CALIFORNIA STATE UNIVERSITY NORTHRIDGE

PSYCHO-EDUCATIONAL CARE PACKAGES FOR PARENTS AND FAMILIES
OF CHILDREN IN TREATMENT FOR SEXUAL ASSAULT

A project submitted in partial fulfillment of the requirements
For the degree of Master of Science in Counseling,
Marriage and Family Therapy

By
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Dedication

I would like to acknowledge and extend my deepest gratitude to the professors, supervisors, staff and counselors of California State University Northridge and The Valley Trauma Center for their professional guidance and support.

I dedicate this project to the young survivors that I had the privilege of working with:

your resiliency transcends words.
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ABSTRACT

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“During the course of their childhood, one in three girls and one in seven boys will be sexually abused” (Briere, 2010, p. 1). While the ramifications of child sexual abuse may differ dependent on the severity and length of the trauma, early therapeutic intervention is crucial in the child survivor’s recovery. In addition, research has shown that non-offending parent(s) and/or caregivers may contribute positively to the therapeutic process, especially when the caregiver is receiving individual services in addition to being directly involved in the therapy of the minor client. However, if the non-offending parent(s) and/or caregivers are not able to participate in a complete therapy program, how may a counselor incorporate them in the child survivor’s therapy in order to increase the probability of positive therapeutic outcomes?

The framework of a three phase psycho-educational model and care package have been created to utilize when non-offending parent(s) and/or caregivers are unable to
obtain their own individual therapy and/or treatment when a minor child is receiving therapeutic services. The project is intended for child sexual abuse survivor’s ages seven to twelve and their non-offending parent(s) and/or caregivers. The model was created in congruence with the therapeutic interventions utilized in the Valley Trauma Center in Van Nuys California, specifically Trauma Focused Cognitive Behavioral Therapy. The overall goal of the project is to improve the efficacy of treatment for children who have been sexually abused by increasing involvement of the non-offending caregivers and facilitating family cohesion and support both inside and outside the professional therapeutic setting.
Chapter I

Introduction

“During the course of their childhood, one in three girls and one in seven boys will be sexually abused” (Briere, 2010, p. 1). Child sexual abuse does not discriminate: it is found in every city, country and culture around the world. Childhelp, a child sexual abuse prevention organization, asserts that, “child abuse occurs at every socioeconomic level, across ethnic and cultural lines, within all religions and at all levels of education” (Childhelp, 2011, para 6). Child sexual abuse is not only widespread in the number of children effected, the symptoms a child endures after the fact are just as numerous: “children and adolescents who have been sexually abused can suffer a range of psychological and behavioral problems, from mild to severe, in both the short and long term. These problems typically include depression, anxiety, guilt, fear, sexual dysfunction, withdrawal, and acting out”(Johnson, 2012, para 1).

While child survivors are helped by a myriad of therapeutic approaches, Pelletier & Handy (1999) believe that the role of parents and families in the road to recovery for these survivors is often underestimated: “Although there is not a strong body of research specifically focused on the experience of the non-abusing parent in cases of child sexual abuse, it is clear from this contextual research that their role is central to the ongoing care and control of children in the community” (p.236). Thus family involvement in the treatment course of a child sexual abuse survivor may have clinical and practical implications for current and future Marriage and Family Therapists. Further research is required in order to comprehend the extent of the relationship between the non-offending parent(s) and/or caregivers and successful results in therapy for the child sexual abuse
survivor. In addition, research is needed to determine what level of parental involvement is necessary to increase the likelihood of a positive outcome for the child survivor. Such an understanding can facilitate the creation of psycho-educational resources and programs that align with the child survivor’s therapy in order to ultimately treat the client and family as whole, integrating the therapeutic process and maximizing successful outcomes.

Sexual abuse survivors, specifically children, may be more dependent on the role of non-offending family members because the child has not even developed a language for what has happened to them in the first place: “No child is psychologically prepared to cope with repeated sexual stimulation. Even a two or three year old, who cannot know the sexual activity is wrong, will develop problems resulting from the inability to cope with the overstimulation” (Martin, 2011, para 3). According to Deblinger, Stauffer and Steer (2001) “Research regarding variables that may contribute to the severity of the difficulties experienced has repeatedly found that supportive responses from non-offending parents are significantly associated with more positive post abuse adjustment in children. The important role of the non-offending parent is confirmed in other research as well (Adams-Tucker, 1981; Conte & Schuerman, 1987, Everson, Hunter, Runyon, Edleson, & Coulter, 1989, p. 333). While it is difficult to quantify the direct effect of parental and/or caregiver involvement, “when the non-offending caregiver was involved in the child’s therapy, there were greater improvements in self-reported measures of depression, abuse-specific distress, support of the child and effective parenting practices (Cohen et al., 2005)” (McPherson, Scribano & Stevens, 2011, p.25). The degree to which the family affects the success and course of treatment of the child survivor is still unclear.
but may be important in order to understand how to deliver effective therapy and support for the child client, which may increase retention throughout treatment. McPherson, Scribano and Stevens identify several obstacles that may present challenges throughout the course of therapy: “Factors associated with higher risk of attrition included minority status, lower education level, low income, caregiver’s perceptions of the therapeutic relationship between the client and therapist, financial stressors due to the cost of service, and less severe of chronic abuse” (McPherson et al. 2012, p.25). If a minor child’s non-offending parent(s) and/or caregivers are unable to see the value in the therapy and do not establish a connection with the therapist the consistency of treatment may be jeopardized for the minor child.

McPherson, Scribano and Stevens further assert that the lack of support on the part of families and parents of child sexual abuse survivors may be a detrimental component in the therapeutic process: “In our study, if the caregiver participated in counseling services (either individual or family therapy) the patient was more likely to successfully complete the recommended therapy. It is not uncommon for non-offending caregivers to suffer from mental health disorders (i.e. depression) that negatively affect a family’s overall level of functioning and compliance with recommended mental health services for the abused child” (2012, p. 27). However if non-offending parent(s) and/or caregivers are involved in the child survivor’s therapy, the study found the likelihood of positive therapeutic outcomes may increase: “the consistency of our results with previous studies suggests that engaging non-offending caregivers in the patient treatment, and providing appropriate levels of support/therapeutic intervention for the caregivers themselves, will significantly increase the likelihood of positive mental health outcomes
for the child victim” (2012, p.27). Connecting the caregivers to the therapeutic treatment enhances the probability of successful outcomes for the child and may increase overall family cohesion in the process.

