Child Planning: A Treatment Planning Overview for Children with Sexual Abuse History

A Treatment Overview for Children with Sexual Abuse History

Duration: 3 hours

Learning Objectives:

Obtain a basic understanding of how to identifying, causes, symptoms of children with lying problems or history, and learn different options to complete a treatment plan that includes:

a. Behavioral Definitions
b. Long Term Goals
c. Short Term Goals
d. Strategies to Achieve Goals
e. DSM V diagnosis Recommendations

***For a full list of 20 short term goals with dozens strategies listed next to each goal check the Child Treatment App for Windows or Apple PC and Android Devices, under our main menu Windows-Apple Apps. Download the Free Demo to Evaluate***

Course Syllabus:
Introduction

Symptoms

Causes

Diagnosis and Treatment

Steps to Develop a Treatment Plan that includes Behavioral Descriptors, Long Term Goals, Short Term Goals, Interventions/Strategies and DSM V CODE Paired with ICD_9 and 10-CM Codes for ODD

Sample Treatment Plan

Introduction:

There is no universal definition of child sexual abuse. However, a central characteristic of any abuse is the dominant position of an adult that allows him or her to force or coerce a child into sexual activity. Child sexual abuse may include fondling a child's genitals, masturbation, oral-genital contact, digital penetration, and vaginal and anal intercourse. Child sexual abuse is not solely restricted to physical contact; such abuse could include noncontact abuse, such as exposure, voyeurism, and child pornography. Abuse by peers also occurs.

Accurate statistics on the prevalence of child and adolescent sexual abuse are difficult to collect because of problems of underreporting and the lack of one definition of what constitutes such abuse. However, there is general agreement among mental health and child protection professionals that child sexual abuse is not uncommon and is a serious problem in the United States.

The impact of sexual abuse can range from no apparent effects to very severe ones. Typically, children who experience the most serious types of abuse abuse involving family members and high degrees of physical force exhibit behavior problems ranging from separation anxiety to posttraumatic stress disorder. However, children who are the victims of sexual abuse are also often exposed to a variety of other stressors and difficult circumstances in their lives, including parental substance abuse. The sexual abuse and its aftermath may be only part of the child's negative experiences and subsequent behaviors. Therefore, correctly diagnosing abuse is often complex. Conclusive physical evidence of sexual abuse is relatively rare in suspected cases. For all of these reasons, when abuse is suspected, an appropriately trained health professional should be consulted.

Causes:
Like many other social problems, child sexual abuse cases is not getting better. This is because the reasons why they happen are a bit complex, and not easy to deal with.

Child sexual abuse is a very secret crime, and unless the victim is bold to tell someone about it, it can be hidden for a lifetime. Children are often scared to tell anyone about the abuse. Many cases of abuse are not reported.

Let us see some characteristics of both abusers (offenders) and victims:

**Abusers:** Many abusers are people that their victims trust. 'In 90% of child sexual abuse cases, the child knows and trusts the person who sexually abuses them'. It is known from research that some child abusers were abused as children. 'Although having been abused as a child heightens the risk for becoming someone who sexually abuses children, the vast majority of sexual abuse victims live their lives without ever sexually abusing others.

Some abusers have mental problems and see themselves as kids too. They tend to have a strong desire for sexual things with kids. This mental condition is called pedophilia. A person suffering from that is a pedophile.

Sexual abusers are usually men, who abuse kids they know. This makes it even more sad because the kids usually have a lot of respect and trust for them.

**Victims:** Sexually abused kids are often vulnerable children (e.g., kids with learning disabilities or isolated kids).

Many abused kids do not tell anyone because they think:

- it was nobody else's business
- it was serious or wrong
- it would be serious for parents to find out, especially if the abuser is known to the family
- didn't want their friends to know
- the offender will kill or hurt them, especially if they were threatened
- none would trust their story

Poverty and needy kids can also fall victim to adult abusers, who pretend to help them, but take advantage of them. This is more true with teenagers from poor or broken homes.

