

Autism and Sexual Assault: the Hidden Life on the Spectrum

Presenters:

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Gammicchia

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- Marriage, Family and Child Therapist
- Certified Sex Therapist
- Board Certified Forensic Examiner
- Child Abuse Forensic Interviewer
- Certified Trauma Specialist

Gammicchias

■ Carolyn:

- Executive Director, L.E.A.N. On, Disability Advocate
- Former LEO, 21 years as P.O., Detective,
- Certified Train the Trainer Instructor ,
- Certified Sexual Assault/Domestic Violence Response Team Professional,
- Forensic Interviewer, C.E.T
- Older brother had Epilepsy and Asperger Syndrome

■ Andrew

- President, L.E.A.N. On Us,
- Police Officer, 25 years,
- Disability Advocate.
- They have a nineteen year old son with ASD

Treatment considerations for children on the Autism Spectrum

PARENTS OF A TEEN WITH AUTISM WILL PRESENT

- Expert and authentic perspectives and guidance as issues of interacting and communicating with children on the Spectrum.
- Materials and curriculum developed for DOJ/OVC Response to Victims of Crime with Autism

WORKSHOP LEADER WILL PRESENT

- Accommodations including office use, lighting, furniture placement, sounds, structure of the session, as well as
- Flexibility in communication style, modality, tone.
- Parents an integral part of the session.
- Issues of treatment options and alternatives
- Information from case studies
- Therapy modalities to use

Learning Objectives

- **1. Describe the Autism Spectrum conditions; be able to describe the three principle aspects of ASD and how to identify how behavior that may be used as communication.**
- **2. List three communication considerations for interacting with children with Autism.**
- **3. Name 3 types of therapy approaches that have been found effective in working with child abuse victims with autism**

Person First Language

- Considers the person first, then the disability, attitudinally, verbally and in writing.
- This language enhances communication by using preferred and respectful terms, usually terms come from identified “group”.
- Example, “the child who has a disability”, so you indicate the child HAS not IS a disability.
- Different disability groups have different guidelines.
- Throughout this presentation PFL is used.

What is Autism?

- Autism is a neurologically based condition that principally effects the social and communication aspects of most individuals, as well as cognitive aspects in some.
- Most individuals who have autism do not have an intellectual disability, although this is often assumed

What is Autism?

- Over the past 15 years, the rate of incidence has increased 600%
- The exact cause is unknown
- There is no “cure”
- Contributors are thought to include genetics, toxin exposure, vaccinations, gastrointestinal function.

What are common factors?

- More males than females
- Diagnosis is usually made between 3-5 years of age
- Some children appear to develop normally until 18 months when language may disappear, then reappear at 36 months, although some do not recover language.

What are common symptoms?

- Constant motion
- Rocking
- Self stimulating behavior such as hand flapping
- Vocalizations (not words)
- Low verbal or non-verbal
- Tactile hypersensitivity

Symptoms

- Require more interpersonal space
- Reduced eye contact
- Hypersensitive to fluorescent lighting
- Usually not violent with others, although may hurt themselves
- May have co-occurring conditions
- May require special diet

Symptoms

- Preference for order
- Seem to do best with structure, both daily schedule and sameness in physical environment
- May have extraordinary skills in special interest area
- Social skills are difficult

What do you mean “Spectrum”?

- The spectrum includes children and adults with severe problems in social interaction and communication, and those with well-developed skills.
- The spectrum includes children with diagnoses of Autism, Asperger’s Syndrome, Pervasive Developmental Delay and Rhett’s Syndrome.

Spectrum

- This is used to reflect the reality that “one size does not fit all” and “one diagnostic category does not fit all”.
- The social skills and communication skills vary greatly within the spectrum, as well as some behavioral aspects.

What about treatment for the ASD?

- There is no medical treatment to cure autism.
- Behavioral teaching through incremental successful practice has been found successful (ABA)
- Exposure to and participation in natural daily activities provides essential learning experiences.

Gammicchias Presentation

The Victims with Autism Assistance, Education, and Training Program

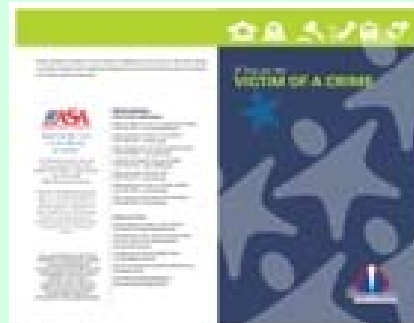
- Funded by a grant from the US Department of Justice Office for Victims of Crime (OVC)
- Partnership between the Howard County Autism Society, the Autism Society of America (ASA), and L.E.A.N. On Us (Law Enforcement Awareness Network)
- 18-month Project

Deliverables

- Training curriculum for police, paramedics, emergency room staff, counselors & other individuals who may come in contact with crime victims with autism
- Fact sheets for professionals
- Brochures for individuals with autism & family members
- Database at Autism Source (www.autism-society.org)

Victims of Crime with ASD

Free to download at www.leanonus.org



The Dignity of Risk

“In the past, we found clever ways to build avoidance of risk into the lives of persons living with disabilities. Now we must work equally hard to help find the proper amount of risk these people have the right to take. We have learned that there can be healthy development in risk taking... and there can be crippling indignity in safety.”

--*Robert Perske (1981)*

Familiarity with Disability & Autism Spectrum Disorders

Exposure, Knowledge, and 50/50
Partnerships are Essential

Exposure is key to understanding people who have disabilities and eliminating the fear of the unknown

- We live in a society that maintains a “disability-negative” attitude. We need to challenge that mindset and offer the same positive regard and level of acceptance to all individuals.
- Many people in the disability community openly state “The biggest disability is the negative attitudes toward individuals with disabilities, not the disability itself.”
- Utilizing Person First Language is a start.

A lack of personal familiarity with individuals who have a disability may cause you to feel professionally awkward and uncertain when providing emergency care

Common reactions to individuals with disabilities include:

- Fear
- Dread being with the person
- Embarrassment and shame
- Pity
- Disbelief, disregard and discounting

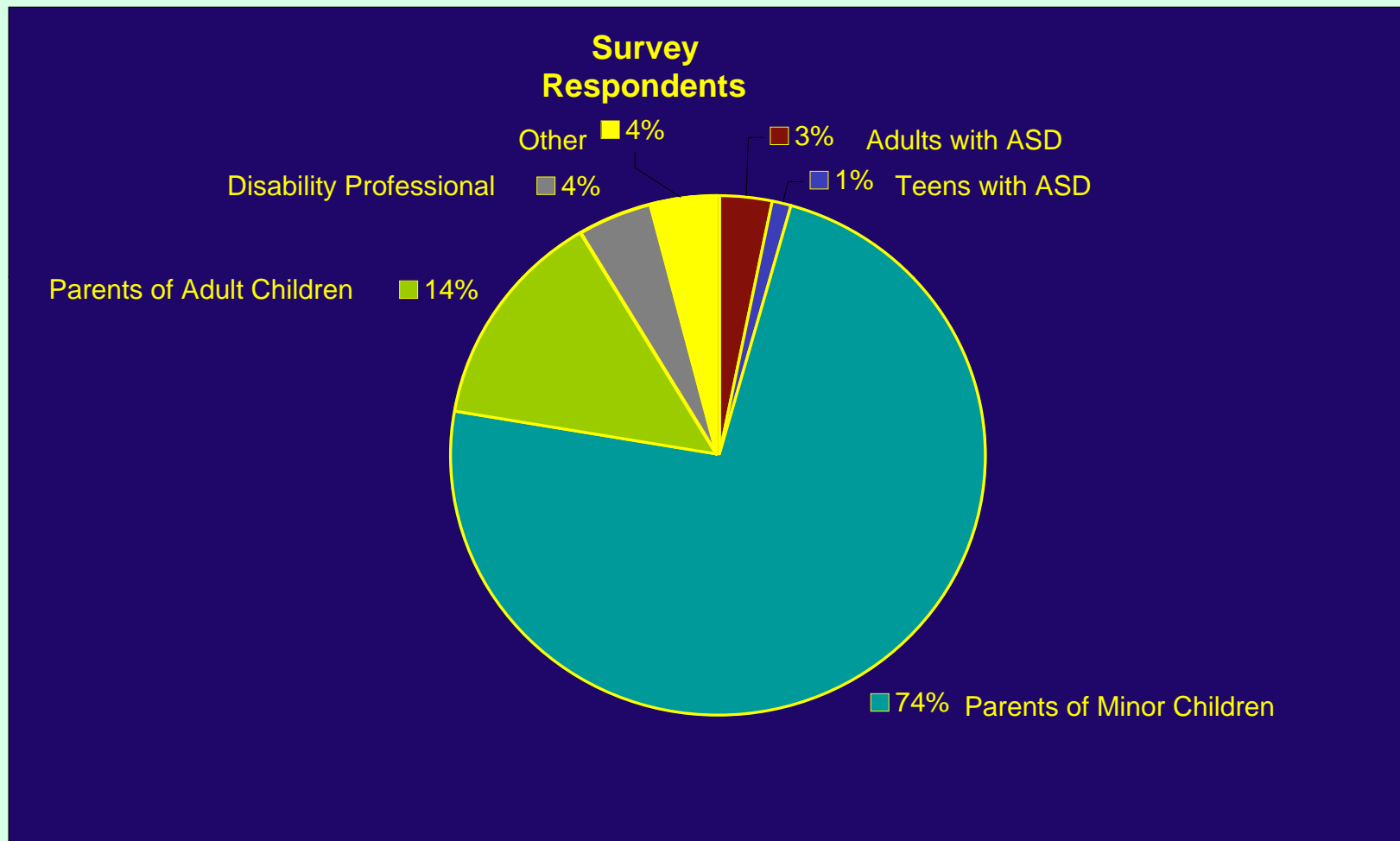
Individuals with disabilities are often taught values & beliefs that affect behavior and social etiquette making them more likely victims

