INTERNATIONAL RESCUE COMMITTEE

unicef

# Caring for Child Survivors of Sexual Abuse

Guidelines for health and psychosocial service providers in humanitarian settings

First Edition

# Chapter One
# CORE CHILD SEXUAL ABUSE KNOWLEDGE COMPETENCIES

This chapter applies to health and psychosocial service providers.

## CONTENTS OF THIS CHAPTER INCLUDE

» Core Child Sexual Abuse Knowledge Competency Areas

## TOOLS IN THIS CHAPTER INCLUDE

» Caring for Child Survivors Knowledge Assessment (CCS-KA) Tool

## CHAPTER OVERVIEW

This chapter applies to health and psychosocial service providers working with children and families affected by sexual abuse. This chapter outlines the core child sexual abuse knowledge areas required for service providers to apply and complement other professional knowledge and skill competencies.[18] Accurate and full knowledge about child sexual abuse is central to delivering appropriate care and treatment to children and families. Service providers have the responsibility to share accurate knowledge about sexual abuse to facilitate recovery and healing. Without accurate knowledge, service providers may perpetuate harmful beliefs that can cause further emotional distress and prevent healing.

In addition to outlining the child sexual abuse knowledge areas, this section introduces a tool for supervisors to assess the knowledge and competencies of individual staff members.

[18] For example, doctors and nurses must demonstrate competent clinical care for sexual assault survivors and psychosocial workers must show competency in case management, in addition to this specialized technical knowledge about sexual abuse.

Photo: Aubrey Wade/the IRC

# 1 CORE CHILD SEXUAL ABUSE KNOWLEDGE COMPETENCIES

**Note**: These knowledge areas are drawn from global facts and information related to the scope of the problem of child sexual abuse, children's reactions to abuse and dynamics related to disclosure of abuse, among other knowledge areas. Therefore, adapting these facts and information to be more locally specific is necessary, as information related to the knowledge areas will vary across local contexts and populations.

## CORE CHILD SEXUAL ABUSE KNOWLEDGE COMPETENCY AREAS

**Health and psychosocial staff have the ability to demonstrate proficient knowledge in core sexual abuse knowledge areas:**

**AREA 1**: Definition of child sexual abuse
**AREA 2**: Scope of the problem
**AREA 3**: Children and sexual abuse disclosure
**AREA 4**: Perpetrators of sexual abuse
**AREA 5**: Sexual abuse and boys
**AREA 6**: Sexual abuse impact across age and developmental stages
**AREA 7**: Impact of sexual abuse on caregivers
**AREA 8**: Needs of children after sexual abuse
**AREA 9**: Children and resilience
**AREA 10**: Local child protection mechanisms and norms
Additional Knowledge Areas (developed locally)

**Health and psychosocial staff are committed to:**

- Having an accurate understanding of child sexual abuse and sharing accurate information with children and caregivers.
- Helping children understand and manage the impacts of abuse through child-friendly education and information sharing.
- Helping families heal by educating about child sexual abuse and supporting the affected child.
- Educating service providers who share misinformation about sexual abuse with children, families and/or community members.

## KNOWLEDGE AREA 1: DEFINITION OF CHILD SEXUAL ABUSE[19]

Sexual abuse is an abuse of power over a child and a violation of a child's right to life and normal development through healthy and trusting relationships. Globally, there is no standard definition of child sexual abuse. The World Health Organization (WHO) defines child sexual abuse as:

> "the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society. Child sexual abuse is evidenced by this activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust or power, the activity being intended to gratify or satisfy the needs of the other person."[20]

In line with the WHO definition, child sexual abuse is defined in these guidelines as any form of sexual activity with a child by an adult or by another child who has power over the child. Child sexual abuse often involves body contact. This could include sexual kissing, touching, and oral, anal or vaginal sex. Not all sexual abuse involves body contact, however. Forcing a child to witness rape and/or other acts of sexual violence, forcing children to watch pornography or show their private parts, showing a child private parts ("flashing"), verbally pressuring a child for sex, and exploiting children as prostitutes or for pornography are also acts of sexual abuse. Specific acts of sexual abuse that include both contact and non-contact behaviors are outlined below.

Abusive physical contact or touching includes:

- touching a child's genitals or private parts for sexual purposes,
- making a child touch someone else's genitals or play sexual games,
- and putting objects or body parts (such as fingers, tongue or penis) inside the vagina, in the mouth or in the anus of a child for sexual purposes.

[19] The information explained in this section combines data from multiple resources. Three main resources include the National Child Traumatic Stress Network (www.nctsn.com); Stop it Now: Together We Can Prevent Child Sexual Abuse (http://www.stopitnow.com/); and Levine, P. (2007). Trauma through a child's eye. California: North Atlantic Books. In addition, the WHO, UNICEF and other key sources of information are cited.

[20] World Health Organization, Social Change and Mental Health, Violence and Injury Prevention, Report of the Consultation on Child Abuse Prevention, pp. 13-17, Geneva, 29-31 March 1999.

# 1 CORE CHILD SEXUAL ABUSE KNOWLEDGE COMPETENCIES

Many people are unaware that sexual abuse does not require penetration, force, pain or even touching. If an adult engages in any sexual behavior (e.g., inappropriate sexual language directed at a child, looking at a child's private parts and/or showing private parts to a child) to satisfy the adult's sexual desires or interest, such behavior is considered sexual abuse. Acts of sexual abuse that do not involve contact or touching include:

» showing pictures of naked men and/or women to a child,
» deliberately exposing an adult's genitals to a child for the adult's sexual pleasure or interest,
» photographing a child in sexual poses,
» encouraging a child to watch or hear sexual acts,
» watching a child undress or use the bathroom for the adult's sexual pleasure or interest,
» and forcing a child to witness rape and/or other acts of sexual violence.