Children and adolescents, regardless of their race, culture, or economic status, appear to be at approximately equal risk for sexual victimization. Statistics show that girls are sexually abused more often than boys are. However, boys’ and, later, men’s, tendency not to report their victimization may affect these statistics. Some men even feel societal pressure to be proud of early sexual activity (no matter how unwanted it may have been at the time). It is telling, however, to note that men who have been abused are more commonly seen in the criminal justice system than in clinical mental health settings.

Studies on who commits child sexual abuse vary in their findings, but the most common finding is that the majority of sexual offenders are family members or are otherwise known to the child. Sexual abuse by strangers is not nearly as common as sexual abuse by family members. Research further shows that men perpetrate most instances of sexual abuse, but there are cases in which women are the offenders. Despite a common myth, homosexual men are not more likely to sexually abuse children than heterosexual men are.

Symptoms:

Symptoms of sexual abuse in children are similar to those of depression or severe anxiety and nervousness:

PHYSICAL SYMPTOMS

Trouble walking or sitting, usually as a result of pain in genital area

Displays knowledge or interest in sexual acts inappropriate to his or her age, or even seductive behavior.

Victim is always hiding and avoiding a specific person for no reason.
Doesn’t want to change clothes in front of others or participate in physical activities.

Sexually transmitted infection (STI), especially for teens.

Pregnancy.

Runs away from home.

New adult words for body parts and no obvious source.

HEALTH SYMPTOMS

Sexually abused kids may suffer:

Bowel disorders, such as soiling oneself (encopresis)

Eating disorders, such as anorexia nervosa

Genital or rectal symptoms, such as pain during a bowel movement or urination, or vaginal itch or discharge

Repeated headaches

Sleep problems
Stomach aches (vague complaints)

SOCIAL BEHAVIOUR

Indulging in alcoholism and drug abuse or engaging in high-risk sexual behavior

Poor school performance and class participation

Have excessive fears

Withdraw from normal and regular activities

Also check for:

Vague or unclear memories of inappropriate childhood sexual abuse

Sexual abuse that can be corroborated by significant others

Clear detailed memories of being sexually abused

Inability to recall a time periods of his or her life

Physical signs of sexual abuse - blood in the underwear - swollen genitalia-tear in vagina or rectum-constant rashes etc
Unable to enjoy any close contact with significant others

Unexplainable feelings of anger or rage

Feelings of rage toward a family relative or family friend

Feelings of fear toward a family relative or family friend

Tendency towards promiscuous behavior

Views relationships with others on sexualization basis

Low self esteem related to the experience of sexual abuse

Has nightmares or other sleep problems without an explanation

Seems distracted or distant at odd times

Has a sudden change in eating habits

Sudden mood swings: rage-fear-insecurity or withdrawal

Writes, draws, plays or dreams of sexual or frightening images

Refuses to talk about a secret shared with an adult or older child
Thinks of self or body as repulsive-dirty or bad

Exhibits adult-like sexual behaviors-language and knowledge

Treatment and Diagnosis:

The first step in helping a victim of sexual abuse is to assess the level of trauma to understand the impact of sexual abuse on a child and the level of the damage. It helps measure the child's perceptions of the abuse from the past and current impact of the abuse, and anticipates future reactions to the trauma. Trauma assessment does not attempt to "solve" problems, but rather to recognize the impact of abuse, understand the damage, and contemplate the treatment work needed.

The assessment must consist of age-appropriate, established questions. It is important to keep in mind the following issues while performing the assessment, as they will influence your treatment decisions:

What is the relationship of the child to the abuser?

How stable is the family?

Are alternative support systems available?

What are the risk factors?

Should the child remain with the family?

Do the courts have a role in the case?
Is there a question of visitation?

Finally, to formulate a relevant treatment plan, the assessment must evaluate all developmental issues, evaluate social areas (self-understanding, self-esteem, perceptions of self and the family), and compare behavior according to what is developmentally "normal" addressing the child's needs one at a time.

When treating a child sexual abuse case it is important to understand how abusers may have groomed the child. This involves deliberately befriending a child (including young adults) over a period of time with the intention of taking advantage. This process can take between 3 weeks and 8 months, depending on the objectives of the offender and the response of the child. Sometimes, the offender may even be in a different country, but may do anything to get the victim (child) into a physical meeting, or connect the child to other offenders in the gang.

