



Chapter Three

CORE SKILLS: ENGAGING AND COMMUNICATING WITH CHILD SURVIVORS

This chapter is for health and psychosocial service providers.

CONTENTS OF THIS CHAPTER INCLUDE

- » Best Practices for Communicating with Child Survivors
- » Guidelines for Talking with Child Survivors about Sexual Abuse
- » Verbal and Non-Verbal Communication Techniques
- » Strategies for Addressing Common Communication Challenges

TOOLS IN THIS SECTION

- » Supervision Tool: CCS Communication Assessment (CCS-CA)

CHAPTER OVERVIEW

This chapter applies to health and psychosocial service providers working with children and families affected by sexual abuse. It introduces best practices for communicating and engaging children who have experienced child sexual abuse. It also includes step-by-step guidance on how to conduct an interview with a child survivor about his/her experience of sexual abuse. Service providers must possess specialized skills in child-centered communication to effectively care for child survivors. Their work, whether as health workers or psychosocial workers, requires them to exchange information with children efficiently and effectively.

DEVELOPING A HELPING RELATIONSHIP THROUGH SAFE AND HEALING COMMUNICATION

HELPING RELATIONSHIPS

The goal of communication between a service provider and child is to establish a trusting, safe and supportive **helping relationship**.

The helping relationship is a relationship of trust that empowers the child and caregiver(s) to feel cared for and respected by the service provider. Every meeting with child survivors and family members are opportunities for service providers to strengthen the helping relationship.

Effective communication skills are fundamental to delivering good care. The heart of compassionate and effective service provision relies on the service provider having the appropriate knowledge, attitudes and skills to communicate trust, comfort and care to children. It is through the dynamic process of communication (verbal and non-verbal) that positive, helpful relationships are developed and healing starts to occur. Evidence⁴¹ shows that health and psychosocial service providers can impact a child's healing based on their responses to a child's disclosure of abuse—in other words, what service providers say and how they say it. For example, if a child discloses sexual abuse and perceives he/she is being blamed for the abuse by the service provider, the child may experience deeper levels of shame, anxiety and sadness. This may result in the child refusing to share further information or even deny the abuse altogether in subsequent interviews because he/she does not feel safe. However, if a service provider communicates immediate belief, care and empathy, the child survivor may be willing to engage further, thus helping the provider to offer appropriate care and treatment.

It is a common mistake to assume that children (from the age of six or so) are too young to be aware of what is going on around them or too young to be adversely affected by dangerous or distressing experiences such as sexual abuse. Children who have experienced abuse may find it extremely difficult to talk to others about what they have experienced. Some will find it difficult to trust adults, especially those they do not know well. Others will be afraid of being overwhelmed by their emotions if they express them to

⁴¹ Perry, B. *The Boy Who Was Raised as a Dog, and Other Stories from a Child Psychiatrist's Notebook: What Traumatized Children Can Teach Us About Loss, Love, and Healing*. New York: Basic Books, 2007.

an adult, while some may use particular behaviors to “test out” whether adults will react critically or sympathetically toward them. For example, children may refuse to speak or they may react strongly (yell or scream) when questioned.

The ability to communicate effectively with children is crucial to sharing information, as well as for encouraging further communication and protecting and assisting these children. Accurate and truthful information can be empowering to children and facilitates their involvement in subsequent decision-making.

As outlined in Chapter 1, some children will feel guilty or ashamed about sexual abuse, especially if they feel in some way responsible for what has happened. Such feelings make it especially difficult for them to talk about what has happened. Effective and compassionate communication is integral to child-centered care and has the additional function of supporting psychological healing from sexual abuse-related trauma. Service providers can promote healing simply through the manner in which they communicate with the child survivor. For example, a caseworker who effectively communicates that he/she believes the child, that the sexual abuse is not the child's fault, and that the child has done the right thing by disclosing abuse is providing a key psychosocial intervention: believing and validating the child.

BEST PRACTICES FOR COMMUNICATING WITH CHILD SURVIVORS

Health and psychosocial service providers responding to child sexual abuse cases should adhere to the following set of communication best practices while working with children who have been sexually abused. While specific communication techniques will need to be adapted according to a child's age and developmental stage, the core communication principles outlined below should guide communication, regardless of the child's age, gender or cultural context. They can be applied in multiple types of interview/communication contexts, including:

- » forensic interviews conducted by health workers or police,
- » medical interviews conducted by health workers,
- » and child intake and assessment interviews conducted by caseworkers.

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Photo: Abigail Erikson/the IRC

Any service provider talking with children affected by abuse should adhere to these guiding principles, regardless of the purpose of the communication, in order to ensure that children are not further traumatized during communications with service providers.⁴²

1. Be Nurturing, Comforting and Supportive

Children who have been sexually abused most likely will come to your attention through a caregiver or another adult; abused children rarely seek help on their own. Children may not understand what is happening to them or they may experience fear, embarrassment or shame about the abuse, which affects their willingness and ability to talk to service providers. Your initial reaction will impact their sense of safety and willingness to talk, as well as their psychological well-being. A positive, supportive response will help abused children feel better, while a negative response (such as not believing the child or getting angry with the child) could cause them further harm.

2. Reassure the Child

Children need to be reassured that they are not at fault for what has happened to them and that they are believed. Children rarely lie about being sexually abused and service providers should make every effort to encourage them to share their experiences. Healing statements such as “I believe you” and “It’s not your fault” are essential to communicate at the outset of disclosure and throughout care and treatment.

⁴² There are more specific forensic interview guidelines for aiding responders in the law enforcement and health sectors. If applicable, they should be known and followed. These guidelines are most relevant to service providers who conduct intake and assessment interviews in the context of case management and health care.

Direct service providers communicating with child survivors need to find opportunities to tell them that they are brave for talking about the abuse and that they are not to blame for what they have experienced. It is required for service providers to tell children that they are not responsible for the abuse and to emphasize that they are there to help them begin the healing process.

