Chapter Six
PSYCHOSOCIAL INTERVENTIONS FOR CHILD SURVIVORS

This chapter is for service providers providing case management and/or psychosocial services.

CONTENTS OF THIS CHAPTER INCLUDE

» Guidelines for conducting a child and family psychosocial needs assessment
» Guidelines for implementing psychosocial interventions for children and families

TOOLS IN THIS CHAPTER INCLUDE

» Child and Family Psychosocial Needs Assessment Tool
» Guidelines for Implementing Core Psychosocial Interventions
  - Healing Education for Children and/or Caregivers
  - Relaxation Training
  - Coping Skills Identification
  - Problem Solving

CHAPTER OVERVIEW

This chapter details how to conduct a more in-depth psychosocial assessment for children and families using the Child and Family Psychosocial Assessment tool, and outlines a set of direct psychosocial interventions that can be offered to children and families affected by sexual abuse.[73]

[73] Direct psychosocial interventions refer to "person-focused" interventions. This means the caseworker directly works with the child and/or family client to improve their functioning and well-being. Community based (e.g., referrals to child friendly centers) are not covered in this chapter.

Photo: UNICEF/ Jill Connelly/ Democratic Republic of the Congo, 2010

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INTEGRATING PSYCHOSOCIAL INTERVENTIONS INTO A CHILD AND FAMILY'S CARE AND TREATMENT

The psychosocial interventions described in this chapter are meant to be provided directly to the child (and family members as appropriate) and aim to help child survivors:

1. understand and manage reactions to the abuse;
2. develop skills for managing anxiety and stress;
3. learn new skills for coping with negative reactions, and;
4. acquire new skills for solving problems.

Some children experience more severe mental health problems as a result of sexual abuse and yet, mental health services are limited in humanitarian settings. This chapter does not provide instruction for how to deliver child mental health services for survivors of sexual abuse. However, the set of four psychosocial interventions described in this chapter can be used as a starting point to help children recover and contribute to their own healing in low-resource settings.[74]

[74] The psychosocial interventions presented in this chapter do not constitute a complete mental health intervention for children suffering from posttraumatic stress disorder, depression or other serious mental health diagnoses.

ASSESSING THE PSYCHOSOCIAL NEEDS OF CHILD SURVIVORS

As discussed in Chapter 5, sexually abused children generally have needs that fall into four categories: safety, health care, psychosocial support and justice/legal services. The standard case management approach focuses on the initial intake and assessment process to pinpoint these needs and on mobilizing intervention support to meet the most immediate needs. From there, caseworkers follow the steps of case management (developing and implementing the action plan, follow-up, and so on) until the child's state of security and well-being has been established.

For case management agencies that offer or would like to offer a set of psychosocial interventions to accompany standard case management, agencies can use a more comprehensive assessment tool to better understand the child's social and family environment, psychological well-being, and strengths to help determine appropriate psychosocial interventions. Caseworkers can integrate the additional psychosocial assessment into the child's care—likely during the "implement actions" step of case management–or when it is most appropriate to do so.

A psychosocial assessment in child sexual abuse cases requires that caseworkers evaluate broader areas and needs of the child and the child's family environment,[75] in addition to possibly gathering additional information about the abuse incident itself. Ideally, children are evaluated within the larger context of their family and community, as these factors always play a key role in the child's care and treatment plan and determine support for overall recovery. Below, a sample psychosocial assessment tool is introduced, along with instructions for caseworkers who can apply this tool to support a more complete psychosocial assessment of child survivors.

REMEMBER

An additional, and more specific, psychosocial assessment takes place only after the child's immediate health and safety needs have been addressed.

[75] Family is defined as a social system in which connected people interact with each other in an organized, predictable way. The process of defining family varies across cultures and should be adapted accordingly.

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KEY CONSIDERATIONS FOR CASEWORKERS BEFORE CONDUCTING THE PSYCHOSOCIAL ASSESSMENT

INVOLVING CAREGIVERS AND OTHER THIRD-PARTY SOURCES IN THE CHILD'S ASSESSMENT

Assessing children and family members affected by sexual abuse requires that information be gathered from the child, the non-offending caregivers and other trusted sources close to the child, as decided and determined by the child and caseworker. An important decision for caseworkers is whether—and how—to involve children's caregivers or other trusted adults, such as teachers, in any interview with a child. Analyzing who, if anyone, is best suited to participate in the child and family assessment depends on specific information likely to have been discovered during the initial stages of case management. For example, a caseworker might consider the presence of:

» A supportive, non-offending caregiver/parent.
» The person who referred the child for services, taking into consideration the person's relationship with the child.
» People identified by the child directly as trusting adults in the child's life, or people who spend significant time with the child.

As a general rule, psychosocial assessments can be conducted with children ages eight and above. Caseworkers must determine the capacity of children to participate on a case-by-case basis, taking into account their capacity to understand what is happening and their willingness to participate. Assessments involving children should ideally include information from other relevant people in the child's life, including parents, caregivers, siblings, neighbors and teachers. In order to talk with other people in the child's life, however, caseworkers must first discuss—and gain permission—from the child. As a general principle, caseworkers should include non-offending parents/caregivers in the child's treatment immediately, right from the very start of services, if appropriate. However, following the standard guidelines, caseworkers should not involve a parent/caregiver in the child's care and treatment if:

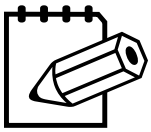
» The caregiver is the suspected/actual child abuser.
» The child does not want the caregiver included in the interview.
» The caseworker feels that the child cannot or will not speak freely.

DEVELOPING AN ASSESSMENT STRATEGY

Before starting the assessment interviews, caseworkers should think through an assessment strategy. This includes considering:

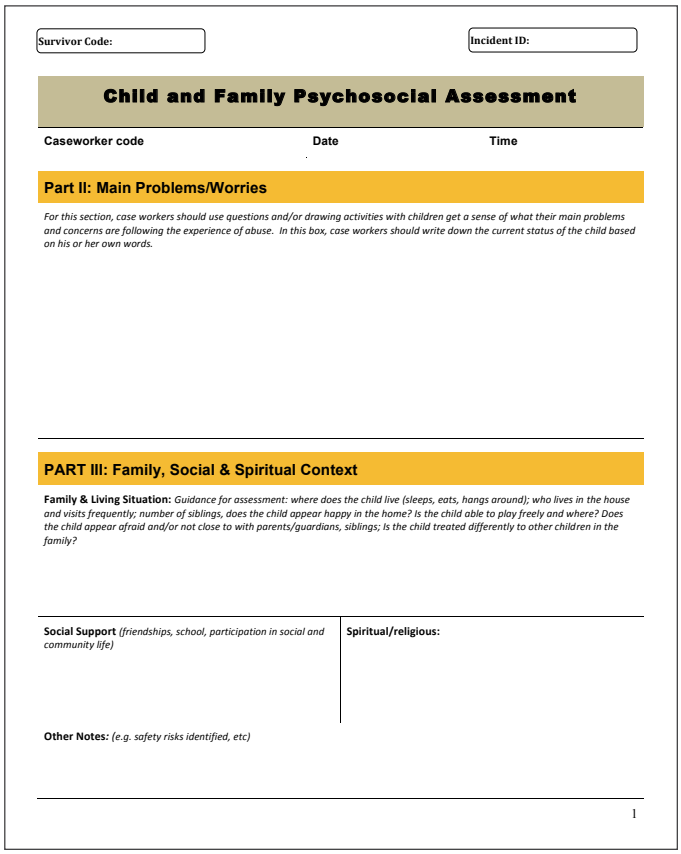
» How to structure the assessment (number of interviews, types of communication techniques, such as verbal and non-verbal games and activities, etc.).
» Who to include in the assessment (caregivers, parents, or other trusted adults).

CONDUCTING THE ASSESSMENT: USING THE CHILD AND FAMILY PSYCHOSOCIAL ASSESSMENT TOOL



The Child and Family Psychosocial Assessment helps caseworkers follow a systematic process for assessing children's and family's psychosocial needs. Structured psychosocial assessments provide caseworkers with a more complete picture of a child's family, home, community, school and individual context to better direct psychosocial support. The Child and Family Psychosocial Assessment Tool guides the caseworker to understand the child's situation in regard to:

full tool at end of chapter



Survivor Code:

Incident ID:

Child and Family Psychosocial Assessment

Caseworker code | Date | Time

Part II: Main Problems/Worries

For this section, case workers should use questions and/or drawing activities with children get a sense of what their main problems and concerns are following the experience of abuse. In this box, case workers should write down the current status of the child based on his or her own words.

