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National Workforce Centre for Child Mental Health

Making use of practitioners' skills to support a child who has been sexually abused

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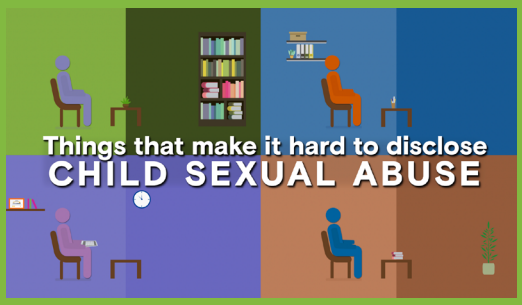
What is this resource about?

- Drawing practitioners' attention to the issue of child sexual abuse (CSA).
- Highlighting skills all practitioners have that can support a child who they suspect has been sexually abused or who discloses CSA.
- Highlighting key principles that can support practice when working with CSA.
- Building the confidence of all practitioners to respond to the issue of CSA, increasing the chances of children receiving help early and avoiding some of the negative long-term impacts of abuse.



This animation highlights some of the messages that children can receive from practitioners that make it either harder or easier for them to disclose sexual abuse.

Who is this resource for?

This resource highlights the issue of child sexual abuse (CSA) and the ways in which practitioners can support children who have been abused. There is a very broad range of services that are likely to encounter children who are experiencing and/or disclose childhood sexual abuse, including early learning environments and schools, general health settings, and mental health support services. Professionals who may be involved in these settings include counsellors, social workers, psychologists, occupational therapists, and GPs, among others.

Child sexual abuse is common and, as highlighted by the Royal Commission into Institutional Responses to Child Sexual Abuse (2017), can have devastating consequences on people's lives. It is important that sexual abuse is identified as early as possible, so that it can be stopped and children can access support to prevent or alleviate some of the negative long-term impacts.

Child sexual abuse is a subject that practitioners, particularly those who do not work in CSA-specialist services, can find confronting. Working in the area of CSA does come with challenges and there is a clear role for specialist services. At the same time, however, there is a great deal that all practitioners can do to support children who have experienced CSA and ensure their healing journey starts early.

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Many of the skills and understandings that practitioners already have, or can easily learn, can be used to support children who have been sexually abused. Applying these can make a significant difference to a child's chances of healing. You might provide support until specialist services can be accessed; or for some children and families, skilled support early on may mean a referral is not even needed.

While specialist services are an essential part of the service response to CSA, all practitioners have an important opportunity to respond to and support children who've been sexually abused. The key principles outlined in this paper can help to support that response.

How common is CSA?

Historically, the public has had little awareness of how prevalent CSA is in Australia. Part of this lack of understanding has been driven by unhelpful cultural attitudes. For example, a tendency to discount the views of children and to see the victim as somehow responsible for the abuse, have served to keep victims silent and the prevalence of abuse to go underreported (Quadara et al., 2017).

Many factors contribute to this silence, including the cultural taboo around discussing sexuality with children at home and school (Collin-Vezina, De La Sablonniere-Griffin, Palmer, & Milne, 2015), making it harder for children to recognise and describe experiences of sexual abuse and adding to their shame. With this context in mind, it's important that practitioners have a more accurate picture of the true prevalence of child sexual abuse.

An international review of estimates of the prevalence of child sexual abuse found that the global prevalence is 11.8% (Stoltenborgh, van Ijzendoorn, Euser, & Bakermans-Kranenburg, 2011), i.e., around 1 in 10 children. Estimates in Australia vary. A review of the prevalence research to- date published in 2010 (Price-Robertson, Bromfield and Vassallo) reported that the rate of penetrative abuse is 7-12% of girls and 4-8% of boys. Non-penetrative abuse is experienced by 23-36% of girls and 12-16% of boys. Estimates can vary for several reasons, including the definition of abuse used in individual studies and the age ranges included in those definitions. It's also important to note that many studies have found that boys and men are much less likely to disclose abuse (Alaggia et al., 2019), meaning they are likely to be underrepresented in the statistics. Regardless of the exact figures, it is clear that sexual abuse is far too common an experience.

Price-Robertson, Bromfield & Vassallo (2010)

80% of victims knew the perpetrator prior to abuse

40% were abused by a family member

ABS Personal Safety Survey (2017)

11.8%

Global prevalence of child sexual abuse

Stoltenborgh, van Ijzendoorn, Euser, & Bakermans-Kranenburg (2011)

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Getting an accurate picture of the numbers of young children who are sexually abused is challenging. Overwhelmingly, research into the prevalence of CSA is conducted retrospectively with adults (Lemaigre, Taylor, & Gittoes, 2017) or occasionally, with adolescents (e.g. Priebe & Svedin, 2008), and the age range used to define child sexual abuse usually goes up to teenage years.

Also adding to the challenge is that disclosure (at least, direct forms of disclosure that are easily recognisable to the recipient) is often delayed. The literature on CSA disclosure estimates that between 60%-70% of victims delay disclosure until adulthood (London, Bruck, Wright, & Ceci, 2008). Abuse that occurs when a child does not have proficient use of language risks going unnoticed if adults are not sensitive to the behavioural and emotional cues that would indicate that something is wrong. In such cases, children may not remember the abuse unless memories are awoken later – for example, when they enter puberty and/or have discussions about sexuality with peers or teachers in the school environment.

