltreatment promoted during the 1960’s. In his view, a focus on parents and their psychopathology as causal in child abuse served to deflect attention from the social and economic inequalities that he believed to be the real cause of child maltreatment.

CAPTA: Etiology of Child Abuse is Parents’ Psychopathology

Psychopathological explanations for child maltreatment were heavily promoted by proponents CAPTA. Walter Mondale and his supporters carefully presented child maltreatment as a private family sickness that crossed all social and economic strata. In the public
view, if parents, regardless of race or class, abuse their children, it stood to reason that there was something ‘wrong’ with the parent. Thus, the policy was termed Child Abuse Prevention and Treatment (emphasis added), in order to make provisions for treatment of sick parents and to protect vulnerable children from them.

CAPTA defined physical and sexual abuse as well as forms of neglect. In this sense, social consensus exists around the obligation of professionally trained adults to protect children by reporting suspicions of abuse to designated Child Protection Services or CPS. The Adoption and Safe Families Act of 1997 (ASFA) edified the expectation that child safety is the central concern for federally funded CPS intervention. ASFA also put a two year limit between the time a state took custody of an abused or neglected child and when that child needed to be in a ‘permanent’ home (Miller-Perrin & Perrin, 2013). CAPTA and ASFA led to nearly as many questions as they did answers. If child abuse is the result of psychopathology, what mental health treatment is appropriate? At what point should knowledge of abuse be shared with law enforcement? If ASFA mandates a focus on child safety and permanence, and the treatment aspects of CAPTA are part of this policy, what does this mean in terms of the nature and scope of assessment and intervention by social workers in mental health, school, medical or other community settings? These closely related historical, social and policy factors and the questions they raise contribute to the complex and emotionally-charged topic of child sexual abuse today. In particular, the medical and psychiatric themes that reinforced the credibility of child welfare policy, have implications for what and how social workers provide assessment and intervention to address the effects of CSA.

PART TWO: Effects of Abuse

Introduction

As social workers, we are familiar with the misperceptions of the general public in terms of child welfare and our involvement (insert mental image of social worker wrenching a distraught, screaming child from an equally anguished parent). Although these misperceptions are diminishing, we are somewhat accustomed to the idea that the sequelae of childhood sexual abuse is characterized by similarly dramatic, but inaccurate, images. In a way, common misperceptions about the aftermath of sexual abuse are like watching a horror movie in a packed theater. The audience shares dreaded anticipation as the terrible impact of the horror is to be revealed in one, graphic, climactic scene. In the reality of our practice experience, what will result from the sexual abuse of a child manifests over time and in subtle, insidious ways that blur the connection between cause and effect. Even for social workers whose work is primarily with children and families who experience sexual abuse, the diversity of outcomes can come as a surprise.

This is partly because we are oriented to the massive body of epidemiological (e.g. Sedlack, et al., 2010; NIS-4) and case study (e.g. Sanford, 1990, 2004) research that predicts and chronicles the devastating effects of CSA. As will be presented for closer analysis below, these effects include internalizing disorders (Brown, Cohen, Johnson, & Salzinger, 1998; Ollendick & King, 1994). Internalizing disorders include eating disorders (Ruggiero, 2004; Wonderlich, 1994) depression (Cicchetti, Rogosch, Gunnar, & Toth, 2010) and anxiety disorders, particularly Post Traumatic Stress Disorder (Sedlack, et al., 2010) as well as social or interpersonal problems (Teisl & Cicchetti, 2007; Putnam, 1997). Externalizing disorders are more often noted among children who have experienced CSA (Briere & Scott, 2013, Sedlack, et al., 2010; Teisl & Cicchetti, 2007). Externalizing reactions are often referred to as disruptive behavior disorders (Greene, 2010). These include Oppositional Defiant Disorder, Conduct Disorder and Attention Deficit Disorder (Cicchetti, et al., 2010, Gled & Teicher, 1996). Externalizing reactions have also been noted which include an increased likelihood that the female sexual abuse victim may sexually abuse others (Miller-Perrin & Perrin, 2013; Putnam 2004). However, this finding has not held up with male offenders (Dobash, Carnie, & Waterhouse, 1993).

Social Work Assessment of the Impact of Child Sexual Abuse

This brief description of the social and historical context highlights how the stigma and secrecy that characterize CSA have limited our willingness to more fully understand the prevalence and impact. The fact that sexual abuse is part of a child or adolescent’s history is frequently noted in social work assessment. As is mirrored in these historical and policy events the effect of stigma steers our attention away from CSA toward the behavioral manifestations, which then become the focus. Discomfort and taboo around sexual behavior and children are factors in the processes that lead to this drift.

Victim Blaming in CSA

It will be difficult to believe, but victim blaming is actually an ongoing issue in the public and in social work. A number of studies using college students, professionally employed adults, and randomly assigned adults found a consistent pattern of blame assigned to children for sexual involvement in various vignettes. Children were most likely to be seen as responsible for adult sexual contact if the child is attractive, past puberty and the vignette describes the child as one who has been known to lie or to be promiscuous (Rogers Josey, & Davies, 2007, Rogers & Davies, 2007; Back & Lips, 1998; Maynard & Wiederman, 1997; Rogers, Josey, & Davies, 2007). Other studies find that respondents minimized the impact of CSA if the victim appeared to have reached puberty (Maynard & Wiederman, 1997; Kennel & Agresti, 1995; Reynolds & Birkimer, 2002; Rogers et al., 2007; Rogers & Davies, 2007). Another group of studies have found that professionals are more likely to believe a younger child’s disclosure and to discredit older children (Kalichman & Craig, 1991; Kennel & Agresti, 1995).
Why Blame the Victim? Children Who Have Been Sexually Abused Don’t Always Act Nice

Stigma and a tendency to blame victims would probably be reduced if there were a clear cause-and-effect relationship between CSA and the impact on the child. The seeming unpredictability of how CSA will affect children in tandem with stigma serve to further explain the complexity in work with children and families where there has been sexual abuse. In social work, interventions are based on assessment (Hepworth, Rooney, Dewberry, Rooney & Strom-Gottfried, 2011) not on whether we believe or don’t believe that abuse has happened or that it affected the child. Because the effects of CSA are so difficult to assess, it can be unclear how to intervene. To further muddy the waters, children who have been sexually abused are likely to mistrust adults, to be aggressive, truant, and argumentative (Noll, Shenk & Putnam, 2009). They steal, lie, test limits, and challenge authority (Finkelhor, et al., 2004). These are not especially endearing qualities but they are often the reason for referral to social work services.

Factors that Influence Social Work Assessment and Intervention with CSA

The dilemma for the social worker in mental health settings is to implement an intervention that is reimbursable as treatment for a medical condition (e.g. a psychiatric diagnosis). For all social workers, our intervention must also take into account the reasons for the referral, which usually center on the secondary effects of CSA. As noted above, the primary effects of CSA have been found to have physiological (Ogden, Minton & Pain, 2006; Rothschild, 2000) and neurological manifestations (Teisl & Cicchetti, 2007). These are expressed through the affective and cognitive impairments that are expressed in the behaviors or symptoms that resemble those associated with childhood internalizing and externalizing disorders.

Ethically, our first priority is to serve our client, who is the child or teen (NASW Code of Ethics, 2008). Practically speaking, we have an obligation to the referral source, such as the school or the child’s guardian who is very likely to want us to reduce the child’s behavior problems. The client may not be in the least bit interested in changing his or her behavior. When client and social worker are not working toward the same goal, it is unlikely that any goals will be met. However, when clients feel the social worker is warm and accessible and that the purpose of the relationship is to help them feel better, there is far less resistance (Kazdin & Weisz, 2003). These and other considerations have contributed to a fundamental change in social work practice and research focus in the area of CSA over the past twenty years (Myers, 2011). Where attention had been directed almost exclusively on taxonomies of pathology that were correlated with the aftermath of trauma (Finkelhor, 2008), more recent endeavors have sought to understand what can go well, how it goes well, why it goes well and what we can do to facilitate better outcomes. This focus in social work research and practice is referred to as resilience theory, or a resilience approach (Liebenberg, Ungar & Van de Vijver, 2012).

