

Beyond the Trauma Basics: Comprehensive Sexual Abuse Therapy for Children & Youth

Course Outline

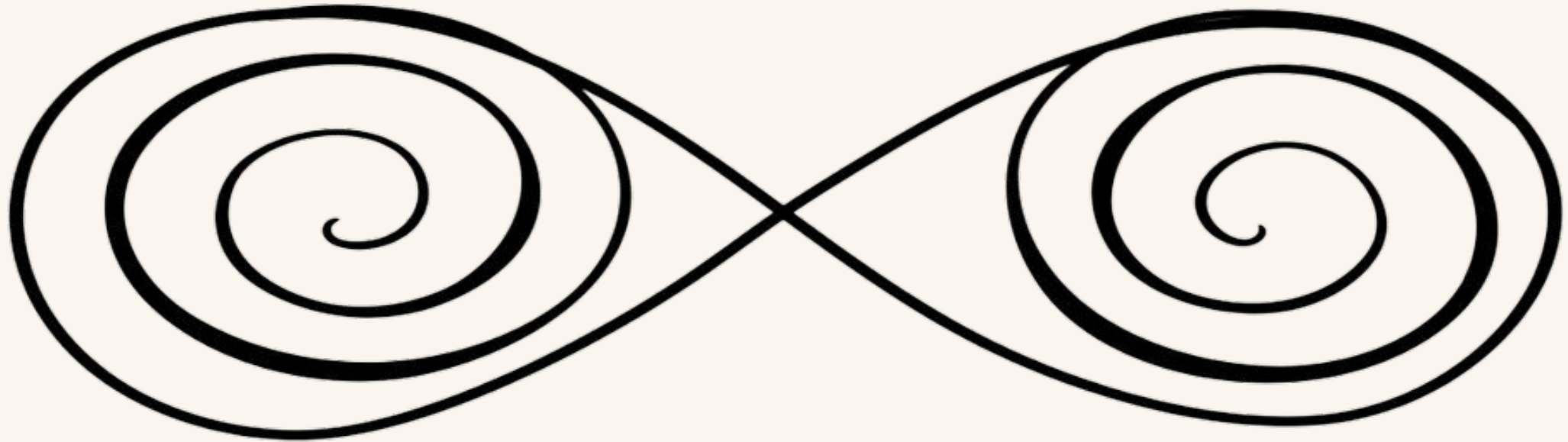
- Defining Our Context
- Defining child sexual abuse (CSA)?
- Understand sibling sexual abuse (SSA)
- Addressing sexual behavior problems (SBP)
- Assessing CSA disclosures
- Outlining play therapy themes
- Building safety with therapist
- Defining the impact of CSA on clients
- Restoring safety within body
- Restoring safety in external world
- Counsellors and the justice system

Defining Our Context



Pendulation

Trauma Vortex



Counter Vortex

Source : Somatic Experiencing 2017

Titration



Fear & Doubts

What are your fears and doubts about working with this population?

Impact On Clinicians

- Hero Archetype
- Disclosures on the plane
- Working with CSA clients as a parent/caregiver of young children

Impact On Clinicians

Vicarious Trauma

- Change of world view
- Destructive coping skills/addictive behaviors
- Avoiding interactions with colleagues
- Aversion to work related topics
- Isolation from friends or family
- Traumatic images
- Hopelessness
- Symptoms consistent with PTSD

Source: www.ovc.ojp.gov

Factors Influencing Vicarious Trauma

Systemic

Organizational

Individual

Source: Tabibi, J., Baker, L., & Lalonde, D. (2021).

Promoting Wellbeing of Anti-Violence Workers

- Advocate for changes at the structural level (i.e. ending the systemic oppressions that influence risk of vicarious trauma and opportunities to build vicarious resilience)
- Prevent vicarious trauma
- Foster vicarious resilience

Source: Tabibi, J., Baker, L., & Lalonde, D. (2021).

Impact On Clinicians

Vicarious Resilience

The positive impacts, empowerment, and personal growth that therapists experience as they observe and interact with the healing, recovery, and resilience of individuals who have experienced trauma.

Source: Hernandez, P., Gangsei, D., & Engstrom, D. (2007); Tabibi, J., Baker, L., & Lalonde, D. (2021).

Beyond Self-Care

- Self-care alone will not protect us from the repetitive exposure to traumatic material
- In session
- Between sessions
- After work
- On the weekend
- Healing across the lifespan

7 types of Rest

1. **Physical:** resting the body (passive & active)
2. **Mental:** giving your brain a break from focusing, thinking, problem-solving
3. **Sensory:** taking a break from overstimulation
4. **Creative:** accessing inspiration, reawakening awe, enjoying the arts
5. **Emotional:** accessing the courage to be authentic, freely expressing feelings, reducing people pleasing
6. **Social:** surrounding yourself with people who are supportive and increase your sense of vitality; having boundaries around those that emotionally drain you
7. **Spiritual:** having the ability to connect beyond the physical and mental; feeling a deep sense of belonging, love, acceptance and purpose

Source: Saundra Dalton-Smith MD



At a fundamental level, child sexual
abuse is an abuse of power.

*“When someone with more power exploits the vulnerability
of someone who is younger, under 18 years of age, and is in
a position of less power.”*

Source: generationFIVE

Why is trauma political?

“Experiences defined as trauma are often better understood as exploitation and oppression rooted in the **political inequities of our unjust societies.**”

Vikki Reynolds, 2020

Trauma, as conceptualised and defined by the mainstream field of psychology centres on descriptions of **individuals' brokenness** which hides the structural violence that promotes suffering.

(Reynolds, 2020, p. 4)

Forms of **structural violence** (i.e., legislative poverty, ableism, developer-created homelessness, ongoing colonial violence, racism, anti-black racism, white supremacy, the prison industrial complex, cis-normativity, heteronormativity, and rape culture) are **excluded** from and **concealed** by psychological conceptualisations of trauma.

(Reynolds, 2020, p. 4)

“The perfect storm of **victim-blaming**”

Vikki Reynolds, 2020

What is child sexual abuse (CSA)?



What is child sexual abuse (CSA)?

- Sexual Exposure/voyeurism
- Exhibitionism or exposing oneself to a child or youth
- Sexual exploitation
- Genital contact
- Penetration
- Fondling
- Sexual Jokes
- Violence that targets the child's genitals
- Invasive hygienic practices
- Sexual Interaction between youth that puts a child at risk for manipulation and abuse due to differences in age (-5 years), developmental stages, weight, and power
- Producing, owning, or sharing pornographic images of movies of children
- Sexual humiliation
- Selling or buying a child or youth for sex
- Sex trafficking
- Obscene phone calls, text messages, or virtual interaction
- Sexualized or invasive attention, sexual preoccupation with a child
- Overexposure of a child to adult sexuality or behavior
- Any other sexual conduct that is harmful to a child's mental, emotional physical, social, and spiritual welfare,

Source: generationFIVE

Canadian Statistics

Women were **3x** more likely than men to have been sexually abused by an adult during childhood.

83% of abuse is not reported to police.

Boys are less likely to disclose SA.

Fear of not being believed, shame, didn't know they could report, no family support were cited as reasons given.

LGBT children and youth are **2-3x** more likely to experience CSA.

The legacy of sexual abuse in residential schools in Canada has resulted in generations of Indigenous children and families living with the trauma associated with childhood sexual abuse. Estimates are **25% to 50%** of Indigenous Canadian children were sexually assaulted.

Children with disabilities are **3x** more likely to experience CSA.

Source: aasas.ca; justice.gc.ca

Children at Increased Risk

- ALL children are at risk
- Factors that increase risk:
 - Child who have not received sexual abuse prevention education
 - Children who are overly compliant
 - Children with lower self-esteem
 - Isolated children
 - Children lacking adequate adult supervision

Who Sexually Abuses Children?

1. Men (not exclusively, but predominantly)

- Biological fathers
- Mom's boyfriend/partner
- Family members

2. Other children/teens

→ 80%+ offenders are known to the child/youth

→ Older children/teens (12+) are more likely to be SA by a stranger

Offenders

- “Offenders” = adults
- **Persistent offenders:** sexually attracted to children (paedophilia), repeat offenders, less likely to have adult sexual relationships, high rate of grooming behaviors, least common type of offender
- **Opportunistic offenders:** involved in other criminal behavior, can also be sexually attracted to adults but use children for sexual gratification, don’t create opportunities to abuse (less likely to use grooming)
- **Situational offenders:** often no sexual preference for children, abuse in response to things happening in own lives (e.g., social isolation), ACES, situational triggers (e.g., substance use, mental health issues)

Source: Richards, K. (2011).