Thus, the role of the family in treatment requires an educational component alongside the child survivor’s therapy in order to promote cohesion, support and alignment of the child and family during the treatment process.

Statement of Need

As previously noted, more research is needed regarding the relationship between non-offending parent(s) and/or caregivers and the success of a child in treatment for sexual abuse. Specifically, what degree of involvement is required from non-offending parent(s) and/or caregivers in order to positively affect the child client’s treatment outcomes? Obtaining additional information regarding the specific level of involvement needed on the part of the non-offending parent(s) and/or caregivers may prove valuable under circumstances in which therapeutic services and/or family resources such as transportation, finances and time are limited. This project intends to stimulate further research on the effect parent(s) and/or caregivers may have on client’s’ experiences in therapy, as well as laying the groundwork for development of a psycho-educational component that will align with the child survivor’s treatment for the caregiver.

Purpose

The purpose of this project is to provide a psycho-educational framework for clinicians to use with minor clients and non-offending parent(s) and/or caregivers that would run concurrently with the treatment of their children (ages 7 to 12) whom are enrolled in a sexual assault treatment program. The project is designed to work in
congruence with the interventions within Trauma Focused Cognitive Behavioral Therapy, one of the main theories utilized in the Valley Trauma Center. The research will support the development for educational material that involves parents and families that may ultimately contribute to positive treatment outcomes for the child survivor. The educational material would include psycho-education, resources and activities designed to integrate appropriate information and support with the child survivor therapeutic program. Ultimately this project will result in the development of the framework of three, psycho-educational counseling sessions for non-offending parent(s) and/or caregivers in which an educational “care package” will be presented and explained for use in alignment with the child survivor therapy. The educational counseling session(s) and corresponding care package(s) will align with where the child client is within the course of his/her therapy. The three psycho-educational sessions are designed to inform parents and family members about the effects of child sexual abuse, specific resources for caregivers and other educational material designed to maintain cohesion and support for the child survivor and family.

**Significance**

The implications for the development of this project will benefit current and future therapists and counselors in treating child sexual abuse survivors and their families specifically when the non-offending caregiver is not enrolled in their own individual therapy and/or group therapy. Increasing support for child sexual abuse survivors and family involvement may increase retention and consistency for clinicians and may positively enhance family cohesion and treatment outcomes for the survivor. In addition, the development of an educational care package that involves non-offending parent(s)
and/or caregivers may increase the likelihood that therapeutic interventions are carried on outside the professional setting and integrated into everyday life in the home.

Terminology

**Intrafamilial sexual abuse:** “sexual abuse that occurs within the family. In this form of abuse, a family member involves a child in (or exposes a child to) sexual behaviors or activities. The “family member” may not be a blood relative, but could be someone who is considered “part of the family,” such as a godparent or very close friend.” (National Traumatic Stress Network, 2009, p.1)

**Non-Offending Parent** – “The term non-offending parent refers to a parent or caregiver who has not been involved in the sexual assault of the child” (South Eastern Centre Against Sexual Assault, 2010, para 1).

**Psychoeducational:** “Of or relating to the psychological aspects of education; specifically: relating to or used in the education of children with behavioral disorders or learning disabilities” (Merriam-Webster, 1993, para 1).

**Sexual assault/abuse:** “A type of maltreatment that refers to the involvement of the child in sexual activity to provide sexual gratification or financial benefit to the perpetrator, including contacts for sexual purposes, molestation, statutory rape, prostitution, pornography, exposure, incest, or other sexually exploitative activities” (Chase, 2011, p. 4).

In order to understand the need for such an educational tool, it is imperative to review the current published literature and research findings concerning the effect non-offending parent(s) and/or caregivers have on the treatment of a sexually abused child as
well as analyzing the successes and failures of previous interventions aimed at a similar goal. This will be covered in the following chapter.
Chapter II

Literature Review

Introduction

The purpose of the review of literature is to examine the current theories, research, ideas and studies related to child sexual abuse and the interventions shown to aid in their therapeutic progress. This chapter will begin with a description of both child sexual assault/abuse in general and child sexual assault/abuse that occurs within the family. It is followed by an analysis of Trauma-Focused Cognitive Behavioral Therapy as a successful example of how integrating the survivor’s family in treatment is beneficial to the child as well as how keeping non-offending parent(s) and/or caregivers uninformed and “out of the loop” can develop into considerable obstacles for the therapist and survivor alike. Lastly, current therapeutic modalities and treatment options such as Play Therapy and Project SAFE are reviewed in relation to the treatment of child sexual abuse survivors.

Child Sexual Assault (General)

In order to better understand the positive effect non-offending parent(s) and/or caregivers may have on a child survivor’s therapeutic treatment, a brief overview of child sexual abuse in general must be considered. According to Freyd (1996), child sexual assault/abuse survivors are not discriminated by socio-economic status, class, creed, color or culture. Children of all backgrounds and geographic locations are victims of child sexual abuse around the world. Furthermore, child abuse is one of the most elusive crimes in regards to the ability to punish the perpetrator based on criminal evidence: “Childhood sexual abuse, whether molestation or even penetration, usually leaves no
lasting physical evidence. It is neither explained nor understandable to the child. It is often not even acknowledged by the perpetrator, except to say it didn’t happen or wasn’t what it seemed to be” (p.4). In addition, child sexual abuse is often reported after considerable time has passed: making the burden of proof even greater to bear for the survivor and their families (p.5).

Pelletier & Handy (1999) assert that the difficulty in pursuing crimes of child sexual abuse is only the tip of the iceberg; the trauma and betrayal as a result of child sexual abuse may have chronic and destructive affects. “Most researchers now agree that child sexual abuse usually causes significant damage, in large part because it entails grossly unequal relationships between offenders and children. Most of the empirical data gathered so far confirms that sexually abused children suffer from more emotional and behavioral problems than non-abused children from the community” (p.57). In addition, when child sexual abuse has become evident, it is unknown as to how long the survivor has been attempting to cope with the trauma that has been unleashed on the child against his or her will.

