Some Considerations About Sexual Abuse and Children with Sexual Behavior Problems

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SUMMARY. In the mid 1980s treatment programs for children twelve years and younger who molested other children began to appear. There was little known about these children and there were numerous misconceptions about this population. It was believed that the primary etiological factor in the development of this behavior was previous hands-on sexual abuse to the child. It was also believed that a majority of sexually abused children would engage in problematic sexual behaviors and that it was quite likely that they would go on to molest others. In the intervening years a great deal has been learned about children who molest. The diversity of reasons for the development of problematic sexual behavior has been researched. Another important finding is that there is a range of disturbed sexual behaviors in children. This is important as there has been an overidentification of children who engage in problematic sexual behaviors as children who are molesting. A continuum of sexual behaviors in children is described which delineates three groups of children who engage in problematic sexual behavior, only one of which is molesting other children. With this understanding professionals can distinguish...
between children who engage in natural and healthy sexual behaviors, sexually-reactive behaviors, extensive but mutual sexual behaviors, and children who molest. This assists in more accurate assessment and treatment planning in an era in which children can be placed on sex offender registries and potentially be subject to community notification.

**KEYWORDS.** Children, child sexual abuse, children with sexual behavior problems, child dissociative disorders

In 1985, the first treatment program designed exclusively to treat children (twelve years and younger) who sexually molest other children and their families opened its doors at Children’s Institute International in Los Angeles. There was very little understanding at that time about this special population of children.

- What are the etiological factors behind this behavior?
- Are all children who molest victims of sexual abuse?
- How many victims of sexual abuse will molest other children?
- How many children who sexually abuse other children are there?
- Are all children who are engaging in problematic sexual behaviors molesting other children?
- How should we define molesting behavior in children?
- What is natural and healthy sexual behavior in children and how does this differ from molesting?

These and many more questions were of immediate concern to the program as it sought to develop treatment tailored to an understanding of the children and their families.

**ARE ALL CHILDREN WHO MOLEST VICTIMS OF SEXUAL ABUSE?**

At the inception there was a belief that the major etiological factor for the molesting behavior by the children was that they had been sexually abuse. This belief was based on the incorrect notion that virtually all
adult sex offenders had been sexually abused, and that the cause for their sexual offending was having been sexually abused (Hanson & Slater, 1988; Murphy & Peters, 1992). As more children who molested were brought into treatment, it was discovered that many did not talk about being sexually abused. As most of the children were boys, a belief developed that the reason more hands-on sexual abuse was not being found in the histories of the children was due to it being difficult for boys to disclose sexual abuse.

In the mid 1980s several articles were published about children who molested other children. In a sample of 14 boys and four girls, Friedrich and Luecke (1988) found that 75% of the “sexually-aggressive” boys and 100% of the “sexually-aggressive” girls had been sexually abused. In a sample of 47 boys, Johnson (1988) found that overall 50% of the children who molested had been sexually abused, with 72% of the 4-6 year olds, 42% of the 7-10 year olds, and 35% of the children between 11-12 years old being sexually abused. Virtually all of the boys had sustained pervasive harsh physical punishment. Forty-six percent (46%) of the victims of these boys were siblings, 18% were cousins, 16% were schoolmates and six percent were foster siblings. In an article on 13 girls who molest, Johnson (1989) found that all of the girls had been sexually abused and they had sustained pervasive harsh physical punishment. Of the first victims of the girls, 54% were siblings, 23% were cousins, and 23% were friends.

While the samples of children who molest were small, the lower than expected incidence of sexual abuse in boys was corroborated by information gathered on adult sex offenders. Murphy and Peters (1992) wrote, “There is a good deal of clinical lore that a history of being sexually victimized is predominant in the backgrounds of sex offenders. However, there are a number of problems when extrapolating the clinical lore to the legal arena. First, one must realize that estimates currently suggest that somewhere between 1 in 9 children to 1 in 10 young males will be sexually abused before the age of 18 (Finkelhor, Hotaling, Lewis, & Smith, 1990). The vast majority of these children do not grow up to be sex offenders and therefore one could not classify someone as a sex offender based on the fact that they have been sexually abused. In addition, (Hanson & Slater, 1988) reviewed data on 1,717 offenders included in 18 different studies. They found that the average rate of sexual abuse across studies was 28%” (pp. 33).