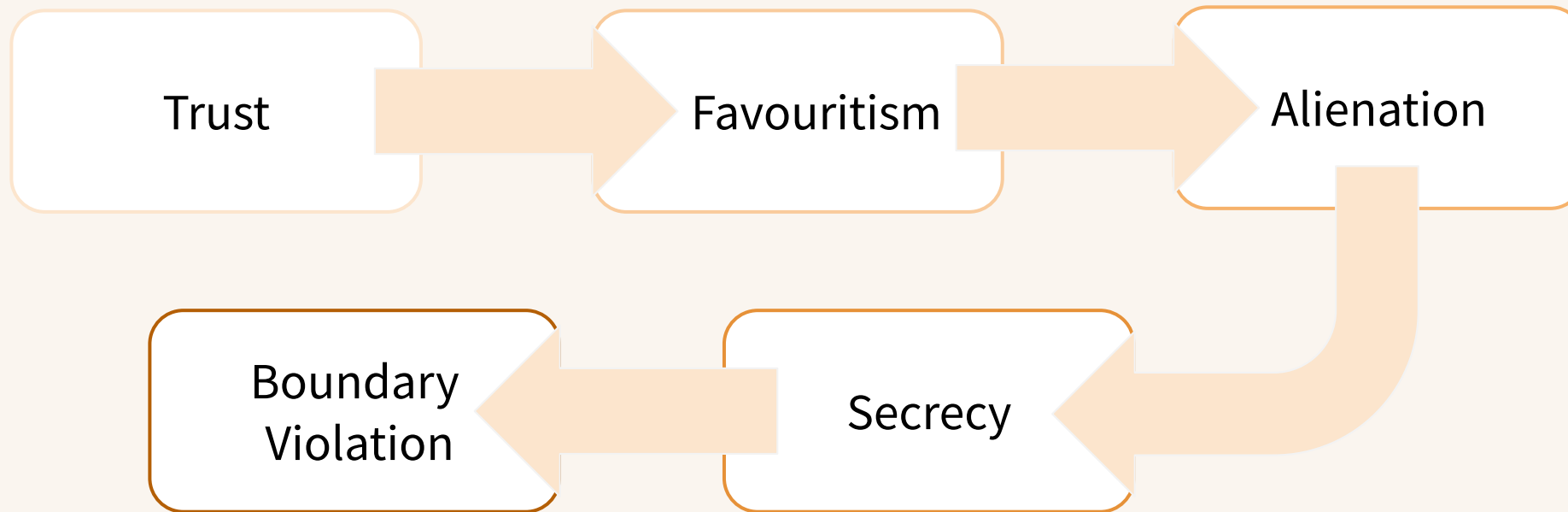
What is Grooming?

- Grooming is a process of building trust with children/youth in order to use the trust of the relationship in order to abuse the child
- Reduces likelihood of “telling”
- Caution around definitively using the term “grooming” in clinical settings and note taking
 - Debate around how to define grooming behaviors
 - Can be difficult to know if behaviors were grooming unless it is determined that the offender is a risk to children
 - However, it can be important to name suspected grooming to prevent harm

Source: Bennett & O'Donohue, 2014

Grooming Stages

Proposed stages of father-daughter grooming:



Source: Bennett & O'Donohue, 2014

Community Grooming

- Grooming of the caregivers, family members, other close adults, and community members to establish a sense of trust and safety in those adults, create opportunities to access the child, and decrease the chances of being caught.
 - E.g., offering financial help to struggling families, offering rides to work
- Many in community hold belief that offenders are going to be "creepy strangers" while many offenders can be very charming
- Includes attempts to groom the therapist

Grooming

- “When a threat or challenge is perceived, the mind and body quickly move into their protective responses to deal with the situation” (Dion, L., 2025).

What if a threat is not perceived due to grooming?

- In some cases, grooming prevents protective responses
- Child who have been groomed are often not aware that what happened was wrong and show distress only in relation to steps taken to protect child (e.g. removal of child from abusive caregiver)
- Value of SA prevention education that is developmentally appropriate and titrated

Grooming – Impact on Therapy

- Trauma re-enactment of grooming: coupling dynamic between relational closeness and SA
- Building safe relationships with adults can feel similar to grooming process

Questions to consider:

- What might “the set-up” be?
- Do children who have been groomed act differently towards therapist?
- How might grooming show up in a child’s play?

Talking About the Alleged Offender

- Balancing conflicting interests (i.e. counselling practices, ethics and the justice system)
 - Important to know what stage of the investigation the case is in.
 - Cases can be reopened if new information is disclosed therefore, we need to be mindful of the legal implications of our work
 - Always need to be careful not to lead the client
 - Our role as counsellors is not to investigate
- The relationship the client had to the AO will guide how we talk to our clients about them
- Grooming
 - Children will organize behavior around maintaining attachment bond

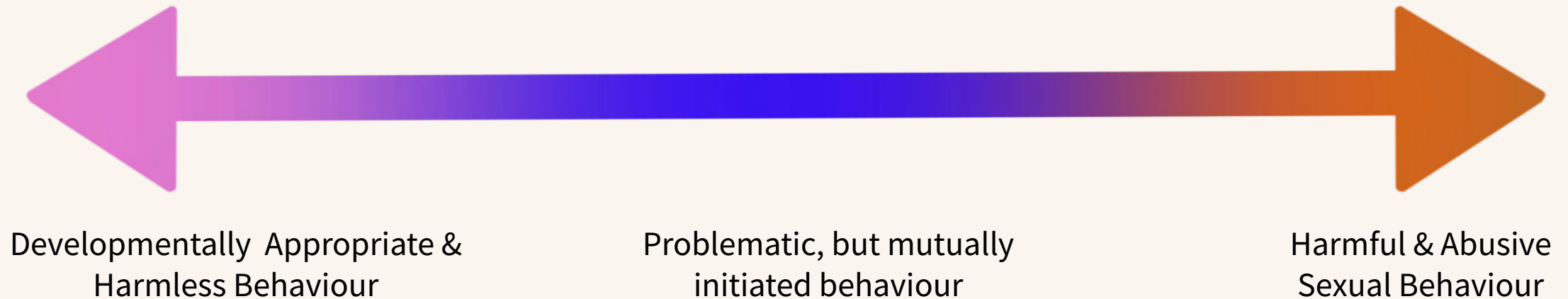
Talking About the Alleged Offender

- When the AO is a parent, clients often fear that they are “just like my dad” so statements you make about AO may be heard as if you are saying them about the client.
- Handout included for situations in which caregiver has been caught accessing child sexual abuse material (CSAM)
 - “Talking to children when a parent has been arrested or convicted with regard to child abuse material on the internet “

Sexual Behaviour Problems (SBP)



Sexual Behaviors Between Children



Sexual behaviours of children can be considered to be on a continuum, ranging from developmentally appropriate and harmless behaviour, to problematic but mutually initiated behaviour, to harmful & abusive sexual behaviour

Sexual Behaviors Between Children

Developmentally appropriate sexual play is typically:

- Non-Coercive
- Spontaneous/Unplanned
- Intermittent
- Does not involve aggression
- Non-threatening
- Does not cause emotional distress
- Does not interfere with other aspects of development

Problematic/Abusive:

- Use of force/aggression
- Age difference (less important than difference in power)
- Size difference
- Differences in ability
- One child has a history of SA
- Coercive
- Planned
- Interactions involve threats
- Emotionally distressing
- Developmental interference

When Sexual Behaviors Become a Problem

- Out of balance with other aspects of life → i.e. they are **preoccupied** with them
- The children engaged in the sexual behaviors do not have an ongoing mutual play relationship.
- Children appear to be **unable to stop themselves** from engaging in sexual behavior
- Is associated with emotional distress → to the child with the SBP, to others involved, and to witnesses
- **Do not respond to** typical parenting strategies (e.g. discipline)
- When the behaviors are associated with strong fear, anxiety, deep shame or intense guilt
- When children use distorted logic to justify their sexual actions (e.g. "she didn't say no")
- Behaviors are initiated with strong, upset feelings, such as anger or anxiety
- Behaviors progress in frequency, intensity, or intrusiveness over time

Source: www.ncsby.org; SAFERSOCIETYPRESS.ORG; Johnson, T. (1994)

Sibling Sexual Abuse (SSA)

- SSA remains under-studied
- Little research on prevalence rates (1-7%)
- Groups of siblings as well as dyads
- According to limited research, brother-sister abuse was most common (62.9%), then brother-brother (20.9%), then sister brother (13.9%) and lastly, sister-sister (2.3%).
- Children can be harmed and cause harm at any age (12+ can be criminally charged)
- Duration: SSA often occurs over long periods of time
- Frequency: over 50% experience 26+ incidences

Source: Yates et al., 2025

SSA – Unique Impact

- Child who have experienced SSA demonstrate parallel symptoms to other forms of CSA.
- SSA also has unique short & long-term impact on families/victims because:
 - SSA tends to be **minimized** (by caregivers, families and professionals)
 - Alternatively, responses that catastrophize and exaggerate are also damaging
 - Family stress existing before SSA worsens and can become a family crisis
 - Confusion among family members and others about where responsibility lies for the abuse (accused is child and their sibling)
 - Shame within both children
 - Caregivers are often torn between child who was harmed and child responsible

Source: Yates et al., 2025

SSA – Contributing Factors

- Parental physical and emotional absence
- Family stress: financial (bed sharing), domestic abuse, high parental conflict, parental affairs
- Sexual boundaries:
 - Too rigid boundaries (sex=taboo; asking questions about sex is discouraged)--> too loose boundaries (e.g., witnessing parents watching pornography, parental intercourse in shared spaces, fathers walking around naked)
- Gender dynamics in families: girls expected to be submissive
- Parents own history of SA
- History of trauma: emotional abuse, physical abuse, neglect, domestic violence
- Other behavioral concerns (e.g., conduct disorder)
- Learning disabilities
- Neurodivergence

Source: Yates et al., 2025

Key Factors to Recovery

- Experienced professionals across disciplines who understand SSA as a complex, multi-faceted phenomenon that requires a collaborative, multi-disciplinary, and whole-family response.
- Siblings are supported to come together to clarify what happened
- Locating Responsibility:
 - Children who were harmed are able to recognise what they experienced was abuse and locate responsibility with the sibling who harmed them
 - Caregivers also support this recognition of responsibility **without blaming** or **shaming** the child who caused harm
 - Child responsible takes accountability (e.g., letter writing)
- All children involved receive therapy (not punishment)
- Safety planning

Source: Yates et al., 2025

Language

- “Offender” vs. “Abuser” vs. “Child with Sexual Behavior Problems” (SBP)

Children with SBP are **qualitatively different** from adult sex offenders. This appears to be a different population, not simply a younger version of adult sex offenders.