CSA Assessment and Resilience Theory

Anthony & Cohler (1987) identified innate qualities, such as intelligence or optimism that enabled the “invulnerable child” to be resilient, despite maltreatment. The nature versus nurture debate extended into resilience research when social work (e.g. Walsh, 1996) and other researchers (e.g. Rutter, 1995) challenged the validity of an exclusive focus on the child’s nature, or innate characteristics, to fully explain resilience. As Walsh (1996) noted, social workers are trained to view all psychosocial outcomes, resilient or otherwise, as the product of the dynamic interplay between both environmental and intra-psychic characteristics. This holistic approach is known in social work as the ‘person-in-environment’ approach, or PIE (Karls & Wandrei, 1994). PIE was developed, tested and endorsed by the National Association of Social Workers (NASW, 1994) and is valued in resilience theory today for its systematic processes to assess and intervene with issues that involve both nature and nurture (Karls, 2002).

Currently, research reflects social work’s person-in-environment (Karls, 2002) conceptualization of resilience. Masten & Coatsworth (1998) identified resilience processes involved in children’s successful adaptation despite chronic exposure to risk factors. Risk factors are characteristics of experience that have been associated with negative psychosocial outcomes, such as child sexual abuse (Sedlack, et al., 2010). Rutter (1995) cautioned that resilience at any one time in life results from interaction between personal and environmental factors that protect a child. However, this buffering effect at one point in development may not be effective in the face of different developmental challenges.

Clearly, there is much to be learned through assessment of the intersecting and interacting influences between child and social environment, of which the family is the most proximal and influential. As social workers identify the idiosyncratic risk and protective factors for a child and family, this assessment points directly to interventions that have been found to reduce the impact of risk and to increase the effect of protective factors.

The pre-abuse characteristics of the child and the family who experience CSA have important implications for the extent to which a child will experience initial and long-term harm (Wilcox, Richards & O’Keefe, 2004). The nature of the abuse, such as relationship with the perpetrator, type of abuse, and the duration of it, have also been found to predict outcomes (Finkelhor, Ormrod & Turner, 2005). What happens after a child discloses she has been sexually abused is also critical. In fact, how the discovery of the sexual abuse of a child is responded to has been found to have more influence on adjustment than any other factor (Lyons & Ahern, 2011). Although these are presented here as separate and temporal categories for the sake of clarity, they are far from separate. Each area interacts with the others and in some cases, there is a cumulative effect and in others, a causal chain or both.

Child Characteristics Prior to CSA: Risk and Protection
Despite the increasing focus on resilience and resilience processes, there is far more known about the statistical relationship between maladaptive outcomes for mistreated children than there is about the pathways or means through which these factors exert protective influence (Liebenberg, et al., 2012). In a global sense, one pathway to understanding risk and protective factors is a child’s developmental stage. The ‘younger’ the child, or the fewer skills and abilities the child has mastered in terms of social, emotional, and physical development, the more vulnerable the child is to the impact of abuse. In this sense, ‘younger’ refers to maturation in terms of the degree to which a child has mastered the developmental tasks of a given stage, rather than the child’s chronological age.

**Development**

Children who have had more opportunities to accomplish as many normative developmental tasks as possible are better equipped to manage stress or trauma (Sikes & Hays, 2010). One way to conceptualize this is in terms of available resources to manage the overwhelming stress of sexual abuse (Cloitre, Cohen & Koenen, 2006). “Psychological trauma is a circumstance in which an event overwhelms or exceeds a person’s capacity to protect his or her psychic well-being and integrity. It is a collision between an event and a person’s resources, where the power of the event is greater than the resources available for effective response and recovery” (Cloitre, et al., 2006, p. 3). In this view, child development and family characteristics are resources that influence the impact of childhood sexual abuse. The clearest example of this inter-relationship can be found in the area of attachment, which many would argue is the cornerstone of human development (Aldgate, 1991; Boon, et al., 2006; Bowlby, 1971; Howe, 1995).

**Implications for Intervention**

Social work interventions to support children as they achieve age-appropriate skills and growth is a multi-systemic endeavor. Children of all ages benefit from clear expectations set by parents, teachers and other involved adults. The expression of these expectations in positive terms “I like it when you” has significantly more valence than pointing out when the child has not met an expectation and issuing a consequence after the fact. This approach to parenting results in demoralization and a sense of powerlessness because the child is not told in advance what the expectation is and how to meet it.

The Collaborative Problem-Solving (CPS) model proposed by Greene (1996) and others (e.g. Madsen, 1999), proposes procedures for reinforcing adaptive behaviors and discouraging maladaptive ones through collaboration among children and adults. It is a fundamentally relational approach to promoting age-appropriate self-regulation. This approach reinforces the child’s developmental capacity to reflect on how she or he can create circumstances for success.

First, the child engages in a developmental self assessment (found at http://www.livesinthebalance.org/sites/default/files/ALSUP_rev_8-29-11.pdf). Next, the child names the problem, such as not completing homework on time. After the identification of how the developmental issues manifests itself, the developmental skill needed to address the problem is identified. In this case, attentional or memory problems are likely. Lastly, the child and adults ‘brainstorm’ ideas that will help the child master the skill (Greene, Ablon, & Martin, A. 2006). CPS means the child and parents work together to identify concerns, conceptualize them as areas of development the child has not yet mastered, and devise a plan to help the child do so.

**Attachment as Risk and Protection**

Developmentally, babies have limited coping, adaptive and self-regulating skills. These include averting the gaze away from unwanted stimuli or people, crying for help, or sucking on fingers or objects. Beyond these skills, the regulatory functions available to babies comes from their caregivers (Polan & Hofer, 1999). John Bowlby (1953, 1958, 1969, 1982) demonstrated the critical importance of attachment between the primary caregiver, usually the mother, and infant/toddler. Attachment is the affectional tie that one person or animal forms between himself and another specific one – a tie that binds them together in space and endures over time (ibid, Ainsworth, 1970, 1978). Attachment is not based on isolated incidents of responsiveness or lack thereof. It is the young child’s internalization, over time, of patterns of responsiveness and availability of the caretaker toward the child. Ideally, this pattern of response is one that offers protection from over-stimulation and communicates a sense of safety (ibid). These patterns of responsive interaction are internalized as “internal working models” (Bowlby, 1969) or interpersonal schemas that enable the child to internalize a sense of security that enables exploration (Bowlby, 1988).

**Attachment and Neuro-biology**

There is emerging evidence that these internal working models are not just theoretical, but are also ‘hard-wired’ in the form of neuro-pathways (Van der Hart, et al., 2006, Seigal, 2001, Rothschild, 2000). Neuro-pathways in attachment are patterns of brain activity associated with self-regulation and safety among securely attached children. Among insecurely attached children they are associated with prolonged periods of arousal in the absence of effective stress response (Van der Hart, Nijenhuis & Steele, 2006). Trauma-informed, attachment-focused interventions have been shown to literally re-wire aspects of the neural maps in the trauma survivor’s brain (Buchheim, Erk, George, Kächele, Kircher, Martius, Pokorny, Ruchsow, Spitzer, Walter, 2007; Sinason, 2011).

**Attachment Assessment: The Strange Situation Test**

As social workers may know, the Strange Situation Test (SST) is used to assess the quality or pattern of a child’s attachment, (Ainsworth, Bell & Stayton, 1971). The SST has four parts. SST first requires observations about the quality and frequency of interaction
between baby and the mother as well as how the baby explores the environment and toys (Ainsworth, 1978). This provides a sense of the baby’s temperament, especially reactions to novel situations, and a general sense of the warmth and responsiveness in the relationship.