For other very young children, a lack of cognitive maturity can mean they are unable to comprehend that what is happening is abusive and that they should alert a safe adult (Collin-Vezina, De La Sablonniere-Griffin, Palmer, & Milne, 2015). Research indicates that the most common age at which CSA begins is 9-10 years (Mathews, 2014).

The dynamics of abuse also contribute to children's delayed disclosure. The ABS Personal Safety Survey (2017) showed that for young people who had experienced sexual abuse before the age of 15 years, 80% knew the perpetrator prior to the abuse starting and 40% were abused by a family member. Children are highly sensitive to their environments and make judgements about whether they are likely to be believed and whether it's safe to tell (Reitsema & Grietens, 2015). The fact that the perpetrator is, in the vast majority of cases, someone known to the child, along with the effects of perpetrator tactics such as grooming, threats, and manipulation, means that it is very difficult for children to disclose at the time of the abuse.

It is also vital to understand the severity of the harm that child sexual abuse can cause. With the advent of the adverse childhood experiences (ACEs) study (Felitti, et al., 1998), there has been a growing awareness that sexual abuse, along with other forms of child maltreatment, can have severe and long-lasting impacts on health and life outcomes.

Child sexual abuse usually doesn't lead to one specific outcome, e.g. substance abuse. Rather, it can lead to a variety of different outcomes including depression, anxiety, personality disorders, suicide, poor educational and occupational attainment, sleep difficulties, and chronic diseases (Bravehearts, 2019; Royal Commission into Institutional Responses to Child Sexual Abuse, 2017). Sadly, people who were sexually abused in childhood often end up burdened with more than one of these negative outcomes. It is also true, however that not all children are permanently impacted by sexual abuse (Cashmore & Shackel, 2013) It is important to keep the different possibilities in mind and approach each situation on a case-by-case basis.

Addressing barriers to support

While consulting with practitioners as part of the research for this paper, it emerged that there are some common barriers to children receiving timely and effective help that could be overcome with relatively small shifts in practice. These barriers are:

1. a perception that providing support around sexual abuse always requires specialist skills
2. practitioners' discomfort in raising the subject of sexual abuse; and
3. a tendency to quickly refer on to specialist services when children disclose.

Is child sexual abuse specialist work?

There is a perception among practitioners that working with children who have been sexually abused requires specialist skills beyond their reach. CSA-specialist practitioners and services certainly play a key part in providing treatment to children; however, there is also a considerable contribution that practitioners in non-CSA focused services can make. By utilising the skills and knowledge they already have, as well as developing other skills that are within their reach, non-specialists can help children and their families to begin to heal.

In some cases, this may look like providing care and support while the child and family wait for an appointment with a specialist service. In other cases, the support you provide may be enough to allow a child and their non-offending parent/s to work through the impacts of abuse, meaning that a referral is not needed. Sometimes just listening to and acknowledging a child's and/or family's pain and confusion is what is needed and helpful.

Practitioners who feel confident and capable to respond to and support children when they disclose CSA will help prevent children from feeling as though they can't be helped or that what has happened to them is too difficult or too awful for others to hear. Overwhelmingly, children who have been sexually abused carry a heavy burden of shame and hasty referrals can inadvertently add to this. The skills and knowledge that many practitioners already have are explored in greater detail in the section below.

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Practitioners' discomfort in asking

> *'I feel like they just need to become comfortable and just talk about it, because children read what we're feeling too. So if we're like "oh I just don't want to face it, it's really uncomfortable", then the client's going to be uncomfortable.'*
>
> **– Amanda, counsellor**

Through our consultations, we found that practitioners' discomfort in asking about sexual abuse is a common barrier to children receiving help. This discomfort can mean that the subject is avoided, even when there is reason to suspect that abuse is occurring. Strategies for navigating these complexities and addressing practitioners' discomfort are the focus of later sections of this paper.

There are several reasons for this discomfort. Sexuality is still largely a taboo subject in society (Collin-Vezina, De La Sablonniere-Griffin, Palmer, & Milne, 2015). Generally speaking, people are not comfortable discussing sex, including what is healthy or unhealthy sexual behaviour. This taboo, which we all absorb to varying degrees and which often goes unquestioned, makes it hard to broach the topic of sex, especially with children, and can erode practitioners' confidence in addressing the issue of abuse. Other reasons for practitioners' hesitation in addressing CSA can relate to a fear of 'getting it wrong' and somehow making the situation worse for the child. The different stages of child development often mean that disclosure of CSA is not a clear, concrete statement but rather many fragments of the child's experience of abuse, revealed over time. In cases where there is little information to go on, a practitioner may be worried about the possibility of 'planting seeds' by raising the topic of sexual abuse, and the potential impact of discussing details of sexual abuse that were not part of the child's experience.

Working with a child who has been sexually abused can also bring with it the added complexity of forensic investigations. While not every case proceeds to court – particularly those involving children due to the challenge in producing evidence beyond reasonable doubt – practitioners may turn down the opportunity to work with a child if there is the possibility that they could be involved in legal proceedings. Some practitioners lack confidence to have conversations about sexual abuse with a child because they feel worried that something they say or do could inadvertently negatively affect any criminal investigation.