PART III: Family, Social & Spiritual Context

Family & Living Situation: *Guidance for assessment: where does the child live (sleeps, eats, hangs around); who lives in the house and visits frequently; number of siblings, does the child appear happy in the home? Is the child able to play freely and where? Does the child appear afraid and/or not close to with parents/guardians, siblings; Is the child treated differently to other children in the family?*

Social Support *(friendships, school, participation in social and community life)*

Spiritual/religious:

Other Notes: *(e.g. safety risks identified, etc)*

1

» Home and social contexts, including an assessment of the parent/child relationship.
» Day-to-day well-being and functioning.
» Caregivers' feelings and beliefs toward the child and sexual abuse.
» Child and family strengths.
» Opportunity to assess further safety issues (as part of ongoing intervention).

USING THE CHILD AND FAMILY PSYCHOSOCIAL ASSESSMENT TOOL

The first step is filling out the administrative section (see pg 225 for full tool), which includes writing on the form the survivor's unique code and the incident number, which is developed from the agency's practice of assigning individual survivors with unique codes. In addition, the caseworker writes in their own personal caseworker code, the date and time of the assessment. Sometimes conducting a full assessment requires more than one meeting with a child. In this situation, the caseworker can record more than one date on the form.

Child and Family Psychosocial Assessment		
Caseworker code	**Date**	**Time**

ASSESSMENT AREA II: MAIN PROBLEMS OR WORRIES (FROM THE CHILD/CAREGIVER)

When conducting interviews with children, it can be helpful for caseworkers to use open-ended questions and ask them for their own perspectives on their lives. This allows children to share whatever is on their minds, rather than immediately asking them about specific aspects of their lives. Children should always feel they can share anything they want and on their own terms. Caseworkers need to assess all data that can help them understand what their child clients perceive to be the main worries or problems in their lives at any given moment.

To effectively dialogue with children in a way which will help them express themselves, caseworkers should draw upon the verbal and non-verbal techniques described in Chapter 3. For example, if the caseworker wants to know how the child is feeling or what the child's main worries are, he/she may want to ask the child to draw a picture to illustrate those feelings or worries. The caseworker can also ask the child to draw a picture of what a typical day looks like. It is important, however, that caseworkers always discuss these drawings with children to avoid inaccurate interpretations.

Caseworkers may want to find out from caregivers what they perceive as the main problems/concerns regarding their case/situation. If possible, assessing the child's main concerns/worries and assessing the caregiver's main concerns/worries should be done separately so both child and caregiver are able to share freely with the caseworker. In instances where the caseworker does not see a need to separate the child and caregiver, their perceptions can be assessed together. Caseworkers will want to pay close attention to whether the child's and caregiver's main concerns/worries are the same or different. If the concerns/worries are different, the

caseworker should discuss the child's concerns with the caregiver to promote communication and understanding between the child and caregiver.

The caseworker records what the child says during these conversations. In particular, the caseworker will focus on worries, problems and other current issues that the child raises. See the diagram below from the Child and Family Psychosocial Assessment form.

Part II: Main Problems/Worries
For this section, case workers should use questions and/or drawing activities with children get a sense of what their main problems and concerns are following the experience of abuse. In this box, case workers should write down the current status of the child based on his or her own words.

ASSESSMENT AREA III: FAMILY, SOCIAL AND SPIRITUAL CONTEXT

Gathering data on the child's family, social and spiritual situations and beliefs is important to understanding the broader context around the child. Children do not live in a vacuum; understanding their family and community environments is necessary to facilitate healing and recovery. Caseworkers should consider the following guidelines for assessing these areas of children's lives:

Family and Living Situation: The caseworker may already know where the child is living and with whom the child is living based on information gathered during the intake and initial assessment sessions. For the psychosocial assessment, caseworkers should focus on gathering specific data about a child's living situation (where does the child eat and sleep, how many people live in the home, etc.), as well as the child's "lived experience." For example:

» Who did the child trust the most in the family before the abuse happened? Who does the child trust after the abuse? Is the child happy at home? Does the child have basic needs met (food, clothing, education, protection)? Is the child treated differently from other children in the family? Is the child able to play freely?

This information helps the caseworker better understand the child in his/her family context, thus enabling the caseworker to direct psychosocial support.

Social/Spiritual Support: A child's social support, which may include family members, is a key area for assessment. Children recover from sexual abuse best when they have social support and are able to resume activities that are developmentally appropriate. Caseworkers should identify, strengthen and build upon areas where children's social support has diminished (lack of friends, failure to attend school, etc.). Caseworkers should also assess children's religious and spiritual beliefs/practices, including the possibility of identifying influential religious teachers or leaders to play a role in the child's recovery.

Based on the information gathered in this section, the caseworker records important details and facts in **Part III: Family, Social and Spiritual Context,** of the assessment tool. In addition, in the section **Other Notes**, the caseworker can record additional details that are important but not specific to the family, social and spiritual contexts.

PART III: Family, Social & Spiritual Context	
Family & Living Situation: *Guidance for assessment: where does the child live (sleeps, eats, hangs around); who lives in the house and visits frequently; number of siblings, does the child appear happy in the home? Is the child able to play freely and where? Does the child appear afraid and/or not close to with parents/guardians, siblings; Is the child treated differently to other children in the family?*	
Social Support *(friendships, school, participation in social and community life)*	**Spiritual/religious:**
Other Notes: *(e.g. safety risks identified, etc)*	

ASSESSMENT AREA IV: OVERALL FUNCTIONING ASSESSMENT

Most children know sexual abuse is wrong. They usually have feelings of fear, shock, anger and disgust. However, a small number of abused children may not realize sexual abuse is wrong. These children might be very young or have mental challenges.

Children who have been sexually abused often show signs of emotional and psychological distress. Children may behave in nervous or upset ways. Children may have bad dreams. Children may appear anxious and worried. Children, especially boys, might "act out" with behavior problems, for example, fighting more often with people. Other children "act in" by becoming

depressed. They may withdraw from friends or family. Older children or teens might try to hurt or even kill themselves.

Conducting a basic assessment of children's functioning (by looking at children's behaviors, feelings and expressions of somatic or "physical" complaints) helps the caseworker identify changes that may have occurred since the instance of sexual abuse and/or disclosure.

PART IV: Child Functioning Assessment			
DIRECTIONS: The caseworker should ask the child survivor these questions in a private, confidential room. Say: I'm going to read some sentences. Please tell me how TRUE these sentences are about you. Think about how true these things are since _____ [describe abusive event…e.g., you were raped]			
There can only be the X mark in one column.	**YES**	**NO**	**COMMENTS**
1. I don't see my friends as much as I used to.			
2. I have stopped my daily activity (e.g. school).			
3. I am having fights with people more than I used to.			
4. I am having a hard time going to sleep or staying asleep.			
5. I am having body aches, stomachache, headache or other aches.			
6. I worry that something bad is going to happen.			
7. I am feeling sad and hopeless.			

ASSESSMENT AREA V: CAREGIVERS'/PARENTS' FEELINGS AND BELIEFS

If possible, caseworkers should assess caregivers' feelings, beliefs and perceptions about their child's sexual abuse. Understanding the caregivers' perspectives provides insight into the support (or lack of support) they are providing and/or can provide to their child. It is extremely important for caseworkers to assess accurately how caregivers behave toward the child, based on their perceptions and beliefs surrounding the abuse, as this will be an important part of the overall child and family treatment planning.

Assessing caregivers' perceptions requires special precautions to ensure child survivors are not inadvertently exposed to negative feelings or perceptions. For example, it is possible that caregivers blame their child or say negative things during this part of the assessment. Therefore, the caseworker should assess caregivers in private (not in front of the child). This allows the

parents/caregivers to share freely their concerns, in a space that is private and safe. The child should be told why their caregivers are being interviewed separately.