When trauma has taken place at a young developmental age, children are left to their own devices until the abuse is either disclosed or discovered. Dr. Toni Vaughn Heineman (1998) describes a glimpse of the way child survivors view their experience: “Abused children often justifiably feel as if they have been treated as impersonal objects—merely used for the expression of another’s sexual or aggressive impulses. Simultaneously, each child is unique and will experience and internalize the abuse in a profoundly personal way” (p.8). This may especially ring true for child sexual abuse survivors with a repeated trauma history. The repetitious sexual abuse may leave the
child survivor with no voice or choice. Basic coping mechanisms are relied upon before, during, and after each sexual assault incident in order to survive the world into which they have been forced (p.8). According to Lamb, (2006): “[Children] develop ways of coping that involve avoiding thinking about the abuse, avoiding the perpetrator, and even dissociating during the abuse, removing themselves psychologically from the scene to preserve themselves and their well being” (p. 79). These maladaptive ways of coping with the sexual abuse continue on until the child survivor learns otherwise. Through a combination of integrative therapeutic tools, models and treatments, a child survivor’s ineffective ways of coping will be-unlearned and eventually replaced. This does not mean that every child survivor of sexual abuse may have the opportunity to learn alternative ways to cope or process their abuse. Some children’s stories are never heard and therefore the basic survival skills they used to tolerate the abuse will have to carry them throughout the rest of their lives (p.79).

Child sexual abuse may become even more complicated for the minor child when the perpetrator is a parent or family member. Therefore the implication of intrafamilial child sexual assault deserves further discussion.

**Child Sexual Assault (Intrafamilial)**

Gilmartin (1994) states that child sexual abuse becomes exceedingly complicated when the perpetrator is a parent or family member, which is categorized as incest and/or intrafamilial sexual abuse. The author defines sexual abuse as:

All unwanted sexual acts involving bodily contact committed by non-familial adults who are at least five years older than the girls or adolescents that they assault. I reserve the term incest for unwanted sexual acts involving bodily contact which are committed by family members and others who have parental types of roles or are in positions of trust (p.19).
The child survivor may develop a level of trust with a family member that would make the abuse damaging in a way different from a survivor whom was abused by a stranger. This is not to say that the trauma or effects of intrafamilial child sexual abuse trump those of other child sexual abuse circumstances. The purpose of differentiating between intrafamilial child sexual abuse and child sexual abuse in general is to further develop an understanding of why the family component in therapy is critical to successful therapeutic outcomes, especially when the family includes both a non-offending parent and an offending perpetrator. According to Chase (2011):

Sexual abuse most commonly occurs by an individual known by the victim, parent or other family member (intrafamilial). Rarely is the abuser a stranger. Intrafamilial and incest sexual abuse is difficult to document and manage because the child can’t just be protected from additional abuse and coercion to not reveal or deny the abuse, while attempts are made to preserve the family unit. Children themselves may also decide to recant their recent accusations of abuse due to fear of retaliation by the perpetrator or other family members. They may also recant out of fear of losing contact with the perpetrator who is commonly a family member or close friend tied to the family by various social means (p.3).

Intrafamilial child sexual abuse complicates the therapeutic process further because of the inability of the family to communicate in a healthy way about the discovery of the abuse. Dependent upon the relationship of the perpetrator to the child in regards to position in the family, immediate blood relation and overall connections to other family members, a child survivor’s main support system may be jeopardized. Parents and other family members’ reactions and emotions regarding the child sexual abuse are further complicated by the fact that they too feel betrayed and traumatized as a result of the abuse occurring within the family.

Families where sexual abuse takes place have difficulties communicating information clearly and resolving differences through negotiation. There is generally little useful discussion of family functioning or of developmental issues such as sexuality. Denial can be an intrinsic part of the family process, and family
members expend a considerable amount of energy keeping ‘secrets’ and maintaining ‘myths’ which are perceived as essential to the maintenance of the family (Pelletier & Handy, 1999, p.46).

The combination of the issues presented for the intrafamilial child sexual abuse survivor further encourages discussion regarding the involvement of the non-offending parent(s) and/or caregiver’s in therapy. The very individuals who were entrusted to protect and guide a child to grow and thrive are the same individuals at the helm of the abuse. Therefore non-offending parent(s) and/or caregivers are needed more than ever.

**Child Sexual Assault Treatment Model**

*Trauma Focused Cognitive Behavioral Therapy*

Child sexual abuse is a traumatic and complex experience for children and their families to endure. However, current treatment models working in conjunction with one another may present comprehensive and effective therapeutic treatment for survivors. This is not to say that there is one specific treatment that will work for every child survivor and his or her family. In fact, the best therapeutic outcomes are those that involve multiple resources, agencies of knowledge and support systems. Authors Tomlinson and Philpot (2008) support the notion that a comprehensive inter-agency approach is key: “A holistic or ecological assessment of a child can only come about by a multi-disciplinary and multi-agency assessment” (p. 23). For the purposes of this project, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is an important treatment model to review. It offers comprehensive therapeutic modalities and tools proven to assist child survivors of sexual assault. This model also creates opportunities for non-offending parent(s) and/or caregivers to become involved.
Trauma-Focused Cognitive Behavioral Therapy as an approach to treat child survivors of sexual abuse will be the main therapeutic approach reviewed for the purposes of this project since this is the dominant model used within the Valley Trauma Center, the original inspiration for this project.

The TF-CBT approach may be described as “a collection of core skills that build on one another. It is not a rigid session-by-session treatment approach, but rather is designed to match the needs of the individual child and family. Sessions are individually based and involve activities such as relaxation training, reviewing the traumatic event via cognitive behavior therapeutic techniques and ending, usually with some sort of permanent product (e.g. a journal)” (Little, Akin-Little, Somerville, 2011, p. 452).

The U.S. Department of Health and Human Services (2007) describes Trauma-Focused Cognitive Behavioral Therapy as:

A short-term treatment typically provided in 12 to 18 sessions of 60 to 90 minutes or longer, depending on treatment needs. The intervention is typically provided in outpatient mental health facilities, but it has been used in hospital, group home, school, community, and in-home settings. Generally, the goals of TF-CBT are to: reduce children's negative emotional and behavioral responses to the sexual abuse, correct maladaptive or unhelpful beliefs and attributions related to the abusive experience (e.g., a belief that the child is responsible for the abuse), provide support and skills to help non-offending parents cope effectively with their own emotional distress and provide non-offending parents with skills to respond optimally to and support their children (2007, p. 4).