3. **Do NO Harm: Be Careful Not to Traumatize the Child Further**

Service providers should monitor any interactions that might upset or further traumatize the child. Do not become angry with a child, force a child to answer a question that he or she is not ready to answer, force a child to speak about the sexual abuse before he/she is ready, or have the child repeat her/his story of abuse multiple times to different people. Staff should try to limit activities and communication that cause the child distress.

4. **Speak So Children Understand**

Every effort should be made to communicate appropriately with children; information must be presented to them in ways and language that they understand, based on their age and developmental stage.

5. **Help Children Feel Safe**

Find a safe space, one that is private, quiet and away from any potential danger. Offer children the choice to have a trusted adult present, or not while you talk with them. Do not force a child to speak to, or in front of, someone they appear not to trust. Do not include the person suspected of abusing the child in the interview. **Tell the child the truth—even when it is emotionally difficult.** If you don't know the answer to a question, tell the child, "I don't know." Honesty and openness develop trust and help children feel safe.

6. **Tell Children Why You Are Talking with Them**

Every time a service provider sits down to communicate with a child survivor, she should take the time to explain to the child the purpose of the meeting. It is important to explain to the child why the service provider wants to speak with them, and what will be asked of the child and his/her caregiver. At every step of the process, explain to children what is happening to help secure their physical and emotional well-being.

HEALING STATEMENTS

"I believe you."

BUILDS TRUST

"I am glad that you
told me."

BUILDS A RELATIONSHIP
WITH THE CHILD

"I am sorry this happened
to you."

EXPRESSES EMPATHY

"This is not your fault."

NON-BLAMING

"You are very brave to
talk with me and we will
try to help you."

REASSURING AND
EMPOWERING

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7. Use Appropriate People

In principle, only female service providers and interpreters should speak with girls about sexual abuse. Male child survivors should be offered the choice (if possible) to talk with a female or male provider, as some boys will feel more comfortable with a female service provider. The best practice is to ask the child if he or she would prefer to have male or female trained staff on hand.

8. Pay Attention to Non-Verbal Communication

It is important to pay attention to both the child's and your own non-verbal communication during any interaction. Children may demonstrate that they are distressed by crying, shaking or hiding their face, or changing their body posture. Curling into a ball, for example, is an indication to the adult working with the child to take a break or stop the interview altogether. Conversely, adults communicate non-verbally as well. If your body becomes tense or if you appear to be uninterested in the child's story, he or she may interpret your non-verbal behavior in negative ways, thus affecting his or her trust and willingness to talk.

9. Respect Children's Opinions, Beliefs and Thoughts

Children have a right to express their opinions, beliefs and thoughts about what has happened to them as well as any decisions made on their behalf. Service providers are responsible for communicating to children that they have the right to share (or not to share) their thoughts and opinions. Empower the child so he/she is in control of what happens during communication exchanges. The child should be free to answer "I don't know" or to stop speaking with a service provider if he/she is in distress. The child's right to participation includes the right to choose not to participate.



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GUIDELINES FOR COMMUNICATING WITH CHILDREN ABOUT THEIR EXPERIENCE OF SEXUAL ABUSE

Sexual abuse can be a traumatic experience for children, and talking about abusive experiences can trigger feelings and emotions that the child experienced during the actual abuse. Service providers must be aware of this and handle conversations about sexual abuse with sensitivity. Service providers need to talk to boys and girls about their experiences of sexual abuse in order to understand what happened and to direct care and treatment.⁴³ Often, children and caregivers will be in crisis during the initial intake and assessment interviews and service providers are responsible for knowing how to create a safe, supportive and caring environment. In addition to adhering to the communication best practices, the following recommendations for handling interviews should be followed.

SETTING THE STAGE: CREATING A SAFE ENVIRONMENT

Service providers are responsible for ensuring that children's emotional and physical safety are safeguarded during all communications with children, particularly during direct interviews about experiences of sexual abuse. The following strategies can help to create a feeling of safety, which is essential for children expected to share personal and painful experiences with service providers.⁴⁴

CREATING A SAFE AND SUPPORTIVE ENVIRONMENT

- 1. Choose a safe location.** Interviews with children should take place in a confidential, safe and child-friendly atmosphere. A child-friendly atmosphere can include child-friendly toys and materials or a space to sit comfortably on the floor.
- 2. Explain who you are.** A GBV social worker, health worker, law enforcement officer or child protection staff person is in a position different from that of parents or teachers.

⁴³ The practice of multiple interviews has been shown to cause additional trauma to child survivors. In Chapter 7: Recommendations for Coordination in Cases of Sexual Abuse, we offer suggestions to service providers on how to best to coordinate multiple interviews.

⁴⁴ This section is adapted from the U.N. International Children's Fund (UNICEF), Training Manual on Caring for Survivors, created 2004 and updated 2010. Formal Reference: IASC Training Manual on Caring for Survivors, United Nations International Children's Fund (UNICEF) (2010).

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All service providers must identify the organization they represent and explain their role and the purpose of the meeting. Below is an example of a service provider working with a psychosocial agency.



“My name is Asha and my job is to help girls and boys when they feel sad or have any problems. The name of my organization is Safe Places and we have six other women here who also help children and other people. My job is to keep you safe and to listen to you, and give you information about how to get help if you need it.”

3. **Obtain permission.**⁴⁵ Talking with children about sexual abuse requires permission from them and their caregivers. However, permission can depend on the child's age and circumstances. If the caregiver or another adult responsible for the child is the suspected abuser, the service provider should seek permission from another responsible and safe adult, for example the person who brought the child in for help. If the person who brought the child in is not the caregiver, and the caregiver is not deemed to be a threat, every effort should be made to locate the caregiver and obtain their consent before proceeding with intake and assessment interviews and other aspects of service. For detailed instructions on how to obtain permission or “informed consent/assent,” please reference Chapter 5.
4. **Maintain equality.** Sit at the same height as the child; keep your eyes aligned with the child's eyes. Try not to bend over or look down at the child, or squat to look up into the child's face. These strategies promote a sense of respect for the child and reinforce feelings of trust.
5. **Ask for permission to speak.** Ask children above the age of seven for permission to speak with them. While children may not be able to give legal consent, they have the ability to “assent” to being asked about their experiences.⁴⁶ Children have the right to express their views and opinions, and seeking permission from children to ask questions demonstrates the service provider's respect of their rights.
6. **Explain what will happen.** The service provider should explain what will happen and what the child's rights are during the session. This helps children know what to expect and what they can control. For example, children have the right to stop the interview at any time or not answer a question. Children have the right to make mistakes and should be allowed to change their minds. Children rarely end conversations arbitrarily, but they and their parents feel safer if they know they can. Finally, it never hurts to remind children that there are no right or wrong answers. You are only interested in their experiences and ideas.

