TEXAS
Department of Family
and Protective Services

Working with Children with a History of Sexual Victimization, Sexual Aggression, or a Sexual Behavioral Problem

Resource Guide

October 2023

Child
Protective Services

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1. Introduction and Purpose

Children who have experienced a sexual incident require special attention and care. These children can have complex needs which may be challenging to understand. To comprehensively address the needs of children and youth who have been victims of sexual abuse or are sexually aggressive, caseworkers need to know how to proactively plan for treatment and interventions, placement, and permanency.

This guide provides direction for ensuring the child or youth is receiving quality services to meet their needs. It is not intended to determine specifically which interventions and supports should be used for children and youth who have been victims of sexual abuse or have demonstrated sexual aggression. The therapeutic treatment plan should be developed by the child's treatment provider with input from the placement resource and caseworker to help the provider understand child history, current needs, and behavior.

See CPS Policy 6419, *Working with Children Who are Sexually Aggressive, Have Sexual Behavior Problems, or Are Victims of Sexual Abuse*.

Acknowledgments

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- Superior STAR Health;
- Children's Advocacy Centers of Texas;
- Helping Hand Home;
- Texas Network of Youth Service;
- Texas Alliance of Child and Family Services;
- Texans Care for Children;
- National Association of Social Workers - Texas Chapter;
- Dr. Kim Cheung; and
- SAFE Alliance.

2. What is Child Sexual Abuse?

In Texas, ***sexual abuse***[1] is conduct harmful to a child's mental, emotional, or physical welfare, including:

- Sexual activity which is:
  - Nonconsensual between children of any age;
  - Consensual between children with more than 24 months difference in age; or
  - When there is a significant difference in the developmental level of the children;
- Failure to make a reasonable effort to prevent sexual conduct harmful to a child;
- Compelling or encouraging a child to engage in sexual conduct including human trafficking and prostitution; and
- Causing, permitting, encouraging, engaging in, or allowing the obscene or pornographic photographing, filming, or depicting of a child.

For purposes of this guide, the term ***perpetrator*** will be used to identify a person committing or suspected of committing sexual abuse against a child. The child or youth being abused will be referred to as the ***victim***. Children in DFPS conservatorship who victimize other children are referred to as exhibiting ***sexually aggressive behavior***. See Appendix A for glossary terms.

In many cases, sexual abuse starts with the victim being "groomed" by the perpetrator. In most cases of sexual abuse, the perpetrator is well known to the victim. ***Grooming*** is the process of building the relationship and preparing the child for the planned sexual abuse. During grooming, the perpetrator deliberately misrepresents moral and behavioral standards. A perpetrator often exploits a child's needs for adult approval and affection, love of games, and interest in material awards, such as money or presents. Often the perpetrator attempts to make the child feel indebted or obligated because of the gifts or the gift of affection. Perpetrators are aided in their efforts by the child's desire to please adults and recognition of their own powerlessness. The perpetrator may also use their power to dominate, bribe, threaten, or emotionally blackmail the child to keep the secret.

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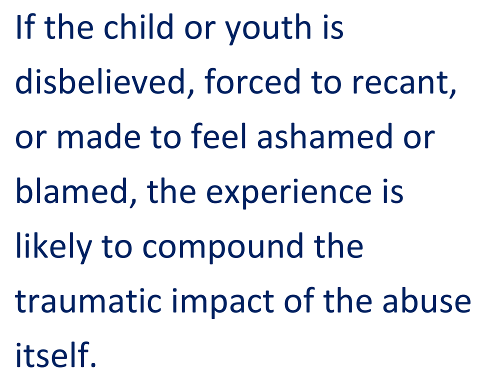
[1] See Family Code, Section 261.001(1)

Trauma from Sexual Abuse

Children and youth respond to traumatic events, including sexual abuse, in different ways. It is important to understand every child will have an individual response and unique needs for care and recovery.

For children who have been sexually abused, the act of sexual abuse is only part of their traumatic experience. Sexual abuse victims are commonly lied to, manipulated, sometimes forced to act against their will, bribed, threatened, and then often disbelieved. These are just some of the ways children who are sexually abused come to feel betrayed and lose trust in the people and systems in place to protect them.



Impacting Factors

One of the most important factors in the impact of sexual abuse is whether the child or youth was believed by the first person they told.

The age and underlying personality of the child or youth, as well as the extent of the abuse, are also important factors. Abuse that progresses to more frequent contact or causes physical injury to the child can cause longer-lasting effects. Current efforts to protect children and youth from sexual abuse have centered on teaching them to protect themselves by saying no, recognize their right not to have their bodies touched, and tell safe adults if they are uncomfortable. Although these efforts may provide some protection, children may still be vulnerable to perpetrators with who they have already built a trusting relationship, such as an authority figure or someone older in age. Many children who are victims of sexual abuse feel great guilt because they may believe they are somehow to blame for the abuse.

When working with a child in the DFPS conservatorship who has experienced sexual abuse, collaboration between treatment providers, family members, placement resources, and the caseworker is essential. One of the underlying principles of this guide is the importance of caseworkers and caregivers collaboration in:

- Assessing the child’s needs on an ongoing basis; and
- Planning for treatment services and permanency.

3. Caseworker Secondary Trauma Stress

Working with victims of sexual abuse can be difficult for caseworkers and other professionals. Caseworkers sometimes experience secondary trauma, as the essential act of listening to trauma stories often takes an emotional toll.

It is important to be mindful of the factors contributing to secondary traumatic stress. These factors may include:

- Personal experiences that mirror the experiences of the child;
- Stress from work, family, or personal relationships;
- The caseworker's relationship to the child making a disclosure; and
- The emotional labor involved in working with and caring for children and youth who have experienced trauma and their families.

Employee Assistance Program

Caseworkers are encouraged to seek support from supervisors and the employee assistance program. Information about the employee assistance program can be found on the DFPS Safety Net.