Caseworkers should ask the caregivers a series of questions and also allow them to share their views, opinions and/or questions freely. The questions should focus on the caregivers' perceptions and how they relate to the child. The key questions are:

- **What is your understanding of the abuse/what happened?** This question helps the caseworker understand how much the caregiver knows and understands about what happened. The caseworker should watch out for statements of blame directed toward the child.
- **What are your feelings about the abuse/situation?** This question explicitly asks caregivers what their feelings are about the sexual abuse. Here the caseworker should attempt to evaluate the caregivers' own level of emotional distress and their feelings toward their child. Caseworkers should ask whether caregivers' feelings have changed toward their child since the abuse.
- **What changes have you noticed in your child since the abuse?** Oftentimes, reports of children's emotional distress come from adults in the child's life who notice behavior changes. This question also provides caseworkers with more information about the caregivers' perspectives on their child.
- **What do you think will help your child right now?** Identifying what caregivers think is useful and important to help their children heal and recover. Supportive caregivers know their children well and their ideas about how to support their children's healing should be asked and integrated into psychosocial care plans.
- **What are your main worries and needs right now?** This question provides an opportunity for caregivers to share their personal worries and fears while alerting the caseworker to additional needs/worries that may impact the child.

Based on the information gathered in this section, the caseworker records answers in the "comments/responses" box in Part V: Caregiver Assessment of the tool. If the caregiver does not answer a question, the caseworker can write "cannot assess," with an explanation.

PART V: Caregiver Assessment (if possible)	
What is your understanding about the abuse and what happened?	
What are your feelings about the abuse and what happened?	
What changes have you noticed with your child since the abuse?	
What do you think will help your child right now?	
What are your main worries and needs right now?	

ASSESSMENT AREA VI: CHILD AND FAMILY STRENGTHS (ALSO CALLED 'RESILIENCIES')

Children and families are resilient. The majority of abused children will cope and recover with good care and support. Children's strengths or "resiliencies" support their natural capacity to heal from difficult experiences. It is the job of caseworkers to help children identify their strong points and identify aspects of life that fill them with hope.

HOW TO ASSESS CHILDREN'S STRENGTHS

Caseworkers should help children identify their own strengths, such as:

- **Their courage.** Children are strong and brave for telling other people their stories of abuse. Caseworkers should emphasize this and ask children for other examples of facing their fears. Additional examples provide more concrete data for children to recognize their bravery.
- **Their positive personality characteristics.** Perhaps a child is funny, smart, talkative, curious, polite or shows other positive characteristics. Caseworkers should talk with children about ways they can use humor/intellect/curiosity to excel in school and life in general.
- **Their pride.** Asking children what they are proud of or what makes them feel good helps to identify inner or unrecognized strengths (such as attending school, being able to make a dress, etc.). Questions such as, "With all that has happened, what makes you smile, even just a

RESILIENCIES ARE

the mechanisms that help individuals, families and communities endure and recover from adversities. Resilience results from individual characteristics, coping mechanisms (innate and acquired) and the protective factors in a child or youth's environment.

little?" can help children identify aspects of their lives that give them hope. If a child cannot identify a strength or area of pride, the caseworker should reinforce those he/she has identified in the child.

HOW TO ASSESS CAREGIVER/FAMILY STRENGTHS

Caseworkers can also identify strengths of caregivers/family during the assessment process. Caregiver strengths include, but are not limited to, the following:

- Supporting their child.
- Advocating for their child's care.
- Protecting their child and reaching out to caseworkers.
- Handling family problems.
- Encouraging hopes and dreams.

Child sexual abuse has an impact on caregivers as well. Caregivers may feel upset, scared, or guilty because they could not protect their child. It is important for caseworkers to help caregivers identify their own strengths and explore examples where they did the right thing. Areas for caseworkers to assess are:

- **Attachment to child**. A strong and positive attachment to their child is a very important family strength. Strong and supportive attachments between caregivers and the child are vital to the child's healing from sexual-abuse-related trauma.
- **Family capacities, hopes and dreams.** Learning how caregivers traditionally solve problems, and what their hopes, dreams and other capacities are (such as friends, faith, nonviolent home, etc.) can help caseworkers pinpoint positive traits to include in the child's psychosocial support action plan.
- **Social support**. The family's connectedness to their community and social support network are important strengths.
- **Jobs and financial assets.** Having a job and income and using family money appropriately are also important strengths.

Child Strengths/Protective Factors (things the child enjoys going, positive relationships to caregivers, people they trust and who support them, able to solve problems, feel hopeful, laugh, etc	**Caregiver & Family Strengths/Protective Factors** (strong and positive relationship with their child, other family members; able to cope with stress; social and community support; job/income)

Photo: Aubrey Wade/the IRC

CHILD AND FAMILY PSYCHOSOCIAL EVALUATION AND INTERVENTION PLANNING

In many settings, more advanced psychosocial and mental health services will not be available to address the specific emotional and psychological distress that many children and families experience following the disclosure of sexual abuse. Despite this, there are common and effective interventions that caseworkers can provide to help children with the psychosocial difficulties discovered during the assessment process.

Following the assessment interview, the caseworker will analyze the information and choose psychosocial interventions as described below, based on the main problems identified. Staff should be trained to provide basic yet effective psychosocial interventions for child survivors, and build these interventions into existing case management and psychosocial care delivery.

Most of these interventions will happen with children in one-on-one sessions. One-on-one sessions between a caseworker and child survivor provide children with structure (for example, they meet their caseworker each week) and a safe space to express their feelings related to the abuse. They allow children a chance to begin to process traumatic events.

If children present no psychosocial problems or needs, they should be offered the opportunity to participate in education sessions that help them learn relaxation techniques and other skills.

6 PSYCHOSOCIAL INTERVENTIONS FOR CHILD SURVIVORS

SET OF CORE PSYCHOSOCIAL INTERVENTIONS FOR SEXUAL ABUSE

The following psychosocial interventions can be applied in cases of child sexual abuse. In addition, healing education and relaxation training can be helpful for child clients even if they do not express psychosocial difficulties following sexual abuse. The psychosocial interventions include:

INTERVENTION 1: PROVIDING HEALING EDUCATION

Providing children and families with accurate information about sexual abuse helps them understand and manage the impact of abuse. The intervention aims to:

a. Provide children and caregivers with an accurate understanding of sexual abuse and its associated impacts.

b. Ensure that children and caregivers can identify signs and symptoms of trauma.

INTERVENTION 2: RELAXATION TRAINING

Children often experience anxiety and/or psychosomatic complaints (racing heart, sweating, shaking) that result from anxiety and stress. Teaching skills for managing anxiety can help children feel more in control of their bodies and calm their minds. This intervention aims to:

a. Ensure that children and caregivers sleep and eat regularly.

b. Ensure that children and caregivers manage stress-related symptoms on their own.

INTERVENTION 3: TEACHING COPING SKILLS

Children may have negative feelings after sexual abuse. Coping skills help children learn to help themselves. This intervention aims to:

a. Help children recognize their feelings, positive and negative.

b. Help children increase their capacity to cope with difficult emotions.

INTERVENTION 4: PROBLEM SOLVING

Children have ideas and knowledge about how to solve their problems. Caseworkers can help children develop "problem solving plans" to address their main problems. This intervention aims to:

a. Teach children and caregivers to identify everyday problems.

b. Empower children and caregivers to think through solutions to their day-to-day problems.

Evaluating the Assessment: Developing the Psychosocial Action Plan

Once the psychosocial assessment is complete, the caseworker evaluates the information gathered using **Part VII: Psychosocial Assessment and Action Plan** of the Child and Family Psychosocial Assessment Tool (see below).

The main assessment areas are described at left side on the table on the following page. The outcome (yes/no) will help the caseworker determine which psychosocial interventions are appropriate.

Note: Specific directions on carrying out the individual interventions (e.g., problem solving, healing education, relaxation training and coping skills) are described in-depth in the next section.

PART VII: Psychosocial Evaluation & Action Planning *(for the caseworker to complete only)*				
Assessment Questions	**Yes**	**No**	**N/A**	**Action Plan for Intervention** (include, what is the action, who is responsible and timeframe)
1. Did the child report having problems functioning (See functioning items 1-3). If yes: interventions required: 1. Problem solving 2. Healing education 3. Relaxation training				
2. Did the child report feeling anxious or worried (See Functioning items 4-6). If yes: interventions required: 1. Relaxation training 2. Healing education Problem solving (if needed)				
3. Did the child report having negative feelings (See Functioning items 7-8). If yes: interventions required: 1. 3-Step Coping 2. Healing education 3. Relaxation training				

In addition, the caseworker will document the child and family strengths identified during the assessment and describe how these strengths can be brought into the child's psychosocial care plan.

