TEXAS
Department of Family
and Protective Services

Working with a Child who has Experienced Sexual Abuse

Resource Guide

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Introduction & Purpose

Children who have experienced sexual abuse require special attention and care. These children can have complex needs which may be challenging to understand. This guide provides guidance for ensuring the child or youth is receiving quality services that meet their needs. To comprehensively address the needs of children and youth who have been victims of sexual abuse, caseworkers need to know how to proactively plan for treatment and interventions, placement, and permanency.

This guide is not intended to determine specifically which interventions and supports should be used for children and youth who have been victims of sexual abuse. 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, and current needs and behavior.

See 6241.11 Working with Children Who Are Sexually Aggressive, Have Sexual Behavior Problems, or Are Victims of Sexual Abuse

Acknowledgments:

DFPS would like to acknowledge the valued contributions to this guide made by our community partners who are experts and leaders in their fields.

Texas CASA

Superior STAR Health

Children's Advocacy Centers of Texas

Helping Hand Home

Texas Network of Youth Services

Texas Alliance of Child and Family Services

Texans Care for Children

National Association of Social Workers - Texas chapter

Dr. Kim Cheung

SAFE Alliance

What is Child Sexual Abuse?

Sexual abuse defined by the Texas Family Code is conduct harmful to a child's mental, emotional or physical welfare, including nonconsensual sexual activity between children of any age, and consensual sexual activity between children with more than 24 months difference in age or when there is a significant difference in the developmental level of the children; or failure to make a reasonable effort to prevent sexual conduct harmful to a child.

In this resource 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 conservatorship of DFPS who victimize other children are referred to as exhibiting **sexually aggressive behavior**.

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.

Trauma and Sexual Abuse

Sexual abuse is a traumatic experience, and the trauma experience and responses are individualized and unique.

For children who have been sexually abused, the act of sexual abuse is only part of their traumatic experience. Victims of sexual abuse 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 that children who are sexually abused come to feel betrayed and lose trust in the people and systems that are in place to protect them.

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. If the child or youth is disbelieved, forced to recant, or made to feel ashamed or blamed, the experience is likely to compound the traumatic impact of the abuse itself.

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, to recognize their right not to have their bodies touched, and to tell safe adults if they are uncomfortable. Although these efforts may provide some protection, children may still be vulnerable to perpetrators with superior knowledge, and the authority of age. Many children who are victims of sexual abuse feel great guilt that they were not able to protect themselves.

When working with a child in Child Protective Services (CPS) care that 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
- planning for treatment services and permanency

Dynamics – Working with a Child who has Experienced Sexual Abuse

Professional Considerations

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

Behavior 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 that indicate a child or youth has experienced other traumatic events.[1] Below are signs that have been identified as ways that children and youth *might* behave as a response to past or ongoing sexual abuse.

- Significant changes in behavior and reverting to behaviors they have outgrown including bedwetting and thumb-sucking
- Unexplained changes in emotional state, including anger or depression
- Sexual behavior inappropriate for their age
- Knowledge about sex inappropriate for their age
- Excessive talk about sex
- Fear of or refusing to be alone with a specific person
- Being secretive
- Pain, blood or redness in the genital or anal area, including pain during urination or bowel movements
- Sexual promiscuity[2]

Important Dynamics of Child Sexual Abuse to Remember[3]:

- It is common for children and youth to delay telling someone about the abuse.
- Most children and youth believe that 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.

[1] https://www.stopitnow.org
[2] NCTSN – Caring for Kids: What Parents need to know about Sexual Abuse

[3] NCTSN – Caring for Kids: What Parents need to know about Sexual Abuse

- When a child or youth has a close relationship with the abuser, they may feel guilty about how telling will affect the abuser or revealing the secret.
- 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 that 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.
- Children and youth respond to traumatic events, including sexual abuse, in different ways. It is important to understand that every child will have an individual response and unique needs for care and recovery.

Responding to a Disclosure of Child Sexual Abuse

As a DFPS employee, you are considered a mandatory reporter and must report any new reports of sexual abuse to Statewide Intake (SWI).

When a child or youth entrusts 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.

> *“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."
– NCTSN[4]

If a child or youth talks about or alludes to current or past sexual abuse it is important to remain calm and be non-judgmental.

