Children exposed to sexual violence

in war, conflict, humanitarian crisis and low resource communities

A mental health manual for helpers

Mental health AND HUMAN RIGHTS INFO

Mental Health and Human Rights Info (MHHRI) is a resource database that gives free information in English and Spanish on the effects of human rights violations on mental health in contexts of disaster, conflict and war. The resource database contains publications that discuss psychosocial interventions at individual and community level. It also provides information about organisations that work in this field.

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Mental Health and Human Rights Info

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Preface

Sexual violence against children is a severe violation of human rights. These rights are frequently violated all over the world but in particular in poverty settings as well as during wars, conflicts, and migration. Additionally, sexual violence often happens in situations where there is limited or no access to specialised health services, and the lack of any help and support causes many children and young people to suffer mentally. This can have severe and negative consequences for the rest of their lives.

In recent years, this gap between the specialist services that are available, and the enormous need for mental help has been of great concern to the World Health Organisation (WHO), and they have developed a strategy on how to fill this gap. It relies heavily on task-sharing, meaning that people without health care qualifications can be trained to provide basic mental health care such as protection, support and psychoeducation. The intention is to prevent people with minor mental health conditions from developing more serious problems. Furthermore, it is also designed to prevent the health systems from being overloaded.

Mental health and Human Rights Info (MHHRI) have earlier developed two similar manuals, one for female survivors of sexual gender-based violence and one for abused boys and men. This new manual from the MHHRI is an important and much needed tool for helpers and caregivers that are working with children who have survived sexual abuse in war, conflict, humanitarian crises or in low resource communities.

The manual is designed to identify and understand reactions to trauma, and deal with the different immediate and long-term responses that children display after they experience traumatic events. The manual explains in accessible terms the psychology of trauma and how traumatic events affect mental health. What are the signs? How can these be assessed and understood? How should helpers and caregivers approach children who are very distressed after having been sexual abuse? How can helpers and caregivers create safe spaces for dialogue and give support that will help the child to recover and heal? In addition, it also shows how we can refer to human rights principles and address the rights of child survivors, and clarify the consequences of violating rights, both for child survivors and for society as a whole. A human rights approach underlines how important it is that the child understands its own story, and that the helpers respect the child's self-determination.

FORUT is very proud to be partnering with the highly professional team from MHHRI. We are grateful that our local partners in Nepal could be test-pilots for the manual and give their valuable feedback. Thank you very much for this opportunity. We are sure that this manual will provide non-specialist helpers who work with traumatised children with good tools that they can use to help children rebuild their lives and regain their sense of dignity.

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Gjøvik, 08.03.2023

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We also thank Plain Sense for their valuable input and for editing and finalising the document.

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1. Introduction and purpose

In part one we provide background information on sexual abuse of children, and practical information about the manual and its purpose, use and structure. We present four cases that contain elements from clinical experience and professional literature. The cases illustrate the experiences of children exposed to sexual violence and provide elements of context. They describe reactions that children often struggle with after such experiences as well as helpful tools for helpers.

1.1 Who is this manual for? What you will learn

This manual is written for helpers and caregivers who work with vulnerable children and their families in war, conflict, humanitarian crises and particularly in low resource communities. Its purpose is to assist helpers and caregivers who meet children exposed to sexual abuse. It is designed primarily for use in training workshops but can also be read individually. Its addresses helpers and caregivers who meet children in their daily lives and who can assist children through play, teaching and socialising. Though they have different roles, the work of helpers and caregivers has much in common.

This is not a therapy manual. It contains exercises which helpers can use with good therapeutic effect. These exercises can be used in training workshops with other helpers or individually with a child. Icons in the margin of the text indicate the purposes of different exercises: for discussion, to sensitise helpers in a workshop, tools for working with abused children, etc.

Sexual abuse occurs all over the world but even more often during wars, conflict, humanitarian crises and in low resource communities, which are generally characterised by poor enforcement of the rule of law, the breakdown of social and family structures, and social discrimination. This manual has been developed for use in situations where helpers, caregivers and humanitarian workers have limited or no access to specialised health services. We hope it will also be useful to those who work with sexual abuse in wealthier countries and countries that are stable.

The manual is therefore written primarily for helpers and caregivers, not only for psychologists and psychiatrists. What do we mean by 'helpers'? Helpers work in a variety of professional capacities. Some have caring for abused children as their primarily function, others may meet them less often. We refer to employees in public or non-governmental organisations (NGOs), such as social workers, nurses, schoolteachers, and volunteers, who in the course of their work come across and assist children who have been exposed to sexual violence, need psychosocial help and support, or should be referred to specialised primary and secondary health services. Caregivers or carers include parents, relatives or others who care for or support children in everyday life, as well as professional caregivers who work in institutions and foster homes. We use the term helper for the both groups, except where the role of a caregiver is explicitly mentioned.

1.2 How to read the manual

The manual can be used to support formal teaching and supervision, group trainings, or personal study (alone or in groups). First of all, it is a collection of useful advice and ideas and seeks to be a practical resource. It contains practical exercises and tools. Also, it brings together background knowledge that can be of value when talking with children who have been exposed to sexual abuse or violence. In addition, it links human rights to practical work with children. Because many children have been exposed to serious human rights violations, helpers should make themselves aware of the relationship between abuses of human rights and provision of care and assistance to children.

What, how and why

Helpers are always looking for sound tools and information that assist them practically on how to help exposed children. In this manual we try to provide exactly that. But in order to give good help, more knowledge is needed. We need to understand **what** is happening in the brain, in the body, in the thoughts, emotions and behaviour of a child who has been sexually abused. We also need to understand **why** children react in certain ways when they experience trauma and **why** we believe the tools we recommend are effective. Some reactions are very common, but at the same time every child and every child's experiences are unique, influenced by the context, pre-trauma experiences, the individual's personality and different resilience factors. A helper cannot therefore apply tools blindly but must adjust them to meet the needs and circumstances of each individual child. Helpers can do this by considering the mechanisms that underpin trauma (the 'what') and why various tools are able to address them (the 'why').

1.2.1 The manual's structure

Part One provides practical information about the manual, its purpose, use and structure. It is followed by four original stories about abuse, which are based on real cases that were sent into us from Afghanistan, Brazil, India, Nepal, Nicaragua, Northern Iraq/Kurdistan, South Africa, and Sudan. Their main purpose is to describe the behavioural and psychological reactions of child survivors of sexual violence concretely, so that children's experiences and responses are recognisable in other situations.

The stories evoke individual and cultural differences in order to assist caregivers and helpers to understand children's reactions and support them in the best possible way. They reflect the diversity of individual experiences; but they share common features in that they all describe experiences of direct or indirect violence and abuse. The stories play a key role in the manual and are referred to in the text. They can also be used metaphorically, as proxies for events that children find difficult to talk about directly.

Part Two discusses the helper's role and responsibility, and how helpers can strengthen their skills. In addition, it considers how to be a good helper and how to create space for difficult conversations.

Part Three discusses what is useful to know when you are working with children who have been sexual abused. It describes theories that explain trauma reactions, and explains how trauma and sexual abuse affect the brain, development and attachment. It also discusses the way children think, their survival strategies, and their resilience. It introduces some key topics, including principles of human rights and the human rights-based approach. A section then discusses how to notice and interpret vulnerabilities, a skill that can assist helpers to identify children who may have been abused or are in a vulnerable situation in other ways. **Part Three** also describes the different trauma reactions that children can experience after sexual violation. The idea is to show the characteristics of such experiences and what children are likely to struggle with after they have been abused.

Part Four discusses 'useful forms of help', practical skills and techniques that helpers can draw on when they work with sexually abused children. This Part includes information about how children express trauma and how to create conditions in which children feel safe, as well as exercises, tools and information on understanding and managing children's emotions.

This Part includes Questions to reflect on, and tools. It can be useful to practise different tools with a colleague. Through role plays, you can rehearse interventions, psychoeducation techniques, and practice applying the case stories. The text speaks of 'tools' and 'toolboxes' to denote some

of the practical skills and approaches it describes, and also refers to the stories. Sections in this Part discuss how a helper or carer can talk appropriately to children, identify opportunities to create trust, respect a child's desire for "distance" and silence, and appreciate their resilience and capacity to survive. In terms of practical approaches, this Part describes additional techniques, exercises and tools that can assist helpers to understand and regulate children's emotions.

Part Five focuses on helpers. Empathy is an important quality for a helper or caregiver; to be able to take care of children who have been traumatised, helpers must feel for the children in their care but must not be overwhelmed by what the children have suffered. This section discusses how to manage the stresses to which helpers are exposed when they work with children who have experienced sexual abuse.

Throughout the manual you will find exercises and questions to reflect on.

In **Appendix 2** we have gathered more stories from around the world to assist helpers to understand the different experiences and more reactions they see in children exposed to sexual abuse and also describes different context for the child and for the helper. These stories can be used when talking to children. The stories enable the helper and the child to examine painful experiences and emotions from a more detached perspective. Stories make experiences and feelings easier to understand and deal with; they make difficult topics safer to touch.

Since this is not an academic text, for readability there are no references in the text, but for your convenience and further reading, we have added a list of literature that we have used in making the manual.

Keys to symbols

Questions to reflect on

Helper Advice

Role Play Exercise
Role Play exercises, for pairs.

Workshop Exercise
Exercises in plenary or small groups.

Work with children

1.3 Abuse in childhood

Aim. To explain how sexual abuse affects child development.

The World Health Organisation (WHO) distinguishes between three different types of abuse in childhood. Sexual abuse (SA) occurs when a child is involved in sexual activity that it does not fully understand, to which it cannot give informed consent, for which it is not developmentally prepared, or that violates the standards of the society in which the child lives. Physical abuse (PA) occurs when a caregiver or another person inflicts actual or potential physical harm on a child. Emotional abuse (EA) occurs when a caregiver or another person fails to provide a developmentally appropriate or supportive environment in which a child can develop a stable and full range of emotional and social competencies, taking account of the child's potential and the social context in which the child grows up.

Because different types of maltreatment often occur together and affect many areas of children's health and development, we have used the concept of 'nurturing care' to assess children's needs and rights. Nurturing care occurs in a relatively stable environment that is sensitive to the child's health and nutritional needs; that protects the child from threats; and that includes responsive and emotionally supportive interactions as well as opportunities to play and explore. The domains of nurturing care include health, nutrition, security and safety, early learning, and responsive caregiving. A child that is mistreated may be developmentally affected in all the above domains and all should be considered when support is provided. It is also evident that a child's needs evolve with age, maturity and functional capacity. This too must be considered. In addition to knowing the child's social context, therefore, helpers and carers must understand child development. The nurturing care framework assists helpers and caregivers to position the child in relation to several domains, assess risks and protective factors, and identify entry points and resources.

Guidelines for mental health and psychosocial interventions in humanitarian settings are also relevant when helping children who have experienced sexual abuse or violence. Relevant guidelines describe the human rights-based approach, the Do No Harm principle, and good practices in relation to co-ordination and integrated services. In general, it is good to avoid standalone interventions that focus on a single group or topic. Ideally, psychological interventions to support child survivors of sexual violence and abuse should be integrated with physical health care, legal support, financial support and other relevant services. The following ethical and human rights principles should guide work with children:

- Do no harm.
- The best interest of the child.
- The evolving capacities of the child.
- Non-discrimination.
- Respect.
- Integrity.
- Participation.

When applying these principles, the concept of nurturing care can help you to consider and take into account a child's age and maturity, as well as relevant values, norms and resources.

1.4 The global context

Aim. To show that the breakdown of social structures worsens the incidence of sexual violence.

Mistreatment of children is a global problem. A review of 217 studies found that one in eight children across the world (12.7%) had been sexually abused before reaching the age of 18. Most research on child abuse has focused on sexual abuse, but it is likely that other forms of abuse (PA, EA) are as frequent and often coincide. Sexual abuse has been found to have particularly severe consequences and is often associated with stigma and secrecy.

In humanitarian emergencies and disasters, children are particularly vulnerable to violence, abuse, exploitation and neglect. These abuses are likely to increase in situations where protective norms cease to function. In armed conflicts and refugee settings, girls are particularly exposed to sexual and other forms of abuse, as well as exploitation by combatants, security forces, members of their communities, aid workers, and others.

In general, orphans, unwanted children, and children who are unprotected for other reasons, are especially vulnerable to abuse. Children with special needs, physical or intellectual disabilities or neurological disorders are also at increased risk, as are children and adolescents who identify (or are identified) as lesbian, gay, bisexual or transgender.

Child abuse may also increase when caregivers or their communities experience financial difficulties, housing problems, unemployment or severe stress, or when for any reason childcare breaks down within extended family systems. Abuse of alcohol and drugs, gender and social inequality, involvement in criminal activity, isolation, family breakdown, or violence between family members are additional risk factors.

Caregivers are more likely to abuse those in their care if they have certain characteristics. For example, if caregivers were themselves abused, have low self-esteem, have poor impulse control, or lack understanding of child development.

Although sexual violence occurs everywhere, risks surge in emergency contexts. During armed conflict, natural disasters and other humanitarian emergencies, women and children are especially vulnerable to sexual violence. This includes conflict-related sexual violence and trafficking for sexual exploitation, as well as other forms of gender-based violence. These crimes are significantly underreported. Save the Children (2017) estimated that more than 20% of all children worldwide have experienced sexual abuse. The UN High Commissioner for Refugees (UNHCR, 2017) reported that boys as young as 10 years of age were subjected to sexual violence in connection with incarceration or arrest during the conflict in Syria. In a qualitative study of relief workers and refugees in Italy, the Women's Refugee Commission (2019) found that a larger number of single male minors crossing the Mediterranean had suffered sexual abuse. Save the Children's report in 2017 found that children who were placed in, or had an association with, asylum centres were very likely to experience violence or sexual abuse.

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Child survivors of sexual abuse are at a higher risk to experience long-term physical and mental effects. This is widely discussed in specialist literature; but knowledge about mental long-term consequences is not generally accessible to helpers and carers who are practically assisting children at risk. Culturally sensitive information is even less available, especially in places that are experiencing a humanitarian emergency.

We know that early intervention is crucial for the physical and mental health, and wellbeing and rehabilitation of such children. Sexual abuse is associated with taboo and shame in most societies, and when it happens to children it is particularly shocking. For the child, and also for the child's family and relatives, it is usually extremely difficult to deal with. We know that few children who experience this type of violence report it to adults (even to adults they trust). Far too few are identified and receive help in well-functioning societies; even fewer are identified and supported in societies that are experiencing war or other emergencies.

1.5 Related manuals – how to prevent sexual abuse of children

Sexual abuse does not occur in isolation. Interventions to protect the mental health of survivors must take account of broader humanitarian guidance. Several manuals about children and sexual abuse already exist. What makes our manual unique is that it aims to support helpers in war, conflict and humanitarian situations and in low-resource settings.

UNICEF's manual Action to End Child Sexual Abuse and Exploitation is designed for policy makers and partners. It proposes a framework of action to prevent and respond to child sexual abuse and exploitation, three common approaches to prevention:

1. Mobilise to change social norms, attitudes and behaviour (most common).
2. The environmental and situational context that creates opportunities for abuse)
3. Reduce risks of children victimisation using social and economic empowerment programmes (cash transfer and social safety net (SSN) projects, life-skills training, education and protection awareness, assisting parents to protect their children, etc.).

Primary prevention programmes increasingly combine these strategies, increasing their effectiveness.

The World Health Organization's manual INSPIRE Handbook: action for implementing the seven strategies for ending violence against children explains in detail how countries can choose and implement interventions. Chapters address implementation and enforcement of laws; norms and values; safe environments; parent and caregiver support; income and economic strengthening; response and support services; and education and life skills.

The Child Protection Working group's Minimum standards for Child Protection in Humanitarian Assistance includes activities that child protection actors, humanitarian staff can use to strengthen local capacities.

The Committee for Children's How to Talk with Kids About Personal Safety and Sexual Abuse is a conversation guide. Talking about personal safety is one of the most powerful ways to protect children from sexual abuse. Based on decades of research, the guide provides practical, digestible advice and age-appropriate conversation starters, giving caregivers and helpers confidence to navigate and normalise conversations with children about their safety.

It is worth stressing that one can talk to children about safety, consent and boundaries without mentioning sexual abuse specifically. An important message to communicate is that a child is in charge of its own body. The videos 'Boss of My Own Body' and 'Consent for Kids' were made to help children understand body autonomy and consent. It discusses what others are allowed and not allowed to do with our bodies. Affirming that children have authority over their bodies teaches them about boundaries, enabling them to recognise inappropriate behaviour. Abusers may encourage the child not to tell anyone about their abuse or try to convince the child that what they do is normal. But the child who understands bodily autonomy will know that such claims are false. Because the child understands what is appropriate and what is not, it may try to stop unwanted actions or tell another adult about them. Knowledge removes shame, and because shame inhibits us from speaking, people – including children – can act to prevent future abuse when shame is removed.

1.6 The human rights-based approach

Aim. To increase understanding of human rights principles, particularly children's human rights, and the consequences of violating them.

Human rights apply to everyone, regardless of gender, race, age, nationality, faith, or other factors. International human rights declarations and conventions affirm that every person is entitled to specific rights and to be treated with dignity and respect. The UN Universal Declaration of Human Rights states that the rights it sets out are the foundation of freedom, justice and peace. The Convention on the Rights of the Child (1989) sets out the rights of all children and affirms that all decisions and all conduct with respect to children should be governed by the child's best interest.

This manual begins from the position that sexual violence against children is a severe violation of human rights. One of its purposes is therefore to make clear how human rights principles protect and address the rights of child survivors of sexual violence and abuse, and the consequences of violating rights both for child survivors and society as a whole.

International legal rights are negotiated by states and set out in international agreements (conventions, treaties, protocols). When a state signs and ratifies a human rights agreement, it assumes legally binding obligations with respect to the rights it affirms. In addition, states have created a number of mechanisms and systems that monitor and investigate states' performance of their human rights obligations, interpret the meaning of conventions, and receive appeals on cases.

Numerous rights are relevant to sexual violence against children, most obviously the right to life and bodily integrity, the prohibition of torture and cruel and inhuman treatment, the prohibition of slavery and forced labour, and the convention on the rights of the child. These principles are deeply entrenched in international law. Sexual violence threatens life and personal integrity and can cause serious harm to individuals who are abused. States are required to follow up allegations or information about violations of fundamental rights, in particular the right not to be tortured or subjected to cruel and inhuman treatment. This means that States must investigate allegations and provide protection and remedy if violations have taken place.

Human rights laws and standards assert that states and other governmental actors have a duty to respect every person's dignity and physical and mental integrity. They therefore provide a foundation of principle for work with children who have been exposed to sexual and other forms of abuse. In practice, this means that psychosocial interventions and treatments that are offered to child survivors of sexual abuse and violence must align with human rights principles. As helpers and carers, our personal conduct and the actions we take should respect the dignity and integrity of survivors; and we should treat and analyse the abuses that children experience in terms of human rights law as well as in medical and therapeutic terms.

In sum, human rights standards can ground and inspire our work with children who have been abused; and provide tools for action. We can explain to children, so that they can see for themselves, that the violence they have experienced violates important rules and principles that are legally recognised internationally and generate legal obligations and duties for public authorities. We can further explain that children who have experienced sexual abuse or violence are entitled to help and support because it is the responsibility of states and other authorities to provide help, treatment and protection to victims of such crimes, and eventually to prosecute those responsible for them. In addition, children are entitled to specific forms of protection that consider their education, care and development as well as their physical and psychological safety.

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The work we do together to mitigate and heal the impact of sexual violence on mental and physical health of children promotes human rights too. It contributes to the protection of rights, individually and societally. Children's rights include protection, provision and participation.

Questions to reflect on

- What violations of children's rights have you witnessed?
- Do you follow human rights practice when you work with children? How?

1.7 Cultural aspects

Aim. This section focuses on some specific cultural mechanisms and practices that helpers can use as "tools for open exploration". The topics are not an exhaustive list: you can add others that are important in your cultural context.

1.7.1 Cultural sensitivity as a tool

Context is crucial to child development, and culture is an important part of a child's context. Culture enables people to create relationships with others and influences child rearing. Cultural attitudes, identity and habits are to a great extent "implicit knowledge". We are seldom aware of our own culture until we meet people from different societies, or experience discrimination, or encounter values and ideas that do not match our cultural beliefs. Working in multicultural settings, helpers cannot be expected to make themselves familiar with every culture. But it is essential to be aware that culture may influence the form that child sexual abuse takes, and even how the child experiences abuse, and the attitudes towards an abused child. Helpers who develop a flexible and open approach to culture put themselves in a better position to understand child sexual abuse in diverse settings, but also make themselves more approachable: children are more likely to disclose abuse to someone they think understands them.

Becoming and remaining culturally sensitive requires continuous work to make ourselves conscious, and remain conscious, of our cultural attitudes. The most important starting points are to be humble and curious and recognise that our knowledge is always limited.

1.7.2 Culture; physiology and the psychology of trauma

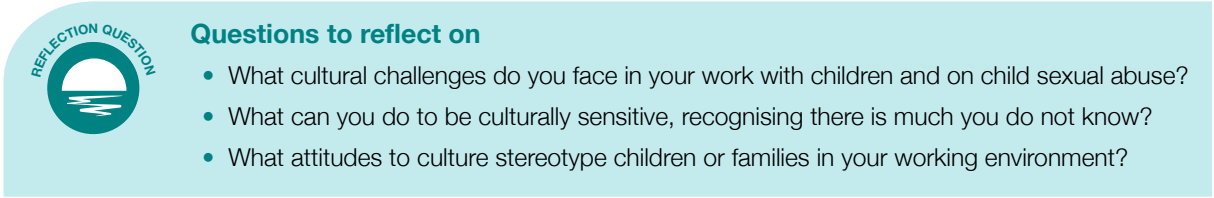
"Physiologically, humans react to danger and shock in much the same way everywhere, regardless of the society they come from. Culture nevertheless influences how people express and interpret their feelings and reactions. This means that people in different societies may show and read responses to danger and shock in various ways."

Physiologically, humans react to danger and shock in much the same way everywhere, regardless of the society they come from. Culture nevertheless influences how people express and interpret their feelings and reactions. This means that people in different societies may show and read responses to danger and shock in various ways.

Culture also influences attitudes to child sexual abuse. In many societies, sexual violence and abuse are taboo, and cause survivors (and their close relatives) to feel guilt and shame. Sexual abuse is condemned in most cultures, but how it is understood and addressed may differ. How a child's family and community respond to child sexual abuse is likely to reflect their attitudes to sexuality, gender, children and childhood. Guilt and shame are culturally conditioned and what they attach to, as well as their expression and gravity, varies from society to society. At the same time, they are feelings that arise within the person; they have a social character, but are also intensely private and personal. Certain cultural or religious attitudes to sexuality depress the reporting of abuse. Society may shame the victim of abuse, even though they were not responsible for it. Survivors may be unable to seek or find support from within their community.

On this question, human rights law is clear. Responsibility for violating a right (including sexual abuse, psychological abuse, rape or sexual violence) lies with the perpetrator. The state has a duty to punish perpetrators of sexual abuse and violence. Child survivors of such violations are entitled to protection, justice and redress.

Through culture we transmit ideas, values and ways of living, and impart knowledge and skills, all the 'wisdom' that a society needs to survive and flourish over generations. At the same time, some elements of culture can be harmful. While we must always bear in mind that we will never fully understand every social context, if we have cultural understanding and sensitivity, we can facilitate the disclosure and discovery of abuse and can understand better the situation of a child who is being abused.



Questions to reflect on

- What cultural challenges do you face in your work with children and on child sexual abuse?
- What can you do to be culturally sensitive, recognising there is much you do not know?
- What attitudes to culture stereotype children or families in your working environment?

1.8 Four cases

Aim. The four stories in this section highlight characteristic experiences and reactions to trauma, and illustrate concepts, theories, observations, reactions, tools and measures that the manual discusses. They provide background and context and illustrate forms of trauma. Trauma can originate as a single experience but can often be due to a succession of experiences and a stressful life situation.

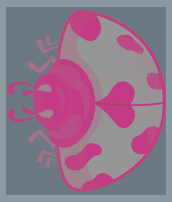
The cases are based on real cases that were sent into us from Afghanistan, Brazil, India, Nepal, Nicaragua, Northern Iraq/Kurdistan, Ukraine, South Africa, and Sudan. In the appendix we have gathered more cases that describe different situations of childhood sexual abuse. It is evident that four stories will not cover every form of experience, and we encourage you to look for case illustrations that are representative of the culture and social context in which you work.

The four cases describe children of different gender and age. The perpetrator and the child's relationship to the perpetrator also vary. They discuss the experiences of three girls and one boy, who are from Nepal, Sudan, Brazil and South Africa, and are 4, 8, 10 and 13 years old. Three of the stories (of girls aged 4, 8 and 13) describe what happened, the girls' reactions, and the help they received. One of the stories describes the experience of a boy aged 10, with whom the counsellor lost contact after two sessions. We would like you to reflect on this problem, which is not uncommon.

Stories help to bring theory and advice alive. We hope these stories will assist you to understand the reactions of children you see who have been exposed to sexual abuse. Stories are also useful tools when talking with children. They can help us talk aloud about painful and private experiences, and to distance such experiences. They make difficult topics safer to touch. Many children find it difficult to open up and tell their own story, especially if it is painful or confusing, or feels shameful. If they are very young, they may not even have the words to articulate clearly what happened to them. But to receive help and assistance, they don't necessarily need to share their own story. They can recognise their own trauma and reactions through the stories presented here.

Rama

13 years old, Nepal



The story describes

- A dissociated state and fragmented memory.
- Multiple traumas.
- That repressed traumas may be triggered by a new trauma (in this case an earthquake).

Rama is 13 years old. Her mother, Sunita, is single. They live in Kathmandu.

Sunita had been forced to marry her brother-in-law. He abused her physically and sexually until she ran from her village and came to Kathmandu, taking Rama with her. Rama was then very young. Sunita took two jobs to earn enough to survive. But she lived close to her sister and her husband who helped her to take care of Rama.

Sunita was also supported by the church community and made good friends with a couple from Britain at her workplace. Rama also went to church regularly and attended Sunday school. She had lots of friends and was a happy girl.