⁴⁵ Specific guidance explaining how to obtain permission or informed consent/assent during service delivery is outlined in Chapter 5.

⁴⁶ This concept and practice of obtaining child informed assent is covered in depth in Chapter 5.



Illustration by Abdifatah Abdukadir Osman

7. **Explain the process.** Explain the purpose of your meeting in child-friendly terms. Either before, during or after the general discussion, tell the child, using language he or she will understand, how the information he or she provides might need to be shared. Tell the child you want to hear about their experience and be as specific as you can. For example, tell the child about other people (“families,” “kids your age,” “people like you”) who have had the same kind of thing happen to them and how they have found it helpful to talk to others.
8. **Talk with the child with trusted adults.** To the greatest extent possible during any intake and/or assessment, children should have a trusted adult with them, especially very young children and children who are afraid of the service provider. During the assessment phase, there may be times when it is appropriate to talk to children and parents separately, but if the parent(s) are not suspected perpetrator(s) and children want them in the room, they should be included. On the other hand, some children will hesitate to speak in front of parents and service providers will need to consider talking with them alone.
9. **Do not make promises you cannot keep.** A child may say, “I have something I need to tell you but you have to promise to keep it a secret.” The child’s trust has most likely been broken already by someone close to him or her. It is important to reassure them that they can trust you, but **also to inform them that you might need to share some of the information they provide in order for you to keep them safe.** If the child discloses he or she is being hurt and is unsafe, you must tell others who need to know, and the child should know that you cannot keep this information confidential.

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10. Don't force or pressure the child to talk. It is better to go slowly and not to ask for too much information too quickly. Children may become flooded with feelings of fear when discussing their experiences of abuse and service providers should stop if the child appears distressed. Follow-up conversations with children who become distressed are not considered "multiple interviews." At all times, the child should set the pace of the conversation, not the service provider.



HELPFUL TIPS: CHILDREN, MEMORY AND EMOTION

- » The experience of trauma can affect a child's ability to remember what happened and pass on information during an interview.
- » Children may not connect emotionally with the story they are retelling in the same way adults might. Children may have no emotional reaction at all, while others will react emotionally in a way that mimics the person talking with the child. This is why it is important for service providers to remain calm, in control and comforting.

USING VERBAL AND NON-VERBAL COMMUNICATION TECHNIQUES

Service providers need to employ various techniques to help facilitate communication according to age and developmental levels. Service providers should be skilled in verbal and non-verbal communication techniques, as some children may not be able to find the words to share important information—because of age or because the challenge of recalling the trauma is overwhelming.

This section walks through effective verbal and non-verbal techniques for gathering important information from children in a caring and compassionate manner. The techniques described in this section, along with the above-mentioned communication practices will help service providers create feelings of trust and safety for children being assessed and/or interviewed. These techniques are not considered counseling; however, these same kinds of engagement strategies are in-line with child-friendly counseling guidelines.

CHILD-FRIENDLY COMMUNICATION TECHNIQUES⁴⁷

Children, ages six years and older, who are able to communicate verbally can benefit from service providers who implement the following strategies:

⁴⁷ This section draws heavily from the IASC Training Manual on Caring for Survivors, United Nations International Children's Fund (UNICEF). (2010).

- » Talk with children about their life, school, family and other general topics before asking direct questions about their experience(s) of abuse. This helps the service provider to gauge the child's capacity to be verbal and helps a child feel at ease with the service provider.
- » Use as many open-ended questions as possible. Avoid multiple-choice or yes/no questions, which can be confusing and lead the child to give inaccurate responses.
- » Avoid using the words "why" or "how come." This will result in answers frustrating for you and the child: "I don't know," for example, or a shrug of the shoulders, or silence. Instead, ask for the child's opinion as to why something is so: "What do you think the reason is...?" In addition, "why" questions can come across as blaming, such as "Why didn't you..." for example.
- » Use words that encourage the child to continue talking:
 - "Tell me more about that..."
 - "What do you mean by..."
 - "Give me an example of..." or "Describe for me..."
 - "Go on..."
 - "And then what happened...?"
- » Don't put words in the child's mouth. Whether using verbal or non-verbal techniques (see below for guidance on using non-verbal techniques), service providers need to be careful not to put words in a child's mouth. For example, do not say, "Did he put his hands on your breasts?" Or if using a doll to help a child communicate what happened, do not point to the breasts on the doll and ask, "Did he touch you here?" Instead, ask the child to show you where he/she was touched. Other examples of useful questions or statements:
 - Has anyone ever touched you in a way that makes you confused or frightened?
 - Share with me how you were touched.
 - Tell me what happened next.
 - Use your own words. It is okay to go slowly.
- » Choose the right words. Children, especially those under the age of six, take words literally, so the service provider must be sure to use concrete language herself. For example, if you ask a young child, "Did he drive you away in his car?" the child may answer negatively—if the actual vehicle was a truck.
- » Empower children. After children describe events or occurrences in their lives and talk about their reactions, they must be reassured that they "did the right thing" by telling another person about these events. It may be helpful to allow them the opportunity to explore their ideas and solutions: "What would you tell other kids to do if they were in the same situation?" If they are unable to reply, you can offer them paper and crayons and see if they want to draw their ideas.

