
IMPROVING THE RESPONSE TO Victims of Child Pornography

Section 5: Clinician Telephone Interviews



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Interview Methods

Purpose

The purpose of the clinician telephone interviews was to identify evidence-supported services and promising practices among mental health practitioners that have worked with child victims and adult survivors of child pornography (CP) production. In addition, we asked about differences in treatment needs, techniques, and challenges presented by victims of child pornography production compared to victims of child sexual abuse in general.

Method

A convenience sample of 40 mental health clinicians with experience providing counseling services within the past 5 years to child victims or adult survivors of CP production completed a telephone interview. Participants were recruited through a section of the Practitioner Online Survey, as well as through email invitations sent by the National Children's Alliance (NCA), members of the study Advisory Board, and professionals from other organizations such as child advocacy and rape crisis centers that had connections to the researchers. In addition, some clinician respondents provided names and contact information for colleagues who worked with victims of CP production and invitations were extended to these clinicians by phone or email. All procedures and instruments were approved by the University of New Hampshire's Institutional Review Board. The interviews lasted approximately 30 minutes and were conducted by one researcher at the Crimes Against Children Research Center who was a trained mental health clinician and also had extensive experience conducting national telephone interviews about sensitive research topics, including child sexual abuse. Responses were entered into a secure web-based data collection system, Qualtrics Research Suite. Interviews were conducted from August 1, 2013, to October 1, 2013.

Sample

The convenience sample of participants was primarily generated through four recruitment methods. First, mental health practitioners who participated in the Practitioner Online Survey were asked to provide contact information if they might be willing to participate in a telephone interview about their experiences treating victims of CP production. Second, directors of the two child advocacy centers (CACs) that participated in recruitment of participants for the parent and child interviews provided the names and contact information for clinicians who had provided counseling for these victims and were willing to participate (no information was collected that would link these clinicians to possible parent or child participants). Third, email invitations were sent to clinicians by the researchers, members of the Advisory Board, and other professionals with connections to the research, especially directors of child

service-related organizations known to have access to mental health clinicians. All email recipients were also encouraged to forward the emails to other clinicians who may have been interested in participating. Fourth, at the end of the clinician interviews, participants were asked to provide the names and contact information for other clinicians who may have provided counseling services to victims of child pornography production. Finally, one additional clinician was identified through the literature search as an author with experience providing counseling to this population and agreed to participate.

Data Collection

The interviewer called or emailed potential participants to arrange for telephone interviews, providing them with an overview of the study and estimated length of time to complete the interview.

The first two telephone interviews were considered pilot interviews and the respondents were asked to offer comments and suggestions. Slight modifications, such as clarifying or rewording questions, were made before completing interviews with the remaining 38 clinicians. Questions were primarily open-ended in nature and clinicians were encouraged to provide as much detail as possible about their experiences, insights, and opinions.

Eligibility

Professionals were eligible to participate in the telephone interviews if they were mental health clinicians who had provided treatment within the past 5 years to victims of child pornography production. There were no restrictions based on the level of education, length of time in the field, or position level of the clinicians, as long as they provided some type of mental health treatment as part of their profession. When professionals questioned whether or not their work would be considered mental health treatment, we provided them with sample questions from the interview and asked if their work experience would provide them with enough information to answer those types of questions. For example, could they provide information about presenting concerns and symptomatology of victims? Could they describe the mental health treatment approaches they used with these clients and the effectiveness of those approaches? In general, professionals needed to have extended contact with victims (i.e. more than just one forensic interview) to be able to answer these questions, so some professionals with more limited experiences were not eligible to participate.

In addition, some clinicians were not sure if their clients' experiences qualified as being victims of CP production. The interviewer clarified that clients could be considered victims whether an abuser created the images of the child or a youth produced sexual images of her- or himself. However, the child had to be personally depicted in the image. There were a few cases where the children had been exposed to child pornography, but not actually photographed, and these cases did not qualify. In addition, clients could be adults at the time of treatment, as long as the images were produced while the client was age 17 or younger. Since it was likely that many clinicians may have not seen the images or may not be familiar with state and federal statutes defining child pornography, there were no restrictions based on

the content of the images (i.e. whether or not the images would legally be considered child pornography). There were also no restrictions based on the context or motivation of the images; a variety of situations would qualify. For example, the images could have been produced by an abuser as part of a child molestation crime, taken and distributed as a form of advertisement in a child sex trafficking crime, or created and shared as part of a romantic relationship between adolescents.

Instrument Design

Before beginning the interview, clinicians were informed that the research was completely voluntary, participation would not impact them or their agencies in any way, and they could skip any questions or stop the interview at any time. They were also informed that responses would be kept confidential, the interviewer would not record any information that could identify them or any victims they might mention, and all responses would be combined and used in reports and presentations. Although there were no anticipated risks or benefits to participating, clinicians were informed that their participation would contribute to knowledge about the victims, their families, and how to help them.

The telephone interview questions were designed specifically for this study and were based on the experiences of the researchers and Advisory Board members and incorporated issues described in other portions of the research (i.e. responses from the parent and child interviews, adult survivor survey, and practitioner online survey). The questions were primarily open-ended and prompted clinicians to describe their experiences, insights, and opinions about various issues.

The interview was divided into the following sections:

- **Preliminary Questions:** This section gathered general information about the clinician's experience as a mental health clinician, such as the type of agency he or she worked for and the number and type of victims of CP production treated in the past five years.
- **Impact of CP Production on Treatment:** This section asked clinicians to describe the process they use, if any, to assess for CP production, as well as any barriers to discussing images with the clinician and the impact of images on treatment in general.
- **Treatment Approaches:** In this section, clinicians were asked to describe the presenting concerns of CP production victims, treatment approaches, treatment outcomes, and whether and how these issues differ from those regarding victims of child sexual abuse in general.
- **Impact of Special Circumstances on Treatment:** This section asked clinicians about their experiences working with victims of CP production whose images were distributed online, or who were unaware of the images at the time they were taken, or who had produced sexual images of themselves. We also asked about differences between working with adult survivors compared to child victims.
- **Legal Involvement:** This section asked clinicians who had provided therapy to clients involved in criminal proceedings how the criminal process impacted victims and what issues this raised in treatment.

- **Training Needs:** In this section, clinicians were asked if they had ever received training specific to providing therapy to victims depicted in CP and, if so, what type of treatment and how they were able to use it with clients. We also asked about additional trainings respondents would find useful, policies specific to treating victims of CP production in clinicians’ agencies, and related questions. Clinicians also were asked about resources they may have found helpful while working with these clients.
- **Conclusion:** In the final section, clinicians were asked what research they think is most needed concerning CP production victims and for names and contact information for other clinicians who might be eligible and willing to participate in an interview.

Data Cleaning and Coding

Data were transferred directly from the online survey software to a data set in SPSS. CCRC researchers cleaned the data and coded open-ended responses. Given the open-ended nature of most questions, many variables were reviewed for general themes rather than distinct coding categories.

Participants

A total of 40 clinicians completed telephone interviews. Four were recruited through the Practitioner Online Survey; eight through the two CACs that participated in the Parent and Child Interview recruitment process and 21 through emails to child service organizations. An additional six clinicians were recruited through other telephone interview participants and one clinician was identified based on an article she authored and when contacted she agreed to participate. Because there is no complete list of individuals who received invitations through the various sources, it is not possible to calculate a response rate. The proportions of participants from each recruitment source, as well as the types of settings they work in and number of years working in the field, are outlined in Table 5-1 below. The largest portion of clinicians reported working for CACs or other multidisciplinary centers (35%), followed by non-profits or community mental health centers (27%) and private practice (23%). The majority of clinicians (95%) had worked as mental health treatment providers for more than five years, with many working in the field for more than 10 years (60%).