It is important to address these reasons for discomfort because avoiding 'going there' can have unintended consequences for children. Children are often sensitive to and pick up on others' feelings; a practitioner's discomfort can send messages to children that it's not safe to share details of the abuse or that they are irreparably damaged by the experience. This can reinforce the child's feelings of fear and shame, leading to delays in disclosing the abuse and receiving help.

Practitioner discomfort may also reinforce a view that child sexual abuse is specialist work, which can lead to hasty referrals and increase the risk of children and families falling through the gap. While it's normal to want to avoid feeling uncomfortable, it is important to choose a more active stance in addressing CSA, especially since children frequently rely on adults to notice that something is wrong and offer help. Adult survivors repeatedly report that one of the main reasons they didn't tell anyone about the abuse at the time was that there was no opportunity to; it never came up in conversation, and no one asked them about it (Allnock & Miller, 2013; Lemaigre, Taylor, Gittoes, 2017; Reitsema & Grietens, 2015).

The tendency to want to immediately refer on

A third barrier, which is likely to be exacerbated by the first two, is practitioners' tendency to immediately refer children on to other services when sexual abuse is disclosed. Given that service environments can often be hindered by delays or limited availability, this tendency results in families falling through gaps and risks further cementing the impacts of abuse on children's mental health.

While a decision to refer on may ultimately be made, practitioners should resist making hasty decisions about this. There is much you can do in the aftermath of a disclosure to help the child begin to heal, and families will likely benefit from being supported in the interim period before specialised therapy can begin.

Another issue to note is that, when working with a child in relation to a certain presenting issue (e.g. being bullied at school or causing trouble themselves at school), just because they have been subjected to CSA it doesn't automatically mean that the abuse is the cause of their other issues. Therefore, there may not be the need to refer on to a specialist service. Practitioners need to use their judgement, skills and knowledge to determine the primary cause of a child's distress and decide on the best course of action to support them.

A child may be best supported by a specialist practitioner or service in situations where a practitioner does not have strong supervision or team support. In part, what makes a service 'specialised' is its supporting organisational structure, including a team working in the same area who bring diversity of experience and knowledge; regular supervision; and greater organisational knowledge of the dynamics of CSA and the justice system.

Another situation is where the case is particularly complex, e.g. when there are intergenerational patterns

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of abuse, or abuse involving multiple family members. In these situations, it may be that the child, family and practitioner collectively decide that they will be best served by specialist support.

If the decision to refer on is made, a supported or warm referral will be most supportive of the child and family, along with a clear and sensitive explanation as to why it is happening. This could be a joint session with the new service, or consent from the child and parent to share information with the new service provider, minimising the extent to which the family needs to tell their story again.

Making use of the therapeutic skills you already have to support a child who has been sexually abused

Many of the skills practitioners already use on a regular basis can be used to support a child who has been sexually abused. Even if there are some areas you feel less confident in, it's very likely that with an openness to trying new approaches, they are within your reach.

Building a collaborative relationship with the child

A key element to supporting a child who has been, or is suspected to have been, sexually abused is the quality of the child-practitioner relationship. A collaborative approach to engaging children recognises the inherent power imbalance between adults and children and seeks to redress this by taking time to build an authentic relationship (Day, 2008).

Building a collaborative relationship involves recognising the child's right to be heard and involved in decision-making, and honours their inherent skills and abilities. It is key to creating a context of safety that enables a child to feel comfortable sharing their story.

It is important that children are given a say over what gets talked about, when it is talked about, and for how long. The act of sexual abuse exploits the child's vulnerability and lack of power; therefore, giving children a choice in the way therapy sessions unfold is a way of restoring their sense of agency and control. It can be helpful to even ask the child where they would like everyone to sit in the room.

For more information on building genuine partnerships with children, see our course 'Engaging with Children: A Foundation'.

Strengthening relationships in the child's life

A common phrase among practitioners we spoke to was 'healing happens at home'. Obviously there are some home environments that are dangerous and where this will not apply, but for most children the quality of support from caregivers in their day-to-day lives will have the most profound impact on their healing (van Toledo & Seymour, 2016), regardless of the professional support they receive. For this reason, working with the child and the non-offending parent/s (or main caregiver) to ensure the relationship is psychologically safe and supportive will have the greatest impact.

This work could involve developing a shared understanding with the caregiver about the way that trauma shapes children's behaviour and emotional reactions; and how this understanding, in turn, can help the caregiver to respond in ways that are useful and supportive. There may also be some work to do to strengthen the relationship between the child and non-offending parent. The relationship can be eroded by the tactics of the perpetrator and/or by the child feeling they weren't kept safe, possibly because they tried to tell and weren't heard or believed.

Some work may need to be done with the non-offending parent/caregiver and other (non-abused) siblings around 'disenfranchised grief' – grief that cannot be openly acknowledged because it is not socially supported (Corr, 1999). In the case of a non-offending parent and/or siblings, it includes grief associated with the loss of earnings, loss of standing, loss of relationship, and loss of parenting support, among other things. Supporting the important people in the child's life enables them to provide a solid base and understanding for the child who has experienced CSA, who may notice these losses in others and feel responsible.