Understand that there is a difference between how you 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 Child Advocacy Center, the attorney representing the Texas Department of Family and Protective Services (DFPS), law enforcement, placement, and therapeutic care providers may also be needed promptly. When a child is making a disclosure your body language, attitude, and words should be attuned to the child or youth.

When engaging with a child or youth who has experienced sexual abuse it is important to 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 that 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.

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 Child Advocacy Center or law enforcement agencies.**

[4] National Child Traumatic Stress Network

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

According to the American Academy of Child and Adolescent Psychiatrists[5], "Children who are listened to and understood do much better than those who are not. Responding to the disclosure of sexual abuse is very important to the child's healing from the trauma of sexual abuse."

> *About Recantation, from the National Child Traumatic Stress Network:*
>
> 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 about 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 are having a difficult time accepting the sexual abuse. In some families, the child is pressured to recant because the disclosure has disrupted family relationships. A delay in the prosecution of the perpetrator may also lead a child to recant in order 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 assure that children maintain connections to with family members and others who are important to them. It is best practice for all staff, regardless of stage of

[5] https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Responding_To-Child-Sexual-Abuse-028.aspx

service, to consider not only legal permanency, but also relational permanency in decision making at every step.

Intrafamilial Abuse

In cases involving abuse by a family member, caseworkers in every stage must consider if safe contact with the perpetrator of the abuse is, if in the best interest of the child, 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. Because 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. 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 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
- Support groups

Changes can be made to the physical home environment and supervision structure in the family so that 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.

If reunification or visitation is considered, address the following with the child's professional team and family:

- Has the victim expressed a desire for future contact with the perpetrator?
- Has the victim been provided with therapy and support from the family?
- Do the parents and caregivers have a clear understanding of the nature of the abuse?
- Which adults will be responsible for supervising the contact?
- What level of supervision is necessary?
- What does the family need to assist them in supervising?
    - Door monitors/alarms
    - Motion sensors
    - Assistance with supervision
    - Training on the components of supervision

Case Management Considerations

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

- Co-occurring criminal case: if the perpetrator is a family member and is also a defendant in an ongoing criminal matter, the defendant may interact with DFPS 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 to ensure that information is shared carefully, and best efforts are made to provide services to the family according to their individual needs.
- 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.

- Often, parents may struggle to understand or believe that sexual abuse has occurred. Parents and caregivers may need support from DFPS as well as service providers. Parents may be shocked and grieving or assume that 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 to resources to help them to cope and heal. In some areas, the Child Advocacy Center may provide parent training, case management, and family advocacy to help parents navigate the special issues involved when child sexual abuse has occurred.

Documenting Incidents of Sexual Abuse

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 as well as provided to the caregiver through the Placement Summary Form (2279), Child Sexual History Attachment A, and the Application for Placement.

A confirmed incident of sexual abuse or

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

- 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, per 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.
- Information from another state welfare system – confirmed allegation (equivalent of a RTB).
- Residential Child Care Licensing (RCCL) Standards Investigations in which victimization is substantiated.

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, per the Human Trafficking Page in IMPACT.
- Information from another state welfare system – unconfirmed (the allegation was neither ruled out nor substantiated).
- 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.
- Incidents (not under DFPS jurisdiction) that are not successfully prosecuted.

All known **confirmed** incidents of abuse must be documented on the person detail page, on the sexual victimization history tab by:

- Entering the incident date and indicating if the incident date is approximate
- Identifying who was responsible for the abuse, the age of the perpetrator, relationship to the victim, and IMPACT person ID number
- Describing the abuse and all pertinent information related to the abuse

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

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

Any sexual victimization history should also be addressed in the child's plan of service. Please see CPS HB policy 6241.11 for requirements related to

case planning and address child sexual victimization and child sexual aggression.

Placement Considerations

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. 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 that need is indicated by other assessments. 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. If symptoms of trauma begin to appear, it is important to engage in treatment as soon as possible. Enlist the assistance of case managers, 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, and ensure the form is provided in full to the next placement.

Treatment and Interventions for a Child who has Experienced Sexual Abuse

Treatment, Services, and Supports

After providing empathic reassurance, and ensuring the child is protected and safe, the caseworker and supervisor should determine whether the case meets criteria for a multidisciplinary team (MDT) response per their local protocols. If so, the caseworker should follow local protocols to initiate the MDT response and involvement with their local children's advocacy center (CAC). CACs help support and

coordinate the MDT's efforts and provide comprehensive support services to child victims and their non-offending family members.