Table 5-1. Characteristics of Clinicians Interviewed

Total Completed Clinician Interviews	n = 40 % (n)
<u>Recruitment source</u>	
Practitioner Online Survey	10 (4)
Direct CAC Referrals	20 (8)
Email Invitations	53 (21)
Referrals from Other Clinician Participants	15 (6)
Author/Clinician from Literature Review	3 (1)
<u>Type of work setting</u>	
CAC or other multidisciplinary center	35 (14)
Hospital/medical facility	13 (5)

Non-profit/community mental health center	27 (11)
Private practice	23 (9)
Other	3 (1)
<u>Number of years working as a mental health treatment provider</u>	
One year or less	0 (0)
More than 1 to 3 years	0 (0)
More than 3 to 5 years	5 (2)
More than 5 to 10 years	35 (14)
More than 10 years	60 (24)

Findings from Clinician Telephone Interviews

Executive Summary of Findings

- The majority of clinicians had provided mental health services to 6 or more victims depicted in child pornography in the past five years.
- Close to half of respondents reported that it was standard practice in their agencies to assess for child pornography production in cases of child sexual assault. Some respondents assess for CP production themselves, while in other cases the assessment was done by other professionals, especially forensic interviewers, and respondents had access to those records.
- Most clinicians believed that victims of CP production were different from victims of contact child sexual abuse in terms of presenting concerns and the need for modifications in treatment approaches. Specifically, they were more concerned about others finding out about what happened to them, and they were concerned about who would see the images during criminal proceedings and about possible online distribution.
- While many clinicians saw these cases as unique because of the existence of images, often child pornography production was one element of prolonged and complex child sexual abuse victimization that many times included a perpetrator who was a parent or close family member.
- In clinicians' experience, victims' willingness to disclose the existence of images and to discuss them varied considerably based on factors such as age, cognitive abilities, rapport with clinician, and stage of psychological processing of the victimization. Case-specific characteristics such as relationship with perpetrator also played a role.
- Victims who refused to disclose or discuss images often had reasons, including being unaware that images were created, loyalty to or fear of perpetrators, shame, and needing time to process the abuse they suffered. Clinicians noted that establishing trust and rapport with victims facilitated disclosure.
- Clinicians had seen a considerable number of cases involving youth produced sexual images (i.e., sexual images created by a minor, often self-images, which meet legal definitions of child pornography). Many clinicians described these as raising distinct issues. For example, some youth were victims of sex trafficking; victims were not always sexually abused and some clinicians viewed these victims as responsible for what happened because they created the images.
- Many clinicians had used Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) with their clients depicted in CP, but most had used other treatment approaches, either in addition to TF-CBT or separately, indicating a great deal of variety in the treatment of these clients.
- Responses were split as to whether differences exist in reactions to treatment for victims of child pornography production compared to other child sexual abuse victims. Some clinicians

believed that victims of CP production need longer treatment because they stay in a heightened trauma state for a longer time and have more triggers and ongoing anxiety, which take longer to address.

- The majority of clinicians had provided services to at least one victim whose images were known to be distributed online. Even when online distribution was not confirmed, most reported that clients were fearful of this happening. Most of these clinicians believed that known or possible online distribution presented distinct challenges and exacerbated the clients' emotional difficulties in various ways.
- Most clinicians had provided therapy to a client involved in criminal proceedings against a defendant who created or possessed CP depicting the client. Many reported that criminal proceedings caused distress due to drawn-out and invasive court procedures, which often needed to be mediated by enhanced mental health services.
- Only about one-third of clinicians had received training that addressed providing therapy to child pornography production victims and even fewer knew of resources (e.g., websites, research articles) that specifically addressed this population in a useful way. Most clinicians were not aware of any specific resources for working with these clients that they would recommend to other clinicians.

Overview

A convenience sample of clinicians with experience providing counseling services within the past five years to child victims or adult survivors of CP production completed in depth telephone interviews. We asked clinicians to identify any differences in treatment needs, techniques, and challenges presented by victims depicted in child pornography compared to other child sexual abuse victims. The convenience sample included 40 mental health clinicians who were recruited through a section of the Practitioner Online Survey, as well as through email invitations sent by the National Children's Alliance (NCA), members of the Advisory Board, and professionals from other organizations (child advocacy centers, rape crisis centers, etc.) with connections to the researchers. Findings are based on respondents' generalizations about clients depicted in child pornography, which may not accurately represent clinicians' full experiences. For these reasons, our findings portray only the opinions and experiences of this specific group of respondents and cannot be generalized to other clinicians who have treated this victim population.

Sample Characteristics

The sample of participating clinicians (n=40) included a variety of professional backgrounds. The majority (95%) had worked as mental health treatment providers for more than five years, with many working in the field for more than 10 years (60%) (see Table 5-2). The respondents had provided mental health counseling services in a number of different settings, including child advocacy centers, non-profit centers and private practice.

Table 5-2. Sample Characteristics

	n=40 % (n)
<u>Number of years working as a mental health treatment provider</u>	
One year or less	0 (0)
More than 1 to 3 years	0 (0)
More than 3 to 5 years	5 (2)
More than 5 to 10 years	35 (14)
More than 10 years	60 (24)
<u>Type of work setting</u>	
Child advocacy or other multidisciplinary center	35 (14)
Hospital/medical facility	13 (5)
Non-profit/community mental health center	27 (11)
Private practice	23 (9)
Other setting	3 (1)

Experience with Clients Depicted in Child Pornography

Frequency and Types of Therapy Provided to Victims Depicted in Child Pornography

The majority of respondents had provided therapy within the past five years to at least six clients depicted in child pornography (70%). We asked clinicians, “About how many clients have you had in the past five years who were depicted in child pornography?” Although some respondents had seen only one or two such clients (15%), others estimated that they had provided mental health services to more than 10 such clients (47%). The mean estimated number of clients seen by the respondents was 16.7 and the median was 10. Four clinicians estimated they had seen 35 or more clients. In total, the 40 respondents reported providing therapy to an estimated 668 victims of CP production within the past five years. Most respondents were providing counseling services to clients depicted in CP at the time of the interview (70%) or they had provided services to such clients within the past year (25%).

Virtually all respondents provided individual therapy to these clients (95%), with many also providing family therapy (63%), group therapy (25%), or other forms of therapy (30%) – including crisis management/safety planning and forensic evaluations. Ten percent of participants supervised other clinicians working on these cases.

Characteristics of Clients Depicted in Child Pornography

Most respondents worked only with child or adolescent victims of CP production (75%), 15% had worked with only adult survivors, and 10% had worked with both child victims and adult survivors. A small number specialized in treating victims of sex trafficking. Of the 668 estimated clients treated by the respondents, an estimated 554 were children or adolescents (under age 18) at the time of treatment and an estimated 114 were adult survivors of CP production.

When asked if they had worked with any clients “who created sexual images of themselves or of other minors (whether by their own decision or at the request of a perpetrator),” 80% of respondents indicated they had treated at least one client like this in the past 5 years. Just under half (n=326) of the total number of cases handled by the respondents in the sample involved victims who produced sexual images of themselves. Based on what clinicians told us, it appears these “youth-produced sexual images” cases included young people who produced images for romantic partners or to attract romantic partners, as well cases of images solicited by adult perpetrators or those made to advertise victims in sex trafficking cases.

Professional Environment: Policies and Colleagues’ Views on Child Pornography

We asked respondents, “Do you feel that you have a supervisor or other clinician in your agency or in your area who is knowledgeable about these types of cases and with whom you feel comfortable discussing any issues that arise?” Most (70%) answered yes, but 25% said no and the remaining 5% were unsure.