Although the empirical literature indicated that not all children who molest other children were themselves victims of sexual abuse, this belief has persisted in the minds of the general public, and in some
police, child protective service workers and mental health professionals (Friedrich & Chaffin, 2000). It is important to counteract this belief in professionals, as some may influence children who molest to make a disclosure of sexual abuse when there has been none. Children may believe that there is only one acceptable explanation for their molesting behavior and move to satisfy the belief of the therapist by fabricating a history of sexual abuse. It is also important that children themselves do not believe that, if they were molested, this is the sole reason for their molesting behavior. This could act as a reason, justification, or a lessening of resolve to curtail sexually aggressive feelings and behaviors. It could also make them feel less competent to cease from engaging in such behaviors. This belief can also dishearten parents who may feel that if their children have been sexually abused that they are destined to engage in aggressive sexual behavior.

The belief that sexually abused children will molest others has had the effect on many in the general public of seeing child sexual abuse victims as a potential threat to their children. Children who have been sexually abused are unjustifiably seen as at substantial risk to molest others (Friedrich & Chaffin 2000). In schools, foster homes and even in the child’s biological home, sexual behavior by a sexually abused child is often seen as far more disturbed than the same sexual behavior by a child who has not been sexually abused.

Understanding the etiological factors for children to molest other children is still in its infancy. Much work remains to be done. Several studies funded by the National Center on Child Abuse and Neglect found similar factors as in the Johnson (1988, 1989) and Friedrich and Luecke (1988) studies (Bonner, 1998; Gray, 1996; Gray, Busconi, Houchens, & Pithers, 1997; Gray, Pithers, Busconi, & Houchens, 1999; Pithers, Gray, Busconi, & Houchens, 1998a, 1998b). The Child Sexual Behavior Checklist (Johnson, 1998) was developed to evaluate the sexual behaviors of the children who have been identified as in need of therapy for sexual behavior problems. Question 17 in Part III asks if the child witnessed violence between people he or she knows. Our unpublished data shows that respondents consistently report that children who molest have witnessed violence between their parents or caretakers. It is possible that some children who live in homes with domestic violence believe that sex and aggression are complementary. Children who live in homes with partner violence often hear intense arguments in which one parent accuses the other of sexual misconduct, attempts to control all of the behaviors of that parent and emotionally and/or physically hurts the other parent as a payback for the alleged or real infidelity.
Children hear angry sexual language and witness violent interactions between parental figures, in which one parent violates the other’s sexual rights. Children do not learn that sex is an expression of love between two people. Rather, constant fighting and jealousy by parents related to sex teaches the children that people use sex to hurt other people and that violence in relation to sex is natural. When sex might possibly appear to be a caring act is generally after violence has occurred. This pairing may also cause confusion for the child’s developing template for sexual relationships. In the homes of children who molest, the children are very aware of the trauma and violence in the parents’/caretakers’ lives and often become part of the drama as one or the other parent pulls them in as an ally or a scapegoat.

**HOW MANY VICTIMS OF SEXUAL ABUSE WILL MOLEST OTHER CHILDREN?**

The belief that sexual abuse was the major etiological factor for sexually abusive behavior in children spawned the alternate belief that children who were sexually abused were likely to sexually abuse other children. This belief has persisted, in spite of literature since 1987 to the contrary. As Kaufman and Zigler (1987) have observed:

The findings of the different investigations are not easily integrated because of their methodological variations. Nonetheless, the best estimate of intergenerational transmission appears to be 30% plus or minus 5%. This suggests that approximately one-third of all individuals who were physically abused, sexually abused, or extremely neglected will subject their offspring to one of these forms of maltreatment, while the remaining two-thirds will provide adequate care for their children. The rate of abuse among individuals with a history of abuse (30 plus or minus 5%) is approximately six times higher than the base rate for abuse in the general population (5%).