When Rama was around 5 to 6 years old, her mother worked in a school as a cleaner. The school provided them with a small flat. Rama used to be on her own when her mother was working. One man at the school was like a father figure to Rama. He used to play with her and sometimes took her on outings when Sunita was working. Rama was happy because the man gave her affection and attention. She wanted him to spend time with her.

When Rama was 13, Nepal experienced a major earthquake. Afterwards, Sunita's friend from the UK noticed that Rama was **acting strangely** and was **very anxious**. After a while, she took Rama to see a counsellor. The counsellor was told that Rama had become anxious during and after the earthquake and that the earthquake may have affected her.

During Rama's first session, the counsellor tried a technique called **EMDR (eye movement desensitisation reprocessing)**. EMDR is a way of tapping into the unconscious and Rama therefore started to reveal things of which she was not herself completely aware. She became very anxious and it took the counsellor a long time to calm her down. Rama said that she saw the figure of a dark man and then that he was going into a deep well. After several sessions, one day she told the counsellor that a man had abused her sexually. When asked more questions, she gradually shared more information about the incident.

Reactions

Once she realised that she had been sexually abused, Rama suffered mentally even more. While continuing her counselling, she also saw a psychiatrist, and was on medication. Despite her treatment, she suffered a range of symptoms.

She became **scared and anxious**. She was afraid to be on her own, and feared closed places. She stopped going to school because she **couldn't concentrate**. She was scared when she saw the school gate and refused to go in. She had **nightmares** and sometimes her mother said she woke up at night and **stared into space**. When she went back to sleep, Sunita had to wake her from this state.

After a year of continuous counselling, Rama was finally able to identify the perpetrator – the man from the school. Once, she told the councillor that she was **afraid of harming herself**. She was also hospitalised because she started showing **psychotic behaviour**. She would **hallucinate**, say that someone was trying to get at her, feel that someone was trying to tell her something. Rama was hospitalised for a few days. Afterwards, she continued her counselling sessions, could differentiate between truth and imagination, and was able to go to school again.

Sunita blamed herself for her daughter's situation. She too went for counselling. Though raised alone by her mother, Rama had support from her aunts, her mother's employers, and some church members. Sometimes the church members suggested that she might be possessed by the devil, so they used to have prayer services for her.

What helped

When Rama came to the counsellor, she was afraid. Neither the counsellor nor Rama knew what was happening. It took them almost six months to find out that she had been sexually abused and almost a year to find out who the abuser was. It took lots of **grounding exercises** to reduce Rama's anxiety.

In the first session, she was so anxious that the counsellor worked only on **calming her. Counting the objects around the counselling room and deep breathing** helped her. The counsellor challenged many negative thoughts and **turned them into positive statements.** She used several techniques. She and Rama created a **coping toolbox** together, with lots of activities for Rama to do when she felt anxious. They made a **list**, which Rama **posted in a visible place in her room**. Much **encouragement, positive affirmation, some Biblical encouragement, prayers, and many therapeutic activities** enabled Rama finally to restart school.

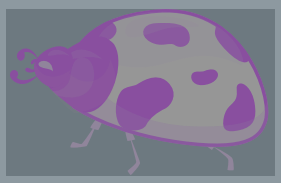
At the end, Rama was able to see the abuser at school without being scared and anxious. (She did not want to press charges because the man was married and had a small baby.) She was also able to separate her hallucinations from reality. (She could say that the figure she saw and the voice she heard were not real and she could challenge them.) She was able to face her fears and go to school.

After almost two years, she reduced her sessions from once a week to once a fortnight, then once a month. The counsellor recommended a follow-up session every three months and then six months; but these did not take place.

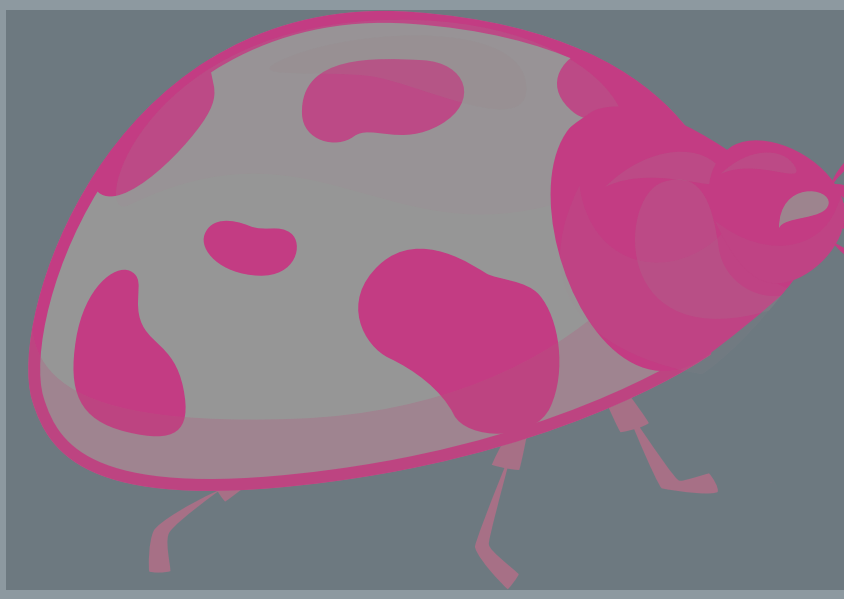
Summary

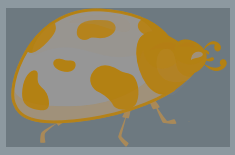
Reactions	Tools	Reflections
• Repressed trauma • Anxiety • Fear of closed rooms • Scared of being alone • Nightmares • Poor concentration • Stops school/avoidance • Thoughts of self-harm • Stares into space/ dissociation • Hallucinations/ psychotic behaviour • Fragmented memory	• Calming • Grounding • Changing negative thoughts • Activity toolbox to regulate • Positive encouragement • Prayers • Support of her network	• Why did she not remember? • How can she regulate herself? • How important is cognitive work? • How can spirituality help? • How important is network support?

Asma



4 years old, Sudan





The story shows that:

- Asma was abused by her father.
- Because she is a small child, she requires different recovery tools than older children, such as playing and drawing.
- Asma has other types of reaction, such as bedwetting and nightmares.

Asma was born in 2015. She lived with her parents until she was 3 years old. Her childhood at that time was good, and she was happy. She often went to the park or went shopping with her parents and her younger sister, Jalila. They were nice days.

When she was about 3 years old, her life changed. Her parents started to have problems. Her father began to beat her mother and refused to take care of Jalila. He injured Asma's mother so badly that she had to go to hospital. Asma was upset by the violence and the injuries to her mother. Her mother asked for a divorce.

Asma loved her parents, even her father, and the divorce was very difficult for her. Both she and Jalila were overwhelmed by sadness and anxiety.

After the divorce, Asma, Jalila and their mother went to live with Asma's mother's relatives. The extended family included grandfather and grandmother, three uncles and two aunts, all living in the same household. Asma had no private area to herself. Her mother had separated from her father, but Asma and Jalila went to stay with their father at his family's house on weekends. Every week, Asma also went to kindergarten.

In 2019, while she was visiting, her father abused Asma sexually. He penetrated her with his finger while she was sleeping and told her not to tell her mother. The abuse continued each time she visited; she told no-one. On one holiday, her father became even more violent. He molested her, beat her and threatened her with a knife. Despite her father's threats, she tried to talk to her paternal grandfather about what was happening, but he did not believe her and beat her for lying.

When Asma returned to her mother's house, she did not tell anyone what had happened, but her **behaviour began to change**. She was **fearful and refused to go to the kindergarten**. She **stopped playing with her sister**. At the time, her mother did not understand what was wrong. When the next holiday came and she was expected to visit her father again, she started crying. Finally, she told her mother what had happened to her.

Her mother took her to the Family and Child Court and a paediatrician did a physical assessment. When the tests confirmed that Asma had been molested, the police imprisoned her father for a few months. For a period, Asma felt safe. Then she started to have **nightmares**. A short time afterwards, she **began wetting her bed**. She displayed **severe fear reactions** when she heard her father's name.

When released from prison, Asma's father went to the Personal Status Court to petition to see his two daughters, and the court granted him access. When Asma's mother refused to implement the ruling, the judge imprisoned her for a month. This worried Asma even more, and Asma's symptoms of **anxiety and fear increased**. She had **more nightmares** about her father and **feelings of insecurity**. Her mother's family tried their best to support the two girls until Asma's mother came out of prison.

Reactions and symptoms

Her father's violence and her parents' divorce made Asma sad. When her father then sexually abused her, Asma became insecure. She was **afraid of men, afraid of closed places, and intensely anxious**. She became **hyperactive and lacked concentration**. She was unable to pick games to play, could not concentrate and was **easily distracted**. She had **nightmares**, and sometimes woke up in panic. She **wet her bed**. She **avoided talking** about her father or what had happened to her, **refused to go to kindergarten**, **lost her appetite** and **felt sad**. At night she felt anxious: darkness triggered bad memories.

What helped?

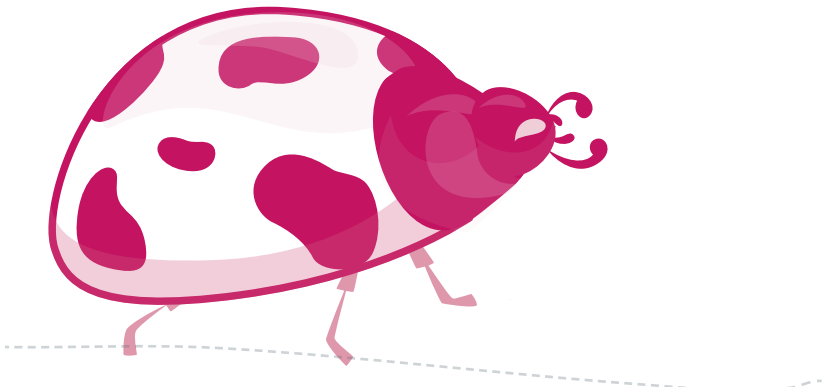
When Asma first visited the therapist at the trauma centre, she was worried and anxious. During the early sessions, she was hyperactive and could not play with one toy at a time or stay in one place. She walked around the room, unable to focus, and was easily distracted. The therapist **explained to her that her feelings were a normal reaction to what she had experienced**. She told Asma that eventually all her fears would go away.

In the beginning Asma and the therapist **played and talked randomly**. The therapist **listened carefully** to Asma's story **without judging** her. This helped **gain Asma's trust**. After a while, Asma started to open up and speak about what had happened to her. She said: "I will not forget when he slapped me". She said she hated going to kindergarten and joining the other children. The therapist listened carefully because she knew Asma had loved kindergarten. They talked about what she liked and disliked; and eventually Asma decided to return to kindergarten and began to play with her friends again. The therapist invited Asma **to draw and crayon to help her express her feelings**. She asked Asma to draw what happened, and to draw pictures of her house and family.

In parallel the therapist continued to **counsel Asma's mother, and to strengthen her ability to support her daughter**. They used **psychoeducation** to talk about symptoms of trauma, and what Asma's mother could do to help Asma. The therapist explained that Asma's hyperactivity and lack of concentration were not forms of misbehaviour but a response to what she had been through; and that avoidance was a way to not re-experience pain.

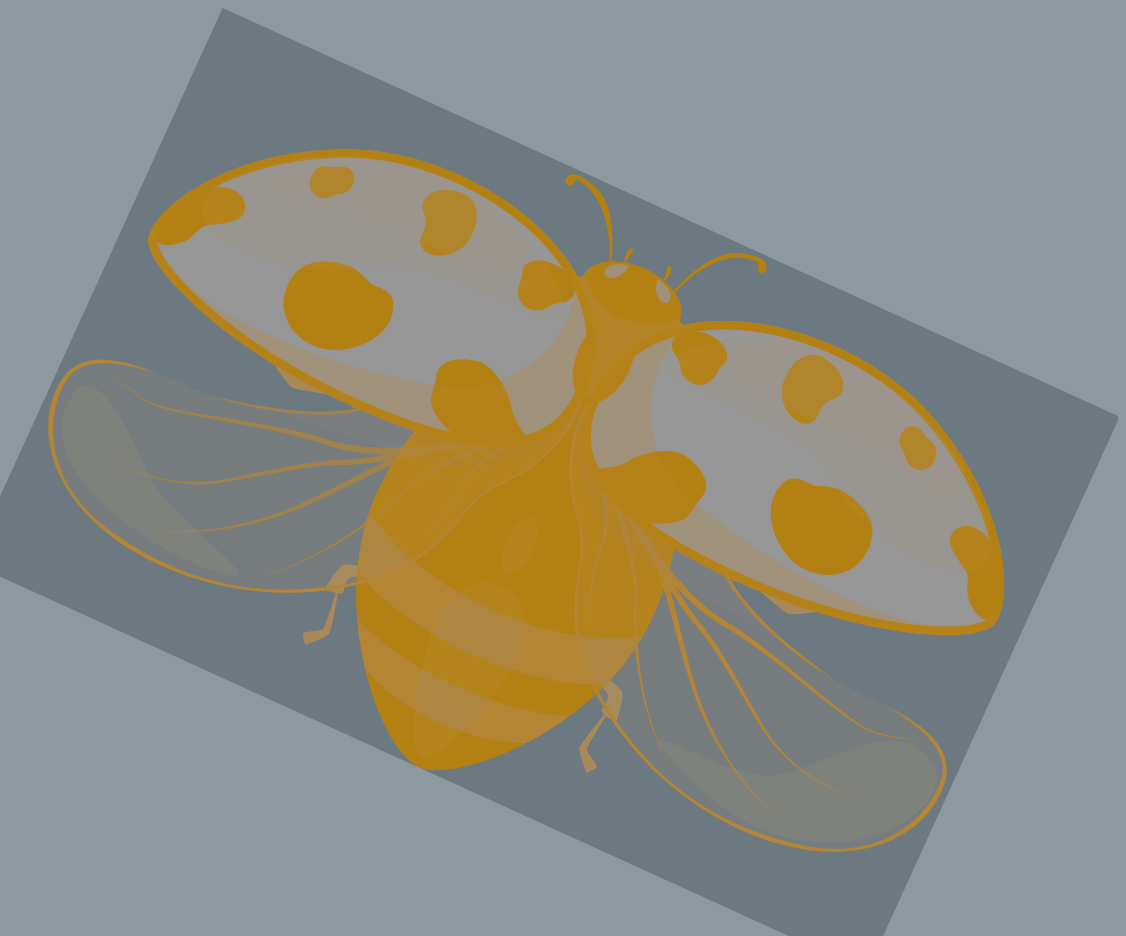
Summary

Reactions	Tools	Reflections
• Bedwetting • Avoidance • Anxiety • Nightmares • Fear of men • Fear of darkness • Distraction • Loss of agency • Hyperactivity	• Patient listening • Building relationship • Play • Normalise reactions • Drawing • Drawing what happened	• Why was play important? • Why can you not just ask? • How to use drawing as a tool. • What are Asma's mother's worries? • What help does a mother need? • Support and psychoeducation.



Sam

10 years old, South Africa



The story shows that:

- Sam comes from a family environment of crime, violence and sexual abuse.
- He exhibits antisocial behaviour and has sexually assaulted a small child.
- Is from a poor and large household.
- Is being neglected by mother, but has a caring grandmother.
- The social environment and low income of Sam's family make it difficult to provide available and affordable support.

We have included this story because:

- It is not always possible to determine what happened on the evidence of a child's behaviour and reactions: you may need to keep an open mind and consider several hypotheses.
- Sam's case illustrates difficulties that helpers may face, due to language, poverty and the social context.

Sam lived with his grandparents and extended family. Sam's grandmother reported that Sam was naughty, stubborn, and angry. Described as a "young criminal", he had stolen money as well as wheel caps and tyre bolts from cars in the community. Sam's father had died several years earlier, when Sam was four, and soon afterwards his mother left him with his grand-parents and moved to Cape Town. Sam's father had severely abused Sam physically. His mother was reported to have neglected him during this period.

Sam's grandmother said that Sam had recently started to touch young girls inappropriately. She did not know where he had learned this behaviour and worried about the safety of her granddaughters who lived at home with them. Sam's school stated that Sam had been 'very slow' since grade 1, but that he had continued to move up with his class. It was reported that Sam had attended counselling in Grade 1, because his grandmother had been concerned about his reaction to his father's death and his mother's departure; the counselling did not last long.

Eleven people lived in Sam's small and impoverished home in the township. The family had an inter-generational history of rape, abuse, under-age pregnancy, and mental illness.

In the summer of 2021, Sam's grandmother said that she returned from a journey to find her granddaughter (Sam's cousin, then one year old) humping and grinding on the couch and touching her vulva a lot. She asked what had happened while she was away and one of Sam's other cousins said that Sam had touched the little girl and put his penis on her vagina. When she confronted him, Sam eventually admitted that this was true. She took both the children to a clinic, where the little girl was found to have a vaginal rash, odour and discharge. After four counselling sessions at the clinic, the childcare worker reported that Sam was 'doing better' and that the main concern was Sam's reading and writing at school; a psycho-educational assessment was recommended

to see whether a different school placement would be appropriate. The grandmother remained concerned for both Sam and the little girl and felt under enormous pressure because she had to look after and feed everyone in her household. Sam subsequently attended two sessions at a community clinic in a town nearby.

Summary of two sessions in 2021

In 2021, Sam attended two sessions with a counsellor at the community clinic. He spoke Xhosa and very little English: the sessions largely focused on his play because the counsellor understood some Xhosa but could not communicate well with him.

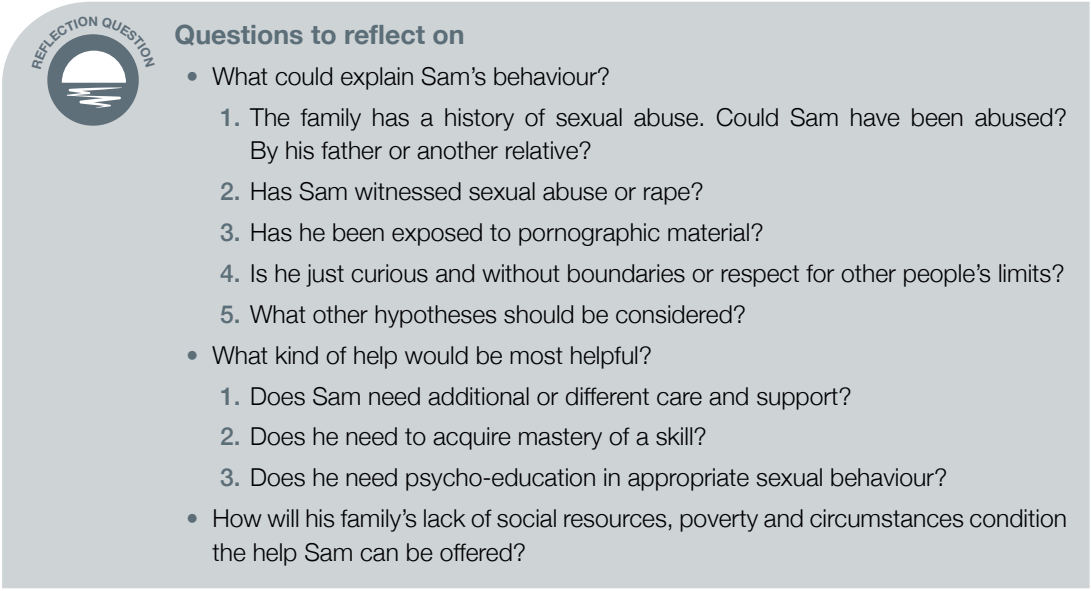
Sam's play was very active and sometimes aggressive; it often included fights with animals and soldiers that nobody won and that left everyone dead. He liked to draw. He also played with the doll's house, where he rearranged the furniture, walked the dolls up and down stairs, and had them cooking and eating. Marbles was his favourite game: he showed the counsellor how he played with his friends. He arrived in his school uniform; he did not wear socks with his shoes, and had painted some of his nails with what looked like paint (rather than nail polish). He liked to play in silence. He needed to leave the room for the toilet once during the second session after he overheard his grandmother say that she had tried without success to contact Sam's mother. Sam could draw and write his name, and the counsellor did not find him to be 'slow'. He missed one session between the two he attended, and then never re-appeared; both his grandmother and mother were hard to reach. The counsellor tried for three weeks without success. Sam's case was classified as "cold" before the generic assessment process could be completed or further assistance or referrals sought.

Current status

When we decided to include this case, it proved difficult to reach the social workers. We needed to do so to understand the process at the community clinic, which might throw light on Sam's needs. For clients who cannot afford to pay for psycho-educational assessment, there is a long waiting list. Until it shortens, Sam's case will continue to be managed through referrals and professional liaison.

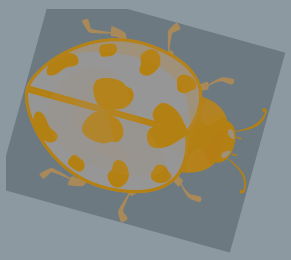
Summary

Main points	Main events	Resources
• Criminal behaviour • Steals • Slow in school • Naughty • Sexual assault on relative	• Abused physically (1-4) • Father dead • Neglected by mother • Traumatised/ abused family • Large and poor household • Abandoned by mother	• Concerned grandmother • Capacity for play/able to symbolise • Gives contact to helper • Admits assault • Seems more able than reported



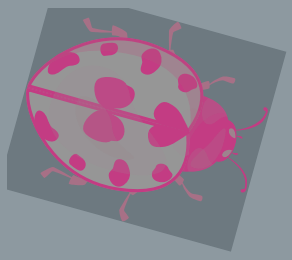
Questions to reflect on

- What could explain Sam's behaviour?
  1. The family has a history of sexual abuse. Could Sam have been abused? By his father or another relative?
  2. Has Sam witnessed sexual abuse or rape?
  3. Has he been exposed to pornographic material?
  4. Is he just curious and without boundaries or respect for other people's limits?
  5. What other hypotheses should be considered?
- What kind of help would be most helpful?
  1. Does Sam need additional or different care and support?
  2. Does he need to acquire mastery of a skill?
  3. Does he need psycho-education in appropriate sexual behaviour?
- How will his family's lack of social resources, poverty and circumstances condition the help Sam can be offered?



Maria

8 years old, Brazil



The story shows that:

- Maria was abused by a relative and was not believed when she told the story to her family.
- She reacts with shame, confusion, anxiety and anger.
- She is ambivalent about sharing her story with a teacher.
- It is important to reach out to the mother and educate her about her child's needs.

Maria lived with her mother, who worked all day to support them because Maria's father left the family when Maria was two. Maria went to a public school. In Brazil, many public schools still do not run full-time classes. Many children attend school for half a day (morning or afternoon). Maria attended the morning session. In the afternoon, her grandma took care of her until her mother picked her up after work.

One day, Maria took a nap while her grandma was running an errand. A few minutes later, her uncle came into the room and laid down in bed with her. He told Maria he was only going to cuddle her. Then, he started to pull her close and run his hands over her body. Maria started to feel confused and nervous because the way her uncle was touching her felt different from the way any adult had ever touched her before. She felt very uncomfortable and ashamed, but she could not understand exactly why.

Maria's uncle assured her that everything was fine and that his behaviour was normal. He told her that he regularly did the same thing with her cousins. He also said Maria's mother and grandmother knew about this behaviour, but it would be best not to mention it. Maria kept feeling more and more anxious and confused. Despite her uncle's comments, she did not feel his behaviour was normal. She continued to feel ashamed, that they were doing something wrong.

To escape the situation, Maria decided to tell her uncle she needed to go to the bathroom. Once inside, she locked herself in until her grandma came back. When Maria got home that evening, she decided to tell her mother what had happened. Unfortunately, Maria's mother got very upset and told her she was imagining things. She said the uncle was just being nice to her and told Maria to forget about it and never say those things again. Maria felt a lot of guilt, confusion and anger, and as if she was carrying a great weight.

Maria had no alternative but to go to her grandma's house after school. She would avoid taking naps even when she felt tired. She asked her Grandma to take her everywhere with her because she didn't want to be alone with her uncle. She felt guilty for avoiding him and was always scared that her Grandma and mother would notice something. Despite her efforts, she still ended up alone with him sometimes. He would always try to cuddle, ask her to sit on his lap, and do other things that made Maria feel uncomfortable. He kept telling her that what he was doing was natural but that she shouldn't say anything about it.

Avoiding her uncle and hiding what was happening became mentally and emotionally consuming for Maria. She **changed from being an outgoing girl to a more timid and angrier child.** She would **avoid hugs** and become **irritated if someone tried to get too close** or show physical affection. She needed to feel she was in control of her body. To be touched made her remember the feeling she had when she was with

her uncle. She was also **easily startled** and had **angry outbursts** when she was frustrated at school.

Finally, Maria's teacher finally noticed the changes in Maria's behaviour, after Maria drew pictures of abuse. Impulsively, the teacher asked Maria whether what she had drawn had happened to her. Maria denied it and said she had drawn a "bad dream". She knew better this time not to mention to adults what was happening.

Noticing that Maria had shut off even more after the drawing, her teacher consulted the school's educational social worker before contacting Maria's mother to get professional advice on how to proceed. At the time, having a social worker and a psychologist was obligatory in Brazil. Maria and her teacher were very fortunate to have these resources. With their help, Maria's teacher was able to find out how best to help Maria.

Summary

Reactions	Tools
• Uncomfortable • Reacts to assault by hiding • Protects herself by avoiding contact • Timid • Ashamed • Confused • Angry, easily startled • Denial • Avoids closeness • Does not believe this is normal	• Consider using "the life story" • Consider using "Naming your feelings"

Questions to reflect on

1. How do children react when they tell and are not believed?
2. Why is it sometimes hard for a caregiver to believe a child's story?
3. Why does Maria show her drawings and then deny the story they tell?
4. What is Maria's survival strategy?
5. How would you approach Maria's mother?
6. What kind of help do you think Maria and her mother need, individually and together?
7. If you were the helper meeting Maria, you might consider using "the life story" (described in 4.7.3) as a tool, because she is expressing herself through drawing. What other tools might be appropriate? Would you use "Naming and colour your feelings" (described in 4.4.1)?