List the strengths (child and family) that can support the child's healing. (school, activities, sense of humor, etc).

Lastly, the caseworker will list additional areas (e.g., child's legal status, family economic issues, school and housing situation) that require intervention either in the form of a referral or through direct action by the caseworker, child and/or caregiver.

Other areas of need identified during the assessment that require intervention (direct and/or referral) *(if not addressed above)*	
Identified Need:	**Action Plan** (include what action, who will do what, and timeframe).

When the assessment and psychosocial support plan is in place, the caseworker, child client, and caregiver (if needed) must schedule the appropriate follow-up appointments.

Next Follow Up Appointment scheduled for (date/time)_____

CHILD AND FAMILY PSYCHOSOCIAL ASSESSMENT CHECKLIST

In cases of child sexual abuse, have the following areas been assessed?

- ❑ Child's expression of needs/problems.
- ❑ Family, social and spiritual context.
- ❑ Child functioning assessment.
- ❑ Caregiver's beliefs/perceptions.
- ❑ Child and family strengths.
- ❑ Additional concerns (safety or other).

The evaluation and intervention planning takes place after the assessment.

HELPFUL TIP

Caseworkers should always remain alert to possible safety risks and concerns that emerge during assessment interviews. Safety issues should be a priority in the child's case action plan.

6 PSYCHOSOCIAL INTERVENTIONS FOR CHILD SURVIVORS

GUIDELINES FOR IMPLEMENTING CORE PSYCHOSOCIAL INTERVENTIONS

Please note: Staff providing psychosocial interventions with children affected by sexual abuse must first be trained in child sexual abuse case management and communication techniques.

INTERVENTION 1: CHILD SEXUAL ABUSE HEALING EDUCATION[76]

WHAT IS CHILD SEXUAL ABUSE HEALING EDUCATION?[77]

Child survivors of sexual abuse need ongoing psychosocial support throughout their case management. Providing information about sexual abuse to children and family members helps them understand the impact of sexual abuse. Children and families learn how to stay safer in the future and how to cope with emotional and physical reactions provoked by abuse. Knowledge empowers children, and helps survivors and family members heal. When a caseworker provides specific, accurate information about sexual abuse and related topics to child clients and family members, this is called healing education. The caseworker's technical knowledge about child sexual abuse (as outlined in Chapter 1) is key to providing high quality psychosocial interventions to children and families, due to the importance of education and correcting false information about child sexual abuse.

Healing education focuses specifically on improving children's and families' functioning abilities to cope with the experience of sexual abuse. Healing education provides additional information (beyond health, safety, legal and psychosocial referral options) intended for children and families affected by sexual abuse, such as: 1) the facts about sexual abuse, to increase the child's sense of understanding of what they experienced; 2) how to stay safe in the future; and 3) how coping and relaxation skills can help children reduce psychosomatic symptoms related to abuse. In addition, there are special healing education sessions for caregivers only, intended to help caregivers provide the best support to children affected by abuse.

[76] Much of the text in the sample scripts and the guidelines for the interventions is taken directly from the evidenced-based model, Trauma Focused Cognitive Behavioral Therapy. http://tfcbt.musc.edu/

[77] The technical term for this is psychoeducation. However, the CCS Initiative prefers the term healing education as it translates more easily in multiple language and settings, as evidenced by the CCS pilots in Thailand and Ethiopia.

WHAT ARE THE TOPICS?

Healing education for children and families can be divided into three categories:

» **Topic 1.** About Sexual Abuse: What Every Child and Caregiver Should Know.
» **Topic 2.** Staying Safe! Body Safety and Safety Planning.
» **Topic 3.** Caregiver Session: Caregiver's Role in the Child's Healing Process.

For caseworkers providing healing education, tips and guidelines for providing healing education sessions are provided below. Remember, the way this information is shared and communicated will need to be adapted based on a child's age and cultural context. Healing education aims to correct false beliefs about sexual abuse, which can lead to blaming the child for the abuse and can often cause further harm to the child survivor. It is recommended that methods for providing healing education for children and families be adapted to the local culture to ensure information is relayed in the most culturally appropriate way possible.

HOW TO PROVIDE HEALING EDUCATION

STEP 1

MAKE AN APPOINTMENT WITH THE CHILD (AND CAREGIVER IF APPROPRIATE)

Caseworkers should ask the child and caregiver if they are willing and interested to participate in a special healing education session. The caseworkers should explain that they would like to share information with the child and caregiver that can help them understand and manage what has happened. Caseworkers should note that the session will take place in a private space and will last no longer than one hour.

How much time a caseworker will have to educate and work with a child and caregiver will depend upon their relationship, the family's willingness to engage, and the context of the situation. Caseworkers will need to work with their supervisor to find ways to structure and deliver the education sessions that cover key information.

STEP 2

CONDUCT THE SESSIONS

As mentioned above, caseworkers will need to determine how many special sessions they can schedule with their clients based upon their relationships and the opportunities for follow-up appointments. If there are opportunities for the caseworker to meet regularly with the child client, he/she should aim to schedule at least three sessions to provide healing education and

support. If the caseworker can plan only one session, then he/she will want to cover as much information as possible with the child and caregiver.

THE FIRST HEALING EDUCATION SESSION

During the first healing education session with the child and caregiver, the caseworker should cover information included in Topic 1: About Sexual Abuse: What Every Child and Caregiver Should Know, and if there is time, Topic 2: Body Safety and Safety Planning.[78]

TOPIC 1: ABOUT SEXUAL ABUSE: WHAT EVERY CHILD AND CAREGVIER SHOULD KNOW

Children and caregivers need to have accurate facts about child sexual abuse. Caseworkers should always explain that child sexual abuse is not the child's fault and he/she is not to blame. Indeed, understanding sexual abuse is important for the child's and family's healing and recovery process. This is why we start with facts about sexual abuse when providing healing education to children and families. The key facts and information to cover in the first session include:

a. Explanation of what child sexual abuse is.
b. Why it happens and who perpetuates it.
c. How children may feel after sexual abuse (common reactions).
d. Children's tendency to remain silent about abuse (especially important for caregivers).

a. What Is Sexual Abuse: Key Information in Appropriate Language

- Child sexual abuse is when an adult or someone older than you touches or rubs your private parts or makes you engage in sexual activity or witness sexual acts. Sometimes the older person asks you to touch his private parts. Sexual abuse is also when someone talks sexually to you, makes you watch sexual videos or look at sexual pictures, or does sexual things in front of you.
- Sexual abuse is always wrong, and it's always the perpetrator's fault.
- **Note:** This information section should be adapted to include information specific to the local context.

b. Why Sexual Abuse Happens and Who Perpetrates Abuse: Key Information in Simple Language

- Sexual abuse happens to a lot of children. It happens to boys and girls of all different ages. It doesn't matter whether you're rich or poor—sexual abuse happens to lots of different kids all around the world.

[78] These topics can be separated into two sessions if needed.

- The important thing to remember is that being sexually abused is not your fault; it's not about what you look like or anything that you did.
- The perpetrator can be someone you know, like your relative or a close family friend. Or, the perpetrator could be a complete stranger.
- Most of the time, children are sexually abused by someone they know and trust.

c. How Children May Feel After Abuse, Common Reactions: Key Information in Simple Language

- Children have many different feelings when they are sexually abused and after sexual abuse. The different feelings can be hard to understand. It's ok for children to have lots of different feelings about the abuse.
- Some children feel really mad at the person or afraid of him. Some children feel sad and don't want to talk to anyone. Some children even feel guilty about what happened.
- All these feelings are okay and common.
- Sometimes these feelings can affect how kids behave. Some children feel scared after being abused, and don't want to sleep alone or don't like to be alone.
- Some kids feel mad a lot and they get into lots of fights. Some kids feel real sad and just want to cry all the time.
- It really helps to talk about all of these feelings.

d. Why Children Don't Tell: Key Information, Especially for Caregivers/Parents

- There are lots of reasons why children don't tell an adult when they have been abused.
- Sometimes, the person who did the abuse tells the child that it's 'a secret,' and that they shouldn't tell anybody.
- Sometimes the person makes threats and says things like 'if you tell anyone, I'll hurt you, or I'll hurt your family.
- The person who hurt your child may even tell your child that no-one will believe them if they tell.
- Sometimes, kids don't tell because they're ashamed or embarrassed or afraid that they'll get in trouble.
- It's important for you to understand what happened is not your child's fault. Your child needs support and acceptance from you.
- You may have many feelings about your child being sexually abused. We can talk about your feelings and how to support you as well.