We also asked respondents, “Does your agency have specific policies or procedures relating to child pornography production? For example, are there procedures specific to these cases that all clinicians are expected or required to follow?” Only 20% of respondents said yes. They described the following types of policies:

- “Restrictions on who can see the images, more on the investigative level rather than the clinical level. They created... best practices, what kinds of things to assess for...”¹⁸
- “In the sense that CP [production] is considered a safety concern, even if there was not hands on abuse... not allowing children who are determined to be perpetrators to be in the same playrooms as the other children. So this is more that [CP production] is not considered an exception to other rules.”
- “If CP is distributed across state lines, it becomes a federal issue... changes how they do the forensic interviews...”
- “Report images as any other child abuse, if this is not already known to police...”

¹⁸ Throughout, some quotations are slightly paraphrased to correct grammar and remove possibly identifying information.

- “All clinicians are required as part of standard protocol to ask about exposure [to CP] or participation in CP [production]”

Only 20% of respondents reported there were “differences of opinion within [their] agency in terms of how to approach these clients.” One referred to differences with law enforcement, stating “Law enforcement criminalizes sexual behaviors, including sexting [i.e., youth-produced sexual images], even when there are many other underlying issues that [I see].” Three respondents noted that some clinicians in their agencies were reluctant to work with victims depicted in CP or differed in how they viewed the importance of the CP production. Several noted different approaches to clients:

- “Many clinicians are reluctant to acknowledge the victim’s role in the crime [referring to cases of youth-produced sexual images]”
- “Treatment approach differences, local treatment center focuses more on brief CBT”
- “...only CBT ... using exposure techniques ... does not work, can actually be damaging if it does not adequately address the issue.”
- Regarding treating adult survivors: “There is a whole group of clinicians that reject the idea of recovered memories, so since the child pornography aspect of these crimes may have been deeply buried and only comes up after extensive therapy, they may not believe it even happened.”

Table 5-3. Experience with Victims Depicted in Child Pornography

	n=40 % (n)
<u>Number of cases of children depicted in CP in Past 5 Years</u>	
One	10 (4)
Two	5 (2)
3 to 5	15 (6)
6 to 10	23 (9)
More than 10	47 (19)
<u>Time passed since clinician last provided therapy for victim depicted in CP</u>	
Currently providing therapy to such a client	70 (28)
1 year or less	25 (10)
More than 1 year to 3 years	0 (0)
More than 3 years to 5 years	5 (2)
<u>Types of treatment (check all that apply)</u>	
Individual Therapy	95 (38)
Group Therapy	25 (10)
Family Therapy	63 (25)
Other (crisis management, forensic evaluations, etc.)	30 (12)
<u>Ages of clients respondents have treated who were depicted in CP</u>	
Children (17 or younger)	75 (30)
Adults (18 or older)	15 (6)

Both children and adults	10 (4)
<u>Respondent handled any cases involving “sexting” (youth-produced images)</u>	
Yes	80 (32)
No	20 (8)
Don’t Know	0 (0)
<u>Clinician has a supervisor or colleague who is knowledgeable about victims depicted in CP</u>	
Yes	70 (28)
No	25 (10)
Don’t Know	5 (2)
<u>Agency has policies or procedures relating to CP</u>	
Yes	20 (8)
No	77 (31)
Don’t Know	3 (1)
<u>Respondents noticed differences in opinion about how to approach CP victims</u>	
Yes	20 (8)
No	60 (24)
Don’t Know	20 (8)

CP = Child Pornography

Assessment, Disclosure, and Presenting Concerns

How Do Clinicians Assess for Child Pornography?

We asked, “In cases of child sexual assault, do you take any steps to determine if the perpetrator took photographs or video of the abuse?” Respondents reported a variety of approaches to assess for depiction in CP among clients who report a history of child sexual abuse (see Table 5-4). Differences emerged depending on many factors, including characteristics of the clients primarily treated (i.e. children/adolescents vs. adults), rules and regulations at the respondents’ agencies, and whether the case involved an investigation by child protective services or law enforcement.

- Close to half of respondents reported that it was standard practice in their agencies to assess for child pornography production in cases of child sexual assault. Some respondents assessed for CP production themselves, while in other cases the assessment was done by other professionals, especially forensic interviewers, and respondents had access to those records.
- About one-quarter of respondents reported that they ask about CP production in some cases of child sexual abuse, but not all, depending on individual circumstances. For example, they may ask follow-up questions about being photographed for CP if others have raised this as a possible concern or if certain “red flags” exist (e.g., the client expresses discomfort being photographed, sex trafficking cases, extensive internet or cell phone use).
- The remaining respondents (about one-third) stated that they do not ask about CP production as part of standard practice.

- Some respondents did not want to cause clients emotional distress by asking such questions
- Some had a less directive style of approaching treatment and preferred to wait for clients to disclose specific information on their own – this was more common among practitioners who treated adult survivors or other clients not involved with child protective services or criminal investigations.
- Others had simply never thought to ask about CP production in a systematic way and, as a result of the interview, were now considering asking about this in future cases.

When Do Victims Disclose Being Depicted in Child Pornography?

When we asked “At what point in treatment do victims of child pornography production generally disclose the existence of images,” respondents reported a wide variety of observations.

- About one-third said it was common for clients to disclose right away or within the first three sessions. However, some respondents stated that some clients who disclosed early were still not comfortable discussing the CP production in detail until after many sessions.
- About one-third of respondents stated that clients almost always take a long time to disclose, waiting until several sessions (or even several months) have passed before disclosing this to the therapist.
 - These respondents noted that children often waited until there was a certain level of rapport between the clinician and client.
 - One clinician related the speed of disclosure to the treatment model used by her agency, stating, “[Our] treatment protocol [is] based on 26 weeks... most trauma narratives happen by 10 weeks, so this is usually when it comes out in the details at this point.”
- The remaining respondents reported a mixture of experiences, with some clients disclosing early and others waiting until later in treatment.

How Willing Are Clients to Talk about the Images?

We asked respondents to describe “what factors, if any, have you noticed that either increase or decrease a client’s willingness to discuss the images?” Many respondents said that basic demographic characteristics, such as the client’s age and gender, had an impact, although respondents differed on how these factors influenced clients’ openness. For example, some respondents said that adolescents were more likely to discuss CP production, as opposed to younger children who may have been confused and unable to articulate what happened. Other respondents indicated that adolescents and adults were less likely to discuss the images, because their better understanding of what happened led them to feel more shame and self-blame. Some respondents noted that adolescents in cases of youth-produced sexual images were more open because they saw their activities as normal.

Other factors reported by the respondents included the clients' intellectual/cognitive abilities, stages of psychological processing of the abuse, and level of trust and rapport with the clinician. Finally, specific case characteristics, such as the victim-perpetrator relationship, whether or not images had been distributed, and whether or not there was an open criminal investigation also played a part in the victim's willingness to speak openly with respondents.

To follow up on this further, we asked "what advice do you have for other clinicians to help their clients to be more comfortable discussing the images in therapy?" Respondents offered a variety of suggestions. Some of the most common suggestions were to focus on building a trusting relationship with the client, adapt all approaches to the individual client's own pace, and destigmatize CP production by telling the client that the therapist is aware of it, willing to talk about it, and able to answer questions the client may have.

- "It is all [about] the rapport you have with the client, similar to anything else sensitive in nature."
- "They need to be ready and feel comfortable."
- "Being up front and honest with them, making it so that they can ask you the hard questions."
- "Talking about the dynamics of sexual abuse and what [it] looks like, it's not only touching, it involves so many other forms. Say 'this is what we know' ... put it out there and let them express it..."
- "Normalize it. Start off conversations by saying something like 'a lot of times people in your situation have had pictures taken.'"

How Does the Victim-Perpetrator Relationship Impact Clients?