4. Child Sexual Abuse

Behaviors and Characteristics

Many children and youth will not acknowledge past sexual abuse or will wait until they are comfortable and feel safe to do so. Victims need support, sensitive care, and responsive treatment regardless of when the abuse occurred or the disclosure is made.

Responses to traumatic events, including sexual abuse, are different person to person. Not all youth who have been sexually abused will respond in the same manner. Often, the responses to sexual abuse are very similar to signs indicating a child or youth has experienced other traumatic events.[2] Below are signs identified as ways children and youth *might* behave as a response to past or ongoing sexual abuse.

- Significant changes in behavior and reverting to outgrown behaviors including bedwetting and thumb-sucking;
- Unexplained changes in emotional state, including anger or depression;
- Rebellion or withdrawal;
- Runaway behavior;
- Change in attitude toward school or academic performance, lack of interest in friends, sports, or other activities;
- Unexplained or frequent health problems like headaches or stomach aches;
- Age-inappropriate sexual behavior;
- Age-inappropriate sex knowledge and/or excessive talk about sex;

It's common for children to blame themselves, fear punishment, or be afraid that they will not be believed. A child may feel embarrassed and ashamed. The avoidance, which is part of post-traumatic stress reactions, may make a child simply try to forget what happened. Many children who have experienced sexual abuse grow up before they tell anyone about what happened.
– National Child Traumatic Stress Network (NCTSN)

[2] https://www.stopitnow.org/

- Being secretive and/or fear of or refusing to be alone with a specific person;
- Pain, blood, or redness in the genital or anal area, including pain during urination or bowel movements; and
- Sexual promiscuity.[3]

Important Reminders[4]

- It is common for children and youth to delay telling someone about the abuse.
- Most children and youth believe they somehow caused or deserved the abuse.
- Many children and youth are very worried that by telling, they will upset the important adults in their life.
- When a child or youth has a close relationship with the abuser, they may feel guilty about how telling or revealing the secret will affect the abuser.
- The child or youth may be especially protective of the abuser if he or she is their sibling or parent.
- The abuser may have threatened to harm the child, youth, or their loved ones if they tell.
- Especially with teenage youth, the abuser may have used social pressure and web-based media to coerce the youth.
- Many children and youth fear not being believed or think they will be blamed or punished for the abuse.
- Children and youth may fear that telling will cause family disruption or separation, especially for children who have been removed from their family in the past.
- Understanding and talking about the abuse can be difficult for younger children and children with developmental disabilities depending on their developmental stage and abilities.

[3] NCTSN – Caring for Kids: What Parents Need to Know about Sexual Abuse Fact Sheet
[4] Ibid.

Responding to a Sexual Abuse Disclosure

Mandatory Reporting Duty

As a Texas child welfare system professional, you are considered a mandatory reporter and must report any new reports of sexual abuse to DFPS Statewide Intake.

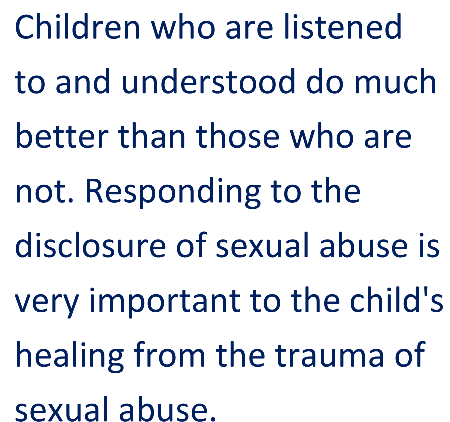
Understand the difference between:

- How to emotionally support a child or youth making a disclosure of abuse; and
- Your responsibilities to report, case manage, and escalate issues of concern.

You will have case management functions to perform if a disclosure is made to you, and the process may vary depending on the situation. Guidance from your supervisor on the next steps should always be sought. Consultation with the local children's advocacy center (CAC), the attorney representing DFPS, law enforcement, and placement and therapeutic care providers may also be needed promptly. See *Children's Advocacy Centers* below.

Trauma-Informed Response

When a child or youth trusts you with a disclosure of sexual abuse, it is critical to use a trauma-informed response. Consider the immediate and long-term impacts of childhood sexual trauma, the dynamics specific to child sexual abuse, and prioritize the child's physical, psychological, and emotional safety.



- When a child is making a disclosure or alluding to current or past sexual abuse, your body language, attitude, and words should be attuned to the child or youth.
- Remain calm and be non-judgmental.
- Listen attentively and demonstrate compassion and understanding.
- Do your best to create a safe space for them to talk to you.

- Acknowledge the importance of the conversation and your understanding that they have chosen to trust you.
- Give assurance that talking about the abuse is the right thing to do, and you will do everything you can to help them.
- Tell the victim that the abuse was not their fault and praise them for their bravery in disclosing.
- As appropriate according to the victim's developmental stage, explain what will happen next.
- Do not make promises you cannot keep, such as not telling anyone else or not reporting the information to authorities.

Seeking Detailed Information

If you need more detail from the child to ensure safety and follow reporting protocols, choose gentle open-ended questions. For example, "Can you tell me more about that?" or "Where did that happen?". Do not censor the child and do not prompt for more detail than is necessary for you to have at that time. At your earliest ability, take appropriate safety measures and follow mandated reporting protocols. This may include involving the CAC or law enforcement agencies.

Your trauma-informed and compassionate response will have an important impact on how the child or youth heals from the trauma of the abuse.

About Recantation[5]

I have heard that some children who disclose sexual abuse later "take it back." Does this mean they were lying?

No. In fact, attempting to "take it all back"—also known as recantation—is common among children who disclose sexual abuse. Most children who recant are telling the truth when they originally disclose, but may later have mixed feelings about their abuser and what has happened because of the disclosure.

Some children have been sworn to secrecy by the abuser and are trying to protect the secret by taking it back. Some children are dealing with issues of denial and having a difficult time accepting the sexual abuse. In some families, the child is pressured to recant because the disclosure has disrupted family relationships.

[5] NCTSN

A delay in the prosecution of the perpetrator may also lead a child to recant to avoid further distressing involvement in the legal process.