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Photo: Abigail Erikson/the IRC

CHILD-FRIENDLY NON-VERBAL TECHNIQUES USING ART, DOLLS AND OTHER ACTIVITIES TO COMMUNICATE

Children who have been sexually abused can benefit from non-verbal techniques to facilitate information sharing throughout all stages of the child's care and treatment process. Non-verbal techniques can be used during assessment interviews with child survivors (for example, to help a child share his/her story or clarify specific information) and as part of psychosocial care (by helping children express their feelings through art, play and other activities). Non-verbal methods of communication offer many benefits:

- » Children may feel less threatened using non-verbal methods than sitting in a room talking.
- » Children may find it easier to express emotions through drawings or stories, especially younger children and children not used to expressing emotions or answering questions.
- » Children express emotions, thoughts, ideas and experiences both during and after the non-verbal communication activity.

EXAMPLES OF NON-VERBAL TECHNIQUES

Children of all ages can benefit from a service provider who has several methods for giving and receiving information. Children who are younger and/or not responsive to verbal communications can benefit from the option of communicating through the use of art and other materials. Service providers can apply these materials in two ways: nondirective and directive.

1. **Nondirective techniques** apply when a service provider invites children to draw a picture or tell a story, but does not give specific directions about what they might draw or say. The person working with the child can then see what the child may be thinking or feeling, based on what the child chooses to draw, and so on. This is a good way to engage children at the beginning of an interview or meeting, allowing the child to relax and engage in a fun and creative activity without being told what to do.
2. **Directive techniques** apply when a service provider asks a child to participate in an art or other creative activity. For example, asking a child to draw a picture “of their happiest memory” or to make a picture or visual depiction of “who lives in their house” are examples of directive techniques. These techniques can be very useful during interviews with children to gather information about specific areas of a child’s life. Examples of directive art and play techniques that can be used to better understand a child include:
 - **Having a child draw his or her family (anyone living in their house).** This can be a very effective way to find out who lives with the child. Once the child draws the picture, service providers can ask additional questions about

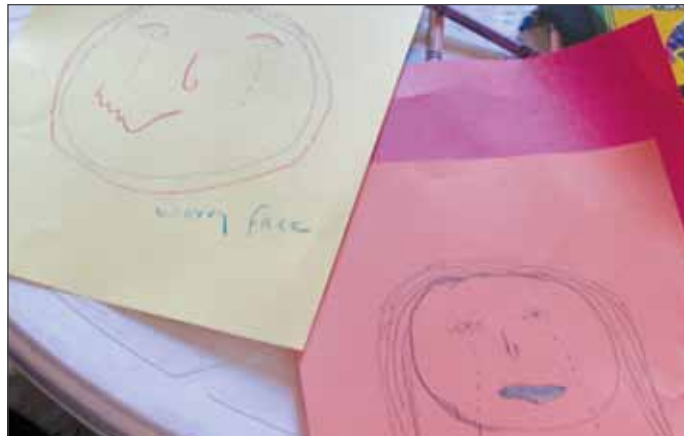


Photo: Abigail Erikson/the IRC

This picture shows drawings made by psychosocial workers to use with their child clients to help the children identify their feelings (sad, worried, happy, etc). Using pictures that show different emotions can be an effective way to help children express their feelings.

CONSIDERATIONS FOR USING NON-VERBAL TECHNIQUES

All communication techniques, including non-verbal techniques, should be implemented by trained staff and with care and caution. They should be used when:

1. The service provider has been adequately trained in communicating with child survivors and has proper supervision support.
2. It is deemed the child is more comfortable using non-verbal communication techniques.

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Photo: Abigail Erikson/the IRC

This picture shows a safety circle drawing. Inside the circle are the things that make this person feel safe and happy. Having children draw their own safety circle (a circle with the people, places and things that make them feel safe and happy inside) is an effective tool for identifying safe people and places in a child's life. This information is essential to incorporate into a child's overall care and treatment planning.

the family: to whom is the child closest? Who is he or she scared of? With whom does he or she get along? What do family members do during the day? ...and so on.

- **Having a child draw his or her daily activities.** This can be an effective way to find out what the child's day is like. Is he or she in school, out of school? Who does he or she spend time with? Does he or she describe certain friends or activities? ...and so on.
- **Having a child draw their safety circle.** The child draws a circle and puts inside the circle what and who makes him or her feel safe. This can be an excellent way to identify safety concerns the child may have. The service provider can take this activity a step further and have the child draw the things outside of the circle that scare them (the circle being the symbolic boundary of safety). This can provide additional information about the child's perception of risk (what and whom) and safety (what and whom).
- **Having a child use dolls.** Using dolls, a child shows where or how he or she was touched.⁴⁸ For example, asking a child to show you where on the doll he or she was touched or hurt. The service provider should not lead the child, for example, pointing to a child's breast, vagina, penis or other body part and asking, "Did he touch you here?" This is a leading question and children may want to please the person asking and could answer "yes" when, in fact, the answer is "no."

⁴⁸ The use of dolls in interviews with children require specific training; caseworkers using dolls should be evaluated on their correct use and understanding prior to using with children.

- **Having a child use dolls to find common language.** It can be very useful to have dolls and drawings to define common terminology for body parts. Studies have shown that children use many different names for private parts⁴⁹, and many young children do not know which parts of the body are considered private.⁵⁰ Young children tend to use a wider range of words to refer to body parts and sexual acts than do older children. Younger children also use the same word or phrases to refer to more than one body part or sexual act. Thus, the service provider must take the time to clarify the words and phrases used by children to ensure an accurate understanding of children's statements.

CASE STUDY: USING A DOLL DURING AN INTERVIEW WITH A SIX-YEAR-OLD BOY SURVIVOR

In a refugee camp, a social worker interviewed a six-year-old boy child about his experiences with sexual abuse. The child had been sexually abused by an older boy, and the child told the social worker that he was hurt in his “bum.” The social worker wanted to make sure that she, and her child client, had the same understanding of the word “bum.” So she brought out her boy doll and she asked the child survivor to show her where the bum was located on the doll. The boy took the doll and pointed to the doll’s rear end. This confirmed for the social worker that she accurately understood what the child survivor was saying.