It is important to recognize that some forms of sexual abuse may be socially promoted, for example, early marriage of girls and young women. In many humanitarian settings, early and forced marriage of young girls is the vehicle for marital rape.

Sexual abuse of children is most often perpetrated by someone close to the child, resulting in the betrayal of the child's trust. Therefore, use of physical force is often unnecessary to engage a child in sexual activity because children trust and often depend on adults they are close to. Children are taught not to question authority and may believe that adult behaviors are always correct, or the adult has unchallengeable authority. Perpetrators of child sexual abuse take advantage of these vulnerabilities in children.

## KNOWLEDGE AREA 2: SCOPE OF THE PROBLEM

Acknowledging that sexual abuse happens can be difficult for members of any community. Yet, the statistics show that globally, sexual violence toward children is alarmingly common. While sexual abuse statistics vary between countries and reports, the data is disturbing:

» Girls are up to three times more likely than boys to experience sexual violence. The majority of perpetrators of sexual violence are men.[21]

[21] Heise, Lori; Ellsberg, Mary; Gottemoeller, Megan. 1999. "Ending Violence Against Women." Population Reports, Series L. No.

- The World Health Organization (WHO) estimates that 150 million girls and 73 million boys under 18 experienced forced sexual intercourse or other forms of sexual violence in 2002.[22]
- The occurrence of sexual violence in the home is increasingly acknowledged. An overview of studies in 21 countries found that 7–36 % of women and 3–29% of men reported sexual victimization during childhood. Most of the abuse occurred within the family circle.[23]
- Similarly, a multi-country study by the WHO, including both developed and developing countries, showed that between 1% and 21% of the women interviewed had been sexually abused before the age of 15, in most cases by male family members other than the father or stepfather.[24]

Data from IRC-supported gender-based violence (GBV) programs collected in conflict-affected settings highlight the frequency of sexual violence toward children. For instance, in the Central African Republic, nearly half of GBV survivors receiving support from the IRC are girls under the age of 18. In Sierra Leone, 73% of female survivors aided by the IRC are under the age of 18, with 23% under the age of 11. Almost all cases were sexual violence, specifically rape (97% for 0–11 year olds and 96% for 12–18 year olds).[25]

It is widely acknowledged that child sexual abuse occurs more often than the reported numbers show. Children comprise a resilient group of the population but are vulnerable given their age, size, dependency on adults and their limited participation in decision-making processes.[26] Children especially vulnerable to abuse include those who:

- have physical or mental/developmental disabilities,
- are internally displaced or refugees,
- are unaccompanied and/or separated from their families and caregivers,
- or live on the streets, in a residential care center or in abusive households.

[22] Krug E.G. et al., eds. World Report on Violence and Health. Geneva, World Health Organization, 2002. (http://www.who.int/violence_injury_prevention/violence/world_report/en/Full%20WRVH%20summary.pdf)

[23] Child Abuse & Neglect, 2005.

[24] Violence Against Women: WHO Consultation, Geneva, Feb. 5–7 1996 (document FRH/WHD/96.27, available at http://whqlibdoc.who.int/hq/1996/FRH_WHD_96.27.pdf, accessed March 18, 2005).

[25] This data is collected from the IRC Gender-Based Information Management System, an information collection and analysis tool that compiles and analyzes information on reported GBV. The data shown here does not represent the total incidence or prevalence of GBV in any one location or group of locations.

[26] Inter-Agency Standing Committee (IASC. Guidelines for GBV Interventions in Humanitarian Settings: Focusing on Prevention of and Response to Sexual Violence in Emergencies. (available at http://www.humanitarianinfo.org/iasc/content/subsidi/tf_gender/gbv.asp).

## KNOWLEDGE AREA 3: CHILDREN AND SEXUAL ABUSE DISCLOSURE

"Disclosure"[27] refers to the discovery of child sexual abuse. A child's capacity to disclose is impacted by several factors, including the child's age, sense of safety, available resources and other factors relevant to a particular context. Often, disclosure of sexual abuse is a process; in other words, children may first "test the waters" to see how adults react to hints about their sexual abuse or give their full disclosure. Adults who react with anger, blame or other negative responses may cause a child to stop talking and/or later deny the abuse disclosed by the child. Service providers are responsible for responding to child sexual abuse disclosure with compassion, care and calm.[28]

### CHILD SEXUAL ABUSE CAN BE DIRECTLY OR INDIRECTLY DISCLOSED

» Direct disclosure occurs when the child survivor or the child survivor's family members/friends directly informs the service provider about the abuse.

» Indirect disclosure occurs when someone witnesses child sexual abuse, or when the child contracts a sexually transmitted disease or becomes pregnant and the disclosure is brought to the surface by a third party or consequence of the abuse (e.g. pregnancy).

Direct and indirect disclosures can occur with or without the child's consent. For example, children may tell their caregivers that they have been sexually abused, and the caregivers may then disclose the abuse to service providers without the willingness of the child. This is considered "involuntary disclosure." However, children can also willingly share information about sexual abuse to trusted adults or service providers themselves. This is called "voluntary disclosure."

Voluntary and involuntary disclosure becomes a necessary consideration when service providers begin care and treatment for an individual child. How the abuse was discovered and disclosed, how the child reacted to its revelation and the number of people who talked with the child may affect a child's willingness to participate in the disclosure process. Some children may be ready to talk, share and receive help while some children may be afraid to do so—every child's experience is different.