TOPIC 2: BODY SAFETY AND SAFETY PLANNING

In addition to regular and consistent safety assessments, caseworkers should have a separate session with children and caregivers on body safety and safety planning. Children need to have the communication skills and the confidence to respond to potentially abusive or traumatic experiences. While personal safety skills training does not guarantee the child will be 100% safe, it may help children feel more control and confidence to respond to threats when they occur. Key information to cover in the staying safe session:

a. Be attentive and knowledgeable.
b. Be cautious and prepared.
c. Be assertive!

a. Be Attentive and Knowledgeable

Caseworkers will need to teach children about possible dangers in their environment and help them pay attention to their intuitions. It is helpful if children can recognize danger signs that indicate heightened risk, and to have children rehearse how they might respond to danger. These discussions may also have taken place in the standard case management.

b. Be Cautious and Prepared

As part of overall safety education, caseworkers talk with children about what to do if/when they feel unsafe. Have children practice proper responses to danger or potential violence through role playing, etc. This can help increase the child's self-confidence and efficacy in handling a potential threat. When teaching a child about safety planning, caseworkers should discuss the following:

- Help the child name some adults that make him/her feel safe (If the child is having difficulty, the caseworker can ask about specific people, such as a teacher, a caregiver, a sibling, a friend). Once the safe people are identified, the caseworker can encourage the child to tell them if they feel worried or unsafe (as part of safety planning, these people should be involved/included in a session to formerly acknowledge them as "safe people" in the child's life).
- Help the child name places that make them feel safe, especially those places they would go if they didn't feel safe at home.
- Map out a plan with the child and practice how the child would respond if he/she felt unsafe. What would he do? What would he say? It is important to have children practice saying "No!" to an adult who is doing anything to make them feel uncomfortable. Role playing is very useful to help children practice saying "No."

Photo: Gina Bramucci/the IRC

c. Be Assertive

This education should start with a review about what is okay and NOT okay touching. Children should practice what they would do if they experience NOT okay touching. It is helpful to explain to the child the following points:

- Nobody should touch your private parts in a sexual way; even if it is someone you know and love.
- If you feel funny, strange or uncomfortable about the way someone's touching you, you should tell that person, "NO!"
- Give children techniques (run, hide, ask for help, call out, scream) to use in response to inappropriate touching or behaviors. Make sure to help the child identify a trusted adult whom he/she can confide in if anyone threatens them again.
- During this session, it is important for the caseworker to help develop the child's confidence and skill in protecting their bodies. As part of this, it is good to review the safety plan that was created with the child during case management services.

HELPFUL TIP

Be wary of sending the message that if abuse happens again it is the child's fault. Sexual abuse is always the fault of the perpetrator, and children who have been taught how to better protect their bodies may still experience abuse. This is NOT BECAUSE the child was unassertive or ill-prepared enough to protect themselves. It is because the perpetrator has more power over the child and the child is in no way responsible for any abuse.

TOPIC 3 (CAREGIVER SESSION): CAREGIVER'S ROLE IN CHILDREN'S HEALING PROCESS

Caregivers and parents play an essential role in children's healing. In fact, healing is facilitated when children are supported by friends and family in their home and community environment. Caseworkers should organize a caregiver session to allow caregivers a chance to share their understanding and feelings about sexual abuse. Caregivers are under a lot of stress after sexual abuse occurs. They may feel guilty for a variety of reasons, such as: not protecting the child; anger because they feel the child has brought them shame; anger at the perpetrator; confusion about what to do next; and many other tumultuous emotions.

During the caregiver session, caseworkers should allow caregivers to express their feelings and voice their concerns without judgment. However, caseworkers should challenge caregivers if they appear to blame the child for the abuse or if they take judgmental attitudes toward the child. Key topics to cover during the session include:

a. The role of caregivers in children's healing.
b. What caregivers should watch for and how they can help.
c. The care services available for the caregiver.

a. Role of the caregiver in children's healing

- Caregivers play an essential role in children's healing. Many children more easily recover from the impacts of sexual abuse when they have support from their mothers, fathers and families.
- Caregivers need to encourage the whole family to lend support to the child. The family should treat the child with compassion and make the child feel loved.
- Children should continue to go to school, play and "be children" after sexual abuse. Sexual abuse should not prevent the child from continuing to develop and engage in child appropriate activities.

b. What to watch for and how to help

- If the caregiver notices their child is behaving differently (for example, refusing to go to school, to see friends, or other changing behaviors) they should talk to their child and, if appropriate, seek help.
- Caregivers can help children by not blaming them for the abuse, making them feel comfortable and happy at home, and allowing them time and space to come to terms with the experience in their own way.
- Caregivers should protect the child and make sure they will not be harmed by the perpetrator or anyone else.
- Caregivers should encourage their child to go back to school and resume daily activities.
- Caregivers should not discuss the abuse with neighbors or other people. Caregivers should not discuss the child's sexual abuse in front of the child (unless the best interest of the child indicates that the caregivers talk about the abuse with a medical doctor, legal counselor or caseworker.
- Caregivers should always reinforce that sexual abuse is always wrong, and always the perpetrator's fault.

c. Care for the caregiver

Caregivers, especially if they are mothers, may blame themselves for the sexual abuse. Caseworkers will need to encourage mothers and not blame them for the sexual abuse.

- Caregivers may also experience strong reactions after sexual abuse happens in their family. They may feel sad, angry, depressed, scared or confused. This is okay. It is normal for people affected by sexual abuse to experience these emotions.
- Caregivers may blame themselves for the abuse. But sexual abuse is ALWAYS the fault of the perpetrator. It is not the child's fault and it is not the caregiver's fault.
- Caregivers should talk to friends or other trusted people if they are having a hard time doing their daily work because of their reactions to the sexual abuse.
- Caregivers should have free access to the caseworker to discuss their feelings about their child's sexual abuse and to find better ways to cope with the impact of the abuse.

HELPFUL TIPS FOR CASEWORKERS

During the session: The caseworker must be certain to listen carefully to the thoughts and feelings expressed by the child and caregivers. During the process of educating children and families, the caseworker may hear parents make statements that may be harmful for children to hear. The caseworker will need to address any beliefs that are potentially harmful for children or these judgments could serve as obstacles in the healing process (for example, if the caretaker appears to blame the child for the abuse and misdirects anger toward the child.

During the session: Always adapt communication techniques (and to some extent the information shared) to the child's age and developmental level. Information should be geared to the child's level of understanding. For example, with younger children, basic information should be provided through drawings, play and role playing. For older children, written materials are useful. This gives them the opportunity to understand things on their own and then ask questions to engage in dialogue.

During the session: Try to include supportive caregivers. Supportive caregivers and children should be provided healing education together so long as the child is comfortable and the caregiver is committed to the child. Having children and caregivers together allows the caseworker to address any misconceptions either the child or caregiver has about the sexual abuse and creates an opportunity for the caseworker to state openly to both the child and caregiver/parent that the abuse is not the fault of the child.

If the caregiver becomes angry: If caregivers begin to blame the child during the session, the caseworker should politely ask them to leave. It is not good to continue a session with a child if caregivers are unable to control their feelings and reactions. The caseworker can work with the caregiver separately in a caregiver session. While anger is a normal human emotion and may be important to the caregiver's healing process, the caseworker and caregivers should work together to manage the caregiver's anger, especially in front of the child.

Ending the session: Before the session is finished, caseworkers should review the information they have discussed with the child and caregiver. The caseworker should ask both parties what they believe has been most helpful in the session. It is also important for the caseworker to ask the child and the caregiver if they have any questions about the information provided during the session. Before the child and the caregiver leave, offer them the chance to join another education session the following week, if appropriate.

INTERVENTION 2: RELAXATION TRAINING[79]

Caseworkers can teach children new ways to cope with stress and reduce physiological symptoms such as racing or pounding heart, difficulty sleeping or concentrating, anger, anxiety, etc. Research suggests children tend to express stress in physical ways. For example, children can report physical symptoms (e.g., headaches, stomachaches, nausea, nondescript aches and pains) when they are experiencing emotional stress. This does not mean that their physical symptoms are not real; they are very real. Children can benefit from understanding the link between emotional stress and its impact on the body. By learning techniques to relax the body, children can gain tools to help reduce their physical symptoms.