A very small percentage of children recant because they made a false statement.

Permanency Planning Considerations

In all aspects of case planning, it is critical to consider the impact of case decisions on permanency outcomes for children and their families. Quality information gathering about the family and their support networks in the investigation stage may prevent removal if an alternative plan can be made for child safety. It can also assist future ongoing staff to ensure children maintain connections with family members and others who are important to them. It is best practice for all staff, regardless of stage of service, to consider not only legal permanency, but also relational permanency in decision making at every step.

Intrafamilial Abuse

Safety

In cases involving abuse by a family member, caseworkers in every stage must consider if safe contact with the perpetrator, if in the best interest of the child, is possible in the future, and what, if any, actions can be taken to enhance safety in the family.

Consult with the child's therapist, parents, caregivers, and family to assess the family dynamics and home. Families have the capacity to make changes in their lives, children can be reunified with a parent when one sibling has abused another or a parent or another family member is the perpetrator. If there is a parent who is willing and able to protect the victim, DFPS can support the family in planning for the child or youth's safety and care.

Parents and caregivers require specialized knowledge and skills to plan for safety when sexual abuse has occurred within a family which comes with thoughtful therapeutic interventions and planning.

Visitation and Reunification

Reunification when there has been intrafamilial abuse requires a careful approach that considers danger and risk to the child, while making efforts to preserve family connections and plan for positive permanency. Dynamics in each case will require careful assessment and judgment.

Interventions and Supports

Interventions which can support a caregiver's knowledge and ability to protect a victim of sexual abuse while maintaining familial connection include thorough:

- Individual therapy;
- Family therapy;
- Engagement and joint sessions with the therapist treating the child or youth who has experienced sexual abuse;
- Engagement and joint sessions with the therapist treating the perpetrator; and
- Support groups.

Home Environment and Supervision

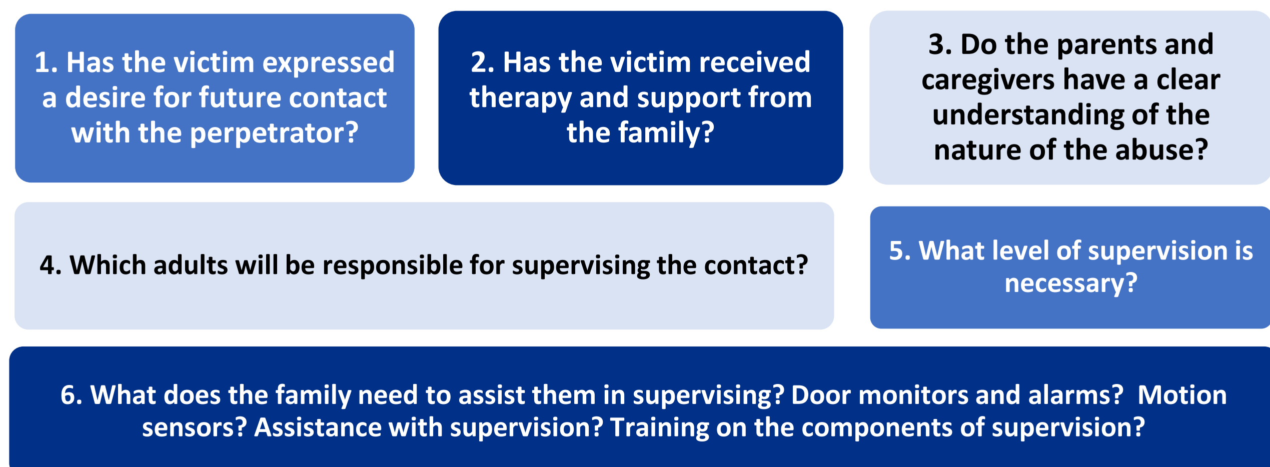
Changes can be made to the physical home environment and supervision structure in the family so children have limited time without adult monitoring, therapeutic care and support, and clear information about safe touch, body autonomy, and how to get help.

If children cannot reside together in the same home following sibling sexual abuse, collaborate with the family and professional team (including current and future identified caregivers) regarding the possibility of virtual visitation or communication between siblings with a goal of face-to-face visits in the future.

Issues to Address

If reunification or visitation is considered in intrafamilial abuse cases, Figure 1 below lists the questions to address with the child's professional team and family.

Figure 1. Visitation and Reunification Questions Related to Intrafamilial Abuse Cases



Case Management Considerations

A variety of factors influence permanency planning and case direction, some of which caseworkers have little control. Outlined below are circumstances that may interfere with or complicate case management and planning. Always work closely with the other members of the professional team (i.e., therapist, attorney, supervisor, CASA or guardian ad litem, attorney ad litem, and caregiver).

Co-Occurring Criminal Case

If the perpetrator is a family member and a defendant in an ongoing related criminal matter, the defendant may interact with DFPS or the Single Source Continuum Contractor (SSCC) staff minimally on the advice of their attorney in the criminal matter. This is especially relevant when a parent is the perpetrator.

Work closely with the attorney representing DFPS or the SSCC to ensure information is shared carefully and best efforts are made to provide services to the family according to their individual needs.

Totality of the Circumstances

Child welfare cases often involve other dynamics and issues aside from child sexual abuse. Case decisions should be made that consider the totality of the circumstances of the family.

Parental Supports and Resources

Often parents may struggle to understand or believe that sexual abuse has occurred. Parents and caregivers may need support from DFPS or SSCC staff, as well as service providers. Parents may be shocked and grieving or assume the child misunderstood what happened.

Caseworkers and service providers can assist the family in supporting the child and nurturing or repairing family relationships by emphasizing the importance of believing the child and establishing open and healthy communication. Parents may need some time to fully understand the situation and can be assisted by participating in their own individual therapy.

Caseworkers and other professionals can also point parents or caregivers to resources to help them to cope and heal. In some areas, the CAC may provide parent education training, case management, and family advocacy to help parents navigate the special issues involved when child sexual abuse has occurred.