Almost all respondents indicated that these cases involved victims with close relationships to perpetrators. In this respect, relationship dynamics between victims and perpetrators were similar to those of child sexual abuse cases not involving CP production. Close relationships with perpetrators impacted victims, and therefore impacted treatment, in a variety of ways and respondents found many different ways to address the challenges presented by these complex relationships.

In general, there were three types of perpetrator/victim relationships that respondents mentioned: 1) parents and close family members; 2) trusted family friends, acquaintances, or authority figures; and 3) romantic partners.

According to respondents, in cases where the perpetrator was a parent or a close family member, the abuse tended to result in many complicated feelings including betrayal, confusion, and a sense of loss and grieving.

- “[Victims] often try to hold on to the positive feelings [about] parents, but have to face that their parents did terrible things or allowed terrible things to happen. Many attachment issues result from these cases.”
- “[You] have to address it head on and let them grieve. A lot of people don’t seem to understand that kids often love their perpetrators and the loss of that person is something they need to grieve. Even if [they are] grieving the idealized person, they are still experiencing that loss.”

Many respondents spoke about the impact on the family as a whole in these situations, as non-offending family members may react in ways that can further impact the victim.

- “All the family pictures had to come down in the house... it was very difficult, because the reminders were constantly around... holidays, family relationships... siblings did not understand. A bunch of family members needed therapy.”

Respondent clinicians handled these cases in a variety of ways. Many emphasized the importance of psychoeducation for both the client and family regarding grooming processes often used by perpetrators. Respondents also described normalizing certain feelings that the client and family members may have, such as self-blame or conflicted feelings about the perpetrator.

- “Psychoeducation, talking about that most sexual abuse is within the family, that perpetrators manipulate people and use opportunities like this to sexually abuse people.”
- “Sometimes adults struggle with being able to fully understand that children are able to separate the abuser versus the person they love in the life, [they] can still have feelings toward that person. That person may have been the one person who showed interest in them, said they were pretty, smart... have to educate about the grooming, manipulation... It is up to the child to decide what feelings they want to have for that person.”

In other cases, the perpetrators were trusted family friends or authority figures such as teachers or coaches. Many themes emerged that were similar to abuse by family members and respondents tended to handle them in similar ways.

- “One in particular was a teacher... that was a very big issue. [The victim] viewed him as her mentor, had a hard time assigning blame, putting the right focus on him as the adult. She loved him in her own way. [This was addressed through] a process of going through and assigning appropriate blame on the perpetrator...”

Romantic relationships between minors or between a minor and an adult were also involved in these cases. Some cases involved adult sex offenders who met victims online; others involved acquaintances who seduced underage victims. In some cases there was legal sexual contact between two minors and in other cases an adult had sex with a youth who had reached the age of consent, but the production of images was illegal. Also, several respondents had worked with victims of sex trafficking and, according to

respondents, these youth often felt a certain level of attachment to their pimps, which differed from other relationships in terms of unique elements of power and control. In these cases, the production of images may have been secondary to other forms of sexual exploitation (i.e., prostitution), but some respondents described how the images added another form of control over the victims, such as when pimps threatened to show these images to victims' family members. One of the biggest issues in romantic relationships, according to respondents, tended to be the difficulty in showing these clients how the relationships they viewed as loving and voluntary were actually exploitive. Many respondents felt that it was important to find out the reason for a client's decision to engage in these relationships and then address the topics of self-esteem and safe boundaries in relationships. Once clients understood the manipulative nature of these relationships, many respondents also emphasized the importance of addressing possible feelings of self-blame and responsibility for producing the images or willingly engaging in other aspects of the crime.

What Are the Presenting Concerns for Clients Depicted in Child Pornography?

Eighty percent of respondents answered yes when we asked, "Have you noticed any differences in presenting concerns for victims of child pornography production compared to victims of other child sexual abuse?" All of the clinicians who had treated ten or more victims answered yes to this question. Many said that victims of CP production tended to be less willing to discuss the abuse due to higher levels of secrecy and difficulty trusting others. Others stated that CP production victims tend to present with more severe symptoms, especially anxiety and self-destructive behaviors (suicidal ideation, substance abuse, etc.), possibly related to the higher levels of shame, embarrassment, and self-blame. Respondents also reported that victims of CP production were more concerned about other people finding out about what happened, especially that others would see the images (both now and in the future), and many respondents believed there was a greater likelihood of the client experiencing re-traumatizing triggers (i.e. media reports on the case, etc.).

Cases of Youth-Produced Sexual Images

We also specifically asked respondents how clients who had created images of themselves may or may not differ in terms of presenting concerns. In these cases, respondents sometimes reported similar client concerns (embarrassment, concern over who would see the images, feelings of shame and responsibility, etc.), especially when clients had been tricked or coerced into producing the images or blackmail was involved. However, in cases of youth-produced sexual images without such aggravating elements, respondents often noted that clients showed lower levels of trauma due to the belief that their behavior was socially acceptable and normal. However, respondents also noted that these clients tended to have other underlying issues, such as unsupportive families. Many respondents emphasized the need to explore why the clients had participated in creating sexual images of themselves, such as peer pressure, pressure from a romantic partner, low self-esteem, or past sexual victimizations that impacted their ability to practice healthy boundaries in relationships. In these cases, presenting

concerns tended to be exacerbated if the images were distributed beyond the client’s control or the client experienced other negative consequences, such as bullying by peers.

Adult Survivors

We also asked respondents who had treated adult survivors to compare these clients to child victims in terms of their presenting concerns. Very few respondents had treated both children and adults, so only a few respondents (n=4) could make comparisons. Some respondents felt like adults presented with more severe trauma symptoms than children due to going so many years without help. Other respondents felt like adults presented with fewer concerns than children and adolescents. In particular, they reported that adult clients were less fearful of images being distributed, since most had been produced before the advent of digital technology, or they were less worried about being recognized, since their current appearances differed so much from how they looked at the time the images were taken. In addition, some respondents reported that adult clients were more prepared for treatment in terms of having clear goals and the cognitive abilities to process the trauma in a meaningful way.

Table 5-4. Assessment, Disclosure, and Presenting Concerns of Victims Depicted in CP

	n = 40 % (n)
<u>How does clinician assess for CP?</u>	
Standardized assessment by clinician	20 (8)
Standardized assessment by someone else (i.e. forensic interviewer)	23 (9)
Informal assessment, depends on situation	27 (11)
No assessment for CP	30 (12)
<u>When do victims disclose CP to respondents?</u>	
Before therapy starts (during forensic interview, on referral, etc.)	13 (5)
Early in treatment – within 3 sessions	23 (9)
Later in treatment – after 4 or more sessions	37 (15)
Mixed – some disclose early and others do not disclose until later	27 (11)
<u>Respondents noticed differences in presenting concerns for victims of CP production</u>	
Yes	80 (32)
No	20 (8)
Don’t Know	0 (0)

CP = Child Pornography

Treatment Approaches, Modifications, and Outcomes

How Are Clinicians Approaching Treatment for These Clients?

We asked respondents, “What types of treatment approaches have you found to work particularly well with children who have been depicted in child pornography?” None of the respondents knew of any

treatment techniques specifically designed for this population, so most used or modified methods used with other clients. Most reported using more than one treatment approach, often saying they found eclectic approaches to be more effective with this population given the complexity of the cases. However, the majority of respondents used at least one standardized method (in its entirety or select elements), meaning they had been trained in this particular approach and the approach had a clear theoretical orientation and guidelines for treatment. Only 5% of respondents did not identify any standardized treatment approaches they had used with these clients.