The second area of observation is how the baby responds to a stranger who is introduced while the mother is present, and who returns during the mother’s brief separation from the baby. The purpose of introducing the stranger is to observe the extent to which the baby shows a preference for the mother, versus another adult. By 3 – 6 months, most securely attached babies show preference for their mother (Reiser-Danner, 2003). Next, observations are made about how the baby responds to brief separations from the mother. For example, the degree to which the baby protests or tries to reuniite with the mother is noted. These are termed proximity seeking and contact maintaining behaviors and the more of them exhibited, the more likely the child is secure in this relationship. Lastly, and perhaps most importantly, are observations of the extent to which the baby experiences reunion with the mother to be a source of comfort. The extent to which the child is able to experience reunion as a relief and to return to exploration reflects the degree of security in the attachment (Ainsworth, et al., 1971).

**Attachment Styles**

Bowlby (1969) had identified two attachment types or styles, secure and insecure. Ainsworth and others have expanded these to four distinct attachment styles: (a) secure which accounts for about 65% (b) insecure–ambivalent (resistant), which accounts for about 10% (c) insecure–fearful/avoidant, which accounts for about 20% and (d) insecure–disorganized/disoriented which accounts for less than 2%.

The table below sketches out the characteristic behaviors of babies by attachment style and response to the four aspects of the Strange Situation Test.

<table>
<thead>
<tr>
<th>Attachment Style</th>
<th>Securely attached</th>
<th>Insecure – Ambivalent / Avoidant</th>
<th>Insecure – Fearful / Resistant</th>
<th>Insecure Disorganized / Disoriented</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proximity – contact seeking behaviors</td>
<td>Baby wants contact with the mother. Makes eye-contact, enjoys her presence</td>
<td>Seems indifferent to mother’s presence or absence</td>
<td>Clingy, vigilant attention to mother</td>
<td>Varies between irritable avoidant passive</td>
</tr>
<tr>
<td>Exploration of the environment</td>
<td>Baby explores toys, interacts with mother, engages her at times, other times explores independently</td>
<td>Interacts briefly with toys but does not engage mother, limited play</td>
<td>Shows fleeting interest in toys, no focused or coherent play, limited play</td>
<td>Toys are used in instrumental ways (e.g. baby doll is used to bang on floor rather than sit in high chair), if at all</td>
</tr>
<tr>
<td>Behavior when separated</td>
<td>Evident anxiety, crying, protest behavior is intended to restore contact</td>
<td>Some distress apparent, notices mother leaving but reserved reaction</td>
<td>Intense reaction, distress, crying, anger</td>
<td>Range from no reaction to extreme distress, inconsolable</td>
</tr>
<tr>
<td>Behavior when reunited</td>
<td>Happy to see mother, if still distraught, recovers and quickly returns to exploration</td>
<td>Does not seek proximity or use mother for comfort or soothing</td>
<td>Does not experience reunion as relief, rejects mothers overtures</td>
<td>Incoherent behaviors such as hand-clapping, head-hanging, or efforts to flee</td>
</tr>
</tbody>
</table>

**Sources:** Sinason (2002), Waters, E. (2002), Ainsworth, Bell, & Stayton (1971)

In terms of protective factors, Bowlby’s inner working models among securely attached children have been found to exert enormous protective influences and to promote resilience (Masten & Coatsworth, 1998, Pearlman, 1998). The pathways or processes through which attachment promotes resilience involve effective skills for self-soothing and self-regulation (affective skills), and effective problem-solving (cognitive skills) both of which have been linked to CSA. These affective and cognitive skills or capacities are absolutely crucial for social and academic success, which, in turn, are strongly predictive of resilience because they help a child to be competent (Masten & Coatsworth, 1998).

**Attachment Style: Implications for Intervention**

Different attachment styles call for different interventions. Disorganized/Disoriented attachment is most often associated with dissociation and dissociative disorders (Putnam, 1997). Dissociation is defined differently by various theorists. Some refer to it as a continuum that exists in everyone, as in Internal Family Systems (Schwartz, 1995), while others note that it involves structural changes in the brain following early trauma (Von der Hart, et al., 2006). (For a more detailed discussion see Boon, Steele & Von der Hart, 2011). Dissociation is a psychological defense used to manage interpersonal trauma, particularly when abuse is perpetrated by
the primary attachment figure (Cloitre, et al., 2006). By holding aspects of the abuse and the abuser experience in one or more ‘part’ of the mind, the child is able to maintain an attachment with the abuser and to maintain a sense of self or integrity (Sinason, 2010). In effect, the child holds on to a ‘good’ parent and sections off part of her self to contend with the ‘bad’ or abusive parent. The more the child needs to use these processes to protect the core self, sometimes referred to as the “Apparently Normal” or AP (Van der Hart, et al., 2006) the more ‘parts’ the child is likely to split off (Sinason, 2010).

Principles of Treatment with Disorganized Attachment

The principles of treatment of dissociation or dissociative disorders include those in which attachment is the primary focus (e.g. Sinason, 2006) and those that involve skill-building to facilitate trauma processing (e.g. Boon, et al., 2011; Ogden, et al., 2006; TF-CBT). Most include an education or informational phase for the parent and child (Briere & Scott, 2013). Next, various exercises to promote emotional (Briere & Scott, 2013) or physiological (Ogden, et al., 2006) regulation are introduced. Other treatment models build on mindfulness principles (e.g. Van der Hart, et al., 2006) to increase affect tolerance and to help the client differentiate between past and present (Napier 1993). Sources for treatment guidelines and protocols are listed in the Conclusion.

Attachment-focused interventions with trauma and dissociation do not emphasize remembering or discussing trauma experiences unless they are directly related to a problem in the present (Von der Hart, et al., 2006). However, processing trauma usually means increasing the client’s capacity to understand what happened (cognitive processing), the client’s emotional reactions to it (emotional or affective processing), and how the client makes meaning of the trauma (identity or sense of self) (Briere & Scott, 2013; Boon, et al., 2011). The neurobiological effects of attachment and trauma as factors in dissociative disorders are addressed through Eye Movement Desensitization Therapy, or EMDR (Shapiro, 2005) and Sensorimotor Psychotherapy (Ogden, et al., 2006) among others.

Principles of Intervention with Insecure Attachment

Interventions with sexually abused children who exhibit Insecure-Avoidant or Insecure-Resistant attachment focus on the child’s perception that others cannot be depended upon and that the child does not need anyone (Muller, 2010). Avoidant children seem detached and indifferent and make few, if any social overtures. This Avoidant child resembles the criteria of Reactive Attachment Disorder: Resistant Type (American Psychiatric Association, 2000). Resistant children can resemble Borderline Personality Disorder (ibid) in their seeking connection followed by intense discomfort and rejection.

In these cases, approaches such as Parent-Child Interaction Therapy or PCIT are recommended. PCIT is based on Kadushin & Martin’s observations about the patterns of interaction between children and their caregivers who are physically abusive. Although these patterns were identified in the context of physical abuse, the implications for attachment and for intervention to repair it were extended to sexual abuse as well. PCIT views the attachment relationship as interactive and thus, the intervention seeks to modify these patterns (Zisser & Eyberg, 2010). The parent is coached to exhibit more behaviors that communicate warmth, acceptance, and responsiveness and to selectively respond to appropriate behavior, while ignoring all others (unless they are unsafe). This intervention has three phases and usually involves about 24 sessions. Sources for treatment guidelines and protocols for PCIT are listed in the Conclusion.

Family Characteristics as Risk and Protection

A number of risk and protective factors can be inferred from research in child resilience. More is known about the demographic characteristics of families whose children experience intra (within the family, also termed incest) and extra (or outside of the family) sexual abuse than is known about specific family dynamics (Miller-Perrin & Perrin, 2013). Some studies have noted higher incidence of assault and sexual abuse to be linked with lower income. However, this may reflect the link between income and risk of a wide range of community violence (Sedlack, et al., 2010) because intra-family sexual abuse has not been found to relate to income (Finkelhor,Hammer, & Sedlak, 2004). Studies have also found sexual abuse to be associated with parental alcoholism, parental rejection, and high levels of conflict. The protective family characteristics such as warmth, acceptance and clear boundaries around rules and expectations have been associated with lower incidence of abuse and of trauma symptoms in both practice and research literature (Masten & Coatsworth, 1998).

