UNDERSTANDING TRAUMA IN CHILD SEXUAL ABUSE

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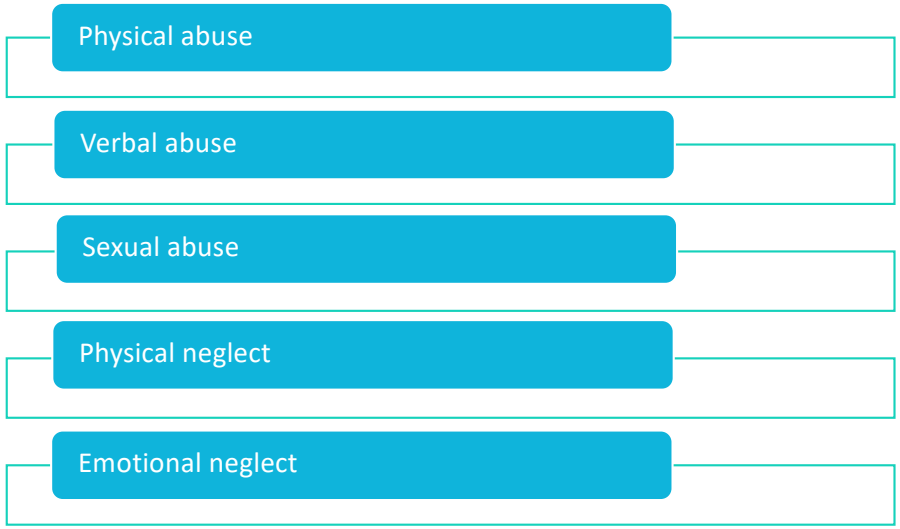
THE NEUROBIOLOGY OF TRAUMA IN CHILDREN

ACES OVERVIEW

There are 10 types of childhood trauma measured in the CDC-Kaiser Permanente Adverse Childhood Experiences Study.

Five are personal:

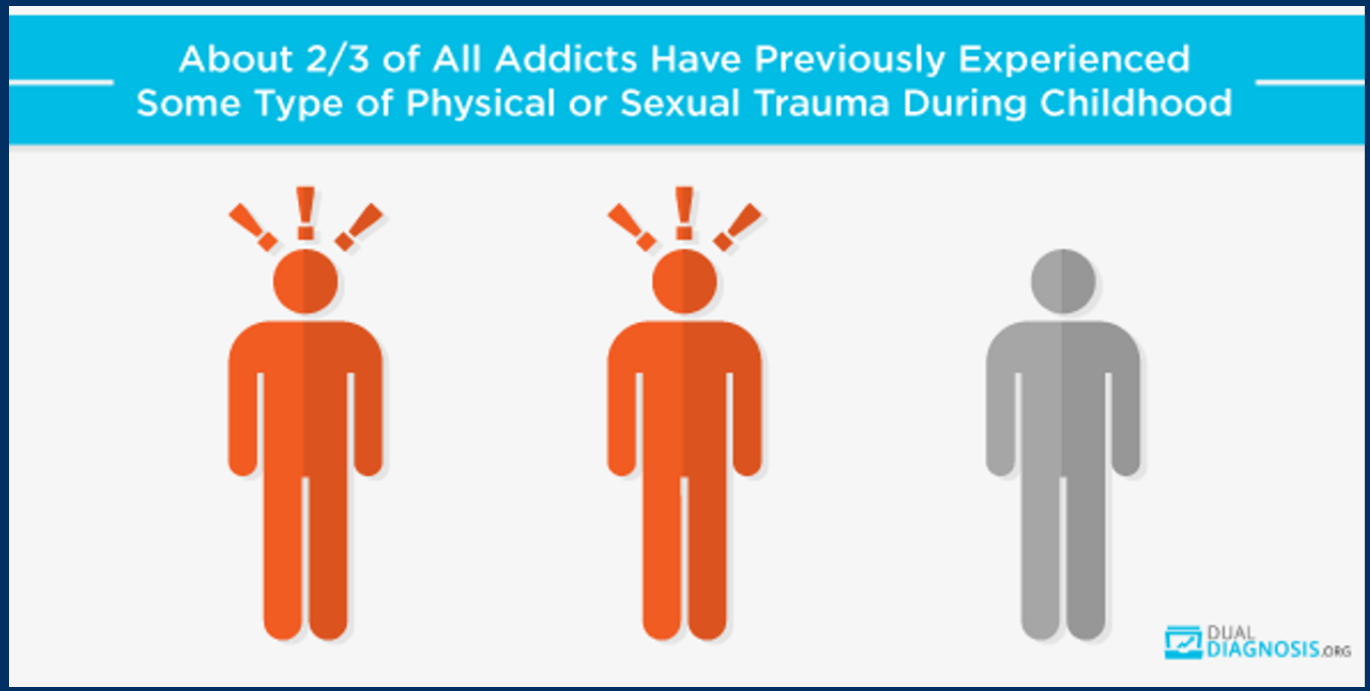


Five are related to other family members: a parent who's an alcoholic, a mother who's a victim of domestic violence, a family member in jail, a family member diagnosed with a mental illness, and experiencing divorce of parents. Each type of trauma counts as one. acestoohigh.org