Respondents used the following treatment approaches:

- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) – Almost 60%
- Eye Movement Desensitization and Reprocessing (EMDR) – Almost one-third
- Play therapy (both directive & non-directive methods) – About one-quarter
- Expressive therapies (especially art therapy) – About one-quarter
- Other cognitive and/or behavioral approaches (not trauma-focused) – Almost one-quarter
- Dialectical Behavioral Therapy (DBT) – Almost 10%
- Other standardized approaches or models not specified above – Almost one-third
- No standardized approaches (informal “talk therapy,” psychoeducation, etc.) – 5% (n = 2)

The most common standardized treatment approach reported by respondents was Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). They often used this approach in conjunction with elements from other treatment approaches. Some respondents reported that their agencies or clients’ insurance companies required the use of evidence-based practices, which specifically included TF-CBT. Despite the wide use of this approach among respondents, 90% used other approaches either in addition to TF-CBT or independently; only 10% used TF-CBT exclusively.

Respondents also described informal ways of approaching treatment for these clients, which they often combined with standardized approaches. Many respondents discussed the need to first ensure the client’s safety. This often meant making sure children were in non-abusive home environments and helping clients to achieve emotional control, especially when they presented with acute issues like self-harm and suicidal ideation. Respondents often emphasized the importance of psychoeducation for victims depicted in CP, both in terms of child pornography in particular and sexual abuse in general. They believed that clients were reassured by hearing that they were not alone and this process of “normalizing” or “destigmatizing” was helpful, especially in terms of reducing guilt and self-blame. Most respondents described helping clients develop coping skills, many of which were based on standardized treatments (especially CBT) but were adapted to the individual client, such as identifying emotions, journaling, and finding safe people in their lives to turn to for support. A common theme was also the importance of involving family members, especially caregivers, in the client’s treatment.

We also asked respondents, “What modifications, if any, do child pornography cases require compared to how you use these treatment approaches with other clients?” Many indicated that they had made

some modifications to treatment; however, many emphasized that they make modifications to treatment in all of their cases based on the characteristics of each client. Respondents reported:

- Some of these modifications were related to the way in which treatment was approached, not content.
 - “Pacing is different, making sure not to do too much too fast.”
 - “Most of them will need to require some type of long term counseling and getting the family involved more...”
- Other respondents said they added specific elements to treatment.
 - “More activities directed toward concerns over lack of control over the images.”
 - “Consider the photographs to be an additional trauma, pull that together in the narrative.”
 - “More internet safety discussions and parent education in these cases.”
- Others purposely omitted certain treatment elements with these clients.
 - “Some are phobic of hypnosis due to techniques used during their abuse, so can’t use hypnotherapy. Some are phobic of cameras/recording devices, so [I] can’t record therapy or use this type of technology as part of treatment or [I] have to do [it] in a very controlled way.”

To gain a better understanding of the rationale for certain treatment approaches and modifications, we asked respondents, “What factors do you consider when choosing a treatment approach for these victims?” Most based methods on presenting symptoms, for example, respondents used trauma-focused methods when victims presented with trauma symptoms. However, respondents noted other factors, for example:

- If clients had been in treatment before, respondents reviewed treatment histories for information about what treatments had worked or not worked.
- For some respondents, a client’s age and cognitive ability influenced whether they used TF-CBT, although one cited TF-CBT as working better with younger children and another said she chose to only use it with children over 12.
- In some cases, respondents noted that the client needed to be stabilized and in a safe environment before proceeding to more in-depth treatment. One example of this was in cases where clients were still involved in sex trafficking.
- Several also mentioned the level of family involvement as an important factor.

Cases of Youth-Produced Sexual Images

We also asked respondents who had worked with youth who produced images of themselves if treatment approaches differed for these clients. Some respondents viewed these clients as primarily victims, especially when the client had been tricked or coerced, situations got “out of control” and the

client was experiencing many negative consequences, or when the client had a history of other forms of abuse. In these cases, treatment approaches tended to be similar to those used with other CP production victims (TF-CBT, EMDR, expressive therapies, etc.). However, many respondents thought that the clients in cases of youth-produced sexual images had at least some responsibility for what happened. In many situations, youth did not understand that they had done something wrong and some youth were adamant that they should be able to decide what to do with their own bodies. In these situations, respondents tended to use much more psychoeducation about internet/cell phone safety and the consequences of images, as well as working on building self-esteem and setting healthy boundaries. Respondents often also indicated that involving caregivers in treatment was especially necessary in these cases, since adults often knew little about how to supervise their children and set limits on technology use. A few respondents noted that group settings were most effective in these cases, since youth were more likely to listen to peers who had experienced negative consequences as a result of youth-produced images. Despite their best attempts, some respondents admitted that they were still struggling to find a good treatment approach for these clients. Overall, many respondents felt like the best way to respond to adolescents in these cases is through prevention efforts, which is why many respondents routinely had conversations with clients and their caregivers about internet safety and healthy boundaries, even if the clients had not created images of themselves.

How Do Victims of Child Pornography Production Respond to Treatment?

Respondents were also asked, “Have you noticed any differences in reactions to treatment for victims of child pornography production compared to victims of other child sexual abuse?” Forty-seven percent of respondents believed that differences did exist, 43% did not see significant differences, and the remaining 10% were unsure. When respondents did notice differences, they mentioned the following:

- “[It’s] more of a challenge in helping them transition from victim to survivor. They stay in that heightened trauma state for a longer time.”
- “[I] tend to see them for the same amount of time initially, but find that they come back to [me] more frequently... they tend to be triggered more, so [they] end up back in therapy more often.”
- “Treatment outcomes are a lot poorer... having the pictures and images out there and knowing that anyone can get them contributes to ongoing anxiety that is hard to address.”
- “Generally takes longer, more complicated... shame is pervasive and [there is a] terrible fear of exposure of the images... [clients] worry that they can never have this gone...”

We also asked respondents, “do treatment outcomes differ between clients depending on how and when they disclose the existence of images?” About one-third felt like treatment outcomes differed. Most of these thought that outcomes tended to be better for clients making early disclosures because this allowed more time for clinicians to work with clients on issues related to the images. However, a few felt that early disclosure led to worse outcomes, usually because early disclosure tended to be associated with poorer emotional regulation and worse coping mechanisms.

About one-third felt like there was no difference depending on the timing or context of disclosure. Some did not see any distinct patterns between disclosure and treatment outcomes. Others felt that treatment outcomes were dependent on individual client factors, not related to when the existence of images was disclosed. About one-third did not feel like they could speak to this, due to having a limited number of clients or the fact that all of their clients tended to disclose in the same way and there was no point of comparison.

One or two respondents commented that outcomes tended to differ based on the extent of control clients had over disclosure of images (i.e. if they disclosed willingly versus being “found out” due to images being discovered). These respondents tended to believe that clients who disclosed at their own pace showed better emotional regulation and were more prepared to process the trauma. In a small number of cases, respondents described how clients were found out due to images being uncovered by others (family members, police, etc.); respondents believed that these clients were less prepared for counseling and outcomes tended to be worse.

How Involved Are the Families of Children Depicted in Child Pornography?

We also asked, “Are there any issues that come up when non-offending caregivers or other family members are involved in the treatment of child pornography victims? Do these challenges differ from the involvement of caregivers in other child sexual abuse cases?” Many respondents reported that the issues were similar to other child sexual abuse crimes. However, some noted the need to educate caregivers about CP production and internet/cell phone safety in cases where adults knew far less about technology than their children. Several respondents mentioned they also had to teach parents that cameras and family picture-taking can be triggers in these cases. Some respondents had had cases where parents presented with a great deal of anxiety about how this crime would impact their children in the future, sometimes to a greater extent than the children. Others had seen cases where parents minimized the importance of images, but one respondent noted that parents are less likely to deny abuse when images exist.