In addition, “TF-CBT is one of only three interventions that have been identified as meeting the criteria for evidence-based practice by the Kauffman Best Practices Project and it is the only trauma treatment for children with a scientific rating of 1” (Little et al., 2011, p.452).
The use of the non-offending parent(s) and/or caregivers within the Trauma Focused Cognitive Behavioral Therapy model is an important component of the therapy because of the direct effect on the child survivor’s progress: “parents are a key component in treatment, and improving parent-child interactions, communication and intimacy are a major focus” (Little et al., 2011 p.453). Additionally, author Andrew Hill (2005) highlights the role of non-offending parent’s in therapy: “to exclude parents is to risk reinforcing patterns of secrecy imposed by the abuser and to increase the barriers to parent-child communication that may have been caused by the abuse” (p.347). TF-CBT aims to integrate parents in parts of the treatment process of the child survivor, in addition to providing resources specifically for the supporting parent(s) and/or caregivers: “If there is parental “buy-in” for non-offending caregiver therapy, the family may be more compliant with treatment recommendations as the non-offending caregiver may be internally motivated to continue in counseling and provide support for the child” (McPherson et al., 2011, p.27). Therefore, integrating the non-offending parent(s) and/or caregivers may increase the likelihood of positive outcomes for the child survivor.

Studies suggest that when non-offending caregivers participate in therapy services, they experience fewer negative emotional reactions toward their child’s sexual abuse and are more likely to have a positive influence on the child’s post abuse adjustment (Deblinger, Stauffer, & Steer, 2001; Stauffer & Deblinger, 1996) (McPherson et al., 2011, p. 27). The intention behind the family component in TF-CBT mirrors the purpose of this proposed project: family support and/or involvement will play an influential role in the child survivor’s ultimate ability to heal. According to the U.S. Department of Health and Human Services (2007):
Recognizing the importance of parental support in the child's recovery process, TF-CBT includes a treatment component for parents (or caregivers) who were not abusive. Children and parents first participate separately in therapy and then attend several joint child-parent sessions. The parent component teaches stress management, parenting, and communication skills. As a result, parents are better able to address their own emotional distress associated with the child's trauma, while also supporting their children more effectively (p.3).

The family inclusion component that contributes to the success of TF-CBT is an important part of the research necessary to further understand the relationship between including non-offending parent(s) and/or caregivers in a child survivor’s therapeutic treatment. However, just as it is crucial to identify therapeutic treatment models that succeed in treating child sexual abuse, understanding the obstacles within those treatments that a therapist and/or survivor may encounter is just as important.

**Family Involvement as an Obstacle in Therapy**

While the previously discussed treatment model of child sexual abuse offers a variety of techniques and tools instrumental in providing therapy, obstacles in the course of treatment are just as noteworthy. Acknowledging specific barriers in treating child sexual abuse survivors further illustrates the need for more comprehensive programs designed to meet the variety of issues that are inherent in the complex road to recovery for child survivors and their families.

Parents of children whom have been sexually abused find themselves conflicted in a variety of areas from how to begin approaching treatment, to pursuing the legal ramifications of the traumatic event. Angelica (2002) asserts that “Often parents whose children have been sexually victimized are confused, frightened, and reluctant to become involved with the prosecution process, knowing the stress which may result from the protracted and public aspects of a criminal trial” (p.54). According to Lipovsky (1998),
the stress and emotional difficulties inherent in being a parent or guardian of a child abuse survivor translates into difficulties in therapy as well. The therapeutic process brings up and challenges a variety of difficult subjects for which the family is not always prepared. “Children should not be treated in isolation of treatment of their family and/or current living situation. It is difficult to specify, however, the precise structure of therapeutic work addressing family issues because these vary considerably depending upon the child’s living context” (1998, p.9). Involvement of the family in conjunction with the child survivor’s treatment may raise obstacles such as “lack of acknowledgement by offender/non-offender parent, lack of resources, lack of motivation to participate in treatment and mistrust of the system (including the counselor/therapist)” (p. 9). Whether consciously or unconsciously, this affects the survivor’s therapeutic process as well as the parent’s ability to deal with the issues their child’s abuse will create for them.

Lamb (2006) asserts that parents and/or guardians of child survivors may find difficulty in implementing preventative tools after the abuse has occurred. Parents have disclosed that even broaching the subject of safe sex and preventative measures were uncomfortable and daunting. Their fear of re-traumatizing their children as well as themselves makes communication difficult and as a result important conversations do not occur:

Many parents want to talk to their kids about sex but feel incapable, embarrassed, and incompetent. With little ones, they are unsure about what to convey and how much is too much. The topic of sex also introduces into their communication a seriousness that for many families is just not a part of normal communication patterns unless someone has died or gotten in to trouble (2006, p.197).

The inability for the family to comprehend and adequately aid in the healing process of a child sexual abuse survivor may have a detrimental effect on the therapeutic
outcome for the child. As previously discussed, the lack of information and guidance provided to a child survivor’s family has a profound effect on the child and family ability to cope and communicate about their experience. Consequently, the developments of psycho-educational programs are needed so that non-offending parent(s) and/or caregivers become a valued source of support and strength rather than an additional roadblock on the road to recovery.

Current Child Sexual Assault Treatment Interventions

In order to obtain an understanding of the ways in which non-offending parent(s) and/or caregivers may play an instrumental role in treatment, therapeutic and educational tools currently used in counseling will be discussed. Without reviewing present therapeutic modalities, one cannot assess where parent involvement would help the course of a child survivor’s therapy.

Play Therapy

Play therapy as a therapeutic approach in combination with other treatment tools offers an outlet for child sexual abuse survivors to comprehend the traumatic experience. According to Rymaszewska & Philpot (2006), “play therapy is defined as a dynamic approach between child and play therapist in which the child explores, at her own pace and direction, matters, past and present, conscious and unconscious, that affect her” (p.94). Play therapy is an alternative approach to gaining access to tumultuous memories that may be too difficult too for the child survivor to re-tell. “Working with children through play an the expressive arts involves physical experiences, feelings and ideas. It links physical emotional and mental experiences. Play can gain access to these early
experiences and make it possible for the child to think about them and make sense of them” (2006, p.94).