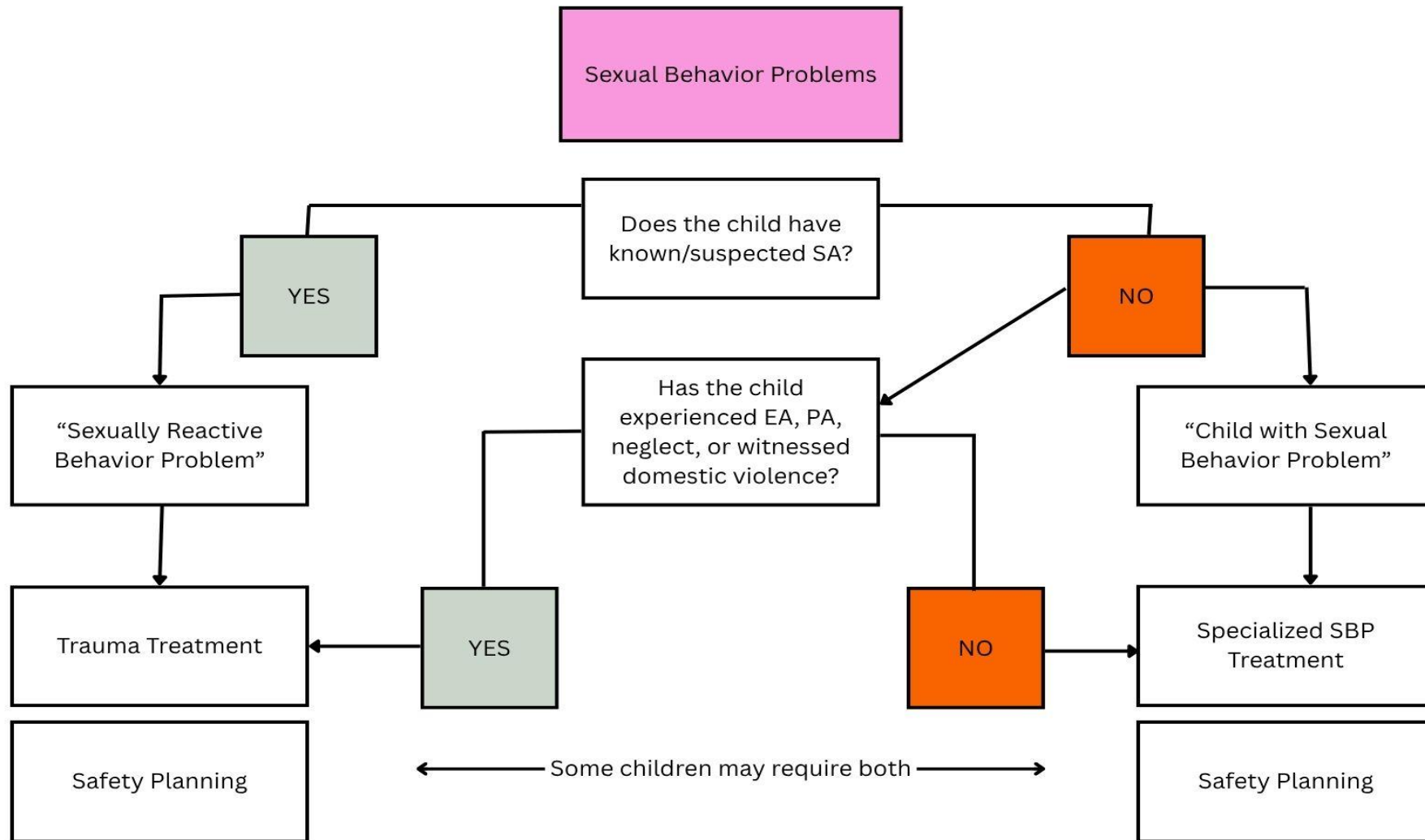
- The available evidence suggests that children with SBP are at very low risk to commit future sex offenses if provided with appropriate treatment.
- Treatment approaches developed for adult sex offenders (i.e. based on punishment) are inappropriate for these children.

Source: Chaffin et al., (2008). Report Of The Atsa Task Force On Children With Sexual Behaviour Problems

SA & SBP

- Not all SBP are caused by sexual abuse and therefore SBP alone can not determine if a child has been sexually abused.
- Children with SBP are more at risk of having been victims of SA than children not showing SBP
- Multiple factors will contribute to the development of a sexual behaviour problem and that MOST children who are sexually abused do **NOT** go on to engage in problematic sexual behaviours.

Source: Boisvert et. al., 2017



Safety Planning for SBP

Safety Planning is:

A contract based
on support and
care

Emphasizes
belonging and
inclusion

Lists
responsibilities for
everyone involved

Reviewed regularly
and revised as
needed

Designed to
empower
caregivers

Could be part of a
larger treatment
plan

Designed for
specific settings

Source: Rudko & Blahey, 2023.

Safety Planning for SBP

Safety Planning is **NOT**:

Punishment

A list of things the
child can't do

A document that is
given out without
collaboration

Without time
limits

Directly targeting
known behaviors
and not based on
speculation or fear

Unrelated to
treatment

A “one size fits all
activity”

Source: Rudko & Blahey, 2023.

Self- stimulation

- Child self-stimulation “aka masturbation” is often not sexual
- It is normal for children to explore, touch, and rub their genitals and to learn about the pleasurable feelings that come from them.
- Self stimulation is a part of healthy sexual development.
- It is not always a signal of an underlying emotional disturbance or a “sign” that something bad has happened to them.

Self-simulation

Reasons children may self- stimulate:

Pleasure

Boredom

Curiosity

Self-Soothing

Dissociation

Medical

Attention

Under-Stimulation

Re-Enactment

When Self Stimulation is a Problem

- They are preoccupied by it
- When it is frequent
- They don't have other things that bring them pleasure
- It causes physical pain or medical issues
- It is a regular departure from their routine
- The child withdraws from others to focus on self-pleasure
- They are using harmful objects
- It is intense
- It happens in public
- When they don't have other ways to regulate their emotions

Source: Sears, W., 2020

Responding to Self- Soothing Self-stimulation

Caregivers:

- Do not send them to their room to touch themselves in private! This teaches children that they need to cope with their feelings on their own using their genitals.

Instead:

- Connect with them
- Help them to soothe/calm
- Redirect them to a relational activity that you can do together
- Model ways to cope with big feelings
- Create space for them to talk about their feelings

Source: Siegel & Bryson, 2012

Responding to Self- Soothing Self-stimulation

In session:

- Acknowledge behavior
- Set limit without shaming
- Coregulation
- Redirect

Unaddressed self-stimulation that happens in session recreates a scenario where a child is stimulated alone behind closed doors with an adult.

Source: Landreth, G. (2012)

Sexual Abuse Disclosures

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Sexual Abuse Disclosures

- Sexual abuse disclosures are often not a one time event - they reveal bit by bit and watch for adult reactions
- Use the language of “telling someone” when talking to clients
- Verbal disclosures (direct/indirect)
 - Direct disclosures are a clear statement that they have been sexually abused
 - Often not clear and direct
 - May sound like, “I’m not comfortable with Uncle Bob”, “Uncle Bob is mean”, “Uncle Bob plays games with me I don’t like”

Source: Options Community Services, Parent Information and Support Handbook

Sexual Abuse Disclosures

Nonverbal disclosures

- Children are less likely to tell you what is distressing them and are more likely to show you through their behaviors therefore, it is important to be familiar with all of the behavioral warning signs a child has experienced SA
- Physical warning signs of sexual abuse also act as a non-verbal disclosure

Disclosures through play

- Trauma re-enactment
- Common Play Therapy themes of children who have been SA

Source: Options Community Services, Parent Information and Support Handbook

Behavioral Warning Signs of CSA

- Acting out in an sexual way with toys or objects
- Age inappropriate sexual play or sexual knowledge
- Disrupted sleep patterns (e.g., restless sleep) and nightmares
- Becoming unusually secretive (i.e. about new friends, phone calls, internet use)
- Regressing to younger behaviours, such as bedwetting
- Outbursts of anger and aggression
- New adult words for body parts and no obvious source
- Self-harm (i.e. cutting, burning, or other harmful activities)
- Refusing to sleep in bed preferring another place (e.g., floor)
- Running away
- Directs sexually intrusive behaviour to adults
- Unexplained developmental setbacks (i.e. not toilet trained)
- Flinches when touched
- Not wanting to be alone with a particular child, young adult, or adult
- Stealing, fire setting
- Becoming withdrawn or very clingy
- Inserts objects into vagina or rectum
- Acting excessive modest/immodest around changing/toileting
- Smearing feces
- Sudden unexplained personality changes, mood swings and seeming insecure
- Changes in school performance/attendance
- Fear of particular places or people
- Involved in sexually exploitive activities (i.e. performing sex acts for money)
- Changes in eating habits (weight loss/gain)
- Misuse of drugs or alcohol
- Talk of a new, older friend, and unexplained money or gifts
- Forces another child to participate in sexual play
- Feeling unsafe in bedroom/certain rooms
- Avoidance of washing or maintaining appropriate hygiene

Source: Options Community Services, Parent Information and Support Handbook

Physical Warning Signs of SA

Discolouration,
bleeding, or discharge
in genitals, anus or
mouth

Persistent or recurring
pain during urination
and bowel movements

Wetting and soiling
accidents
unrelated to toilet
training

Pregnancy

Sexually
transmitted
diseases

Source: Options Community Services, Parent Information and Support Handbook

Non-verbal Disclosures & Suspected Sexual Abuse

- Assessment needed to differentiate between developmentally appropriate psychosexual development & cause for concern
- Assessment factors:
 - Is there a change in the indicators over time (before/after)?
 - Was there the opportunity?

Note: if the answer to either of these is “no” and there is no noticeable change in symptoms over time and there was no clear opportunity, this does not mean that abuse didn’t happen.

When The Child's Disclosure Isn't Believed

- Believing a child's disclosure improves long term prognosis
- Just because a caregiver doesn't believe the disclosure doesn't mean they knew about the abuse.
 - Denial is a protective response to their world being shattered - particularly if the offender was their partner.
- Recanting is more likely:
 - When AO is parent
 - Younger children
 - **When child is not believed**

Ethical question: Is this a child protection issue?