[27] The information explained in this section draws upon three key resources: National Child Traumatic Stress Network (www.nctsn.com); Stop it Now: Together We Can Prevent Child Sexual Abuse (http://www.stopitnow.com/); and Levine, P. (2007). Trauma through a child's eye. California: North Atlantic Books.

[28] How to handle disclosures of sexual abuse is discussed in more detail in Chapters 3, 5 and 6.

## COMMON REASONS WHY CHILDREN DO NOT DISCLOSE SEXUAL ABUSE

**FEAR OF CONSEQUENCES**: Many children are afraid to tell an adult about abuse because they feel physically threatened, or because they believe they will be taken away from their families or blamed for shaming the family or involving outside authorities. The fear of the consequences may be greater than fear of the abuse itself.

**FEAR OF DISMISSAL**: Children are often afraid that adults will not believe them. They are afraid that their parents, community leaders, clan members, religious leaders and others will dismiss their claims and refuse to help. The perpetrator may compound this fear by convincing the child that no one will believe them, or that they will get into trouble if they speak out, etc.

**MANIPULATION**: The perpetrator may trick or bribe the child (for example, give the child a gift in exchange for non-disclosure). The perpetrator will often make the child feel embarrassed or guilty about the abuse. Sometimes the perpetrator will blame the child, saying he or she invited the abuse.

**SELF-BLAME**: Children may believe the sexual abuse is their fault or they may think the abuse is deserved (for example, the child may think it was his/her fault for inviting the perpetrator to his/her place or for being in the wrong place at the wrong time). A child may feel that they allowed the abuse and should have stopped it. **In no case is a child ever responsible for the sexual abuse they experience.**

**PROTECTION**: The child may want to protect the perpetrator and/or family in some way, especially if the perpetrator is close to the child and his/her family.

**AGE**: Children who are very young may be unaware they have experienced sexual abuse. They may think that the abuse is normal: particularly if the abuser is someone the child knows and trusts. Younger children may also have linguistic or developmental limitations that prevent disclosure.

**PHYSICAL OR MENTAL DISABILITY**: Children may be unable to disclose the abuse if they are unable to speak to or otherwise reach out to a service provider.

All disclosures of all sexual abuse must be heard with respect and believed. Caregivers, service providers and adults have the responsibility to hold the perpetrator responsible for the abuse and not the child.

# 1 CORE CHILD SEXUAL ABUSE KNOWLEDGE COMPETENCIES

## HELPFUL TIP ON HANDLING DISCLOSURE

A key skill for service providers is their ability to handle the disclosure of child sexual abuse. Service providers must be aware of the impact their reactions can have on a child's psychological health. Negative, angry, accusatory reactions can further traumatize and harm a child who has disclosed sexual abuse, whereas a calm, affirming and supportive reaction can foster a child's feeling of safety and acceptance—both of which help the process of recovery and healing.

Chapter two outlines core values and beliefs that support the service provider's ability to be calm and affirming during disclosure and throughout a child's care and treatment. Chapters three and five provide guidance for the service provider on how to handle disclosures of sexual abuse and the steps to take following disclosure to assist a child survivor with their health, psychosocial, safety, and legal justice needs.

## KNOWLEDGE AREA 4: PERPETRATORS OF SEXUAL ABUSE

In different parts of the world perpetrators of sexual abuse may have different characteristics, although the majority of perpetrators of sexual abuse are men. Perpetrators of sexual abuse can be family members (fathers, grandparents, siblings, uncles, aunts, cousins, etc.). They can also be neighbors, religious leaders, teachers, health workers, or anyone else with close contact to children. Because of this, children can be sexually abused over a longer period of time and the abuse can happen more than once. Children can also be sexually abused by someone they do not know, although statistics confirm this is not as common.

### CAN A CHILD ABUSE ANOTHER CHILD?

YES. Some children who sexually abuse other children fully understand the harmful impact of their actions. Some children, especially younger children, may not understand that his or her forceful sexual actions toward another child are harmful. Some children who commit sexual abuse have been abused in some way themselves.[29] It can be a learned behavior as a result of their personal experiences. It is important for children who are perpetrators of sexual abuse to also be offered psychosocial support and rehabilitation services. While most children who have been sexually abused never sexually harm another child, without treatment they may be more vulnerable to and confused about what is considered inappropriate behavior.

[29] Being sexually abused does not mean that the sexually abused child will always develop sexually abusive behaviors. However, without care and treatment, a child who has been sexually abused may be more at risk to being abused again or to be confused about which behaviors are appropriate.

### WHY WOULD AN ADULT SEXUALLY ABUSE A CHILD?

There is no simple reason for why someone misuses a position of power or influence to be sexual with a child. The answers are not only complex, but as different as the people and situations involved. Characteristics of perpetrators vary across local cultures and contexts. For some men, sexually abusing a child is motivated by the desire to feel more power and control in their own lives. Some men are sexually attracted to children. There are many different reasons why adults abuse children. One feature is always present in the abuse: **abuse of power over a child for sexual purposes.**

## KNOWLEDGE AREA 5: SEXUAL ABUSE AND BOYS

Many facts and information related to sexual abuse are applicable to both boys and girls; however, there are specific issues related to boy child survivors. Research studying the specific issues related to male survivors of sexual abuse in humanitarian settings is scant. Moreover, the differences between male and female victimization is largely impacted by cultural beliefs and stereotypes of femininity and masculinity, which vary across contexts. With this acknowledgment, current research[30] on male experiences of sexual abuse finds that beliefs impact how boys, particularly adolescents, experience and externalize sexual abuse:

» A boy may see himself as less than male (emasculation).
» He may see himself as being powerless and thus flawed.
» He may see himself as being labeled as sexually interested in males (homosexual).
» Adolescent boys may also believe that no matter what, all sexual activity is appropriate for males.[31]

In general, males, especially adolescent males, may be much less likely to disclose and/or speak about their abuse experiences because being a victim can be seen as a countercultural experience for an adult male and/or male child/adolescent.