- Obey the rules and those in charge
- Don't be assertive or get angry
- Agree with adults or authority figures
- Honor other people's opinions
- Taught to be obedient and dependent
- Reluctance to express negative feelings or a desire for change
- Personal choices may not be possible
- Refusal is not usually accepted

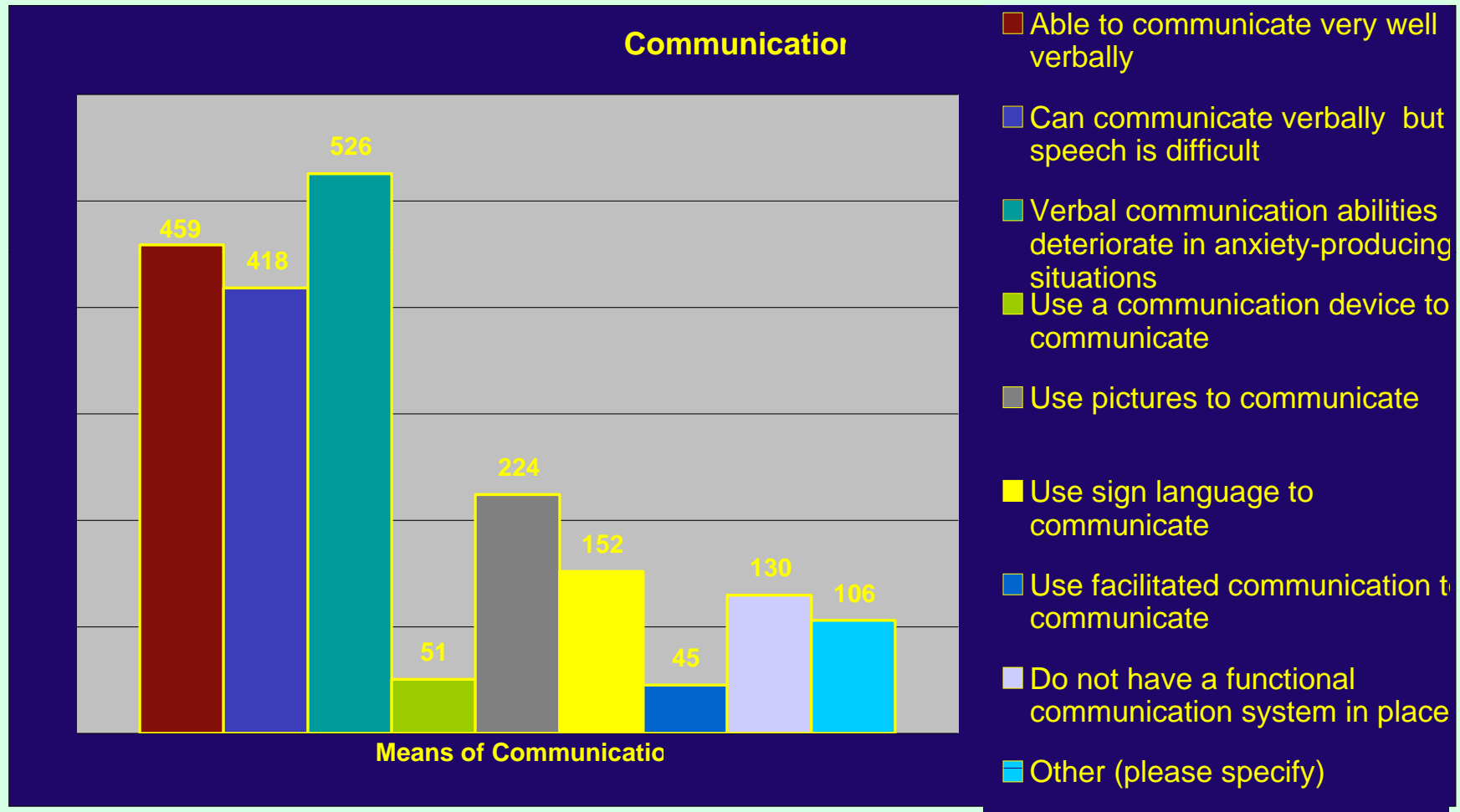
Social Variations which may lead to high risk for victimization and abuse include:

- Privacy is greatly reduced or does not exist
- Healthy sexuality and adapted maturation programs are seldom taught
- Expectations for life and achievement are often less due to life circumstances
- Obedience and passivity are rewarded
- Being the object of negative attitudes/ being ignored are common
- General friendships are limited & social isolation is the norm
- Difficulty being accepted when social opportunities arise