In cases where the non-offending parent/s have their own history of CSA or other trauma, more involved support may be required as the parent's own trauma responses may be triggered by the situation. Work can be done to unpack how that distress may be reducing their capacity to respond to the new revelation about their child's experience of abuse. Parents with their own histories of CSA may need separate support around this, and it will be important that the parent receives this support as part of helping to strengthen their relationship with their child. Related to this, it is important to gently correct any belief a parent/caregiver has that their child's life is ruined as a result of the abuse.

Practitioners must also be mindful of not letting professional expertise inadvertently undermine the non-offending parent's skills and abilities to support their own child. Where a parent is highly distressed themselves with the belief that they 'allowed' the abuse to happen, they may appear to hand over their child to an 'expert' to 'fix' because they feel helpless. Effective initial support can focus on what parents have done: how they have responded and how they know their child better than anyone else. While a child often needs their parents with them for a conversation, parents will need time separately to speak about their own experience in order to better assist their child.

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Working from trauma-informed principles

While in many cases CSA is a highly traumatic event for a child, it's also worth noting that not all children will be traumatised by the experience. For some younger children, it can be their parent's reaction that is the cause of alarm and confusion, rather than the experience itself. It is important to bear these different scenarios in mind while also having an understanding of what trauma is and how best to respond to it.

Trauma is not an event but rather an individual's reaction to it (Andrews, 2019). Whether or not a person is traumatised by an experience depends on whether they interpret it as having threatened their life. The trauma response impacts the body's nervous system and when it has not been properly processed, can lead to heightened sensitivity to signals of danger and ongoing re-experiencing of the trauma. Very often, our nervous system detects these dangers subconsciously (NICABM, 2019), shifting the body into a state of 'fight', 'flight', or freeze'.

Creating a felt sense of safety for someone who is traumatised, whether adult or child, is the most important aspect of trauma-informed practice (Kezelman & Stavropolous, 2019). Very often, traumatic events involve violations of safety in a relationship, as is the case with CSA. Forming a safe, supportive relationship with a child is the first step in creating a space in which the impacts of abuse can be expressed, explored, and responded to, if they wish to do so.

It is important to take time to observe a child's body language and facial expressions to identify whether they might be in an activated state. As well as the more obvious 'fight' and 'flight' states, a child could be in a 'freeze' state. A child in 'freeze' may seem 'spaced out', frozen, very quiet, or may be frequently saying 'I don't know'.

If a child's nervous system is detecting danger, it will be difficult to engage them in conversations and language-based processes, and more work will need to be done to create safety in the therapeutic relationship. This may look like inviting the child to move their body (e.g. through jumping, shaking, throwing a ball) to shift the fight or flight energy. It could involve spending some time playing with the child until they are calmer. It is also important for the practitioner to check in with their own nervous system and possibly adjust their tone of voice and/or facial expression to send a signal of safety to the child.

While the impacts of trauma are serious and can be life-long, it is also important for practitioners to keep in mind the very real potential for healing and recovery. That a child is believed and accesses support for sexual abuse while still in childhood is very positive and presents a good chance of recovery. Children's nervous systems and their associated neuronal pathways are still highly malleable (Gaskill & Perry, 2012; Kays, Hurley, & Taber, 2012), meaning that positive experiences of working through the impacts of abuse with safe, supportive adults can shape the child's neurobiology in a positive and enduring way.

Another important piece of this understanding is the concept of 'the whole child'. Viewing children as active and knowledgeable contributors to their worlds, as well as keeping in mind a child's family, social, and community context works to counteract the potential overemphasis of the role of trauma. Overemphasising trauma can lead to viewing a child as 'damaged' or 'helpless' or exclusively a victim of traumatic experiences (Yuen, 2019).

Developing shared understandings of children's emotions and behaviour

When traumatic memories get reactivated (usually by something in our environment that reminds us of the event), the parts of our nervous system concerned with survival take over. This survival mode activates certain behaviours, which can get noticed and labelled, particularly in children, as being 'aggressive', 'clingy', 'defiant', or 'zoned out'.

The way a child who has been traumatised behaves when their nervous system is activated will vary depending on their age and stage of development. Very young children might demonstrate distress through more frequent bed wetting, clinginess, or nightmares. Older children could complain of aches and pains, have angry outbursts, or become withdrawn. Some children may indicate something is wrong through sudden or unusual sexualised behaviour, whereas other will not. These are just some examples of behavioural signs of distress. It is important that practitioners are aware of the link between trauma, a dysregulated nervous system, and behaviour, and that they ask children and caregivers a broad range of questions to understand what is going on for a child.

Practitioners also have an important role to play in helping parents understand this link between trauma and behaviour. Having conversations about the underlying causes of their child's behaviour can help parents to respond in a more empathetic way (van Toledo & Seymour, 2016). This also allows for the creation of greater safety in the parent-child relationship, strengthening the support that a child receives at home.

These conversations could include sharing information with parents about differences in behaviour, such as internalising (e.g. becoming withdrawn, quiet, or more introverted) or externalising (e.g. aggression towards others, running away, trying to be overly helpful). Some children might tend toward one type, whereas others

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will express a combination of both internalising and externalising behaviour. It is important to highlight that children who seem to be quiet and well-behaved can sometimes be overlooked because they are thought to be doing well, when in fact they might not be.