These researchers (2006) believe that play therapy allows a child survivor to guide a therapist in to his or her inner world without requiring the survivor to recall a concrete narrative which may be difficult to articulate: “The use of toys also allows children to communicate less directly. They may not have the verbal skills, or even concepts, to speak about what happened; and given how painful their memories may be, they may not be able or wish to do so. This indirect communication through playing with toys, which can be revealing and vivid as any words, can be less damaging to them” (p.62).

While this researcher indicates that Play Therapy is an important tool in reaching and understanding some of the most painful parts of a survivor’s sexual abuse, it is unknown whether or not family involvement increases or deters its effect. Further research is needed in order to comment on the relationship between non-offending parental involvement and the success of the child survivor in therapy in regards to therapeutic tools such as those used in Play Therapy.

*Project SAFE*

A current treatment program that involves the non-offending caregiver in addition to the minor client in a group therapy setting was created at the University of Nebraska-Lincoln titled Project SAFE (Sexual Abuse Family Education). Project SAFE was specifically designed for children ages seven to sixteen and their non-offending parent(s) and/or caregivers; “Project SAFE is unique in that it utilizes a standardized manual, involves the non-offending caregivers in a parallel group, and incorporates a
comprehensive assessment battery to evaluate treatment efficacy” (Clemmons, Davies, Flood, Hans, Hansen, Holguin, Holm, Hsu, Nash and Sedlar, 1997, p.1). Project SAFE is based on a twelve-session model in which both the minor child and non-offending caregiver participate in approximately ninety-minute group sessions that run parallel throughout the course of treatment. Project SAFE was designed to focus on “three critical target areas impacted by sexual abuse: the individual or self (e.g., internalizing feelings); relationships (e.g., social interactions and externalizing problems); and sexual abuse related issues” (1997, p. 1). Project SAFE’s efficacy was measured using an open clinical trial including twenty-four child client participants and twenty-three of their non-offending caregivers were assessed.

In order to ascertain the efficacy of Project SAFE, assessments were conducted prior to initiating treatment, after the completion of treatment and three months after termination. In the child self report measures, the data showed a reduction in Post Traumatic Stress symptoms, attributions about the abuse, intrusive thoughts, hyper-arousal, sexual anxiety and self-blame (1997, p.4). In the parent self report measures, significant differences were seen on the anxiety/depression, social problems, thought problems, attention problems, delinquent behaviors and aggressive behaviors subscales related to their child’s behavior (1997, p. 5). The child and caregiver were also asked to complete evaluations of Project SAFE related to treatment goals and the overall course of therapy. Child participants stated, “group topics were important and [they] were able to understand group topics most of the time. Overall, 20 children (95.2%) reported that most or some of the time they feel better off than when Project SAFE groups began 2 months
Evaluations of caregiver satisfaction also reflected positive satisfaction and outcomes:

Parents rated their therapists as very or extremely supportive and knowledgeable. Regarding procedures, parents found it beneficial to summarize the content of the children’s group at the beginning of each session and to meet with the child therapist at the end of each session (1997, p. 6).

Although Project SAFE utilizes a group therapeutic model, the importance of non-offending parent(s) and/or caregivers involvement and the positive effect it may have on the minor child is noteworthy.

**Conclusion**

This project is intended to provide information on the importance of developing a psycho-educational component for non-offending parent(s) and/or caregivers in conjunction with their child’s survivor’s treatment. Specifically, the reviewed research has outlined the need for educational material, resources and activities to be developed in the form of a care-package that families can use at home outside the child survivor’s individual treatment. The care package, in combination with an educational psychotherapy counseling session, includes: information regarding the effects of child sexual abuse (on the survivor and family), activities aimed at increasing family cohesion and additional resources of support that will aid both survivor and family members throughout the course of treatment. The aim is to better integrate the child survivor’s treatment course and the involvement of non-offending parent(s) and caregivers in order to increase the likelihood of success in therapy and ultimately contribute to a greater degree of healing for the survivor.
Chapter III

Audience and Implementation Factors

Introduction

This graduate project presents a product that is needed in order to increase the likelihood that non-offending parent(s) and/or caregivers will positively contribute to the treatment of their children in a sexual assault therapy program. It is important to understand how this three phase psycho-educational model and corresponding care package developed, whom the model is intended for, the individual experience and professional qualifications necessary for successful implementation and a brief overview of the product itself. Each psycho-educational session contains a proposed care package comprised of educational material for parents and/or caregivers and cohesion building activities. In addition each psycho-educational session correlates with the child’s current progress in treatment (initial phase, working phase, reflection and evaluation phase) which further aligns the non-offending parent(s) and/or caregivers with the child during the course of therapy.

Overview of the Product

The product of this graduate project contains three psycho-educational sessions designed to increase the involvement of the caregiver(s). Each session contains step-by-step instructions for the counselor and is conducted with the minor client and his or her non-offending parent(s) and/or caregivers. The session’s cover various components of the therapeutic process and provide the non-offending parent(s) and/or caregivers with information related to where their child is within treatment. In addition, each psycho-
educational session contains a list of items that would be included in a care package that the family is able to take home and utilize outside the professional setting. The care packages are explained before hand within the psycho-educational session as well as their intended use. The items listed in the care packages contain information, activities and resources intended to facilitate familial cohesion and allow the minor client an opportunity to share parts of his or her treatment with non-offending family members. The care package activities listed in each psycho-educational session are based on interventions used within Trauma-Focused Cognitive Behavioral Therapy and can be re-arranged and/or replaced based on counselor discretion and/or treatment plan goals.

**Development of Project**

The development of this project originated from the experience acquired when working with children at the Valley Trauma Center in Van Nuys, California. Specifically, counselors in the Sexual Assault Program found themselves confronted with less than desirable retention rates of child clients, when their non-offending parent(s) and/or caregivers were not involved in either their own individual therapy, family therapy or direct and repeated interaction with their child’s therapist. The project is designed to work in conjunction with the Valley Trauma Center’s twelve-session model and use of Trauma Focused Cognitive Behavioral Therapy within the Sexual Assault program.

Once the need for the project was identified, counselor trainees, clinical supervisors, licensed marriage and family therapists and Valley Trauma Center staff was conferred with regarding the content and structure of the psycho-educational sessions as well as the proposed care package materials. Furthermore California State University
Northridge professors were consulted in order to develop a psycho-educational model that would be feasible for the setting in which it was intended. In addition, the care package content is tended to reflect the principles and activities used in Trauma Focused Cognitive Behavioral Therapy.