2. How to be a good helper

Part Two concentrates on how to be a good helper and useful knowledge when working with abused children; the helper's challenges; helping skills and self-reflection; and how to keep healthy boundaries.

2.1 The good helper

Aim. To identify the helper's own resources, and additional skills and resources they might need.

Sexual abuse is a trauma experienced in a relationship and thereby differs from accidents or natural disasters. What has been destroyed in a relationship must be healed in a relationship. That is why the role of a helper is so crucial.

Helpers can act in many ways and have access to a wide range of tools. Sometimes it can be difficult to know what you can do in terms of helping. Wanting to help can create a weight of responsibility, the feeling that you are never doing enough. A helper should therefore set boundaries and decide what level of contribution is realistic. If you set no limits, it is easy to become overwhelmed; the road to burnout is short.

Questions to reflect on

- For me, what does it mean to be a helper?
- What personal experience do I bring to this work?
- What parts of the work are difficult for me?
- Where can I contribute, and where do I need to learn more?
- What is the most valuable contribution I can make?

It can help to discuss questions with colleagues. What are the qualities of a good helper? What resources do helpers need to carry out the work they do? What can helpers do to increase their skills and capacity?

Workshop exercise. Describe the qualities of a good helper

Draw a helper on the flipchart. Discuss the following questions. Write the participants' comments and conclusions on the flipchart.

- Do men and women helpers help in different ways?
- How would you describe yourself as a helper?
- What do you do when you meet a child who is overwhelmed by emotions (sadness, shame, anger, anxiety, numbness)?
- What factors sometimes make it difficult to help such children?
- Have you ever consciously used a human rights-based approach in your work? Did it help?

ROLE PLAY EXERCISE

Role play. The first meeting between a helper and a traumatised child

Practise how to meet a child who has been traumatised by sexual abuse. Helpers need to bear in mind: body language, distance and closeness, cultural codes, the words the child uses, and non-verbal feedback.

Instructions:

- Form pairs. One helper should play the role of the child, the other a helper.
- Agree in advance how old the child is, and its emotional maturity.
- Role play the child's first meeting with the helper.
- If there is time, reverse roles.

After the role play has finished, "brush off" the roles you assumed and return to being yourselves.

Discuss together how you experienced being a helper and being the child. What worked well and what might you do differently in a real situation?

2.2 The helper's challenges

The helper is the most important instrument in the "toolbox". If helpers do not function well, other tools will be difficult to use. It is crucial therefore that you are aware of the wear and tear that make your role challenging, and take steps to ensure that you can function optimally.

Working with children who have experienced severe trauma is emotionally challenging, for professionals as well as friends and family. Their stories, mental suffering, and desperation can cause helpers to feel confusion and distress. You can be affected even more strongly because the person before you is a child. Both to protect themselves and to be of use to the child, helpers need to understand traumatisation and trauma reactions.

Empathy is an important quality; but to be able to take care of children who have been traumatised, helpers must feel for the children in their care but not be overwhelmed by what they have suffered. Helpers need to observe their own reactions too, and decide when they need to withdraw a little or take a break. As a helper, you do not have control over what has happened to a child in the past: but you do have control over the choices you make when you take care of yourself and the child. To protect yourself emotionally, you need to be conscious of your state of mind, how your own history may influence it, and how the suffering of others can affect your mental health. For example, if you have had an experience resembling that of a child who has been abused, you may be triggered when the child talks about its past.

"As a helper, you do not have control over what has happened to a child in the past: but you do have control over the choices you make when you take care of yourself and the child."

2.3 Basic helping skills as a good helper

Aim. To encourage helpers to adopt and practise the qualities and psychological skills below, and thereby promote a healthy relationship with the child they assist.

We are using the WHO guidelines to focus on the basic helping skills:

- **Confidentiality.** The children you help need to know that they can speak to you openly about personal things, and that the information they give you will remain confidential or private. At the same time, you need to make clear the legal boundaries of this confidentiality. For example, depending on the laws of the country and the protection and social services in place, you may have a duty to divulge information given to you confidentially if a child appears likely to end its life or harm others. You may also have a duty to divulge information that a child has told you in confidence if not doing so will put that child at risk. Information must be kept safe. You must know how to deal with information you receive when you speak to colleagues and supervisors; and how to protect information about other people who have not consented to its communication.
- **Listen attentively.** Good communication is an important tool. Children and others who have experienced maltreatment or been through a crisis may be shy, upset, anxious, or confused; or they may feel guilt, shame or a range of other emotions. Be calm and show understanding: this helps people in distress to feel safer, understood, respected and cared for appropriately. Children who have been through distressing experiences may want to tell you their stories. They are likely to feel supported if an adult listens to them. However, it is important not to pressure a child to tell you what has happened to it. You may need to practise not talking too much; train yourself to allow silence. Be aware that many children need time and support to talk about sensitive and difficult experiences. And that young children may lack language to describe their feelings or what has happened to them.
- **Hone your non-verbal skills.** Be aware of both your words and body language, including facial expressions, eye contact, gestures, and how you sit or stand in relation to the child. Speak and behave in ways that take into account the child's age, culture, gender, social customs, and religion.
- **Regulate your concern.** Try to understand the child's experiences and feelings, but do not claim you know exactly how those experiences felt. Do not get too involved in the child's feelings. Do not confuse them with your own.
- **Praise openness.** Very often an abused child has been ordered by the perpetrator not to speak about what has happened. To speak, a child must deal with many feelings: fear of punishment by the perpetrator; possible feelings of betrayal; shame and guilt; fear the helper may refuse to listen, or may disbelieve, or may condemn what the child says. If a child starts to talk, therefore, be patient, listen attentively, and recognise and praise the child's courage in speaking.
- **Validate.** The child needs a witness to make its experience feel real. Your validation is very important. The child needs to hear: "Yes, this happened to you".
- **Put aside your personal values.** If you have strong convictions (that every perpetrator must go to jail, that mothers should put their children first, that children should avoid certain risks,

that girls must behave in a certain way), these may not be the best interest of the child who is talking to you. You must put your personal attitudes aside.

- **Consider carefully the advice you give.** Giving advice means telling a child what to do and what not to do. All helpers will feel tempted to give advice, but often it is not appropriate to do so. You should know the difference between giving advice and providing necessary information (for example, about legal services, or other forms of referral that might be helpful). At the same time, children are entitled to be protected by adults and to receive guidance from them. Depending on their age, they are not expected to be responsible for every decision that concerns them. All children should be treated with respect, but small children should not be asked to take decisions they cannot take. If the child has been abused sexually, it is very probable that you will have a duty to refer the child's case to the appropriate authorities, for investigation, care, and psychological support.

Always take account of the child's age, culture, gender and language.

2.3.1 Tolerate the pain

Helpers must be able to absorb and tolerate pain, perhaps particularly when they are dealing with the abuse of children. Children and adolescents (and caregivers) must feel that the person listening to them can cope with what they have to say, and carry its weight without panic or distress. The helper needs to be empathetic but to remain clear-headed, able to assume responsibility. Ask how you would feel if you were in the child's situation, but above all ask what the child needs. "We must dare to feel our own pain in order to use our experiences in a conscious way." Your task is not to take away the child's pain, but to help the child feel less lonely in that pain. You can help to do this by making the child feel more supported and more understood.

2.4 Boundaries and demarcation

Aim. To understand children's rejection as a trauma response.

At the centre of the experience of many survivors of sexual violence and abuse, including children, is the feeling that others have fundamentally violated their personal boundaries. This can also affect their relations with helpers.

In some cases, children who have been sexually abused reject assistance. They may be rude, aggressive or dismissive and give the impression that they do not want help. Keeping people at a distance is often a form of self-protection. It can also be a way to avoid disappointment, or express an unconscious desire to punish others for the cruelty they have experienced.

For other children, their abuse can lead them to misread their own and others' boundaries. When they meet a helper, they may be excessively demanding, clinging and appealing, or over-obedient and self-effacing. Or sexually provocative. Or helpless and passive.

It can be difficult to cope with these behaviours. When they feel rejected, some helpers may be dismissive and critical in return, and others over-accommodating and apologetic. When children make boundless demands or appear helpless, some helpers will set very strong boundaries while others will do all they can, and more than they should, to help.

"It is important to remember that your reactions are influenced by your own experiences and background; and to remember always that you are the adult, and that you are caring for a child."

It is important to remember that your reactions are influenced by your own experiences and background; and to remember always that you are the adult, and that you are caring for a child.

Look past the child's behaviour or lack of boundaries to understand why the child is behaving in this way. Is the child scared? Does the child think this is the only way to get help? Does the child know what healthy boundaries are? As noted, it is important to set your own boundaries and understand your limits, and, when you need, to seek support from colleagues and supervisors. Saying yes to everything is not positive. You may end up wearing yourself out and, if you do, you will not be of help.

2.5 Becoming a predictable helper/ caregiver

Aim. To understand traumatised children's need for predictability.

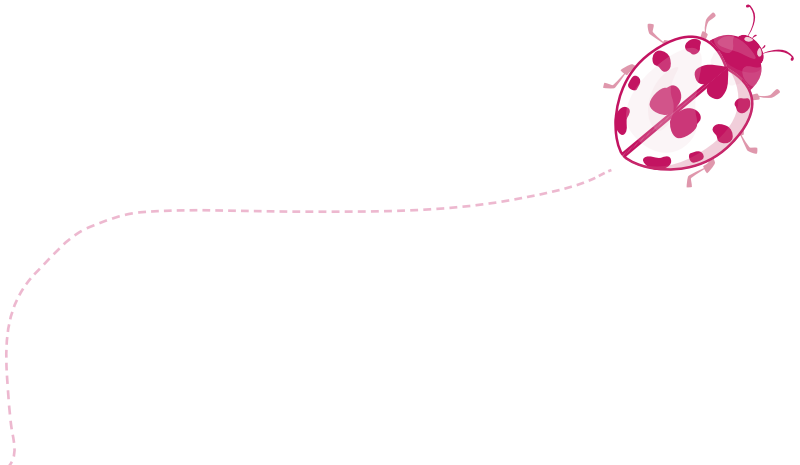
All children, but especially children and young people who have been traumatised by sexual abuse, need love, care and boundaries. They need clear rules for what is right and wrong, guidance, and help to understand situations and learn new skills. However, it can be challenging to use common upbringing tools such as praise and setting boundaries. Some children have experience of adults who lost control, were violent, or acted invasively and inappropriately. Boundary setting can be associated with extreme feelings of helplessness and vulnerability.

To such children, adults who set boundaries and try to be predictable can seem threatening.

"For children who have experienced unpredictability and chaos, their typical coping strategy is to try to control the environment and those around them. Controlling behaviour is an attempt to find security in a world that has been threatening and unpredictable."

For children who have experienced unpredictability and chaos, their typical coping strategy is to try to control the environment and those around them. Controlling behaviour is an attempt to find security in a world that has been threatening and unpredictable.

When applying the advice below, always consider the child's age, experience, cultural background, social situation, and gender. All children should be treated with respect; older children are entitled to discuss decisions that affect them, to negotiate outcomes, and receive reasoned explanations. Though the advice below is general, it is crucial for abused children.



HELPER ADVICE

Advice to helpers when working with children

- Clarify which rules are essential and unconditional and which rules are more flexible.
- Give the child clear expectations and explanations of what is acceptable and what is not acceptable. A few simple rules work best.
- Give the child responsibility for tasks that the child can master and feel proud of.
- Be clear, calm and consistent.
- Give choices when you can. It is a good idea to give the child an experience of control. (For example: "Do you want to do homework in your room or in the kitchen?")
- Pay attention to the child's age and emotional maturity. Be aware of reasons why the child may not listen to you. It may be that the task is too difficult, or it may be because you are trying to decide. Offer help and divide tasks into smaller parts.
- Monitor the child's state. When the child is restless, reflection will be difficult.

Pay special attention

- Be aware of triggers. Boundaries can be a trigger. Be careful of threatening to punish or impose sanctions.
- Avoid causing shame or embarrassment. Explain why the boundary is being set. Link the boundary to the child's safety. "I care about you!"
- Avoid actions that are emotionally impulsive (anger, shouting, punishments, etc.). They will increase the child's anxiety or fear.
- Explain consequences. ("If you destroy your toy, it disappears and is gone.")

How to use praise

- Be warm and positive!
- Recognise the child's attempts to achieve goals. If you have asked the child to be patient, praise its attempts to endure frustration without acting out. ("I'm so proud of you. I asked you to wait a few minutes and you did. Well done!)
- Define success and praise attempts that go in the right direction. If you have asked a child not to hit, praise the child for not doing so even if the child is howling and screaming instead.
- Try to give six positive feedbacks for each correction.
- Build self-esteem. ("I like you just the way you are. I'm so proud of you, to me you are perfect!")

Be aware when praise is a trigger.

- Do not take it personally! Recognise that praise is a trigger.
- Tolerate the reaction of the child without feeling rejected.

REFLECTION QUESTION

Questions to reflect on

- What are your best qualities in the work you do with children who have been sexually abused?
- After this session can you add more qualities?

2.6 Message to caregivers

Know yourself – Learn to understand your own reactions.

Being challenged by children can teach you about yourself and your reactions. You may experience reactions you never had before. Most of us become more childish when we are challenged or emotionally triggered. It can be demanding to understand and regulate your reactions, but it can also help you to develop and to come closer to the children you care for.

Think about how you react in difficult situations with the children. Do you typically become logical and rational? Do you have very strong emotions? Are you emotional and rational at the same time? Most likely your behaviour will vary according to the circumstances and your mood.

It is as important to be curious about your own behaviour as to be curious about the child's. To regulate your own emotions, you need to be attentive to what is going on inside you. Self-care is easy on good days but can be arduous on difficult days. Try to explore your own reactions, talk to someone you trust, learn more about what you can do when you feel you are losing control.

Identify difficult situations

- In what situations do you feel provoked or challenged?
- Do you find it is difficult to handle specific emotions or behaviour of the child?
- What situations are most difficult?
- Do those situations remind you of an experience when you were scared, or powerless?
- When are you most effective as a caregiver?
- When are you least effective as a caregiver?
- Are certain reactions of the child hard to understand?
- What other behaviours or situations cause you to lose control or focus?

Monitor your own reactions

- What are you feeling in your body? What is happening to your breathing? Your heartbeat? Do you feel pain or discomfort? How do you feel when you begin to lose control and focus?
- What thoughts do you have often, about yourself as a caregiver, and the children you care for?
- What do you do when you struggle the most? Do you punish yourself? Feel resigned? Put it out of your mind? In the moment, do you freeze, fight, flee or withdraw?

Advice to the helper. Regulate yourself before you try to regulate the child

- Try to be in the moment.
- Monitor your level of arousal.
- Take a deep breath.
- Reflect: what need is the child expressing at this moment?
- Meet the child's need.
- Take responsibility. You are the adult!

Act to prevent new traumas

Research indicates that a child who has experienced sexual abuse is more likely than other children to be abused again later in life. It is important to focus on how to protect children who have been sexually abused from additional adversity. Build protective shields around children in your community. Help caregivers to identify and avoid situations that are risky. Teach children and adolescents about safety, self-care, their value, and the importance of caring for each other.

How to support parents of an abused child

When a child is experiencing sexual abuse from a perpetrator outside the family, the parents of the child are also traumatized. (The trauma definition clearly states that traumatization is when you encounter an event that is a threat to your physical og psychological integration or being witness to someone close experiencing this.) For parents a threat towards your child is therefore a shock. Many parents react with disbelief and denial. Instead of criticising the parents for this, as helpers we should help the parents through their process and assist them in being good protective shields for their child.

The normal reactions after the first initial shock period are to go through a series of emotions; guilt and self-blame, (and sometimes blaming the child), shame, anger and grief. Often, the mother will react different than the father. A father will often react with anger whereas a mother will react with self-blame and shame.

The deep feeling of guilt and self-blame is connected to the attachment bond between the parent and the child and the need for a parent to feel that he or she is capable to keep their child safe.

At the same time the sexual assault of a child evokes a grief, a deep feeling of loss and sadness.

This is a sort of mourning of the loss of innocence, loss of trust and the ability to trust the world to treat my child with care and respect, and lack of hope for the future.

Advice to parents

Parents are the most important people in a child's life. Tell parents:

- You are the most important person in your child's life, be the protective shield. Rebuild the child's core sense of trust.
- Your reaction to the trauma is crucial. The child looks to the parent to explain the meaning of things.
- The child does not forget. Even if the child has not put what happened into words, the memory of what happened stays in the body and in inner pictures and can be triggered.
- Your child has not had sex. It was the adult's sexual desire and the adult's need for power that determined what happened.
- Your child is not damaged for life. If helped, wounds will heal.
- This event does not define your child's identity. Both you and the child need to see the child's whole identity. The child is not just a victim.
- Be absolutely clear where the responsibility lies. The child is not guilty and is not sinful. Convey hope and trust for the future. Show the child that you love him or her.

HELPER ADVICE

Advice to helper

When working with families of an abused child, remember that parents have many reactions, and sometimes mother and father differ in their reactions. The most common reactions are:

- **Shock, denial and shame.** They also react with **guilt and blame**. They can feel that they failed as a mother or father, not protecting their child or blaming the child. **Anger** and **grief** are also common. Research has consistently shown that supportive and empowered caregivers play a major role in lessening the negative impacts of trauma on children and in promoting healing and recovery. We should assist the parents and not blaming them for their first reactions.

2.7 Summary of advice to helpers

Below are some of the basic principles described in this manual. It can be helpful to keep them in mind when working with children who have been abused sexually.

- Sexual violence is a human rights violation and must be understood in those terms.
- Traumatic events cause grief and pain, and often generate overwhelming trauma memories that children who have been abused are not able to control.
- Intrusive memories influence both the present and the future.
- Reactions in connection with traumatic events should be understood as survival mechanisms.
- Trauma reactions can be identified and addressed.
- Children are not responsible for the abuse they experience. It is the adults that have responsibility to care for and protect children.
- Recognise the value of your knowledge and expertise when you work with survivors.

Some steps are especially important when approaching a child who has been traumatised by sexual abuse or violence.

- Act in a way that reassures the child that you are there together with him or her.
- Never be intrusive; respect the child's comfort zone and keep an appropriate distance.
- Always make sure that the child continues to accept your presence.
- Communicate your understanding of the child's situation and experience. Where you can, carefully explain the possible reasons for the child's reactions.
- Ask if the child is willing to accept help and say that it is the child's choice to talk or not.
- Explain clearly what your responsibilities as a helper are, and that, while you will respect the child's privacy as far as possible, you have a duty to report any cruelty to or abuse of children.
- Explain clearly that the child is not responsible for what happened to it, and that adults are responsible for the care and protection of children.
- Provide specific and practical forms of help, if you can.
- Before the child tells you what happened, make sure you can be present to follow up afterwards.
- Make sure the child receives any health care it needs.
- Help the child to breathe calmly; help the child to do exercises from the manual.
- Take into account the child's age and emotional maturity.
- Take care of yourself as a helper and make use of the skills you have learned.

3. What do you need to know when you are working with child sexual abuse

In this part we discuss what it is useful to know when you are working with children exposed to sexual abuse. It provides information about trauma reactions and how trauma and sexual abuse affect the brain, development and attachment. We also discuss the way children think, their survival strategies, and their resilience.

3.1 Basic knowledge of trauma, trauma reactions and triggers

Aim. To understand common survival and trauma reactions.

'Trauma' means wound. In both medicine and psychology, it refers to major physical or mental injuries, including threats to life or physical integrity. As Judith Herman (1992, p. 33) phrased it, a trauma is "a personal encounter with death and violence". A 'traumatic event' is one that has the capacity to cause mental or physical trauma. Faced by such an event, the immediate response of the body and the mind is to struggle for survival. Behaviourally, this fright reaction generates "fight, flight or freeze" responses: the person at risk tries to resist or to escape or submits – the body closes down and the person becomes passive ("plays dead").

A severe traumatic event often changes the way in which the children understand the world around them. They may lose their sense of safety and feel vulnerable and helpless. If the event involved acts of violence and the intention to hurt, trust in other people may be lost and the child's inter-relational world seriously disturbed. Personal encounters with human or man-made violence are considered the most disturbing forms of trauma, likely to have the most lasting impact. Loss of safety, control and trust commonly lead to depression (deep sadness, loss of the will to live, etc.) or anxiety. A personal encounter with violence and death may also haunt the child, who may painfully re-experience the event in dreams or daily life (intrusion). Intrusion is often set off by reminders, which may cause the child to try to hide from anything that might bring to mind the event (avoidance). In this manual, we call the reminders that cause intrusion 'triggers'.

A trigger can be anything which is associated with the trauma. Triggers can be any stimuli coming from outside as a sound, a smell, a sight, a touch and from interaction with others. Or it may come from inside like heartbeats, nausea or thoughts and feelings. These reminders lead to uncommonly strong reactions. Sometimes the connection between a special feeling or reaction and the traumatic event is obvious, but at other times this link is less clear. In many children we may see sudden reactions such as panic attack or temper tantrum where neither the helper nor the child are aware of the connection, and the sudden reaction appear difficult to understand. Being a "detective" together with the child to find the connection- what happened just before the strong reaction /what triggered you now- is a good help.

Children may also feel disconnected from their bodily sensations and feel numb or be unable to recall traumatic memories. A state of heightened arousal is also common. The child may be on its guard all the time, startle easily, sleep poorly, be irritable, or find it difficult to remember and concentrate (hyper-arousal). If the child lacks support and help, these reactions may last for months or years. Psychiatrists call this state of mind 'post-traumatic stress disorder' (PTSD).

Three types of symptoms are typical of severe trauma-related disorders:

- Intrusions: intrusive memories, flashbacks, nightmares.
- Avoidance: shunning situations that recall the catastrophe.
- Changes in arousal (high or low): a person is easily startled, tense and has angry outbursts, or is numb or depressed. Individuals who have been exposed to trauma may therefore experience a great deal of anxiety and sadness, and feelings of hopelessness and worthlessness.

The techniques proposed in this manual aims to restore their sense of control and empower them by giving them coping skills and helping them to rebuild social relationships and trust.

The table below summarises common trauma criteria, reactions and challenges.

What is a trauma	What trauma reactions follow	What the helper needs to try to do
A threatening external event *Attacks the person's sense of reality.*	The experience feels unreal, dissociated	Be a witness; confirm what happened, make it real
The event is sudden, the person cannot control it. *Attacks the person's self-agency.*	The person has a deep feeling of helplessness.	Strengthen the person's sense of autonomy, influence and self-agency.
The event is emotionally overwhelming. *Attacks the person's emotions.*	The person feels overwhelmed and has unregulated emotions.	Co-regulate the person's emotions. Expand the window of tolerance.
The event is hard to understand. *Attacks the person's cognition.*	The person is confused, blames him or herself, feels guilt and shame. Memory is fragmented.	Correct misunderstandings. Give a correct picture of responsibility. Create a coherent narrative.
Loss of relational protection *Attacks the person's trust in personal relations and their attachment system.*	The person becomes mistrustful. Insecure attachment shows clinging or avoidant behaviour.	Build a trustful relationship. Help understand and set appropriate boundaries for himself/herself and others.

3.2 Trauma and the brain

Aim. To understand how children respond to traumatic experiences.

KEY TO KNOW

Human beings (and animals) developed very early during the evolution an alarm system that assisted them to survive. These basic physical responses to danger occur below consciousness and are controlled by an ancient part of the brain located in the amygdala (the watch dog). They enable the body to react to danger before you have even started to think about what is happening. These physical reactions can respond in as little as 1/100 of a second and are automatic 'survival reactions' are ways we react to dangerous or overwhelming situations that can be understood as 'strategies' designed to help us survive. The main reactions or survival 'strategies' that human beings display when faced with life-threatening events are:

- **Fight**
- **Flight**
- **Freeze ('Playing dead'/submission)**

When a traumatic event occurs that threatens life, we cease to process events in the usual way. We no longer store our emotions, feelings, and perceptions of the situation in the cerebrum, as we usually do, but process them at a 'deeper' level. This can produce the 'primitive' defence responses mentioned above.

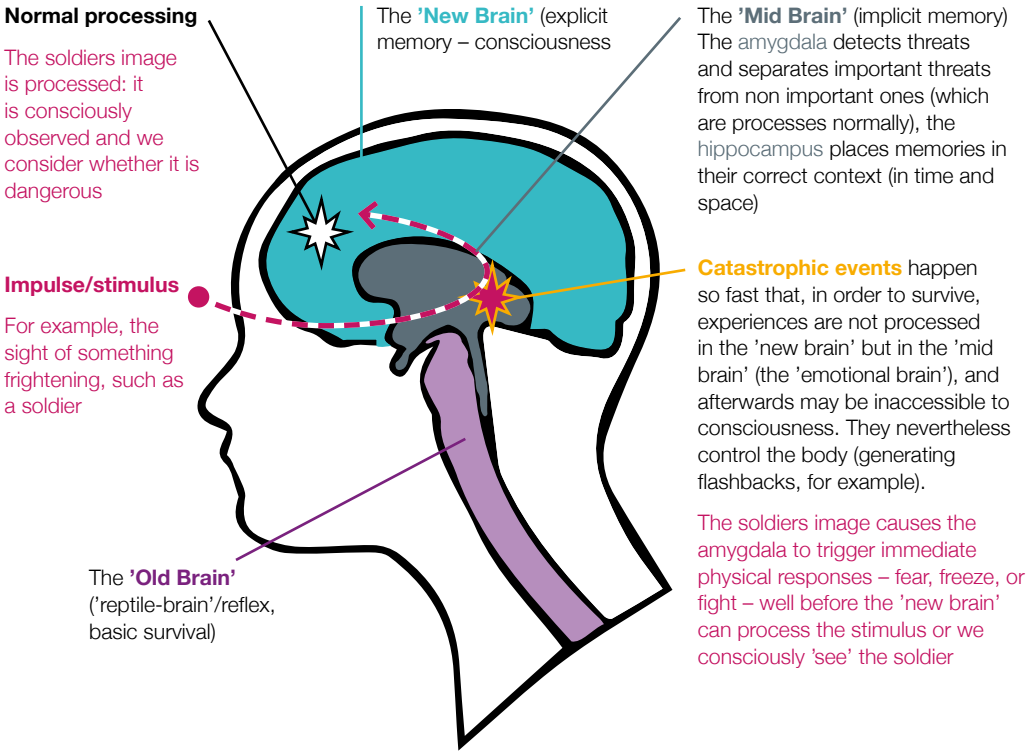
It is said that traumas **affect** an adult brain but **organise** how the child brain is structured.