This section will introduce two relaxation techniques that caseworkers can teach children and caregivers. Please note that these techniques may not work for all children. It is recommended that social service providers determine what local activities can be promoted to help children relax. Samples can be saying a prayer; watching a candle flicker; dancing and singing; and/or any other technique that can help a child relax his/her body and mind. The relaxation techniques described in this section are:

» Controlled "belly breathing."
» Body relaxation.

RELAXATION TECHNIQUE: CONTROLLED BELLY BREATHING

Controlling our breathing is a useful technique to help children and adults manage anxiety and stress. It's usually taught to help children cope with stressful thoughts and situations that are likely to occur as a result of being abused. The goal of controlled breathing is to have children focus on their breathing so that they breathe deeply and slowly. Breathing in this manner tends to relax their physical body. Controlled breathing teaches several lessons. First, children learn that they can control some of their automatic functions. They also learn that they can eliminate or reduce feelings of tension or anxiety. Finally, they learn that by concentrating on their breathing patterns, they can distract themselves from unpleasant thoughts or images. One advantage of a tool like controlled breathing is that caseworkers can demonstrate it to children and can also monitor closely their progress in using the strategy correctly. When teaching controlled breathing to children, the following steps should be taken:

[79] Much of the text and interventions in this section comes from the Trauma Focused Cognitive Behavioral Therapy model developed for child survivors of sexual abuse. For more information, please go to: http://tfcbt.musc.edu/modules/breathing/technique/index.php?f=4.

STEP 1

EXPLAIN THE BELLY BREATHING TECHNIQUE.

Caseworkers will need to explain to the child why they should learn a breathing technique. A sample script could be:

SAMPLE SCRIPT

"Today we're going to learn one way to help ourselves calm down and control our nervousness and upset feelings. I'm going to show you a breathing activity that can help you calm your mind and your body. When we get upset, we tend to breathe faster and not as deeply. This does not allow enough air into our lungs, which can make our body feel out of control. Doing this breathing exercise when you are upset will help you get more air into your lungs. Controlling your breathing will help your body and mind relax. It's also something you can do anytime and anywhere. When you get good at it, we will also show your caregiver how to do it, too."

STEP 2

DEMONSTRATE THE BELLY BREATHING TECHNIQUE.

Caseworkers should show the child how to breathe in and out slowly. The directions for controlled breathing are:

» Get into a comfortable position (either lying down or sitting comfortably in a chair).
» Concentrate on breathing, inhaling and exhaling through the nose. One hand should be on the stomach and one hand on the chest. When inhaling, the hand on the stomach should move up, and when exhaling it should move down. The hand on the chest should stay still and not move the whole time.

STEP 3

HAVE THE CHILD PRACTICE BELLY BREATHING.

» Some children might like to lie on the floor with a small toy or object on their belly. With each breath, the object should move up and down.

» Be sure to praise the child as he/she practices the technique. Once the child has tried a few breaths, instruct the child to breathe more slowly on the exhalations than on the inhalations. It can help to count during breaths, by saying the following:

- "First take slow deep breaths in through your nose. Count in 1…2…3 and watch your stomach, not your shoulders, rise. Then breathe out 1…2…3…4…5 and watch your stomach fall."

» Once the child is able to get into a breathing rhythm, have him/her choose a word to say silently while they exhale. Good examples are "calm" or "relax." Instruct the child to try to think only about their breathing and this word. As other thoughts come into his/her head, the child should try to picture them floating away.

» **Give homework!** Ask the child to practice controlled breathing every day, for 10 minutes. Children can practice while they are falling asleep at night or at another time that is right for them. Older children can record these home practices on a form and discuss later with the caseworker. The caseworker should help the child decide when/where the homework will be done, trying to identify likely barriers to practicing on their own. Initially, the practice sessions should be done when the child is calm and can concentrate, not at times of stress and anxiety.

HELPFUL TIP: INCLUDE THE CAREGIVERS/PARENTS

Parents can be taught controlled belly breathing in order to help their children learn and practice these skills at home. In addition, parents often benefit from these skills themselves, given the high levels of stress they may be experiencing. The same controlled breathing technique taught to the child can be taught to the parent. To help reinforce the skill, children can be involved in teaching their parents the technique in session.

6 PSYCHOSOCIAL INTERVENTIONS FOR CHILD SURVIVORS

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RELAXATION TOOL: BODY RELAXATION

Children and adults can use this tool as a way to relax their bodies and decrease muscle tension. This is helpful for children and adults who have trouble falling asleep or who have physical symptoms of anxiety. Body relaxation is usually taught by having people alternate between tensing and relaxing their muscles. Focusing on this difference teaches children how to recognize tense feelings and neutralize them. There are many ways to teach children relaxation skills, some of which depend on the child's age. This section will explain some of them, but caseworkers should always feel free to be creative when helping children learn to relax. Games, dance, music and other activities can be used to teach the technique.

STEP 1

EXPLAIN BODY RELAXATION.

Caseworkers will need to explain what body relaxation is and why it is important. A sample script could be:

SAMPLE SCRIPT

"Sometimes we all feel a little scared or nervous. When we have these feelings, our bodies can get tense or tight. This is an uncomfortable feeling; sometimes it even hurts. To help get rid of these tense feelings, we're going to help you learn to relax your body. This can help you feel looser and calmer."

STEP 2

LEAD THE CHILD THROUGH BODY RELAXATION EXERCISE.

Caseworkers should be trained in (and know how to practice) body relaxation to make sure they can demonstrate it effectively. Caseworkers can guide children in body relaxation techniques by following these directions:

1. Have the child sit in a comfortable position. Lying down is okay, too. The child should get as comfortable as possible. Have the child close their eyes if they would like.
2. Tell the child, "Take a deep breath in and out through your nose. Do this again. What you'll be doing is tightening and relaxing specific muscles in your body. Concentrate on how your muscles feel, specifically the difference between tight and relaxed. After tightening, a muscle will feel more relaxed."
3. Here is sample script to read to the child:

"First concentrate on the large muscles of your legs. Tighten all the muscles of your legs. Feel how tight and tense the muscles in your legs are right now. Hold it for a few moments more...and now relax. Let all the tension go. Feel the muscles in your legs going limp, loose and relaxed. Notice how relaxed the muscles feel now. Do you feel the difference between tension and relaxation? Enjoy the pleasant feeling of relaxation in your legs.

Now focus on the muscles in your arms. Tighten your shoulders, upper arms, lower arms, and hands. Squeeze your hands into tight fists. Make the muscles in your arms and hands as tense as you can. Squeeze harder...and harder…hold the tension in your arms, shoulders, and hands. Feel the tension in these muscles. Hold it for a few moments more…and now release. Let the muscles of your shoulders, arms and hands go limp. Feel the relaxation as your shoulders lower into a comfortable position and your hands relax at your sides. Allow the muscles in your arms to relax completely.

Focus again on your breathing—slow, even, regular breaths. Breathe in and relax. Breathe out the tension. Breathe in and relax. Breathe out the tension. Continue to breathe slowly, in and out.

Now tighten the muscles of your back. Pull your shoulders back and tense the muscles along your spine. Arch your back slightly as you tighten these muscles. Hold…and relax. Let go of all the tension. Feel your back comfortably relaxing into a good and healthy posture.

Turn your attention now to the muscles of your chest and stomach. Tighten and tense these muscles. Tighten them further...hold this tension…and release. Relax the muscles of your chest and stomach.

Finally, tighten the muscles of your face. Scrunch your eyes shut, wrinkle your nose and tighten the muscles of your cheeks and chin. Hold this tension in your face…and relax. Release all the tension. Feel how relaxed your face is!

Try to think about all the muscles in your body...notice how relaxed your muscles feel. Allow any last bits of tension to drain away. Enjoy the relaxation you are feeling. Notice how calm you breathe, how relaxed your muscles are. Enjoy this relaxation for a few moments."

STEP 3

When the child is ready to return to the usual level of alertness and awareness, have them slowly reawaken their bodies. They can wiggle their toes and fingers, swing their arms gently or stretch out their arms and legs.

STEP 4

Encourage children to practice this at home before they fall asleep.