**Intended Audience**

The target population for the purposes of this project will be male and female children between the ages of seven to twelve who have been sexually abused and their non-offending parent(s) and/or caregivers who the child either lives with and/or spends the majority of her/his time with. The applicability of the psycho-educational model and corresponding care package are not limited by the client or caregiver’s ethnicity and/or race.

For the purpose of this project, the psycho-educational model and care package would be inappropriate for implementation if the child client’s caregiver is unwilling to fully participate in the three psycho-educational sessions and/or apply the care package components in the home. Furthermore, if there were restrictions or elements that affect the stability or consistency of the non-offending parent or caregiver in the home, the model would be in inappropriate to use in conjunction with the child’s individual therapy.

**Personal Qualifications**

In order to implement the product of this project successfully, the individual implementing the psycho-educational sessions must also be the child survivor’s individual therapist. This is a key component of the model since the consistency of the
therapist role directly relates to the models ability to promote cohesion between the therapist and family and have the caregiver connect to the therapeutic process of the child survivor. Additionally, the recommended qualities the therapist and/or counselor should possess when implementing this psycho-educational model include:

A. Second year standing and/or completion of a master’s level marriage and family therapy, master of social work or psychology graduate program.

B. Completion of the Trauma Focused Cognitive Behavioral Therapy certification and experience in face-to-face client hours using the interventions within the modality.

Lastly, individuals utilizing this psycho-educational model should maintain supervision and/or professional consultation throughout the course of treatment regardless of licensure status. The model requires the counselor to not only foster a therapeutic relationship with the child survivor, but the family as well in order to encourage cohesion at home outside the professional setting. Therefore supervision and/or professional consultation may be helpful if and when the non-offending caregivers are having difficulty connecting with the therapist or adhering to the model.
Chapter IV

Conclusion

Summary

“During the course of their childhood, one in three girls and one in seven boys will be sexually abused” (Briere, 2010, p. 1). While the ramifications of child sexual abuse may differ dependent on the severity and length of the trauma, early therapeutic intervention is crucial in the child survivor’s recovery. In addition, research has shown that non-offending parent(s) and/or caregivers may contribute positively to the therapeutic process, especially when the caregiver is receiving individual services in addition to being directly involved in the therapy of the minor client. However, if the non-offending parent(s) and/or caregivers are not able to participate in a complete therapy program, how may a counselor incorporate them in the child survivor’s therapy in order to increase the probability of positive therapeutic outcomes?

The framework of a three phase psycho-educational model and care package have been created to utilize when non-offending parent(s) and/or caregivers are unable to obtain their own individual therapy and/or treatment when a minor child is receiving therapeutic services. The project is intended for child sexual abuse survivor’s ages seven to twelve and their non-offending parent(s) and/or caregivers. The model was created in congruence with the therapeutic interventions utilized in the Valley Trauma Center in Van Nuys California, specifically Trauma Focused Cognitive Behavioral Therapy. The overall goal of the project is to improve the efficacy of treatment for children who have been sexually abused by increasing involvement of the non-offending caregivers and facilitating family cohesion and support both inside and outside the professional therapeutic setting.
Evaluation

The psycho-educational model would benefit from the creation of quantitative assessments such as questionnaires and evaluation measures. These may be used to assess the effectiveness of the model and aid in understanding if the involvement of the parent made a significant difference in the treatment outcome for the minor child versus no parental and/or caregiver involvement throughout the course of therapy.

The questionnaires and/or evaluations would cover such areas such as parent concerns for their child, parent understanding of counseling, parent knowledge of how to support their children, etc. It may be beneficial to administer a questionnaire to the non-offending parent(s) and/or caregivers before the psycho-educational model begins and at the completion. The questionnaire would be comprised of a series of true or false statements as well as scales that ask the participant to what degree do they agree or disagree with a given statement. The questionnaires would be completed in the psycho-educational sessions with the counselor available for questions. A similar questionnaire or evaluation may be developed to assess the efficacy of the care package in the home outside of the professional therapeutic setting. It may be beneficial to create two versions of the proposed care package evaluation (one for the minor child and one for the caregiver) in order to encapsulate a complete view of the use of the care package. The child evaluation would ask the minor client to self report and rate symptoms, state any problems they are currently experiencing and future concerns.
Discussion

During the process of creating this project, several changes were implemented based on evaluations from professionals within the field. The project was developed from the need to include parents in the treatment process with sexually abused children and was created to work in congruence with the interventions used within Trauma Focused Cognitive Behavioral Therapy, an evidence based practice utilized within the Valley Trauma Center. Originally, the three part psycho-educational model did not utilize a specific therapeutic theory and/or set of interventions. This revision created cohesion in the curriculum used with the minor client and created a specific intended audience for the future implementation of the project.

Future Work

In the future, research measuring the efficacy of the psycho-educational model is necessary in order to accurately quantify the effect of the non-offending parent(s) and/or caregivers on the therapeutic outcomes of the minor client. In addition, compilation of data from the previously discussed questionnaires and/or evaluations will aid in understanding which types of non-offending parent(s) and/or caregivers were the most influential in the minor client’s therapeutic outcomes (e.g. both parents, one caregiver, etc).

Future versions of this model should include the actual psycho-educational handouts, interventions and resources intended for use within the care packages after acquiring the proper copyright and reproduction rights. Further research is also needed regarding the resources contained within the proposed care packages and how effective the information was in aiding the non-offending parent(s) and/or caregivers during the
treatment course of the child. Research regarding Bibliotherapy may also prove helpful in the future in order to increase the probability that non-offending parent(s) and/or caregivers connect with and utilize the information intended for exploration in the home.
Bibliography


APPENDIX “A”

Psycho-educational Session One

(Child Client & Non-Offending Parent(s)/Caregivers)

*Note: Session One material & related care package will be facilitated before the child’s first one on one session with his or her counselor.