Victims of Crime with Autism Survey

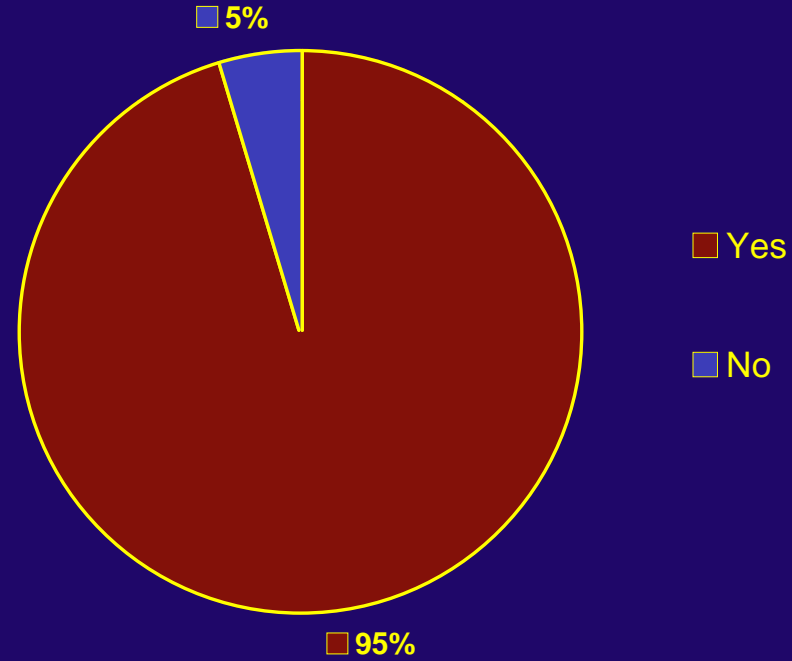


Mode of Communication



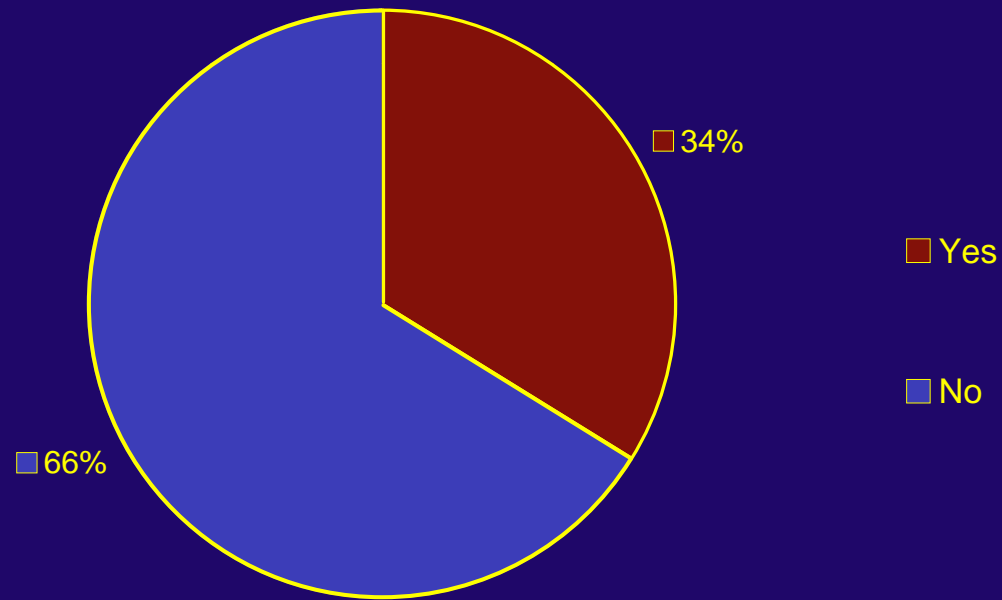
Behavior

Has Behaviors That May Appear "Different" or "Strange" To Others

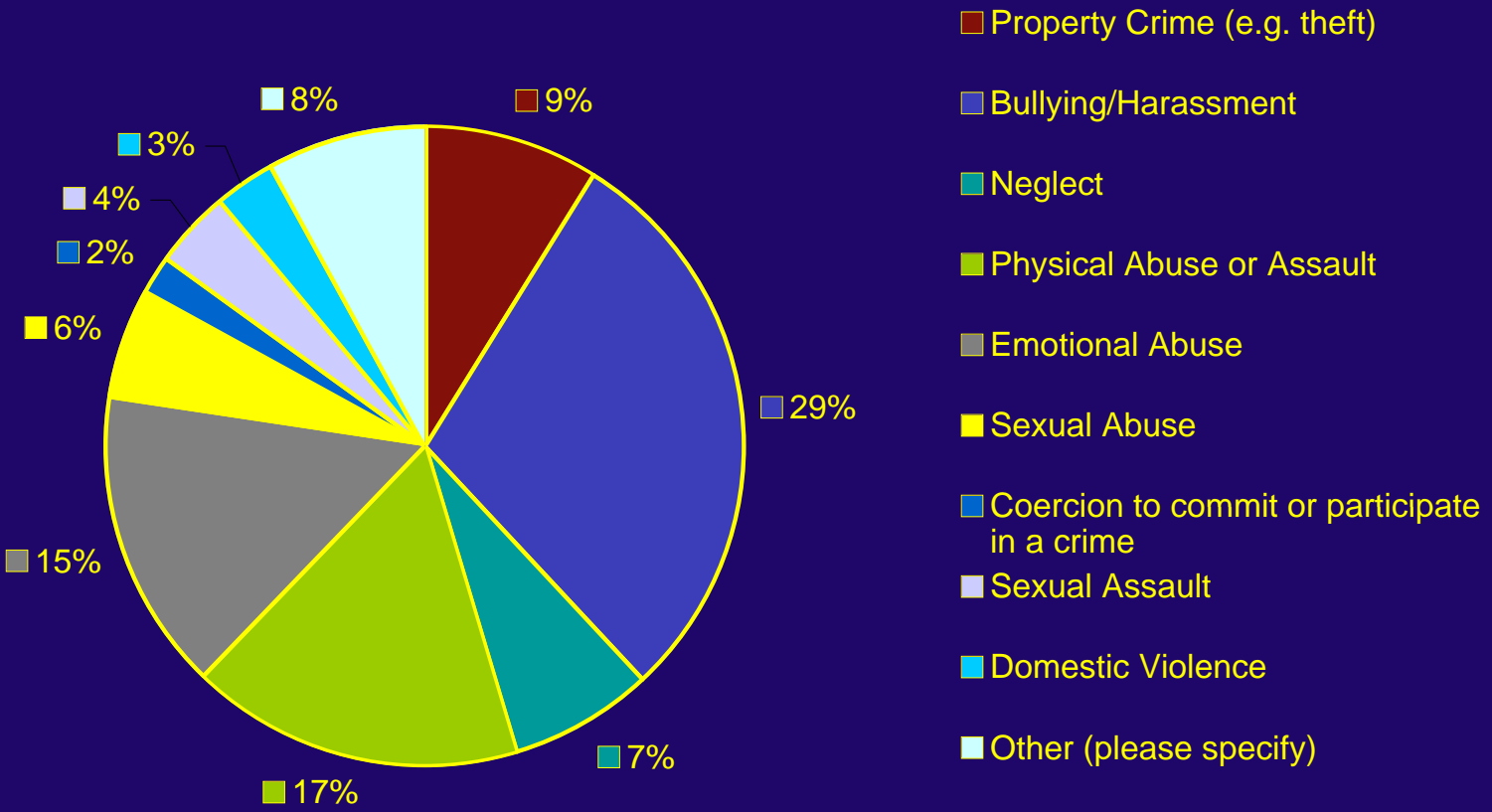


Number of Victims of Crime

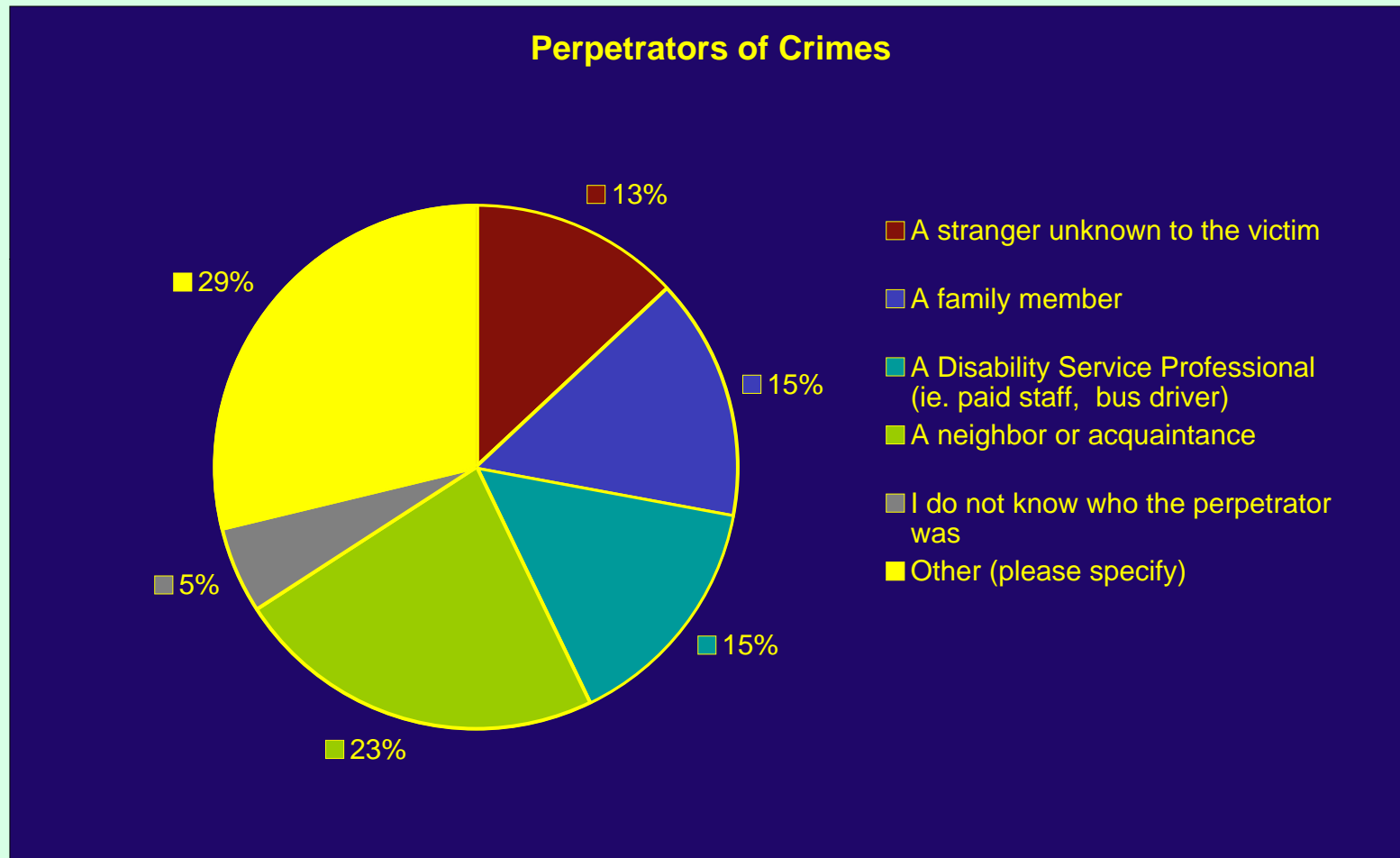
Victims of Crime with Autism Spectrum Disorders