ACES OVERVIEW

The more ACES you have, the higher the risk you could experience health consequences. This is called a “dose response” relationship. The health consequences can manifest as physical health issues such as heart disease or obesity, or psychological issues such as depression, PTSD, or addiction, to name just a few

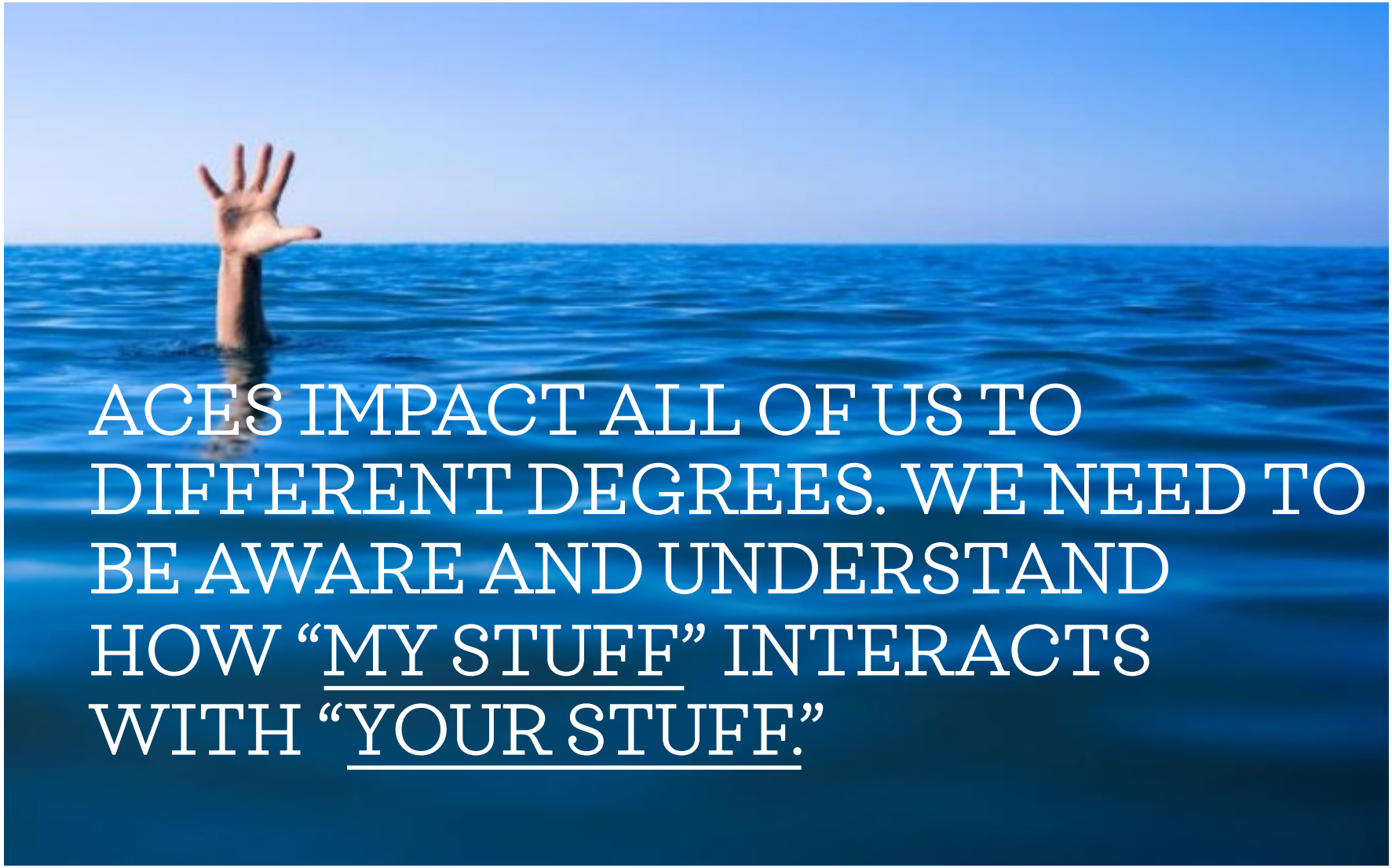
PEOPLE WITH ACE SCORES ARE TWO TO FOUR TIMES MORE LIKELY TO USE ALCOHOL OR OTHER DRUGS AND TO START USING DRUGS AT AN EARLIER AGE.