Family Communication and Structure

Communication and interactional patterns among family members are well-established in physically abusive families where pathways in the cycle of violence have been charted (Gelles, 1974, Kadushin & Martin, 1981). However, far less is known about the communication patterns or family dynamics associated with sexual abuse. This is very likely because severe cases result in a crisis wherein either the child or the offending adult is removed from the home. Some research and practice literature points to family structure and communication patterns associated with CSA. These families are characterized by high levels of hostile and dominating family communication, such as frequently interrupting each other or sarcastic and contemptuous comments (Blaske, Borduin, Henggeler, and Mann, as cited in Morenz and Becker, 1995). Elliott & Briere (1992) found the highest levels of family dysfunction were accompanied by the highest levels of trauma symptoms among a sample of 2,964 resilient, professional women who were sexual abuse survivors. In this study, dysfunction was defined in terms of critical and negative family communication patterns and poor
problem-solving abilities. These forms of dysfunction are also associated with substance abuse, and mental health problems which are disproportionately found in families where there is CSA (Miller-Perrin & Perrin, 2013, Finkelhor, et al, 2008).

The use of denial in family communication has also been related to several risks for CSA. When adults use denial, it invalidates the child’s experience and increases the level of confusion and obfuscation that are among the necessary conditions for sexual abuse (Douglas & Finkelhor, 2005). Another area denial can manifest is the disavowal of a connection between a child’s emotional or behavioral problems and the experience of sexual abuse (Ballou & Brown, 2002; Trepper & Barrett, 1989).

Family Structure as Risk or Protection

The findings relative to the structure of a family involves observations about the organization and the roles of the parent and child generations (Minuchin, 1974). Family structure that is associated with risk of the incidence of abuse, and for greater negative impact, points to poor boundaries between the parent and child generations (Masten & Coatsworth, 1998, Trepper & Barrett, 1989). In these cases, parents relate to their children as peers or friends. The expectations for appropriate behavior are murky and sexually offending adults are likely to take advantage of this ambiguity (Miller-Perrin & Perrin, 2013; Trepper & Barrett, 1989; Briere & Elliott, 2003).

Demographic Correlates with Risk and Protection

Empirical research offers information about correlations between demographic characteristics and family as resources for resilience. For example, girls who have experienced parental divorce or separation or have lived for an extended time without one parent and children who live with step-parents are at higher risk for sexual abuse than girls from intact families (Finkelhor, 1999). Income is not associated with the incidence factor for sexual abuse per se (Finkelhor, 2008) but financial security is a protective factor when CSA occurs (Miller-Perrin & Perrin, 2013). Social isolation or limited engagement with the community is a commonly cited risk for CSA (Berliner, 2011). As would be expected, strong community connections have a protective influence for individual victims (ibid) and for the family’s effective adaptation (Miller-Perrin & Perrin, 2013).

Implications for Intervention with Family Structure, Communication and Demographics

Most of the family correlates with CSA that promote resilience are modifiable. Some are proximal factors such as communication and family structure. Others are distal, such as stigma, the degree to which there is community violence or opportunities to increase family income. The focus here is on family interventions to address communication patterns and the structure of the family. Any effective social work intervention begins with a trusting relationship (Hepworth, et al., 2013). The stigma, shame, and denial that accompany CSA will need to be addressed in order to engage with the family. The ideas presented here are drawn from practice and from the research literature.

Engagement

For the family to engage with the social worker, principles from Motivational Interviewing (MI: Miller and Rollnick, 2002) may be integrated with any of the interventions presented in this training. Motivational Interviewing was developed to address substance abuse, which is nearly universally found among abusive families (Sedlack, et al., Finkelhor, et. al, year). If the stigma, shame and denial that characterize CSA are not an ongoing focus of intervention, it is unlikely the family will be able to engage with the social worker. To engage a family, there needs to be an agreed-upon purpose for the intervention. If the fact that CSA exists, or the impact on the child(ren) are denied, it will be difficult to engage a family to address them.

Denial

Recall that denial is a defense mechanism used to disavow reality in order to avoid expected, overwhelmingly negative consequences that the family worries will ensue if they accept or believe the child. From this assessment, the family sees there is much to lose if they relinquish denial. Intervention must help the family to see that there is something to be gained by believing the CSA. To begin, it is helpful to use MI principles that are intended to create discrepancy between the family’s goals and aspirations and its current behavior. For example it is helpful to ask the family to envision how they would like to be. The social worker uses empathy and active listening to help the family collaborate to develop their vision of how they would want to communicate. Family habits of returning to blame and denial can be addressed by re-directing the conversation toward hopes and plans for the family’s communication and structure in the future.

During this process, the social worker can address denial. Families with high levels of conflict and poor boundaries are likely to envision less chaos and more supportive interactions. As the social worker explores discrepancies between how things are now, and how the family wants them to be, the sexual abuse is likely to emerge. This is an opportunity to gently ask open-ended questions that reflect the reality that the abuse happened.

Case Example: Working with Denial

The social worker elicits a vision for the future from 42 year old Marie. She is the mother of 13 year old Suzeth, who was sexually abused by Marie’s boy-friend, Tod.
Marie: (In a disparaging tone) My so-called vision is for her to show a little respect. She just blames me for everything she does wrong. Her counselor at school encourages her! How is it my fault that she skips school? Like, I see her get on the bus in the morning. So how the hell is her smoking and skipping school my fault?

SW: What would a conversation sound like if there were less blame going on?

Marie: She wouldn’t be calling me a bad mother and saying she wants to go live with her father and she hates me and all that %*&.

SW: What is this bad mother and blame stuff about?

Marie: Oh, she says Tod did some stuff, which he didn’t! (Escalates with anger) And he has had to put up with her &*%& too! Some people outside of the family even know about this! I can’t believe she would do this to us. Now my sister kind of thinks I’m a bad mother too! All because of her (mood shifts from anger to dejection or sadness).

SW: So, you are getting blamed for the situation with Tod? That must be tough.

The Importance of ‘Situating’ the Problem

The ‘situation with Tod’ is named. In this, the problem is situated as a product of Tod’s behavior. If the situation with Tod is the problem, Marie is not to blame. The goal is to reduce denial of the abuse, and to reduce denial of the impact of abuse. Incrementally, references to the ‘situation with Tod’ reinforce the reality of the abuse, while further eroding denial that Tod’s abuse of Suzeth is implicated in Suzeth’s truancy and failing the test.

Marie: Yeah, just now the school called me. Like I am supposed to do something about what she does at school. I’m not at school. They are! Why am I to blame for her failing a test at school? I didn’t take the test. She did!

SW: So, when the school told you that, what was your reaction?

Marie: I thought ‘What the hell is wrong with these people! Suzeth failed the test. Suzeth skipped that class for three days and that’s why she didn’t know there was gonna be a test in the first place. So she didn’t do anything to get ready, and so she failed. And now, I’m a bad mother because she skips school and fails stuff.’

SW: What is going on with her skipping school?

Marie: She just won’t go sometimes.

SW: So she goes some days, but not all the time?

Marie: I guess so. I don’t know. Yeah, probably. I mean she goes sometimes.

SW: What does Suzeth say about skipping? Like what does she say about it? (deliberately assumes Marie has communicated with Suzeth by asking ‘what does she say’ but avoids asking Marie ‘why does she skip’)

Marie: She has some half-assed excuse about how Tod is this and that and I am a bad mother, and how she hates it here so much and how she wants to live with her Dad and how we can’t make her do anything... It’s like we are the worst people.

SW: So she blames what Tod did to her for her decisions not to go to school?