The human brain is very complex, and researchers are still discovering new aspects in its functions, especially about how different networks in the brain collaborate. A good metaphor of how the brain works that is often used in the trauma field is "the triune brain". It is used to describe the connection between brain functions and trauma reactions.

The brain is hierarchically built, first – the **"Old brain"- the survival brain** – the brainstem with all the automatic activities like respiration, heartbeat, bodily sensations. Secondly the **"Mid brain"- the feeling brain** – the limbic system with hippocampus where our memories are stored with connected emotions. In the limbic system amygdala; when encountered with danger, elicits the fight, flight or freeze reactions. The **"New brain" – thinking brain**, is the area in the brain that is developed last, and is the neocortex, where our abilities to reflect, think, and plan are centred.

In this model of the brain it is emphasized that the three parts of the brain are connected, meaning networks transport information from the brainstem through the limbic system and then to neocortex for evaluation, then back to the limbic system and the brainstem. When trauma reactions are present, the connections between the three parts of the brain are not working efficiently, so the hypersensitive alarm reactions can fire without feedback systems "calling off" the danger.

When trying to help a child who has been sexually abused, we should bear this in mind; we need to address activities in the **old brain**, in the brainstem. We need to work with the breathing and the muscle tonus in order to help the child calm down or being awakened from a state of numbness. We need to address the **mid brain**, the limbic area, to build trust and address the emotions and find an entrance into the child's memory. Additionally, we need to address the **new brain**, the neocortex in order to understand and correct the way a child has giving meaning to the traumatic event.



In this picture of processes in the brain when encountering danger, we have used an example of a child that has been raped by a soldier. Whenever the child sees a soldier or a man wearing an uniform the brain needs to process the stimulus and distinguish between danger and safety. If considered as danger the amygdala will elicit the fight, flight or freeze reaction.

Adversity + chronic stress = toxic to the brain

When traumatic experiences last for a long period of time, a condition called chronic stress develops. Prolonged stress is toxic to the brain.

- After experiencing danger, the brain is in a state of alert. It must readjust to its normal state.
- If it does not readjust, this affects functioning and development.
- The ability to self-regulate declines because the alarm system remains hypersensitive, and the regulation system is less effective.
- Memory is fragmented; this affects capacity to learn.
- Slower learning is due to reduction of the brain's network speed.
- Fewer neural synapsis network connections reduce the brain's flexibility.
- When we are stressed for a long time, it becomes more difficult for us to handle stress. Synapses in the brain can lose contact with each other, and thus communication between several parts of the brain deteriorates. This makes us forgetful and confused.

3.3 Child development: how trauma affects children according to their age

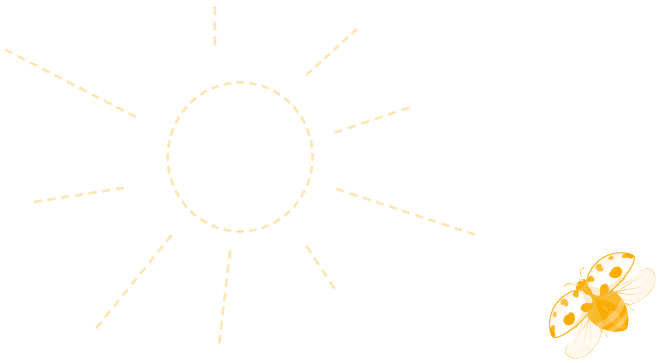
A variety of explanations are needed to understand the symptoms and behaviour of children who have been exposed to sexual abuse. In terms of their development, first of all, children exhibit different reactions to specific kinds of trauma at different ages. In addition, though the effects on children of sexual abuse resemble the effects of other traumatic events in many ways, sexual abuse has certain specific effects. It involves a human relationship; it exposed children to adult sexuality; and it is often combined with threats and secrecy.

Though we speak of "childhood", children's capacities and responses evolve as they develop.

Here is a model of how a child reacts to danger according to their developmental level:

Developmental model

Stage of development	Maturity level (Pynoos)	Factors that protect – resilience (Werner)	Developmental task (Punamaki)	Trauma influence
Infancy (0 -2)	The child socially refers: checking with their close relation	• Easy temper Easy to regulate • Has a good/ close relation with the regulating other	• Attachment • Imitation • Exploration • Perspective (theory of mind)	• Attachment disorder • Insecure • Disorganised • Regulation disorder
Early childhood (2-6)	The child elicits the caregiver's protection when needed	• Independence • Sociability • A good caring environment	• Emotional self-regulation • Mentalisation • Play • Capacity to symbolise	• Poor emotional regulation • Poor symbolic capacity • Poor play • Poor mentalisation • Poor self-agency/ efficacy
Childhood (6-12)	The child considers the reasons for danger/fear and the need for protection	• Capacity to cope • Motivation • Supportive family network	• Peer identification • Friendships • Learning • Problem solving	• Asocial behaviour • Mistrust of adults • Mistrust of self and others
Youth (teens)	• He/she practises emotional self-regulation when faced by danger • He/she is able to plan • He/she is able to foresee danger	• The teen has an "internal locus of control" • He/she is independent • He/she has close friends	• Intimate relationships • Individuation and autonomy • Moral development • Future planning	• Poor planning skills • Low emotional awareness • Sexualised behaviour • Autobiographic fragmentation



In babies and toddlers (0-2 years), trauma reactions take the form of clinging, crying, sleeping difficulties, and eating problems. At this age, trauma may lead to attachment problems (where the child fails to establish a secure relationship to its parents or close family members).

See the case of Sam, who was physically abused when he was less than four years of age.

Pre-school children (2-6) are clinging and experience sleeping, eating and separation difficulties. They may lose acquired skills, such as speech or toilet training (regression), and may be passive or helpless. Their capacity to play and use objects to represent (or symbolise) other objects, may decline; their play (if present) can be repetitious, aggressive or fatalistic. Some children exposed to sexual abuse exhibit sexualised behaviour towards other children.

See the reactions of Asma. She had poor self-regulation, poor playing capacity, a poor sense of agency.

Schoolchildren (6-12) who have been traumatised may display repetitious, aggressive and sometimes sexualised play. In addition, they display many somatic complaints (headaches, stomach pain, etc.). They also frequently exhibit learning problems, lack of concentration, and poor memory. Some report flashbacks and nightmares. They are likely to be anxious, restless and aggressive. Such behaviour may be triggered by sights, experiences or sensations that recall the traumatic event.

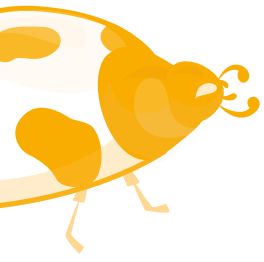
Teenagers (12-18) display inappropriate sexual behaviour, or impulsivity; they may self-harm, use drugs or show self-destructive behaviour. Nightmares and flashbacks are common, as are self-blame, guilt, shame, depression and lack of hope in the future.

See the case of Rama, who felt guilt, shame and social withdrawal and thought of harming herself.

Concluding remark

When a child is exposed to sexual abuse, their normal development may be affected, as shown in the “Developmental model”.

Normal developmental tasks, such as attachment, playing, learning, socialising, and moral development, also need to be addressed and put back on track.



3.4 Developmental trauma disorder

Aim. To understand the impact of a single versus repetitive sexual abuse.

It is important to distinguish between children who have been exposed to trauma *repetitively or regularly* during childhood from children who have been exposed to one or two traumatic events. Children exposed to repetitive trauma do not display the symptoms of classic post-traumatic stress disorder (PTSD). They tend to suffer instead from developmental trauma disorders (DTD). This diagnosis has not yet been accepted in diagnostic manuals, but it is widely used by researchers and clinicians. DTD is characterised by lack of regulatory capacity in three areas:

1. **Lack of capacity to regulate emotions and bodily states.** Children shift rapidly between affective states; have low moods; are excited; are hypersensitive; lack affect awareness; have sleeping problems; have eating disturbances; lack temperature awareness; have delayed motor responses.
2. **Lack of capacity to regulate attention and behaviour.** Children are impulsive, attracted to tension and danger, prone to have misconceptions, and focus on possible threats to them.
3. **Poor capacity to regulate closeness and distance in relationships.** Children have poor socio-emotional functioning; do not trust others; are constantly prepared for rejection; do not trust themselves with changes in cognition and identity.

Due to the pervasive character of these symptoms, clinicians often misinterpret the symptoms of children with DTD and diagnose them as having bi-polar disorder, anxiety disorder, depression, attention deficit and hyperactivity disorder (ADHD), or borderline disorders.

3.5 Sexual abuse and trauma

Survivors of sexual abuse have many symptoms that resemble the symptoms of other traumatised children, but they have some specific reactions due to the relational and sexual aspects of this particular trauma.

A child who is sexually assaulted by an adult will not easily distinguish between bad things being done *to* them and bad things being done *by* them. This affects their view of themselves. “The dirty things done to me make me a dirty person.” Many children will blame themselves for their assault and tell themselves “I am a bad person”, “I am dirty, disgusting”, “I am to blame”.

Their reactions are sometimes difficult to understand for the child. They include:

- Extremely low self-esteem, even self-hate.
  - Children tend to take the blame themselves, believing they are guilty for what happened. Perpetrators are also responsible for this response if they call the children they abuse bad, naughty, unlovable, etc.
- Lack of trust, constant expectation of betrayal.
  - Especially when the perpetrator is a trusted person, such as a relative, a teacher, or a religious leader, the child feels betrayed. This response also occurs if the child does not feel protected by adults, or adults have not believed the child.

- Shame and feelings of guilt.
  - Since children depend on adults for their security and basic needs, it feels dangerous to believe that adults will harm them; it is easier and safer to think that bad things are their own fault.
- A tendency to be re-victimised.
  - Some children who have been abused seem to lose their alarm signals; they do not seem to be able to distinguish what is safe from what is dangerous. Perpetrators also find it easy to identify children who will freeze (rather than resist) when they are assaulted.
- Self-destructive behaviour.
  - We think self- destructiveness is a fight response that turns inwards, instead of being directed at perpetrators. It can also be a way to numb oneself; the child chooses physical rather than psychological pain.
- Sexualised behaviour.
  - A child always wants to make sense of experiences. A child that does to others what has been done to it is searching for meaning. (Is this what might have happened to Sam?)
  - For some children, the abusive relationship has taught them that they acquire value by offering sexual services. When they reproduce this behaviour to please others, they expose themselves to new violations. “The child asked for love but was met with sexuality. Now it offers sexuality in the hope that this will give him/her love” (Tillman Furniss).
  - A child who is traumatised by sexual abuse sometimes dissociates (forgets, feels numb), has blurred memories (like Rama), or exhibits undiscriminating closeness.

Sexual abuse is invasive: it involves lack of respect; but it is also about not being protected. “Nobody saw, nobody intervened, nobody protected me.” The failure to protect causes the child to distrust others and undermines the child’s basic trust in the world. One effect may be to create a discontinuity in the child’s relational perception – in how the child appears to itself and how the child feels it is perceived by others.

The power balance in the adult’s favour is not only physical. Perpetrators also have the power to determine and define what has happened. “This is normal”, “This happens in every family”, “This is because you did something wrong”. The perpetrator’s (abuse of adult) authority fuels the child’s self-hate.

Threats and fear of punishment usually accompany sexual abuse. As a result, the child is constantly anxious that he or she will be punished, by the perpetrator, or by other adults who realise what has happened, or both. The child is also afraid of being judged by family members or other adults.

Summary

Children who have been traumatised by sexual abuse may display disturbing behaviour. They may display sexualised behaviour; self-harm (cut themselves); dissociate (forget, be numb); have blurred memories; or exhibit undiscriminating closeness.

KEY TO KNOW

3.6 How attachment is affected by trauma

Children depend for their survival on their parents. Biologically there is an attachment bond from child to parents and from parents to child. When a threat (or trauma) occurs, the child expects the parents to provide a “protective shield”.

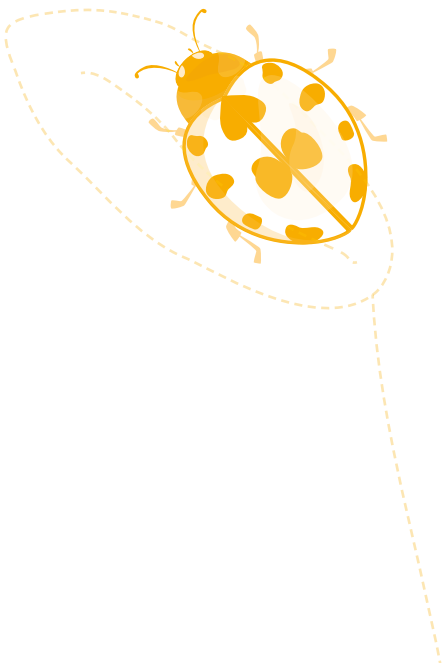
Robert Pynoos, a staff member at the National Child Traumatic Stress Network (NCTSN), used the term “protective shield” to analyse how trauma affects children. For many children exposed to a threat or traumatic event, the main concern is whether someone is present to protect them, regulate their fear, and soothe them.

- If parents are available, Pynoos claims, even after potentially traumatising events the child may still feel safe and may not show trauma reactions.
- When the parents are physically or emotionally unavailable, the child feels unprotected and has no resources for emotional regulation.
- The most harmful scenario for a child is one in which the person who puts the child in danger is the person who should be its protective shield.

Pynoos also claims that a trauma always triggers a child’s attachment system (its safe relationships that can regulate pain). He calls trauma reactions “an unanswered cry”, with the emphasis on “unanswered”.

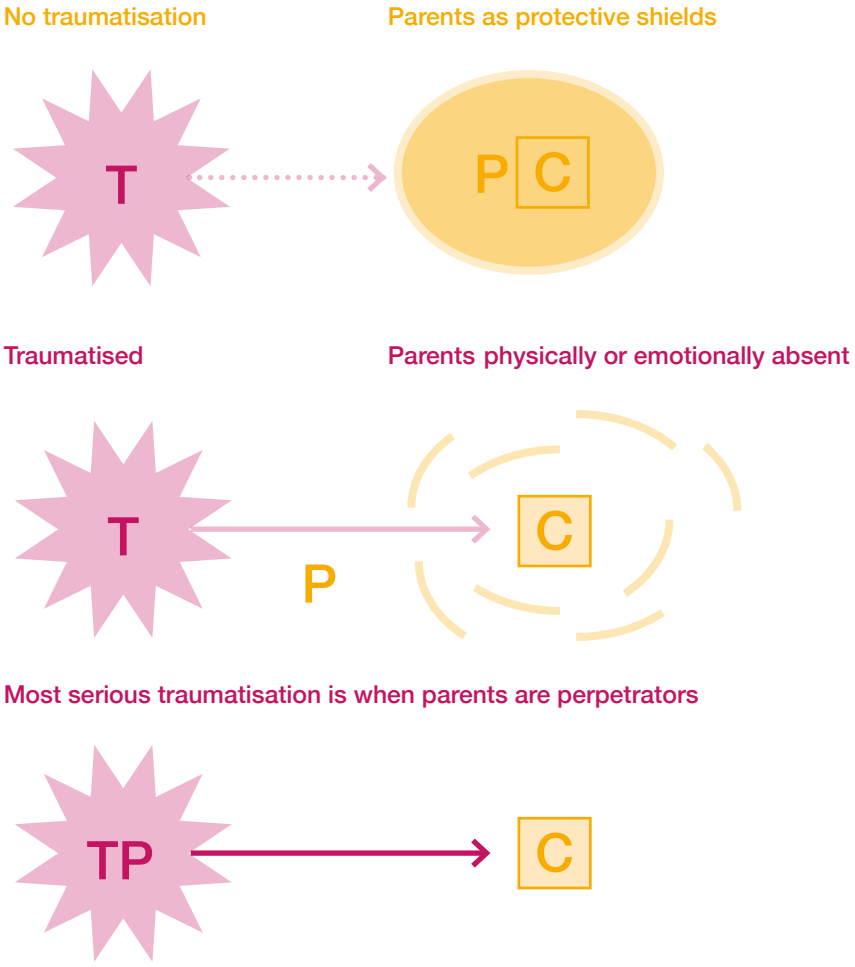
Pynoos argues that, when the protective shield fails, it triggers a fantasy response. Children have fantasies of fear (focusing on further dangers); revenge fantasies (a fight response); or rescue fantasies. Sometimes the boundaries between fantasy and reality becomes blurred (as we saw in Rama’s case).

These fantasies sometimes blend into the child’s narrative of what happened, and as a result the child may be accused of lying. (For instance, one four-year-old girl, who had been raped by a stranger, said: “Then I kicked him hard in his face”. This was a revenge fantasy.)



"The Protective Shield"

(T=trauma P=parent/caregiver C=child)



- When the protective shield breaks, anything can happen (three phantasies: fear, rescue and revenge)
- Unanswered cry
- Traumatisation always triggers the attachment system

Summary

If the protective shield fails in the face of a serious threat (because adult protection was not robust or adults were absent), the child is likely to be traumatised. If the adult who was expected to protect the child is also the same person who abuses the child, this causes the most severe form of trauma. But the child needs to be attached, and therefore often blames itself for what happened. The child thinks that what is bad is a part of the child itself. This generates a conflict between the attachment system and the stress-response system (the reaction of fear). Children who have been abused therefore hide the truth and protect perpetrators because they desperately need attachment. They may develop insecure attachment which is characterised by avoidance or clinging behaviour.

3.7 How play is affected

Play is important for a child's development. Through play a child explores the world, learns mastery, imagines things that are not there, and starts to symbolise. Fantasies, symbols and metaphors are tools that they can use to process bad memories.

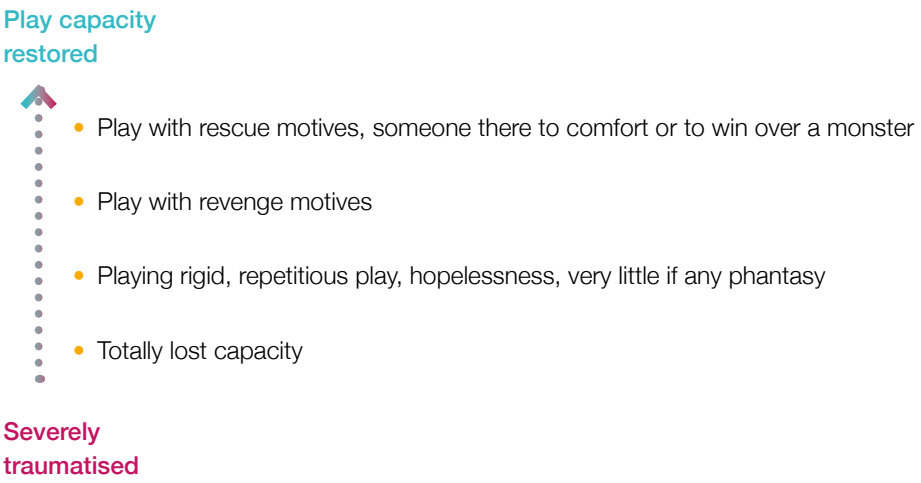
Play can therefore contribute to the healing process. However, severely traumatised children lose some of their capacity to play.

- They may play repetitively, acting out a traumatic experience that has a fatal ending.
- They may engage in revenge play, in aggressive acting out.
- They may lose the capacity to imagine, and may become passive and without fantasy.

By playing together with a child who has been traumatised, helpers can restore the child's capacity to play.

What happens to the capacity to play?

(Kostnley, Eriksson Inst.)



Children often play games in which they explore sexuality. They can play alone or with others. It is completely normal for children to explore their bodies and touch their genitals. How adults react to this – both with words, tone of voice and facial expressions – helps to shape the child's perceptions of and feelings about sexuality. It is important to recognise a child's exploration of sexual play because it helps the child to know its own body and to set and respect boundaries.

However, sexually abused children may have a higher, even intense interest in sexual play and often compel other children to participate in it. Such children may need a helper to assist them to regulate their behaviour, learn what behaviour is appropriate, and respect other people's boundaries.

3.8 Understanding the way children think

Many abused children do not communicate what happened in a linear and coherent way. Imagination and magical thinking are often elements of the story they tell and can help the child to cope with its experiences. It is common to minimise what happened in order to sustain the good image of the offender and distance the abuse. Children think in an egocentric and practical way. They want to know what will happen next, and fear that things can be worse. Young people have fewer concepts and more limited understanding and may therefore find it difficult to understand complex situations. They are also extremely loyal to, and dependent on, their caregivers. They will often minimise the seriousness of the trauma to protect the relationship. Being abandoned by a loved one can be more threatening than telling the truth about what happened.

3.9 Two different memory systems

Our memory system is very complex. We have different forms of memory, which affects how we recall and remember experiences. *Implicit memory* stores perceptional and unconscious emotional memories. *Explicit memory* stores and recalls information and experiences that we can consciously recall at will. Experiences from early in life may be stored as implicit memories; we may have no words for them, but they may still impact the way we interpret and experience and act in current situations. Sexual abuse during early childhood can be difficult to recall in a conscious way because it is stored in the implicit memory system. Early memories can be triggered by smells, sights and objects in the environment that are associated with the abuse. We often say that our body "remembers" what happened, even when no words are available to describe it. Trauma can be expressed through body sensations, body posture, play, games, behaviour, and in relationships.

"We often say that our body "remembers" what happened, even when no words are available to describe it. Trauma can be expressed through body sensations, body posture, play, games, behaviour, and in relationships."

3.10 Survival strategies

Children who have been sexually abused find ways to adapt to cope with harmful situations. They display many symptoms that we can address, including attention problems, lack of trust, impulsivity, and withdrawal. Viewed from a survival perspective, many of these symptoms make sense. When a child faces a danger, or its needs are not met, this immediately triggers its alarm response. The child may be unable to regulate itself, may be unfocused, impulsive and out of reach. The alarm response becomes particularly sensitive in children who have already been traumatised.

Various survival strategies can protect children in such situations. Common responses include the attach response (cry for help), the flight response (escape), the fight response (resist), the freeze response (remain immobile, try not to feel, wait for a reaction), and the submission response (give in, submit to remove the danger).

Which coping strategy is activated depends on the child's history and personality, how the response has worked in the past, and the situation the child is in now. A child who has been sexually abused develops longer term strategies based on its acute survival experiences.

Typical long-term survival strategies

The table below lists long-term survival strategies and how these strategies are expressed.

Scan/freeze	Attach	Flight	Fight	Submerge	Dissociation (shutting down)
Focuses on potential threats. Lacks concentration. Thinks rigidly. Tense.	Clingy. Rejects others or feels rejected. Fears abandonment.	Runs away. Hides. Isolates. Avoids. Withdraws.	Hyperactive. Unable to follow through. Compulsive. Impulsive. Resists. Hits or kicks.	Compliant, submissive, reserved. Pleasing. Does not show needs. Focuses mostly on the needs of others.	Forgetful, daydreams. Numb, tired. Low energy. Passive. Collapses. Somatic complaints.

REFLECTION QUESTION

Questions to reflect on

- What kind of survival strategies do you recognise in the children you work with or have responsibility for?
- In what situations do you think survival strategies are activated?
- What functions do survival strategies have for a child?

3.11 Risk and resilience factors

Some children are more vulnerable to stressful life events than others. Resilience is the ability to thrive even in the face of challenges. It is therefore important to understand the factors that help healing and enable children to cope.

Research has shown that resilience is not just a personal characteristic. An individual's ability to cope is complemented by external factors that protect the person against risk.

"Research has shown that resilience is not just a personal characteristic. An individual's ability to cope is complemented by external factors that protect the person against risk."

Resilience factors include:

1. Genetic inheritance. We are born with degrees of robustness or vulnerability.
2. Experiences before exposure to trauma.
3. The character of the trauma event.
4. The situation immediately after the trauma event (for example, how quickly help arrived).
5. The situation in the long term (for example, the quality of rehabilitation support received).
6. For children who are sexually abused, the most crucial factors are whether they have a safe attachment person in their life, whether their story is believed, and whether the perpetrator is made unambiguously responsible for the abuse.

3.12 Disclosure of Sexual Abuse

Why do most children **not** talk about sexual abuse or rape? Where to start?

Children keep such experiences secret for many reasons. In many cases, they do so because the perpetrator threatens to punish them if they tell anyone or threatens to punish or tell their parents. The child may also imagine such threats; or remain silent from shame or guilt, believing that he or she is responsible for what happened, or that the family or society will reject or condemn the child for what has happened. The child may feel confused loyalty; or remain silent out of respect for authority, or because she or he believes it should not 'rat' or 'tell tales'. The child may have no independent adult to hand who it trusts sufficiently. In addition, depending on age and emotional maturity, the child may lack language to describe what has happened; and, if the experience was traumatic, the child's memory of the events may be fragmented or may not be stored as a coherent narrative. In this case, the child may be in no position to tell the story at all. Children will seek to protect others and themselves. Often, for their own security or because they cannot make sense of it or because it is too painful, they will simply try (but in vain) to put the experience out of their mind.

Children therefore have many reasons for not disclosing their abuse. They include fear of punishment, self-blame, and lack of words. However, even if they are silent, children that have been abused sexually nevertheless reveal symptoms and behaviours that can indicate what has happened to them. These change with age and maturation (see section 2.2). The signs may include collapse of trust, sexualised behaviours, repetitive play, and somatic pain. If a child who has been abused sexually cannot tell its story in words, it can often communicate in other ways, for example through drawing and play.

Many children do not know that what they have experienced is abuse; they believe such behaviour is a normal part of relationships. It is common to experience arousal during the abuse as a reaction to sexual touch. Many victims can assume that this means they wanted the sexual interference to happen and can even feel responsible for the assault. Shame and guilt contribute to the silence.

Questions to reflect on

- If a child's behaviour (or the behaviour of adults who are around the child) gives you reason to believe that the child may have been sexually abused, how do you start to find out and to help?