Reference-
dualdiagnosis.org

ACES

What we know about children who experience sexual abuse is that many of these victims have other ACES which can result in significant health consequences in the future. That is why it is critical to identify, support, and treat children who are victims of abuse. Research supports that the earlier we can intervene, the better we may be able to mitigate the long-term consequences.

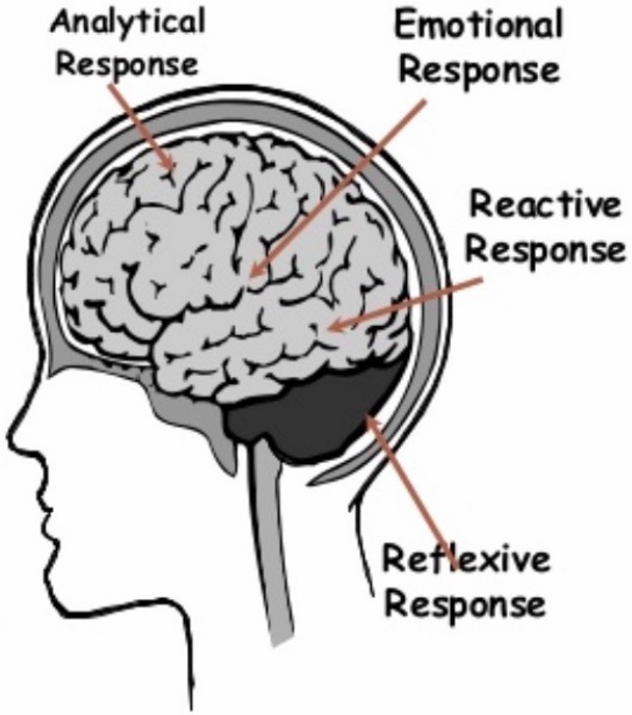

ACES IMPACT ALL OF US TO DIFFERENT DEGREES. WE NEED TO BE AWARE AND UNDERSTAND HOW "MY STUFF" INTERACTS WITH "YOUR STUFF."

ACTIVATION

Traumatized children can struggle to problem-solve or participate in their own safety after they have downshifted out of their neocortex when threatened. “Thinking/reasoning” is impaired.

UPSTAIRS/DOWNSTAIRS BRAIN

- Downstairs brain:
  - **Brain stem and limbic region**
  - **Basic bodily functions, emotional reactivity, attachment, fight/flight/freeze**
- Upstairs brain:
  - Cerebral cortex
  - Decision making, planning, self-understanding, control over emotions and body, empathy, morality, executive functioning




W I S E


BIG EMOTIONS

LOOKING THROUGH THE TRAUMA LENS

How does viewing behavior through the trauma lens change the understanding of behavior?

PERCEPTION OF THREAT

WHAT MAKES THIS ROOM FEEL UNSAFE?