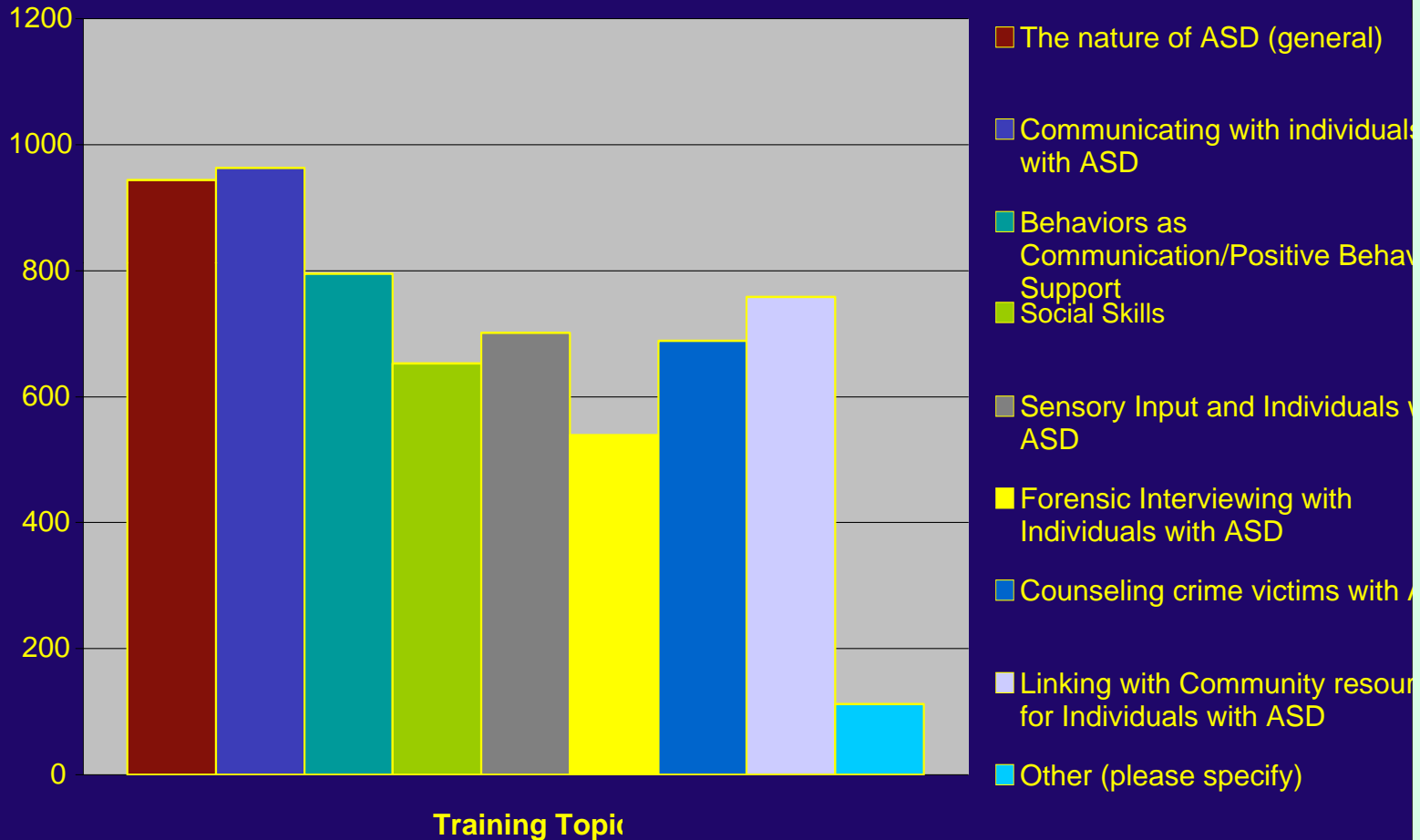
Types of Crimes



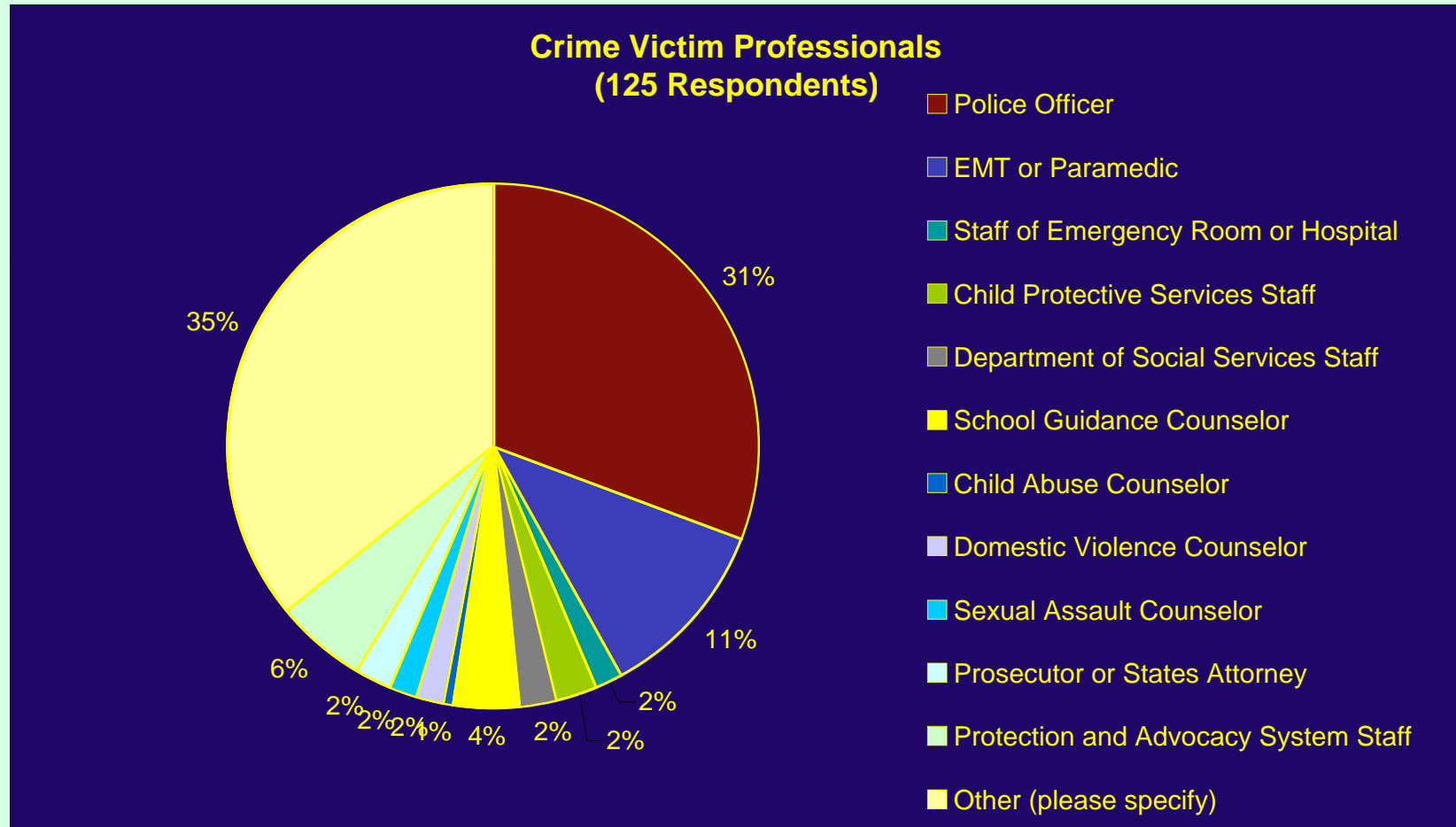
Perpetrators



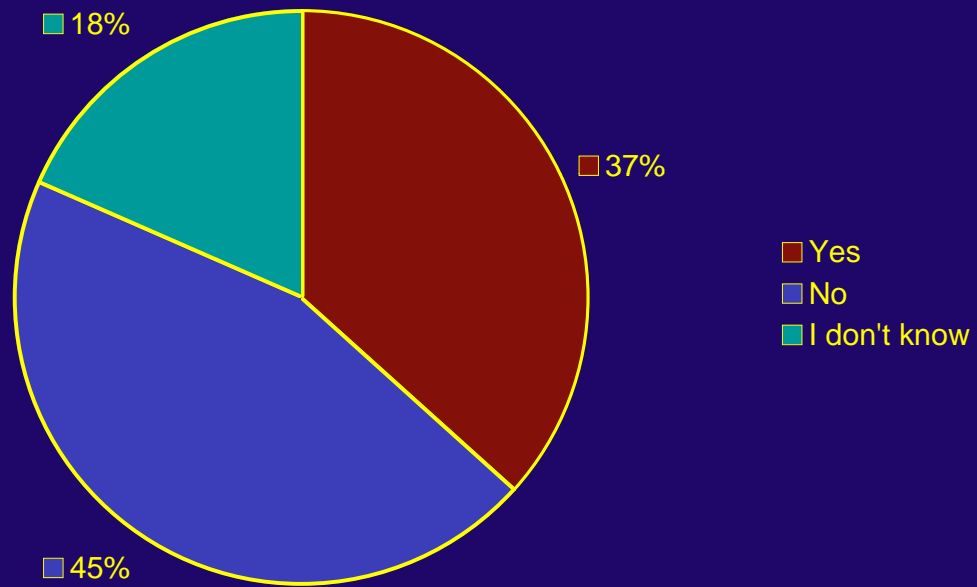
What Training Do You Think Crime Victim Professionals Would Benefit From?



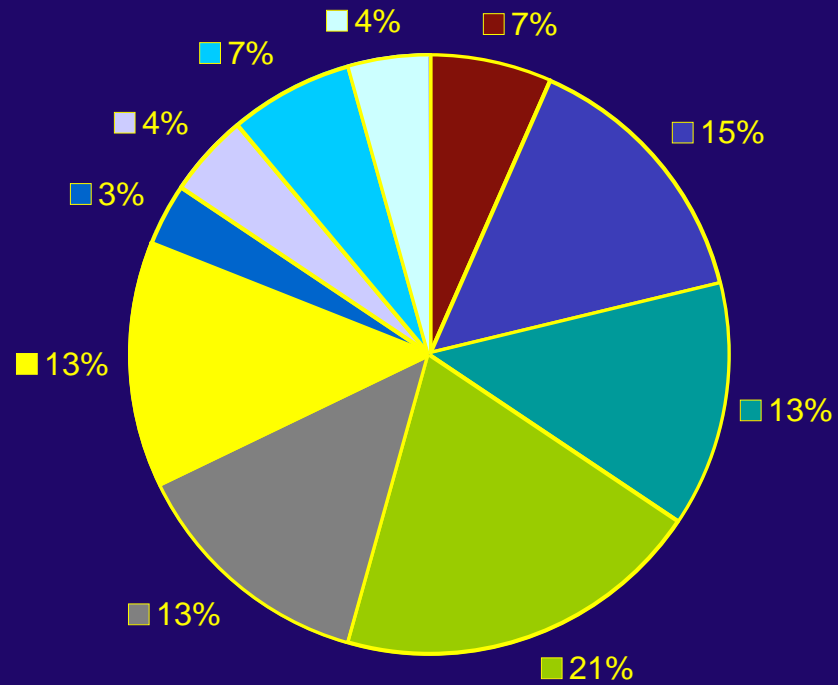
Crime Victim Service Professionals