Maintaining regular routines is important to supporting children through crisis or traumatic events and is a more practical response that a parent can take. It is important to balance routines with flexibility, especially if the child has been traumatised; nevertheless as a general principle, maintaining routines supports a child to feel a sense of normalcy and security.

'Sexual abuse is a different type of childhood trauma, but it's still a developmental trauma. A lot of workers have a basic understanding of trauma-informed care, so it's really about not being overwhelmed by the sexual nature of trauma and remembering that it's a trauma in childhood, and how would you support parents if it was a disclosure about neglect or emotional abuse.'

– Clare Klapdor, manager

Responding to disclosure

If you are the recipient of a disclosure, you have a powerful opportunity to set the child on a positive recovery journey and your immediate response is crucial to this.

Research indicates that the response a child receives is linked to the impact of the abuse on their mental health and long-term wellbeing (Reitsema & Grietens, 2015). Negative reactions to a child's disclosure may contribute to longer term psychological adjustment than other factors. Responding in a positive, affirming way can be profoundly supportive of a child and ensure they continue to access help.

Key to all conversations about child sexual abuse is remaining clear that the perpetrator is responsible for what happened, not the child. Practitioners should also be prepared that this understanding may take time to be internalised. This is because the tactics of the perpetrator often serve to make the child feel as though they allowed the abuse to happen and are somehow complicit in it. The issue may need to be revisited over and over until the sense of responsibility for the abuse starts to shift.

Responding when a child discloses CSA

'There are ways of asking open questions… so that the questions aren't leading or suggestive to the child. These kinds of questions are recommended because they encourage the child to tell you about their experiences in their own words, and this is better than asking lots of direct, specific questions of a child as these could be leading and influence the child's responses.'

– Vanessa Richardson, clinical services manager

If you are the first person to respond to a child's disclosure of CSA, there are some important principles to follow to make sure you respond in an effective way:

- Listen calmly and carefully and without judgement.
- Allow the child the time they need to tell their story without interference.
- If you need to clarify the situation with the child, use open-ended questions (e.g. 'Mum said you told her something about your uncle. Can you tell me what you told her?'; 'Tell me more about that…'; 'What else happened?').
- Explore the child's immediate and ongoing safety (e.g. when they will have contact with the offender again, and whether they have any current or past genital soreness, symptoms, or injuries).

Immediately following the conversation with the child, write their statement down and date it, being sure to use the child's words (Government of NSW, 2020). This information will need to be notified and will assist with decisions regarding any urgent investigative and medical needs. For information on reporting child abuse across different states and territories, see the Australian Institute of Family Studies' 'Reporting child abuse and neglect' fact sheet.

It is recognised that after disclosing some children may recant at the time, or later, due to others' reactions or fear about the consequences of their statements. Practitioners need to understand this and continue to support the child.

Responding when you suspect CSA, but the child hasn't disclosed

The literature on CSA disclosure makes it clear that disclosure is rarely a one-off event, but rather is better understood as a process involving indirect and non-verbal signals (Reitsema & Grietens, 2015). Young children in particular are more likely to signal that they are being abused through their behaviour, such

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as refusing to visit certain people and places, angry outbursts, nightmares, and increased anxiety. It can include uncharacteristic sexual behaviour such as the sudden use of adult sexual language, but this does not always happen. In a service setting, it might present itself through children's play or drawings (Centres Against Sexual Assault, 2019).

If you suspect a child might be being sexually abused, you can respond by providing opportunities for them to tell you about it. An invitation to talk can include statements such as:

- 'I'm a safe person for kids to talk to if anything is making them feel sad or scared or yucky. Has anything like that happened to you?'
- 'Has anything happened that has made you feel hurt or unsafe?'
- 'If you ever have any worries, I am here to listen to you.'
- 'Would it be okay if I talked a little bit about my experience or ask you some questions?'.

Sometimes children respond to hearing about other children's experiences, as this helps them to understand that they are not alone. Particular resources (e.g. story books) may give children an opportunity to be exposed to the experience of others. It may help them to find ways to talk about what's happened without the need to put a name on the experience, i.e. not referring to it as 'sexual abuse'.

Despite invitations, children may choose not to disclose straight away, or at all. Sometimes they might return to a later session wanting to talk or ask more questions. It is important to be patient and not rush the process, keeping in mind that it can take a very long time for a child to feel safe enough to tell someone they are being abused. While it is helpful to ask clear, open questions, being too direct may overwhelm a child. There is a balance between being too rushed and direct versus shying away from asking questions.

Practitioners may have concerns about how the therapeutic process interacts with the legal process. It is not within the scope of this paper to go into detail about the legal proceedings associated with CSA. You are encouraged to familiarise yourself with the basic information in your jurisdiction about navigating the legal processes as a practitioner. If you have any specific concerns or questions, it may be useful to contact your local child protection authority for specific and confidential advice. You can find details of each state and territory child protection services in the Australian Institute of Family Studies' 'Reporting child abuse and neglect' fact sheet.

It is important to remember that the child's immediate safety is paramount and should be prioritised over concerns about possible contamination of a legal process. There does not have to be a disclosure to make a notification. It is important that practitioners notify on the basis of their suspicion of CSA. It is helpful to create a space to begin to explore what's going on for a child in the present in terms of their feelings, thoughts, and behaviours; to address any urgent needs for safety and/or material support; and to spend time strengthening relationships in the child's life. This can be significant work and can be undertaken without going into the details of the abuse, the circumstances surrounding it, and the associated risks of potentially contaminating forensic evidence.