(Approximately 60 minutes)

Introduction and Therapy Goals

Goals:

Introduction

- To explain the course of therapy and goals
- To present and explain issues of confidentiality and safety
- To present and explain consent to assessment and treatment
- To introduce Care Package Part One

Objectives:

By the end of the session, participants will be able to:

- Explain the difference between one-on-one therapy and conjoint therapy
- Describe what confidentiality and safety mean
- Understand and sign the consent to assessment and treatment
- Understand the care package and how it will be used

Materials Required

- Assessment Consent (Minor & Adult)
Care Package Proposed Contents (Part One)

- Child Sexual Abuse Myths & Facts Handout
- Child Sexual Abuse Signs & Symptoms Handout
- Self Care for Children & Parents Handout
- Feeling’s Identification Activity
- Feelings Bingo Activity

Procedures

1. Introduction
   - The counselor will welcome the non-offending parent(s) and/or caregivers and the minor client.
   - The counselor will briefly introduce him/herself, describing their experience working with children and their families.
   - The counselor will ask the non-offending parent(s) and/or caregivers of the minor client if they have had any previous experience with counseling. Counselor may repeat question to minor client.

2. Course of Therapy & Goals
   - The counselor will explain the difference between the joint psycho-educational sessions, which occur three times (with the non-offending parent(s) and/or caregivers, minor child and therapist) versus the one on one weekly therapy sessions (with the minor client and therapist).
The counselor may explain this format in the following ways: “Since this is our first time together, I would like to explain what our future meetings will be like. I will be your counselor (Minor Child’s Name) we will meet weekly and get to know each other. There may be times your (Parent/ Caregiver Name) may meet with us during these sessions, but for the most part it will be you and me meeting weekly.

The counselor may continue his/her explanation: “However there will be three special times, when all of us will meet, like we are today. This way we can all talk about how therapy is going for you and your family. We will even talk about things to do at home that can make therapy even better.”

The counselor will further explain, “the goals of both your time with me (minor client), and these joint sessions with (parents/caregivers) is to gain a better understanding of what has happened and how it is affecting (minor client), the family and how everyone can help each other in overcoming problems and healing.”

The counselor may want to reiterate this structure and goals again, emphasizing that the counselor’s primary role is the child’s therapist.

3. Confidentiality & Safety

In detail the counselor will cover the issues related to confidentiality and safety as well as limitations to confidentiality: instances where a child or dependent adult is at risk to themselves, someone else, or threatening self harm or harm to another.
The counselor may discuss how the purpose of the three joint sessions is not to share information the minor client may have disclosed to his or her therapist, but an opportunity to see how the entire family is progressing. However, explain to the minor client there may be instances the counselor feels it is important to discuss what is going on in therapy with the parents / caregivers.

The counselor may emphasize the importance of the confidential information in the sessions and reiterate that anyone outside of these sessions, unless they have the minor child and/or parent/caregiver consent, will not be shared and discussed. The counselor may highlight the importance of this step because it helps keep therapy sessions a safe place to explore difficult thoughts and feelings they may not always be comfortable with everyone knowing.

4. Consent to Assessment & Treatment

The counselor will provide consent to assessment and consent to treat forms to the parent(s) and/or caregivers.

If applicable, the counselor may also ask the minor child to sign a separate consent to assessment and consent to treat forms in order to increase the minor client’s awareness regarding his/her importance in the participation of the therapy process.

The counselor may explain each component of the consent to assess and consent to treat form and subsequently allow the parent and/or non-offending caregiver to sign after each explanation has been given.
➢ The counselor may ask if there are any questions or concerns regarding the consent forms and address them as needed.

5. Introduction of Care Package Part I

➢ The counselor will present Care Package Part I to the minor client and the non-offending parent(s) and/or caregivers. The counselor may open the package and display the contents, explaining which materials the non-offending parent(s) and/or caregivers may use and which the minor client may use.

➢ The counselor will then ask the non-offending parent(s) and/or caregivers the best days and times during the week the care package material may be utilized. The counselor can remind the family the activities should be used at a time where all family members are present and there is a sufficient amount of time to complete each activity. The counselor may further explain the handouts specifically for the non-offending parent(s) and/or caregivers may be read at any time, but preferably before the beginning of the Care Package activities.

6. Closing Psychoeducational Joint Session One

➢ The counselor may explain the first joint session has now been completed and discuss the day and time of the one on one counseling session between the minor client and the therapist at this time.

➢ The counselor may ask if the non-offending parent(s) and/or caregivers or the minor client may have any questions regarding
therapy, the care package, etc. before this joint session comes to a close.

Care Package Proposed Contents (Part One)

- Child Sexual Abuse Myths & Facts Handout
- Child Sexual Abuse Signs & Symptoms Handout
- Self Care for Children & Parents Handout
- Feeling’s Identification Activity
- Feelings Bingo Activity
Psycho-educational Session Two
(Child Client & Non-Offending Parents/Caregiver)

*Note: Session two materials and related Care Package are to be facilitated in the beginning of the working phase of therapy, after rapport has been built between the counselor and minor client and before the trauma story/ trauma narrative has been initiated

(Approximately 60 minutes)

**Working Phase of Therapy**

Goals:

- Review Course of Therapy, Confidentiality & Safety
- Discuss Working Phase of Therapy
- Review Trauma Story / Trauma Narrative
- Explore use of Care Package Part Two at home

Objectives

By the end of the session, participants will be able to:

- Understand the difference between initial phases of therapy compared to the working phase of therapy
- Describe the trauma story / trauma narrative
- Explain how the care package is used in the home
Care Package Proposed Contents (Part Two)

- Discussing Child Sexual Abuse with Children Handout
- Thoughts, Feelings & Actions Handout
- Relaxation Exercises Handout

Procedures

1. Course of Therapy, Confidentiality & Safety

- The counselor may begin the psycho-educational session by checking in with the minor client and his/her family, asking how they have been since everyone met together, what their week/day was like, etc.
- The counselor will reiterate the purpose of today’s psycho-educational session and the difference between the joint psycho-educational sessions, (this being the second one, out of three) which will occur one more time (with the parent/non-offending caregiver, minor child and therapist) versus the one on one weekly therapy sessions (with the minor client and therapist).
- The counselor may reiterate that the purpose of the joint session is not to share information the minor client may have disclosed to his or her therapist, but an opportunity to see how the entire family is progressing.
- At this time the counselor may explore with the family what it has been like coming to therapy each week and attempt to gain a sense of how the family and minor client feel about the weekly process (e.g.
safety in the space, relationship with therapist, adequate resources/referrals maintained) and address any concerns or questions the family may have.