[30] Bergstrom, Sage. Butler, Tracy L., Karp, Cheryl L. (1997). Treatment Strategies for Abused Adolescents: From Victim to Survivor. Interpersonal Violence: The Practice Series, Volume 19.
[31] Ibid.

# 1 CORE CHILD SEXUAL ABUSE KNOWLEDGE COMPETENCIES

Photo: Gina Bramucci/the IRC

Service providers working with male survivors must be aware of the specific facts and issues related to a boy's experience of sexual abuse. Service providers need to pay very close attention to their own beliefs and attitudes about a boy's experience of sexual abuse, as harmful beliefs may affect a child's willingness to disclose and cause further psychological harm. Some key facts for service providers include:

- **Acknowledging that boys can be sexually abused.** An overview of studies in 21 countries found that 3–29 % of men reported sexual victimization during childhood. Most of the abuse occurred within the family circle. The statistics show that the majority are sexually abused by adult males; however, there are also cases of adult females sexually abusing boys, and/or male children/adolescents abusing boys.
- **Understanding that sexual abuse does not cause homosexuality.** Service providers are responsible for educating child survivors, caregivers and community members about the effects of sexual abuse. Homosexuality carries an additional stigma across communities and mistaken beliefs about the effects of sexual abuse may make it more difficult for a male teen sexually abused by an adult male to disclose.
- **Recognizing that boys do not always prefer to speak with male service providers.** In fact, the opposite may be true. Never assume that a boy or girl will feel more comfortable speaking with a service provider of his or her own gender. Rather, children should ideally be offered a choice of male or female service provider.

- **Recognizing there can be internal (individual) and external (social) barriers to receiving care.** Social stigma, including the fear of being labeled homosexual, as well as issues related to victimization and masculinity may make it difficult for boys to seek help. Moreover, in many settings, services for sexual violence are geared toward women and girls; boys may not be aware of similar opportunities for them to seek help.
- **Accepting that boys require care, support and treatment to recover and heal.** Male child survivors have the same needs as female child survivors—they need to feel safe, cared for, believed, encouraged and assured that seeking help and/or acknowledging sexual abuse is the right thing to do.

## KNOWLEDGE AREA 6: SEXUAL ABUSE IMPACTS ACROSS AGE AND DEVELOPMENTAL STAGES

Sexual abuse occurs throughout childhood and across contexts, cultures and classes. Service providers, teachers, parents, caregivers, and others need to be aware of the common signs and symptoms of sexual abuse in their particular setting, because most boys and girls will remain silent. Any one sign or symptom does not mean that a child has been abused, but the presence of several signs may suggest that a child is at risk.[32] Remember that it is important to believe reports of sexual abuse no matter what you observe about the child. Keep in mind that some of these signs can emerge during periods of stress, such as the loss of a loved one or other traumatic event, even long after the abuse has occurred.

Boys and girls react differently to sexual abuse based on several factors, including their age and developmental stage and cultural context. The majority of signs and symptoms are behavioral and emotional in nature, but physical changes can indicate abuse as well. The following are the most common physical signs of sexual abuse:

- Pain, discoloration, sores, cuts, bleeding or discharges in genitals, anus or mouth;
- Persistent or recurring pain during urination and/or bowel movements;
- Wetting and soiling accidents unrelated to bathroom training;
- Weight loss or weight gain;
- Lack of personal care.

[32] For some children, behavior and physical indications of abuse are not always apparent.

## INFANTS AND TODDLERS (AGES 0–5)

It is common for young children (ages 0–5) to show regressive behaviors. This means that children seem to lose certain skills or behaviors they previously mastered (for example, bladder control), or they may revert to behaviors they had previously outgrown (thumb-sucking). Similarly, young children often become clingy to familiar adults, including caregivers and teachers to whom they feel close. They may also resist leaving places where they feel safe (their home or classroom), or be afraid to go places that may trigger memories of a frightening experience. Significant changes in eating and/or sleeping habits are common and young children may complain of physical aches and pains that have no medical basis.

## YOUNGER CHILDREN (AGES 6–9)

Younger children may also exhibit regressive behaviors, such as asking adults to feed or dress them, or they may report unexplained physical symptoms just as young children do. However, older children have a better understanding of the meaning of sexual abuse and they have more advanced thoughts and beliefs about what they experience and what they perceive as negative consequences. This results in the development of emotional reactions ranging from sadness, fear, anxiety and anger, to feelings of shame and guilt. As a consequence, older children may begin to withdraw from their friends and refuse to go to school, or they may begin to behave aggressively. They may also be unable to concentrate, resulting in a decline in school performance.

## ADOLESCENTS (AGES 10–19)

Adolescence is defined as the period between ages 10 and 19 years old. It is a continuum of development in a person's physical, cognitive, behavioral and psychosocial spheres. Adolescents face particular challenges that are specific to their developmental stage. Adolescence is often described as a time of transition into adulthood, which can be a very trying time because he or she is no longer viewed as a "child," but is not truly regarded as an "adult."[33]

On one end of the continuum is early adolescence (ages 10–14), which is marked by puberty and important physical changes to the body. Although they may be emotionally and cognitively closer to children than adults, adolescents in this age group are just beginning to define their identities. As early adolescents begin to become aware of their sexuality, they may begin to

[33] The specific initiation practices that mark girls' and boys' transition from childhood to adulthood are different across cultures.

experiment with sex or be targeted for sex. Adolescents in this age group, especially girls, tend to be dependent on others, lack power within most of their relationships and are not given an opportunity to participate in the decisions that affect them.