INTERVIEW GUIDELINES BASED ON AGE AND DEVELOPMENTAL STAGE

Talking with child survivors requires service providers to take into consideration several factors, including the child’s age and stage of development. The level of a child’s development is influenced by many factors besides age. The environment has an important impact, as do education, culture, nutrition, access to health care, social and family interactions, as well as war and violence and their consequences (psychosocial and mental health problems, displacement). Service providers responsible for talking with children about their abuse experience should adapt the length of time according to the child’s age. Age-appropriate lengths of time to talk with children about sexual abuse are:

- » 30 minutes for children under the age of 9;
- » 45 minutes for children between 10–14 years;
- » One hour for children 15–18 years old.

⁴⁹ Cheung, K.F.M., Stevenson, K.M., et al. Competency-based Evaluation of Case Management Skills in Child Sexual Abuse Intervention. Child Welfare League of America, pp. 425-435.

⁵⁰ Ibid.

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INFANTS AND TODDLERS (0-5 YEARS OLD)

- » Children in this age range should not be interviewed directly about their abuse. They have limited verbal communication skills and are unlikely to make any disclosures about abuse.
- » The non-offending parents/caregivers should be the primary sources of information about the child and suspected abuse. Other significant adults in the child's life, particularly people who have provided care, should be consulted, including the person accompanying the child.

YOUNGER CHILDREN (6-9 YEARS OLD)

- » Children in this age range can be directly interviewed by the service provider, although we recommend that, if possible, information about the abuse be gathered from trusted sources in the child's life.
- » Children in this age range may have a difficult time answering general questions. This may result in children saying, "I don't remember" or "I don't know" often, or they may give vague responses such as, "The man did a bad thing," but fail to share more.
- » Caregivers/parents or someone the child trusts can be involved in the interview as long as the child requests that the adult be present (and the adult is not a suspected abuser).
- » Children in this age range benefit greatly from a mixture of both verbal and art-based communication techniques.
- » Children in this age range shouldn't be asked questions that involve abstract ideas like justice or love. They tend to think in concrete (literal) terms.

YOUNGER AND OLDER ADOLESCENTS (10-18 YEAR OLDS)

- » Children in this age range can be directly interviewed by the service provider. Open-ended questions can produce important information about sexual assault.⁵¹
- » Caregivers/parents or someone the child trusts can be involved in the interview as long as the child requests that adult to be present (and that adult is not a suspected abuser).
- » Adolescents have more capacity for analytical thought and reflection but service providers should remember they are also still developing.

⁵¹ IASC Training Manual on Caring for Survivors, United Nations International Children's Fund (UNICEF) (2010).

ADDRESSING COMMON COMMUNICATION CHALLENGES

CHILDREN WHO REFUSE TO SPEAK

In some cases, children who are able to communicate verbally may refuse to talk about the sexual abuse they have experienced. Following the communication principles, children who refuse to speak should not be forced to do so. Service providers need to be patient in order to create an environment in which the child feels comfortable enough to disclose information about the abuse. Service providers also need to communicate with the adults that the child trusts in order to determine if there are any urgent medical or safety issues that need to be addressed. In addition, service providers should work with other adults in the child's life to coach them on gathering information that may be helpful in understanding the situation.

Service providers should watch closely for possible reasons as to why the child refuses to speak. It may be that a particular child is just not comfortable with a certain service provider because of his or her sex, age or another factor. Service providers should find another person within their agency to work with the child. Service providers should also consider the following factors:

- » Is there someone in the room who seems to make the child reluctant to speak?
- » Does the child stop speaking when left alone with the service provider, indicating he or she is afraid to talk without another trusted adult present?
- » Are they not speaking because the environment around them is not safe or private, or because they are not ready to trust the service provider? If a child does not want to build trust with a particular service provider, it is not that person's fault. Find other ways to help the child through referrals, talking with family members, etc.

Many other factors may influence why a child refuses to speak about sexual abuse, including fear of consequences (being forced to marry the abuser, for example) and shame. The service provider may want to be proactive in addressing these fears to provide the child survivor with some reassurance that they will be properly helped. If a child never speaks about the abuse, caregivers can often provide adequate information for the child to receive care.

CHILDREN WHO DENY SEXUAL ABUSE

In most child sexual abuse cases, particularly involving younger children, someone other than the child will refer him or her for assistance. There may be times when an adult suspects or has witnessed a child being sexually abused and has disclosed this information to a service provider without the child's permission or knowledge.

In these situations, the role of the service provider is not to determine whether or not abuse has occurred, but to establish a relationship where the child feels safe enough to disclose abuse.

If sexual abuse has been disclosed by a third party, a child may be more likely to initially deny the instance of abuse. Service providers should not attempt to confirm or deny children's initial statements. As we have documented above, children often deny abuse for good reasons—fear of stigma, shame, or retaliation. Sometimes a parent refers an older child or adolescent for services because they are concerned the child is sexually active before marriage. The child however, may not view the sexual activity as abusive and/or may be embarrassed and unwilling to admit to premarital sexual relations.

Service providers will need to gather more information from the caregiver and child separately to gain a better understanding of the situation. They will want to pay special attention to the age and role of the alleged perpetrator. In some situations, there may be age appropriate sexual attraction between teenage girls and boys, which may be upsetting to the parents but is not necessarily an act of sexual abuse.

Service providers will need to use the following strategies in addressing allegations of abuse that the child survivor denies:

- » **Stay neutral:** Do not confirm or deny what the child is saying. Let the child know that you are not there to judge but to listen, understand and help.
- » **Get more facts:** Talk with the child and the person who has referred the child separately. Ask questions that provide a bigger picture of what may be happening: What is the age of the child and the alleged perpetrator? What is their relationship? What is the relationship between the person who reported the case and the child?
- » **Be patient:** Children may not be willing or able to talk about sexual abuse because of the associated shame or stigma. Do not force children to talk about sexual abuse. Service providers need to meet children at their current capacity to share and communicate.

CHILDREN WITH PHYSICAL AND/OR MENTAL DISABILITIES

Children with physical or mental disabilities (for example, deaf and mute) who are suspected or confirmed to have been sexually abused will likely not benefit from verbal interviews. With these child survivors, health and psychosocial service providers will want to use the following strategies:

- » Identify and obtain information from the child's caregiver (a person that the child seems to know and trust).
- » Communicate care and comfort to the child using non-verbal communication techniques (for example, smiling).
- » Use dolls, toys and other art materials to allow the child to communicate freely.
- » Follow the Case Management Guidelines in Chapter 5, which includes guidance for making decisions on behalf of children who are unable to communicate their thoughts and opinions due to disability or some other reason.