Suspected Sexual Abuse

- Balancing conflicting interests - counselling role/ethics & legal system
- Even if MCFD and police/RCMP have closed their file therapists, in practice, need to believe the child in order to provide effective therapy
 - Without using language that is definitive in clinical notes
- Low rate of false allegations
 - Even if there is a false allegation made these children are still in distress and need support
 - False allegations are more likely to come from caregivers, relatives, etc.

Suspected Sexual Abuse

- When suspected SA arises in highly contentious divorces/custody battles proceed with caution and get supervision
- Counsellor is not an investigator – *so don't try to be one!*
- Important to remind caregivers that counselling is not to be used to try to elicit a disclosure/get more information

Therapy

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Sexual Abuse Themes in Play

- Sedation
- Hypnotizing
- **Disgust**
- Gross
- Textures
- **Slimy**
- Sick
- Germs
- Cleanliness
- Washing
- Covering body
- Exposing body
- Drowsy
- **Boundaries**
- Fairness
- Justice
- Fixing
- Containment
- Betrayal
- Body parts
- Rescue
- **Good/Evil**
- Aggression
- **Powering over**
- Victim/perpetrator
- Harm
- Bum focus
- Toilet talk
- **Constriction**
- Tension
- Constipation
- **Competence**
- **Control**
- Dominance
- Shame
- Belittling
- Touch
- Sexual Activities
- Rubbing
- **Security**
- **Messiness**
- Overwhelm
- Anger
- Embarrassment
- Trust
- **Helplessness**
- Safety
- Death
- **Shaming therapist**
- Burying hiding
- **Protection**
- Sleepy
- Neglect
- Family
- Transformation
- Confusion
- Manipulation
- Game playing
- **Tricking**
- Secrets
- Surprising
- **Police**
- Gagging
- **Mouth/throat related**
- **Parents not paying attention**
- Belonging

Sexual Abuse Themes in Play

Client advocacy statement example:

“Client demonstrates play therapy themes and associated patterns of distress consistent with children who have experienced SA.”

Toys

- Children project their inner worlds onto the toys
- How they play with the toys is the most important aspect (Dion, 2025)
- Toy selection can support “bringing trauma into the room” (Pare, 2017)

Treatment Phases

Safety & Stabilization

- Safety with therapist

Trauma Processing *“Remembrance and Mourning”*

- Safety in body

Reconnection & Integration

- Restoring safety with external world

Source: Herman, J. (2015)

Treatment

Building safety with therapist

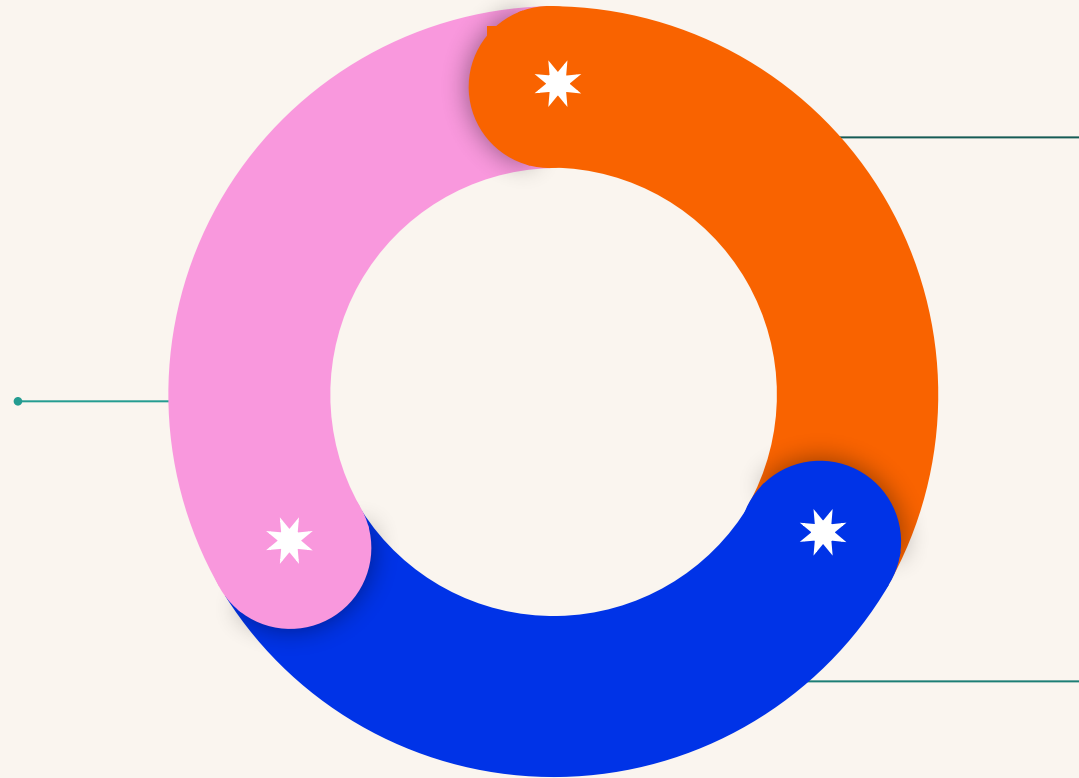
Attachment
Consent
Confidentiality
Containment
Boundaries

Building/restoring safety within body

Understanding the nervous system
Working with dissociation

Building/restoring safety with others & external world

Working with family
Sexual abuse prevention
Online safety



Treatment Summary

Effective treatment includes:

- Addressing trauma symptoms
- Engaging caregivers and families in process
- Helping children and youth become more resilient

Source: Lucio, R., & Nelson, T. L. (2016).

Building Safety with Therapist



Hello, My Name is...

Introducing yourself to a client who has been referred for SA:

- Do you name why the child has been referred to you?
- Do you tell them you are a SA therapist?
- Does the type of disclosure change how you would introduce yourself?
- Does the stage of the investigation change how you introduce yourself?
- Are there benefits of sharing referral reason?
- Are there risks of sharing referral reason?

It is important to be very clear about why you will be an adult alone in a room with a child.

Make the unknowns known.

Involve caregivers in clarifying your role.

Attachment Trauma

CSA= Attachment Trauma

- Children and youth who have experienced CSA often challenge/test the attachment relationship, engaging in behaviors designed to "test" if the therapist/caregiver is going to abandon, betray or harm them.
- Use attachment principles to build a safe attachment relationship through predictability, consistency, boundaries, communication of unknowns, speaking honestly and openly in developmentally appropriate way
- Attachment approaches:
 - E.g., PACE by Daniel Hughes - Playfulness, Acceptance, Curiosity, Empathy
- Important for therapist having tolerance for the client's fluctuating need for closeness and distance and to respect client's attempts to re-establish autonomy and self-control (Herman, 2015)

Consent

CSA = my “no” means nothing, saying “no” is dangerous, my voice can’t keep me safe

- Trauma/survival responses will emerge when client is asked to give consent
 - Hypervigilance- everything is a threat say “no” to everything/everyone
 - Dissociation - not knowing what situation calls for “no”
 - Fawn response - “no” is unsafe, say “yes” to everything

Consent

- Need to have some connection to self and connection to body to know what is “yes” and “no”
- Therapists can help them understand HOW they know something is a “yes” or a “no” through checking in and making reflections
- Therapist can model listening to body to give consent
- Always give them time to listen to their body
- Develop somatic consent through non-sexual exploration of preferences and pleasure

“What does your body do when it’s a ‘no’ or ‘yes’?”

“Hmm the way my body went really tense is telling me I don’t want to wear the handcuffs behind my back today”

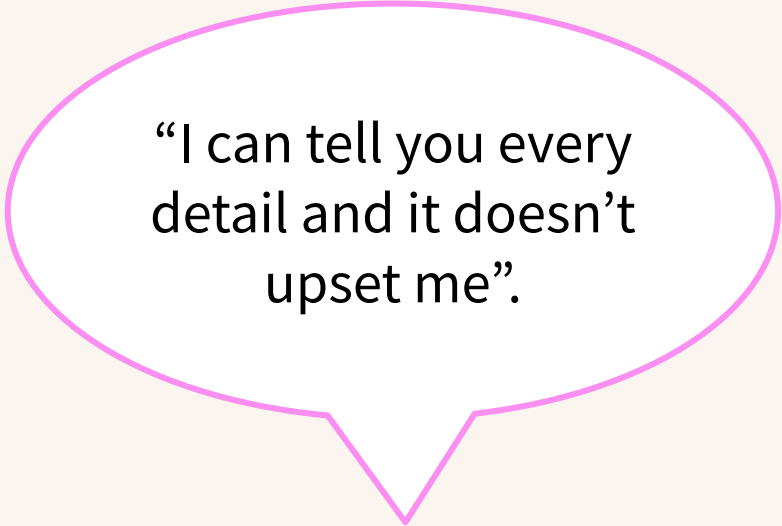
“When you wash your hands do you like warm water or cold water? How do you know?”

Consent

Integrating body/touch consent into therapeutic process:

- Asking to touch a client's wheelchair
- Vocalizing any contact that happens between your bodies using TAPS language
- Letting them know and getting their consent if your going to touch them
- Being thoughtful around directive activities that will bring them into their body (e.g., body mapping)
- Some approaches to Play Therapy also would apply this to not touching the sandtray

Talking About SA



“I can tell you every detail and it doesn’t upset me”.

Client wants to give full trauma narrative early on in therapeutic process



Client does not want to talk about it

Full avoidance of all SA topics

Talking About SA

- Some clients have not shared their story in detail within anyone and want to
- Trauma is in here and now – so it will show up even without “talking about it”
 - Through play
 - Through talking about other life events

Confidentiality

- Important to ensure the child understands the difference between confidentiality/privacy and secrets
- Important to remind children that a **grown up should never ask them to keep a secret** and that you will never ask them to keep a secret
- What they do and say in session is private, not a secret
- “Do you know what the word private means?”