At the other end of the continuum is late adolescence (ages 15–19), when puberty has ended but the body is still developing. Adolescents in this age group tend to act more like adults, but have yet to reach cognitive, behavioral or emotional maturity. Their capacity for analytical thought and reflection is enhanced but is also still developing. Peers are extremely important and influential during this time period. This is extremely important in relation to girls who have limited exposure to their peers and others outside their immediate families. Girls who have reached physical maturity have an increased chance of being targeted for sexual violence and exploitation.

In general, adolescents tend to place more importance on peer groups and "fitting in." This can complicate their efforts to come to terms with sexual abuse, given the high level of stigma and shame that sexual abuse carries across communities. Adolescents may be reluctant to discuss their feelings or may even deny any emotional reactions to the sexual abuse, in part because of their desire to fit in and avoid the shame and stigma associated with sexual abuse. Adolescents, especially older adolescents, are more likely to show traumatic responses similar to those seen in adults, including:

» Flashbacks
» Nightmares
» Emotional numbing
» Avoidance of reminders of the trauma
» Depression, suicidal thoughts
» Difficulties with peer relationships
» Delinquent and/or self-destructive behavior (for example: changes in school performance, changes in or abandonment of friendships, and/or acts of self-harm).

Typically, adolescent survivors are struggling with many issues and therefore, developing a strong relationship can be difficult and time consuming for the service provider. Service providers working with abused adolescents will find that developing a rapport and building trust with an adolescent client is an important goal. As service providers develop a stronger rapport with adolescent clients, they may be more willing to share their feelings. Establishing a solid foundation of trust is paramount to the healing and recovery process.

# 1 CORE CHILD SEXUAL ABUSE KNOWLEDGE COMPETENCIES

For all boys and girls who experience sexual abuse, certain factors affect the severity of the reaction to abuse. These factors include:

- **The perpetrator of the abuse**: Effects are generally worse when the perpetrator is a parent, step-parent or trusted adult, rather than a stranger. This will impact a child's ability to trust adults as well as impact their feelings of safety and security with adults.
- **Whether or not violence was involved**: The level and degree of trauma and distress that the child experiences will be impacted if physical violence is involved. If serious physical violence is involved, the more serious the emotional and health consequences can be for the child.
- **How long the abuse went on**: The longer the duration of the abuse, the more serious the emotional and health consequences can be for the child.
- **Whether the child told anyone**: The response the child received when they disclosed is also critical. Doubting, ignoring, blaming and shaming responses can be extremely damaging–in some cases even more than the abuse itself.
- **What happens after the abuse:** If a child receives care and help, they will suffer less, but if a child is blamed and shamed by the community or family, or does not receive help, this will impact a child's ability to heal, feel safe, and experience normal developmental patterns.

The table below represents the most common signs and symptoms according to age:

| COMMON SIGNS AND SYMPTOMS OF SEXUAL ABUSE ACCORDING TO AGE | |
|---|---|
| INFANTS & TODDLERS (0–5) | » Crying, whimpering, screaming more than usual.<br>» Clinging or unusually attaching themselves to caregivers.<br>» Refusing to leave "safe" places.<br>» Difficulty sleeping or sleeping constantly.<br>» Losing the ability to converse, losing bladder control, and other developmental regression.<br>» Displaying knowledge or interest in sexual acts inappropriate to their age. |
| YOUNGER CHILDREN (6–9) | » Similar reactions to children ages 0-5. In addition:<br>» Fear of particular people, places or activities, or of being attacked.<br>» Behaving like a baby (wetting the bed or wanting parents to dress them).<br>» Suddenly refusing to go to school.<br>» Touching their private parts a lot.<br>» Avoiding family and friends or generally keeping to themselves.<br>» Refusing to eat or wanting to eat all the time. |

| COMMON SIGNS AND SYMPTOMS OF SEXUAL ABUSE ACCORDING TO AGE | |
|---|---|
| ADOLESCENTS<br>(10–19) | » Depression (chronic sadness), crying or emotional numbness.<br>» Nightmares (bad dreams) or sleep disorders.<br>» Problems in school or avoidance of school.<br>» Displaying anger or expressing difficulties with peer relationships, fighting with people, disobeying or disrespecting authority.<br>» Displaying avoidance behavior, including withdrawal from family and friends.<br>» Self-destructive behavior (drugs, alcohol, self-inflicted injuries).<br>» Changes in school performance.<br>» Exhibiting eating problems, such as eating all the time or not wanting to eat.<br>» Suicidal thoughts or tendencies.<br>» Talking about abuse, experiencing flashbacks of abuse. |

In addition to the emotional, psychological and behavioral impacts of sexual abuse described in the signs and symptoms section above, children can face serious social consequences once they are identified as survivors of sexual abuse.