Being maltreated as a child puts one at risk for becoming abusive but the path between these two points is far from direct or inevitable. In the past, unqualified acceptance of the intergenerational hypothesis has had many negative consequences. Adults who were maltreated have been told so many times that they will abuse their children that for some it has become a self-fulfilling prophecy. Many who have broken the cycle are left feeling like
walking time bombs. In addition, persistent acceptance of this belief has impeded progress in understanding the etiology of abuse and led to misguided judicial and social policy interventions. The time has come for the intergenerational myth to be put aside and for researchers to cease asking, “Do abused children become abusive parents?” and ask, instead, “Under what conditions is the transmission of abuse most likely to occur.” (p. 192)

Research on sexually abused children does not show that the majority of sexually abused children will engage in worrisome sexual behaviors, much less sexually abusive behaviors. In a meta analysis of studies of sexually abused children Kendall-Tackett, Williams, and Finkelhor (1993) noted: “Across six studies of sexually abused preschoolers (the children most likely to manifest such symptoms) an average of 35% exhibited sexualized behavior” (p. 170). Friedrich, Gramsch, and Damon (1992), using an instrument specially designed to measure a wide range of sexual behaviors, detected a somewhat higher percentage. But across all sexually abused children it may be only a half of all victims who engage in any type of sexual behavior when younger than 12. The lowest estimate was 7% based on a very large study, including many well functioning older children (Conte & Schuerman, 1987).

Johnson (1998) estimated that less than .5 % of sexually abused children would go on to sexually abuse other children during childhood. In fact, specialized residential treatment programs for children who molest are generally unable to find sufficient numbers of children with the severest level of sexual behavior problem to fill up their beds (Johnson, 1998). Unable to fill all of their beds with children who sexually offend, these facilities accept children with a lesser degree of sexual problems. This can present a danger to children who are sexualized but who are not offending (see below, A Continuum of Sexual Behaviors).

The belief that if a child were sexually abused, the child would go on to abuse other children has been especially strong when a child, particularly a boy, has been sexually abused in a particularly cruel manner and for an extended amount of time. This can have exceptionally negative and unfair effects on the sexually abused and traumatized child as illustrated in the following clinical vignette.

Enrique’s early life while financially poor, was enriched by his mother’s love. His recollections of his mother are very fond. He remembers no turmoil or trouble at any time when they lived together. He recalls spending a great deal of time at amusement
parks. He wants to preserve this idealized view of his mother as it is all he has of his past.

His mother lived on and off with his birth father who was physically abusive to her and had many extramarital affairs. Enrique’s father left before he was four. He has no recollection of his father—no physical or mental picture of him.

Enrique’s mother remarried when he was six years old. This marriage was also very violent and abusive. His mother was raped and physically battered repeatedly by her second husband. After having two children, she left him. In order to get money from the second husband to care for her three children, she complied with the husband’s demand that Enrique go over to his house when he requested. During these visits to his stepfather’s home, Enrique was locked in a room, blindfolded, and chained to a bed. The stepfather and other men sodomized Enrique and forced him into oral/genital contact. If he told his mother, Enrique was fearful for his mother’s life and that his stepfather would sexually abuse his brothers. The stepfather reinforced these threats every time he dropped Enrique home.

By chance, Enrique’s stepfather was stopped for a traffic violation. Pornographic pictures of Enrique being sodomized and fellated by the father and other men were found in his possession. Enrique and his two brothers were removed from his mother due to lack of protection and put in foster care. Due to the social worker’s concern that Enrique would molest his brothers because he had been sexually abused, they were separated into different foster homes. After his stepfather was convicted of sexual assault and sent to prison, his mother absconded. Enrique never heard from her again. Lost and alone, his behavior escalated into rages and destruction of property. The staff in the residential facility feared that he would sexually victimize other boys in the facility and watched him diligently. Any hint of physical contact, that was vaguely suspicious, got strong reprimands from the staff. They made it clear that they did not trust him to be close to any of the children, due to “his history.”