Placement Considerations

Placement Planning

Placement planning for children and youth who have experienced sexual abuse can be complicated. It is important to carefully assess the victim's needs and the abilities and needs of the caregiver on an ongoing basis. Communicating with current, prior, and intended placement resources is key to planning for a child's successful treatment and positive permanency.

Caseworkers should always listen and respond to placement resources and provide support. The placement will have important insight and information about the child's needs, health, functioning, well-being, and emotions. Caregivers should be asked about sleep routines, eating habits, responses to stress, social skills, school performance, hobbies, and interests. If the placement resource is a kinship caregiver, collaborate with the kinship development worker to ensure the caregiver receives all available support. The caregiver and the child or youth should be asked about how they are adjusting to the placement.

Proactive Treatment

Treatment needs should be addressed proactively from the beginning of a placement rather than in reaction to incidents. Early treatment could include a trauma history assessment, psychosocial or psychological evaluation, and psychiatric consultation if the need is indicated by other assessments.

If symptoms of trauma begin to appear, it is important to engage in treatment as soon as possible. Enlist the assistance of case managers, the treatment team, STAR Health, and others to support the caregiver and the child. When planning for placement changes, support and assist the caregiver in completing the *Placement Summary Form 2279*, and ensure the form is provided in full to the next placement. See also *Treatments and Interventions* below.

5. Child Sexual Behavior Problems and Aggression

Behaviors and Characteristics

There are many possible reasons why children exhibit sexually aggressive behaviors. In general, children's sexual behavior problems are rarely about sexual pleasure.

Contributing Factors

Sexually aggressive behaviors are much more likely to be related to these factors:

- Exposure to traumatic experiences, such as abuse, natural disasters, accidents, and/or violence, including domestic violence;
- Excessive exposure to adult sexual activity and/or nudity in the home, including media exposure through television or the Internet);
- Inadequate or inappropriate rules about modesty or privacy in the home; and
- Inadequate or inappropriate supervision in the home often because of parental factors, such as depression, substance abuse, or frequent absences.

While the following behaviors do not necessarily indicate sexually aggressive behavior, they are examples of behavioral and social difficulties children with sexually aggressive behavior may also exhibit:

- Impulsiveness and a tendency to act before thinking;
- Difficulty following rules and listening to authority figures at home, in school, and in the community;
- Problems making friends their own age and a tendency to play with much younger children; and
- A limited ability to self soothe (i.e., calm themselves), so they may touch their own genitals or masturbate as a way to release stress.

Questions for Caregivers

Once sexual behavior is observed in a child, discuss the following questions in Table 1 with the caregiver.

Table 1. Child Sexual Behaviors Questions for Caregivers

What to Ask	Why
1. When did someone first notice the behavior? Have there been any recent changes or stressors in your family? Have there been any new relationships or access to new people?	The behavior may be related to a recent stressor such as a new sibling or parent separation.
2. How often have you seen the behavior? Is the frequency or nature of the behavior changing?	Escalation in the number or frequency of behaviors may indicate increased anxiety or stressors contributing to the behavior.
3. Has anyone ever spoken to the child about possible abuse?	Sexual behaviors in children are associated with physical abuse, sexual abuse, and neglect.
4. Does the child become anxious or fearful during the behavior? Has the child been diagnosed with emotional or behavior problems?	Sexual behavior problems in children have been associated with conduct and other behavior disorders.
5. Does the behavior occur at home, school/day care, or both?	If only observed at home, the behavior may be related to stressors, supervision, or changes at home or differences in observer perception.

What to Ask	Why
6. Is there any violence among persons living in the home?	Intimate partner violence has been associated with sexual behaviors in children.
7. Does the behavior involve other another person?	Most sexual behavior problems involve other persons
8. If the behavior involves another person, how old is the person?	Determine if the behavior is occurring with someone in their peer group. Sexual behaviors involving persons much younger or less powerful are considered inappropriate.
9. Is the activity disruptive, intrusive, coercive, or forceful?	Disruptive, intrusive, coercive, or forceful behaviors are abnormal.
10. Can the child be easily distracted from the behavior? How do you (the caretaker) respond to the behavior?	Normative behavior is usually easy to divert. Caretaker distress may escalate the behavior.
11. Does the child have or has the child had access to sexual material, acts, or information, including pornographic movies or images, nudity, Internet chat rooms, and texting that includes sexual language?	Children may mimic what they see or hear.

Responding to Sexually Aggressive Behavior

It is extremely important to note much of the shame and psychological damage that occurs – not only with child victims of sexual abuse, but also with sexually reactive children – stems from the reactionary behaviors of adults. When first encountering sexually aggressive children, caregivers, parents, and adults should:

- Attempt to remain calm in the presence of the children;
- Phone a specialist or mental health professional immediately;
- Talk to the child, without expressing anger, and ask where the child learned the behavior; and
- Do not punish or hit the child, as the child may not have known what he or she was doing was wrong. This would only result in an intense level of shame which could carry over for years.

Room Sharing Recommendations

A child designated as having sexually aggressive behavior should never share a bedroom with:

- A child identified with sexual victimization history;
- Children designated with a sexual behavior problem, but are not sexually aggressive; or
- Children identified as having an intellectual or developmental disability.

Best Practice

The best practice for a child who is designated as having sexually aggressive behavior is to provide the child with a private room; however, the child may be able to share a bedroom with other children in DFPS custody if all the following criteria have been met:

- The child placing unit (CPU) or SSCC intake staff have reviewed the sexual history of all children in DFPS custody at the placement and shared the outcome of their review with the DFPS or SSCC caseworker. The DFPS conservatorship program administrator or SSCC equivalent is responsible for making the determination about room sharing and placing the child with sexual aggression.
- The DFPS caseworker has provided the placement with a complete and current *Placement Summary Form 2279* and *Child Sexual History Attachment*

A that includes supervision requirements for the child. Both documents must be signed by at least one required caregiver on the date of placement.