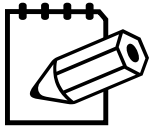
GUIDELINES FOR ASSESSING AND MONITORING CORE COMMUNICA- TION SKILL COMPETENCIES

Health and psychosocial staff responding to cases of child sexual abuse are required to receive training in specialized communication and engagement skills described in this section. A key difference in working with children versus adults is the additional skills needed to effectively communicate. These skills do not come naturally, yet are fundamental to effective care (e.g. case management and psychosocial support) for child survivors.

There are different methods for evaluating staff communication competencies; the following two are recommended:

1. Assessing individual staff members' communication skills using an assessment tool;
2. Directly observing staff providing services to children and giving feedback on examples of good and bad practice during individual and group case supervision.

3 CORE SKILLS: ENGAGING AND COMMUNICATING WITH CHILD SURVIVORS



SUPERVISION TOOL: CCS COMMUNICATION ASSESSMENT (CCS-CA)

The CCS Communication Competency Assessment Tool (CCS-CA) can be used by supervisors to measure an individual staff member's ability to communicate and engage with child survivors as described in this section. This supervision tool can be used in addition to other tools employed by health and psychosocial service providers.⁵² The CCS-CA is a simple supervision tool to implement. It should be used with staff responsible for providing services to child sexual abuse survivors and, if possible, should be administered following a formal training on communicating with child survivors.

USING THE CCS-CA TOOL

STEP 1

Set up an assessment interview session between the supervisor and staff person being evaluated. The assessment interview should take place in a private and quiet space and will take between 30–60 minutes.

⁵² For example, the CCS-KA and the CCS Attitude Scale can be used in conjunction with the CCS-CA Tool. These three tools used together provide a structured method for assessing knowledge, attitude and communicate competencies for working with child survivors. Demonstrating competency in these three areas shows that field staff has the requisite foundational knowledge and skills to provide more advanced services such as health care, case management and psychosocial care.

full tool at end of chapter

Supervision Tool Caring for Child Survivors Communication Assessment (CCS-CA)

Date:
Staff Name:
Supervisor:

Instructions for Administering the Tool

PURPOSE

This assessment represents the minimum communication skills standards for psychosocial and health staff working with child survivors of sexual abuse. Competent care rests on service providers being able to communicate (giving and receive information) with child survivors appropriately. This is a staff supervision tool for managers/supervisors to use periodically with staff providing care directly to children and families.

INTRODUCTIONS

- (1) This supervision tool should be performed through a verbal interview between the staff and his/her supervisor in a quiet and confidential location.
- (2) The supervisor should inform the staff person this tool is being used to assess areas where further capacity building is needed. It is not a performance evaluation tool. The supervisor should explain they will receive a score to determine if individual staff member 'meets' the overall communication competency assessment.
- (3) The supervisor asks the staff person to explain/describe the concepts below and score accordingly:
 - **Met:** If the individual is able to answer the questions correctly and fully, they will receive a mark of 'met'.
 - **Partially Met:** If the individual is able to answer at least 50% of the question, they will receive a mark of partially met.
 - **Unmet:** If the individual is unable to answer the question, they will receive a mark of 'unmet'.
- (4) Once the assessment is complete, the supervisor will score the assessment and discuss with the staff member his/her scores, what they mean, and any further capacity building needed

Administering the Tool

Child Communication & Engagement Skill	Criteria for Answering Correctly	Met 2 pts	Partially Met, 1 pt	Not Met 0 pts
1. Healing statements: child survivors should hear from a service provider throughout care?	Need to list at least 4 statements for full (100%) score, and at least 2 statements must be 'not fault' and 'I believe you': <ol style="list-style-type: none">1. I believe you.2. This is not your fault.3. I am very glad you told me.4. I am sorry this happened to you.5. You are very brave for telling me and we will try to help you.6. Other culturally appropriate healing statement			
2. Describe how you should begin an intake and assessment session with a child.	Need to at least say the importance of starting with general questions and building some trust before asking: <ol style="list-style-type: none">1. Warm welcome2. Start with general questions3. Ask the child if h/she knows why they are speaking with you4. Explain the child's rights (allowed to not answer a question or stop at anytime, etc.)5. Offer the child a toy or something to hold on to (if there is something)6. Offer encouraging statements along the way.			
3. Describe how to use your body language (i.e. eye contact, position of your body) to help a child feel safe and comfortable.	Need to explain 4 ways body language would be adapted for full points: <ol style="list-style-type: none">1. Sit on the floor with a younger child2. Use appropriate eye contact3. Friendly expression on face4. Soft, gentle voice5. Other culturally appropriate thing to do			

STEP 2

Explain to the person being assessed that:

- » The purpose of the assessment is to identify areas of strength and where additional training on child specialized communication skills would be beneficial. The purpose of the assessment is to evaluate specific skills on communicating with child survivors.
- » He/she will not be penalized if he/she does not fully meet the competency assessment. However, he/she will need to demonstrate improved skills over time to avoid other consequences.
- » **Note:** Supervisors should approach these assessment interviews in a friendly, supportive and relaxed manner. This does not mean that the assessment is not taken seriously. Rather, a friendly and supportive approach can help ease the nervousness and fear a person may be feeling.

STEP 3

Implement the CCS-CA Tool

- » The CCS-CA Tool is divided into 14 questions on the essential communication skill areas outlined above.
- » The supervisor verbally asks the individual to explain the specific points being asked. The supervisor can also ask the individual to role play answers during the assessment in order to more easily observe skills in action.