Motivational Interviewing: Amplifying Discrepancies

In this synopsis, Marie’s denial erodes as she and the social worker evoke Marie’s vision for her family. The social worker reflects and empathizes with Marie’s experiences as Suzeth’s mother, which currently include feeling blamed for Suzeth’s abuse-related difficulties. In this, Marie expresses a discrepancy that is expanded upon by the social worker. Marie does not want to be blamed or to be viewed as a bad mother by Suzeth, the school, or by her sister. Suzeth’s behaviors are related to the abuse by Tod. In this vignette, the social worker delicately explores the apparent discrepancy between this mother’s wish to be a good mother and how this denial of the abuse prevents her from being able to protect, care for and support her daughter, which interferes with this wish. In the process of surfacing this discrepancy, the social worker develops an alliance or joins with Marie in her family role as mother. This vignette also illustrates principles of intervention to address family structure and boundaries that are essential when parental roles or family structure based on them contribute to CSA. Additional sources for treatment guidelines and protocols to address communication are listed in the Conclusion.

Principles of Intervention to Address Family Structure and Boundaries
To address family roles and boundaries, Structural Family Therapy (Minuchin, 1974) recommends the social worker uses joining and enactment skills. Joining with the adult(s) is accomplished through exploration of the problems in the family. In the vignette above, the social worker joined with Marie in her experiences as Suzeth’s parent. Marie is uncomfortable with the idea that she is responsible for her daughter’s school attendance and performance. In this sense, she overlooks the authority that her role as mother carries. A genogram of this family would place Marie and Suzeth in the same generational sub-system. Joining with Marie in her role as parent, serves to nudge Marie toward her position in the parent generation.

Structural family intervention also involves enactments, or role-plays, in which the family demonstrates what happened during a recent argument. In this case, an enactment enabled the social worker to support Marie as she becomes more comfortable with parental authority. As is consistent with structural interventions, the social worker observes what happened, and then directs a re-enactment in which members of family sub-systems are given permission to interact within the boundaries of their role.

**Enactment to Realign and Reinforce Boundaries and Roles**

Prior to the dialogue below, Marie, her son Andrew (15) and Suzeth have just demonstrated or re-enacted a recent argument. At the conclusion, Suzeth responds to the social worker:

**SW:** So this was mostly about friends and a little about Andrew?

**Suzeth:** Well, yah, she doesn’t let me do anything. When I tried to go out with my friends she just said no. For no reason. Like why not? My dad would let me and he has to drive me like almost an hour to get to her house.

**Andrew:** Yeah. And she does that all the time to Mom. She’s all like ‘Dad is so great and you are so rotten’.

**SW:** Andrew, it sounds like you were frustrated because you tried to help Mom and Suzeth. When nothing you said worked, you got stressed out and is that when you punched the wall?

**Andrew:** Yeah. It was like, they just wouldn’t drop it.

**SW:** It sounds like this was pretty frustrating for everyone. Could you do something with me? Andrew, I want to give you permission to be Suzeth’s brother. You can hang out, or not (laughs) with Suzeth. (Turns to Marie) I want to give you, Marie, permission to be the parent to Andrew and Suzeth. You can be in charge. You can have rules they don’t like and you can be nosy about what they are supposed to do for school. Ok, so, Andrew, I would like for you to move over here (Andrew moves chair from its space next to Marie, to space next to Suzeth. Suzeth is no longer in his line of vision. Marie now sits across from both children). Now, I would like for you, Marie, to explain to Suzeth what you said to me about your right to have rules.

**Marie:** You don’t have to think my rules are right or to agree that they are right. Sometimes I have reasons that I don’t talk about but that doesn’t mean I don’t have reasons.

**SW:** Do you need to have reasons for the rules?

**Marie:** I mean, not really. I can’t just make stuff up. Like I can’t have a rule like everyone hops on one foot! (Suzeth and Andrew smile). But, no. I don’t have to have reasons. It just starts another fight if I say why. So I just don’t say why, and that starts a fight, too.

**SW:** So, you have reasons, but you don’t say what they are because you don’t want an argument. You do have the right to say “I’ll explain the reasons, but that doesn’t mean I want to debate about them”. So, the adult can say, “I decided this. You don’t have to agree with the decision, but it is my decision”.

**Discussion of enactment**

The structure of this family had drifted from one in which Marie and her ex-husband were a parent sub-system, and the children were a sibling sub-system. Following divorce, Andrew gravitated toward the parental sub-system. Soon after, Suzeth found that challenging the limits set by Marie was effective, and Marie became less clear about how to enact her parental authority. Andrew’s after-school activities and Marie’s job working second shift meant Tod and Suzeth were together often. Tod and Suzeth related to one another as peers and these dynamics led to a breakdown in boundaries, connections, structure, and communication that Tod used as an opportunity to sexually abuse Suzeth.

Additional sources for treatment guidelines and protocols to address family structure are listed in the Conclusion.

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**PART THREE: Characteristics of the Sexual Abuse and Disclosure Experiences as Risk and Protection:**

Implications for Assessment and Intervention

The nature and the type of sexual abuse, the relationship between the victim and the perpetrator, and the duration of the abuse exert independent and combined effects on resilience outcomes for children who experience CSA (Finkelhor & Russell, 1984; Herman,
How the child and adults react to CSA have important implications as well. Children who react to CSA with externalizing behaviors, especially sexual behaviors, present unique needs for assessment and intervention. So, too, do the adult reactions to CSA. Each of these is presented in order to inform social work assessment and intervention.

### Nature and Type of Sexual Abuse

When sexual abuse is accompanied by threats, force or violence, there is a greater likelihood for short and long-term traumatic reactions (Tyler, 2002). These reactions are closely linked with affective and cognitive processes used to cope with abuse initially and over time. Affective processes associated with abuse experience include feelings of shame, guilt and disgust (McMillen & Zuravin, 1997). From a behavioral perspective, these affective states become conditioned or associated with proxies, such as places, smells, colors, or even feeling states associated with the abuse (Berliner, 2011, Van der Hart, et al., 2006). When the child is exposed to one or more proxy, intense, unwanted and overwhelming feelings are too often aroused. To avoid this, the child avoids proxies, often referred to as ‘triggers’. The kind of avoidance is a hallmark symptom of Post Traumatic Stress Disorder (PTSD: American Psychiatric Association, 2000). Children and teens may also avoid these feelings by numbing themselves or restricting the range of feelings they can experience, or through substance use (Boon, et al., 2006). In a sense, these ‘symptoms’ of Post Traumatic Stress Disorder (PTSD) help the person avoid the intensely distressing feelings that accompany traumatic memory.

### Relationship to Perpetrator

An organizing principle of this training is that sexual abuse is most often relational trauma. As such, the implications for a child’s ability to trust, particularly to trust adults are profound. Social workers, teachers, and other adults in positions of authority can be ‘triggers’ for trauma-related reactions. The most reliable estimates attribute about 16% of all sexual abuse to fathers or step-fathers. Prevalence estimates that are based on substantiated sexual abuse reported to the authorities provides some, albeit limited data about the relationship between perpetrator and child. The National Incidence Study’s fourth wave of data collection and analysis puts the percentage of intra-familial sexual abuse at about 60% (Sedlack, et al., 2010). Large scale, non-clinical samples of adults asked about various forms of contact sexual abuse yields the opposite finding. In these, about 60% of all sexual abuse of children is committed by someone outside of the family who the child knows, such as a neighbor, teacher, coach or clergy and 16% by a father or father figure (Berliner, 2011; Bolen, 2000, Finkelhor, et al, 1990). Only about 11% of CSA is perpetrated by strangers (Berliner, 2011). Taken together, these estimates point to about 90% of childhood sexual abuse also involves some degree of relational trauma (Schore, 2001) because the child is very likely to depend on the abuser.