Children who are sexually abused may be rejected by their family and community, experience extreme social stigma, and/or suffer the loss of educational and employment opportunities. In addition, as sexually abused children age, they may see avenues for broader social acceptance and integration closing down. As a result, providing care to a child who has been sexually abused requires working with the family and community systems to address familial and social consequences. Different groups should implement community-based education and sensitization campaigns about sexual abuse in order to address any stigmatizing or shameful community practices toward children survivors of abuse. These types of community-based interventions can have a direct positive impact on sexually abused children successfully reintegrating into their communities.[34]

## KNOWLEDGE AREA 7: IMPACTS OF SEXUAL ABUSE ON CAREGIVERS

When non-offending caregivers first find out about their child being sexually abused, they will experience a wide range of feelings. The following emotional reactions are normal responses to a child disclosing sexual abuse. Caregivers may feel: anger, disbelief, shock, worry, deep sadness, and fear. Caregivers may not know what to do or where to seek help. They may want the problem to "go away" or not even realize that sexual abuse can cause harm and that their child

[34] This is an area of concern that requires study beyond the reach of these guidelines.

needs care. They may become angry and scold or beat the child. Some caregivers blame themselves for not paying attention to their child's behaviors or may feel they have failed as parents and have not protected their child. Some parents may wonder why their child chose to disclose to others and not them directly.

Some caregivers also feel conflicting emotions, especially if the accused perpetrator is someone that is a trusted and close friend or family member. Caregivers may experience betrayal, confusion and disbelief. In addition to a wide range of emotional experiences, parents may also experience insomnia, change of appetite or other physical complaints that are a result of the stress and fear associated with learning their child has been abused.

Caregivers also need support in coping after a disclosure of child sexual abuse, because they suffer emotionally and because the child needs the caregiver's support and attention to facilitate their own healing. Caregivers need to be aware that believing their child and standing by him or her is crucial for their child's recovery. Therefore, responding to cases of child sexual abuse requires service providers to have strategies and skills for positively involving non-offending caregivers in the child's healing and recovery.

## KNOWLEDGE AREA 8: NEEDS OF CHILDREN AFTER SEXUAL ABUSE

Following the experience of sexual abuse, children may have immediate response needs that require service providers to mobilize crisis intervention support. Specifically, the need to ensure children's physical and emotional safety needs are met and access to timely health care is ensured.

Following the immediate crisis response, children may require additional care and support to help them recover and heal and to positively and fully engage in daily life. Longer-term needs include:

- **Psychological Needs.** Children will need support to feel safe and trusting of adults again; to understand their feelings about the abuse; and to cope with post-traumatic stress symptoms that surface (flashbacks of the abuse, obsessive thoughts of the abuse, self-respect issues).
- **Social Needs.** Children (and families) will need help to recover and heal from the impacts of sexual abuse on the family and familial relationships; to ensure that they are able to go back to school and participate in community and social events; and to develop and sustain positive and trusting relationships with peers and adults in the community.

- **Care Arrangements.** Children will need a secure place to recover if abuse happened in the home and children cannot return.
- **Legal/Justice Needs.** Children have a right to justice and may need support while the legal investigation and the prosecution of their cases occur.
- **Other protection interventions.** Children who are separated or unaccompanied or who are facing other protection risks require targeted protection interventions.

## KNOWLEDGE AREA 9: CHILDREN AND RESILIENCE[35]

### WHAT IS RESILIENCE?

"Resilience," as defined by the Interaction Child Protection Task Team, is the ability of individuals, families and communities to endure and recover from adversities.[36] The IRC Child and Youth Protection and Development Unit defines a resilient child or youth as one who maintains or recovers his or her well-being despite experiencing adversity. A child's resilience results from both individual characteristics and coping mechanisms (innate and acquired) and the protective factors in a child's ecology or environment. These innate and acquired characteristics and mechanisms include biological, physical and psychological traits and health, as well as skills and knowledge. Children use these characteristics to defend themselves against violations of their rights and to cope with and recover from adversity.

External or environmental factors influence a child's or youth's resilience. The external conditions that enable children to endure and recover are known as protective factors. At the family level, these protective factors include positive attitudes and involvement on the part of parents or caregivers, family cohesion, adequate housing and stable and adequate income. At the community level, protective factors include involvement in community life, peer acceptance, supportive mentors, and access to quality schools and health care. It is essential for service providers to build on both a child's individual coping mechanisms and protective environmental factors that support the healing and recovery of children following sexual abuse.

Working with child survivors requires service providers to be able recognize and build upon their resiliencies to help them cope with the impacts of sexual abuse. Identifying and building upon children (and families' resiliencies) during service delivery is discussed in Chapter 6.

[35] The discussion of resiliency is drawn primarily from the IRC Child and Youth Protection and Development literature on children and resiliency.

[36] International Rescue Committee's Child and Youth Protection and Development Sector Framework. A guide to sound project design and consistent messaging. January 2012.

## KNOWLEDGE AREA 10: LOCAL CHILD PROTECTION MECHANISMS AND NORMS

Every community cares for its children and wants to protect them in principle. However, the ways in which communities protect children vary from community to community. Prior to working with child survivors in any community requires service providers to assess the child's environment, including the factors and actors that protect or pose risks to children. This requires learning about local norms, practices, and capacities, particularly in regards to child rearing. It also requires identifying and determining the protective capacities of individuals or groups in the community who may play an important role in a child's healing. Throughout the case management process, caseworkers should work closely with these individuals and groups, including children and families, to identify community resources, promote protective practices, and link child survivors and their families to the services and support they might need. Caseworkers should use their knowledge about local norms, practices and capacities to ensure that case management decisions address risks and capitalize upon protective factors that exist in families and communities. Specific information on this knowledge area should be developed locally.