Podcast: An interview with Secrecy

As part of this series of resources, we created a special podcast episode about the role that secrecy plays in child sexual abuse. Using a narrative approach to externalising problems, we interview 'Secrecy' about their tactics and motivations when it comes to children who have been sexually abused. The interview highlights the challenges children can face in disclosing abuse, as well as the practices that weaken Secrecy's power.

Key principles for working with CSA

The following section outlines a set of principles to guide practitioners in supporting a child who has been sexually abused. These principles can be helpful whether the support is short term or ongoing.

Believing the child

One of the most important things you can do to support a child who tells you they're being sexually abused is to believe them. The first response a child receives to their disclosure can be crucial to their future wellbeing (Reitsema & Grietens, 2015). Sending a clear message that you believe what they say helps to build trust, which is important for the child's healing journey. It is not a practitioner's job to determine the truth of the claim. This responsibility lies with the justice system and regardless, research evidence and practitioner accounts indicate that false allegations are rare (e.g. O'Donohue, Cummings, & Willis, 2018).

As well as being believed, the child needs to be affirmed and validated for their decision to tell someone. It takes tremendous courage for a child to speak about being exploited by an adult, particularly when the abuse is shrouded in secrecy and self-blame. Helpful statements include:

- 'I believe you and I'm glad you told me.'
- 'I'm sorry that this happened to you.'

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- ‘You are not to blame for this happening.’
- ‘Telling someone was the right thing to do.’
- ‘It’s very brave of you to tell me that big story. It must have been hard keeping it all inside.’

These statements send an explicit message to the child that you have heard and accepted what they have told you (Education Centre Against Violence, 2015).

It is also important to tell a child what the next steps are that you are going to take. Do not make any promises you can’t keep (e.g. ‘I’ll make sure this doesn’t happen to you again’; ‘I won’t tell anyone else’). Use language that is age and developmentally appropriate to explain any action you are going to take to notify significant adults in the child’s life and/or child protection authorities or police. Once you have let the child know, give them the chance to respond to what you have told them. For example:

- ‘What’s it like for you to hear that I’m going to take those steps?’
- ‘What do you think about what I’ve told you I’m going to do?’
- ‘Are you a bit worried about that, or pleased about it, or maybe both?’
- ‘Do you have any other ideas about what I should do from here?’

Although the child does not have a veto over the actions you need to take, these enquiries provide you with the opportunity to further understand, respect, and acknowledge the child’s responses, feelings and ideas.

Responding calmly

Responding calmly to a child’s disclosure of sexual abuse is important. Although practitioners and society more broadly (quite rightly) feel a sense of outrage about acts of child abuse, expressing this at the time of disclosure is not helpful. Appearing to ‘catastrophise’ the situation may feed into a child’s beliefs that they have done something wrong and that their lives may be ruined. Also, children who are exposed to negative responses or sense that adults are upset or angry about alleged abuse may feel reluctant to discuss their experiences further during investigative interviews.

Another reason responding calmly is important is that the relationship between the child and the perpetrator is often a complicated one. The perpetrator may be someone close to the child or the child’s family and children can have conflictual feelings toward them (Reitsema & Grietens, 2015). Also the grooming process that the child (and often a non-offending parent too) is subjected to, may mean that there are aspects of the relationship that the child enjoys. It might not be obvious to the child that the relationship is abusive.

Instead, it is important to contain any strong negative emotions that might arise and remain present and attentive to what the child is saying.

Use children’s words and language

Practitioners have talked about the importance of using children’s words and language as much as possible in conversations about the abuse. Mirroring in this way not only builds rapport, it can also be helpful in situations where it’s unclear exactly what might have taken place between the perpetrator and the child.

By using the child’s language, you are staying in the boundaries of what the child has chosen to share with you and are unlikely to introduce information that is outside of the child’s experience. This approach avoids the risk of potentially contaminating evidence that may be part of legal proceedings.

If a child tells you, they want you to help them

If a child happens to disclose to you that they are sexually abused, this is a strong signal that the child thinks that you will be able to help them. Children are often highly attuned to their social environment and make decisions about who to share important information with based on who they perceive to be trustworthy (Reitsema & Grietens, 2015). Additionally, going for counselling or therapy is sometimes not something a child has chosen to do, meaning that they may feel reluctant, and possibly even frightened, to be there. For these reasons, if a child does disclose to you, they are likely to benefit the most from your continued support.

Helping after a sexual abuse disclosure does not mean a quick fix and could require specialist referral. But you have an opportunity to help the child begin to question some of the messages the perpetrator instilled in them. Even after referral, you could continue to play a role in providing stability and a safe environment for the family during a difficult process that can involve multiple agencies and practitioners.

Considering the child’s relationship with you as part of any decision to refer on to another service, including the child and family in any decision to refer, and facilitating a warm referral will help to sustain a child’s trust in practitioners and hope for improved emotional health and wellbeing.

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Providing space to explore CSA experience

It's possible to support a child to explore their experience of abuse and its impacts, without having to go into the specific details of the abuse. If a child has been traumatised by the abuse, creating a safe space to feel any emotions associated with the experience may be helpful.