2. Working Phase of Therapy

➢ The counselor at this time may explain where the minor client currently is in the course of therapy, the Working Phase. The counselor may briefly explain the stages in therapy based on the below information:
  
  o **Beginning Phase** – Introduction to Therapy, Assessment, Relationship Building, Goal Setting,
  
  o **Working Phase** – Interventions (Coping Skills, Stress Management, Feelings Identification, Trauma Story/Narrative)
  
  o **Evaluation & Reflection Phase** – Reiterating successful skills learned, reflection of progress and termination of counseling

➢ Depending on the rapport/therapeutic relationship between the minor client and the counselor, the counselor may take this time to review the goals the minor client set in therapy, which marks the end of the Beginning Phase and the movement in to the Working Phase

➢ The counselor explains that during the Working Phase of therapy, the minor client practices exploring his/her feelings, talking about how they make him/her feel and act and how to make sense of confusing or overwhelming thoughts and/or emotions. The counselor normalizes that this may be a challenging time for the minor and client and his/her
family as it may bring up feelings/emotions that are uncomfortable/overwhelming but it is important to support the minor client as well as each other. The counselor may reiterate the use of the Self Care Handout in Phase One of the Care Package.

3. The Trauma Narrative / Trauma Story

- Briefly describe what a Trauma Narrative / Trauma Story is and the purpose of its use in therapy. Explain to the minor child and non-offending parent(s)/caregiver(s) that from what we know about working with children whom have been sexually abused, it is helpful to talk about the abuse. The counselor may choose to describe the various mediums and ways of creating a Trauma Narrative / Trauma Story applicable to the child’s age / development.

- The counselor can reiterate support and empowerment through this phase of therapy for the minor client and family and encourage them to voice any concerns and or utilize the information and activities in Care Package Phase One and Care Package Phase Two.

4. Care Package Use at Home

- The counselor may check in with the minor client and family regarding the use of the Care Package information and activities at home.

- The counselor may inquire what information was the most useful, which information was not useful, is their additional information they would like? The counselor may also ask the minor client if he/she
played/used any of the activities at home and reflect on the experience shared by the minor client and/or family members.

5. Closing Psychoeducational Joint Session Two

   a. The counselor may ask if the parents/non-offending caregiver or the minor client has any questions regarding therapy, the care package, etc. before the joint session closes.

Care Package Proposed Contents (Part Two)

- Discussing Child Sexual Abuse with Children Handout
- Thoughts, Feelings & Actions Handout
- Relaxation Exercises Handout
Psycho-Educational Session Three

(Child Client & Non-Offending Parents/Caregiver)

Evaluation & Reflection Phase of Therapy

*Note: Session three materials and related Care Package are to be facilitated in the beginning of the evaluation and reflection phase of therapy, after the topic of completion of therapy has been introduced to the minor client but termination has not yet been initiated.

(Approximately 60 minutes)

Goals:

- Discuss evaluation and reflection phase of therapy
- Review progress of minor client and non-offending parent/caregiver
- Explore use of Care Package throughout therapy
- Review future resources and support system

Objectives:

By the end of the session, participants will be able to:

- Understand the difference between the working phase of therapy compared to the evaluation and reflection phase of therapy
- Discuss progress made in counseling by minor client and non-offending parent/caregiver
- Identify supportive resources to utilize after therapeutic services have terminated
Care Package Proposed Contents (Part Three)

- Survivor of Child Sexual Abuse Handout
- Community Resources Handout
- Family Portrait Activity
- Survival Tool Box Activity

Procedures

1. Evaluation and Reflection Phase of Therapy

   - The counselor may briefly reiterate the three stages of therapy in which the minor client and family have moved successfully through, noting activities and/or interventions used.

   - The counselor at this time may explain the minor client is in the final phase of therapy, the Evaluation and Reflection Phase. The counselor may describe the transition from the Working Phase of Therapy in which the trauma story/narrative was created to the current phase, recognizing the accomplishment the minor client and non-offending parent/caregiver has achieved.

   - This step is important in that it initiates reflection on previous sessions, which creates a foundation for the minor child and parent/non-offending caregiver to further reflect on their progress in the psycho-educational session.

2. Evaluation of Therapeutic Progress
At this time the counselor may begin exploring the progress of the minor child and non-offending parent/caregiver.

It is important for the counselor to site concrete examples and/or related interventions the minor client/non-offending parent/family member have successfully completed as opposed to generalized reflections. This serves several purposes:

i. Allows for the opportunity for the therapist to model appropriate praise and/or self-reflection, reinforcing strengths and progress.

ii. Specific examples of success may increase cohesion between the minor client and non-offending parent/caregiver as a family/supportive unit capable of success upon termination of therapeutic services.

iii. Concrete examples of the family’s progress discussed during the psycho-educational session may be later used in the survival took kit activity the family creates together in Care Package Phase Three.

3. Evaluation of Care Package

Once the minor client and non-offending parent’s/family member’s successes have been explored, the therapist may inquire and/or reflect on the final phase of the care package that would be given in this final psycho-education session.

Furthermore the therapist may briefly reiterate the goal of the care package in order to directly licit feedback related to the effectiveness of
this model. The therapist may ask the minor client or the non-offending parent(s) and/or caregivers how they felt before they participated in a Care Package activity versus after, if they noticed any changes in their feelings before, during or after the care package activity, etc. The important component in the evaluation of the care package is to reinforce instances where positive family cohesion and communication occurred. The therapist may also inquire how the family will continue to spend time together once the care package activities are no longer provided.

4. Future Resources

- After both the client and non-offending parent(s) and/or caregivers have had an opportunity to reflect on the progress made throughout therapy the counselor may inquire how they will continue to progress outside of counseling.
- The counselor may identify coping skills that both the client and/or the caregivers have been successful in using throughout the course of therapy in order to aid in this process.
- At this time the counselor may inquire about any resources the minor client had previously brought up in the beginning of therapy that were positive sources of support. The counselor may facilitate discussion between the minor client and non-offending parent(s) and/or caregivers regarding the role of those supportive resources moving forward after therapy has terminated.

5. Closing Psychoeducational Joint Session Three
➢ The counselor may ask if the parent(s) and/or non-offending caregiver
or the minor client has any questions regarding the termination of
therapy, the care package, etc. before the joint session closes.

Care Package Proposed Contents (Part Three)

➢ Survivor of Child Sexual Abuse Handout
➢ Community Resources Handout
➢ Family Portrait Activity
➢ Survival Tool Box Activity