3.12.1 How can children express trauma?

Children express trauma in many ways. Some children will describe directly what happened in words, while others will communicate more indirectly. For example, the abuse can be shown indirectly in play and behaviour. Pieces of the story can be told in drawings, and in writing, often mixed with fantasy and unrealistic elements that may make the facts difficult to understand. Sometimes the play can have a sexual character, and echo what the child experienced. Some will show harmful sexual behaviour that is threatening to other children and grown-ups.

"Play becomes problematic or harmful if it is characterised by force, threats, and coercion. Such behaviour must be stopped in an age-appropriate and respectful manner. It is important to be curious about what is behind this behaviour. Sexual abuse is one of many hypotheses."

Play becomes problematic or harmful if it is characterised by force, threats, and coercion. Such behaviour must be stopped in an age-appropriate and respectful manner. It is important to be curious about what is behind this behaviour. Sexual abuse is one of many hypotheses.

Trauma is often communicated indirectly through reactions such as somatic discomfort, sleep problems, behaviour problems, and anxiety. Some children will show acute trauma symptoms, such as intrusive memories, avoidance, and changes in arousal. Children who continue to keep their abuse secret, and who face being exposed to new assaults, can develop cumulative stress symptoms that may have a serious impact on their development (as explained earlier).

For many individuals it will take many years before they tell, and they may never reveal what happened. Some children will drop small and ambiguous hints, to check how adults around them respond. If an adult tries carefully to understand why, it can help the child say more. But if no one picks up the child's cues, the child may keep the secret for a long time. Many will never talk directly about it but continue to express their woundedness in indirect ways.

3.12.2 Can we trust children?

Research on children's memory demonstrates that children as young as 2 or 3 years old can accurately recall events they have observed, but they need support and structure to correctly describe them. All children can be influenced by others in what they recall and what they say. Pre-schoolers are more susceptible to influence than schoolchildren. The ability of children to express themselves is strongly linked to the adult's ability to pay attention and listen. It is important to remember that underreporting of violence and abuse occurs more often than lies.

Be open and curious

How can we best assist children to speak freely?

By showing interest, engaging, and demonstrating that you care. Children will usually tell their secrets to someone they trust, someone whom they believe can help.

Advice for communication

- Be open, curious and adopt an exploratory approach.
- Take responsibility for the conversation.
- Make the conversation meaningful, say why you want to talk to the child.
- Give the child agency and make the child feel comfortable.
- Keep several hypotheses in your head at the same time. Abuse is usually only one of several possible reasons for a child's behaviour.
- Open-ended questions are better than closed ones.
- Acknowledge what your child is telling you and summarise what you hear.
- Listen more than you talk and endure pauses.
- Show your empathy but try not to become over-involved in what the child says.
- Accept denial and other defensive mechanisms.
- Be clear about confidentiality. Tell the child if you need to report or involve other people. Let the child know before you bring information forward.
- Do not pressure the child to talk.

3.12.3 Direct interview and exploration

When there is a suspicion that a child is exposed to abuse, either because the child has changed behaviour, has sent out "test balloons" in play or drawings or has uttered ambiguous statements, we need to know more concretely the reality in order to stop and prevent ongoing abuse and remove the child from an abusive situation if possible. The helper or caregiver also must be the one who decides to report to the police because a child has no responsibility for this. For this reason, we have included this section about disclosure.

However, for many children it takes time to be able to put the abuse into words, and to build the trust that is needed. Therefore, one should consider who the child feels safest with and when the time is right for the child to open up.

If you find yourself in the position of a helper, and suspect that a child has been sexually abused, you should talk with the child directly. Think carefully about where to hold the conversation, and who should be present. Find a place that is comfortable for the child. Tell the child directly about your concern and why you want to have this conversation. Focus on one event that made you worried. For example: "I want to talk to you because you told me that the banana looked like the penis of your uncle. Can you tell me more about that?" Try to use questions that are as open as possible, in order to support the child's story without influencing it. Invite the child to talk about specific situations. Explore details as they come up.

For example:

Child: I was all alone at night, then I was very scared. And uncle was the only one in the house after dad left.

Adult: Tell me more about it, as best you can. Use your own words. Try to explain.

Child: Uncle came into my bedroom when it was late, he came to my bed.

Adult: And what happened then?

Child: Uncle came into my bed and started to touch me.

Adult: So, you were in your bedroom alone after dad left, and then your uncle came into your bed and started to touch you. Is that right?

- Validate what the child says and support the child to continue saying what happened.
- Summarise what the child says. Check that you have understood correctly.
- Active listening will support the child to continue to tell.
- Summarise what the child says. Check that you have understood correctly.

For example:

Adult: So, what happened after that? Tell me as well as you can, in your own words.

Child: It didn't help to scream. He hit me.

Adult: OK, I see.

Child: That's when the worst stuff began.

Adult: Tell me more about the worst part …

Exploring further

- Ask the child to think back to where the event happened, and then about what happened: this facilitates memory recall.
- Ask practical and neutral questions, such as "Can you draw your room?" or "Where is your bed located?"
- Ask clarifying questions: "What tends to happen when you're so scared?"
- Ask the child to be specific, but always in its own words. "You said they took you behind the house... Can you say any more about that?"

It is not uncommon for children to stop suddenly or deny saying what they have just said. Adults need to be patient, and not pressurise a child when it shows resistance. Often, the same information will emerge at a later time.

Role play. Exploring and disclosure.

Instructions:

- Work in pairs.
- One pretends to be the child and one act as the adult.
- If you are the adult, pick a situation from your work. Help the child to say what happened in that situation.
  - Validate and support the child.
  - Ask open questions.
  - Practice active listening.
  - Summarise.

After the exercise, share with your partner what it felt like to be the child, and what it felt like to be the adult. What worked? What did not work? What made you and the child feel comfortable in the conversation?

Screening adverse experiences

Standardised questionnaires exist for screening potential trauma. Research shows that children will report more adverse experiences when they are asked directly. We have gathered some resources in the appendix See for example ISTSS (2014). *Child and Adolescent Trauma Screen* in the literature list)

3.12.4 The obligation to report and the duty to prevent

Child abuse is a serious criminal act. Therefore, be as precise as possible when you do your documentation. You have an obligation to report to and involve child protection services (or other relevant services) in your country. You also have the duty to prevent further criminal acts and report allegations of abuse to the police department. Make yourself aware of the laws in your country and consult your supervisor, leader, or other authorities in your community. Ensure that, when you document allegations, you are as precise and as detailed as possible.

If you do need to report an allegation, make sure that you inform the child and take steps to protect the child's safety. Your role is not to investigate crime. Judicial investigation requires specific skills in working with children.

HELPER ADVICE

For a child who has been sexually abused, the main forms of help and support are:

1. To be safe. Safety includes physical, relational and emotional safety.
2. To obtain help to regulate feelings, attention and relations.
3. To have its story validated and confirmed.
4. Help to make clear who is responsible (thereby reducing shame and guilt).
5. Help to process the trauma-story, and to make its life-story coherent, in words, drawings or play.
6. Help to (re-)start normal development. This implies help to:
    - Play and symbolise.
    - Acquire body-awareness, balance and boundaries.
    - Socialise, take turns, share, regulate distance and closeness, etc.
7. Help to learn and master skills, emotions and information.

4. What we may need to do when working with sexually abused children

In this part, we discuss good practices for helpers and caregivers. Though their roles are different, we speak to both because we focus on elements that they share. Helpers are usually individuals working in a professional capacity, who do not necessarily work primarily with children. Caregivers or carers look after children, either as professionals in institutions such as foster homes, or as parents or relatives.

4.1 Caring and safety

For a child who has been abused and mistreated, the most important thing is to improve the quality of care so that the child feels protected and loved. Supporting the child's caregivers is usually the best way to support the child. Reactions to abuse and maltreatment can be complex and difficult to handle both for the child and for caregivers. The focus should be on understanding and meeting the needs of the child. To do this, it is important to explore carefully the child's reactions, as well as the reactions of caregivers.

4.1.1 Safety

Aim. To do exercises on safety and discuss how to increase a child's sense of safety.

A child's survival strategies activates when experiencing a threat, without the needs are being met. Victims of sexual abuse often feel unsafe in their bodies; they can feel fragile and insecure. They have experienced not being protected, and their boundaries have been violated. Helpers should assist caregivers to be aware of how the child feels, so the caregiver can try to help the child regain a sense of safety and protection. There are many aspects to feeling and being safe. It is worth separating them out.

Physical safety

Consider the level of safety in the community. Help caregivers to make sure that the child lives in an environment where it can be protected. Discuss how security can be maximised even in unsafe environments. Help caregivers to be aware of who they bring close to the child, and their responsibility to protect the child.

Emotional safety

Though the child may be safe physically, it may feel unsafe inside. Caregivers should be available and sensitive to signals the child gives, and help the child to recognise what being safe inside feels like.

Relational safety

A child who has been sexually abused will mistrust others, and it is often difficult to restore trust. Respecting the child's need to regulate distance and establish its personal space is crucial. Children exposed to abuse can easily feel invaded. Be aware of physical distance, and intimacy. Be particularly sensitive when it comes to physical touch; respect the child's need for personal space. Some children who have been abused can misinterpret actions as sexual and confuse intimacy with sexuality. Some children will invite to sexual contact with other children or adults, putting themselves and others at risk of sexual abuse. It is important to protect the children in question and others from new abusive situations, and to manage potentially risky situations (children playing together, going to bed).

Routines and repetition in daily life

Sexual abuse is associated with loss of control. Predictability helps restore a sense of safety. Routines and repetition in daily life can increase a child's sense of security. Routines are also important to help children acquire skills. Try to incorporate routines in the home and public settings. Routines will naturally change as the situation changes and as children grow and evolve developmentally.

EXERCISE

WORK WITH CHILDREN

Workshop exercise. What is safety?

We do this exercise to reflect on the idea of safety. This can either be as a discussion in a group or a conversation with a child.

Instruction. Think about:

1. What makes you feel safe?
2. What makes you feel unsafe?
3. How does it feel to be safe/unsafe?

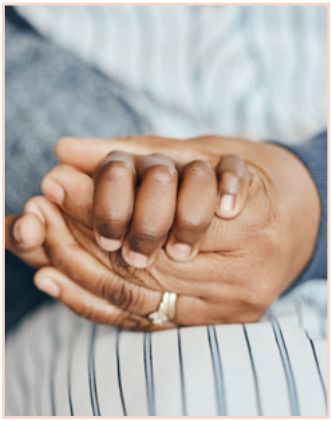
REFLECTION QUESTION

Questions to reflect on

- What is the natural rhythm of the day? How do you support that rhythm?
- Are some areas of the child's life chaotic? Can their unpredictability be reduced?
- What areas are most challenging? Mealtimes, transitions, bedtime? How can you give structure to those situations?
- How can you support families to develop new routines after transitions, particularly when children move to new homes?

Make a physical safe place for the child

If possible, make a physical safe place, a comfort zone for the child, with different sensory inputs. Fill it with safe, comforting materials so that the child can rest and feel comfortable. Include books to read and toys to play with. The safe place can be at home, in school, or in kindergarten. Say that this is a special place for the child, to go to and rest whenever it needs a break, or space to itself.



EXERCISE

Workshop exercise. Make an emotional safe place for the child

This can either be as a grounding exercise in a group or a conversation with a child.

Ask the participants to sit in a comfortable position. Do the Safe Place exercise.

(The version below is a shortened version. For the full exercise, see Additional Tools.)

EXERCISE

WORK WITH CHILDREN

Exercise. Imagine your own safe space

Think about the best place to be in the whole world. It can be your favourite place, a place you have been before, a place that you have seen in a film, or heard about. Or it can be your own fantasy place. Where are you? What does it look like? Are you alone, or with someone else? Imagine the colours, the smells, the sounds around you. Perhaps you can feel totally relaxed and safe inside. How does your body feel? Imagine that you have a special space inside you where this feeling of safety exists and that you can go here whenever you need to. Maybe the feeling has a colour. What is the colour? Or does it remind you of an animal? What animal is it? Maybe you can describe this special place with a word or a sentence? What words come to you?

You can end the exercise with the “Butterfly Hug”. Cross your hands on your chest, as if you are giving yourself a hug. Then clap your chest with your hands rhythmically, left hand then right hand. At the same time, say a comforting sentence inside yourself (such as “I’ll be fine”).

How do you feel? Do you feel more or less relaxed?

- Ask the participants to discuss the Safe Place exercise. Ask whether anyone wants to share their safe place with the group.
- If you do the exercise with a child who has been sexually abused, the child may not come up with anything and you may need to make suggestions. Test out your suggestions. Ask “Is this OK?”, “Is it like that?”, “We are safe here”, “You will be fine”.
- How can you use this exercise with the children you work with?

4.2 Regulation and stabilisation

By 'regulate' we mean the capacity to adjust our inner state so that it matches the situation here and now. Children are born with a sensitive alarm system and an under-developed self-regulation system. They need a close relationship with an adult to build their capacity to self-regulate. A child that is traumatised as a result of sexual abuse needs this assistance even more.

We call the cooperation that adults provide '**co-regulation**'.

4.2.1 Co-regulation. "Remember to put on your oxygen mask first."

To meet the needs of the child, the helper (or caregiver) must be regulated and present. Co-regulation occurs when a caregiver uses his or her active and safe presence to help a stressed child to calm down. Through different senses, the adult's calmness transfers to the child. As in a dance, two people move together in the same rhythm, but the adult leads and gives structure and direction. Through such care experiences, the child gradually develops a capacity to self-regulate and learns to tolerate stress without being overwhelmed. Many abused and mistreated children experience co-dysregulation. Rather than receiving help from its parents to calm down, the child has had to find its own ways to manage emotions and pain. Such children may not believe that adults can be helpful and trustworthy. Their experience is that adults have only made things worse. Some ways they find to reduce their discomfort may include daydreaming, overeating and self-harm.

It can be demanding to provide children who have been traumatised with new experiences that are associated with positive co-regulation. Children whose behaviour is challenging or aggressive provoke reactions in those who care for them, that make the children more anxious. "Putting your own oxygen mask on first" is therefore important. Children exposed to repeated stress and lack of support struggle to express emotions and needs effectively, which can confuse caregivers. Helpers and caregivers are also led by their own experiences: it is in situations where they feel scared or inadequate that the most automatic responses occur.

"Children exposed to repeated stress and lack of support struggle to express emotions and needs effectively, which can confuse caregivers. Helpers and caregivers are also led by their own experiences: it is in situations where they feel scared or inadequate that the most automatic responses occur."

Workshop exercise

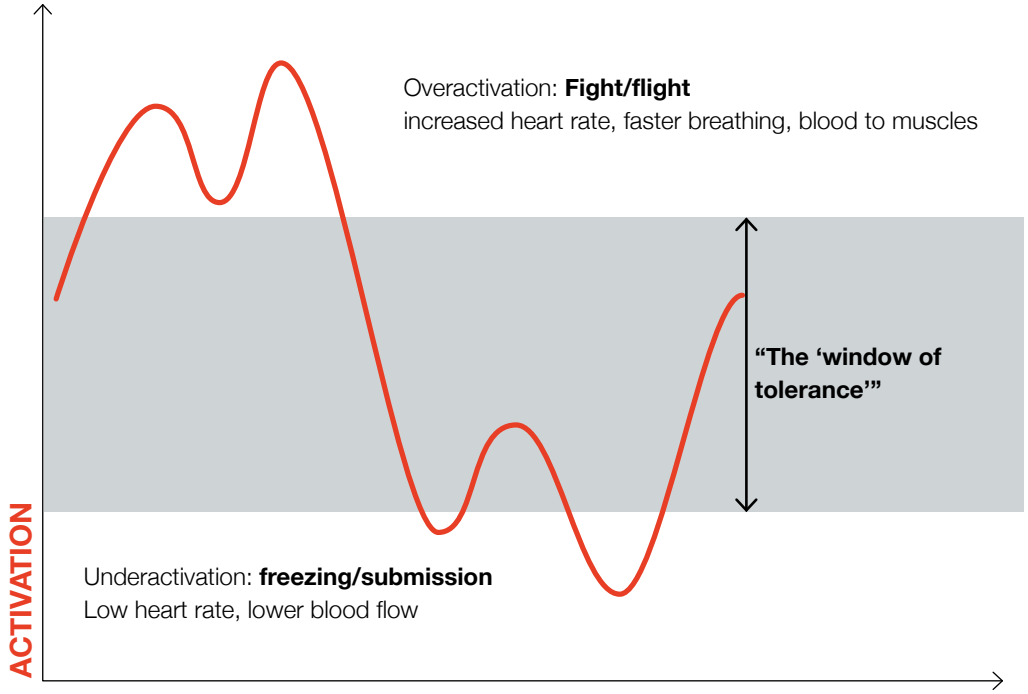
Aim. To get in touch with the feeling of fear.

Instructions.

- Can you recall a situation in which you were afraid or felt terror?
- How did you feel? How did your body feel? How did you react?
- What did you need from others? What made the situation worse? What actions helped you to return to a peaceful state?
- Ask the participants if they would like to share their experiences with the group.

4.2.2 Window of tolerance

The "window of tolerance" is a therapeutic metaphor that is used to explain trauma reactions (Daniel Siegel). It centres on the idea that every person tolerates or is comfortable with a certain level of arousal or energy. Below, we provide information that will help children to understand their trauma reactions and help carers to understand the trauma reactions of the children in their care. The manual also provides tools and grounding techniques that can help children to stay within their window or return to their window when they lose control.



The metaphor is very simple. The graphic shows the level of activation. All people have a zone (between the two lines) in which they are balanced – where the person is in a state of mind that permits him or her to be present in the situation, able to concentrate and learn. If a person is above the top line, we say that he or she is over-activated (hyper-activated). Their activation is too high. If the person is below the bottom line, we say that he or she is under-activated (hypo-activated). Their energy is too low.

Traumatic memories can trigger a flight/fight response. This is a hyper-active reaction, in which the body is highly activated because it is readying itself to flee or fight threats. When we are frightened by a threat, the body automatically shuts down certain activities and reinforces others. For example, the heart beats faster and we breathe more quickly; more blood flows to the brain, arms and legs; muscles prepare for fight or flight, while the brain shifts its activity from areas that help us think through complex problems to areas that help us to respond to danger.

If you cannot fight or flee (because, for example, you are a small child), your body will fall back on the most basic survival strategy we have: it will shut down. This mechanism can be observed in many small animals: they become totally inactive when they are attacked. This is a hypoactive reaction: activation falls to a minimum. The child becomes immobilised.

Most of us occasionally exceed our window of tolerance. When this happens, we need strategies that enable us to regulate (return to a tolerable state of mind).

Role Play. The window of tolerance.

Aim. To practise using the window of tolerance.

Duration. 25 minutes.

Instructions:

1. Form pairs.
2. Explain the window of tolerance to a colleague. Draw the model and demonstrate it. Use examples from your own practice.
3. How can you help a child that is unregulated to re-enter the window of tolerance? Write down two effective ways that you know from your work

(See also the exercise My Motor in Additional Tools. My Motor It is a simplified version of the "window of tolerance" that can be used with small children.)

4.2.3 How to regulate

Breathing exercises

When we are frightened, we breathe shallowly. To relax and calm down, it is helpful to pay attention to the depth and the speed of our breathing.

- Ask the child to breath in and imagine breathing out like a leaf falling from the three.

Or

- Ask the child to place a hand on its stomach and slowly breathe in through the nose, counting to 4.
- Ask the child to feel its stomach expand.
- Then breathe out through the mouth, once more counting to 4.

Breathing techniques (middle childhood).

- Ask the child or children to raise their arms. Ask them to breathe in as their arms go up and breathe out as their arms come down. See how slowly they can move their arms up and down.
- Ask the child or children to take a deep breath and then blow out an imaginary birthday candle. Ask them to smell flowers. Ask them to puff the seeds from a dandelion.

Rhythm

Rhythm has a particularly calming effect on the stress response system. Rhythm can be found in music, in dance, in touch, and in the regularity of daily activities. Rhythms are predictable; they are calming and give pleasure. They were also important stimuli before birth, in the uterus. Children who have been abused sexually have experienced a dislocation in their relationships. Doing rhythmical things with others can help them to relax and feel more confidence in relationships. Examples of rhythmical activities include throwing and catching a ball together, singing together, running together, or dancing.

Workshop exercise.

Aim. To experience rhythm in a relationship, and how to recover rhythm; to be in synchrony and out of synchrony.

Time. 20 min

Materials. Balloons, or a ball that you can throw together. Work in pairs, or small groups

Instructions:

- Throw the ball or balloon to each other. Find a rhythm. Match the intensity of your partner. Try to synchronise.
- Vary the rhythm and tempo. Try to be out of synchrony. Introduce surprises; be unpredictable and competitive.
- Return to a rhythm. Synchronise again.
- How do being in and out of synchrony feel different? How does restoring synchrony with your partner feel?
- Share your experiences (5 minutes).

You can also do this e*xercise* with a child or with a group of children.

Sensory stimulation

Sensory stimulation can also regulate the body. Children naturally booth seek and avoid sensory stimulation; through movement and play, they obtain what they need for development and learning. However, some children who have been sexually abused lose contact with their bodies; they no longer feel grounded. Physical activities can help them to reconnect to their bodies, learn how their bodies function and feel, re-experience joy and comfort. For children who have symptoms of dissociation (disconnected from themselves), sensory stimulation can return their body to the present. It is important to find activities that the child enjoys and can integrate in daily life. For example, take small breaks for physical activity during the school day. This benefits all children, but is particularly important for children who are struggling to regulate their bodies.

Choose activities that fit naturally in your culture.

Examples of sensory activities

Sound. Listen to music; use headphones to drown out noise; noise machines.

Touch. Weighted blankets; soft pillows; stuffed animals; cool stones; chewable jewellery; hugs.

Smell. Lotions; air fresheners; flowers.

Taste. Gum or hard sweets to suck on.

Sight. Pictures of safe people; pictures of favourite places; gardens; views that minimise visual stimulation.

Give the child the sensory input it needs. Try to seek out activities that the child enjoys and wants. Avoid activities that the child shows reluctance for. If the child receives sufficient sensory stimulation, that stimulation will support its learning and development.

Regulating activities

Below we have listed activities that can be used to raise or lower activation when a child is outside its window of tolerance. These activities can be comforting and can help the child to establish contact with itself and its surroundings, and to explore and develop self-regulation strategies. Many of the activities can both "wake up" and "calm down". It is a good idea to practise them when the child is in a calm state. Explain to the child that these activities may be helpful in stressful situations.

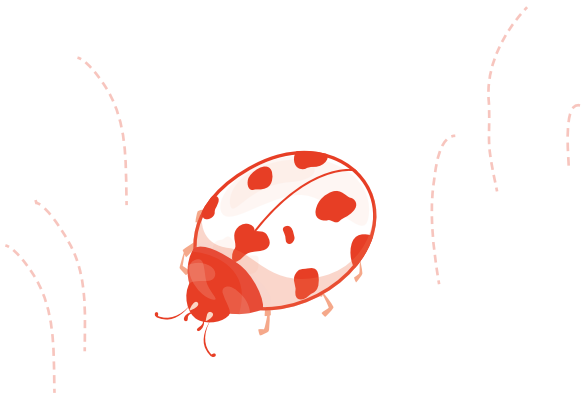
Regulating down	Regulating up
• Squeeze a stress ball. • Butterfly self-hugs (arms crossed across chest). • Calming music. • Pet animal or soft material. • Safe touch, massage. • Heavy blankets. • Balancing activities. • Grounding stone. • Mild and pleasant smells.	• Squeeze a stress ball. • Focus on things in the environment. • Bike, run, jump. • Music with fast rhythms. • Chew different forms of food. • Play the "taste game", the "smell game" and the "sensory game". • Chew gum, blow bubbles. • Taste ice cream. • Touch ice-cubes.

The activities we have listed are just suggestions. Find activities that fit the child's and your social environment. See also regulating activities according to age in Additional Tools.

REFLECTION QUESTION

Questions to reflect on

- What activities calm or stimulate a child you know?
- What activities in your social environment /culture have calming or stimulating effects?



4.3 Relationship and intimacy

Aim. To help a child to appropriately regulate its closeness to and distance from other people.

A child that has been exposed to sexual abuse can find it difficult to regulate personal space and distance from other people, because it has a history of being invaded and losing control over its own body. Intimacy can be closely associated with abuse. Many abused children struggle with physical regulation and becomes easily overwhelmed by bodily sensations. They may find it difficult to recognise their own needs and to disclose their needs to others. Some children have adopted a submissive survival strategy because it helped them to reduce the confusion and pain they felt when they were abused. Some children who have been abused sexually will seek intimate contact, almost inviting to sexual contact, as a way to predict or control situations. Others avoid intimacy, and react aggressively or by escaping if someone moves too close to them. Some children oscillate between these states, at one moment seeking intimacy, and the next rejecting it. Changes can be sudden and confusing, both for the child and caregivers. Caregivers and others therefore need to be sensitive and help the child to regulate personal space and distance so that it can acquire experience of being safe with others. Parallel activities (reading together, watching films together, taking car journeys together) can establish distances that these children tolerate. Abused children can be very sensitive to eye contact.

Advice on safe physical contact

- Make sure that all physical contact is safe.
- Be aware of possible triggers in relation to physical and emotional intimacy.
- Teach the child about boundaries and safe touch. One exercise is to draw a circle around the body and talk about intimacy zones. “This is your space. No-one who you do not want to be close to you can enter this circle.”
- When children are sensitive about physical contact, teach them about safe touch in non-triggering situations, such as sports and play.
- Test safe touch on less intimate parts of the body, for example by massaging hands and feet. Wrap the child in warm or heavy blankets. Give the child a footbath. Resting in a hammock can also feel safe.
- Be alert to the child’s signals. Check regularly whether the child feels comfortable and adjust your distance if it does not.
- Talk about potentially risky situations. How can the child be protected? What can the child do to feel safer?

Workshop exercise. Your personal space

Aim. To test the limits of your personal space.

Instruction.

- Work in pairs.
- Stand at a distance and move slowly towards one another.
- When you notice that you are becoming uncomfortable, make a stop sign with your hand.
- Test different distances. Share your experiences afterwards.