Shame is an emotion strongly associated with experiences of abuse, as is fear. Children might also experience anger, disgust, and sadness. You can help the child to understand that any recurring physical sensations they experience after they are no longer in contact with the abuser, such as a racing heart, sweating, trembling, or zoning out are the body's normal reaction to scary events and its way of signaling the need for help. So long as a child is in a safe environment, they can be reassured that these sensations do not mean they are in danger again.

It is important to always to be guided by the child as to whether or not they wish to participate in therapeutic or counselling process. Some children may not want to and it's important to respect this and not push for a child to recall any emotions, thoughts, or behaviours that they don't want to.

Sitting with the complexity of relationships

'Without context of what adults should and shouldn't do to you, I think it's can be really tricky [for a child]. It's not just like, "these bad things happened to me and I know it's bad. And I'm going to tell someone." Often there are a lot of nice things that go along with that person and that's all part of it. But that's very hard for a child to disentangle.'

– Levina Clark, clinical psychologist

It can be initially shocking for practitioners to learn that for some children, there are aspects of the relationship with the perpetrator that they enjoyed or valued.

Children who are isolated and go unseen in their families, particularly where there are other family problems such as violence and substance use, have a higher chance of being sexually abused (Reitsema & Grietens, 2015). The perpetrator may have invested considerable time and energy in building rapport with the child as part of the grooming process so that they will trust them. For a child who has not received the love and attention they need, this newfound attention from an adult can be very welcome in their life.

There is also the reality that CSA often occurs within families, including between siblings, where the presence of emotional bonds complicates the picture. Some children feel a sense of attachment and loyalty toward perpetrators despite the abuse, and may want to protect them (Munzer, Fegert, Ganser, Loos, Witt, & Goldbeck, 2014). Being aware of these nuances and being able to sit with them without immediately reframing a child's experience with the perpetrator is an important part of supporting a child who has been sexually abused.

Sitting with parents' uncertainty

'I still maintain that support for the parents is one of the most important things for children who have experienced sexual abuse. So, it might be allowing the parent to sit with you and talk about what's causing them a little bit of doubt and what's hard for them in this space. What's going to be hard about them accessing this counselling, and really unpacking and doing that work with parents to get them ready for this journey. I just think that's hugely important for the children.'

– Clare Klapdor, manager

While it's in the child's best interests that their parents or caregivers believe them, it is also understandable if the caregivers take some time to absorb the abuse allegation. This is another aspect of CSA that involves nuance and the capacity to sit with discomfort.

The non-offending parent/s have often also likely been subjected to grooming by the perpetrator and so initial disbelief can be common in these situations. It is important to be mindful that initial doubt or uncertainty is not necessarily evidence that a parent or caregiver is not able to protect their child. Providing space for the non-offending parent to explore their feelings about the abuse and make sense of it, can be very beneficial to the child's wellbeing in the longer term. A parent's actions, what they actually do at home to support their child, as well as the intent behind their actions is more important than the things they might say in the counselling room.

Focusing on what will be most beneficial to the child and their recovery is also helpful in situations where parents might be confused or conflicted. This includes parents telling their child that they believe them and that they did the right thing to tell someone, even if the parent is feeling doubtful; and creating space for the child to talk about what happened to them and how they are feeling (if they want to). It includes helping the parent to understand that their child may be more emotional or reactive than usual and that this is a response to distress and possible trauma, not the child being difficult.

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Access to supportive supervision or colleagues

Access to supervision is an important part of effective practice across all specialities, not just when working with CSA. However, working with child sexual abuse along with other forms of abuse, especially where it is severe and deeply entrenched, can be especially demanding on a practitioner's resources and capacity to cope.

It is important to have someone, ideally a supervisor, to talk to about your own emotions and reactions that arise while working with a child around sexual abuse. It can also be beneficial to have a team or colleague who you can talk with about decision-making strategies regarding notifications that might need to be made. It could also be helpful to find out whether specialist services in your area will provide informational support, perhaps regarding child protection and legal processes.

Summary

This paper aims to draw attention to ways that practitioners, across many disciplines and specialties, can support children who have experienced sexual abuse. Sexual abuse is too common in Australia and without early intervention and support, it can be devastating for children's mental health and longer-term health outcomes.

One of the key barriers to children disclosing sexual abuse is not being asked about it and not having any opportunity to disclose. This paper outlines a set of principles and suggestions for ways of working that can support all practitioners in their work with sexually abused children. It is time for more adults in helping roles to step up to the challenge of identifying and addressing CSA.

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Further resources

Emerging Minds: Engaging with Children (e-learning course)

CFCA: Reporting child abuse and neglect (fact sheet)

ECAV: Responding to suspected child abuse (practice paper)

WestCASA: Responding to children and young people who disclose child sexual abuse (web page).

Emerging Minds is committed to producing quality resources to support practitioners and services to respond to this important social issue.

Because you have taken the time to read this paper, we would value your comments about additional resources that would support your work in this area. We have three questions for you here.

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References

Allnock, D. and Miller, P. (2013). *No one noticed, no one heard: A study of disclosure of childhood abuse.* London, NSPCC.