We also asked what advice clinicians would give to other clinicians “regarding the involvement of parents and family members in the course of therapy for victims of child pornography production?” Most respondents did not have advice specific to CP production cases. Those who did advised: a) educating parents about internet and cell phones; b) emphasizing safety rather than morality when talking to parents about images; c) connecting parents with services, especially when there is a criminal court case; and d) validating children’s fears about others seeing images. One respondent said that, when victim notification laws apply, clinicians should discuss the implications of this with the parents and victims early on to prepare the child to decide on notification when she or he turns 18.

Table 5-5. Treatment Approaches, Modifications, and Outcomes

	n = 40 % (n)
<u>Treatment approaches used by respondents (check all that apply)</u>	
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)	57 (23)
Eye Movement Desensitization and Reprocessing (EMDR)	30 (12)
Play therapy (both directive & non-directive methods)	25 (10)
Expressive therapies (especially art therapy)	25 (10)
Other cognitive and/or behavioral approaches (not trauma-focused)	23 (9)
Dialectical Behavioral Therapy (DBT)	7 (4)
Other standardized approaches or models not specified above	33 (13)
No standardized approaches, informal treatment only	5 (2)
<u>Respondents made modifications to treatment approaches for CP victims</u>	
Yes	73 (29)
No	27 (11)
Don't Know	0 (0)
<u>Noticed differences in reactions to treatment for victims of CP production</u>	
Yes	47 (19)
No	43 (17)
Don't Know	10 (4)
<u>Respondents noticed differences in treatment outcomes depending on how and when clients disclose CP images</u>	
No difference	30 (12)
Yes, early disclosure leads to better outcomes	33 (13)
Yes, early disclosure leads to worse outcomes	5 (2)
Don't Know	33 (13)

CP = Child Pornography

Special Circumstances for Respondents and Clients in CP Production Cases

Distribution of Images

The majority of respondents (75%) reported that they had handled at least one case in which CP images of the victim were distributed online. Another 20% did not know if images had been distributed in any of their cases and only 5% indicated that they had never handled a case in which images were distributed online. However, it is important to note that even respondents who reported handling one or more cases involving online distribution usually had many other cases that did not involve distribution, so the actual portion of cases involving distribution may be relatively small. Although we did not ask respondents directly about the context in which images were distributed online, many mentioned the various ways, ranging from limited distribution (i.e. between romantic partners) to widespread online distribution across networks of perpetrators interested in child pornography.

Even when distribution was not confirmed, or the images were only thought to be distributed to a small number of people, some respondents said their clients still feared wide distribution.

- “Mostly just distributed to intended recipients... no confirmed incidents where it got out to a wider audience, but this is something the teens worry about a great deal...”
- “Most people seem to jump to the idea that they could be out there, especially if done digitally.”

Some respondents felt like the impact of distribution depended on victims’ ability to comprehend the implications. In particular, many felt like younger children did not fully grasp the concept of images being permanent and available to others.

- “Distribution impact depends on the age of the child; young children don’t understand the full extent of the distribution, while a teenager does have that knowledge.”
- “For the younger clients, they don’t comprehend the long-term, the pictures are out there, no getting them back. But for the teenage clients, this is a real concern for them.”

However, in these cases some respondents said the parents tended to show anxiety about distribution and feared that people they knew would find out what happened or the images would resurface and impact the children later in life.

- “A lot of concern from the parents... about images coming up later, other people finding out.”

Many respondents described how victims worry that people they know will see the images and some described how their clients had already experienced social repercussions when friends and community members found out what happened. In some cases, respondents reported that their clients became less social due to harassment or fear of being recognized, while one respondent felt like her clients in these situations become more reckless.

- “A lot of concern about others seeing the pictures, all over the news, impacted socially, didn’t want to go out in public, didn’t want to go to school, got in more fights because felt like people targeted her.”
- “So much peer harassment once it gets out there. They are in a rural area, so it makes it difficult for the children to go to school, out in the community... much, much worse.”
- “[These clients] become more reckless, throw caution to the wind, feel like they’re doomed already.”

Related to this, respondents described a mix of client fears, with some worrying about how friends and family will react in the present, others worrying that the images will surface in the future, and some worrying about both the present and future.

Many respondents reported that clients had much more difficulty establishing closure in distribution cases, both because images might be seen by others and because these cases tended to be more widely publicized by the media and sometimes involved prolonged court involvement, providing more frequent triggers for symptoms.

- “...just the ongoing knowledge that whatever is out on the web, no matter how much you try to get them off the web, you can’t. Kids are technologically savvy, so they know this. [Online distribution] presents a big challenge when kids feel like they can’t move on...”
- “The whole piece of it not being finished, not being able to put it in a little box and put it aside, the lid is always open, they have to figure out a way to deal with that.”
- “There is more closure when the images are not distributed. [Clients] can just think about who may have seen the hard copies of the photographs. The people, other than the perpetrator, did not seek it out for sexual purposes, so that is easier to get closure from. Online distribution makes it much harder to get closure.”

Victims Unaware of Images at the Time of Production

Forty-seven percent of respondents had handled at least one case where a client was unaware of the images at the time they were produced, but found out about them later. In most cases, the victims were unaware due to their young age or being unconscious or intoxicated at the time the images were created. For the young victims, they may still have been unaware by the time of treatment, making it difficult for respondents to determine how this will impact them in the future. For the older children, adolescents, and adults, finding out about the images effected them in a variety of ways.

- Some clients were not aware of the images until police contacted them as part of the investigation.
- Others found out through friends or family members who discovered the images.
- Some clients had forgotten, blocked out the memories, or did not understand what happened until later in adulthood when memories resurfaced, either in therapy or due to some type of trigger.
 - In one case, the client did not realize until coming across the photographs later in life that the images were sexual in nature (close-up images of his clothed genitals while he was playing). At the time the images were taken, he thought the perpetrator was taking normal photographs.
 - In two cases from different respondents, the clients recalled seeing a blinking red light while being sexually abused, but did not make the connection that this was a recording device until they were older.

Some clients felt betrayed by the person who had created the images and presented with shock, disbelief, and difficulty trusting others. Trust issues were especially noticeable in cases where other

people (parents, police, etc.) knew about the images, but waited a significant length of time before informing the client. However, respondents stated these clients usually experienced less self-blame and guilt, since they could not have known about the images or done anything to stop the crime. Other clients, especially those who were intoxicated when the pictures were taken, felt a great deal of self-blame for allowing themselves to be in a situation where something like that could happen.

Ethical Issues When Clinicians Know More about the Images than Clients and Families

We asked respondents, “Have there been any situations where you were aware of an aspect of the child pornography crime that your client was not aware of (such as distribution of the images)? What were the ethical implications in terms of addressing this with your client and how did you handle this situation?” About half of respondents reported that they had been in a situation such as this. They described two main situations that involved this dilemma, which they handled in many different ways. One situation was when and how to disclose the CP production to victims in cases of very young children who did not appear to know about or remember images being produced. In many of these cases, the clinicians worked collaboratively with the parents to tell the children during the course of therapy or advised parents on how to tell their children about the images in the future. The second situation was that, in a small number of cases, parents did not wish to tell their children about the images. Some respondents did not agree with this, but felt they had to respect parents’ wishes; even so, these respondents sometimes tried to find ways to tell the child or attempted to work with parents to change their attitudes and avoid perpetuating a family secret. Only one clinician agreed with parents in a case that it would be too traumatic to tell the child about the images. One clinician described the importance of teaching clients coping skills before telling them about the images.

In a small number of cases, respondents were privy to more information about the images than the client and family, such as specific forensic evidence, especially when the respondents worked in multidisciplinary agencies. These respondents generally deferred to law enforcement and prosecutors’ wishes about what to disclose to their clients and families.