There are two broad approaches to the treatment of child sexual abuse:

- victim advocacy/child
- family-systems model

A comprehensive treatment model that utilizes elements from both the child advocacy and family system approach can be the most effective. A comprehensive program will treat all members of the family and include the larger legal and social justice systems as well. There is no one cause of sexual abuse in the family, and good treatment should address all levels of vulnerabilities to abuse.

The essential goal of any family sex abuse treatment program has to be the immediate termination of all forms of abuse within the family. This goal will take precedence over all others and may determine the structure of therapy and the timing of interventions. If the child is at risk for further abuse because the abusing family member denies the abuse, then removal of the abusive family member would be in order.

Another goal is to identify the family's vulnerabilities to abuse and eliminate them or
Cognitive Therapy focuses in how to identify, evaluate, and reframe the dysfunctional cognitions related to the specific trauma and its intense negative emotions and behavioral reactions. Cognitive Behavior Therapy (CBT) includes a range of approaches that have been shown to be effective in treating posttraumatic stress disorder caused by the sexual abuse. Cognitive-behavioral therapy (CBT) methods stem from the central principle that an individual's cognitions play a significant and primary role in the development and maintenance of emotional and behavioral responses to life situations. The manner in which individuals emotionally and cognitively process a traumatic experience contributes to the development and maintenance of PTSD. A central theme contributing to the onset and persistence of PTSD is a perception of ongoing threat, even when the trauma occurred in the distant past.

Trauma-Focused Cognitive Behavioral Therapy is a psychosocial treatment model designed to treat posttraumatic stress and related emotional and behavioral problems in children and adolescents. Developed to address the psychological trauma associated with child sexual abuse. TF-CBT is comprised of:

- education about childhood trauma and PTSD;
- emotion education and emotion regulation skills;
- relaxation and stress management;
- connecting thoughts, feelings, and behaviors related to the trauma;
- direct discussion or sharing of the traumatic event.

There is an emphasis on the connection between the survivor's symptomatology and past environment in order to decrease distress levels by recovering and reinterpreting memories of the trauma. The main strength of this treatment modality is the fact that it teaches coping skills and the ability to feel safe in future situations; a necessity for victims of...
Steps to Develop a Treatment Plan:

The foundation of a good treatment plan is based on the gathering of the correct data. This involves following logical steps the built-in each other to help give a correct picture of the problem presented by the client or patient:

The mental health clinician must be able to listen, to understand what are the struggles the client faces. This may include:

issues with family of origin,
current stressors,
present and past emotional status,
present and past social networks,
present and past coping skills,
present and past physical health,
self-esteem,
interpersonal conflicts
financial issues
cultural issues

There are different sources of data that may be obtained from a:

clinical interview,
Gathering of social history,
physical exam,
psychological testing,
contact with client’s or patient’s significant others at home, school, or work

The integration of all this data is very critical for the clinician’s effect in treatment. It is important to understand the client’s or patient’s present awareness and the basis of the client’s struggle, to assure that the treatment plan reflects the present status and needs of the client or patient.

There are 5 basic steps to follow that help assure the development of an effective treatment plan based on the collection of assessment data.

Step 1, Problem Selection and Definition:

Even though the client may present different issues during the assessment process is up to the clinician to discern the most significant problems on which to focus during treatment. The primary concern or problem will surface and secondary problems will be evident as the treatment process continues. The clinician may have to plan accordingly and set some secondary problems aside, as not urgent enough to require treatment at this time. It is important to remember that an effective treatment plan can only deal with one or a few problems at a time. Focusing in too many problems can lead to the lost of direction and focus in the treatment.

It is important to be clear with the client or patient and include the client’s or patient’s own prioritization of the problems presented. The client’s or patient’s cooperation and motivation to participate in the treatment process is critical. Not aligning the client to participate may exclude some of the client’s or patient’s needs needing immediate attention.

Every individual is unique in how he or she presents behaviorally as to how the problem affects their daily functioning. Any problems selected for treatment will require a clear definition how the problem affects the client or patient.