Anthony, A. (2019). Stephen Porges: 'Survivors are blamed because they don't fight'. *The Guardian*. Accessed 6 May 2020. Available here.

Australian Bureau of Statistics (2017). *4906.0 - Personal safety, Australia, 2016*. Accessed 20 Feb 2020. Available here.

Bravehearts Foundation (2019). *Child sexual assault: Facts and statistics*. Arundel, QLD: Author.

Cashmore, J. and Shackel, R. (2013). *The long-term effects of child sexual abuse*. Melbourne, VIC: Australian Institute of Family Studies.

Centres Against Sexual Assault (2019). *Fact sheet: Responding to children talking about sexual abuse*. Melbourne, VIC: Author.

Child Family Community Australia (2019). *Reporting child abuse and neglect: Facts for service providers*. Melbourne, VIC: Australian Institute of Family Studies.

Collin-Vezina, D., De La Sablonniere-Griffin, M., Palmer, A., & Milne, L. (2015). A preliminary mapping of individual, relational, and social factors that impede disclosure of childhood sexual abuse. *Child Abuse and Neglect, 43*, 123-134.

Corr, C. A. (1999). Enhancing the concept of disenfranchised grief. *OMEGA – Journal of Death and Dying, 38*(1), 1-20.

Day, C. (2008). Children's and young people's involvement and participation in mental health care. *Child and Adolescent Mental Health, 12*(1), 2-8. doi: 10.1111/j.1475-3588.2007.00462.x

Education Centre Against Violence (2015). *Helping to make it better: Important information for parents and carers about the sexual assault of children*. Paramatta, NSW: Education Centre Against Violence.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., … Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) study. *American Journal of Preventive Medicine, 14*(4), 245-258.

Gaskill, R. L. and Perry, B. D. (2012). Child sexual abuse, traumatic experiences, and their impact on the developing brain. In P. Goodyear-Brown (ed.), *Handbook of Child Sexual Abuse: Identification, Assessment, and Treatment*. Hoboken, NJ: John Wiley & Son, Inc.

Kays, J. L., Hurley, R. A., & Taber, K. H. (2012). The dynamic brain: neuroplasticity and mental health. *The Journal of Neuropsychiatry and Clinical Neurosciences, 24*(2), 118-124.

Kezelman, C. A. and Stavropolous, P. A. (2019). *Practice guidelines for clinical treatment of complex trauma*. Milsons Point, NSW: Blue Knot Foundation. Available here.

Lemaigre, C., Taylor, E. P., & Gittoes, C. (2017). Barriers and facilitators to disclosing sexual abuse in childhood and adolescence: A systematic review. *Child Abuse & Neglect, 70*, 39-52.

London, K., Bruck, M., Wright, D. B., & Ceci, S. J. (2008). Review of the contemporary literature on how children report sexual abuse to others: Findings, methodological issues, and implications for forensic interviewers. *Memory, 16*(1), 29-47.

Mathews, B. (2014). Mandatory reporting laws and identification of child abuse and neglect: Consideration of differential maltreatment types, and a cross-jurisdictional analysis of child sexual abuse reports. *Social Sciences, 3*(3), 460-482.

Münzer, A., Fegert, J. M., Ganser, H. G., Loos, S., Witt, A., & Goldbeck, L. (2014). Please tell! Barriers to disclosing sexual victimization and subsequent social support perceived by children and adolescents. *Journal of Interpersonal Violence, 31*(2), 355-377.

O'Donohue, W., Cummings, C., & Willis, B. (2018). The frequency of false allegations of child sexual abuse: A critical review. *Journal of Child Sexual Abuse, 27*(5), 459-475.

Price-Robertson, R., Bromfield, L., & Vassallo, S. (2010). *The prevalence of child abuse and neglect*. Melbourne, VIC: Australian Institute of Family Studies. Available here.

Priebe, G. and Svedin, C. G. (2008). Child sexual abuse is largely hidden from the adult society. An epidemiological study of adolescents' disclosures. *Child Abuse & Neglect, 32*(12), 1095-1108.

Quadara, A., Stathopoulos, M., Carson, R., Bilgic, S., Kaspiew, R., Romaniuk, H., … Dunstan, J. (2017). *Pathways to support services for victim/survivors of child sexual abuse and their families*. Melbourne, VIC: Australian Institute of Family Studies. Available here.

Reitsema, A. M. and Grietens, H. (2015). Is anybody listening? The literature on the dialogical process of child sexual abuse disclosure reviewed. *Trauma, Violence, & Abuse, 17*(3), 330-340.

Royal Commission into Institutional Responses to Child Sexual Abuse (2017). *Final report: Volume 3, Impacts*. Canberra, ACT: Commonwealth of Australia. Available here.

Stoltenborgh, M., Van Ijzendoorn, M. H., Euser, E. M., & Bakermans-Kranenburg, M. J. (2011). A global perspective on child sexual abuse: Meta-analysis of prevalence around the world. *Child Maltreatment, 16*(2), 79-101.

van Toledo, A. and Seymour, F. (2016). Caregiver needs following disclosure of child sexual abuse. *Journal of Child Sexual Abuse, 25*(4), 403-414.

Yeun, A. (2019). *Pathways beyond despair: Re-authoring lives of young people through narrative therapy*. Adelaide, SA: Dulwich Centre Publications.

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