Secrets

- Distinguish between good/bad secrets and surprises
 - Bad secrets: if someone has been hurt or could be hurt, makes you feel uncomfortable, involves someone telling you not to talk to a safe adult, are never told
 - Bad secrets make problems grow
 - Good secrets & surprises
- Teach caregivers the importance of not using the language of “secrets” between children and adults
- Breaking family patterns of secret keeping

Containment

CSA → body overwhelm, intimate details shared and questioned, fragmentation of memory, fragmentation of self

- Therapist can support containment through:
 - Increased intentionality around sharing information
 - Obtaining consent to enter their internal world and guiding caregivers to do the same
 - Keeping lists of topics that emerge through process that client want to return to
 - Articulating through lines
 - Ensuring client has access to containment based toys
 - Not going over session time
- Containment exercises
 - Psychological/memory based fragmentation
 - Supporting containment within body

Boundaries

CSA = life threatening boundary violation

- Being without boundaries makes neuroception of danger grow
- Setting boundaries with clients will become more authentic, flexible and tailored to the client's needs as time goes on
 - Best to begin relationship with firm clearly stated boundaries
- Articulate boundaries that exist - E.g., role/rule boundaries
- Teach clients how to set boundaries
 - Model setting boundaries

Power Dynamics

CSA = Power-over dynamic

- Important to explore personal aspects of power, privilege and oppression to reduce implicit biases and microaggressions.
- Therapists hold power as helper
- Talk about differences in power related to race, sex/gender, age, ableism
 - The complexity of racial trauma intensifies if the trauma is not acknowledged or validated
 - Especially important for white therapists
 - Especially important for cis-gendered men, male identifying, and masc of center therapists

Abandonment

CSA = I am alone in my distress

- Children will project inner world onto therapist- including distress and dissociative states (Dion, 2025)
- Mindful Attunement + Titration + Coregulation
 - Trauma reenactments with no intervention can rupture trust in therapist
 - “Let’s experience the event together”
- Relationships reduce alienation

Impact

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Sexual Abuse Trauma

- “Victim” language vs. “survivor” language
- CSA can be understood through lens of developmental trauma, complex trauma, attachment trauma, PTSD
- CSA can uniquely shape trauma responses
- Trauma as a form of acquired neurodivergence

The Impact of Developmental Trauma: The 7 Domains of Impact

Attachment

Insecurity & Distrust
uncertainty about reliability
Problems with boundaries

Behavioural Control

Impulse control
Traumatic reenactments

Emotional Regulation

Difficulty describing internal
experience
Difficulty communicating
wants/needs

Self-Concept

Lack of continuous,
predictable self
Identity formation
compromised
Guilt and Shame

Brain & Biology

Sensorimotor developmental problems
Somatization
Increased medical problems
(ACES study)

Dissociation

Alterations in states of consciousness
Amnesia
Depersonalization/Derealization
Spacing out

Cognition

Learning & language difficulties
Difficulties with executive functioning
Attention, regulation, concentration
Difficulty processing new information

Source: Shaw, J. (2015) Lecture.

Sexual Abuse Trauma Symptoms

- Children with multiple marginalized identities (e.g., race, ethnicity, gender, socioeconomic status, and spiritual) may have increased exposure to trauma with magnified effects due to limited access to resources.
- When assessing symptoms and exploring trauma responses important to keep race/culture and intergenerational trauma in mind to best support client needs
 - E.g., negative experiences of accessing health care, collective cultures experiencing shame for seeking support outside of family, immigration history, etc.

Source: Taylor & Turner, 2025

Sexual Abuse Trauma Symptoms

“My child is transgender because of the abuse”

- Some children and youth will come out as transgender during the course of SA therapy
- This does not mean that the abuse caused them to be trans
- They are trans **in spite of** the abuse
- As SA therapists we can explore gendered experiences of safety without pathologizing being trans

GUILT

Focus on negative aspects of one's own behavior

Self blame

"I did something bad"

SHAME

Focus on negative aspects of self

Self-concept merged with abuse symptoms and experience

"I am bad"

BOTH create dysregulation that leads to further disconnection from self

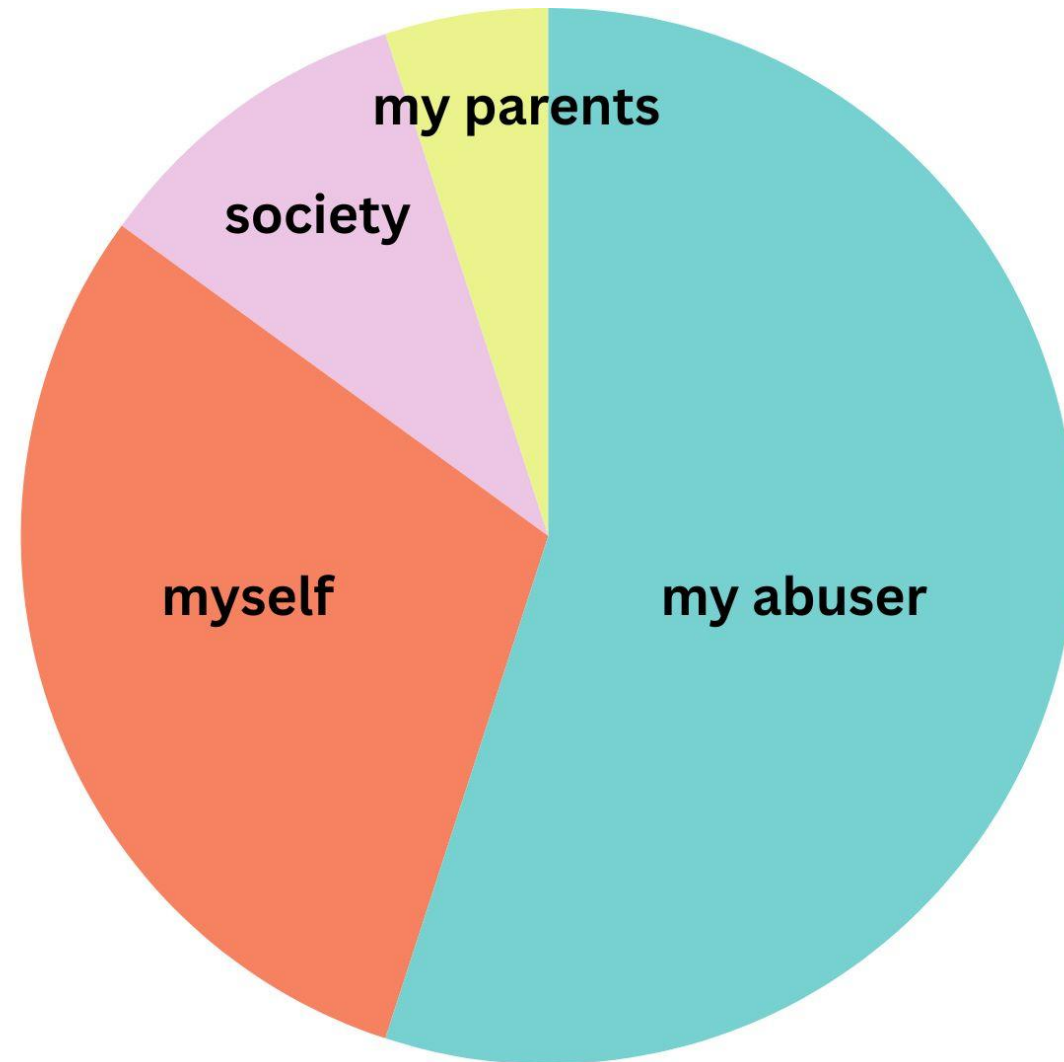
Self-Concept

- Sense of self overcoupled with guilt & shame
- Overidentification with abuse experience:
 - “I am what happened to me” → “I am dirty”, “I am bad”
- Resources **devoted to survival** instead of towards developmental task of self-identity formation
 - “I don’t know who I am”, “I don’t know what I like”
- Impact on self-identity is factor that makes children and youth more vulnerable to trauma (Pare, 2017)
- Internalizations of societal messages around worth

Blame

- Children and youth will blame themselves for the abuse
- Approaching “it’s not your fault” from various angles
- Associated with incomplete protection responses
 - “I should have fought back”
- Some children and youth have been blamed and abandoned for “ruining the family”
- Creating opportunities for clients to express how they feel their parents failed to protect them

Blame Chart



Shame

- Child and youth take responsibility for the abuse and links this with perceived negative feature of self
- Reinforced by explicit and implicit messaging from abusive caregivers
- Important part of treatment is linking children's emotional and behavioral symptoms to the SA by the adults involved (foster parents, schools, caregivers, etc.)
- CSA can be associated with feelings of pleasure→shame

Fostering a sense of **belonging** can be a powerful **antidote** to shame.