CRITICAL CONCEPTS

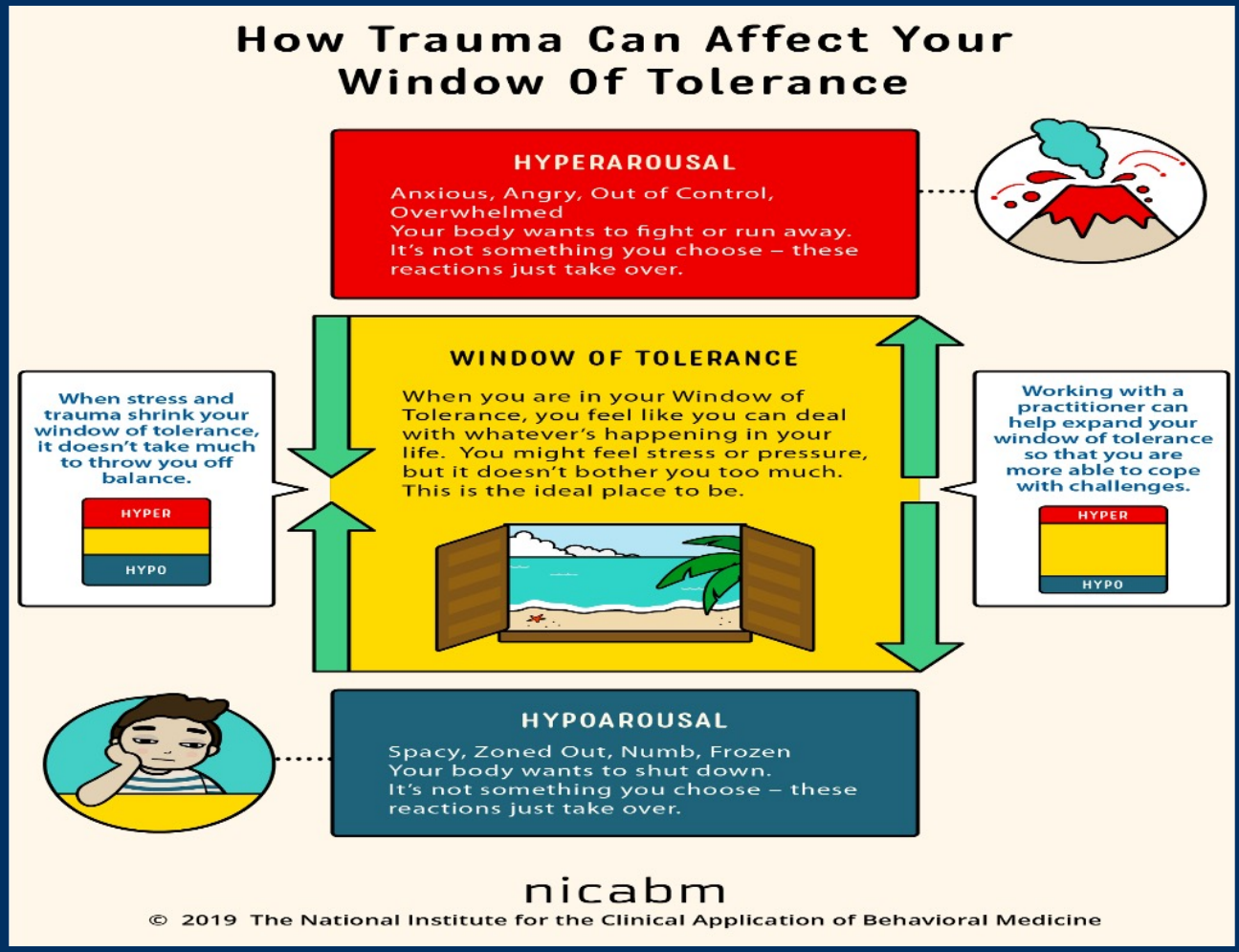
- Perceived vs. Real Threat
- Being Safe vs. Feeling Safe
- Being Scared = Being in danger
- Fight/Flight → Reactivity →Breach of Integrity

HOW DOES THIS LOOK IN YOUR WORK?

Things to consider when:

- Talking with children in their homes
- Speaking to them in other environments
- Interactions with the systems they may have negative experiences with

How Trauma Can Affect Your Window Of Tolerance



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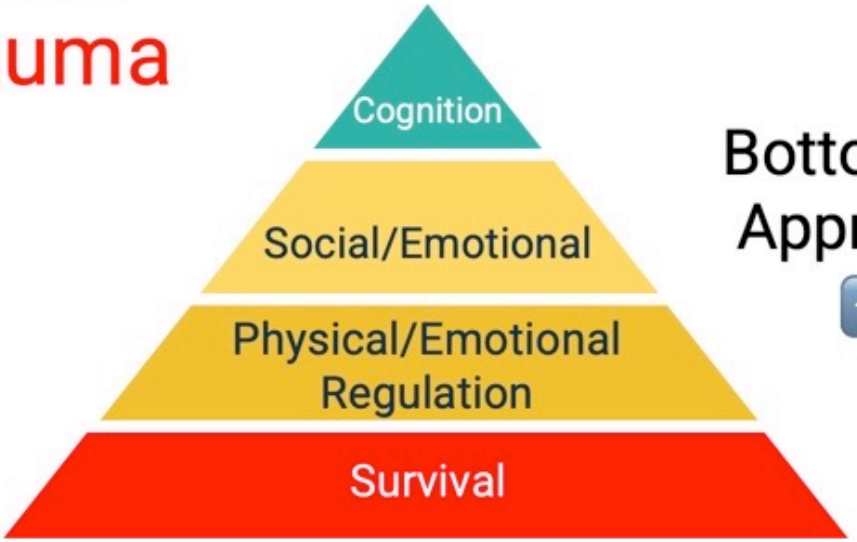
TYPES OF TRAUMA

- Acute – One episode
- Chronic- Repeated episodes
- Complex – Multiple different episodes, trauma is cumulative