Court Involvement

Most respondents (80%, n = 32) had handled at least one case in which a client was involved in criminal proceedings against an individual who produced or possessed child pornography depicting the client. Of these 32 respondents, only five described the court process as being a positive experience for the client, in which clients felt like they had a chance to tell their story, experienced a sense of justice when perpetrators were held accountable for their crimes, and felt relief and a certain degree of closure once the case ended.

- “Can be positive, can feel like their story was told, have the benefit of doing a victim statement, there is a therapeutic part of feeling like it has been resolved in some way, usually don't have to

be in court personally (more video, impact statement, etc.), so not as hard as having to testify. Outcomes tend to be better (more likely to convict), because the evidence is right there.”

- “A lot of them felt like it was their opportunity to confront and talk about [what happened]. The fact that evidence existed seemed to make it somewhat easier, because there was proof, more validation.
- “Once the proceedings are done, there is relief, but also reorganization that needs to go on, because so much energy went into keeping it together.”

Five respondents were unsure of how the court process impacted the victim, usually because it was still early in the case or the clinician did not have much involvement in the court process.

The remaining 22 respondents reported that their clients had negative experiences with the court process. In general, the cases involved charges against the producer of the images, primarily related to contact sexual abuse rather than CP production in particular. Most respondents had not provided therapy to clients involved in prosecutions of people in possession of their images. Because of this, the negative court experiences may be similar to cases involving other forms of child sexual abuse, rather than distinct issues related to child pornography production cases.

Respondents reported that the victims felt a great deal of anxiety related to testifying, either because they were uncertain about what the process would be or they were fearful of facing their abusers and being questioned by attorneys. Many respondents reported that their clients were involved in long, drawn-out court proceedings, some lasting for years, which prolonged feelings of victimization, frustration, and lack of closure for the victims and their families. Many respondents also reported that court proceedings presented more opportunities for the triggering of trauma symptoms, such as victims having to describe the events multiple times or being the subject of media stories that made them feel exposed and vulnerable. Clinicians described the following impacts on clients:

- “[Court involvement] tends to result in higher anxiety; older kids seem to be even more anxious, because they understand how big a deal this is.”
- “Having to relive it, [the client] felt guilty, didn’t want to tell the whole truth because didn’t want Dad to get in trouble... [The client] started acting out in other ways, couldn’t interact with other teens because they would harass her after seeing things on the news.”
- “Victims and families may feel alienated; [there’s] no closure, especially when the case does not move forward as they would like.”
- “Because the legal system drags things out, the rights of the defendant, the process itself, it seemed to make it harder to resolve feelings and recover when the situation is basically continuing.”

The roles of respondents throughout clients’ criminal proceedings varied a great deal. Some respondents took a very active role, helping clients to prepare for testifying in court, teaching specific

coping techniques to control anxiety, or even accompanying the clients to proceedings. Other respondents referred their clients to court advocates or other professionals, so they were less involved in the court process. Some respondents even reported that they were not allowed to discuss court issues with clients, since this could be seen as leading the victim and could compromise the case. Most respondents, regardless of the extent of their involvement in the court case itself, did report a rise in clients' symptoms, so that clients needed enhanced emotional support while going through the court process.

Some respondents noted that criminal justice professionals did not always consider how traumatic it can be for victims to recall the details of what happened. One respondent made the following statement:

- “Therapy and the legal system want the opposite things from the victim. Therapists want to slowly work on this, find out what it means and how it impacts the victim, but authorities are more focused on finding out exactly what happened, even though this could be very triggering and retraumatizing, so that they can find and prosecute the perpetrator. Clients often feel like ‘collateral damage’ in these cases – it’s not about them so much as about the perpetrator.”

Table 5-6. Special Circumstances in CP Cases

	n = 40 % (n)
<u>Provided therapy to CP victim whose images were distributed online</u>	
Yes	75 (30)
No	5 (2)
Don't Know	20 (8)
<u>Had cases where victim was unaware of images at the time they were taken, but found out later</u>	
Yes	47 (19)
No	43 (17)
Don't Know	10 (4)
<u>Respondents knew more about CP images/case than clients</u>	
Yes	50 (20)
No	50 (20)
Don't Know	0 (0)
<u>Provide therapy to a client involved in criminal proceedings against an individual who created or possessed CP depicting the client</u>	
Yes	80 (32)
No	15 (6)
Don't Know	5 (2)
<u>Respondents' perceptions of the impact of court proceedings on victims</u>	
Mostly positive	13(5)
Mostly negative	55 (22)
Don't Know	13 (5)
Missing (Only asked if respondent answered yes to previous question)	20 (8)

CP = Child Pornography

Personal and Professional Reactions to Working with Victims of CP Production

Are Clinicians Always Comfortable Discussing Images with Clients?

We asked respondents, “Have there been any times when you felt uncomfortable discussing child pornography images with your client(s)? Could you describe what happened and why it felt uncomfortable?” Many respondents had instances when they felt uncomfortable. Usually they described cases early in their careers when they had less experience or discomfort regarding specific cases that were particularly disturbing. Others expressed discomfort due to uncertainty either stemming from a lack of necessary information about a case (such as whether or not images had been distributed) or uncertainty about how the client would react when the clinician brought up this topic in therapy. Importantly, virtually all respondents stated that they had found a way to deal with their discomfort without adversely impacting the client. Some examples of uncomfortable situations included the following:

- “One client in particular really affected [me]. It was very graphic, detailed... so that made it very hard, hard to believe something like that could happen to a child by someone so close to them... Knowing that you’re helping in the healing process helps.”
- “[I was] not uncomfortable while in there with the child, more uncomfortable when thinking about it in preparation, how will [I] approach this and deal with this?”
- “[It is] hardest if [I] only have ‘half information’ – knowledge that there were images, but no discussion from the referral source about more details of the case, which is often an issue with ongoing investigations.”
- “Definitely, [it can be] very uncomfortable and painful, even though [I] didn’t have to view [the images], thinking of what it was like for [the client]. Just hearing it described was very awful. [I] discussed [the case] in supervision a lot.”

What Are the Personal and Professional Challenges for Clinicians in These Cases?

We asked respondents, “What personal or professional challenges, if any, do these cases present for you as a treatment provider? Do these challenges differ from the impact of other child sexual abuse cases?” Many respondents felt like these cases were challenging, but not necessarily due to the images in particular. For example some cases were challenging due to the severe nature of the abuse as a whole, while others were challenging due to unsupportive family members. However, some respondents did feel as though the existence of images made these cases more difficult.

- “It is different because it is so visible. Even though [I] don’t see the images, [I] can imagine it and [I] can only imagine how traumatized the children are, the posing, the shame that comes with it.”

One of the most common responses was that the existence of images made the experience harder for victims, which in turn made treatment harder for the clinicians. In particular, respondents found it much more challenging to help clients fully process and move past the trauma when images were online.

- “The biggest challenge is that closure is difficult. No matter how horrendous hands-on abuse can be, they can at least know who the perpetrator is and that it is over. The huge challenge with these cases is that the images are online and can never be stopped. [You] just have to help [clients] get things as normal as possible, but the reality is that you can only go so far, [the crime] can never completely be over.”

Other respondents reported challenges related to mandatory reporting laws, especially in cases of youth-produced sexual images, as well as issues related to court involvement in CP production cases, which respondents believed tended to be more complicated and took longer to resolve.

- “One of the things is that in [youth-produced images] cases, there is always that question of, ‘do we report? Do we not report?’ It is a really fuzzy area... [My] big challenges if that [I] know it is wrong and illegal, but do [I] risk damaging the relationship by reporting?”
- “This specific case brought up new issues due to requiring testimony in court. [It] has become a really large case with a lot of court involvement. [It] requires [me] to step out of bounds from normal [therapy]. [It] took a longer period of time for law enforcement to process the case.”