Source: Baita & Moreno, 2025

Restoring Safety within Body



Restoring Safety within Body

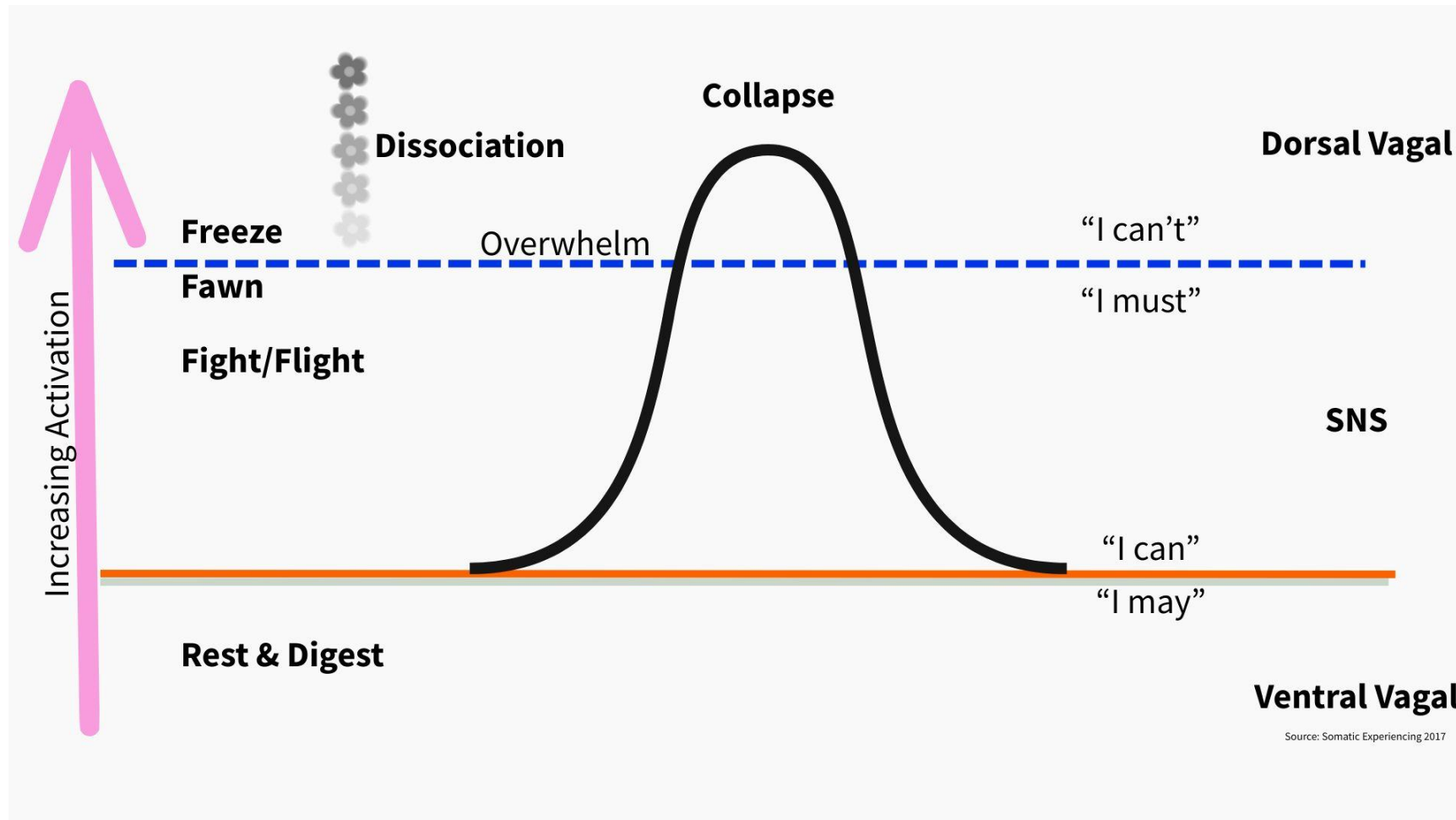
CSA = Erosion of trust in internal signals of danger

- Importance of somatic therapies/approaches informed by the nervous system
- Need to restore/build interoception and neuroception of safety

Triggers

- Identifying triggers helps client feel more in control of their body and their surroundings
- Sensory based triggers are common
- Posture based triggers
- Intimacy triggers for teens
- Location based triggers
- Interplay between racial trauma triggers and CSA trauma triggers
 - E.g., microaggressions/witnessing microaggressions towards caregivers during police investigation

Autonomic Nervous System Process



Orienting Response

- **Orienting**: response to novelty in environment
- **Defensive orienting** occurs in response to a threat (e.g., orienting to find an exit during emergency)
- For a traumatized person the novel stimulus will activate trauma responses (fight, flight, freeze, collapse) **without discernment** (overcontrol of reptilian brain)
 - Defensive orienting is stuck “on” → **hypervigilance**: excessive arousal/alertness
 - Defensive orienting is “extinguished” → **hypo-vigilance**: not noticing/ under responding to stimuli

Source: Somatic Experiencing Manual (2007)

Hypervigilance

In Clients

- Everything is unsafe
- “All men are bad and dangerous”
- “All intimate touch is dangerous”
- “All sounds are dangerous”
- “School is unsafe”



In Both

Impact of microaggressions



In Parents

- As a result of their own SA history and/or SA of their child
- Distress of the child is perceived to be related to the SA – therapy is never done
- Suspected abuse cases

Hypovigilance

In clients:

- Higher risk of revictimization
- Not registering signals of danger
- Engaging in high risk behaviors in an attempt to regulate state

Survival Response – Fight

- Fight reflects a belief that they can do something about the threat
- Often fight energy exists as an incomplete self protection response for CSA victims
 - Movements connected to fight such as pushing away become very charged and overwhelming
- Working with client with feelings about their offender
 - Violent fantasies
 - Pressure to forgive
- In therapy
 - Paying attention to moments when the victim fights back/resists/pushes away or when they can't fight back (e.g., when they are restrained, tied down)
- Resistance is culturally shaped as fighting back or speaking up (Reynolds, 2020)
 - important to witness and amplify even the nuanced expressions of resistance against all abuses of power and oppression

Survival Response – Flight

- Flight reflects a belief that they can get away from the threat
- Flight energy also often exists as an incomplete self protection response for CSA victims
 - Flight response was not available and therefore this energy is stored in the body
- Constant state of urgency
- Flight energy shows up most frequently as **avoidance**
- Flight in the playroom
 - Paying attention to moments when the victim runs away or alternatively is trapped and can't escape
 - What isn't showing up in the play/sandtray?

Survival Response – Freeze

- Fear and immobility
- Full activation of SNS (“stuck on”) and PNS (“stuck off”)
 - “If your body could move just a bit, where might it want to move?”
- Highly activated on the inside, frozen on the outside
- Often feels good until client thaws
- Frequently observed to be coupled with sexual arousal
 - Clients who then use pornography and self-stimulation to regulate

Survival Response – Fawn

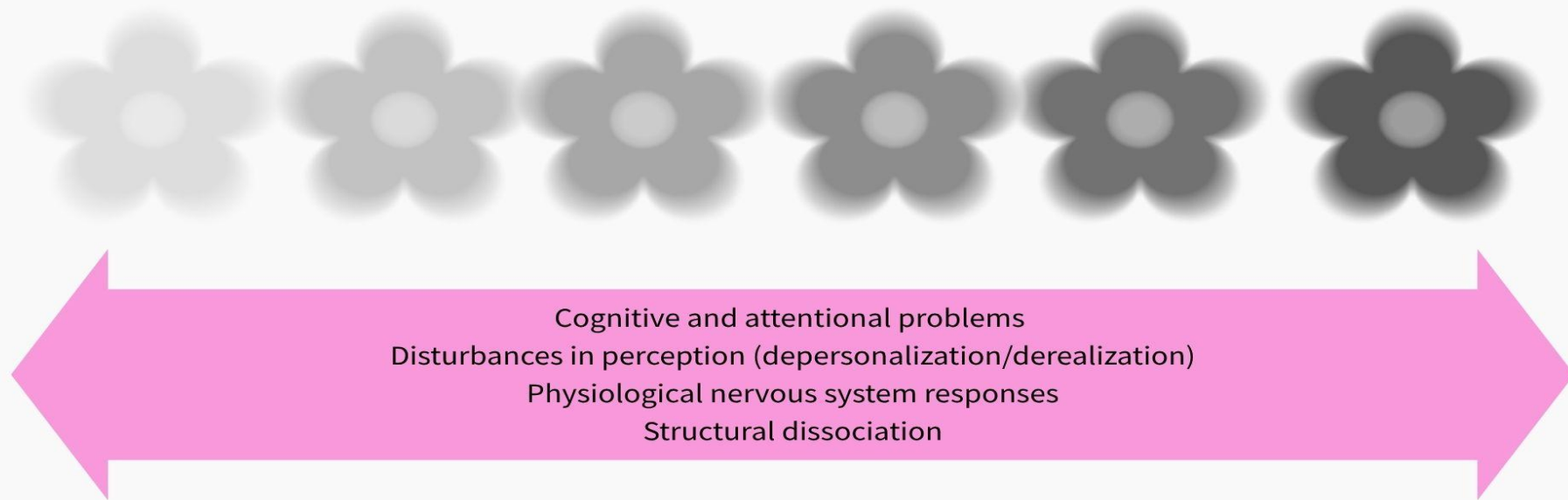
- Connected to CPTSD; prolonged abuse (more than one incident)
- Fawn is a form of people pleasing and active appeasement to avoid danger
 - Excessive kindness, apologizing, agreeable, appearing loyal
 - Feeling responsible for other's feelings
 - Lack of awareness of boundaries and no ability to set them
- Seems to present with high SNS and dissociation
 - Fear based survival response
 - Dissociated from self and therefore unable to access ones one needs/wants
 - Fully orient to needs of abuser as a way to stay safe
- Fawn response towards the therapist
- People pleasing as response to racialized trauma

Survival Response – Collapse

- Demonstrates belief that death is inevitable
 - Suicidal ideation tends to live here
- Conservation of energy
- When coming out of collapse/dissociation: highly activated fight/flight energy shows up

Dissociation

- Adaptive strategy for self-preservation and protection (Dion, 2025)
- Dissociation allows the individual to feel separate from their thoughts, feelings, and sensations, thus creating a **psychological escape** when a physical escape is not possible (Dion, 2025)



Source: Dion, L. (2025); Steele, K. (2025), Taylor & Turner (2025)

Working with Dissociation

Explore therapists beliefs about dissociation:

- It can be uncomfortable to attune to a client who is dissociating
- Belief that if client dissociates in session therapist has caused them harm
- Fear of getting lost in dissociative state
- Viewing dissociation as dysregulation that client needs to be pulled out of

Treatment for Dissociation

Mindfulness

Mentalizing

Emotional
Regulation
(teens)