COMPLEX TRAUMA

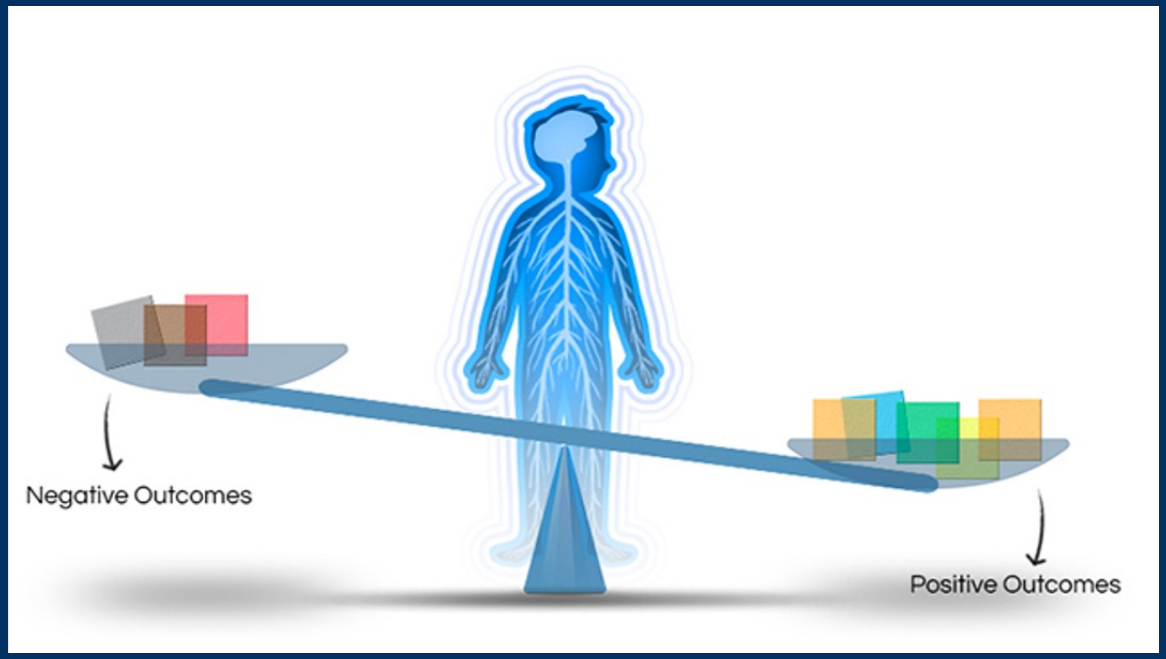
- What a victim defines as their most traumatic event may not be what we think or expect
- Some victims can become acclimated to even the most serious types of abuse, especially if abuse starts at a young age - their response may not be what we expect, or they may be more upset by something we may deem “lesser” than another trauma
- Case example – rape vs. chronic neglect

Direct Trauma



Bottom Up Approach ⬆️

WHEN POSITIVE EXPERIENCES OUTWEIGH NEGATIVE EXPERIENCES, A CHILD'S "SCALE" TIPS TOWARDS POSITIVE OUTCOMES.



THE SCIENCE OF RESILIENCE

Resilience requires supportive relationships and opportunities for skill-building.

Ref: Center on Developing Child (2015). *The Science of Resilience (In Brief)*

THE SCIENCE OF RESILIENCE

Learning to cope with manageable threats to our physical and social well-being is critical for the development of resilience.