It is important to identify the symptom patterns as presented by the DSM-5 or Diagnostic and Statistical Manual or the International Classification of Diseases (ICD).

SEXUAL ABUSE BEHAVIORAL DESCRIPTORS:

1. Vague or unclear memories of inappropriate childhood sexual abuse that can be corroborated by significant others.
2. Clear memories of being sexually abused with clear, detailed memories.

3. Inability to recall a time periods of time or periods of his or her life.

4. Physical signs of sexual abuse, blood in the underwear, swollen genitalia, tear in vagina or rectum, constant rashes etc.

5. Unable to enjoy any close contact with significant others.

6. Unexplainable feelings of anger, rage, when coming into contact with a close family relative or family friend.

7. Unexplainable feelings of fear when coming into contact with a close family relative or family friend.

8. A history of promiscuity or tendency towards promiscuous behavior.

9. Views relationships with others on sexualization basis.

10. Low self esteem related to the experience of sexual abuse.

Step 2, Long Term Goal Development:

This step requires that the treatment plan includes at least one broad goal that targets the problem and the resolution the problem. These long term goals must be stated in non-measurable terms but instead indicate a desired positive outcome at the end of treatment.

LONG TERM GOALS SEXUAL ABUSE:

1. Explore the issue of being sexually abused with an better capacity for intimacy in relationships.

2. Start the healing process from sexual abuse with gaining a new enjoyment of appropriate sexual contact.

3. Successfully work through the issues related to being sexually abused with a greater understanding and better control of feelings.

4. Learn to recognize and accept the sexual abuse without sexualization of relationships.

5. Determine whether sexual abuse occurred.

6. Help minor move away from being a victim of sexual abuse and become a survivor of sexual abuse.
Step 3, Objective or Short Term Goal Construction:

Objectives or short term goals must be stated in measurable terms or language. They must clearly specify when the client or patient can achieve the established objectives. The use of subjective or vague objectives or short term goals is not acceptable. Most or all insurance companies or mental health clinics require measurable objectives or short term goals.

It is important to include the patient’s or client’s input to which objectives are most appropriate for the target problems. Short term goals or objectives must be defined as a number of steps that when completed will help achieve the long-term goal previously stated in none measurable terms. There should be at least two or three objectives or short-term goals for each target problem. This helps assure that the treatment plan remains dynamic and adaptable. It is important to include Target dates. A Target day must be listed for each objective or short-term goal.

If needed, new objectives or short-term goals may be added or modified as treatment progresses. Any changes or modifications must include the client’s or patient’s input. When all the necessary steps required to accomplish the short-term goals or objectives are achieved the client or patient should be able to resolve the target problem or problems.

If required all short term goals or objectives can be easily modify to show evidence based treatment objectives. The goal of evidence based treatment objectives (EBT) is to encourage the use of safe and effective treatments likely to achieve results and lessen the use of unproven, potentially unsafe treatments. To use EBT in treatment planning state restate short term goals in a way that steps to complete that goal and achieve results. For example, the short term goal “13. Increase positive self-descriptive statements.” Can be restated as; “By the end of the session the patient or client will list at least 5 positive self descriptions of himself or herself, and assess how they can help alleviate the presenting problem.” Remember, that it must be stated in a way one can measure effectiveness.

It is important to note that traditional therapies usually rely more heavily on the relationship between therapist and patient and less on scientific evidence of proven practices.

EXAMPLES OF SHORT TERM GOALS FOR SEXUAL ABUSE:

1. Implement a clear plan to protect minor or other minors in the family from any future
sexual abuse.

2. Allow minor time to describe the entire story of the abuse.

3. Develop clear intimacy boundaries within the family.

4. Identify any family stressors or dynamics that contributed to the sexual abuse.

5. Assess the type of abuse, frequency, and duration of the abuse.

Step 4, Strategies or Interventions:

Strategies or interventions are the steps required to help complete the short-term goals and long-term goals. Every short-term goal should have at least one strategy. In case, short-term goals are not met, new short-term goals should be implemented with new strategies or interventions. Interventions should be planned taking into account the client’s needs and presenting problem.