In terms of the impact of CSA, dissociative disorders (Boon, et al., 2006, Putnam, 1997), severe PTSD symptoms (Cloitre, et al, 2006) and depression (Schore, 2001) are closely linked with perpetrators on whom a child relies for care and safety. As noted, this is termed relational trauma. The betrayal experienced by the sexual abuse perpetrated by someone a child relies on probably explains why sexual abuse perpetrated by a father figure is associated with more severe and persistent trauma symptoms (Briere & Scott, 2013). When the perpetrator is not the father or a father figure, a close relationship with the abuser predicts a more negative self-view and diminished capacity to cope over time (Salter, 1995). However, the nature of the relationship or the duration of abuse did not predict whether the child would abuse others (Briggs and Hawkins, 1996). What is known is that adolescent males who sexually abuse children are not dissimilar from their peers who commit other forms of violence. That is, many researchers concur that child and adolescent female sexual offending is linked with sexual abuse but this connection does not hold true for males.

### Women and Girls as Perpetrators of CSA

In terms of gender and the relationship with the abuser, less is known about the impact of abuse perpetrated by women or girls (Gilgun, 2010). Available data, mostly in the form of anecdotal report and qualitative interviews, indicates maternal sexual abuse is an especially pernicious form of sexual violation. Maternal sexual abuse is perpetrated in the context of the routine physical care of children. The duplicity involved when a mother or other caregiver engages in sexual acts during routine physical care is bewildering to the child who is often unable to know if these were intentionally sexualized acts (Boon, et al., 2011, Gilgun, 2012, Courtois, 2009, Ogden, 2006). Empirical studies of children raised in an atmosphere characterized by the deliberate obfuscation and sexualization of the mother-child bond are needed. Given that stigma clouds our perception of the impact of childhood sexual abuse perpetrated by men, it seems unlikely that a social consensus to address this issue will emerge or be sustained.

Some prevalence estimates of sexual abuse by women, which are of highly questionable reliability for all of the reasons stated here, do exist. Sexual abuse by women is reported at rates varying from 1.5% (Snyder, 2000) to 10% (Putnam, 2003). Data about the age of the female perpetrator and nature of her relationship to the victim is inconsistent. It does seem apparent that abuse perpetrated by females is less likely to be reported. Among those who did report, boys who are molested by adult women expected to be ridiculed because sexual contact should be wanted. Others worried they would be perceived as less masculine because they didn’t stop the abuse (LeClerc, Wortley, & Smallbone, 2012).
Duration of Abuse

Abuse that is chronic, or ongoing is associated with higher levels of impairment overall (Cicchetti, 2004; Finkelhor, 2009). The more opportunities for safe, developmentally appropriate experiences and relationships the child has, the more resilient the child is likely to be. Extended periods of betrayal, secrecy, threats or harm are clearly antithetical to a child’s healthy development. Most of the data regarding the impact of abuse that continued over a year or more is from retrospective studies (e.g. Finkelhor, 2008) and clinical samples (e.g. Herman, 1989; Sanford, 2006). Clinical samples are clients in psychotherapy or other health settings who participate in research. By virtue of being in a clinical sample, respondents are more likely to have mental health and related concerns (Douglas & Finkelhor, 2005). The limitations of this data notwithstanding, there is consensus that one-time incidents have significantly fewer deleterious effects than prolonged or repeated acts (ibid, Cicchetti, 2004; Van der Hart, Nijenhuis, & Steele, 2006).

Implications for Intervention: Relationship, Duration, Type of Abuse

Engagement

The likelihood that a known and trusted adult is also the perpetrator in child sexual abuse may influence a child or adolescent’s willingness to engage with the social worker due to the violations of trust and boundaries inherent in child sexual abuse. Other factors related to the nature of the abuse and the abuser will also have influence. However, most children and adolescents don’t consciously make the connection between physical characteristics, such as gender, stature, facial expression, or gestures in an adult in the present as ‘triggering’ feelings or physiological reactions associated with past abuse (Briere & Scott, 2013). Given this, and the general principles of social work practice, the initial step for engagement is for the child to perceive the social worker as a safe and trustworthy person. This can take time. The attachment style is a significant contributing factor here. The insecurely attached child will engage and then become afraid of the connection and want to exit the relationship. Like the mother in “Runaway Bunny” adults who can interpret these distancing behaviors as such, and avoid taking them personally, are essential to the child’s healing.

Relationship as ‘Trigger’

Interpersonal dynamics such as limit-setting between adult and child have been the source of betrayal in CSA. Thus, understanding that relationships are the proverbial ‘scene of the crime’ provides a way to make sense of a child’s unpredictable behavior. As discussed, when abuse is accompanied by force or violence, there are more trauma symptoms. When the abuse is perpetrated by a caregiver, the child must somehow hold onto a ‘good’ caregiver whom s/he can internalize as a source of care and protection. To do so may require dissociation, avoidance, or numbing. These trauma-specific defenses call for interventions that address the cognitive, affective, and the somatic aspects of CSA. An example of a somatic therapy that addresses these is the Sensorimotor Approach (Ogden, et al., 2006).

Sensorimotor Therapy

Many interventions are, logically, concerned with cognitive and emotional processes associated with CSA. These foci address the multitude of practice and research findings that identify beliefs about who is to blame, cognitive schemas that exacerbate excessive fearfulness and a sense of helplessness, and attachment styles that perpetuate self-isolation. Interventions that address these and other factors are valuable and relevant when they are connected to the assessment of impact of CSA on the child. When sexual abuse is repetitive, or ongoing and committed by a trusted adult, the impacts extend beyond affective and cognitive, to somatic or influences on the body.

According to Siegel, (2006) Sensorimotor Psychotherapy integrates many of the neuro-biological and attachment findings presented here to facilitate the processing of not only cognitive and affective effects of interpersonal trauma, but also the physiological effects. The duration and type of abuse are important information to know because they provide clues about the somatic impact of CSA. Sensorimotor Psychotherapy (SP: Ogden, 2006) and other somatic approaches to trauma work are predicated on the awareness that PTSD symptoms share the common theme of unassimilated experience.

Sensorimotor Psychotherapy proposes that the physiological effects associated with Hippocampal-Pituitary-Axis (HPA) deficiencies that were found in the MRI studies reported in the Introduction, influence a person’s ability to integrate cognitive and emotional experiences of CSA. Where most interventions work with feelings and thoughts, SP works with the physiological impacts of CSA by teaching the client how to regulate stress reactions in the body.

Relationship as Source of Co-regulation to Address Attachment

Contemporary attachment theory and research have found that neuro-pathways associated with attachment are learned through experience. Like other learned experiences, they can be re-learned, and thus re-wired regardless of the person’s age (Haizan,Campa, & Gur-Yaish, 2006). The therapeutic relationship can create the possibility for attachment which facilitates ‘co-regulation’ (ibid). Interactions between the client and therapist help the client increase awareness of situations in which s/he is dysregulated. By attending to body sensations, along with emotions and cognitions in the context of the relationship, SP enables clients to self-regulate. Self-regulation facilitates the cognitive processes involved in putting feelings and experience into words, which is essential to
working through CSA. The processes involved in helping a child to put feelings and somatic experiences into language are the focus of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). TF-CBT is especially useful because it actively addresses this issue. It also addresses the importance of how an adult responds to a child’s disclosure of abuse.

**Disclosure Experiences: Risk and Protection**

How the discovery or disclosure of sexual abuse is handled is often more important to the child than the abuse itself (Sanford, 2010, Boon, et al., 2006, Van der Hart, et al., 2006). Among adults interviewed about childhood experiences of contact sexual abuse, 74% of women and 78% of men didn’t tell anyone of the abuse as children (London, Bruck, Wright & Ceci, 2008). Reasons for non-disclosure among this and other study respondents include embarrassment and shame, fears that they would not be believed or helped, or that they would be blamed for the abuse (ibid, Fleming, 1997, London, et al., 2008). Understandably, children with closer relationships or who are dependent upon the abuser are least likely to disclose (Kogan, 2004, Wyatt & Newcomb, 1990) and most likely to recant. To recant is to take back a disclosure of abuse. In one study, about a quarter of substantiated cases of sexual abuse had been recanted at least once (Malloy, 2007).