4.3.1 Difficulties in maintaining good relations

Children who have been sexually abused can be scared when they receive kindness or have pleasant experiences, because their pain increases when the moment of kindness ends; such children often feel kindness will be withdrawn, or believe they do not deserve it to continue.

For these reasons, they may react strongly during or after pleasant activities. It may seem that they want to destroy moments of happiness, whereas their behaviour may be an attempt to protect themselves from further disappointment by maintaining a predictable worldview. Helpers and carers should try to understand the child's perspective. It may take many repetitions of kindness to change such expectations, but it is possible to transform the child's expectations over time. Often the child can be most destructive when its inner expectations are about to change, because the risks of disappointment have become higher. ("Just maybe, this person will continue to take care of me?") Be patient and do not give up during this period. Anger and emotional destructiveness may be a sign that the child is beginning to have confidence in you.

4.3.2 Repairing is gold!

Repairing is very important. Children who have been betrayed and experienced many ruptures and disappointments in their relationships often express their pain and sense of rejection in forms that cause them to be rejected again. As a helper or carer, you cannot meet all the child's needs or cope entirely with the child's difficult behaviour. You too are likely to feel frustrated and face issues of self-regulation. As an adult, take responsibility for repairing the relationship. Wait until both you and the child have calmed down, then talk about what happened. Remember that you are the adult and can take responsibility. Everyone is allowed to make mistakes.

Repair is an opportunity for new learning

Children exposed to sexual abuse have experienced broken relationships and betrayal and feel mistrust. They quickly feel unsafe and expect bad things to happen. When such children see that relationships can be repaired, they begin to understand that relationships can have solid foundations, and may start to put confidence in the words and good will of others.

Reflection exercise

Think of a difficult situation that you managed to repair afterwards. What did you do? How did you feel during it? How do you think the child felt?

4.3.3 Play

Play is a natural way to heal.

Play helps children to thrive, process experiences, learn and express feelings. A child traumatised by sexual abuse can process its experience through play, and find meaning, control, solutions and a sense of coherence. Some children will play the same game over and over again; they seem stuck in destructive themes associated with the abuse. These children might need help to find hope, and new forms of play. Some children stop playing altogether after abuse, a very severe effect that can have developmental consequences for the child. Such children need help to recover the ability to play.

Advice and ideas for play

Make sure that the child has a safe place to play. Be interested, available and supportive when you play together with the child. If the child seems helpless and out of control, help to find solutions. Follow the child's lead and focus on what the child shows you. Remember that children can re-experience their trauma during play. They may want you to be the victim or give you a role. Help the child to find safe ways to express what has happened to it. If the child re-enters a traumatic state, for example because it has re-enacted the abuse, the child may become hyperactivate, impulsive, lack body control, become numb or break contact. Try to restore contact and bring the child back to here and now. Good ways to do this include playing catch together, singing a song, or helping the child to organise a game or build something.

Workshop exercise. Share a play-memory from your childhood

Aim. To make contact with your playfulness.

Duration. 7 minutes.

Instructions.

- Go back to your childhood and try to remember yourself playing. You can be playing alone or with another child or an adult. How old were you? What was the play about? What did you enjoy?
- Share this memory with the person sitting next to you.

4.4 Reason and verbal intervention

You can adopt different approaches when you talk with children about sexual abuse. You can speak to the child in your care about what children in general have experienced and how they reacted. Or you can speak directly or less directly about what happened to the child in your care.

4.4.1 Naming feelings

Many abused children seem to have little awareness of how to distinguish their feelings.

They may also not be aware whether they are cold or warm, hungry or full, tired or not (their somatic state).

They may feel overwhelmed by emotions (excited, upset, frustrated, numb) but be unable to judge whether they are hurt, disappointed or frustrated, for example. To help a child become more aware of its feelings, try looking together at pictures of faces that express different feelings, or pictures of different situations. Work with the child to distinguish the intensity of feeling (on a scale of 0-10 for example).

Workshop exercise. Role play – What am I feeling?

Aim. To get in touch with feelings, and experience how to work with feelings.

Duration. 10 minutes.

Materials. A box or basket. Put slips of paper in the basket with a feeling written on each.

Instructions:

- Form pairs or a group. One participant acts a feeling; the others guess what the feeling is.
- The actor picks a note from a basket. (Prepare by trying to feel the feeling inside you.)
- Act the feeling. You cannot use language, but you can use your whole body.
- The other participants guess the feeling.
- Discuss afterwards what the actor did to demonstrate the feeling, and how the other participants recognised it. You can have this discussion with children too.

EXERCISE

WORK WITH CHILDREN

Drawing exercise to describe feelings and spaces

(You can use Maria's story as an example.)

Instruction. Make a drawing of the places a child visits every week. This can open a conversation about the different feelings the child associates with each area.

Start with drawing a circle for each place: let the child name them: home, school, out with friends, grandma's house.

Then ask the child about which feelings they associate with the places.

Consider: being joyful, sad, frightened, angry, happy, silly, playful… Ask the child if you should add other feelings.

Ask the child to give a colour to each feeling. What is the colour of joy? Of sadness? Let the child choose.

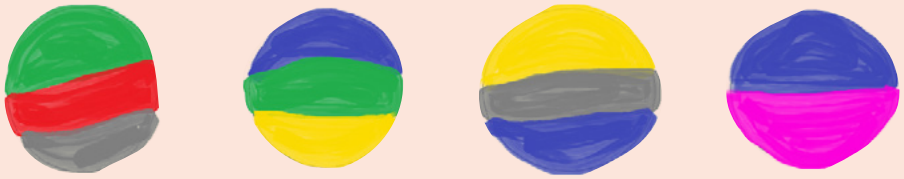
For example:

Then ask the child to colour each of the places it visits during the week.

Say: "Look at the different places you visit. Which colours should we put in which circle? Think of something that makes you happy / angry / frightened / sad… You can use several colours in each circle."

When all the areas have been coloured, ask the child: "Can you tell me what especially makes you have that feeling in, for example, school? When you are at home? When you are out with grandma's friends?"

Home **School** **Out with friends** **Grandma's house**



Remember. This exercise creates an opportunity for the child to tell, but that is not the only purpose. If you work together on different colours and different areas, the child may start to feel that you are interested in its whole life, and are not merely an abuse detective. This game can be a good starting point for talking about strategies to seek safety, obtain help and resources, etc.

4.4.2 Psychoeducation

Children who have been sexually abused have often been told by the perpetrator that "doing this is normal", "it happens in every family", "this is good", or "I am entitled to do this because I am a grown up and you are a child". This confuses the child. Being touched in their intimate parts feels intrusive, is secret, but appears to have adult approval. Address directly the child's right to boundaries. Teach the child what behaviour by an adult is correct and incorrect, in relation to a child and a child's body.

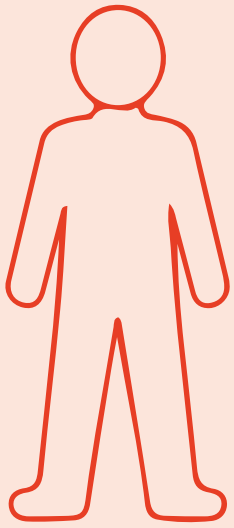
Teach the child what is a normal reaction when boundaries are violated. Many children who have been sexually abused are afraid of their own reactions. They want to be normal, like their friends. When they are easily startled, moody, have flashbacks, nightmares or similar reactions, they may feel there is something wrong with them. Stress that their reactions are normal and foreseeable. This often eases the child's anxiety. You can approach this subject in different ways. It may be possible to speak directly of the child's own experience, but you can also tell the story of an imagined child, or speak in general terms. Take the child's age and emotional maturity into account.

Exercise. My body.

Sexually abused children often have poor body awareness and cannot differentiate their feelings (affect differentiation). Drawing the body and asking a child to locate its feelings on the body can be one way to increase the child's awareness and connectedness.

This exercise can be used as a tool to talk about and differentiate feelings, or to educate about appropriate body boundaries.

I have a body



Instructions

Make an outline of a human body. (Children below 5 years of age often enjoy it if you draw round their body as they lie on a large sheet of paper.)

Say: "When we have strong feelings, we can usually feel them in our body. For instance, I feel as if my throat is being narrowed when I get scared. I feel a pain in my tummy when I am sad.

Remember the colours you associated with different places you visit every week? Let's colour your body in the same way. Where do you feel happiness? Where do you feel sadness? Anger? Etc."

Or: "Where do like to be touched? Where do not like to be touched? Who is allowed to touch which parts of your body? Imagine now that the body is the body of someone else. Which parts of it are OK for you to touch, and which parts should you not touch?

4.4.3 Trauma triggers

Our nervous system associates stimuli that occur in the same place or at the same time. We link a certain jumper with the smell of wool; a car journey with a certain tune, etc. This power of association can cause children who have been abused sexually to associate non-dangerous situations and objects with invasive events they have experienced. Trauma triggers recall a pain that has happened; they bring to mind an experience of being abandoned, let down, hurt, or humiliated. Triggers can be inner experiences such as emotions or thoughts; physical and sensory experiences (sounds, smells, colours); objects (an ornament, a place); or events (holidays, dusk), etc. They can also be relational: for example, intimacy or eye contact. Many triggers are subtle and difficult to recognise.

Try mapping the child's triggers. This can help you to understand the child better, and may help the child to understand its own reactions. List together what seem to be the child's triggers. Explain to the child that the brain makes all kinds of associations between stimuli that appear at the same time. If the abuse happened at night in a bedroom, there can be many potential triggers. For example: bedtime, bed, dusk, being alone, lamps, toys, books, tiredness. All these can remind the child that going to bed is a moment of potential threat. It is important to enable the child to regain a sense of safety by removing or countering some triggers. For example, you can remove certain objects from the room; or help the child to calm down by playing music, being close, offering new safe objects and toys, and checking the room together.

For children who are or have been abused, typical triggers include:

- New or challenging situations or environments.
- Intimacy.
- Lack of control.
- Limit setting and praise.
- Eye contact.
- Physical contact.

Role-play. Managing trauma triggers

Aim. To practise talking about trauma-triggers.

Duration. 10 minutes.

Instructions:

- Work in pairs. One is the child, the other a helper.
- Try to explain to a child what a trauma trigger is.
- "Triggers are things that remind you about bad and scary events that happened to you. They make you feel that event is happening all over again. You feel caught in the past, not where you are here and now. If what happened occurred at night, going to bed, or getting tired can be a trigger. If the person that abused you used a perfume, this smell can awaken feelings associated with what happened, like disgust, fear, and shame. These are real feelings, but now the abuse has stopped and is no longer happening, so when you are triggered you need to find your way back to what **is real, here and now**."
- After explaining, talk to the child about ways to "get back to here and now" using SOS.

Exercise. Helping a child to regulate using SOS:

S **S**top and take a few deep breaths.

O **O**rient. Check your surroundings. Where are you? What do you see? What do you hear?

S **S**eek help. Is someone nearby who can support or comfort you?

Exercise. Trigger plan

Agree on a plan to handle trigger with the child, steps that both of you will take to manage triggers. You might discuss:

- How can we make daily life more predictable? Can we find some safe routines that you trust?
- Who can support you when you are triggered? What kind of support will help you most?
- Are there situations we should avoid?
- How can we help you to get back to "here and now"? For example, does the SOS exercise help you enough? What else would help?
- Shall we practise positive self-talk? Will physical activity and movement help you?
- Shall we create a safe space you can always go to?
- Agree activities, "signs", routines, safe spaces.

4.4.4 Reduce intrusive memories

If the child has intrusive memories, there are techniques for gaining more control over memory. Aim to enable the child to control the image or memory, not be controlled by it. Practise the exercise below.

Workshop exercise.

Aim. To practise controlling intrusive memories.

Instructions:

- Form pairs.
- One participant thinks of a disturbing image. The other participant uses the technique to help the first participant to cope.
- Reverse roles.

"Draw the image you have in your head on this sheet. Imagine being able to change the colour. Can you change the colour to black and white? Imagine putting the picture in a frame. Imagine being able to move the image in its frame around the sheet. Can you pretend that the image is inside a TV screen? Can you imagine that you have a button that will turn the TV off? Is it possible to turn it off, just for a moment?"

4.4.5 Identity and hope

Many children who have been sexually abused feel that they are destroyed. They feel that what has happened to them defines who they are and who they can be. Some children feel "bad", "ugly", "unlovable"; they feel they are undeserving of a good life. Children who have been abused are also likely to be afraid that they will transfer their trauma to their own children and become an abuser themselves. Others do not want to see themselves as a victim, refuse help and do not admit that they feel vulnerable. These children need adults who will accept them, and their pain, and are prepared to talk with them about sensitive issues. It is essential to recognise the pain and the hurt the child is feeling and to be available to the child. Allow and support the child to explore and understand what happened to it at its own pace.

Support positive self-image

Sexual abuse affects a child's self-image and self-worth in serious ways. The invasive, humiliating, sometimes violent things that it experienced can colour a child's self-image.

Recognise and highlight the child's positive qualities. This will help the child to regain self-respect and provide a foundation for self-care.

Here are four examples of activities that can be helpful:

- Make a book about "My power". Help the child to decorate the book and highlight strengths the child has, or powers the child needs or wants.
- Allow the child to fantasise about "superpowers" that help it to do amazing things in the world (as a superhero, an animal, a sports star, etc.).
- Make a "boast collage". Decorate a poster with images and objects, pictures, colours, stickers, activities, words – which the child finds positive.
- 'My superhero'. Discuss the child's superhero. What qualities does the superhero need (strength, courage, endurance, etc.)? What superhero qualities would the child like to possess?

Take into account the child's age and emotional maturity.

4.4.6 Support hope for the future

Experience of sexual abuse affects a child's attitude to its future. Many children who have been abused sexually find it difficult to look backwards or forwards. It is very important to help them recover hope for the future and to give them experiences that show life can be OK.

Here are some activities that you can do with the child:

- **Imagine you are an adult.** What does it feel like? Who do you want to be? What do you want to be doing?
- **Imagine writing a book about "My Life".** What experiences have you had that prepare you for the future? What qualities do you have that will help you? What qualities do you need to practise and develop to achieve what you want?
- **Role reversal** (see the exercise below).

Note. With adolescents, this discussion can be more detailed. Invite them to imagine what they want to be doing in five years' time. What will you need to do to reach these outcomes? Who can help you to achieve them? What qualities do you have that will help you?

Role play. Role reversal for an adolescent and an adult.

Aim. To practise role reversal with an adolescent.

Duration. 15-20 minutes.

Instructions:

- Ask one participant to play an adolescent and another to play the adult.
- Take two chairs. One chair represents youth today (the "youth chair"); the other represents youth in the future (the "adult chair").
- Invite the adolescent to sit in the "adult chair". Ask: "Do you, as the adult, have good advice for yourself as a young person?"
- Now ask the adolescent to sit in the "youth chair"; repeat the advice from the "adult chair" so that the adolescent can hear it.
- Discuss together what the adolescent discovered or felt during the exercise.

4.4.7 Help children to gain meaning and a sense of coherence

Children need information that is appropriate for their age about what has happened to them and what will happen in the future. They also need explanations that will enable them to give meaning to their experiences. This is particularly true for children who have been sexually abused. When children have overwhelming experiences, it challenges the memory system and it becomes difficult to integrate information in a normal way. Traumatic memories can "pop up" when a child sees, hears or touches things. A person's face can suddenly morph into the face of the child's abuser. Even young children can have strong visual and somatic memories, which they cannot articulate or understand. It is important to monitor carefully the child's capacity to gradually and spontaneously process its trauma.

For some children it is very important to tell and recognise their story. This is so, in particular:

1. When the child's experiences feel unreal to the child, as if they did not happen (derealisation); as in a film. Or when it seems to the child that the events did happen but to someone else (depersonalisation).
2. When the child's experiences do not form a coherent narrative but are retained in fragmented pictures and sensations. To store the memory in the child's mind as something that happened then and not now, the child needs to create a narrative that has a beginning, middle and end.

The abuse that traumatised the child left it in a helpless position. Helplessness may have become a part of the child's belief system. "There is nothing I can do or change." Helping children who have been sexually abused is therefore also about strengthening their feelings of agency, enabling them to believe that they are the subject of their lives, in charge of what they become and do next.

It is important to help the child express emotions in a range of ways, through play, conversation, sport, music, dance and other creative activities.

WORK WITH CHILDREN

These activities can help a child to find meaning and a sense of coherence:

- Draw a timeline and mark on it important events in the child's life.
- Make a photo album and look at it together. Help the child to remember.
- Make a "Story of my life". Help the child to write down the story of its life so far. Add photos and other objects and points of reference that can give the story detail and body.
- Participate in drama and theatre. Dramas address many themes that children can identify with and acting is (or should be) an inclusive collective experience.
- Tell stories, share stories, and write stories about daily life and past events.
- Encourage and support fantasy and playfulness.
- Talk together about life, and why bad things happen. Help the child to tolerate its pain.

Helping a child to manage

When an abuse is revealed, it is important to remind the child that this part of its history is not the whole life; a child should not be reminded of the scary parts of its life the whole time. Draw a river or lay a rope on a long piece of paper on the floor to illustrate life. Encourage the child to talk about different events in its life and to put symbols of good things (such as pearls, flowers or other nice things), and symbols of bad or difficult things (such as stones etc.), along the line while it tells its story. (See Additional Tools 4.7.2.)

Note. Stories do not need to be about the child. It is often easier to write about invented people. In either case, writing and telling stories can release feelings and thoughts that otherwise may be too painful or difficult to express.

Always take account of the child's age and emotional maturity.

4.5 What is trauma processing?

'Trauma processing' refers to the ways in which people integrate traumatic memories so that they become less disruptive and more tolerable. For children who have been traumatised by sexual abuse, it involves learning to understand, tolerate and accept what happened, but also to realise that what happened belongs in the past. In this process the child recognises and assembles the fragments of its experience and puts them together in a way that gives them meaning and direction. Trauma processing can take different forms. It may involve verbal and symbolic expression, or nonverbal expression through the body and play. Trauma processing can transform the child's understanding of what happened to it. The child may shift from thinking "this was my fault" to understanding that "the abuser was responsible".

The process of integration usually extends through childhood into adulthood. A young child and an older child need different information. The story also grows as the child grows. Children naturally express feelings and reactions through play or other forms of symbolisation like music and the arts. Adults play an important role in this process. They help the child to find words and meanings for their experience, provide points of reference and comparison, and give shape and context to the child's life as it evolves.

When children have been traumatised by sexual abuse, they need adults to help them process what has happened to them. Helper and caregivers participate in this. You may have witnessed what happened; you receive the confidences of the child; you assist the child to understand and tolerate its feelings, and support the child in its anger, guilt, shame and grief. Adults play a critical role in helping a child who has been sexually abused to restore its self-respect and autonomy and acknowledge that the child was not responsible for what happened.

"Adults play a critical role in helping a child who has been sexually abused to restore its self-respect and autonomy and recognise that it was not responsible for what happened."

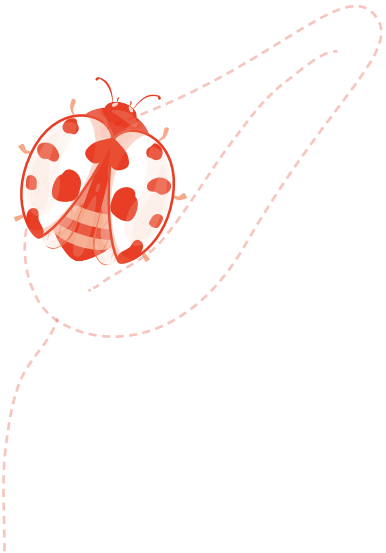
The child may need assistance to correct misperceptions, about who was to blame for what happened, who was responsible for not protecting it, and why the abuse "happened to me". The importance of cognitive work should not be underestimated.

First and foremost, however, work to restore the child's trust and confidence in others, in the world, in the future, and restore the child's sense of dignity and self-esteem.

HELPER ADVICE

Talking to children about abuse

- Be present and attuned: show you are ready to hear the child's story or participate in its play.
- Be aware of your own reactions. Take a deep breath and tolerate the pain.
- Expect the child to wander in and out of the story or play.
- Help to clear up misunderstandings if they come up.
- Listen carefully and be sensitive to the child's reactions.
- Accept the child's reactions (for example, guilt and shame).
- Take breaks when it becomes too intense. Help the child to "get back to here and now" by doing regulation activities (suitable for its age).
- Have cold water at hand; stand up and move around; wake the child's body if the child disconnects or becomes withdrawn.
- Keep reminding the child that what happened is now over and that the child is safe now (if that is true).
- Try to get through the most difficult and painful part of the story. End the conversation when the child returns to safety. When ending the conversation, help the child back to here and now.
- Find an activity that will occupy and please the child. Go for a walk, bake a cake, cook, garden, play with a ball, listen to music, dance…



Help the child to position its abuse in the past

Traumatisation is about being held in the past. It is important to help the child find the here and now and distinguish present from past. Try to help the child focus on being here with you now and emphasise that the abuse is over.

"Traumatisation is about being held in the past. It is important to help the child find the here and now and distinguish present from past. Try to help the child focus on being here with you now and emphasise that the abuse is over."

Here are some examples of comments you might make to help the child during the conversation.

- What can remind you that it is over now?
- Can your body recognise that it is over?
- Can you make a drawing to show that it is over?
- Would you like to say something to the perpetrator if you could? What would it be?
- Would you like to do something to protect yourself? What would it be?
- Can you imagine that you are safe now? Can you imagine that you are protected?

Role play. Talking about the abuse

Aim. To practise talking a child through its traumatic experience and recalling it to the here and now.

Duration. 20 minutes?

Instructions:

- Work in pairs. A is a child, B is a helper.
- A chooses a difficult memory to share. A talks about the experience. B supports A, helps to regulate A, takes A through the worst part, and brings A back to here and now.
- A and B swap roles.

Help adults to take responsibility for failing to protect

"If a caregiver takes responsibility for her or his part in what happened, this can greatly help the child to process trauma. The caregiver can reduce the child's feelings of guilt and shame. The child can put responsibility where it should be put. In many cases, caregivers will need help to take responsibility, because it is painful and distressing for them too."

If a caregiver takes responsibility for her or his part in what happened, this can greatly help the child to process trauma. The caregiver can reduce the child's feelings of guilt and shame. The child can put responsibility where it should be put. In many cases, caregivers will need help to take responsibility, because it is painful and distressing for them too.

Below are the words of a mother who, with support, was able to take responsibility for not protecting her child.

"I should have taken care of you, but I didn't know."

I know I should have left your father earlier, but I was too scared. It's not your fault. I'm sorry it happened. I wish I could have protected you, but I couldn't. I imagine you are sad, angry and scared. Is that right? You're entitled to be. I didn't know that Dad abused you and I can understand that you did not dare to tell me. Still, I should have protected you, mothers should do that. He is responsible for what he did. He should never have done it. But you lived with me also, and I should have protected you.

4.6 Trauma-focused treatment

Strong trauma symptoms can put the development of children at risk. It is important to monitor the development of any child that has been traumatised by sexual abuse and provide appropriate support.

If the child continues to struggle, therapies that focus on trauma may be required. Several methods can effectively treat PTSD, including EMDR (eye movement desensitisation and reprocessing) and trauma-focused cognitive behavioural therapy (TF CBT). Please see the guidelines of the International Society for Disease Surveillance (ISDS) for more information. This handbook does not describe professional therapies but sets out general principles that are of value.

4.7 Additional tools

4.7.1 Safe place

Aim. To regulate emotions

The safe space exercise can be a good tool for a child. It can help a child to stay within its window of tolerance, able to avoid being overwhelmed by negative emotions such as fear and anger.

Sometimes when we are upset, we might imagine a calm place or a time that makes us feel better. Imagine such a place. It might be somewhere real where you have been, somewhere you have read about in a story, or somewhere that you invent and make up yourself.

Take several deep steady breaths. Close your eyes and carry on breathing normally. Bring up a picture of your Safe Place and imagine that you are standing or sitting there. Can you see yourself there? In your imagination, look about you. What do you see? What do you see nearby? Take in the detail, see the materials it is made of. The different colours. Imagine reaching out and touching it. How does it feel? Now look further away. See the colours, shapes, and shadows. This is your Safe Place and you can imagine it whenever you like. When you are there, you feel calm and peaceful. Imagine your bare feet on the ground. What does the ground feel like? Walk around slowly, notice the things around you. Observe how they look and how they feel. What can you hear? Perhaps the gentle sound of the wind, or birds, or nature. Can you feel the warm sun on your face? Can you smell flowers perhaps, or your favourite meal being cooked? In your Safe Place, you can see the things you want, and imagine touching and smelling them, and hearing pleasant sounds. You feel calm and happy.

Now imagine that someone special is with you in your place. [This might be a fantasy figure or someone that makes you feel strong and calm.] This is someone who is there to be a good friend and to help you, someone strong and kind. Now imagine you are walking around and exploring your Safe Place slowly with this person. You feel happy to be with this person, who is good in solving problems.

In your imagination, look round once more. Have a good look. Remember that this is your Safe Place. It will always be there. You can always imagine being there when you want to feel calm, secure, and happy. Your helper will always be there whenever you want. Now get ready to open

your eyes and leave your Safe Place for now. You can come back when you want. As you open your eyes, you feel even more calm and happy.

Well done! What was that like? Would any of you like to describe your Safe Place? How did it make you FEEL being there?

You can see that you can choose what to see in your mind and that this makes a difference to how you feel.

Your Safe Place can be the first tool in your Toolbox. You can take it out whenever you need to, whenever you feel sad, or scared.

Note. For some children it may be difficult to imagine a quiet place, or being immobile. When this happens, suggest to the child that it can think about a favourite sport or an activity it loves, like dancing or playing football.

You can end the exercise with the "Butterfly Hug".

Instruction for the Butterfly Hug:

Cross your hands on your chest, as if you are giving yourself a hug. Then clap your chest with your hands rhythmically, left hand then right hand. At the same time, say a comforting sentence to yourself (such as "I will be fine").

How do you feel? Do you feel more or less relaxed?