EXPLAINING BODY RELAXATION TO YOUNGER CHILDREN

Younger children will not be able to follow detailed instructions, so caseworkers should be creative when teaching them body relaxation techniques. As an example, caseworkers might teach the relaxation by comparing a body to a noodle or uncooked bean (or another food that is more appropriate in the local setting). Here is an example using an uncooked bean:

» "Have you ever seen beans before they are cooked? What do they look like? They are very stiff. How about beans after they're cooked, what are they like? They are soft and mushy. Let's pretend we are cooked and uncooked beans! First, we'll pretend to be uncooked beans and be very tense and strong and stand up very straight. And then we'll be cooked beans, loose and relaxed and soft. Let's try again (repeat here, having the child follow you): Let's be uncooked beans... okay, now cooked beans... then uncooked beans... then, pause a few seconds and say cooked beans..." (can repeat several times).

INCLUDE THE PARENTS

Parents can be taught body relaxation in order to help their children practice these skills at home. In addition, parents benefit from these skills themselves, given the high levels of stress they may be experiencing. The same body relaxation techniques taught to children can be taught to their parent. To reinforce the skill, children can help teach their parents in session.

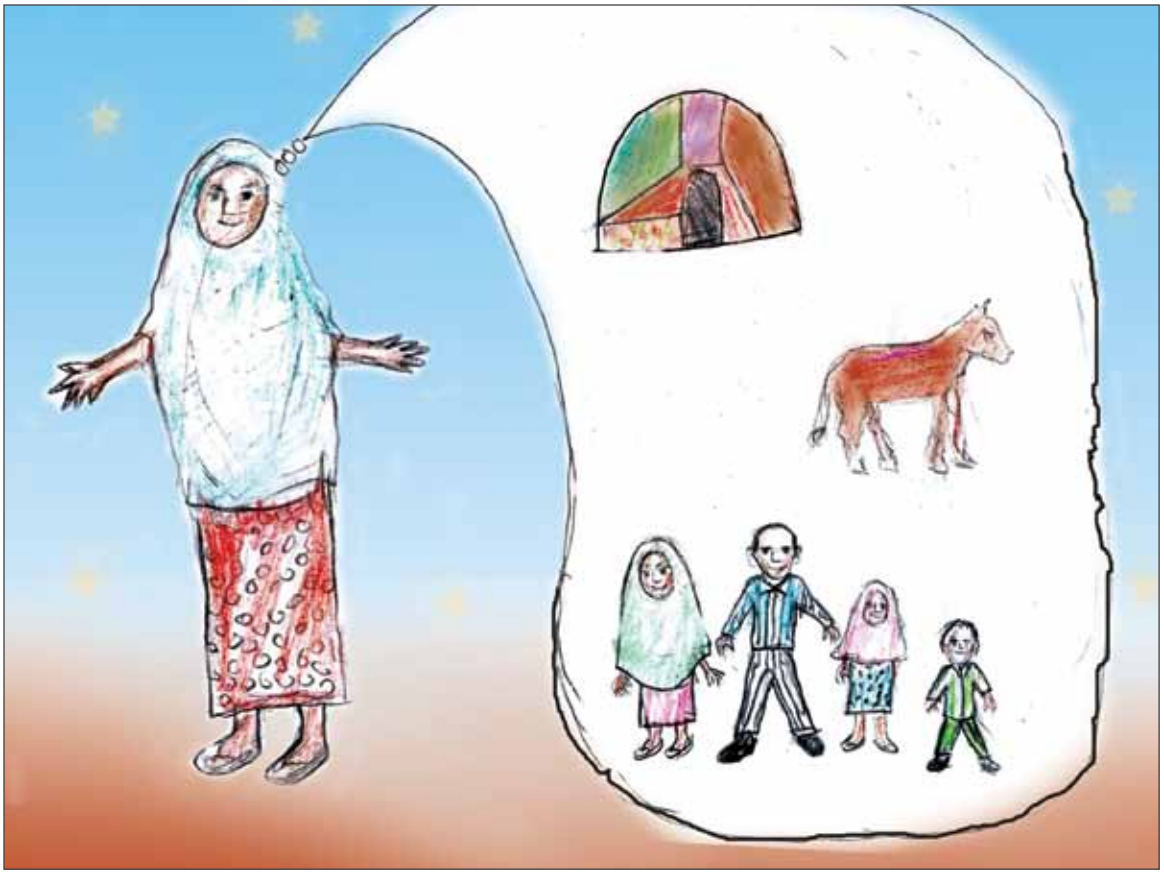

Illustration by Abdifatah Abdukadir Osman

INTERVENTION 3: HELP CHILD WITH COPING SKILLS

The aftereffects of sexual abuse can be hard for child survivors. They may feel ashamed and sad. They may refuse to attend school and spend large amounts of time by themselves. They may have a hard time finding the right people and resources to help them cope with the impact of sexual abuse. Children need to remember that they are strong, and that it's possible for them to heal, recover and live happy and healthy lives. While we can provide children with techniques they can use to relax their bodies and minds, caseworkers may need to help children develop a coping plan which includes social support and activities that build on their interests and strengths. Through such a coping plan, caseworkers can encourage children to participate in positive activities that they enjoy. The more active children's lives are, the better their moods and more likely they are to return to normal functioning (going to school, playing with friends, talking with others, etc.). During the assessment, if children identify negative feelings, the caseworker can initiate a series of questions to help them develop a coping action plan.

3-STEP COPING PLAN PROCESS

- **Step 1**: Ask children, "When you feel [sad or lonely or scared—whatever the child has expressed their feeling to be], who can you talk to?" Then have children list the people they feel comfortable talking with.
- **Step 2**: Identify the activities children enjoy. Building on the information the caseworker gathered during the assessment, identify the child's interests, activities and strengths. The caseworder can then help children identify positive feelings (happy, relaxed, etc.) associated with the interests and activities they described.
- **Step 3**: Building off the child's answers, the caseworker can develop a plan with the child to engage the people, activities, interests and other strengths they have identified, to help them when they need support. The caseworker can ask caregivers to support the child in carrying out the plan. The caseworker can follow-up with the child and caregiver at their next meeting to find out if they have tried the plan and whether or not it is helping the child to feel better.

Some useful activities caseworkers can do with children to help them identify their own strengths and interests may include:

- Talk/draw/play games with children to help them identify the people they feel safe with and supported by. Be sure children know how to locate these people.
- Talk/draw/play games with children to learn about their faith and their spiritual beliefs. Help children reconnect to faith if they are feeling isolated.
- Talk/draw/play games with children about what they can do when they feel sad. Find out what kind of activities make them happy and who are their friends and "safe people."
- Encourage children and help them recognize their own strengths. Praise them. Children need to see themselves as capable human beings who deserve love, happiness and protection.

INTERVENTION 4: PROBLEM SOLVING

During the psychosocial assessment, children may report difficulties or problems they face in their day-to-day lives. Children may find themselves struggling to feel accepted by a parent or friends, or they may have problems going back to school. There are many different kinds of problems that children will face, and it is likely that not all of these problems are directly related to the sexual abuse the child experienced. Other contributing factors can be: money stressors at home; alcoholism at home; the child has not been going to school for a long time; the child is engaged in harmful work; or perhaps the child is living on the street. It is nevertheless important for the caseworker to take the time to listen to the child and give the child the opportunity to talk about their problems. Caseworkers assess children's main problems throughout the

psychosocial needs assessment, and with this information can help children take steps to solve the most important problems they face. Caseworkers can follow these simple steps to help children identify their own power in being part of solving problems they face, while supporting them fully in the problem solving process.

STEP 1

IDENTIFY THE PROBLEMS WHICH CONCERN THE CHILD THE MOST.

Caseworkers can ask question such as, "What worries you the most right now?" or "What problems do you have right now?" (This information should be in the first section of the assessment.) Some children may have a hard time answering such questions. Caseworkers can also refer to information gathered during the initial assessment. For example, a caseworker might say, "When we first talked, you mentioned that you are not going to school right now, but this is an activity that you enjoy. Can you tell me more about why you are not in school?"

Depending on the problems identified, the caseworker will then need to assess which problems are directly related to the sexual abuse and work with the child on a plan to address these problems. Problems of broader concerns related to the well-being of the child must also be taken into consideration. The caseworker will either provide advice to the child on how to address these issues, or refer the child for further services and support which are beyond the capacity of the caseworker.

STEP 2

PRIORITIZE THE PROBLEMS.