Ref: Center on Developing Child (2015). *The Science of Resilience (In Brief)*

THE SCIENCE OF RESILIENCE

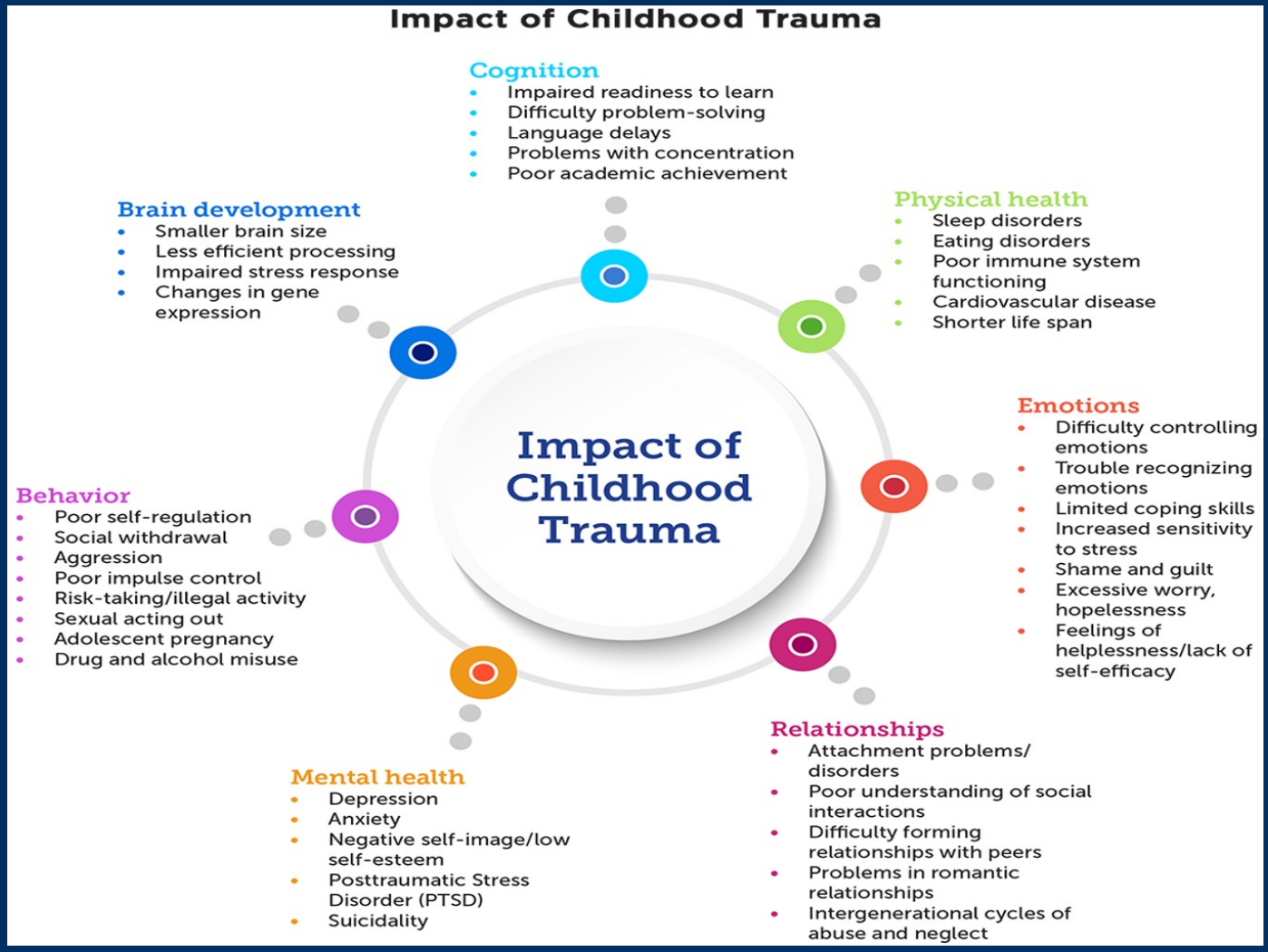
Some children respond in more extreme ways to both negative and positive experiences.

Ref: Center on Developing Child (2015). *The Science of Resilience (In Brief)*

THE SCIENCE OF RESILIENCE

Resilience can be developed at any age, but earlier is better.

Ref: Center on Developing Child (2015). *The Science of Resilience (In Brief)*



Ref: SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach (2014)

WHAT CAN TRAUMA LOOK LIKE?

- Use of drugs or alcohol
- Daydreaming/Dissociation
- Avoidance of people or places
- Increase in discipline issues
- Poor hygiene, appearance
- School Absenteeism
- Deterioration in relationships
- Changes in Sleeping/eating
- Academic failure

Children at Risk: Evidence

Which professionals can look for signs and evidence of risks to children?

Every professional who comes in contact with children and/or parents/caretakers has the opportunity to identify risks to children. This would include the obvious: child welfare, law enforcement, medical, teachers/educators, prevention and treatment professionals, and fire/ems. But it can also include the not so obvious: code enforcement, camp counselors, housing authorities, utility workers, nurse-family partnerships, and others.

None of these professionals are likely to observe all of the signs and evidence of risks to children, but each of these professionals may have the opportunity to provide a critical piece of the picture of a child that could result in an intervention.

Why is it critical that professionals understand and identify risks to children?

- To be able to report to appropriate agencies (i.e. child welfare, law enforcement)
- To allow for earlier identification, intervention, and services for drug endangered children
- To increase information and evidence for other professionals in order to help drug endangered children
- To enhance investigations and cases of all disciplines
- To enhance the capacity of each agency to better serve children
- To increase the likelihood of breaking the multigenerational cycles of abuse and neglect and substance abuse

What can professionals look for?