REFLECTION QUESTION

Questions to reflect on

- At the end of the Safe Place exercise, ask the participants to discuss it.
- If you do the exercise with a child who has been sexually abused, the child may not come up with anything and you may need to make suggestions. Test out your suggestions. Ask "Is this place right?", "Is this what it is like?", "Are you feeling safe here?".
- How can you use this exercise with the children you work with?
- You can also make a physical safe place, a comfort zone for the child, with different sensory inputs. Fill it with safe, comforting materials so that the child can rest and feel comfortable. Include books to read and toys to play with. The safe place can be at home, in school, or in kindergarten. Say that this is a special place for the child, to go to and rest whenever it needs a break, or space to itself.



4.7.2 Regulation activities for different ages

Young children. Let the child touch and play with physical objects.

To regulate down	To regulate up
• Play with pets (kind and calm animals). • Wrap the child in a blanket. • Sing or read to the child. • Cradle the child, let it sit in your lap (safe touch). • Play calm music. • Play with stuffed animals. • Magic rocks. • Pleasurable smells.	• Play “I spy” (notice things in the environment). • Describe objects in view (name 10 things). • Rub hands with glitter cream. • Play with water and sand. • Throw balls. • Make a box with different things to touch. • Pick flowers, berries, leaves, seeds. • Stand on one foot (like a ballerina). • Jump up and down. Play “popcorn hop”: pretend to be heated like popcorn in a pan. • Visual contrasts, strong colours.

Children of school age. School children may enjoy the same activities as preschool children, but they can bring objects with them to play with and will understand simple psychoeducation.

Regulating down	Regulating up
• Squeeze a stress ball. • Butterfly self-hugs (arms crossed across chest). • Calming music. • Pet animal or soft material • Safe touch, massage. • Heavy blankets. • Balancing activities. • Grounding stone. • Mild and pleasant smells.	• Squeeze a stress ball. • Focus on things in the environment. • Bike, run, hop. • Music with fast rhythms. • Chew different forms of food. • Play the “taste game”, the “smell game” or the “sensory game”. • Chew gum, blow bubbles. • Taste ice cream. • Touch ice -cubes.

Adolescents. Adolescents may enjoy the same activities as younger children but can also manage more complicated activities. They are able to understand more complex psychoeducation explanations.

Regulating down	Regulating up
• Hot shower. • Herbal tea. • Lying in a hammock. • Yoga. • Massage. • Calm music. • Writing/painting.	• Cold room, cold water. • Music with fast rhythms. • Aerobic exercise, brisk walking. • Driving a car/bike on a bumpy road. • Strong smells, strong food. • "Chili challenge" (taste chili). • Light touch. • Describe 3 things you hear, see, touch. • Describe what you feel inside.

Tools when talking to children

4.7.3 Life history role play.

Aim. To create a coherent narrative.

When a child is traumatised, their memory may become fragmented. Restoring or creating a coherent narrative can be helpful or essential. This exercise helps a child tell its story on a timeline. We have used the case of Maria (Case 4 in the manual) to illustrate this. If you prefer, you can use the story of a child you have met as a helper.

To the helper: Imagine that you are a school counsellor. You have already met Maria (aged 8) several times and now you want to try to let her tell her life story.

The helper: "Hello Maria. I've brought pencils, crayons and paper. Let's do some drawing together. Before you were born, you were a foetus in your mummy´s womb, and when you were born you lived in a house with you mum and dad. Let's draw you in the womb and then the three of you in your house."

You in the womb

You, your mum and dad

"Then, when your dad left, you and your mum moved to another house."

You and your mum

"Let's also draw your school. Do you want to include anyone special in the picture?"

School

Out with friends

"When mum is at work, you go to your granny's house. Let's draw you and granny."

"And sometimes your uncle visits granny's house when she is out."

"You told your mum that uncle touched you in an unpleasant way, but she thought you just made it up. Is that right?"

"Then you made a drawing at your school that made your teacher wonder if someone had touched you where they shouldn't. But you said no. Is that what happened?"

"But the teacher feels you have changed since then and you seem to have trouble sleeping, you get nightmares and wake up. Is that so?"

"You know, when children get nightmares and seem more scared, most of the time it is because they have experienced something unpleasant that has frightened them."

"We can be here together, we can play and talk, and if you like we can find out what might have frightened you and given you nightmares, and stop them happening again."

Perhaps Maria may start to tell you about her uncle and the abuse; or perhaps she will not. Drawing the life line gives her space to talk, but the aim is also to let her see that you know her story, and to start the process of linking events and reactions.

At the end, bring your discussion to a positive conclusion.

The helper: “We have to finish for today soon. So let’s draw your house of the future.”

“What and who should be in your good house in the future.”

Note. Sometimes a traumatised child is not able to think about the future. Drawing and playing future scenarios is an important part of the healing process.

4.7.4 Using a box with a lid

The helper can use this exercise to end a session and make the child feel safer about what has been said. Always end with some words of praise.

The helper: “I know that this was hard for you. You have been very brave. Well done!”

“Before we finish, let us make a drawing (or a little story) about what happened to you, the things we have talked about that scared you (use the word the child has used for the abuse) and put it in this box and close it with a lid. Then I can keep it in a safe place here.”

“We can open it when we want to. But in the meantime, it will stay locked up. Until you feel like talking again. We will know that it is safe here.”

4.7.5 Worry time

A child who has spoken to someone about frightening things is likely to feel worried and anxious afterwards.

Say to the child that it is not always possible to forget every worry, but a person can set a worry-time, for example between 5.45 and 6 pm.

The helper: “If you do that, when a worrying thought comes along, you can say to it: ‘Hello, I hear you, but you will have to wait until quarter to six. Then I will attend to you’.”

4.7.6 Role play and symbolisation

These tools help children to tolerate their mixed feelings with regard to the perpetrator.

When a child has told the story of its abuse and the story has been recognised by adults, the child may need to explore and distinguish the different feelings it has for the perpetrator. This is because the perpetrator is sometimes someone the child is very fond of, someone close. Even though the abuser has betrayed the child’s trust, the child may still have warm feelings for him or her.

Role play. In role play, the helper might play the role of the perpetrator in a jail or in a police station, where the child visits him. The child says to the perpetrator what it feels. For example, the child might say: "You should not have done what you did. Promise you will never do it again." Or: "What you did wasn't nice. Do you understand? You should be sorry for what you did to me."

Symbolisation. The helper plays a game in which the child becomes things or creatures that represent its feelings or events that have happened.

For example, the helper can say to the child: "Imagine you are a bird that can fly away. Imagine that you are a tiger that can scratch and roar. Imagine you are a cat that can purr and snuggle up. Which animal do you like to be?"

The child can try all three roles, and so rehearse flight and fight and affection.

Let the child understand that mixed feelings are very common. For instance, sometimes we are angry with the people we love most. Discuss this.

4.7.7 Regain self-agency

At the core of trauma is an intense feeling of helplessness. Abused children may feel they are objects, not subjects in the world and that they wait passively for things to happen to them. Help the child regain feelings of influence and self-agency. In daily life, it is important to distinguish spaces in which the child can take charge, spaces in which it can make plans and have influence, and spaces over which it has no control.

Start by marking a vertical line on a sheet of paper.

Discuss with the child something it might want to happen and decide whether it inside or outside its control. Make a list.

Outside my control	In my control
The weather	Games I want to play
Where I live	Things I want to learn
My family	People I want to be with
My age, etc.	Management of some of my feelings

When the child has listed what is in its control, make a plan together for doing or achieving one or more of those things.

As a helper you can sometimes assist the child to differentiate between what is possible and what is not. A child may have wishes that are unrealistic – or may give up all its wishes because it believes they are impossible, and therefore not worth trying for.

Restoring hope and facilitating self-agency are of the utmost importance.

Note. "Remembering goodness is as important to healing as remembering hurt" (Lieberman et al).

4.7.8 The three houses

Children seek mastery and normality and are longing for good things. Traumatic events and abuse may overshadow what s good things in their lives and block their capacity to hope and dream about the future. At the same time, their worries need to be out in the open.

In this exercise, the child lists what the "houses" below should contain.

House of worries	House of good things in my life	House of dreams about the future

Discuss all the houses thoroughly.

4.7.9 My engine

The helper says to the child:

Imagine you have an engine inside you that drives you along like a car. To stay on the road, cars must adjust their speed. If the road is winding, they must slow down. Also, on steep hills! Our engines do something similar. When they are running slowly we feel tired and it can be difficult to focus on tasks. At other times, we have a lot of energy, we race around and it can be difficult to sit still. When we are learning things, the engine needs to run at the right speed – not too slow and not too fast. Then we can hear what others are saying and take in information we are given.

We also have an alarm system that activates automatically when something threatens us. It allows us to respond quickly and appropriately to sudden changes in our situation. If we are afraid or feel threatened, our energy immediately surges, making us ready to flee or fight. If we cannot resist or escape, however, our bodies tend to shut down. They slow right down, just as an animal plays dead if it cannot escape a predator. This can be an effective defence. We don't feel as much pain, and immobility may help us to hide. In a way we also hide in our minds. We try not to experience what is happening. Sometimes we escape into fantasy: we let ourselves feel that we can decide what has happened or is going to happen. All of these are ways to protect ourselves.

So, when a child is sexually abused, the engine may go very fast if the child tries to escape, but may slow down to the point where the body does not respond at all. Many children who have been assaulted feel that they did not do enough to stop their abuse, and that this means they even wanted it to happen. In fact, their alarm system was trying to protect them. They responded in a normal way to danger. There is nothing wrong with them.

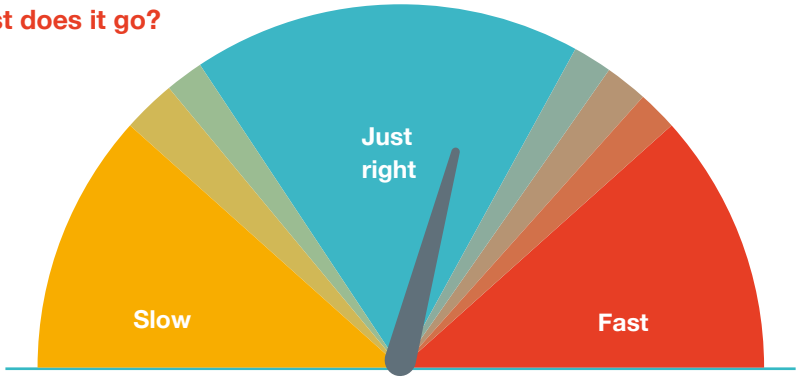
Sometimes our alarm systems go off when there is no danger. False alarms happen for many reasons. We imagine things in the dark, or misunderstand someone's behaviour. We even like to awaken our alarm system a little bit by listening to exciting stories or watching frightening films. Some children who have been sexually abused cannot turn their alarm system off, however. They feel they can never relax, must always be vigilant, prepared for bad things to happen. They often feel restless, angry, unable to concentrate, out of control; or they feel exhausted, even numb.

When the alarm system has been used a lot, it is easily activated. A small incident, even a thought, can set it off. This is frightening and very stressful. You are tired when you need energy, and restless when trying to sleep.

Once again, however, there is nothing wrong with children in this situation. Their alarm system is reacting predictably to repeated risk. They need to practice gradually adjusting their engine speed until they can feel comfortable again in ordinary situations.

My engine

How fast does it go?



HELPER ADVICE

Questions to discuss with the child

- When does your engine go fast?
- When does your engine go slow?
- When does your engine go “just right”?
- Can you remember occasions when your alarm system protected you from danger?
- How do you know when your alarm system is on? How do you know when it is off?
- What do you need others to do when your alarm system turns on?

5. Helping the helpers

This part discusses how to manage the stresses to which helpers are exposed when they work with children who have experienced sexual abuse.

5.1 Secondary trauma

Secondary trauma is a specific challenge for helpers: the memories, experiences and ailments of children who have been traumatised by sexual abuse can undermine helpers' own mental health. In this sense, the responses to trauma can be described as contagious. This is called secondary trauma. It can develop in helpers who meet traumatised people and who do not process their own feelings and reactions. It is perhaps particularly likely to occur to helpers who work with traumatised children.

Interpreters are also at risk of secondary trauma. Even experienced interpreters can occasionally be emotionally overwhelmed by difficult stories. If you collaborate with interpreters in your capacity as a helper, take care of their well-being too.

5.2 Vicarious traumatisation

As they accumulate experience of human suffering, helpers' attitudes may evolve. They may become cynical or pessimistic about the world. This can cause them to undervalue themselves and others, or lose their belief in the possibility of change; they become indifferent. Over time, some helpers may feel that their personality has changed.

5.3 Compassion fatigue

Empathy is vital to the work of all helpers; but it is not an inexhaustible resource. If helpers constantly give without replenishing their resources and strength, they start to feel empty and tired. They feel exhausted, demotivated, demoralised, and hopeless. They may start to have sleep problems, somatic difficulties, and drink or take drugs. They may even come to feel that their own problems, needs and well-being are less important and do not deserve attention. If they become less available emotionally to their family or friends, their personal relationships may falter, causing loneliness. In the end, they are no longer able to carry out their role as a helper.

5.4 Warning signals that may occur after a long period of being a helper

Here are some warning signals that may occur in helpers over time, which can make them difficult to detect. Experiencing just one of these signals does not indicate that you are at risk of developing compassion fatigue or secondary traumatisation, but a combination of them might.

- Lose their ideals and become cynical.
- Feel unvalued or betrayed by their organisation.
- Lack energy.
- Exaggerate their significance or their importance.

- Display heroic but ruthless behaviour.
- Neglect their safety and physical needs (no breaks, no sleep, long hours, etc.).
- Show suspicion of their colleagues and managers.
- Display antisocial behaviour.
- Are excessively tired.
- Lack concentration, are inefficient.
- Have difficulty sleeping.
- Consume too much alcohol, tobacco or drugs.

Helping is often demanding. Helpers must push themselves but also take care of themselves, which can be difficult to balance. They risk secondary trauma when they listen to children's experiences, particularly if they have been abused themselves. Despite their efforts, they may at times struggle to deal with their emotions, have relationship problems, find it difficult to make decisions, experience physical pains or illness, feel hopeless, think their life has no meaning, or suffer a collapse in self-esteem. This is burnout. Early recognition and awareness are crucial to preventing it. Helpers need to develop strategies for coping that pre-empt secondary traumatisation. The sections that follow provide more information on what helpers and their employers can do to protect themselves.

"Helping is often demanding. Helpers must push themselves but also take care of themselves, which can be difficult to balance. They risk secondary trauma when they listen to children's experiences, particularly if they have been abused themselves."

At the same time, helpers would not do this work if it did not have positive effects. One of these is resilience: the capacity to recover from difficult experiences. Many helpers feel that witnessing the extraordinary resilience of children who have been abused has changed how they react and behave, not only at work, but as people; it has helped them to handle their own sorrows and challenges.

5.5 Prevention of secondary trauma and compassion fatigue

Early recognition and awareness are essential to prevent helpers from suffering secondary traumatisation or compassion fatigue. Even large institutions sometimes fail to take care of their employees because managers are not adequately trained to detect and identify symptoms, are not ready to intervene early, or have poor follow-up procedures. These risks are particularly acute for helpers who work alone in small municipalities, lack access to larger networks, and have few resources and little support. All helpers who work closely with children who have been abused should regularly step back to assess their emotional state and review whether they need to protect themselves from secondary traumatisation and compassion fatigue. Individuals must learn to foresee risk while they are still able to take control of their situation. Organisations should develop procedures and practices for detecting when helpers need extra support or a break, and make sure that helpers know they are entitled to ask for such support.

5.6 What helpers can do to help themselves

"Fortunately, what works for survivors can also work for helpers. If symptoms of secondary traumatisation or compassion fatigue occur, the tools that help survivors can often assist helpers. Helpers should try to recognise their own reactions and understand what has caused them."

Fortunately, what works for survivors can also work for helpers. If symptoms of secondary traumatisation or compassion fatigue occur, the tools that help survivors can often assist helpers. Helpers should try to recognise their own reactions and understand what has caused them. If helpers are haunted by stories they have heard, or feelings of fear and insecurity, they can use grounding exercises to remind themselves they are safe. Helpers need to discover their strengths and sources of resilience. What helps you to put your work-related thoughts aside? What helps you to rest your body and mind? What activities inspire you and put you in a good mood? In addition, it is important to take care of yourself: to eat well, sleep sufficiently, see friends and family, exercise, etc.

Advice to helpers. Handling warning signs:

- Acknowledge that you are reacting in normal and predictable ways.
- Consciously try to relax.
- Talk to someone with whom you feel comfortable.
- Express your feelings in other ways than talking: draw, paint, play music, pray.
- Listen to people you love and reflect on what they tell you.
- Exercise, do yoga, meditate.
- Go for walks, preferably in nature.
- Do grounding exercises.

5.7 Building resilience

"Supporting yourself as a helper is also about building resilience and mapping a course of action."

Supporting yourself as a helper is also about building resilience and mapping a course of action. Coping skills can be understood as resources that are available and that the helper is capable of using in challenging situations.

In the book 'BASIC-Ph', a team from the Community Stress Prevention Center in Tel Aviv tried to combine studies of coping and resilience in one holistic model. BASIC Ph stands for **B**elief and value systems, **A**ffects, **S**ocial support, **I**magery, **C**ognition and **P**hysical interventions. Below is a brief account of each of these dimensions:

Belief and value systems. The theory often refers to Victor Frankl, a psychiatrist who lost his entire family in captivity during World War II and was himself interned in a concentration camp.[1]

During the war, he observed that those who had strong political or religious beliefs and a deeply rooted value system survived better. Their "basic assumptions" were not crushed; or they found a new meaning, something to fight for. (Many prisoners of war become ardent human rights defenders.) This is also consistent with Antonovsky's finding that meaning and context are decisive factors when people bear a lot of stress.[2]

Affect focuses on the ability to regulate emotion. Many trauma survivors have a phobia about feeling; it is part of the avoidance reaction. Affect awareness is not just a matter of talking about the emotions, however. One can express emotion through activities, music, dance, sport and in many other ways. Through psychoeducation and communion with like-minded people, survivors whose affect has been harmed may gradually reawaken their feelings.

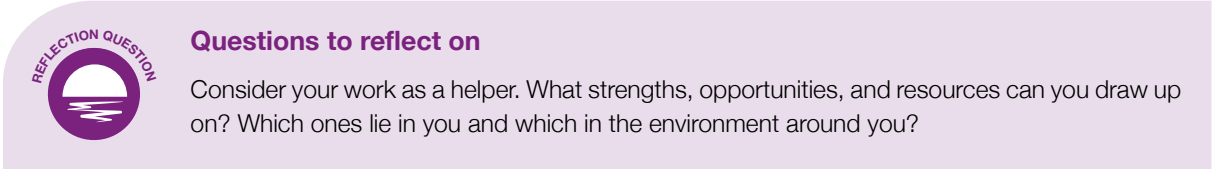
Social support and sense of community. Many survivors are able to regain self-esteem and trust in others when they encounter help and peer support. Activities and sports, education, colleagues, friendships, neighbours can build resilience by providing an experience of belonging and community.

Imagery includes all creative expression. Music, drama, painting, dance and other activities not only interrupt thinking but teach skills and promote symbolisation. Imagery also includes such exercises as fantasy travel, playing, and dreaming about the future.

Cognition is about strengthening cognitive processes. Psychoeducation is an example. C also stands for information, the need to know what has happened and what will happen next; good information feels reassuring. Many cognitive techniques provide tools for dealing with anxiety and can help survivors to restore assumptions that have been thrown into the air by trauma.

Physical includes grounding exercises, breathing exercises, relaxation exercises, rest, physical therapy, etc. Contact with one's own body and the experience of physical mastery and strength can restore a survivor's feeling of agency, revive energy, and bring self-confidence. Physical activities, such as sport, also make survivors feel they belong in a community.

The BASIC-PH model aims to strengthen resilience by assisting survivors to expand their repertoire of skills. Many survivors have one preferred strategy for recovery or self-development; the model suggests it is a good idea to use a broader range of strategies. Helpers can consciously encourage survivors to explore their experience of achievement and self-respect, their experience of having influence, their belief that they can obtain help, and their confidence that their future can change and improve. This is what building resilience means.



Questions to reflect on

Consider your work as a helper. What strengths, opportunities, and resources can you draw up on? Which ones lie in you and which in the environment around you?

1 HHRI, 'Window of tolerance'.

2 Nielsen, H. (2014), 'Interventions for physiotherapists working with torture survivors - With special focus on chronic pain, PTSD, and sleep disturbances', Dignity Publication Series on Torture and Organised Violence, *6,* www.dignity.dk/wp-content/uploads/pubseries_no6.pdf.

Appendix 1. Contributors

Helen Christie is a clinical psychologist and former director of the East and South Regional Centre for Child and Adolescent Mental Health – Research and post graduate centre (RBUP). She has worked extensively on sexual abuse of children and on patients with late effects, including adults. She has also worked with traumatised refugee children in Norway, and children in war zones. Helen has written numerous articles and books on trauma, sexual abuse and resilience. She was a co-author of the manual *Stabilisation and Skills Training in Trauma, of MHHRI's training manual for women titled Mental Health and Gender Based Violence – Helping Survivors of Sexual Violence in Conflict*, and the paired manual on boys and men exposed to sexual violence. She has run different trainings on gender-based violence, helped traumatised children, and provided family guidance trainings around the world.

Mari Bræin is a clinical psychologist specialising in children and adolescents and is clinical director of the Center of Trauma and Stress Psychology in Oslo. She has extensive experience of working with children, young people and families exposed to trauma and abuse both in Norway and internationally, for, among others, UNICEF. For many years she worked as a special adviser for the Regional Centre for Trauma, Stress and Suicide prevention (RVTS) where she trained professionals on trauma-sensitive care. She has extensive experience of specialist trauma treatment and has developed and adapted several therapeutic tools used in trauma treatment in Norway.

Lise Ulvestrand is a clinical psychologist. She also studied political sciences and Latin languages and has worked with NGOs in Norway, Latin-America and Asia. She has coordinated international development programmes on human rights, indigenous people's rights, the right to education, gender violence, women and youth empowerment, and mental health. In 2022 Lise wrote her Masters' thesis on psychologists' understanding of culture and human rights in the treatment of child sexual abuse. She has a special interest in the treatment of complex psychological states. Lise currently works with long-term adult in-patients.

Nora Sveaass is a clinical psychologist and professor emeritus at the Department of Psychology, University of Oslo (UiO). She is the chair of the organisation Mental Health & Human Rights Info (MHHRI). She is a researcher on refugees, human rights violations and the psychological consequences of torture and violence, as well as the treatment and rehabilitation of survivors of torture and violence, including women exposed to sexual violence in war and conflict. She was a member of the UN Committee against Torture between 2005 and 2013. Since 2014, she has been a member of the UN Subcommittee on Prevention of Torture. She has published numerous books and articles and was the editor and a co-author of *Mental Health and Gender Based Violence – Helping Survivors of Sexual Violence in Conflict and the manual Sexual violence against boys and men in war, conflict, and migration – A mental health manual for helpers.*

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Appendix 2. All cases in full

We have gathered these stories together to assist helpers to understand the different experiences and reactions they observe in children exposed to sexual abuse. You can use these stories when you talk with children. Some children may find it difficult to open up about what has happened to them. But to receive help and assistance, they don't necessarily need to share their own story. They can recognise their own trauma and reactions in the stories presented here.

The stories enable you and the children you help to examine painful experiences and emotions from a more detached perspective. Stories make experiences and feelings easier to understand and deal with; they make difficult topics safer to touch.

We have gathered several cases from around the world, sent by counsellors from Afghanistan, Pakistan, Nepal, Sudan, South Africa, Nicaragua, Ukraine and Brazil. We encourage you to look for cases that match the social context and culture in which you are working.

All names and locations have been changed or anonymised to protect the identity of those involved.

The story of Luana, six year old, Brazil

Luana

The story shows:

- Abused by her adopted father from the age of six.
- Became pregnant at 15.
- Shows obsessive behaviour towards her two-year-old child.

Until she was three years old, Luana lived in a group foster home for children. One day, she was adopted by a farming couple who lived in the countryside and could not have children. They were a withdrawn couple who did not express affection or emotions.

At the age of six, her adoptive father took her out to fish on the lake. They did not return for a long time, but the mother did not pay attention. That day, Luana was raped for the first time. Luana remembers the pain she felt during that first sexual assault, which was an anal rape.

Her adopted father continued to abuse Luana for several years. The assaults remained secret. Luana had ambivalent feelings for her father, whom she felt she should protect, though he attacked her. Her affection was mixed with fear, and fear of the violence associated with her repeated abuse. She attended school regularly, but never told anyone what was happening.

The years passed and Luana became sexually mature. At the age of 15, she discovered that she was pregnant. Her mother, who had neglected her for years, defended her husband and told Luana not to reveal his name. She competed with Luana for her husband's attention. The adopted father manipulated and controlled Luana by giving her gifts.

Alone, afraid of her parents' threats, Luana obeyed. Under pressure from the community, she even accused a classmate of being the baby's father, so that the suspicion would not fall on the family.

After an investigation by the Guardianship Council and the court of justice, it became clear that her adopted father was the aggressor. In this terrible situation, Luana's grandmother, who lived nearby, was the only family member to support and guide her, strengthening the bond between them.

Luana was 17 years old when an anal exam revealed old wounds and fissures. She and her daughter, Bruna, then 2 years old, were placed in a group foster home. They lived there for ten months. Luana was able to tell her story and receive support from professionals and helpers. She told them of her parents' emotional neglect, that they fought constantly with her and did not buy her clothes.

Luana was very possessive of Bruna. She was afraid of losing her, that she might be stolen, especially at night. She stayed with Bruna all the time, and needed to sleep with her, feel her body. She had nightmares about losing the right to keep her daughter.

While in the shelter, Luana showed several psychiatric symptoms, including fatigue, frequent crying crises, fragmented sleep, headaches, sadness, feeling of worthlessness and guilt. She also suffered from binge eating. She attended weekly individual psychotherapy sessions and the psychologist identified severe depressive symptoms with suicidal thoughts. She took medication for some time.

At the shelter, Luana came to like an older caregiver who guided her on how to behave in social situations and how to take care of her daughter. Luana was visibly unable to take care of herself.

She did not shower, brush her teeth or exercise genital hygiene. She needed help to organise her possessions, plan her day, and complete activities.