In the course of the treatment it became evident that Enrique’s rages and destructive behaviors exploded when he felt trapped, or unloved and misunderstood. These two situations related directly to traumatic events and memories in his earlier life. In school situations, if the teacher demanded that he finish his work, and would not allow him to take a break or take a time out, but made him sit at
his desk, Enrique would hear the voice of his stepfather and see his face. In a dissociated state, he would see black and go into a rage. Unaware of where he actually was, he would lash out and try to run away, sometimes throwing things. This feeling of being trapped and unable to move, catapulted him back to the sexual abuse, locked in the room, blindfolded and chained. When the staff tried to restrain him, he would struggle violently to get away. He never hurt any staff.

His feeling of absolute emotional devastation at the disappearance of his mother created overwhelming feelings in him that he couldn’t tolerate and would frequently dissociate. At other times, when he experienced these feelings of loss he would externalize the terrifying feelings and blame her loss on the staff. In his thinking, if he hadn’t been taken away from her and placed in residential treatment, his mother never would have left him; therefore it was Child Protective Services and the staff who sent his mother away. He could not emotionally tolerate alternative explanations for her disappearance. This irrational thought would pervade his thinking and he would become argumentative. He would then engage staff in interminable circular verbal altercations about his current behavior that were without foundation, and sometimes destroy property. On these occasions he was in a dissociated state and had no control of himself and little recollection of the events until the next day.

Enrique rarely argued intensely with the female staff, and always sought out one female staff person to relate to in a positive manner. Throughout his time in out-of-home care he found a “protective female” staff to whom he could talk and go to after his rages. He would relate to this staff person as if she were his mother. There were no sexual overtones attached. Unfortunately, due to the highly fluid nature of residential staff, Enrique would frequently become attached to a female staff who would leave for a higher paying position. Each of these losses further catapulted Enrique into despair and dissociation of the devastating feelings. While a protective female staff person fulfilled some of his needs for nurturing, she could rarely stop his rages. In fact, staff would say that many times he seemed to see and hear no one.

When Enrique began to understand the trauma-related nature of his thoughts and feelings and was able to talk about his mother, his abuse and his fears, he needed to dissociate less. However, he continued to have major problems in interactions with staff who trig-
gered memories of his abuse. After his dissociative process was diagnosed and he agreed that his therapist could talk with him and the staff together to develop methods to assist him, his dissociative states gradually diminished. Enrique was able to use methods to ground himself in the present, internally say and think soothing thoughts, while the staff verbally assisted him to stay present and know what was happening and that there was no present danger and then direct him to a person to help him. With this, and the development of strong and permanent attachments, the rages abated totally.

Unfortunately, the staff at his facility continued to believe that he would sexually abuse someone due to the severity of his abuse. There were no reported aggressive sexual thoughts or desires on Enrique’s part towards either adults or children. At age 15 Enrique began a relationship with a same age girl. At six months into the relationship there were no sexual problems. He was aware of his strong desire for a relationship to replace his parents and of the abandonment he may feel, if the relationship ends with the girl leaving him. He continued to monitor his sexual feelings, thoughts and behaviors for any confusion, aggressive or submissive trends.

**A CONTINUUM OF SEXUAL BEHAVIORS**

An additional complication that emerges when working with children with sexual behavior problems is defining when the sexual behavior is abusive and when it is less serious and not intended to harm, but is clearly beyond what can be considered within the normal and healthy range.