Have You Served An Individual with an ASD?

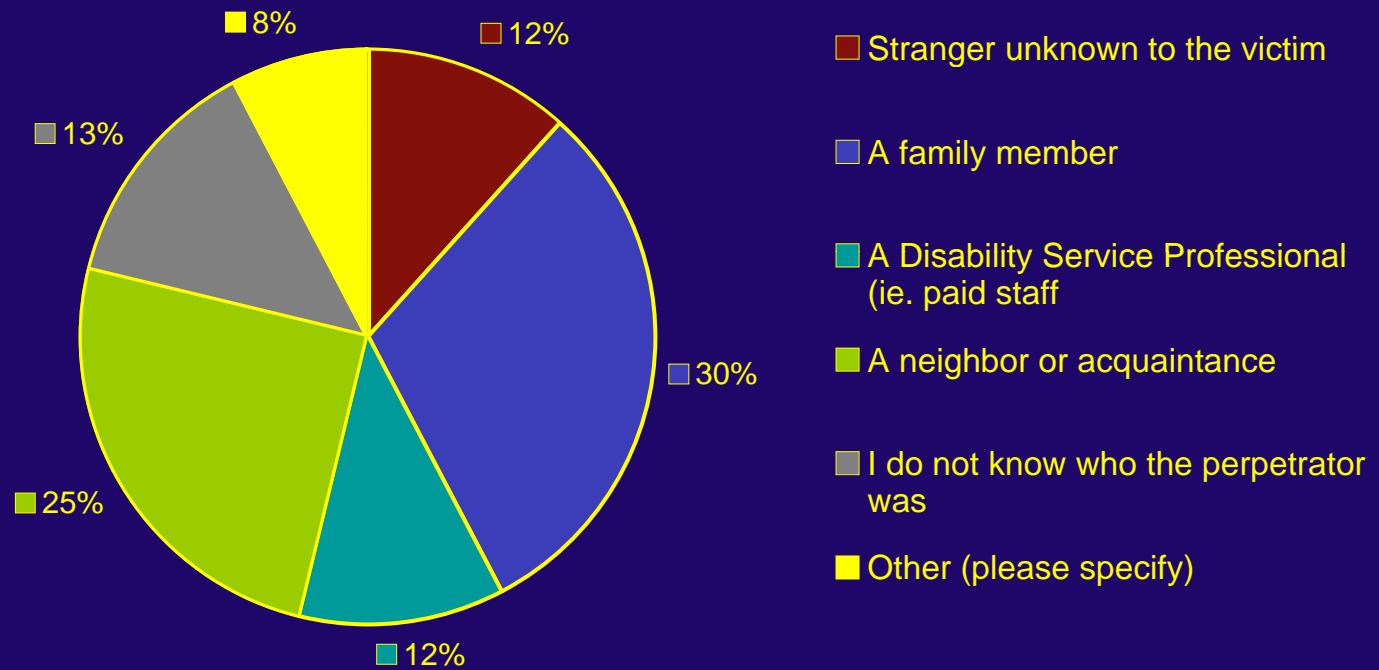


Types of Crimes



- Property Crime (e.g. theft)
- Bullying/Harassment
- Neglect
- Physical Abuse or Assault
- Emotional Abuse
- Sexual Abuse
- Coercion to commit or participate in a crime
- Sexual Assault
- Domestic Violence
- Other (please specify)