EXAMPLES OF INTERVENTIONS FOR SEXUAL ABUSE:

1. Confront and challenge any denial of sexual abuse within the family.

2. Implement a clear plan to protect minor and other children from any further sexual abuse.

3. Teach minor how to empower herself or himself to protect himself or herself.

4. Explore family dynamics and identify any stress factors that contributed to the sexual abuse.

5. Assess whether perpetrator needs to be remove from the home.

Step 5, Diagnosis:

The diagnosis is based on the evaluation of the clients present clinical presentation. When completing diagnosis the clinician must take into account and compare cognitive, behavioral, interpersonal, and emotional symptoms as described on the DSM-5 Diagnostic Manual. A diagnosis is required in order to get reimbursement from a third-party provider.
Integrating the information presented by the DSM-5 diagnostic manual and the current client’s assessment data will contribute to a more reliable diagnosis. It is important to note that when completing a diagnosis the clinician must have a very clear picture all behavioral indicators as they relate to the DSM-5 diagnostic manual.

**DSM V CODE Paired with ICD_9-CM Codes:**

**Possible Diagnostic Suggestions for Children with Sexual Abuse History: (Parenthesis Represents ICD-10-CM Codes Effective 10-2014).**

- 309.89 (F43.8) Other Specified Trauma- and Stressor-Related Disorder
- 309.9 (F43.9) Unspecified Trauma- and Stressor-Related Disorder
- 309.21 (F93.0) Separation Anxiety Disorder
- 312.23 (F94.0) Selective Mutism
- 309.81 (F43.1 0) Posttraumatic Stress Disorder (includes Posttraumatic Stress Disorder for Children 6 Years and Younger)
  - Specify whether: With dissociative symptoms
  - Specify if: With delayed expression
- 308.3 (F43.0) Acute Stress Disorder
  - Adjustment Disorders Specify whether:
    - 309.0 (F43.21) With depressed mood
    - 309.24 (F43.22) With anxiety
    - 309.28 (F43.23) With mixed anxiety and depressed mood
    - 309.3 (F43.24) With disturbance of conduct
    - 309.4 (F43.25) With mixed disturbance of emotions and conduct
    - 309.9 (F43.20) Unspecified
- 307.47 (F451.5) Sleep Terror
- 307.47 (F51.5) Nightmare Disorder
300.23 (F40.1 0) Social Anxiety Disorder (Social Phobia)

Specify if: Performance only

300.01 (F41.0) Panic Attacks

(Only if causes for Panic Attack can not be better explained as a specifier within the context of that main disorder such as Anxiety Disorder, Post Traumatic Stress Disorder etc.).

Panic Attack Specifier

300.22 (F40.00) Agoraphobia

300.02 (F41.1) Generalized Anxiety Disorder

300.09 (F41.8) Other Specified Anxiety Disorder

300.00 (F41.9) Unspecified Anxiety Disorder

Major Depressive Disorder

Single episode

296.21 (F32.0) Mild

296.22 (F32.1) Moderate

296.23 (F32.2) Severe

296.24 (F32.3) With psychotic features

296.25 (F32.4) In partial remission

296.26 (F32.5) In full remission

296.20 (F32.9) Unspecified

Recurrent episode

296.31 (F33.0) Mild

296.32 (F33.1) Moderate

296.33 (F33.2) Severe

296.34 (F33.3) With psychotic features

296.35 (F33.41) In partial remission
296.36 (F33.42) In full remission

296.30 (F33.9) Unspecified

300.4 (F34.1) Persistent Depressive Disorder (Dysthymia)
Specify if: In partial remission, In full remission
Specify if: Early onset, Late onset
Specify if: With pure dysthymic syndrome; With persistent major depressive episode; With intermittent major depressive episodes, will current episode; With intermittent major depressive episodes, without current episode
Specify current severity: Mild, Moderate, Severe