- If possible, the child's therapist has been consulted about concerns related to room sharing, and this has been documented as a contact narrative in IMPACT 2.0.
- The child's supervision requirements are included in the current Child Plan of Service.
- Any implemented safety plans at the placement are acknowledged and signed by all required caregivers. Depending on the child's needs, the safety plan may be terminated if the supervision plan in the Child Plan of Service and on the *Child Sexual History Attachment A* are updated, acknowledged, and signed by the required caregivers.

GRO Placements

For placement into a general residential operation (GRO) including emergency shelters and residential treatment centers, the following caregivers must acknowledge receipt of the information by signing the *Placement Summary Form 2279* and *Child Sexual History Attachment A*:

- GRO administrator;
- Receiving intake staff, if applicable; and
- Child's case manager.

GRO staff is responsible for making sure any other caregivers receive the information before supervising or providing care to the child. Direct care staff will sign *Certification of Receipt of Child Sexual Abuse* or *Sexual Aggression Information Form 2279B* to certify receipt of information about the child's sexual history.

Foster or Kinship Placements

For placement into a foster or kinship home, the new caregivers (i.e., all foster parents or kinship caregivers) and the caseworker must acknowledge receipt of the information by signing *Placement Summary Form 2279* and *Child Sexual History Attachment A*.

See CPS Policy 4133, *Provide and Discuss the Placement Summary (Form 2279)*.

Specific House Rules

These house rules found in Figure 2 may be shared with the caregiver and potentially used in service planning with the child and caregiver.

Figure 2. House Rules for Children with Sexual Behavior Problems and Aggression

6. Documentation

Documentation of sexual victimization incidents is an important component in providing case management to children. If a child is identified as a victim of sexual abuse, the incident must be:

- Documented in the child's case record; and
- Provided to the caregiver through the *Placement Summary Form 2279, Child Sexual History Attachment A*, and the *Application for Placement*.

Confirmed History

A child is considered to have a confirmed history of sexual victimization if the child is identified as one or more of the following situations:

- Reason to Believe (RTB) sexual abuse finding by DFPS Child Protective Investigations (CPI) or Residential Child Care Investigations (RCCI), even if the perpetrator is unknown;
- Designation as a confirmed sex trafficking victim as indicated on the human trafficking page in IMPACT;
- Confirmed by DFPS as a victim of child sexual aggression;
- Criminal conviction for a charge related to sexual abuse of a child;
- Confirmed allegation information from another state welfare system (i.e., RTB equivalent);
- Violation of Texas Health and Human Services (HHSC) Residential Child Care Licensing (RCCL) Standards; and
- Substantiated victimization in an investigation.

Unconfirmed Victim

An unconfirmed victim of sexual abuse is identified through other information suggesting victimization history, including but not limited to:

- Designation as a suspected human trafficking victim as indicated on the human trafficking page in IMPACT;
- Unconfirmed allegation information from another state welfare system (i.e., the allegation was neither ruled out nor substantiated);

- HHSC RCCL Standards investigations in which victimization is alleged, or information is gathered, and the allegation was neither ruled out nor substantiated;
- DFPS CPI or RCCI investigations in which victimization is alleged, or information is gathered, and the allegation was neither ruled out nor substantiated;
- Incidents not under DFPS jurisdiction that are being investigated by another entity; and
- Incidents not under DFPS jurisdiction that are not successfully prosecuted.

IMPACT Data

Confirmed Incidents

All known confirmed incidents of abuse must be documented on the person's detail page on the sexual incident history page by:

- Entering the incident date and indicating if the incident date is approximate;
- Indicating if the incident occurred while the child was in DFPS custody;
- Identifying who was responsible for the abuse, the age of the perpetrator, relationship to the victim, and IMPACT person identification number; and
- Describing the abuse and all pertinent information related to the incident.

Other Important Information

Other important information regarding the child's sexual victimization history including unconfirmed incidents is documented on the sexual incident history page by:

- Describing any other relevant information regarding unconfirmed findings that may impact the child; and
- Listing all persons for whom the child must be closely supervised or have no contact.

Child's Plan of Service

Any sexual victimization history should also be addressed in the Child Plan of Service.

7. Children's Advocacy Centers

Multidisciplinary Response to Child Sexual Abuse

Connecting a child with a CAC opens the door to evidence-based, trauma-informed mental health, medical, and family advocacy services for the child and family. CACs are community-based nonprofit organizations that facilitate a multidisciplinary response to cases of child sexual assault, abuse, and neglect.

While each Texas CAC is unique to the community it serves, all CACs share two primary goals:

1. **Minimize re-victimization and re-traumatization** of child victims and their protective family members while they are going through the investigation, assessment, intervention, and prosecution processes; and
2. **Facilitate successful case outcomes** through effective fact finding and strong, collaborative case development.

A CACs' most important role is to facilitate communication between partners to assist with coordination of case activities. For instance, when notified of a pending investigation from either DFPS' CPI or RCCI or law enforcement, the CAC immediately begins facilitating communication and coordination to reduce the administrative burden on either agency, minimize confusion, and ensure a timely response on behalf of the alleged victim and his or her protective family members.

Multidisciplinary Teams

Multidisciplinary teams (MDTs) are composed of committed child abuse professionals known as partner agencies. The following disciplines are an integral part of the CAC model:

- Child protection (i.e., CPI, CPS, RCCI, SSCCs and Adult Protective Services);
- Law enforcement;
- Prosecution (i.e., civil and criminal; juvenile and adult);
- Medical;
- Mental health; and
- Family advocacy.

Local CAC's Role with Child Behavior Problems and Aggression

The local CAC may be able to help to determine whether there are any immediate safety concerns related to self-harm or suicidal ideation via appropriate assessment. A local CAC forensic interview may be appropriate to assist in identifying whether an alleged child has been abused or neglected prior to the identified sexual aggression. The CAC forensic interview of the child victim should be used to inform the evaluation of what occurred in cases with a potential child with sexual aggression.

Additionally, the local CAC facilitates regular case review meetings to discuss cases and share information with law enforcement and other CAC multidisciplinary partners, as required by law.