Attunement &
Co-Regulation

Activation of the
Ventral Vagus
System

Source: Dion, L. (2025) MacIntosh, H. (2019)

Strategies for Working with Dissociation

When child is not dissociating:

- Mapping Nervous system
 - E.g., Deb Dana ladder mapping
- Create list of dissociation triggers
- Create cue words/hand gestures/items that support ventral vagal activation in dissociate state
- Symbol of safety

Strategies for Working with Dissociation

During dissociation:

- Stay in it without trying to change it (unless session is ending and you need to bring them back into the room)
- Support ability to talk about being in the state through metaphor and imagery
- Bring in the ventral vagal system through connection
 - E.g., "I'm here with you"
- Use of touch in therapy
- Use soft and gentle tone of voice- like you are gently waking someone up
- Connect with symbol of safety, use cue words, or hand gestures
- Orienting to surroundings

Source: www.isst-d.org

Strategies for Working with Dissociation

After dissociation:

- Support them to become aware of when they are dissociating
- If possible, tell them what led to the dissociation
- If unclear, become detectives to determine what happened just before dissociation
- Support caregivers to understand and effectively respond to dissociation

Source: www.isst-d.org

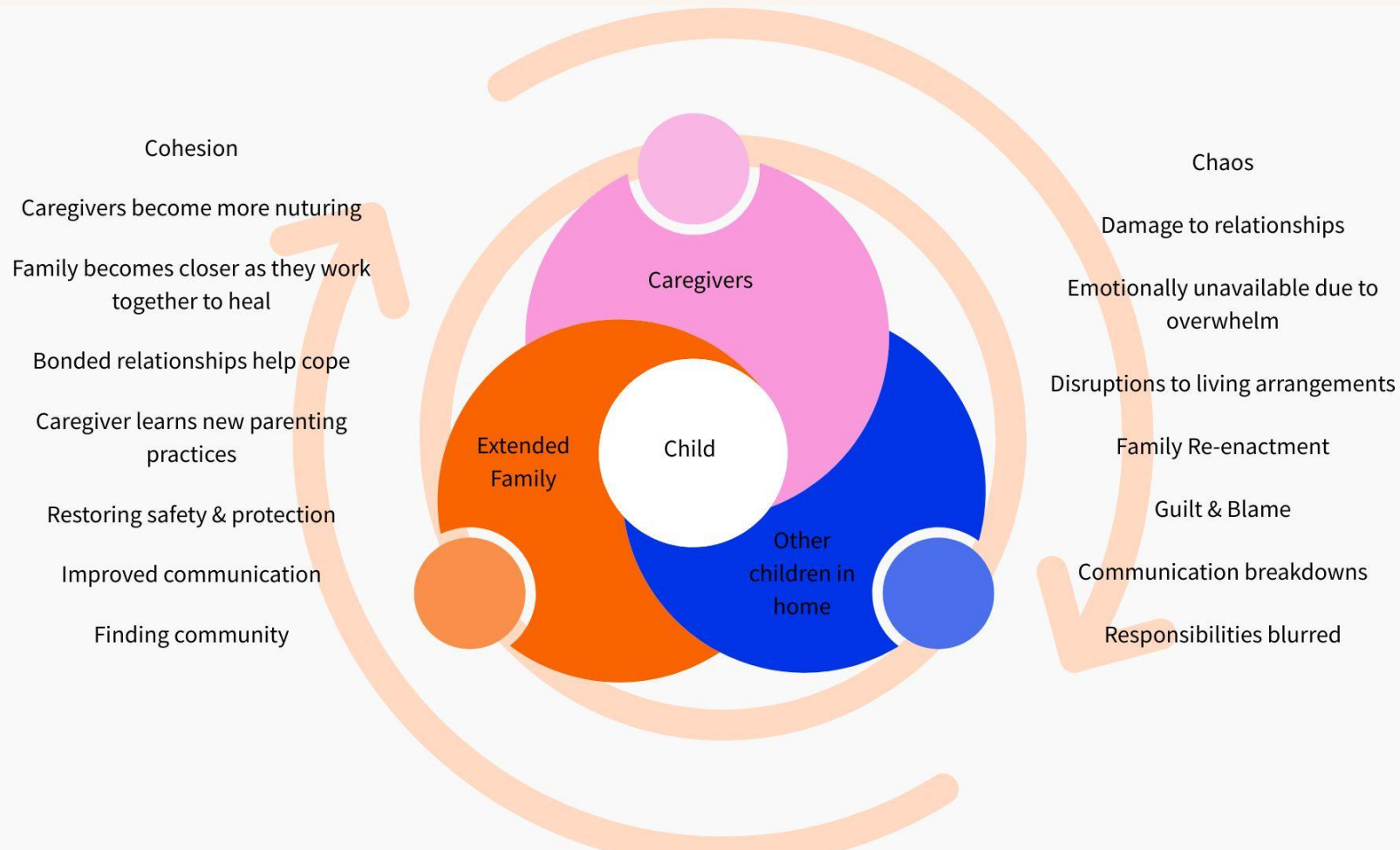
Restoring Safety in External World

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Restoring Safety in External World

- Protection
 - Reassurance
 - Reminders of safe people
- Building healthy relationships/support network/community
- Supporting caregivers to get therapy to support their hypervigilance
- Race-based trauma can cause feelings of hopelessness and powerlessness—threatening their view of a just and safe world (Taylor & Turner, 2025)
- Reconnection to culture

Supporting the Family System



Caregiver Support

- Instillation of HOPE
 - Amplify impact of believing their child and responding in a protective manner
 - Amplify protective factors and efforts to build them
- Reinforce caregivers **trust in themselves and their ability** to protect and know what is right for their children
- Provide space for caregiver to express the emotional impact the SA has had on themselves and their family
 - Address and support self blame, shame and guilt
- Validate anger & rage in response to the justice system & MCFD
- Support them/remove barriers to accessing their own therapy
- Advocate for the caregiver in ICM meetings and with social workers

Psychoeducation with Caregiver

- Prevent reinforcement of shame through trauma informed parenting
 - Psychoeducation re: trauma & SBP
- How to respond to disclosures/report
- Attachment
 - How to understand what their child needs from them
 - How to re-establish relational safety with each other
- Discipline and limit setting
- Sexual abuse prevention education
 - Support them to be comfortable/capable of continuing sexual abuse prevention work at home
- Navigating and understanding the legal/justice system

Source: Baita & Moreno, 2025

Sexual Abuse Prevention



Sexual Abuse Prevention Questions

- What makes CSA victims more likely to be re-victimized?
- Is assuming we can provide sexual abuse prevention education victim blaming?

Systemic Sexual Abuse Prevention

- Social justice
- Systemic transformation can support healing

“Social change requires masses of people building together toward collective safety, belonging, and dignity, and systems that support this” – Haines, 2019

“If we do not understand and integrate the shaping power of institutions, social norms, economic systems, oppression, and privilege alongside the profound influences of family and community, we will not understand trauma or how to heal from it. We will not understand how to prevent it” – Haines, 2019, p.11

Sexual Abuse Prevention for Children

- Sex Education is sexual abuse prevention
 - Children who have been sexualized need to have sexual education that matches their level of exposure
 - Confronting beliefs that teaching children will “sexualize them”, “take away innocence”
- TAPS Program - moving beyond “good touch/bad touch”
- [Amaze - video resources for children, youth, and parents](#)
- Telling safe adults
- Consent
- Secrets
- Assertiveness skills
- Creating opportunities for disclosure
 - Do non-verbal children have avenue to disclose if needed?

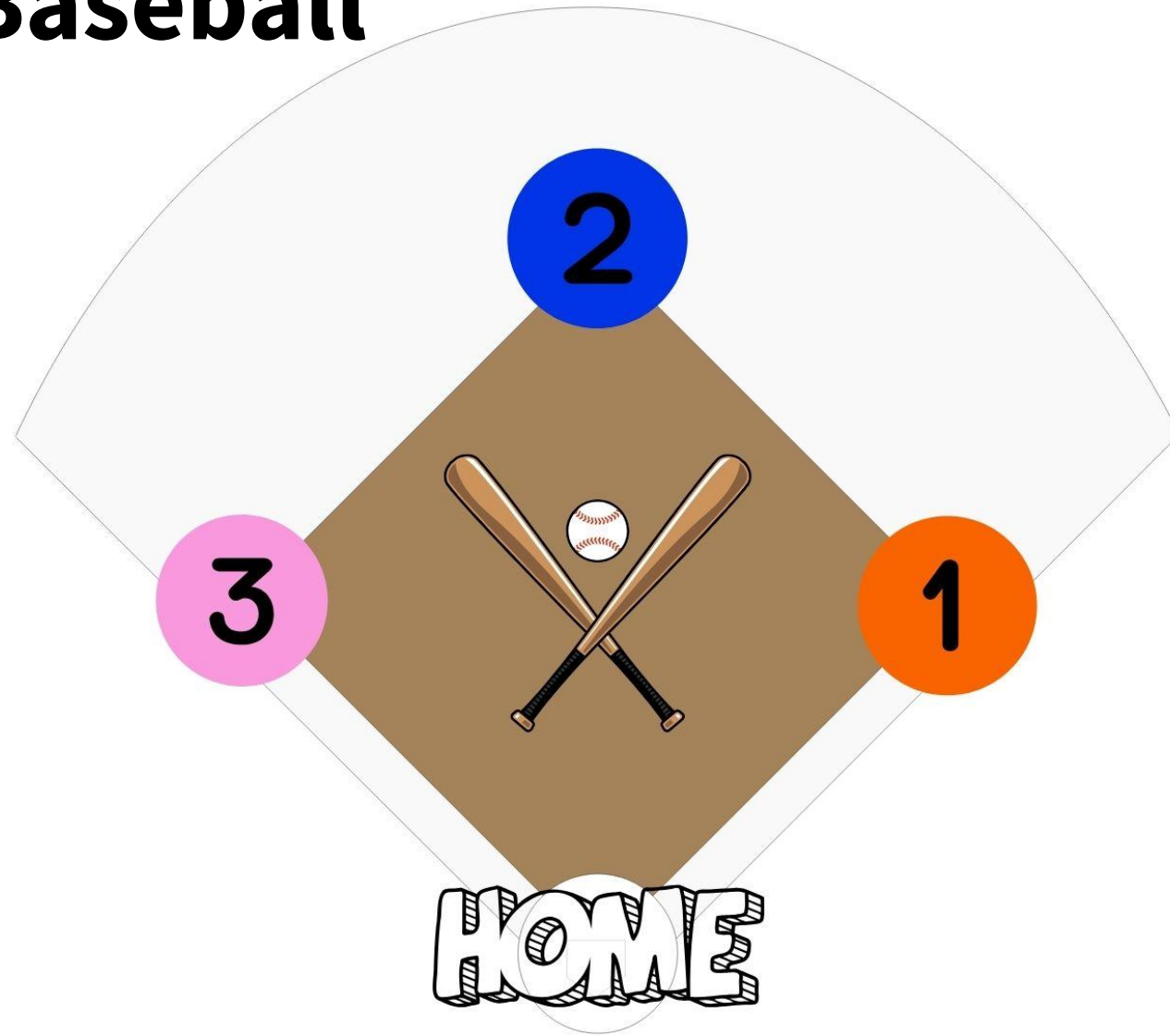
Talking About Personal Space (TAPS)