### DEVELOPING ADDITIONAL KNOWLEDGE AREAS AND ADAPTING TO CONTEXT

There may be additional knowledge areas related to child sexual abuse in the particular setting where services are being offered that are important for staff to know. In addition, information about sexual abuse may vary from one setting to another, based on population receiving services. For this reason, managers and supervisors are encouraged to build on and/or adapt the core knowledge areas outlined in this chapter. It is recommended that supervisors hold a meeting with 3-5 members of the local community to discuss local experiences and information about child sexual abuse services that are important for service providers to know. During this meeting, supervisors can also go through Knowledge Areas 1-10 and ensure that the information accurately represents the local context. In the Somali refugee camps, for example, it was deemed important for staff to understand the link between early marriage and sexual abuse. Therefore, the program included specific information related to Somali children's experiences with early marriage and sexual abuse. Staff are now assessed for their competency with regard to this knowledge.

Program managers and supervisors are responsible for improving the overall knowledge areas by making them more specific, wherever possible.[37]

[37] This should happen prior to any training with service providers to ensure the most relevant and accurate knowledge concepts are conveyed and applied.

### KEY FACTS TO REMEMBER

» Sexual violence occurs throughout childhood, across contexts, cultures and classes.
» Perpetrators are often people the child knows and trusts. This can result in abuse happening over a longer period of time and becoming more invasive over time.
» Disclosure is a process. Children may not share all information at first; rather, their stories merge over time.
» Children can heal. Caregivers and service providers can have a very positive impact on the healing process if they believe and support the children in their care.

# GUIDELINES FOR ASSESSING AND MONITORING CORE KNOWLEDGE COMPETENCIES

Service providers are required to demonstrate competency in the core knowledge areas outlined above.[38] Competency means that individuals are able to recall facts and information about children and child sexual abuse accurately and on their own. As noted already, technical understanding of child sexual abuse is fundamental to providing appropriate treatment and care. For example, service providers are responsible for understanding how a child's age and development affects their reactions to abuse and the particular dynamics of sexual abuse disclosure. In addition, service providers are responsible for educating children and families about sexual abuse during care and treatment and therefore, must have full and accurate information to do so.

The following methods for monitoring and assessing individual staff competency are:

1. implementing a knowledge assessment tool with individual staff;
2. directly observing individual staff providing services to children and providing feedback during individual and group case supervision.

The section below introduces a knowledge assessment tool to support managers and supervisors in assessing individual staff knowledge of the competency specific to the core knowledge competency areas outlined in this chapter.

[38] Health and/or psychosocial staff gain core knowledge through structured training and capacity building activities offered by their agency or another identified and competent agency in the field setting.

Children's abilities to form and express their opinions develop with age, and most adults naturally regard teenagers as more mature and knowledgeable than preschoolers. In some situations, adolescents who are seeking psychosocial and health services may have very good reasons for not wanting their caregivers to know what happened and why they are seeking care. This is particularly true in sexual abuse cases involving family members and/or close family friends. Nevertheless, service providers should aim to help identify a safe and trusted adult in the child's life who can be involved in care and treatment decisions. Otherwise, service providers can benefit by understanding the age and developmental stages of children and how they affect children's rights to participate in decision-making. For example:

- Children 15 years and up are generally mature enough to make their own decisions.
- Children 13 to 14 years are presumed to be mature enough to make a major contribution to decisions affecting their care and treatment.
- Children 10 to 12 years can meaningfully participate in the decision-making process, but maturity must be assessed on an individual basis.
- Children 9 years and younger have the right to give their opinion and be heard. They may be able to participate in the decision-making process to a certain degree, but caution is advised to avoid burdening them with decisions beyond their ability to understand.

Service providers are responsible for understanding and assessing a child's age and development, and based on this information, providing children with sufficient information to make informed choices. In addition, children should be given the opportunity to express their opinions. That being said, children may not always have their wishes and desires met; in such cases, children have the right to be informed as to why their wishes cannot be accommodated.

# CONCLUSION

This chapter covered key issues that arise while working with child survivors. For instance, service providers need to understand the laws and policies in their practice settings as well as protocol regarding confidentiality prior to working directly with children. Working with children requires a solid understanding of the local laws and systems as well as good judgment and an emphasis on promoting safety and security. Working with children is complex; agencies offering case management and psychosocial services must have established supervision systems and staff training programs in place prior to need. Chapter 5 continues with instructions to provide case management services for child survivors and brings to life several of the issues discussed in this chapter.

- ways in which the client information will be used (data collection, information sharing for case management).
- **Caseworkers should always offer children and caregivers the opportunity to ask questions or share concerns during this discussion.**

## HOW TO OBTAIN PERMISSION FROM CHILDREN AND CAREGIVERS

Explaining case management services, including the need to collect, store and possibly share their information, and obtaining permission to proceed does not need to be complicated. However, caseworkers are required to know how to obtain permission based on local laws, the child's age and maturity level, and the presence of non-offending caregivers.

As a general principle, permission to proceed with case management (and other case actions) is sought from the child as well as the parent or caregiver, unless it is deemed inappropriate to involve the child's caregiver. Permission to proceed with case management and other care and treatment actions (e.g., referrals) is sought by obtaining "informed consent" from caregivers or older children and/or "informed assent" from younger children. Informed consent and informed assent are similar, but not exactly the same.

- **"Informed consent" is the voluntary agreement of an individual who has the legal capacity to give consent.** To provide "informed consent" the individual must have the capacity and maturity to know about and understand the services being offered and be legally able to give their consent. Parents are typically responsible for giving consent for their child to receive services until the child reaches 18 years of age. In some settings, older adolescents are also legally able to provide consent in lieu of, or in addition to, their parents.
- **"Informed assent" is the expressed willingness to participate in services.** For younger children who are by definition too young to give informed consent, but old enough to understand and agree to participate in services, the child's "informed assent" is sought.