**Recanting Sexual Abuse**

Recanting has been attributed to Child Sexual Abuse Accommodation Syndrome (CSAAS; Summit, 1983) which is a term developed in legal and forensic clinical settings (O’Donahue & Benuto, 2012). Summit (1983) described secondary trauma as a consequence of children’s disclosure of abuse experiences which he noted were often discredited by professionals. Summit noted that the child victim of sexual abuse is characterized by those who do not wish to believe the abuse happened as manipulative, dishonest, or imagining things. Building on Summit’s observations, the misattribution of children’s reactions to experiences of sexual abuse may be partly attributable to social expectations for how a ‘victim’ behaves. As noted in the Introduction, victim characteristics influence the extent to which the professionals who work with sexually abused children are likely to believe that sexual abuse happened, and to attribute their difficulties to the abuse.

**Interventions to Promote Resilience Following Disclosure**

Trauma-focused Cognitive-Behavioral Therapy is a manualized intervention with children who have experienced one or more traumatic experiences, particularly sexual abuse. It is important to note cognitive-behavioral approaches are based on the presumption that a child’s cognitions or cognitive schemas are faulty. In the case of CSA, interventions with a primary focus on cognitions would seem to contradict the point made here about the significance of relationally-focused assessment and intervention. However, the TF-CBT protocol includes clear information and guidance for adults to support children following disclosure. There are several components to this intervention and a free, on-line training offers CEU’s (see resources at the end of this article).

**TF-CBT Principles to Improve Talking Out Feelings and Reduce Acting Out**

The protocol includes psychoeducation and parenting skills. Both the child and caregiver are taught about what to expect in terms of emotional and behavioral reactions to sexual abuse. Caregivers, who are most often the non-offending parent, are guided in how to differentiate their own reactions to the abuse from those of the child. The parent or caregivers’s needs are clearly differentiated from the child’s. Support, guidance and referrals are made to address the adult’s reactions that interfere with the child’s healing. The child is taught a range of self-regulation skills, such as diaphragmatic breathing, progressive muscle relaxation, etc. These self-regulation skills build the child’s capacity to manage reactions to ‘triggers’. Although TF-CBT does not explicitly address relational triggers, or relationships with adults as triggers, the social worker can include these. The intervention also guides caregivers to anticipate potential environmental triggers and provides both adult and child with strategies to manage these.

**Trauma Narrative**

The trauma narrative and processing component helps the child to put feelings, thoughts, and body sensations into words. As discussed, this enables the child to increasingly ‘talk them out’ rather than ‘act them out’. The capacity to process traumatic experience through language greatly increases the child’s resilience. Unfortunately, many children do not have this support. As introduced above, the tendency to act-out serves to reduce the child’s credibility and compounds their trauma experiences.

**Acting Out or Externalizing Behaviors**

A ‘victim’ is defined as “someone or something which has been hurt, damaged or killed or has suffered, either because of the actions of someone or something else” (Cambridge Dictionary, 2012). The victim is not responsible for what happened, someone else is. Child victims are expected to act accordingly. In this sense, the perfect child victim is passive, withdrawn, cooperative, and provides a coherent account of the events. Summit noted that the standards for “normal” victim behavior are inappropriate and serve to further harm children. This is likely because victimized children express their distress in more complex ways. Among these are the ‘externalizing’ behaviors discussed above. Sexualized behaviors blur the line between victim and perpetrator (Wilcox & Richards, 2002) because sexually active children are not well understood.
When Sexual Behavior is Acting Out, and When It Is Not

Children’s internalizing reactions to abuse include avoidance, numbing, and dissociation as addressed above. They may also be expressed in the form of externalizing reactions associated with disruptive behavior disorders. When children can talk out their feelings and experiences, they are less likely to act them out. A specific externalizing behavior that is often believed to be acting out sexual abuse is sexualized behavior. It is often believed that sexual behaviors are a proverbial ‘red flag’ for sexual abuse (Wilcox, Richards & O’Keefe, 2004). As was outlined in the Introduction, children who engage in sexual behavior, especially children who are post-puberty, are far less likely to be viewed as a victim of CSA. Some worry that all sexual activity between children is exploitative or predatory in nature. Thus, the child can be cast as the perpetrator and the adult as the victim (Finkelhor, et al., 2010; Trepper & Barrett, 1989). Others view child sexual behavior as a sign that the child has been sexually abused when this is not the case (Finkelhor, et al., 2010). These beliefs about children’s sexual behavior as a sign of sexual abuse or as a warning sign pointing toward future sexual offending, have been challenged in both research, (Dobash, Carnie, & Waterhouse, 1993) and in practice literature (Wilcox & Richards, 2002).

Many of the sexual behaviors in children are attributable to premature and overly explicit ‘adult’ media exposure through the internet or television (Cavanaugh, 2001). This premature exposure is believed to be over-stimulating or confusing. Too much exposure leads to increased sexual exploration. However, the sexually charged climate in which many American children live doesn’t lead to sexualized behavior for all children. What is a sexualized behavior? What is a normal sexual behavior for a child? How do social workers differentiate between ‘normal’ exploration from that which is attributable to over-exposure, or to sexual abuse?

Guidelines for Preliminary Assessment of Sexual Behavior in Pre-pubescent Children

The work of Tony Cavanaugh (2001) provides guidelines for assessment. These are presented here, along with additional research and intervention literature. Cavanaugh proposes a four-group matrix to organize the assessment of child sexual behavior. These are:

- **Group One:** Children engaged in natural and healthy childhood sexual exploration
- **Group Two:** Sexually reactive children
- **Group Three:** Children who mutually engage in a range of adult sexual behaviors
- **Group Four:** Children who molest other children

**Group One: Healthy Exploration**

Children explore gender-related adult roles and behaviors through imaginative games with developmentally similar peers and siblings in which the roles of doctor, nurse, family members, teachers, police, and other significant figures are emulated. The spirit or nature of these activities is playful and fun. If one child does not want to touch or see another child’s body part, this is usually respected.

Specific sexual behaviors of Group One include autostimulation, self-exploration, kissing, hugging, peeking, touching and/or the exposure of genitals of other children, and rarely, simulating intercourse (a small percentage of children 12 and under engage in sexual intercourse).

**Group Two: Sexually Reactive**

This group engages in sexual behavior that is out of step with their peers. It is accompanied by feelings of shame, guilt and discomfort. Specific sexual behaviors among sexually reactive children include excessive or public masturbation, they may initiate sexual play with adults, they may insert objects into their own or other’s genitals, or they may be preoccupied with performing these acts with toys, and they may be preoccupied with conversations with sexual themes. In some cases, there has been sexual contact with the child by an adult, and in others, there has been exposure to sexually explicit media.

A sexually reactive child who is redirected or told to stop these behaviors, usually does. There will not be a pattern of secretive, manipulative or highly charged sexual behavior as is seen in Group Three.

**Group Three: Extensive, Mutual Sexual Behaviors**

The children in this group have far more pervasive, frequent, and focused, adult sexual behaviors than Group Two. Unlike Group One and Two children, these children engage in oral, genital, and anal intercourse. In terms of consent, they may use persuasion, but they usually do not use physical or emotional coercion to gain another child’s participation. In many cases, the sexual behavior is a means for the child to connect with and relate to other children. Their relationships with adults are superficial and seem almost utilitarian. Although the spirit or nature of the activity is secretive, this is not due to the shame and anxiety of the sexually reactive children in Group Two. There is no aggression or duplicity as is seen in Group Four. Many Group Three children have been sexually abused by adults and continue this way of relating in an intimate and private way with other children as a force of habit.

**Group Four: Molestation Behavior**

Group Four children are most often male and engage in same-sex relations. There is not only a lack of consent and equality between children, there are various forms of coercion. Coercion includes a range of threats or actions to intimidate or manipulate younger children to comply with sexual demands. Group Four is considered predatory and usually in need of institutional care and containment.
Additional sources for treatment guidelines and protocols in the assessment and intervention with childhood sexualized behaviors are listed in the Conclusion.