1. Signs of children
2. Indicators of increased risk of abuse or neglect
3. Signs of actual abuse: physical, emotional, sexual
4. Signs of actual neglect

Signs of Children:

Child car seat or booster seat in car	Children's drawings on refrigerator
Toys in yard or driveway of residence	Diapers or school papers in trash
Pictures of child on cell phone/computer screen	Child food items in trash (e.g. graduate brand foods, Gerber containers, etc.)
Sidewalk chalk drawings at residence	Children's items hanging in windows

What increases the likelihood of the risk of abuse and/or neglect?

Caregiver's substance use or withdrawal	Impaired or intoxicated caregiver
Increased family stressors (e.g. loss of housing, employment, income, death in family, medical issues, birth of a child, etc.	Drug users, dealers, drug cooks, parolees, probationers, sex offenders, or other unknown people in/around residence
Harmful substances within the residence	Caregiver has out of proportion anger/rage or has impulsive, erratic or aggressive behaviors
Chaotic environment	Previously reported abuse or neglect
Caregiver has irrational thinking or other mental health issues	Child has behavior problems or is difficult to manage
Weapons/booby traps in residence	Domestic violence in the residence

Possible signs of abuse (physical, emotional, sexual):

Unexplained injuries to the child	Domestic violence in the residence
Cuts, welts, bruises, burns or other marks on the child (e.g. belt marks, linear marks, bruising on or behind ears, black eyes, etc.)	Caregiver swears at, insults, puts down, or talks negative to child or about child
Child seems fearful of caregiver	Evidence of abuse to pets or other animals
Child has knowledge beyond their age of sexual activity or acts out sexually	Unusual markings on the child that are not easily explained

For more information on Drug Endangered Children please contact National DEC:www.nationaldec.org or Michigan DEC: https://www.michigan.gov/msp/0,4643,7-123-72297_34040_75047---,00.html

Children at Risk: Evidence Sheet

CHRONIC AND TRAUMATIC STRESS

Emotional (How I feel)

Physiological (What my body is doing)

Relational (How to be with people)

Intrapersonal (self/identity) (Who I am)

Cognitive (How I understand and act upon the world)

HOW CAN WE HELP IMPROVE OUR APPROACH?

Change our understanding of problem behaviors

Change our reactions to the behaviors

Challenge the idea of “bad kids” -- really is bad behaviors

BEHAVIORAL RESPONSES AFTER ABUSE

- May still love and still want to see offender
- School performance decline
- Increased use/abuse of substances
- Delinquency/violence
- Risky sexual activity and maladaptive attitudes about sex
- Problem sexual behaviors
- Change in trajectory of "normal" vs. "abnormal" sexual development
- Becoming acclimated to the abuse so it seems "normal" (esp. younger children)
- Sexual risk-taking can be an anxiety reducing behavior

“JENNA” – AGED 15

Behaviors presenting at intake:

- Truancy
- Drug and alcohol use
- Running away
- Stealing from foster family

"JENNA" – AGED 15

Initial Disclosure:

Initial disclosure- forced sexual intercourse by father before she was allowed to go out with peers- angry at her father for not allowing her to see her friends, minimized other incidents

Information Disclosed in Therapy:

sexual abuse since age 4, coercive control, isolated from any family who became concerned. Initial allegations by mother dismissed as custody issues (Mom bipolar and substance use history)

HOW DID “JENNA” RESPOND?

BEHAVIORAL RESPONSE TO ABUSE

Good articles to review:

- In the Wake of Child Maltreatment- Kelly et al. (1997)
- Child Maltreatment and Adolescent Development-Trickett et al. (2011)
- The Aetiology of Child Sexual Abuse: A Critical Review of the Empirical Evidence- Clayton et l. (2018)
- Sexual Abuse of Children with Disabilities-Helton et al. (2018)
- Child Maltreatment and Risky Sexual Behavior: Indirect Effects Through Trauma Symptoms and Substance Use- Thompson et al. (2017)

HONORING THEIR PAST EXPERIENCE

- Children can have complex/conflicted feelings about their offender(s). It is often the case that they can hate what they did but love and miss the offender.
- We need to honor those feelings and reflect them instead of challenging them.

THE PRESSURE TO VIEW THE OFFENDER AS BAD/HORRIBLE/EVIL

"He was my father, he didn't become a monster after I told them what happened. But that's what everyone involved in the case told me. I couldn't tell them how I felt. He was a wonderful man when he wasn't hurting me. I continue to grieve the loss of that version of my father."

RESPONSES TO ABUSE

There can be a great deal of pressure on victims and caregivers from community members, investigators, and other family members to “hate” or be angry with the offender. This may result in not being able to process those feelings and could have a negative impact on recovery. These conflicting feelings can also be interpreted by investigators as resistance or neglect. When someone you love is also your offender, the feelings about the abuse are incredibly complex. There is no “right” way to respond.