Perpetrators



“Autism & Informed Response”

Video

South Carolina Autism Society

www.scautism.org

The A.I.R. Program was developed to assist Law Enforcement in providing appropriate services to individuals with ASD

Four Components of ASD

Impairments in Social Interaction

- Marked impairment in the use of multiple nonverbal behaviors such as eye to-eye gaze, facial expression, body postures, and gestures to regulate social interaction
- Failure to develop peer relationships appropriate to developmental level
- A lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest)
- Lack of social or emotional reciprocity

Four Components of ASD

Impairments in Communication

- Delay in, or total lack of, the development of spoken language (not accompanied by an attempt to compensate through alternative modes of communication such as gestures or mime)
- In individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others
- Stereotyped and repetitive use of language or idiosyncratic language
- Lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level

Four Components of ASD

Restricted Repetitive and Stereotyped Patterns of Behavior, Interests, and Activities

- Encompassing preoccupation with one or more stereotyped patterns of interest that is abnormal either in intensity or focus
- Apparently inflexible adherence to specific, nonfunctional routines or rituals
- Stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole-body movements)
- Persistent preoccupation with parts of object, i.e. wheels on a toy car.

Four Components of ASD

Sensory Processing Deficits and Behavioral Effects

- Often have a dysfunctional sensory system. Sometimes one or more senses are either over- or under-reactive to stimulation.
- These may be the underlying reason for such behaviors as rocking, spinning, and hand-flapping.
- Believed that the problem stems from neurological dysfunction in the central nervous system--the brain.
- When sensory input is not integrated or organized appropriately in the brain it may produce varying degrees of problems in development, information processing, and behavior.
- Behaviorally, the person may become impulsive, easily distractible, and show a general lack of planning. Some may also have difficulty adjusting to new situations and may react with frustration, aggression, or withdrawal

Sensory Processing Deficits and Behavioral Effects

Tactile System: Includes nerves under the skin's surface that send information to the brain. This information includes light touch, pain, temperature, and pressure. These play an important role in perceiving the environment as well as protective reactions for survival.

- withdrawing when being touched,
- refusing to eat certain 'textured' foods and/or to wear certain types of clothing,
- complaining about having one's hair or face washed, avoiding getting one's hands dirty (i.e., glue, sand, mud, finger-paint),
- using one's finger tips rather than whole hands to manipulate objects

Sensory Processing Deficits and Behavioral Effects

A dysfunctional tactile system may lead to a misperception of touch and/or pain (hyper- or hyposensitive) and may lead to self-imposed isolation, general irritability, distractibility, and hyperactivity.

Sensory Processing Deficits and Behavioral Effects of Dysfunction

Vestibular System: The vestibular system refers to structures within the inner ear (the semi-circular canals) that detect movement and changes in the position of the head. For example, the vestibular system tells you when your head is upright or tilted (even with your eyes closed).

- Some hypersensitive to vestibular stimulation and have fearful reactions to ordinary movement activities (e.g., swings, slides, ramps, inclines). They may also have trouble with stairs or hills or walking or crawling on uneven or unstable surfaces. They seem fearful in space may appear clumsy.
- Others may actively seek very intense sensory experiences such as excessive body whirling, jumping, and/or spinning. This person demonstrates signs of a hypo-reactive vestibular system; that is, they are trying continuously to stimulate their vestibular systems.

Sensory Processing Deficits and Behavioral Effects of Dysfunction

Proprioceptive System: The proprioceptive system refers to components of muscles, joints, and tendons that provide a person with a subconscious awareness of body position.

Some common signs of proprioceptive dysfunction are clumsiness, a tendency to fall, a lack of awareness of body position in space, odd body posturing, minimal crawling when young, difficulty manipulating small objects (buttons, snaps), difficulty with writing skills, and resistance to new motor movement activities

Sensory Dysfunction Challenges for Service Providers

Suggestions for providing appropriate assistance:

- Ask what sensory issues may exist, obtain information from the person or a care provider
- Ask permission when taking action, explaining how you will assist the person
- Approach calmly and slowly
- Allow for response time to verbal commands or instructions when using gestures
- Do not have the expectation for eye contact
- Speak in a calm tone, pacing your words
- Do not touch the person unless needed. When necessary use only one hand placing same gently on the arm or shoulder

Sensory Dysfunction Challenges for Service Providers

Additional Suggestions for providing appropriate assistance:

- Eliminate distractions or sensory stimuli from the scene such as other people, lights, sirens, or other noises. Move to a less stimulating site if possible
- Behavior may escalate, be alert to signs of increased frustration and try to recognize the source and eliminate it if possible
- Do not stop repetitive behaviors that may serve to calm the individual
- Be aware that any person's cognitive ability will decrease, as much as 30%, in a heightened anxiety situation. Remember this will also happen to responding officers and other professionals

Challenges Which May Affect Individuals with Autism Spectrum Disorders

Identifying and Understanding
Subtle Characteristics

Case Studies Examples

- Easily Misinterpreted Declarative Statements
- Two Families – One Community
- Abandoning a Belief
- Rising Numbers – The Need for Data
- Prioritizing Need

The Challenges of Communication

- If able to speak, answers may seem loud, blunt, or tactless
- May not understand what you say
- May appear deaf and may not respond to verbal cues
- Unable to speak (30-50% non-verbal), or speak with difficulty, rambling speech, or echo what you say
- May repeat words or phrases several times
- Become frustrated when not sign language or gestures are not understood.

The Challenges of Repetitive, Over-Focused, or Stereotypical Behavior

- May exhibit inappropriate laughing or giggling.
- Engage in self-stimulatory behaviors or “stims”, like hand-flapping, body rocking, finger-flicking, spinning, or shaking parts of their body.
- Have difficulty judging personal space, touch in socially-inappropriate ways
- May stare at you with an atypical gaze or into space
- Attachment to objects that are not age-appropriate.

Safety Factors to Consider with Individuals with Autism

- Up to seven times more contacts with law enforcement.
- Behaviors draw attention and may limit credibility.
- May not respond to stop or other commands.
- May flee when approached.
- May repeat words or mimic gestures of first responder.
- May answer no or why to all questions.
- May invade your personal space
- May reach for a firearm due to curiosity

Safety Factors to Consider with Individuals with Autism

- Elopement and wandering.
- Attracted to water, lights, reflections, shiny objects, or high places.
- May not know what to do or how to seek help.
- May not be able to communicate needs.
- May not react well in emergencies (re-enter burning home or touch downed power lines).
- May not recognize real danger.
- May have very high tolerance for pain
- May have “fight or flight” response

Recognizing Trauma Identifying Symptoms

Reactions by a person with ASD
to Victimization and Abuse:

- May lose ability to communicate
- May not want to be separated from abuser due to dependency
- Challenging behaviors may increase in frequency and intensity
- Inability to transition from location where event took place
- Separation from the reality into safe zone such as cartoon or favorite movie
- Regression in achievements

Recognizing Trauma

Identifying Factors

Recognizing symptoms of disorders associated with trauma from events:

- Post Traumatic Stress Disorder
- Acute Stress Disorder
- Adjustment Disorder (Usually in Children)
- Generalized Anxiety Disorder
- Addressing Trauma Bound Shame
- Legal System Trauma

Practical Guidelines for Emergency Response

- When possible, avoid the use of sirens and flashing lights as sound and light sensitivity are common among people with ASD
Remember that restraint systems used in ambulance transfers may frighten people with ASD; explain and get consent from the person or guardian before attempting to strap onto a backboard or stretcher
- Try to communicate with receiving hospitals before arrival to request a quiet isolated room for the person with ASD
- Be aware of hypotonia- people with ASD usually have under-developed trunk muscles and may be unable to support their airway when lying flat on their chest

Practical Guidelines for Emergency Response

- Whenever possible, avoid touching people with ASD because some, but not all, will become more agitated, and possibly aggressive, when touched
- They may fixate on an object in the room or on your body such as a badge, earrings, or parts of an ambulance or fire truck
- People with ASD may not respond to directives because they do not understand what's being asked of them or because they are scared. The fact that they're scared is the only thing they will be aware of- they may not be able to process language or understand the directive when fearful