Sexual Abuse Prevention Education for Teens

- Support them to understand how survival/trauma responses may impact their ability to protect themselves
- [CONSENT Tool](#) (VCH Boundaries Program)
- Consenting to sexual activity and the close in age exception
- Healthy relationships/intimacy
- Assertiveness skills
- Sexual Health/ Safe sex practices
- Internet safety
- Pornography education

Consent Baseball



Internet Safety & Pornography



Internet Safety

- Critical thinking is the MOST important skill for online safety - children under 10 years old do not have the critical thinking skills to be online alone
- Support conversations on application of sexual abuse prevention skills to online context (consent, healthy relationships, etc.)
- Empower parents to learn internet safety skills
- Racial trauma through media
- Inform clients about risks of using AI for mental health support and companionship

Children & Pornography

Average age of first exposure to pornography is 12 years old

1/3 exposed are age 10 or younger

- Exposure to pornography can be both traumatizing and increase risk for SBP
 - Compelled to share
 - Compelled to re-enact
- Support parents to avoid punishing children who are exposed or access pornography
- Therapists and caregivers need to talk to them and to support them to understand what they saw

Teens & Pornography

98% of youth have seen pornography

- Use in teens ranges from normal to problematic
- Talk to your clients about pornography
- Support pornography literacy
- Accessing pornography as trauma reenactment
- Using pornography to regulate emotions/soothe
- Support parents to talk to their children about pornography (begin talking about pornography when you begin talking about sex)

Sexual Exploitation and Sextortion

Sexual exploitation: is any type of sexual activity with children and youth in exchange for money, drugs, food, shelter or any other considerations (includes sextortion)

Sextortion: coercion to share sexual images/videos followed by blackmail

- Teach children common strategies used by adult online offenders
- Discuss “**exit strategies**” for getting out of uncomfortable situations
- Support parents to identify indicators that their child/youth is being targeted by an online offender

Counsellors and the Justice System



Impact on Clinicians – Confronting the Realities of the Justice System

- There is often a large disparity between what we believe should be the consequences for CSA and the reality of our justice system.
- The disproportionate lack of justice for survivors of sexual violence **erodes our sense of hope and justice.**
- Although we can not bring justice for our clients our belief in them, our standing with them as they experience systems of injustice, supporting them to access resources (e.g., protection orders) is powerful and important.

Source: EndingViolence.org

Clinical Notes

Do not document details of the SA disclosure in your clinical records

1. Create a informal note (temporary working document) where you write down details of the abuse, and any exact quotations.
2. Use this informal note to make Child Protection report
3. Document only that the child made a SA disclosure and that all details have been reported to MCFD (date and time of report)
4. Once you have made the report to MCFD shred your informal note

Source: McEvoy, 2013

Clinical Notes

- Be careful not to demonstrate bias
 - Use acronyms like “AO”= ALLEGED offender vs. “abuser” or “offender”
 - If investigation was closed with no charges: “**alleged** abuse” “**reported** abuse” vs. “abuse”
- Ensure that you demonstrate an awareness that what someone tells you is not ‘objective fact’
 - Use words like “client **reported**”, “**according** to caregiver...”

Source: McEvoy, 2013

Clinical Notes

- Do not omit sensitive information that may be embarrassing or uncomplimentary to your client as this places you at legal risk
 - Omissions will typically be interpreted negatively
 - E.g., ensure to document incidences of SBP
- Document consultation
 - Regarding difficult clinical decisions and,
 - most importantly, ethical decision making re. **duty to report**

Source: McEvoy, 2013

Clinical Notes

- Do not write your notes specifically for court
 - Undermines focus of counselling
 - Will not always turn out as you expect/plan
- Include contextual information when documenting sensitive information
 - E.g., why your client may still be struggling with pornography addiction vs. just stating they are "addicted to pornography"

Source: McEvoy, 2013

Clinical Notes

Be careful when documenting flashbacks:

- Record timing of flashback (in session or out)
- Intervention used
- Write briefly about flashback
- This demonstrates that we are leaving room for changes and corrections as clients reconstruct memory
- Writing extensive details may be used against client during cross examination

Source: McEvoy, 2013

Clinical Notes

- Do not redact or edit clinical notes once they have been saved into database.
 - Instead write a separate note that says “addendum to clinical note from September 29, 2025...”
 - **Especially if you have already received subpoena**
- Avoid using terms that may be misinterpreted as suggesting the client does not give accurate information.
- Distinguish between thoughts, feelings, and facts
- Clearly indicate when a client is referring to a dream, imagination, or fantasy.
- Include descriptions of reported indicators of sexual abuse

Source: McEvoy, 2013

Being Subpoenaed

- Being subpoenaed often elicits lots of big feelings from counsellors – and that's okay!
 - Fear of work being scrutinized
 - Fear of client's confidential information being shared
- Do not allow SNS charge to guide decision making
- Get legal and clinical consultation
- Make sure you are actually being subpoenaed – counsellors may receive requests for notes from lawyers which is not the same as a legal subpoena
- Follow confidentiality
 - Can't confirm that you are seeing that client until you have signed consent form the client

Being Subpoenaed

- You can't ignore a subpoena but have options for responding
 - There is a process to resist production of your notes- seek legal counsel
- Not legally required to release records until you take the stand but there are benefits to doing so that may help your client
 - You can release notes directly to their lawyer or crown counsel with consent of client
 - No power of subpoena that requires you to release records directly to defense counsel – they may try though!
- Notes, artwork, **client's journal** etc. are all materials that can be requested in subpoena

Source: McEvoy, 2013

Being Subpoenaed

It is **ALWAYS** better to take the stand and testify with your notes vs. sending your notes without testifying!

Source: McEvoy, 2013

Testifying in Court

- As lay witness – testifying to facts
- As expert witness – testimony can contain opinion
- You are under oath
- Remain neutral – there to give evidence, not argue the case
- Not permitted to give evidence on issue of whether or not abuse occurred

Source: McEvoy, 2013

Testifying in Court

- Crown counsel examination vs. defense counsel examination
- Responding to questions:
 - You can always ask them to repeat the question
 - You can always state that you don't understand the question
 - You can take as long as you need to answer
 - If you don't remember, tell them that – do not try to go based on memory if you are not certain
 - Give brief straightforward answers
 - Do not answer questions outside of your scope
 - Look at the judge when you respond

Source: McEvoy, 2013

Attending Court as Support Person

- In many SA cases the family members will also be testifying therefore they can not be in the courtroom when the child/youth is testifying
- Victim service workers
- Always nice to have a friendly face in the courtroom
- Support regulation and connection

Preparing Clients to Testify in Court

- Always connect your client with a victim support worker (victimlinkbc.ca)
 - They will orient client to Court house/room and explore options for testifying
- Prepare them for cross examination
- Just have to tell the truth
- Remind them of same rules around responding to questions
- They can always ask for a break
- They are allowed to have sensory tools and water
- “Post court syndrome”

Source: McEvoy, 2013

Resources



Crime Victim Assistance Program (CVAP)

- Victim Applications
- Immediate Family Applications
- Witness Applications

Useful Links

- [Association for the Treatment and Prevention of Sexual Abuse \(ATSA\)- Sexual Behavior Problems](#)
- [Boundaries VCH CONSENT Tool](#)
- [Canadian Centre for Child Protection](#)
- [Centre of Expertise on Child Sexual Abuse-Supporting parents and caregivers: A Guide for those working with families affected by CSA](#)
- [generationFIVE- Ending Child Sexual Abuse - A Transformative Justice Handbook](#)
- [Guide for Parents to Talk to their Children about Pornography](#)
- [Humanizing the Hero- This Jungian Life](#)
- [Online Safety Advice by Age](#)

Useful Links

- [Options Community Services- Sexual Abuse Counselling Centre: Parent Information and Support Handbook](#)
- [Parenting Teens and Tweens in the Digital World](#)
- [Revisiting Vicarious Trauma In Gender-Based Violence Work: Opportunities For Fostering Vicarious Resilience & Collective Wellbeing](#)
- [The 7 types of rest that every person needs. TED. \(n.d.\).](#)
- [Trauma and resistance: 'hang time' and other innovative responses to oppression, violence and suffering Vikki Reynolds](#)
- [UNDERSTANDING CHILD SEXUAL ABUSE A guide for protective parents/guardians](#)
- [Vicarious Trauma Tip Sheet for Sexual Assault Centre Workers](#)

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Staying Connected

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