In a series of papers, I have described a continuum of sexual behaviors in children (Johnson, 1988, 1999, 2000). Along this continuum, four groups were identified. One group consists of children who engage in natural and healthy sexual behaviors. The other three groups consist of children with sexual behavior problems. These three groups are defined as: sexually-reactive children, children who engage in extensive, mutual sexual behaviors, and children who molest other children. I believe it is essential to differentiate between the three groups because the treatment needs and the “systems” interventions are different. This differentiation is also essential in making certain that children with less serious sexual behaviors are not misidentified as children who molest.
Natural and Healthy Sexual Behaviors

Natural and healthy sexual exploration during childhood is an information-gathering process in which young people explore each other’s bodies by looking and touching (“playing doctor”) as well as by exploring gender roles and behaviors (“playing house”). Children involved in healthy sexual play are of similar age, size, and developmental status and participate on a voluntary basis.

When siblings engage in mutual sexual exploration, most sexual play is between children who have an ongoing, mutually enjoyable play and/or school friendship. Their sexual behaviors are limited in type and frequency and occur at several periods of their young lives. Children’s interest in sex and sexuality is balanced by their curiosity about other aspects of their lives. Healthy sexual exploration may result in embarrassment but does not usually result in deep feelings of anger, shame, fear, or anxiety. If children are discovered in sexual exploration and instructed to stop, the behavior generally diminishes, at least in the view of adults. Children’s feelings regarding their sexual behavior are generally light-hearted and spontaneous. Children usually experience pleasurable sensations from genital touching. Some children experience sexual arousal while some children experience orgasm. Sexual arousal and orgasm are reported more frequently in older children entering puberty (Johnson, 1988, 1999, 2000).

Sexually-Reactive Children

These children may engage in self-stimulating behaviors and/or sexual behaviors with other children and, sometimes, with adults. This type of sexual behavior is generally in response to environmental cues that are overly stimulating or reminiscent of previous abuse or to feelings that reawaken other traumatic or painful memories. Many of these children have lived in sexually overwhelming environments in which they have not been shielded from adult or adolescent sexuality.

These children engage in sexual behavior is a way of coping with overwhelming feelings of which they cannot make sense. Hiding the sexual behaviors or finding friends to engage in the behaviors in private may be less possible for these children as the behaviors may be compulsively used for tension-release. This type of sexual behavior is often not within the full conscious control of the child. In some situations, children are trying to make sense of something sexual done to them by doing it to someone else. They do not coerce others into sexual behaviors
but act out their confusion on others in an attempt to reduce anxiety and confused sensations and feelings. Many do not understand their own or others’ rights to privacy or physical space integrity. While there is no intent to hurt others, receiving sexual behaviors can be confusing for the other person and feel like a violation or abuse (Johnson, 1988, 1999, 2000).

In the following vignette, the problem with differentiating between sexually abusive and sexually-reactive behavior is illustrated. Additionally, the confusion of environmentally induced confusion rather than hands-on sexual abuse to the child is portrayed.

Tanya was born to a 19-year old drug-addicted mother. Her mother had no knowledge who the father was. Throughout Tanya’s early life she lived with her mother in different motel rooms. During this time Tanya took care of her mother, soothing her when she was distraught, talking to her when she wanted to talk, and being quiet when she didn’t want her to talk. To get food and drugs Tanya’s mother engaged in sexual relations with a very wide variety of men. While her mother engaged in sexual activity with the men, Tanya would look on. Over the course of these early years, Tanya called 911 on three separate occasions when her mother had been badly beaten up by one of the men.

During Tanya’s first three and a half years of life her mother had two other children. Tanya did her best to help care for the littler children. After the first two 911 calls, the children stayed with their maternal grandmother who was alcoholic while their mother recuperated. After the third 911 call, the Child Protective Services placed all three children in foster care and identified the mother’s pattern of behavior to the court. After this the mother disappeared for over a year and returned in a very weakened physical condition with severe liver damage.

Tanya and her brother, Paul, were placed in a foster home in which the prospective foster parents had said that they would not accept children who had been sexually abused. The infant was placed in a different foster home. As there were no indications that the children had been sexually abused, Tanya and Paul moved into this foster home. Within three months of moving into the foster home, Tanya began to masturbate. The masturbation increased to the point that she was humping and rubbing her genitals in a rhythmic fashion almost everywhere. She would use the foster father’s leg, the leg of the dining room table, the arms of the sofas, and
stuffed animals. In another few months she started to suck on the neck of the foster father, she touched the male social worker on the upper thigh, moving her hand toward his genitals.