Evaluation Process

Forensic Interview

Depending on local MDT protocols, most children and youth who disclose sexual abuse are referred for a forensic interview at the CAC. The forensic interview is a non-leading, non-suggestive, factfinding interview conducted by a trained forensic interviewer. The interviewer may also be able to help caseworkers determine whether there are any yet unidentified safety concerns related to ongoing sexual abuse.

After providing empathic reassurance and ensuring the child is protected and safe, the caseworker and supervisor should determine whether the case meets the criteria for an MDT response per their local protocols. If so, the caseworker should follow local protocols to initiate the MDT response and involvement with their local CAC which helps support and coordinate the MDT's efforts and provide comprehensive support services to child victims and their non-offending caregivers or family members.

Medical Examination

Children and youth who disclose sexual abuse should also be assessed to determine the need for a medical evaluation performed by a specially-trained medical professional. These evaluations can be done by a:

- Pediatric physician who specializes in child maltreatment as part of a CAC evaluation or at an academic center or community clinic; or
- Certified forensic nurse in the form of a Sexual Assault Nurse Examination, a service available at many different emergency rooms, CACs, and free-standing clinics across the state.

If the alleged sexual abuse has been recent, this evaluation should be done urgently. Of note, it is not common for physical evidence of abuse to be found, but timely examination is essential to increase the probability of finding important evidence.

The provider will obtain a complete medical history from the victim, conduct a head-to-toe examination, look for physical signs of abuse, and test for sexually transmitted infections.

Mental Health Assessment

Children and youth who have experienced sexual abuse should be referred for mental health services, including thorough assessment and treatment. Often, either due to the trauma or in addition to trauma, a child or youth may experience extreme emotional distress.

It is important to understand that these issues are not always obvious, especially in cases of chronic abuse or neglect where a child has learned to hide or mask his or her psychological distress. In some cases, a child or youth may need psychiatric treatment in addition to therapy. Caseworkers should work with the child's therapist to determine the need for this type of referral.

When referring a child or youth to therapy, all history of abuse should be provided to the treatment team. A history of abuse can complicate the treatment of current abuse, and it is important to have the full picture of what trauma should be addressed and treated. See also Treatments and Interventions below.

Family Services and Supports

Sexual abuse not only involves the original victim, but often involves the whole family, and even the whole community. As such, it is important that services and support address these factors as well. This is especially significant given that most child sexual abuse perpetrators are known and trusted by the victim.

In addition to victims blaming themselves for the abuse, they often feel responsible for splitting up their family after abuse has been disclosed. If intergenerational

abuse (which is common) has occurred, parents may have a difficult time providing the secure, consistent support a child needs to express their emotions and needs. In such cases, referring family members (i.e., parents, siblings, etc.) to treatment services can be an essential part of a child's path toward healing.

Law Enforcement

Law enforcement is an essential part of the process for public safety, legal justice, and the healing process. Child sexual abuse cases are very likely to involve the criminal justice system.

Texas law requires DFPS to refer child sexual abuse allegations from a professional (e.g., teacher, medical professional, therapist) directly to a CAC for a facilitated joint investigation. Screening in the field should be limited. When CPI screens out cases in the field, abuse is sometimes ruled out, and the case is closed without law enforcement involvement.

Timely initiation of a CAC-facilitated, joint investigation is critical to ensure opportunities for justice are not missed.

8. Treatments and Interventions

The therapy models discussed in this guide are generally available statewide, but some are more common (i.e., play therapy) than others. Consult with your well-being specialist on which modalities are available in the child's area.

Evidenced-Based Trauma-Informed Care

Evidence-based practice applies research-based treatments to support the use of a therapy model tailored to people for whom it is intended. Some interventions or therapy models have more evidence or are better supported than others. Treatment providers have detailed training on different therapy models and for whom they work best.

> It's likely everyone has experienced an event that could be considered traumatic. Many factors influence how a child, or an adult will make sense of and cope with traumatic events. Not everyone who experiences a traumatic event shows trauma symptoms or identifies with being traumatized.
>
> – Hopper, Bassuk, & Olivet, 2010

In working with children who have experienced sexual abuse, it is important to remember each child or adolescent's treatment path is individualized, and it is key that treatment providers are able to identify what approach works best for the child or youth they are treating. A trauma-informed provider can still engage in ***trauma-informed care*** (TIC) when working with or using a variety of modalities and approaches. The important components of TIC are found in Figure 3 below.

Figure 3. TIC: Strengths-Based Framework

Therapy Modalities Used in Child Sexual Abuse Treatment

The most effective therapy occurs when there is a safe, trusting relationship with the therapist. If the child does not feel comfortable with the therapist or the modality used, another therapist may be considered. Regardless of the therapeutic modality chosen, it is essential the therapist has experience with trauma-informed therapies.

The type of therapy children need will depend on their ages, developmental stages, and capacity to understand what has happened. Child welfare professionals may benefit from basic knowledge of treatment modalities supported by research and may be used by therapists and mental health providers.

Table 2 includes some of the most common modalities. While some of the modalities have been validated for adults, they may be appropriate for adolescents who choose extended foster care services for ages 18 to 21 or older teenagers. The treatment provider can offer case-by-case guidance on this use.

Many of the modalities are offered through STAR Health; however, the availability of providers certified in these types of treatment is limited.

Table 2. Common Therapy Modalities

Therapy Type	Treatment Population	Description
Cognitive Processing Therapy	Primarily focused on adults	This therapy focuses on a specific traumatic event or memory to: • Change the existing thought patterns around the traumatic event; and • Replace them with a healthy thought pattern that allows the patient to move forward. The standard approach follows a 12-session timeline.