Children's Advocacy Centers

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/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.

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 (CPI, CPS, RCCI, and Adult Protective Services (APS))
- Law Enforcement
- Prosecution (civil and criminal; juvenile and adult)
- Medical
- Mental Health
- Family Advocacy

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 CPI, 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/her protective family members.

Depending on local MDT protocols, most children and youth who disclose sexual abuse are referred for a Forensic Interview (FI) at the

CAC. The forensic interview is a non-leading, non-suggestive, fact-finding 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.

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 that specializes in child maltreatment (as part of a CAC evaluation, or at an academic center or community clinic), or by a certified forensic nurse in the form of a "SANE" (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 increasing 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.

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. 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 (parents, siblings, etc.) to treatment services can be an essential part of a child's path toward healing.

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 that come from a professional (e.g., teacher, medical professional, and therapist) directly to a Children's Advocacy Center for a facilitated joint investigation. Screening in the field should be limited; when cases are screened out in the field by CPI, 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 that opportunities for justice are not missed.

Evidenced-Based Trauma Informed Care (TIC) Modalities

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

Evidence-based: This means that there is evidence from research to support the use of the therapy model with the 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.

Trauma-Informed Care: In working with children who have experienced sexual abuse, it is important to remember that each child/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 when working with or using a variety of modalities and approaches. The important components of trauma informed care are outlined below.

Trauma-Informed Care is a strengths-based framework that:

- Is grounded in an understanding of and responsiveness to the impact of trauma.
- Emphasizes physical, psychological, and emotional safety for both providers and survivors.
- Creates opportunities for survivors to rebuild a sense of control and empowerment.

> *"It's likely that 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."*[6]

The type of therapy children need will depend on their ages, developmental stages, and capacity to understand what has happened. Typically for children 8 years old and younger, Play Therapy is the optimum modality and the most readily available in the Star Health system. For children over 8 years old, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a good choice and offered by a large majority of providers. For teenagers, there are other options that may be helpful; Eye Movement Desensitization and Reprocessing (EMDR) has shown a lot of promise. For adolescents who have suicidal thoughts and behaviors, Dialectical Behavioral Therapy (DBT), or Mentalization Based Therapy (MBT) are often appropriate. It is important to note that 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 that the therapist has experience with trauma informed therapies.

Child welfare professionals may benefit from basic knowledge of treatment modalities that are supported by research and may be used by therapists and mental health providers. The modalities below are some of the most commonly used, while some of the modalities have been validated for adults, they may be appropriate for adolescents who choose extended foster care services for ages 18-21, or for older teenagers. The treating provider can offer case by case guidance on this use. While many of the modalities are offered through Star Health

[6] Hopper, Bassuk, & Olivet, 2010

the availability of providers who are certified in these types of treatment is limited.

- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) – Validated for use with children and adolescents. This approach is a set outline of identifying a specific trauma and then walking through specific steps to retrain the thoughts and behaviors associated with the identified trauma and replace unhealthy responses with healthy responses. The standard approach is 8-12 sessions, but it can last longer.
- Parent Child Interaction Therapy (PCIT) – Validated for children age 2-7. This therapy is delivered with the caregiver and the child. The caregiver has an earbud in and the therapist "coaches" the caregiver on how to respond and interact with their child and manage behavior. This coaching occurs in an observation room as part of the therapy clinic with a one-way mirror or live video stream with the therapist observing and the caregiver in the room with the child.
- Eye Movement Desensitization and Reprocessing (EMDR) – Validated for adults. This approach uses physical cues such as lateral eye movement or hand tapping to access traumatic memories and then 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.
- Cognitive Processing Therapy (CPT) – Primarily focused on adults. This approach is also grounded in the cognitive therapy approach. It typically follows a 12-session timeline to focus on a specific traumatic event/memory. The focus is on changing the existing thought patterns around the traumatic event and replace them with a healthy thought pattern that allows the individual to move forward.

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 symptoms of Post-Traumatic Stress Disorder (PTSD) 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 from victim to survivor. It is important to keep in mind that, like with talk-therapy, it is important for the psychiatrist to have experience treating trauma/PTSD.

STAR Health benefits – Evidenced based trauma treatment therapies are a covered benefit of STAR Health. The STAR Health member connections team, Service Coordinators, and Service Managers can serve as a resource for caregivers and caseworkers to identify and locate trauma informed providers in the identified 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.