Practical Guidelines for Emergency Response

- Exterior and interior doors may be locked to keep person with ASD from wandering, so forced entry will be most likely
- Windows can be barred, nailed, or locked as well
- Plexiglass or Lexan windows, which are harder to break through, might be used instead of regular glass windows
- Fences may have locked gates

Practical Guidelines for Emergency Response

- Adults with ASD are just as likely as children to hide in a fire situation. Closet, under the bed, and behind furniture checks need to be done during searches and rescues
- To move a person with ASD quickly, wrap them in a blanket with their arms inside. This will give them a secure feeling and may help to calm them during a rescue. This will also help prevent thrashing while trying to escape an emergency situation

Practical Guidelines for Emergency Response

- Extreme caution should be used with any rescue from heights. An aerial tower or platform would be the easiest way to remove an individual with ASD. This person may aggress towards the rescuer during this operation. Always make sure you are secured before you attempt to rescue the individual
- People with ASD are a bolt risk after rescue
- A firefighter or medic should stay with the person if a family member or care provider is not present
- Remember to preserve evidence if possible

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DATA

Child abuse & ASD

- Children with autism are particularly susceptible to abuse because of the verbal language issue. It is thought that they cannot communicate (by many including perpetrators) which makes them a “perfect victim”.
- Although there are no studies on children with ASD, children with disabilities are abused 3.4 more often than generic children.

Generic Child Sexual Abuse Comparisons

- Rates have been cited at 1 in 4 girls and 1 in 7 boys.
- When you multiply 25% of the girls in the population x 4, the estimate is 100%
- When you multiply 14% x 4 = 57% of boys.
- Under-reporting is a problem in both populations.

INTERACTION SKILLS FOR ABUSE VICTIMS WITH AUTISM

Accommodations

- Office use
 - Make sure there are not objects that could be harmful
- Lighting
 - Use full spectrum bulbs or incandescent or natural light
 - Ask how they prefer the lighting
- Furniture placement
 - Keep office furniture in same configuration
- Sounds
 - Minimize external loud noises as much as possible or talk about them when they occur
- Structure of the interaction
 - Design and maintain both a structure and flexibility based on victim's needs/preferences

Flexibility as an Accommodation

- Conumdrum: structure and sameness are very important AND “extreme flexibility” at the same time.
- Essential to receive victim at the appointment time ... waiting can be excruciating, & create anxiety.
- Essential to allow victim to move around the room as needed, sit where and when they are comfortable.

Flexibility

- Allow victim to use supplies differently than you may be used to (pad of paper);
- Allow victim to stand, sit, lie on floor, touch items in the office at will.
- Allow victim to make adjustments to the room as needed such as closing drapes, collecting all the coasters in one pile instead of having them placed around the room; these may increase the person's comfort.
- You may ask the victim how lying on the floor is better for them in that moment.

Communication

- Flexibility in communication style
 - Match or approximate child's communication style
- Modality
 - Use child's communication modality such as sign language (if you know it or get an interpreter)
 - Facilitated Communication - be familiar with this modality. Often the parent is the facilitator which is fine for daily communication but not for the forensic interview. Know how to communicate using this method
- Tone
 - Use a tone that is normal, not infantilizing, gentle

Facilitated Communication

- The support person will facilitate the victim's expressive language
- The interviewer must write down what is said (by both parties).
- Can use Notebook or LiveScribe, if is not frequently moving about.
- Interviewer often may need to follow victim about the location

FACILITATED COMMUNICATION

- This is the application of resistive support to the hand or arm against which the typer must press to access the desired letter.
- Used by individuals with autism, Down Syndrome, Cerebral Palsy; others unable to speak.
- This may be the only mode of communication for the victim.

A	B	C	D	E	F
G	H	I	J	K	L
M	N	O	P	Q	R
S	T	U	V	W	X
Y	Z	?	!	+	-
YES	NOW	WANT	NEED	LATER	NO
GO	FOOD	Bath- room	PAIN	SLOW	STOP
&	MORE	DRINK	WATER	LESS	.

FACILITATED COMMUNICATION

- Often the facilitator (and therapist) are surprised by what the child/adult types. This is a validation of the communication.
- “The right to communicate is a basic human right, without which no other rights can be accessed.” quote from Rosemary Crossley’s first student.

Literal Thinking

- 14 year old child had been used for sex by his mother's renter (as usual) unbeknownst to her. The next day he was masturbating at school. The teacher said that "that" was dirty. He went home and to fix that problem poured shower cleanser on his penis. This caused a great deal of pain.
- The doctors failed to offer any tx., just wanted to "observe" the child but not look at his penis. They said they did not believe that a child with autism experiences physical pain. This was way back in 2007.

Parents an integral part of the person's life.

- Children on the spectrum often feel better when a familiar person is in the room with them.
- Must be
 - The non-offending parent
 - Encouraged to participate in the therapy
 - Prepared for the difficult material discussed
 - Receiving separate therapy to deal with the content and emotional reaction of their child.

Case Examples

Case #1

Vignette: 14 year old girl dx. Autism, now electively mute after 3 weeks tx @ UCLA. After CSA now violent with mother and brother. Assailant, paternal grandfather, no longer allowed to see child. Pt. referred from UCLA, for trauma treatment for child sexual abuse.

Discussion

What more do you need to know?

Communication skills

Social skills

Family constellation

Abuse history

Treatment history

Building an Interactional Foundation

- First job is to develop rapport with child
- First job is to develop rapport with parent
- First job is to provide sense of safety with you as a person
- First job is for you to understand history of violence for your own safety and that of child/parent during the interview.

How to Communicate

- Options to work with mutism
- How to direct your comments
- Acting “as if” child understands everything (presumption of competence)

Analysis

- What worked?
- Why?
- What could have been done differently?
- What other approaches in that first meeting could have been used?
- What is next for this child?

Case #2

Vignette: 15 year old boy dx Autism, mild mental retardation, Tourette's. Single event CSA by general education boys in bathroom. Boy immediately drew scene in classroom where communication through drawing was being taught, but the teacher's missed the communication.

Discussion

What more do you need to know?

Communication skills

Social skills

Family constellation

Abuse history

Treatment history

Building therapeutic expectations

- Began session with self-introduction, brief summary of what I had been told by referring source.
- I observed his method of communication. He was quite verbal, repeated himself, had some grunting and other Tourette's symptoms (although no seizure disorder or use of bad language)
- He was anxious to be able to talk about what had been done to him.

Respect & Expectation

- I asked about how child has changed since abuse began and how that changed things at home
- I stated that such things are, sadly, quite common, there are many children who experience CSA in various forms.
- Child was anxious to talk about what had happened to him, and did so with great gusto, angry but smiling while describing abuse. NOTE: facial expressions may not match content of what is being discussed. This is typical of the population, not to be taken as a sign of emotional response.

Confirming Symptoms

- Child complained of being afraid to go to school; nightmares; day-mares. Could not concentrate; frequent focus on assault.

Case #3

Vignette: Assessment requested by Regional Center. 14 year old boy with Autism, mother questions if he had been sexually abused by in-home behavior specialist (male). Child is non-verbal, only child of married couple. He attends local NPS and has 4 hours in-home workers after school. Respite care is provided on the weekends. Parents are “having a hard time” managing this growing teenager. Both parents attended session as requested.

Discussion

What more do you need to know?

Communication skills

Social skills

Family constellation

Abuse history

Treatment history

A little surprise!

- I went to the waiting room to let parents know I would be seeing them in 5 minutes. Child walked toward me, body-slammed me against the hall wall. Parents observed. Child ignored my request to return to the waiting room, went quickly to my office, reached into the fish tank and grabbed a fish, which he appeared delighted to have caught.

Surprise!

- I asked him to put fish back, he just held it while grinning. Soon his parents came in. Mother told him to put let fish go, which he did then grabbed another. Mother struggled with child to let go of 2nd fish, closed the top, told him to sit on the couch. She sat with son on one couch, father sat on adjoining couch at 90 degree angle. Father observed. Mother was plainly embarrassed and out of control.