Administering the Tool				
Child Communication & Engagement Skill	Criteria for Answering Correctly		Met 2 pts	Partially Met, 1 pt
1. N healing statements child survivors should hear from a service provider throughout care?	Need to list at least 4 statements for full (100%) score, and at least 2 statements must be 'not fault' and 'I believe you':	1. I believe you. 2. This is not your fault. 3. I am very glad you told me. 4. I am sorry this happened to you. 5. You are very brave for telling me and we will try to help you. 6. Other culturally appropriate healing statement		
2. Describe how you should begin an intake and assessment session with a child.	Need to at least say the importance of starting with general questions and building some trust before asking:	1. Warm welcome 2. Start with general questions 3. Ask the child if h/she knows why they are speaking with you 4. Explain the child's rights (allowed to not answer a question or stop at anytime, etc). 5. Offer the child a toy or something to hold on to (if there is something) 6. Offer encouraging statements along the way.		

**CCS-CA
Answer Sheet**
(first page of tool)

3 CORE SKILLS: ENGAGING AND COMMUNICATING WITH CHILD SURVIVORS

- » The supervisor assesses the accurateness of the answer using the “criteria for answering correctly.” Answers are rated according to three possible levels:
- **MET:** If the individual demonstrates 100% competency in the communication skill area(s), they will receive a mark of “met.”
 - **PARTIALLY MET:** If the individual demonstrates 50% competency in the communication skill area(s), they will receive a mark of “partially met.”
 - **UNMET:** If the individual is unable to answer or demonstrate competency, they will receive a mark of “unmet.”

STEP 4

Scoring the CCS-CA Tool

- » The supervisor administering the tool will need to add up the points in each column and then total each column for a final score. Only one score is allowed per question.

CCS-CA
Scoring Section
(last page of tool)

TOTAL POINTS QUESTIONS 1-15				
TOTAL SCORE				
Evaluating Communication Skill Competency 20-30 points: MET: Scores in this range indicate that the individual has met the core communication skill requirements and is able to work independently with children and families, with ongoing supervision. 10-18 points: PARTIALLY MET: Scores in this range indicate additional training is needed to build knowledge and skills on child-centered communication. The staff person should be monitored very closely if working on child sexual abuse cases. A capacity building plan should also be put into place. This may include one-on-one mentoring sessions, additional training opportunities, shadowing fellow staff members, among other capacity building activities. 0-8 Points: NOT MET: Scores in this range indicate that the staff person does not yet have the sufficient knowledge and skills to communicate with child survivors. Additional training and support should be provided and the CCS-CA should be re-administered again after further training. A capacity building plan should also be put into place. This may include one-on-one mentoring sessions, additional training opportunities, shadowing fellow staff members, among other capacity building activities.		Final Evaluation: _____ MET _____ PARTIALLY Met _____ UNMET		

- » Understanding the score:
- **20–30 points: MET** Scores in this range indicate that the individual is able to demonstrate ability in child-centered communication and interviewing skills. The individual is able to work independently with children and families with ongoing supervision.
 - **10–18 points: PARTIALLY MET** Scores in this range indicate additional training is needed to build skills and understanding in communicating with child survivors. The individual should be monitored closely if working on child sexual abuse cases and actively engaging children in case management or psychosocial services.

- **0–8 Points: NOT MET** Scores in this range indicate that the individual does not yet have sufficient skills to communicate with child survivors. Additional training and support should be provided and the CCS-CA tool should be re-administered after further training and skills development.

STEP 5

Review the score with the individual:

- » Review the final assessment score as soon as possible so the staff person need not be anxious about his/her performance. It is recommended the score be communicated to the staff person immediately following the assessment interview.
- » Review the correct and incorrect answers with the individual. Reassure and affirm the staff person on the communication skills he/she demonstrates well. Answer any questions the individual may have; allow him or her to ask questions and share their thoughts and concerns.
- » Develop a plan for additional training and capacity building. This plan can be written into the CCS-CA Tool and the supervisor and staff person may keep a copy. The supervisor should store the CCS-CA results in a locked file in their personal file cabinets to protect the individual's confidentiality. Explain to the staff person where their assessment will be stored; explain their rights to confidentiality and make sure a plan is in place if they did not fully meet the competency.

ONGOING MONITORING

After the initial evaluation, it is recommended that the CCS-CA tool (or another communications competency tool developed locally) be administered to staff every six months. This provides an opportunity to see if the staff member's application of skills is changing over time and to correct any communication skill deficiencies that may have developed since the initial evaluation. In addition, this provides opportunity to service providers to engage in their own self-learning process when working on cases as challenging as sexual abuse toward children.

DIRECT OBSERVATION AND SUPERVISION

In addition to administering the formal CCS-CA Tool to assess technical communication skills, supervisors should identify ways to directly observe staff working with children and families. Direct observation is a more accurate assessment of an individual's competency in working with children and families in a direct response capacity.

CONCLUSION

This chapter outlined the guidance for communicating with child survivors, including verbal and non-verbal communication techniques, and guidelines for structuring interviews. In addition, we introduced the CCS-CA assessment tool to help supervisors assess and monitor competency among individual staff. Effective communication is extremely important for ensuring that:

- » A caring and compassionate relationship develops between the service provider and child and family clients.
- » Service providers communicate important information to children and families in a way they can accept and understand.
- » Service providers obtain crucial information about a child's exposure and experiences with sexual abuse that can be used in direct care and treatment.

Supervision Tool

Caring for Child Survivors Communication Assessment (CCS-CA)

Date:

Staff Name:

Supervisor:

Instructions for Administering the Tool

PURPOSE

This assessment represents the minimum communication skills standards for psychosocial and health staff working with child survivors of sexual abuse. Competent care rests on service providers being able to communicate (giving and receive information) with child survivors appropriately. This is a staff supervision tool for managers/supervisors to use periodically with staff providing care directly to children and families.