311 (F32.8) Other Specified Depressive Disorder

311 (F32.9) Unspecified Depressive Disorder

Problems Related to Family Upbringing
V611.20 (Z62.820) Parent-Child Relational Problem
V61.8 (Z62.891) Sibling Relational Problem
V61.8 (Z62.29) Upbringing Away From Parents
V611.29 (Z62.898) Child Affected by Parental Relationship Distress

Other Problems Related to Primary Support Group
V611.03 (Z63.5) Disruption of Family by Separation or Divorce
V61.8 (Z63.8) High Expressed Emotion Level Within Family
V62.82 (Z63.4) Uncomplicated Bereavement

Child Maltreatment and Neglect Problems Child Physical Abuse
Child Physical Abuse, Confirmed
995.54 (T74.1 2XA) Initial encounter
995.54 (T74.1 2XD) Subsequent encounter
Child Physical Abuse, Suspected
995.54 (T76.12XA) Initial encounter
995.54 (T76.1 2XD) Subsequent encounter

Child Sexual Abuse
Child Sexual Abuse, Confirmed
995.53 (T74.22XA) Initial encounter
995.53 (T74.22XD) Subsequent encounter
Child Sexual Abuse, Suspected
995.53 (T76.22)(A) Initial encounter
995.53 (T76.22XD) Subsequent encounter

Child Neglect
Child Neglect, Confirmed
995.52 (T74.02XA) Initial encounter
995.52 (T74.02XD) Subsequent encounter

Child Psychological Abuse
Child Psychological Abuse, Confirmed
995.51 (T74.32XA) Initial encounter
995.51 (T74.32XD) Subsequent encounter
Child Psychological Abuse, Suspected
995.51 (T76.32XA) Initial encounter
995.51 (T76.32XD) Subsequent encounter

Overall Integration of a Treatment Plan:

Choose one presenting problem. This problem must be identified through the assessment
process.

Select at least 1 to 3 behavioral definitions for the presenting problem. If a behavior definition is not listed feel free to define your own behavioral definition.

Select at least long-term goal for the presenting problem.

Select at least two short-term goals or objectives. Add a Target Date or the number of sessions required to meet this sure term goals. If none is listed feel free to include your own.

Based on the short-term goals selected previously choose relevant strategies or interventions related to each short term goal. If no strategy or intervention is listed feel free to include your own.

Review the recommended diagnosis listed. Remember, these are only suggestions. Complete the diagnosis based on the client’s assessment data.

Sample Treatment Plan:

Present Behavioral Descriptors of Problem:

Clear memories of being sexually abused with clear, detailed memories.

Unexplainable feelings of anger, rage, when coming into contact with a close family relative or family friend.

Unexplainable feelings of fear when coming into contact with a close family relative or family friend.
Long Term Goals:

Start the healing process from sexual abuse with gaining a new enjoyment of appropriate sexual contact.

Successfully work through the issues related to being sexually abused with a greater understanding and better control of feelings.

Help minor move away from being a victim of sexual abuse and become a survivor of sexual abuse.

Short Term Goals Objectives:

Implement a clear plan to protect minor or other minors in the family from any future sexual abuse.

Identify any family stressors or dynamics that contributed to the sexual abuse.

Strategy or Intervention for Goal 1:

Implement a clear plan to protect minor and other children from any further sexual abuse.
Teach minor how to empower her or him to protect himself or her.

Assess whether perpetrator needs to be remove from the home.

Report sexual abuse to appropriate child protection agencies.

Strategy or Intervention for Goal 2:

Explore family dynamics and identify any stress factors that contributed to the sexual abuse.

Probe for any family history of prior sexual abuse.

Increase family knowledge on sexual abuse impact, and develop appropriate ways to help minor recover from sexual abuse.

DSM V Diagnosis:

DSM V CODE Paired with ICD_9-CM COdes:

Diagnostic Suggestions for Children with Specific Phobia: (Parenthesis Represents ICD-10-CM Codes Effective 10-2014).

Adjustment Disorders Specify whether:

309.4 (F43.25) With mixed disturbance of emotions and conduct

307.47 (F451.5) Sleep Terror
Child Sexual Abuse
Child Sexual Abuse, Confirmed
995.53 (T74.22XA) Initial encounter