Therapy Type	Treatment Population	Description
Dialectical Behavioral Therapy	Often appropriate for adolescents who have suicidal thoughts and behaviors	A type of cognitive behavioral therapy that tries to identify and change negative thinking patterns and pushes for positive behavioral changes. It may be used to treat suicidal and other self-destructive behaviors.
Eye Movement Desensitization and Reprocessing (EMDR)	• Validated for adults • Promise shown for adolescents	This approach uses physical cues, such as lateral eye movement or hand tapping, to access traumatic memories and associate them with a healthy response instead of the existing unhealthy response. This allows the removal of the emotional distress originally associated with the trauma.
Mentalization Based Therapy	Often appropriate for adolescents who have suicidal thoughts and behaviors	This therapy focuses on the person's mental state, including their thoughts, feelings, and desires. One of the initial treatment goals is to stabilize how emotion is expressed in therapy. This can mean helping the person control their emotions so they do not act impulsively.
Parent Child Interaction Therapy	Validated for children ages 2 to 7	This coaching occurs in an observation room as part of the therapy clinic with a one-way mirror or live video stream. The therapist “coaches” the caregiver on how to respond and interact with their child and manage behavior through an earbud while the therapist observes the caregiver in the room with the child.

Therapy Type	Treatment Population	Description
Play Therapy	Typically for children 8 years old and younger	This therapy establishes an interpersonal process where trained therapists use the therapeutic power of play to help children prevent or resolve psychosocial difficulties and achieve optimal growth. The child is encouraged to explore his or her feelings and understand, accept, and process them using his or her innate imagination and creativity. It is the optimum modality and the most readily available in the STAR Health system.
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)	• Validated for use with children and adolescents • A good choice for children 8 years and older	This therapy includes a set outline of: • Identifying a specific trauma; • Walking through specific steps to retrain the thoughts and behaviors associated with the identified trauma; and • Replacing unhealthy responses with healthy responses. The standard approach is 8 to 12 sessions, but can last longer. This therapy is offered by a large majority of providers.

Psychotropic Medication

While talk therapy is an essential aspect of treating trauma, it is important not to overlook the potential benefit of psychotropic medication. Due to the extreme emotions and symptoms experienced by sexual abuse victims, they are sometimes unable to meaningfully participate in psychotherapy without the support of medication.

There are several key symptoms to look out for that suggest a victim will benefit from medication. Some of the most common PTSD symptoms include nightmares and hypervigilance, which will often respond to medications that can improve sleep quality, giving the victims some much-needed rest. There are other treatments, which can empower the victim to be in control of their emotions and facilitate their

transition to healing. Like with talk-therapy, it is important for the psychiatrist to have experience treating trauma or PTSD.

STAR Health Benefits

Evidenced based trauma treatment therapies are a covered benefit of STAR Health. The STAR Health member connections team and service coordinators and managers can serve as a resource for caregivers and caseworkers to identify and locate trauma-informed providers in the community or geographical area. They can also identify providers to address sexual abuse. These same staff can help identify what is a covered Medicaid benefit and if additional evaluation or testing is needed to take full advantage of the child's covered benefits.

Services and Supports for Children with Sexual Behavior Problems and Aggression

Services and supports for children with sexual behavior problems and/or sexually aggressive behavior must be two-fold to address both the:

1. Sexual behavior problems and potential accompanying sexually aggressive behavior; and
2. Possible abuse or trauma the child may have experienced before or after the incident.

Both sexual behavior problems and sexually aggressive behaviors may require safety planning.

Immediate Intervention and Response Goals

1. Be sure the child is not being sexually abused or abusing others.
2. Report all incidents of sexual abuse to all parties involved.
3. Provide "sight and sound supervision" at all times.
4. Involve relatives, parents, and caregivers when appropriate in the child's therapy to participate and support the child.
5. Always follow a written safety plan.
6. Refer for psychiatric and/or medical evaluations when needed.
7. Collaborate with school, day care, or after school care personnel.

Treatment Options

Studies support the belief that most sexually abusive youth are amenable to and can benefit from treatment. Children who act out sexually, despite their acts, need to be viewed compassionately and with a hopeful attitude toward recovery. These children are often victims of maltreatment themselves and deserve a chance to heal and live healthy lives.

- Treatment options range from basic psychoeducation to cognitive-behavioral therapy to in-patient licensed sex offender treatment.
- It is important to initially evaluate with a therapist the length of the services or treatment program needed and communicate those expectations to the child and caregivers.
- It is also necessary for a treatment provider to re-assess the child to determine whether the chosen form of treatment is making a positive impact and additional services and supports are necessary.
- CACs provide TF-CBT at the facility, off-site with a CAC provider, or via a community provider. If a CAC is involved, the CAC can assist in assessing and providing appropriate clinical services, as necessary. Note: Local CAC working protocol, case acceptance criteria, and/or capacity may dictate whether these services are available at the local CAC.

Caregiver involvement in any services and supports provided, as appropriate, is important. It may also be beneficial for the caregivers to be involved in related clinical sessions – both independent of and with the child – as determined by the clinician. This will ensure everyone understands their role and the plans for the children and will establish common expectations of all involved. This will also facilitate healing for everyone involved.

Appropriate Treatment Goals

Generally, the younger the child, the more critical it is for the caregivers to be involved in the treatment goals. The caseworker should work with the child's therapist to develop the treatment goals and ensure those goals are outlined in both the child's treatment plan and plan of service. If the child does not have a therapist, the caseworker must arrange for one immediately.

Table 3 below lists some examples of appropriate treatment goals for children with sexually aggressive behaviors. The goals vary based on age and development, as does the level of involvement by the caregivers.