If multiple problems are identified during the assessment, hopefully some of them can be addressed through the stress reduction, education and coping skills interventions; otherwise, further referrals need to take place to ensure appropriate further support for the child. The caseworker should work with the child to prioritize problems that concern the child the most, and can be addressed at some level of intervention. Based on these problems, the caseworker needs to decide whether a referral for further support is needed or whether the problem can be addressed through the psychosocial interventions. For example, if a child is worried he/she is being blamed by family for the abuse, the caseworker can conduct a healing education intervention with the caregivers and work with the child to identify other actions to solve this problem. In other situations, a referral may be needed. For example, if the child is living without an adult caregiver, the caseworker would need to inform the child protection agency. For direct interventions by the caseworker, generally, caseworkers should keep the problems limited to 3 or less, and be sure that concrete actions can be taken toward solving the problems.

The caseworker can use a ranking exercise to help the child prioritize the problems she/he is experiencing. This starts with a free listing of all problems faced by the child and identified during the assessment. The caseworker and/or child can write/draw each of these on a piece of paper or use a symbol for each problem (e.g., a book to represent school), and place these on a table or the floor. The caseworker then asks the child to identify out of the total list which 3-5 problems she/he considers to be the biggest problems from the child's perspective. If the problems are written/drawn on a piece of paper, the child can mark the key problems. If the problems have been symbolized, the child can lift the key problems and place them in another site.

It might be that the child prioritizes problems which the caseworker does not consider to be the most important problems, but it gives an important insight to the experience of the child, and should not be denied. The next step here could be for the caseworker to do a ranking of 3-5 problems from the caseworker's perspective. There might be overlaps, which should be the areas that need to be addressed. In situations where the caseworker might have prioritized different problems, there needs to be a discussion around these differences and why these were prioritized. If the differences are minimal, all problems can be included in the problem solving plan. If the differences include many problems, a further ranking can take place based on the combined child's and caseworker's initial ranking.

STEP 3

DEVELOP A PROBLEM SOLVING PLAN WITH THE CHILD.

Problem solving requires some simple steps. The first step is to identify the problem. The second step is to identify a goal (in other words, what the child's life would be like with the problem solved). The third step is to brainstorm all possible solutions to the problem and those that can be accomplished by the child, caregiver, caseworkers or others who can offer help. Problem-solving steps must be concrete and specific. Here is an example:

CASE DESCRIPTION

Alisha is worried that her father is going to be angry when he comes home and finds out she was raped. Alisha is worried that her father will throw her out of the house. Until now, Alisha has had a good relationship with her father and her mother is supportive of her. Alisha furthermore indicated that she has problems at school, as her classmates ignore her and she is excluded from the recreational activities happening in and around school—this has been happening for a long period of time.

MAIN PROBLEMS AND GOALS

1. Alisha's father will punish her for being raped. Alisha's goals: to be accepted and not blamed by her father; to live happily at home.
2. Alisha is not included in recreational activities by her classmates. Alisha's goals: to be accepted by her classmates and to take part in recreational activities.

POSSIBLE SOLUTIONS (brainstormed by the caseworker and Alisha together)

» Alisha shares her fears with her mother.
» Caseworker and Alisha's mother sitting with the father to explain the situation to him.
» Having someone whom the father respects and trusts involved to help tell the father what happened.
» Have a backup plan for Alisha in case her father does force her to leave home.
» Help Alisha cope with the constant worry about her father.

PROBLEM SOLVING PLAN

Based on the possible solutions brainstorm, Alisha and the caseworker decided on the following actions to solve the problem. There are different ways to help children develop a plan to address their stated problems. See Alisha's problem solving plan below.

ALISHA'S PROBLEM SOLVING PLAN

PROBLEM	GOAL	SOLUTIONS	WHEN	WHO
ALISHA'S FATHER WILL PUNISH HER FOR BEING RAPED	Alisha's father to accept her and not blame her.	Discuss Alisha's fear.	Next week.	Caseworker, Alisha's mother and Alisha.
		Meet father with support person.	When he comes home.	Caseworker and Alisha's mother.
		Provide education to father to help him accept and understand what happened.	When he comes home and 3 times after the initial meeting.	Caseworker and Alisha's mother as she wishes.

PROBLEM	GOAL	SOLUTIONS	WHEN	WHO
		Make back-up plan...	Next meeting.	Caseworker and Alisha.
ALISHA NOT INCLUDED IN RECREATION-AL ACTIVITIES	Alisha's classmates to accept her and invite her to participate in activities.	Referral to teacher of school.	Today.	Caseworker.
LIST ADDITIONAL PROBLEMS HERE				

Problem solving plans can come in many different formats. They can be in a diagram as shown above; they can be in a simple list format. Caseworkers and children can use drawings or symbols rather than words to describe the problem, goals and steps toward solving the problem.

CONCLUSION

This chapter described how to conduct a more comprehensive child and family psychosocial needs assessment and offered targeted psychosocial interventions for children. Offering direct psychosocial interventions to children and families works best in contexts that are stable and where caseworkers have regular access to clients over time. This is because the psychosocial needs assessment and delivery of psychosocial care requires the caseworker to meet regularly with the child (and family members as appropriate) over a period of time.

Caseworkers should discuss with their supervisors what happens after each meeting with the child survivor. This allows for reflection on what worked and didn't work, and for case supervision if difficulty arises when conducting the assessment and delivering psychosocial interventions.

Survivor Code:	Incident ID:

Child and Family Psychosocial Assessment

Caseworker code	Date	Time

Part II: Main Problems/Worries

For this section, case workers should use questions and/or drawing activities with children get a sense of what their main problems and concerns are following the experience of abuse. In this box, case workers should write down the current status of the child based on his or her own words.

PART III: Family, Social & Spiritual Context

Family & Living Situation: *Guidance for assessment: where does the child live (sleeps, eats, hangs around); who lives in the house and visits frequently; number of siblings, does the child appear happy in the home? Is the child able to play freely and where? Does the child appear afraid and/or not close to with parents/guardians, siblings; Is the child treated differently to other children in the family?*

Social Support *(friendships, school, participation in social and community life)*	**Spiritual/religious:**

Other Notes*: (e.g. safety risks identified, etc)*

Survivor Code:	Incident ID:

PART IV: Child Functioning Assessment

DIRECTIONS: The caseworker should ask the child survivor these questions in a private, confidential room. Say: I'm going to read some sentences. Please tell me how TRUE these sentences are about you. Think about how true these things are since _____ [describe abusive event…e.g., you were raped]

There can only be the X mark in one column.	YES	NO	COMMENTS
1. I don't see my friends as much as I used to.			
2. I have stopped my daily activity (e.g. school).			
3. I am having fights with people more than I used to.			
4. I am having a hard time going to sleep or staying asleep.			
5. I am having body aches, stomachache, headache or other aches.			
6. I worry that something bad is going to happen.			
7. I am feeling sad and hopeless.			

PART V: Caregiver Assessment (if possible)

What is your understanding about the abuse and what happened?	
What are your feelings about the abuse and what happened?	
What changes have you noticed with your child since the abuse?	
What do you think will help your child right now?	
What are your main worries and needs right now?	

PART VI: Child & Family Strengths

Survivor Code:	Incident ID:

Child Strengths/Protective Factors (things the child enjoys going, positive relationships to caregivers, people they trust and who support them, able to solve problems, feel hopeful, laugh, etc	Caregiver & Family Strengths/Protective Factors (strong and positive relationship with their child, other family members; able to cope with stress; social and community support; job/income)

PART VII: Psychosocial Evaluation & Action Planning

(for the caseworker to complete only)

Assessment Questions	Yes	No	N/A	Action Plan for Intervention (include, what is the action, who is responsible and timeframe)
1. Did the child report having problems functioning (See functioning items 1-3). If yes: interventions required: 1. Problem solving 2. Healing education 3. Relaxation training				
2. Did the child report feeling anxious or worried (See Functioning items 4-6). If yes: interventions required: 1. Relaxation training 2. Healing education Problem solving (if needed)				
3. Did the child report having negative feelings (See Functioning items 7-8). If yes: interventions required: 1. 3-Step Coping 2. Healing education 3. Relaxation training				

Survivor Code:	Incident ID:

List the strengths (child and family) that can support the child's healing.
(school, activities, sense of humor, etc).

Other areas of need identified during the assessment that require intervention (direct and/or referral)
(if not addressed above)

Identified Need:	**Action Plan** (include what action, who will do what, and timeframe).

Next Follow Up Appointment scheduled for (date/time)_____