**Implications for Intervention**

Although sexual behaviors may be ‘reactive,’ children whose behaviors are consistent with Group One and Two are not in need of a formal sexual offender intervention (Cavanaugh, 2001). These children benefit from redirection and education about the appropriate times and places for sexual behavior. Group Three and Four children are most often formally assessed for their risk to others. Interventions often address either victimization or offending behaviors but rarely both (Hof, Dinsmore & Hock, 2009). However, among children who have experienced CSA, the reasons for offending behaviors influence the intervention. Some Group Three and Four children offend as an expression of the need for power, control, and revenge. Others offend as a compulsive method to work out the abuse or to retain an attachment to the offender with whom the child has a complex relationship. This complexity further illustrates the focus throughout this training; effective assessment and intervention with CSA requires mindful attention to the etiological factors, which are fundamentally relational.

**About the Author**

April Berry-Fletcher, LICSW, Assistant Professor, Social Work, has, in addition to her teaching experience at Boston College, Regis College, Salem State College, served as Training Consultant at the Department of Children and Families. She was Director of the Counseling Service at Mount Ida College; College Counselor at Bradford College; Program Director for Child and Family Home-Based Services at Greater Lawrence Mental Health Center; and Coordinator Crisis Planning Team for the MA Department of Mental Health. Professor Berry-Fletcher is a certified trainer for NASW-MA Chapter’s Social Worker Safety program. She has presented locally and nationally on topics in social work education and in child welfare. She has been awarded several grants for work with homeless youths and psychosocial interventions to support academic persistence among at-risk college students. She has a small private practice in the Greater Boston area and can be reached at fletchap@gmail.com.

**Resources**

- **Child sexual behaviors**

- **Overview of treatment protocol for children who are both victims and offenders**

- **Parent-Child Interaction Therapy**
  Promotes attachment, targets interactions and relationship dynamics between adult and child rather than adult behavior or child behavior.

- **Collaborative Problem Solving**
  Provides a developmental framework for child’s externalizing behavior. Parent and child collaborate to identify developmental issue and how to address it.
  [http://www.ccps.info/](http://www.ccps.info/)

- **Somatic Therapies**
  Based on findings of the somatic components of CSA, somatic therapies integrate attachment, cognitive, and affective concerns.
  [http://www.sensorimotorpsychotherapy.org/home/index.html](http://www.sensorimotorpsychotherapy.org/home/index.html)

- **Trauma-Focused Cognitive-Behavioral Therapy**
  A phased, manually intervention that addresses post-disclosure relationship dynamics in terms of caregiver’s expression of anxiety, fear, etc. and the impact of this on the child. This link is to the on-line training which is free.
  [http://tfcbt.musc.edu/](http://tfcbt.musc.edu/)

**Bibliography**


• Kogan, 2004 and Wyatt & Newcomb, 1990 in Myers, chpt. 14


• Malloy, et al.2007 in chpt. 14


• Masten & Coatsworth (1998) in Kindle


• Siegel, D. J. (1999). The developing mind: How relationships and the brain interact to shape who we are. New York: Guilford.


1. Which of the following is a commonly misdiagnosed disorder among children who have been sexually abused?
   a. Depression
   b. Self Injury
   c. Anxiety
   d. ADHD

2. The effects of stigma associated with child sexual abuse include all EXCEPT which of the following:
   a. Stigma serves to inhibit this behavior.
   b. Stigma serves to limit our willingness to acknowledge that it happens.
   c. Stigma is understood by social workers who are clear about the impact of CSA.
   d. Stigma creates a climate of secrecy that is a necessary pre-condition for CSA to occur.

3. Collaborative Problem Solving (CPS) is recommended for intervention with children who have experienced CSA because
   a. It is an intervention that addresses the range of behavioral problems such as truancy and delinquency.
   b. It is a school-based strategy that improves academic success.
   c. It is a cognitive intervention that helps the child to identify cognitive errors and to replace these with more adaptive cognitions.
   d. It is fundamentally interpersonal rather than behavioral and this helps with the trust and relationship issues that characterize CSA.

4. Check the answer that is NOT one of the reasons a relational approach to social work with sexual abuse is suggested:
   a. Sexual abuse of a child perpetrated by adults on whom a child relies erodes a child’s trust in adults, which is called relational trauma or betrayal trauma.
   b. Different brain regions and neuro-pathways are involved in relational trauma than with other childhood concerns.
   c. Children who have been sexually abused are extremely likely to molest other children.
   d. Stigma associated with CSA may discourage social workers from pursuing the appropriate assessment and intervention.

5. Children who have been sexually abused are equally likely to be diagnosed with internalizing behavior problems as they are with externalizing behavior problems.
   a. True
   b. False

6. The attachment style that is most closely linked with dissociation is
   a. Insecure resistant
   b. Insecure avoidant
   c. Secure
   d. Disorganized

7. The social policy that mandates states to establish hotlines and for professionals to report suspicions of child abuse and neglect is
   a. Adoption and Safe Families Act (ASFA)
   b. Social Security Act (SSA)
   c. Child Abuse Prevention and Treatment Act (CAPTA)
   d. Omnibus Budget and Reconciliation Act (OBRA)

8. True or False: The sexual abuse of a child always results in severe emotional damage.
   a. True
   b. False

9. Current research based on resilience theory proposes that
   a. Innate qualities in the child account for differences in resilience.
   b. Family communication and structure account for differences in resilience.
   c. Community factors, such as good schools and access to needed services, account for differences in resilience.
   d. Factors in the child, family and social environment exert risk and protective influence that account for differences in resilience.

10. The ________ is the assessment protocol developed by Mary Ainsworth and her colleagues to identify attachment styles among young children.
    a. Adult Attachment Interview (AAI)
    b. Strange Situation Test (SST)
    c. Insecure Attachment Evaluation (IAE)
    d. Secure Babies, Secure Moms program (SBSM)

11. True or False: Attachment-focused interventions with trauma and dissociation emphasize remembering or discussing trauma experiences.
    a. True
    b. False
12. The principles of ___________ address the relationship between parent and child or their interactions, rather than child or parent behavior.
   a. Collaborative Problem Solving
   b. Parent-Child Interaction Therapy
   c. Somatic Therapies
   d. Structural Family Therapy

13. Family roles and boundaries in families where there is CSA have been found to be characterized by:
   a. Blurring of boundaries between parent and child generation
   b. Clear boundaries between parent and child generation
   c. Sub-system roles are defined and understood by all family members
   d. All of the above

14. In families where denial of CSA occurs, a recommended intervention includes all EXCEPT:
   a. Ask the family to envision how they would like to be.
   b. Use of empathy and active listening to help the family collaborate to develop their vision of how they would want to communicate.
   c. Use re-direction toward the future to address denial
   d. Use the authority of the social worker’s role to overcome denial

15. True or False: Children who have been sexually abused by a person they rely on may experience relationships in the present with adults to be ‘triggering’.
   a. True
   b. False
Circle the most appropriate number below to indicate the extent to which the course’s learning objectives were achieved. \( (5 = \text{Achieved in full} / 1 = \text{Not Achieved}) \)

1. Learn the role of social networks in mental health interventions.  
\[ (\text{Achieved in full}) \quad 5 \quad 4 \quad 3 \quad 2 \quad 1 \quad (\text{Not Achieved}) \]

2. Learn how to develop self-efficacy and critical consciousness.  
\[ (\text{Achieved in full}) \quad 5 \quad 4 \quad 3 \quad 2 \quad 1 \quad (\text{Not Achieved}) \]

3. Learn about the intergenerational effects of trauma that stems from interpersonal and structural violence.  
\[ (\text{Achieved in full}) \quad 5 \quad 4 \quad 3 \quad 2 \quad 1 \quad (\text{Not Achieved}) \]

4. Learn the usefulness of social network inventories and bridges.  
\[ (\text{Achieved in full}) \quad 5 \quad 4 \quad 3 \quad 2 \quad 1 \quad (\text{Not Achieved}) \]

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