Table 3. Treatment Goal Examples for Children with Sexually Aggressive Behaviors

Goal Examples
1. **Decrease the child's sexually aggressive behaviors.** These may include persistent, intrusive, and recurrent sexual thoughts; sibling incest; impulse control; aggression; and power and control issues.
2. **Increase the child's understanding of his or her unhealthy associations and beliefs regarding sex and sexuality.** For example, sex equals secrecy, dirtiness, filth, shame, or guilt; sex is "nasty"; sex equals love and caring or where and how to get nurturing.
3. **Teach the child the differences between "okay touch ", "not okay touch", and "secret touch."**
4. **Increase the child's awareness of his or her own and family patterns that precipitate, sustain, or increase sexually abusive and other non-adaptive behaviors.** For example, physical battery in the family; alcohol and drug abuse; role definition in the family; role reversals; parentified children; family scapegoats; family favorites; sibling rivalry; sociopathic tendencies of the family; and consequences of actions.
5. **Provide support and teach the child's caregiver behavior-management techniques for sexual behaviors and other problematic or disruptive behaviors.** This also helps channel energies that might have become sexual behavior into more age-appropriate activities by having a caretaker monitor the child, interrupt any sexual acting out, and provide opportunities for positive alternative behaviors.
6. **Help the child understand and regulate his or her feelings and thoughts connected with prior victimization.** This includes physical, sexual, and emotional abuse; abandonment; neglect; family breakups; and deaths. Areas to focus on may include secrets; nightmares; safety; responsibility for abuse; abuse reminders; Post-Traumatic Stress Disorder (PTSD) symptoms; dissociation; emotional, physical, and sexual boundaries; feelings about offenders; and damaged feelings. Provide support to the caregiver to assist the child with managing his or her feelings and thoughts.
7. **Help the child make appropriate choices and decisions including practicing behaviors in everyday activities.** Provide support and teach the child's caregiver strategies to help the child with these choices and behaviors.

Goal Examples
8. **Develop with the caregiver and the child a detailed and specific short- and long-term safety plan.** This includes recognizing inappropriate thoughts, impulses, etc., may be normal at times and understanding it is acceptable to talk about them and not be afraid or ashamed to ask for help in coping. Emphasize this shows good decision making and choices (i.e., a life preserver) and paradoxically a sign of real strength. Caregivers and other supportive adults should be involved in developing the safety plan.
9. **Help the child learn and demonstrate skills to calm and reduce stress.**
10. **Help the child observe and assess his or her own behaviors, be aware of the circumstances preceding those behaviors, and think of the consequences of those behaviors before he or she acts.** Integrate these behaviors into everyday situations. Identifying and participating in some outside social/athletic/educational activity which matches the youth's interests/abilities should be a requirement before treatment completion
11. **Increase the child's ability to observe and appreciate other people's feelings, needs, and rights with exercises related to victim empathy and moral development.**
12. **Help the child understand his or her needs and values and develop his or her own goals and internal resources**.
13. **Increase the child's ability to meet his or her needs in socially appropriate ways.**

List of Acronyms

Acronym	Full Name
CAC	Children's Advocacy Center
CASA	Court Appointed Special Advocate
CPI	Child Protective Investigations
CPS	Child Protective Services
CPU	Child Placing Unit
DFPS	Department of Family and Protective Services
EMDR	Eye Movement Desensitization and Reprocessing
GRO	General Residential Operation
HHSC	Health and Human Services Commission
MDT	Multidisciplinary Team
NCTSN	National Child Traumatic Stress Network
PTSD	Post-Traumatic Stress Disorders
RCCI	Residential Child Care Investigations

Acronym	Full Name
RCCL	Residential Child Care Licensing
RTB	Reason to Believe
SSCC	Single Source Continuum Contractor
TF-CBT	Trauma-Focused Cognitive Behavioral Therapy
TIC	Trauma-Informed Care

Appendix A: Glossary

Cognitive Processing Therapy: This therapy focuses on a specific traumatic event or memory to change the existing thought patterns around the traumatic event; and replace them with a healthy thought pattern that allows the patient to move forward.

Dialectical Behavioral Therapy: A type of cognitive behavioral therapy that tries to identify and change negative thinking patterns and pushes for positive behavioral changes. It may be used to treat suicidal and other self-destructive behaviors.

Evidence-Based Practice: A therapeutic practice which applies research-based treatments to support the use of a therapy model tailored to people for whom it is intended.

Eye Movement Desensitization and Reprocessing: This approach uses physical cues, such as lateral eye movement or hand tapping, to access traumatic memories and associate them with a healthy response instead of the existing unhealthy response. This allows the removal of the emotional distress originally associated with the trauma.

Grooming: The process by which perpetrators build a relationship and prepare a child for planned sexual abuse.

Mentalization Based Therapy: This therapy focuses on the person's mental state, including their thoughts, feelings, and desires. One of the initial treatment goals is to stabilize how emotion is expressed in therapy. This can mean helping the person control their emotions so they do not act impulsively.

Parent Child Interaction Therapy: The therapist "coaches" the caregiver on how to respond and interact with their child and manage behavior through an earbud while the therapist observes the caregiver in the room with the child. This coaching occurs in an observation room as part of the therapy clinic with a one-way mirror or live video stream.

Perpetrator: A person committing or suspected of committing sexual abuse against a child.

Play Therapy: This therapy establishes an interpersonal process where trained therapists use the therapeutic power of play to help children prevent or resolve psychosocial difficulties and achieve optimal growth. The child is encouraged to

explore his or her feelings and understand, accept, and process them using his or her innate imagination and creativity. It is the optimum modality and the most readily available in the STAR Health system.

Sexual Abuse: Conduct harmful to a child's mental, emotional, or physical welfare, including (1) sexual activity which is nonconsensual between children of any age, consensual between children with more than 24 months difference in age, or when there is a significant difference in the developmental level of the children; (2) failure to make a reasonable effort to prevent sexual conduct harmful to a child; (3) compelling or encouraging a child to engage in sexual conduct including human trafficking and prostitution; and (4) causing, permitting, encouraging, engaging in, or allowing the obscene or pornographic photographing, filming, or depicting of a child.

Sexually Aggressive Behavior: Conduct exhibited by children in DFPS conservatorship who victimize other children.

Trauma-Focused Cognitive Behavioral Therapy: This therapy includes a set outline of identifying a specific trauma; walking through specific steps to retrain the thoughts and behaviors associated with the identified trauma; and replacing unhealthy responses with healthy responses.

Trauma-Informed Care: A strengths-based framework grounded in an understanding of and responsiveness to the impact of trauma; emphasizing physical, psychological, and emotional safety for both providers and survivors; and creating opportunities for survivors to rebuild a sense of control and empowerment.

Victim: The child or youth being abused is referred to as the victim.