Initial contact

- Began session with self-introduction, brief summary of what I had been told by referring source.
- I described how I do an assessment, collecting information from the parents about a child's mood, behavior prior to suspicions of abuse, what were the changes that led to a suspicion of abuse, what had been said to the child, had there been prior assessments. I asked if the child had been able to communicate with them about suspected abuse (what was done, who done it, when, etc.).

Respect & Expectation

- I asked about how child has changed since abuse began and how that changed things at home
- I stated that such things are, sadly, quite common, there are many children who experience CSA in various forms.

More surprises

- While providing verbal framework for an assessment, son placed one hand down mother's dress and the other hand up her dress. She made verbal protests, and slid down to the floor to avoid the hand up the skirt. Dad silently observed. This happened about 6 times.
- It was not possible to carry on a conversation with the struggles occurring. I recommended a re-evaluation of child's dx.

Analysis

- What worked?
- Why?
- What could have been done differently?
- What other approaches in that first hour could have been used?
- What is next for this child?

Case #4

Vignette: 16 year old boy with “severe” autism who was sexually assaulted while at camp. Camp counselor sexually assaulted him while he was changing into hiking clothes. He is very bright, uses FC for communication. Has regressed in toileting and increased aggressive behavior.

Discussion

What more do you need to know?

Communication skills

Social skills

Family constellation

Abuse history

Treatment history

Building therapeutic expectations

- I met the boy and his parents at my office. The parents explained that he does like to remain active, and sometimes bolts, so we locked the door of my office.
- I explained to all about the work I do, to help children and teens who have been sexually assaulted to feel better, normalized (this happens to many), and provided the SURVIVOR guidebook volumes one for the boy and the volume for parents.

Respect & Expectation

- I addressed the boy directly at times, and at times one or the other of the parents.
- I expected that he was understanding all I said, although there was no outward indication of this.
- Mother acted as facilitator for her son.

Confirming Understanding

- The boy said that he wanted to do anything to feel better.

Ending of 1st session

- At the end of the first session, he stated that he felt “a lot better”. He was very tired. He wanted to go home.
- The parents were very appreciative of the improvement in feeling states, and also remarked on how calm he was compared to when they had arrived.

Analysis

- What worked?
- Why?
- What could have been done differently?
- What other approaches in that first hour could have been used?
- What is next for this child?

Case #5

Vignette: John was 17 and had been gang raped by 6 boys who lived at his apartment while his father had left him alone for “just a few moments” to go to the store. John had gone to throw something into the trash at their apartment building.

Discussion

What more do you need to know?

Communication skills

Social skills

Family constellation

Abuse history

Treatment history

Building therapeutic expectations

- This boy had been referred by the local disability services agency, since his traumatic response to the assault had not improved at all in response to the services provided.
- The services were provided by the sexuality education unit at UCLA, where they had spent one year teaching him about sexuality and how to put on a condom. Although he could do the practice of this on a banana very well, this had not resolved the trauma of the gang rape. Little surprise. The Educator told me that he did not know why they referred him to a seemingly inappropriate intervention.

Respect & Expectation

- With his father and the client present, I explained my work in alleviating fear, phobia, and trauma for sexual assault victims.
- We discussed what he had learned at UCLA and if that had been helpful. I told him that we would check in every 3 weeks to see if our work was helping at all.
- Communication was difficult as this boy was low verbal, spoke sotto voce, and appeared quite fearful.

Confirming Understanding

- While discussing the trauma, he described the boys and what they had said to him. We talked about anyone could have been trapped as he had been; about hate crimes; about disability; about he is not the only one; about shame/embarrassment due to it being a sex crime.

Child-directed therapy

- In order to administer the therapy, the father was more than willing to participate, as he of course was a secondary victim of the crime.
- In fact, he was seen separately on several occasions to work on his own traumatization and guilt.
- We addressed issues of the trauma as well as designed a risk-reduction Individualized Plan for this boy and the family.

Analysis

- What worked?
- Why?
- What could have been done differently?
- What other approaches in that first hour could have been used?
- What is next for this child?

Case #6

Vignette: This is a 14 year old boy with autism. He had been a typically developing child until age 2 after a vaccination changed him completely. 6 months prior after learning FC, he disclosed to his FC teacher that he had been sexually assaulted throughout his childhood by an uncle.

Discussion

What more do you need to know?

Communication skills

Social skills

Family constellation

Abuse history

Treatment history

Building therapeutic expectations

- I met with the boy and his mother at my office. He is quite tall. He does not talk but vocalized, requires a lot of room to walk (pace), and requires frequent breaks in the session.
- He said “I am not gay”. We discussed that sexual assault does not change one’s sexual orientation.

Respect & Expectation

- Police had been notified of the disclosure. I met with them a few times at my office for them to interview him, but they gave up after 2 sessions with an independent Facilitator, as the boy had not developed sufficient communication skills with the Facilitator. They also said that since there was no corroborative evidence, they would not file the case for prosecution. The boy, Max, felt betrayed by the police, and likened them to his uncle who had also betrayed him.

Analysis

- What worked?
- Why?
- What could have been done differently?
- What other approaches in that first hour could have been used?
- What is next for this child?

Case #7

Vignette: The disability-services agency suspected that this child, Amparo, 9 years old, may have been sexually assaulted at school. She did not want to and eventually refused to go to school, refused certain foods, and refused to talk about school. She is low-verbal and very bright.

Discussion

What more do you need to know?

Communication skills

Social skills

Family constellation

Abuse history

Treatment history

Building therapeutic expectations

- This child and her parents attended each session. I told her that she was there to be able to talk about...or communicate in some way...what was happening at school.
- She said that nothing had happened, “everything is fine”...
- She was encouraged to draw pictures (a forte of hers), but none had indications of trauma or sexual themes.
- She never sat in a chair. She preferred to wander about the office, admiring and touching/examining various items displayed

Respect & Expectation

- I allowed her to talk about or draw or play to develop a sense of safety and comfort in the office.
- We discussed her homelife, and the parents engaged in discussions about her childhood, the school, their home, their family life. She would interrupt from time to time to talk about either relevant or irrelevant topics.

Confirming Understanding

- At each session, I reminded her that I want her to be safe and comfortable at school, and when she is comfortable to talk about what caused her to not want to go.
- However, she continued to say all was well until the last session, when she described a boy at school who often pulled her hair, that hurt her, and he kicked her, but she said it did not hurt a lot. She did not tell either her teacher or the school nurse. She knew that this would not stop.

Analysis

- What worked?
- Why?
- What could have been done differently?
- What other approaches in that first hour could have been used?
- What is next for this child?

Most effective interventions

- Create an place and atmosphere that is comfortable, structured and flexible.
- Use the communication method used by the child.
- Use standard “goalposts” as in any child abuse interactions.
- Demonstrate respect for the child and that you believe the child.

Most effective interventions

- Using drawings, role-play, psychoeducational methods, normalizing, open discussion without fear or repugnance in discussing exactly what happened; using the victim's words to describe what happened.

Contact Information

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Free Resources Available

“Serving Crime Victims with Disabilities”

DVD, www.ovc.gov

“Victims with Disabilities: The Forensic Interview”

DVD & Booklet, www.ovc.gov

“Victims with Disabilities: Collaborative,
Multidisciplinary First Response” DVD, www.ovc.gov

“Victims of Crime with Autism”

www.leanonus.org

OVC Professional Development Scholarship Program

Amount: \$1,000/individual or \$5,000/group

Deadline: Open

Sponsor(s): Office for Victims of Crime Training and Technical Assistance Center

Eligibility: Service providers from any organization-public, nonprofit, or faith-based-that assists victims of crime but does not have an adequate budget to support training is eligible for the OVC Professional Development Scholarship Program.

Visit the web site for complete eligibility information.

Web Site: <http://www.ovcttac.org/taResources/scholarship.cfm>

Description: The Office for Victims of Crime (OVC), through its Professional Development Scholarship Program, provides financial assistance for qualified victim service providers for continuing education. The scholarship program is designed for service providers from small, community-based or faith-based organizations or agencies that assist crime victims and operate with limited budgets or resources.

Contact for Additional Information



L.E.A.N. On Us
The Law Enforcement
Awareness Network
www.leanonus.org