She found it difficult to separate out her feelings and emotions, and name them. She had little insight into her thoughts or what she was feeling.

Luana had very low self-esteem. She believed she was a fat and ugly girl and found it difficult to know how to dress and behave with other people. She was needy and affectionate; she obeyed the shelter rules without question. She was very sensitive to any kind of comment about herself. In general, she was immature for her age.

She had twice repeated a year at school. The professionals at the foster shelter diagnosed a significant learning deficit. These cognitive difficulties frustrated her attempts to learn skills (like baking a cake). In spite of these adverse experiences, she nevertheless had friends and tried to be sociable, outgoing and make bonds.

During the period at the shelter, she often felt guilty about the punishment that might be imposed on her father and mother. After two years of legal proceedings, the father was arrested. On one occasion, her foster mother turned up at the shelter and accused Luana of being responsible for his conviction.

Luana and Bruna left the shelter after being adopted by a couple that lived in a nearby city, who already had two children.

After a while, she met a man, much older, who had never been married and was a successful farmer. He and Luana got on well together, and he liked Bruna too. They married some months later and have had a harmonious relationship for six years.

The story of Ruby, fifteen years old, Brazil

Ruby

The story shows:

- Abandoned by her mother at the age of one.
- Raised by her alcoholic father.
- Abused sexually by several adult men.

Ruby is 15 years old and has lived in a shelter with eight other children since she was 12 years old. Her mother and father lost their rights as parents.

When Ruby was about one year old, her mother abandoned the family, left the city and formed another family; she lost contact with Ruby. Ruby and her brother Heitor (two years old) were raised by their father, who suffered from alcoholism. Throughout their childhood, the psychosocial care network worked to remedy the family's many problems and dysfunctions.

Ruby was six years old when she started to attend a psychosocial community service that helped children to bond with other children and professionals and reduced their exposure to risks and violence. In this period, Heitor was aggressive towards Ruby, copying the behaviour of their father. Very often, the helpers had to give her a shower because she arrived wearing filthy clothes; she had lice so other children were obliged to keep their distance. She told the workers that her father argued with her and beat her frequently, and that the house was always "full of dad's friends", drinking and playing cards. After some home visits, the professionals concluded that her father was regularly drunk and that Ruby did all the housework.

Having observed her behaviour, the institution also suspected that Ruby might have been sexually abused. An examination confirmed that her hymen had been ruptured. Ruby could not explain what had happened; confused, she accused different people (her father, neighbours, relatives, her uncle). As a result, neither the Court of Justice nor the Guardianship Council was in a position to intervene.

From this point, Ruby seems to have learned how to attract attention. She started to invent situations and to lie. Once she falsely declared that her birthday was the next day in order to receive gifts; she revealed the deception after people sang Happy Birthday for her.

As Ruby matured, she started to leave the institution in the late afternoon and go to neighbours' houses, sometimes to see single men; on occasion, she returned the following day.

These problems worsened in her teens and the Guardianship Council worked to find Ruby a foster home. They tried her mother's relatives: the grandparents, an aunt and, finally, her mother. In every case, Ruby systematically accused people of sexually abusing and mistreating her. An attempt to place her with her aunt (her father's sister), in a different city, also failed.

After these attempts, she was sent to the shelter she lives in now. She finds it difficult to follow rules, is aggressive to other children and staff, argues constantly, swears, fights, lies, and has poor hygiene habits. After further medical and psychological tests, health care professionals discovered that she has a mild mental disability and conduct disorder. Ruby takes a variety of psychiatric medicines.

Unfortunately, her persistent behavioural problems, mood swings, dishonesty, and complaints of illness and maltreatment are exhausting the capacity of professionals to give her a stable and decent life.

The story of Myada, ten years old, Sudan

Myada

The story shows:

- **Grew up in a violent home.**
- **Sexually abused by her father.**
- **Suffers from anxiety, irritability and nightmares.**

Myada lived with her father, mother and two older brothers in Omdurman. Her parents were in conflict much of the time. Her father regularly beat and insulted his wife and his children. Life in the house was not comfortable.

The situation worsened when Myada was ten. Her father interfered sexually with her and ordered her to tell no-one. He continued abusing her sexually while the mother was sleeping, and showed her pornographic videos on his phone.

During this period, the mother warned her children how to protect themselves from abuse; so Myada told her mother what her father had done. It was a big shock for all the family and the mother decided to report the case to the police. The father denied Myada's allegations but gradually disappeared from the house and their lives.

Myada was checked physically at the hospital and her mother allowed the law to take its course. Myada suffered from anxiety, irritability and nightmares. Her behaviour changed. She was afraid she would see her father, did not want to go so school, and cried all the time. Despite these difficulties, the mother succeeded in helping her daughter to adapt to their new situation and to manage her fears.

A few months later, Myada was invited to visit her aunt, who lived with the extended family of her husband's parents and siblings, in another area in Sudan. Myada loved her aunt and was happy to go.

Myada liked watching TV, and at her aunt's place she would go to another part of the house to watch cartoons. When the cartoon was finished all her cousins went back to their home and left Myada alone with the grandfather. When the grandfather started to abuse her sexually, Myada resisted him and ran off. He tried again several times while she was staying with her aunt, and at last Myada told her aunt, who investigated, found her claims were true, and sent the girl back to her mother in Khartoum.

Then Myada's father turned up again and started to meet her every day after school.

Myada relapsed. She had no energy, showed no interest in life, had many nightmares, and started to urinate involuntarily. She became very afraid of seeing or hearing about her father or grandfather.

Reactions and symptoms

Myada was **afraid** as a result of sexual abuse by her father and grandfather. She **avoided** discussing the subject and told her mother she wanted to stop the therapy sessions. She was **sad, cried all the time, lost interest in life**, even her friends, and her **school performance fell away**. She **dropped out** of school because she didn't want to meet her father. **Avoidance** became her dominant behaviour. She developed symptoms of **physical arousa**l (including **panic attacks, headaches, sweating**), and frequent **nightmares**.

What helped

Myada attended Ahfad Trauma Centre, where the psychologist who assessed her concluded that Myada had several symptoms of PTSD.

The psychologist prioritised these symptoms in relation to Myada's immediate needs. She helped Myada manage her fears. She encouraged Myada to talk freely and helped her to take up many activities in the centre. She did not push Myada to talk; Myada chose to play and draw and posted her drawings on the centre's poster wall.

Gradually Myada started to relax and feel comfortable with the psychologist and finally decided to tell her everything.

The psychologist taught her different techniques of relaxation and also sleep hygiene. Each session, the psychologist asked Myada to stand on the dais in the child corner and read a story loudly and confidently. She always acknowledged Myada's performance and gave her positive feedback. This helped Myada to rebuild her confidence and also raised her self-esteem.

The psychologist told Myada that it was normal for her to feel sadness. She said she would help Myada to overcome these feelings and talked to her about optimism and hope and said she had a long life ahead of her and that she had people who loved her and would stand beside her to help her. She helped Myada to think about techniques that could help her to feel better and happier.

Myada said she liked to play with her close friend, to visit the park with her mother, and to read books. The psychologist recommended some books that talk about happiness, courage and fun.

From then, every session Myada would talk about the book she had read and she and the psychologist discussed her feelings about what she had read.

Myada is very close to her mother. She wants to be with her all the time. Her mother played a vital role in supporting and comforting her. Myada almost regained her confidence that she had someone she could trust, who would protect her.

The psychologist suggested to the teachers in Myada's school that, to boost Myada's confidence and increase her social participation, they should encourage her to participate in the school assembly and give her leadership tasks.

Myada began to feel safe and secure. She started to form a social network with the people around her.

Myada now has more trust in people, including men. She still feels uncomfortable when she talks about her father but tolerates meeting him.

The story of Sheila, ten years old, Nicaragua

Sheila

The story shows:

- **Assaulted by a neighbour when she was ten years old.**
- **The family decided not to report the assault.**
- **The family took her out of school to protect her.**

Sheila was born in a fishing community on the Caribbean coast of Nicaragua. She was loved by her mother and grandmother. Over the years two younger brothers arrived. Sheila was a happy girl and grew up like other children from the indigenous and Afro-descendant communities of the Caribbean region. She played in a large garden round their home. At school, she participated in sports and cultural activities. On Sundays she went with her family to mass. She was a girl with the traditional values of her community.

At the age of nine, she began to help round the house. She cleaned, did laundry, cooked and carried drinking water from the well. She was happy to help her grandmother while her parents were at work.

A few days after her tenth birthday, Sheila met a neighbour at the well. The neighbour said: "Come, I have a birthday present for you". Naively, Sheila followed him. "What are you going to give me?" "You will see!" he said.

The neighbour took her to the outskirts of her community where he raped her. He immediately left the community for fear of retaliation from the girl's family. When they found Sheila, she was in a terrible physical and emotional state. The family decided to heal her physical wounds at home, with herbs and home remedies; but her emotional wounds went unnoticed.

The family decided not to report the abuse because they were afraid Sheila would be misjudged by the community. They took the view that "problems must be solved at home!" Reporting to the police would make the rape public. In their region, sexuality is taboo: no one talks about it openly.

The family mourned silently and spoke to no-one. But both Sheila and her family felt broken. The father blamed the mother and accused her of being a bad mother, a very wounding accusation. The mother was deeply distressed and locked herself away in the house.

After a year Sheila returned to school, but she had changed. She was sad; her childhood had faded. She no longer played or joined in community activities.

At the age of 12 a girlfriend asked her: "Is it true that you are going to get married to an old man because nobody is going to love you?" Sheila did not understand the question. When she got home, she told her grandmother about the conversation with her friend and, offended, the family decided to take her out of school.

The family did this to "protect" her, so that no-one would make fun of her. The girl stayed at home, where she learned to cook and sew clothes with her grandmother.

The story of Shabana, eight years old, Pakistan

Shabana

The story shows:

- **Shabana was abused by her older sister, 18-year-old.**
- **Then a friend of her father attempted to assault her.**

Shabana's family of six were refugees. They lived in Peshawar. Because of their difficult living situation, the parents gave little attention to their younger children. Shabana, the second youngest, was an outstanding student. She had several schoolfriends.

Shabana wanted to be a journalist and speak to the country. She was admired more by her father than her mother. Her mother used to say that she was irritating and impolite. She had a very good relationship with her 18-year-old sister, Rabia, who always helped her in her studies and supported her in the family.

Shabana and her sister slept together in the same bed. When Shabana was eight years old, Rabia asked her to kiss and caress her and touched her private parts. She had oral sex with Shabana. Shabana felt weird and upset and was confused. After several nights, Shabana asked Rabia why she wanted to do this. She said she felt awkward, and dirty. Rabia told her that desire is a need that comes to a person, and that normally it is fulfilled with someone of the opposite sex. But she had no-one to ask, so she asked Shabana to help her feel good.

Shabana felt guilty for asking the question. She thought she should help her sister, who had helped her and protected her from her mother's anger. The situation continued for more than 6 months.

Then one day a friend of Shabana's father visited. When her father went to the bathroom, the man stood up and kissed Shabana on the mouth. Shabana disliked what he did and felt guilty and dirty. But she did not have the courage to tell anyone, not even her sister. After the incident, Shabana became depressed and started to have problems with her friends. She started to fight at school. She stopped talking to Rabia and refused to sleep with her in the same bed. She said she wanted to sleep with her mother, where she felt safe.

Time passed and Shabana made no new friends, distrusted people, and feared they would molest her. She felt that someone who hugged or touched her must be bad. She did not let her friends hug her, so they doubted her affection for them. When she saw two girls talking together, she assumed they were having a "dirty relationship" (her words).

When Shabana went to university, her isolation continued.

Shabana blamed her sister for these problems. At university she liked a boy, but when he wanted to kiss her, she withdrew. She continued to think this way for over twenty years. She had more than twenty relationships, all short for the same reason, and came to believe she was incapable of remaining close to someone. In the end, she went for counselling. When she started therapy she understood the issues and was finally able to forgive her sister and end all the blame and recrimination. Shabana still struggles with intimacy, but she has good friends, respects herself, and has worked out a philosophy for her life. Her therapist taught her that, although our past may be dark, we decide how we respond and deal with it. The happier we are, the more we attract happy people towards us.

The story of Malebo, nine years old, South Africa

Malebo

The story shows:

- **Malebo lives with her extended family.**
- **Malebo is abused by her father.**
- **Her mental and emotional needs are not met.**

Malebo was referred to Ububele Centre by her mother's employer. At the time of referral, mother worked as a domestic worker in a big city and Malebo was nine years old.

Malebo's family lived in a neighbouring country. Malebo's mother had moved to South Africa to find work, leaving her daughter at home with the extended family. They were very poor. Though most of Malebo's physical needs were met, her psychological and emotional needs were not.

On one of her annual visits, Malebo's mother found a foul a discharge in Malebo's underwear. When she asked Malebo about it, Malebo said that her maternal uncle had been raping her. She was not able to say when the assaults started; they had been going on for more than 3 years. Malebo also reported that was she was living in cruel conditions and was forced to do chores that were too heavy for someone her age.

Malebo's mother was distraught and angry. Medical examinations confirmed the rapes. The mother confronted her brother and took Malebo back to South Africa with her.

At the Ububele Centre's initial meeting with the mother, she was extremely tearful, overcome by guilt and full of anger. She blamed herself for putting her daughter at risk and wished she had kept Malebo with her. After this meeting, it was decided that Malebo would have therapy once a week to help her to process what had happened to her.

At the beginning of treatment, Malebo was very anxious. She struggled to make eye contact with the therapist and barely said a word. When she did speak, she whispered. She seemed to be very anxious when she was alone with the therapist, who assumed that Molebo was afraid that her

boundaries would not be respected or that she would be molested. To help her feel safe, Malebo's mother waited for her outside the therapy room, which seemed to help.

Malebo also showed signs of regression. She played baby-like games, on her own, and often with her back to the therapist. Male dolls were not included in her play, or they were thrown violently across the room.

The therapist was patient and for a long time just allowed Malebo to feel safe in the room. Gradually, Malebo turned towards her as she played. She began to make eye contact at the start and end of sessions.

The pain she felt was palpable. The therapist often felt helpless and sad that she could not do more.

The Centre also offered Malebo's mother therapeutic support, to help her process her feelings of guilt, rage and heartbreak. She took a long time to accept and, when she did, it became apparent that the mother had been afraid that, if she had sessions (even with a different therapist), she would be privileging her own pain and denying Malebo care that she needed.

The mother had reported the uncle to the police, which caused a deep rift within the family. Other family members condemned the mother for 'betraying' her brother. As a result, the mother and Malebo were cut off from most members of their family. The mother felt extremely lonely.

Malebo was in psychotherapy for 18 months. Over time, she communicated more, sometimes in words but mostly through drawings. She would often draw a car, a police car or an ambulance. Through these drawings she communicated the terrible abuse that she had experienced and the absence of anyone to help her. She talked to the therapist about the male dolls she flung violently across the room, about the man who abused her, and about her feelings of rage towards her mother who had not been there to protect her. It was extremely difficult for Malebo to acknowledge this rage and disappointment because she loved her mother: it helped Malebo to transfer these feeling to the 'mother' therapist.

The mother enrolled Malebo in school. Initially she struggled to adjust. The language was new, the context was new, and she would often feel different and isolated. She was not only very wary of adults, but also male pupils. At the same time, Malebo clearly wanted to learn: she was a bright child who grasped concepts quickly and started to excel scholastically. This indicated her potential to be extremely resilient.

After 18 months, she ceased to attend sessions. The day she finished, Malebo drew a picture for the therapist. She put the therapist in the centre of the paper, with a sunset and the words 'thank you mam'. It showed that this young girl, who had faced unimaginable abuse, had found a way to work through her experiences with an adult who she had slowly come to trust.

The story of Ali, 15 years old, Northern Iraq

Ali

The story shows:

- Experienced several serious losses, including the death of his father in an explosion.
- Experienced repeated sexual abuse from his stepfather.
- Escaped and spent some time in a large refugee camp.
- Struggles after being resettled in a new country, feeling guilt for his mother, concern for his younger siblings, and no faith in his stepfather.
- Is depressed, sad, unable to eat, solitary, passive.

Ali lived with his family in a village surrounded by hills. His father had a small shop near the market. Ali's mother always encouraged Ali to study and to help his father in the store. He was very close to both his parents and dreamed of becoming a successful businessman.

War became part of their everyday life. The children went to school, the adults worked, the market bustled with people from all over the area. One day Ali and his father went out to look for some herbs that grew in bushes on the outskirts of the city. About five hundred metres from his home, Ali's father suddenly shouted "Watch out!" and there was a loud explosion. Ali's father had stepped on a landmine. Ali was all alone in the field with his dead father. **He felt a great pain in his chest, his feelings were confused, and he did not understand what had happened.**

After this incident, Ali and his family went through a very difficult period both financially and socially. Ali was plagued by nightmares and flashbacks about what had happened to his father. After a while, Ali's mother remarried. Ali was initially happy to have a new father figure. But **his new stepfather came into his room when he was asleep and abused him sexually. Night after night.** His nightmares and traumas, which had weakened for a while, reappeared. Ali again felt desolate, sad and distant, and this time his mistrust affected his relationship with his mother. He preferred to be out of the house and was late going to the market. When it got dark, Ali was afraid to go home but did not know where else to go. His mother saw his pain but did not understand the cause; she thought the old trauma had returned.

Ali decided to go away. He remembered that some of the older boys in the market had spoken of a man who, for money, could help him leave the country. Early one morning, Ali took money from his stepfather's savings and boarded a truck alongside other young people, men, and some women with children. It was dark, and the person in charge told them to be quiet. **Terrified, he sat with his knees tucked against his chest.** He lost track of the time. Suddenly the truck stopped and someone opened the doors. After walking for several hours, they arrived in a refugee camp.

One day, Ali was led by an employee into an office in the camp. The official wanted to know his age and whether he had identification. Ali took his ID from a plastic bag. The man started typing on his computer. Ali was photographed and fingerprinted. Many months later, Ali was told he could collect his belongings because he had been granted asylum abroad. After a long flight, Ali arrived in his new country and was placed in a reception centre. A nurse gave him a medical examination. The abuse he had suffered was not mentioned. At the centre, he was perceived to be a very scared and shy boy that no one could reach; he was especially inaccessible to male employees. Ali had his own room and on most days he stayed in bed.

After he was resettled and placed in a reception centre in his new country, Ali started going to school. But he did not talk much, looked no-one in the eye, and took lunch alone. At night, the nightmares returned, and he woke up screaming. He turned on the light and calmed himself but kept his eyes open and stayed awake. Ali l**ooked nervous every time someone approached him**, and if someone came too close, he walked away. In class, **his feet were in constant movement** and he often **stared out of the window, paying no attention** to what the teachers said to him.

Many of these reactions persisted: **hyperarousal, mistrust, anxiety, social withdrawal and nightmares.** He was **triggered** by the voice of an older man he met.

A helper at the reception saw all this and **invited Ali on regular trips to chat.** At first, Ali was reluctant, but **the helper explained that daylight and movement would help him to sleep.** When he tried it, he found it was good to get out. They talked about how he could change the stories in his nightmares and do **grounding exercises, such as the Safe Place exercise.** When he woke at night, the exercise created a safe environment in his mind. The **conversations went better when they walked in the fresh air rather than sat in the office.** Because Ali's personal boundaries had been invaded by his stepfather, **Ali needed to decide how close the helper should be.** When they walked, it was easier for Ali to regulate the distance from his helper.

After they had talked about what happened to him, Ali told the helper that he became nervous when someone came too close to him because it triggered bad memories. He would walk away. In the classroom, he said he often had restless legs and had difficulty sitting still. At other times he stared out of the window without being able to pay attention to what the teachers said. **To help him manage his agitation and dissociation, the helper taught him some grounding exercises.** She explained that other boys in his situation reacted the same way and that these responses to very painful experiences were normal.

The helper showed Ali the **Grounding the Body exercise.** He pushed himself back in his chair and reminded himself that he was in the present and not in danger. They also explored **the window of tolerance**, which helped Ali understand the difference between being under- and over-activated. Slowly but surely, he became better acquainted with his reactions and began to understand why he reacted so strongly.

When the helper learned that Ali used to play football, she **arranged for him to participate in football training** with some of the other boys at the centre and gradually he began to settle into the social community. The reception centre also possessed exercise equipment and he started **weight training**, coached by members of the staff. Through these physical activities, Ali became more confident of his body. He felt he was "taking his body back", re-owning it. Since the abuse, he had not felt that his body was his; he felt his body had been taken from him and he felt no pride or joy, or clarity about his boundaries. He **recovered the physical memory of being strong and resilient that he had before.** As he gradually regained his skills and learned to control his reactions, he began to concentrate better at school. His taste for education and hope in the future revived, which motivated him further.

Reactions

- Distrust of others.
- Nightmares.
- Flashbacks and triggers.
- Anxiety and depression.
- Social withdrawal.
- Overactivation and restlessness.
- Dissociation.

Tools

- Provide psychoeducation for better sleep hygiene. Also provide knowledge about guilt and shame.
- Teach grounding exercises.
- Help Ali to reassert control over his body and physical distance to other people.
- Put words to his feelings and regain influence over his own life.
- Explore the BASIC-Ph model, with an emphasis on physical activity.
- Use the metaphor of the Window of Tolerance.

Reflections

1. How could the abuse have been detected earlier when Ali came to the new country?
2. How would you have approached Ali when he showed rejecting behaviour?

The story of Alina, ten years old, Ukraine

Alina

The story shows:

- Connected with perpetrator online.
- Groomed to gain trust.
- Experienced repeated sexual abuse from perpetrator.
- Instructed to do sexual activities with other children while the perpetrator was filming.
- The parents discovered the films and blame Adelina.
- The father denied everything when talking to the investigators.
- Alina connects with the helper and starts to open up.

Alina is a 10-year-old girl, and she is the only child in her family. The family lives in the eastern part of the country. Alina is an exemplary girl: she is fond of dancing and wins prizes in competitions all over Ukraine. She studies well to get the highest scores in an elite school. The parents are 40 years old, they are engaged in war related activities and devote most of their time to this. They want the family to be the example of a model family and for Alina to be obedient in everything. The atmosphere at home is good, everyone treats each other with respect, but, unfortunately, the parents do not have enough time for Alina. Despite all Alina's activities, a large number of friends at school and dance acquaintances, she feels lonely and smiles very seldom. At home, she is introverted and keeps to herself. She also keeps a diary where she records all her worries. On internet, she discovers a chat group, and she meet a boy named Bohdan (a fictitious name). Even though he is 30 years old and lead a very active life, he shows interested in Alina's affairs and feelings. Alina opens up, because no one has ever shown interest for her before. She starts skipping dance classes and begins to date Bohdan.

After six months of communication and complete trust, Bohdan entered into sexual contact with Alina, despite the pain the child felt, he argued that since they were friends, and they should help each other. These meetings and an intimate relationship grew stronger. He also asks Alina to please him orally. After this, Alina could not eat for several weeks, because everything provoked a gag reflex in her. Bohdan later brought in other girls and instructed Alina to do sexual activities to him together with the other children.

All meetings were filmed. He sent some short films to Alina and instructed her to practice to become better, because if she didn't, he would break their friendship. Even though Alina felt excruciating pain through every sexual act, she could not refuse. She was afraid to lose the only person for whom she was important. One time Alina forgot her phone at home and her parents found out about the whole situation. Instead of being supportive, the child was accused of being a "little whore". They also said that if this came out it would be a disaster for the whole family. Alina became even more introvert. The parents took away her phone and computer and told the teacher at school that she was ill. In this way she was not allowed to communicate with anyone. Again Alina found herself lonely, useless and unworthy of love.

Alina vomited often and she could not wash her genitals, because her parents explained that it was "the evil that caused us to be disgraced by the whole city." Nothing brought her pleasure, she could not dance because her whole body resembled his touch. Her parents' reaction was always

in her head, that it was her well-groomed, toned body that was to blame for everything. Alina feels that the world is a dangerous place and that she is dirty and unwanted. She believes that after what happened she will never have friends nor family, because her parents told her so.

This story became known during the investigation of other crimes. At the first meeting with the parents, the child's father behaved aggressively and said that this had not happen, and when the video recording was shown, he denied that it was his child, and yelled at the helper. After 2 hours of communication, the father calmed down by hearing stories about other children. The helper also made him understand that the child was not to blame for being violated. After that, permission was obtained to meet with Alina. Contact was established between the helper and the child through common interest in dance. The helper managed to create a safe space with caring and trust. Alina opened up told about everything that Bohdan did to her. The helper explained that not all people are bad, and she shouldn't close in on herself. The helper also explained that her parents were just concerned about her and that's why they said unpleasant things, but they love her very much and worry about her. The parents were told the importance of Alina visiting a psychologist and working through the past trauma.

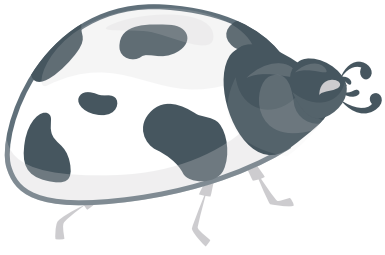
After some time, Bohdan was brought to justice. Alina, who underwent therapy and was happy that Bohdan could not hurt anyone again. She was happy about her achievements, her friends and travels.

Reactions and symptoms:

- Withdrawal/isolation
- Loss of appetite
- Refusal of doing activities
- Association of body and self as a whole as something dirty
- Feeling of disrespect for oneself
- Lost sense of security and trust in people.

Tools that help:

- Dialogue in the broadest sense of the word
- To make clear the uniqueness of each person and the fact that a person should be respected simply for what she is
- Make it clear that the child is never to blame.



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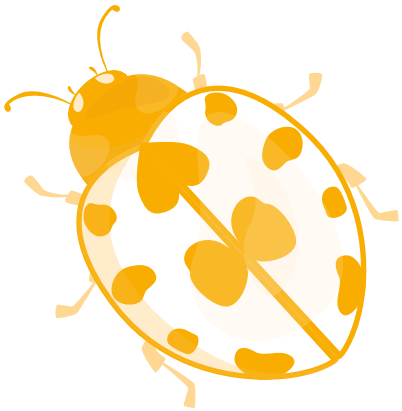

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