## GUIDELINES FOR OBTAINING INFORMED CONSENT/INFORMED ASSENT FROM CHILDREN AND CAREGIVERS

The age at which parental consent is needed for a child depends on the laws of the country. This means that when the child is under the age of legal consent, caregiver consent is required. In the absence of any clear laws or adherence to laws, children under the age of 15 require caregiver consent as a general rule.

## INFANTS AND TODDLERS (AGES 0–5)

Informed consent for children in this age range should be sought from the child's caregiver or another trusted adult in the child's life, not from the child. If no such person is present, the service provider (case worker, child protection worker, health worker, etc.) may need to provide consent for the child, in support of actions that support their health and well-being.

Very young children are not sufficiently capable of making decisions about care and treatment. For children in this age range, informed assent will not be sought. The service provider should still seek to explain to the child all that is happening, in very basic and appropriate ways.

## YOUNGER CHILDREN (AGES 6–11)

Typically, children in this age range are neither legally able nor sufficiently mature enough to provide their informed consent for participating in services. However, they are able to provide their informed assent or "willingness" to participate. Children in this age range should be asked their permission to proceed with services and actions which affect them directly. This permission can be provided orally by the child, and documented as such on the informed consent form. For children in this age range, written parental/caregiver informed consent is required, along with the child's informed assent. If it is not possible to obtain informed consent from a parent or caregiver, then another trusted adult, identified by the child, who can be safely brought into care and treatment decisions should be approached to consent for the child.

## YOUNGER ADOLESCENTS (AGES 12–14)

Children in this age range have evolving capacities and more advanced cognitive development, and, therefore, may be mature enough to make decisions on and provide informed assent and/or consent for continuing with services. In standard practice, the caseworker should seek the child's written informed assent to participate in services, as well as the parent/caregiver's written informed consent. However, if it is deemed unsafe and/or not in the child's best interest to involve the caregiver, the caseworker should try to identify another trusted adult in the child's life to provide informed consent, along with the child's written assent. If this is not possible, a child's informed assent may carry due weight[62] if the caseworker assesses the child to be mature enough, and the caseworker can proceed with care and treatment under the guidance and support of his/her supervisor. In these situations, caseworkers should consult with their supervisors for guidance.

[62] Due weight refers to the proper consideration given to the child's views and opinions based on factors such as his or her age and maturity.

### OLDER ADOLESCENTS (AGES 15–17)

Older adolescents, ages 15 years and above, are generally considered mature enough to make decisions. In addition, 15-year-olds are often legally allowed to make decisions about their own care and treatment, especially for social and reproductive health care services. This means that older adolescents can give their informed consent or assent in accordance with local laws. Ideally, supportive and non-offending caregivers are also included in care and treatment decision-making from the outset and provide their informed consent as well. However, decisions for involving caregivers should be made with the child directly in accordance with local laws and policies.

If the adolescent (and caregiver) agrees to proceed, the caseworker documents their informed consent using a client consent form or documenting on the case record that they have obtained verbal consent to proceed with case management services.

**NOTE**

Caseworkers are required to follow these informed consent/assent procedures and guidelines during the case action planning step when referrals for additional services take place.

## SPECIAL SITUATIONS

**If it is not in the best interest of the child to include a caregiver in the informed consent process**, the caseworker needs to identify whether there is a trusted adult in the child's life who can provide consent. If there is no other trusted adult to provide consent, the caseworker needs to determine the child's capacity in decision-making based on their age and level of maturity.

**If a child under 15 does not assent but caregivers do OR if both the child and caregiver do not consent OR the child above 15 does not consent**, the caseworker needs to decide on a case-by-case basis and based on the child's age, level of maturity, cultural/traditional factors, the presence of caregivers (supportive), and the urgency of care needs, whether it is appropriate to go against the wishes of the child and/or caregiver to proceed with case management and assisting the child so that they can receive needed urgent care and treatment services. [63]

[63] Reference **Chapter 4** for more discussion on this key issue. The decision to go against children and/or caregiver's wishes is a serious decision which should be determined, in large part, by the urgency of the child's needs (for example, to secure their immediate safety and/or to mobilize life-saving medical interventions.

**In situations where children and/or caregivers are hesitant to proceed**, caseworkers should ask additional questions to determine the cause of the hesitation to receive services. Perhaps, for example, the child and/or caregiver are afraid of losing their confidentiality because of a mandatory reporting law. In this situation, the caseworker can further discuss the client's right to participate in how to share information if warranted (e.g., in a mandatory reporting situation) and/or further discuss the risks of reporting. If serious risks are identified, then it may not be in the best interest to report, and the caseworker can further explain and discuss this with the child client and subsequently with his/her supervisor. Caseworkers should take the time to discuss the child's and caregiver's fears and concerns around proceeding with case management, and provide clear and accurate answers to help address these specific fears and concerns.

## SNAPSHOT OF INFORMED CONSENT/ASSENT GUIDELINES

| AGE GROUP | CHILD | CAREGIVER | IF NO CAREGIVER OR NOT IN CHILD'S BEST INTEREST | MEANS |
|---|---|---|---|---|
| 0–5 | - | Informed consent | Other trusted adult's or case-worker's informed consent | Written consent |
| 6–11 | Informed assent | Informed consent | Other trusted adult's or case worker's informed consent | Oral assent, Written consent |
| 12–14 | Informed assent | Informed consent | Other trusted adult's or child's informed assent. Sufficient level of maturity (of the child) can take due weight. | Written assent, Written consent |
| 15–18 | Informed consent | Obtain informed consent with child's per-mission | Child's informed consent and sufficient level of maturity takes due weight | Written consent |