Table 5-7. Respondents’ Reactions to Working with CP Victims

	n = 40 % (n)
<u>Clinician has been uncomfortable discussing CP images with clients</u>	
No, never	30 (12)
Yes, but only early in career/not recently	27 (11)
Yes, recently	43 (17)
<u>Clinician has noticed personal or professional challenges in CP cases that differ from other child sexual abuse cases</u>	
Yes, challenges differ when images are involved	63 (25)
No different challenges or the challenges in these cases are related to other factors besides images (i.e. family support)	37 (15)

CP = Child Pornography

What Resources Exist and What Do Respondents Most Need to Treat Victims of CP Production?

Have Clinicians Received Training on How to Provide Therapy to These Victims?

One-third of respondents had “received any training specific to providing therapy to victims depicted in child pornography.” We asked those respondents to describe the training they received. Most described training segments of broader programs that addressed topics such as child abuse, sexual trauma, sex trafficking, or internet-related victims. We also asked respondents, “How helpful have these trainings been? Have you been able to use the techniques you learned while providing therapy to your clients?” Several found trainings pertaining to the law enforcement and technology aspects of child pornography production and distribution especially helpful.

- “The trainings that have been most helpful are understanding the legal process, technology, ways to communicate with the kids. Other emotional issues are more universal across CSA [child sexual abuse] cases.”
- “Having an understanding on how it works, how the CP works, the ICAC program, how the internet works. Passing info on to the families and own understanding.”
- “Very helpful. Just in general, it makes you a little more mindful that those things are out there and you need to be assessing these things... incorporate [it] into TF-CBT trauma narrative. One of the things that was most helpful was training with the police department about how they go about identifying these children ...”

Are Clinicians Able to Access Helpful Resources While Providing Therapy to These Clients?

We told respondents, “We’re interested in finding out about resources specific to providing therapy to victims of child pornography production.” Then we asked, “What resources (trainings, websites, research articles, or treatment handbooks) have you used?”

- About half of respondents had not found any materials that they found helpful. In some cases, the respondents had not looked, but many had looked and were unable to find anything helpful available.
- About one-third had found information that was related to CP production, but the respondents said the information was helpful only in general sense. These were often trainings or resources that clinicians tried to adapt to use with victims depicted in CP. Examples included:
 - Resources on internet-related crimes against children in general
 - Trainings on treating victims of child sexual abuse in general
 - Trainings on sex trafficking

- About 20% of respondents had found materials that specifically addressed CP production and were helpful while treating victims. Examples included:
 - Conference presentations by researchers or clinicians who had worked with victims of CP production
 - Articles on CP production (e.g. prevalence, perpetrators)
 - Internal best practice models that had been developed based on the anecdotal experiences of select agencies' staff members.

What Types of Trainings and Research Would Clinicians Like to See?

We asked all respondents, “What types of (additional) trainings, if any, do you think would be helpful for you to provide better treatment to clients depicted in child pornography?” We also asked, “What research do you think is most needed concerning victims of child pornography production?” Virtually all respondents agreed that they could benefit from specific trainings on how to treat victims depicted in CP and most identified specific topics that they would like to see addressed in these potential trainings. Research and training requests were highly related; respondents usually wanted trainings informed by research findings as well as clinical experience.

Respondents often wanted to see more research and trainings on characteristics of victims and risk factors for CP production victimization. They felt like this information would help them to know what to look for in terms of identifying clients who may have been depicted in CP or are at higher risk. Related to this, many respondents wanted more training on how to assess for CP production.

- “...facts about how common it is, the types of pornography, how victims are pulled into the world of pornography...”
- “...something in regards to signs victims may show.”
- “...more trainings on how to assess this, becoming comfortable asking children and families about this and asking correctly.”

For both training and research, the most common request was for information about treatment approaches. Respondents were curious to see what approaches other respondents are using and they were especially interested to learn what treatment approaches were most effective and how to go about using those approaches with CP victims.

- “More evidence-based treatments, what is available that can lend some treatment options for therapists, beyond TF-CBT, especially with difficult clients when other approaches aren't working.”
- “Evidence-based or other commonly used approaches for helping these clients, any better approaches, [I] would be open to that...”
- “[It] would be helpful to see what works for other clinicians.”

Some respondents thought there needed to be more research on whether or not these clients differ from victims of other child sexual abuse crimes and, if so, they wanted to know how to accommodate those differences.

- “What role does pornography play in sexual abuse? How are these cases unique?”
- “Trainings addressing any differences that people are finding in the clinical settings, developing and learning specific interventions for child pornography cases.”

Other respondents wanted to know more about the impact of being depicted in CP on clients and their families, both in terms of the short-term and long-term effects. Related to this, they wanted to know how to help clients cope with issues they felt were especially salient in these cases, such as distribution of images, and prepare clients for future challenges.

- “Anything that talks about the impact on the whole family, how the family dynamics play into all of it...”
- “... how to prepare these victims for the future, building self-esteem and coping techniques.”
- “In cases where the images continue to circulate, how to help parents and children deal with that, what issues come up and how therapists can address that revictimization. How to manage anxiety and worry.”
- “...greater awareness of the impact, the ripple effect, how it impacts the child when the pornography has been distributed, more about how to use coping skills, what is effective.”

Some respondents wanted training on how to work with other systems involved in these cases, such as law enforcement and court, including information about how these cases are handled by those systems.

- “More information about law enforcement and forensic interviewers’ roles in these cases. Also how prosecutor’s office can help to prepare children for testifying.”
- “Understand more about the court process and what they’re taken through as part of that process...”
- “...need a training more specific to legal consequences for child pornography cases, what to expect in the courtroom...”

Other respondents felt like they needed more education about the technical aspects of these crimes.

- “[I] need more information about the advanced technology, maybe more information about internet safety.”

Finally, many respondents wanted more information about how to increase awareness, both with their clients and families as well as the public in general, with the goal of preventing these crimes from occurring.

- “How to educate parents and families about these cases. How to protect children from future risks...”

Table 5-8. Respondents’ Access to Resources on Treating CP Victims

	n=40 % (n)
<u>Respondent received training specific to providing therapy to victims depicted in CP</u>	
Yes	33 (13)
No	67 (27)
Don’t Know	0 (0)
<u>Respondent has found helpful resources when working with CP victims</u>	
Resources that specifically address CP and/or sexting	17 (7)
General resources (not specific to CP – i.e. internet safety training)	27 (11)
Don’t know (could not recall information to identify resources)	5 (2)
No resources	50 (20)

CP = Child Pornography

Limitations

Findings from the Clinician Telephone Interviews are limited in multiple ways. First, this was a convenience sample of clinicians generated through recruitment efforts targeted at mental health practitioners for whom we had a method to contact (i.e. Children’s Advocacy Centers, previous Practitioner Online Study participants, trauma-focused clinician listservs, etc.). Because of this, these clinicians and their clients should not be seen as representative of the mental health community as a whole.

Second, the study was primarily exploratory in nature. The goal was to learn about clinicians’ experiences through broad, open-ended questions. Although this provided us with very detailed information, this methodology does not allow for a great deal of quantitative analysis. Related to this, all findings are based on respondents’ *impressions* of these victims; it is possible that findings would be different if other procedures were used, such as reviewing case files, and results should not be considered representative of all relevant issues presented in these cases.

Third, the interviews were based on respondents’ memories of these cases rather than specific case files, so respondents may have forgotten or confused certain details. However, by limiting the timeframe to the past five years our goal was to reduce this potential issue; very few of the respondents

stated that they had difficulty remembering these cases and many stated that the severe nature of these cases tended to make them more salient in their memories. This time limit also allowed us to look at how clinicians are currently approaching these clients, rather than reporting on older practices.