INTRODUCTIONS

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 - **Unmet:** If the individual is unable to answer the question, they will receive a mark of 'unmet'.
- (4) Once the assessment is complete, the supervisor will score the assessment and discuss with the staff member his/her scores, what they mean, and any further capacity building needed

Administering the Tool

Child Communication & Engagement Skill	Criteria for Answering Correctly	Met 2 pts	Partially Met, 1 pt	Not Met 0 pts
1. N healing statements child survivors should hear from a service provider throughout care?	Need to list at least 4 statements for full (100%) score, and at least 2 statements must be 'not fault' and 'I believe you': 1. I believe you. 2. This is not your fault. 3. I am very glad you told me. 4. I am sorry this happened to you. 5. You are very brave for telling me and we will try to help you. 6. Other culturally appropriate healing statement			
2. Describe how you should begin an intake and assessment session with a child.	Need to at least say the importance of starting with general questions and building some trust before asking: 1. Warm welcome 2. Start with general questions 3. Ask the child if h/she knows why they are speaking with you 4. Explain the child's rights (allowed to not answer a question or stop at anytime, etc). 5. Offer the child a toy or something to hold on to (if there is something) 6. Offer encouraging statements along the way.			
3. Describe how to use your body language (i.e. eye contact, position of your body) to help a child feel safe and comfortable.	Need to explain 4 ways body language would be adapted for full points: 1. Sit on the floor with a younger child 2. Use appropriate eye contact 3. Friendly expression on face 4. Soft, gentle voice 5. Other culturally appropriate thing to do			

4. Describe how you would explain a health referral to a child survivor between the ages of 10-12	Should include all the following points for full score:	<ol style="list-style-type: none"> 1. Accurate description of health care services (includes risks/consequences) and 2. What the child's rights are during the health care treatment and exam. 			
5. Describe how you would explain a protection referral ages of 10-12	Should include all the following points for full score:	<ol style="list-style-type: none"> 1. Accurate description of the protection services (includes risks/consequences)and 2. Explaining what will happen when the protection staff talk to the child. 3. Explaining what the child and family's rights are during the police interviews 			
6. Explain how to find out how a child is feeling using child friendly materials (drawings, toys, etc)	Correct answers can include any of the following ideas:	<ol style="list-style-type: none"> 1. Draw pictures of faces that represent different feelings and ask the child which one is the closest to how he or she feels. 2. Ask the child to draw a picture about what is the feeling in their mind and heart 3. Ask the child to use colors to represent the different feelings they have 4. Other idea/activity that the social worker has that would be good to try 			
7. What are some important choices you should offer to children before talking with them about their abuse experience?	Need to provide at least 3 choices to get full score:	<ol style="list-style-type: none"> 1. The choice to have a caregiver or trusted person in the room 2. The choice of where to have the conversation 3. The choice to decide when to have the conversation. 4. If possible, the choice to have either a male or female interviewer - this is more specific to boy child survivors. It is always best practice for girls to be interviewed by female counselors as they are almost always abused by men. 			
8. If a child is under the age of 5, who should you talk to find out what happened to the child	Must make the following 2 points for full credit.	<ol style="list-style-type: none"> 1. First, the person who brought the child is 2. The child's caregiver (if appropriate) 			
9. What are some key healing statements to say to a non-offending caregiver/parent who is distressed by their child's sexual abuse	Need to name at least 4 statements for full credit:	<ol style="list-style-type: none"> 1. This is not your fault (if that is true) 2. We can help you and your child get better. 3. This happens to other children too. 4. You are not a bad parent because this happened. Sexual abuse is the fault of the perpetrator. 5. Other statement that is culturally relevant. Problems developing, such as losing ability to talk. 			
10. What is the maximum amount of time you should interview a child about his/her sexual abuse	Correct answer	<ol style="list-style-type: none"> 1. Depends upon the age of the child, between 30 minutes to one hour. 			
11. What is the difference between interviewing a 7 year old and a 17 year old	Need to name at least 2 points for full credit:	<ol style="list-style-type: none"> 1. 17 year old can understand what has happened more 2. 17 year old will have more capacity to offer ideas, opinions about what should happen. 3. 17 year old will be more concerned about social impacts and stigma of abuse. 			
12. If a child refuses to talk to you (and is not disabled or hearing impaired) what are three things you should evaluate as the service provider?	Need to name at least 2 points for full score:	<ol style="list-style-type: none"> 1. Is there somebody in the room the child does not feel safe speaking in front of 2. Are you acting in a way that is making the child uncomfortable 3. Is the interview place safe for the child to speak 			

13. Give me an example of how you would respect a child's view, beliefs and opinions when you are working with him/her	Need to name at least 2 points for full score:	1. I would ask the child what his/her thoughts are about a particular action 2. I would tell the child in the beginning and throughout my communication with him/her that s/he has the right to share how s/he feels and thinks. 3. I would create space for the child to talk. 4. Additional point relevant to the context.			
14. Describe how a helper's attitude and beliefs about sexual abuse impact communication with children	Need to name at least 2 points for full credit:	1. When helpers have the right attitude and belief they communicate in a genuine and caring way. 2. They are more committed to caring for the child 3. They provide accurate and non-judgmental information and counselling. 4. Other point that the interviewer feels is right.			
15. EXTRA QUESTION FOR COUNTRY PROGRAM ADAPTION					
TOTAL POINTS QUESTIONS 1-15					
TOTAL SCORE					
Evaluating Communication Skill Competency 20-30 points: MET: Scores in this range indicate that the individual has met the core communication skill requirements and is able to work independently with children and families, with ongoing supervision. 10-18 points: PARTIALLY MET: Scores in this range indicate additional training is needed to build knowledge and skills on child-centered communication. The staff person should be monitored very closely if working on child sexual abuse cases. A capacity building plan should also be put into place. This may include one-on-one mentoring sessions, additional training opportunities, shadowing fellow staff members, among other capacity building activities. 0-8 Points: NOT MET: Scores in this range indicate that the staff person does not yet have the sufficient knowledge and skills to communicate with child survivors. Additional training and support should be provided and the CCS-CA should be re-administered again after further training. A capacity building plan should also be put into place. This may include one-on-one mentoring sessions, additional training opportunities, shadowing fellow staff members, among other capacity building activities.			Final Evaluation: _____ MET _____ PARTIALLY Met _____ UNMET		
OTHER OBSERVATIONS AND COMMENTS (here explain direct observation of the staff person that is important to include in the communication assessment). STAFF FURTHER CAPACITY BUILDING PLAN (if needed)					

SUPERVISOR SIGNATURE _____

STAFF SIGNATURE _____