How we talk about what happened to them will shape how they feel they can discuss things with us. Therapy can provide a safe space to discuss these conflicting feelings where they are acknowledged and accepted.

TRAUMA AND MISDIAGNOSIS

Trauma symptoms can often be mislabeled as things like ADHD, , Bipolar, Oppositional Defiant Disorder, etc. If a family is “hiding” the abuse or the child has not felt safe to tell, then misdiagnosis and unnecessary/inappropriate medication prescriptions can be made.

It is very important to coordinate referrals with other agencies/professionals involved in the case.

Case example—"Jamie” aged 5- Diagnosed with Autism and Bipolar Disorder

SEXUAL ABUSE MYTHS

MYTH 1:

Delay in disclosure, retraction, and inconsistent reporting of sexual abuse are uncommon and are indicative of fabrication of allegations of sexual abuse.

SEXUAL ABUSE MYTHS

MYTH 2:

The higher the trauma symptom level and intensity the more severe the sexual abuse.

SEXUAL ABUSE MYTHS

MYTH 3:

That usually victims of child sexual abuse are fearful of the perpetrator; and most children will display clear behavioral indicators of sexual abuse.

SEXUAL ABUSE MYTHS

MYTH 4:

That most cases of child sexual abuse involve physical force and sexual intercourse, and that physical findings will usually exist.

UNDERSTANDING NON-OFFENDING CAREGIVERS' RESPONSE TO SEXUAL ABUSE

Wallis, Cassidy R.D, and Woodworth, Michael. "**Non-offending Caregiver Support in Cases of Child Sexual Abuse: An Examination of the Impact of Support on Formal Disclosures.**" *Child Abuse & Neglect* 113 (2021): 104929.

"Caregiver support acted as a protective factor against delays of disclosure. However, this support decreased significantly when the abuser was closely related. The current study provides evidence for the need to support caregivers of children who have been abused with educational programs and resources so they can properly support the child impacted."

WALLIS, CASSIDY R.D, AND WOODWORTH, MICHAEL. "NON-OFFENDING CAREGIVER SUPPORT IN CASES OF CHILD SEXUAL ABUSE: AN EXAMINATION OF THE IMPACT OF SUPPORT ON FORMAL DISCLOSURES." *CHILD ABUSE & NEGLECT* 113 (2021): 104929.

- Non-offending caregiver support has four major dimensions: believing the child, protecting the child, emotionally supporting the child, and obtaining resources for the child
- Parental reactions to disclosures of sexual abuse are vital and can determine whether the child will make a formal disclosure
- Talking about sexual health and behavior with children can be difficult for some caregivers. Although discussing sexual behavior can be challenging, caregivers clearly play an instrumental role in disclosures. So much so that even the child's perception of a strong relationship with their caregiver(s) can result in higher rates of disclosure

MCELVANEY, ROSALEEN, AND NIXON, ELIZABETH. "**PARENTS' EXPERIENCES OF THEIR CHILD'S DISCLOSURE OF CHILD SEXUAL ABUSE**." *FAMILY PROCESS* 59.4 (2020): 1773-788.

- Three Themes:
- Making sense of the abuse in the retrospect
- Negotiating parental identity as protector
- Navigating the services

MCELVANEY, ROSALEEN, AND NIXON, ELIZABETH. "PARENTS' EXPERIENCES OF THEIR CHILD'S DISCLOSURE OF CHILD SEXUAL ABUSE." *FAMILY PROCESS* 59.4 (2020): 1773-788.

"Parents' struggle to make sense of their child's experience focused on two issues. The first issue pertained to why their child did not disclose the abuse sooner or did not disclose to them before they disclosed to anybody else. The second issue was concerned with how parents retrospectively drew new connections between the knowledge now gained that their child had been sexually abused and their child's behavior prior to the disclosure. For some parents, it was noticing a change in their child's behavior that led them to question their child, which played a part in the disclosure process."

"Parents would benefit from education about the multiple complex factors that influence CSA disclosure. This may help them understand that while a trusting relationship is important, children do not typically disclose CSA spontaneously."

SUGGESTED CONVERSATIONS TO HAVE OVER THE COURSE OF TIME WORKING WITH THE FAMILY

1. Are there experiences the family had that could influence their engagement in the process? - Many clients have past experiences with law enforcement, CPS, other systems that may impact their engagement.

2. Review of normal vs. abnormal sexual development in children- A caregiver's understanding of "normal" sexual development can be influenced by their own trauma or general experiences.

3. Responses that siblings may have to the disclosure and process- Siblings may have significant behavioral and emotional responses to the victim's disclosure due to changes that occur within the family. Their response to the abuse can increase family distress and influence the victim's recovery.