Approximately six months into the placement Tanya was found humping her little brother, Paul, who was a year younger than her. The initial reaction of the social worker was to remove Tanya, saying that she was molesting her brother. However, Tanya’s behavior was more akin to that of sexually-reactive children than children who molest. She liked her brother, and her humping of her brother was exactly what she had watched her mother do for years when the door to the bedroom was open. Her brother yelled to the foster parents to get her off of him. There was no force or coercion, no threats or intent to harm. Her brother said she just got on top of him and started humping. Since this author had just started providing service to Tanya, I requested that she not be removed but that we work with both children to decrease the sexual behavior and understand the source of the premature sexual activity.

The foster mother believed that Tanya had to have been sexually abused. While the possibility that Tanya was sexually abused in the situation in which she lived for her first four years of life were high, Tanya had no conscious recollection of having been touched in a sexual manner by any of the men who came into her mother’s life. What did emerge in the course of the therapy were certain traumatic memories that precipitated Tanya into the sexual behaviors. Some triggers for the behavior were external to her and could be identified by others. Hearing any siren, whether it be police, fire, or ambulance, as well as hearing arguing between adults, or even minor disagreements, triggered her to sexual behavior. The third trigger was internal. At times Tanya was overcome with anxiety and depression at the loss of her mother. She desperately worried about her mother’s safety and felt she needed to take care of her. The triggers caused an internal state of panic in Tanya, and her response was an immediate attempt to dampen her anxiety by the rhythmic motions of her genitals against objects. Tanya did not use her hands but humped anything she could find. With the help of her foster mother and hard work in therapy, she recognized that she was doing what she watched her mother do to men. This behavior did not lessen her panicky, sad or worried feelings, but transmit her to a dissociated state where she split off from her feelings and her body. In this dissociative state, she was oblivious to her environment and could no longer feel. With the help of her fos-
ter parents, Tanya was gradually able to identify the situations and feelings as they arose, and then engage in active strategies to diminish the feelings while staying present. Working with Tanya and the foster parents together, many activities were chosen and agreed upon that would be used when Tanya started feeling anxious and depressed. She learned to engage in fun and movement oriented activities with her foster parents, to leave the situation, or to talk about her thoughts and feelings with her foster parents and her therapist.

Additional factors that may encourage sexually-reactive behavior in children are: not getting clear messages about unacceptable sexual contact, and sexual abuse that is repressed as in the following vignette.

John’s mother and father were drug addicts. He was removed from them when he was an infant, and lived with his paternal aunt and uncle. John’s parents continued their drug use for the first six years of his life. While John was living with his aunt and uncle, his mother had sporadic visits with him, and his father disappeared. When he was around five years old, on one of these visits, he told his mother that his uncle’s friend had made him suck on his penis, and this man had also sucked on John’s penis two times. He said he liked the man very much and they had a really good time playing video games. The mother immediately told the Child Protective Service’s worker. When the CPS worker asked John, he denied the story. The police also interviewed John to no avail.

John was put in therapy to see if this information would come forward. John’s uncle and aunt selected the therapist and took John to the therapy appointments. The aunt and uncle insinuated to the therapist that the allegations were trumped up by the drug-addicted mother, who wanted to get the aunt and uncle in trouble. The therapist had no contact with the mother, and did not directly ask John at any time during the therapeutic process whether someone had engaged him in oral/genital contact. The therapist believed that if this had happened, the child himself would bring it up.

The aunt and uncle did not make the man who allegedly abused John leave the home. When John’s mother would visit, she would ask him if the man who molested him was still at the house. John would tell the mother that he was, but then when the mother confronted the aunt and the uncle, John would generally retract his statements. On the occasions when he didn’t retract his statements,
the aunt and uncle would say they were not leaving the man alone with John. Worrying about her son’s safety increased her strength to get off and stay off drugs. At the age of six and a half, John was able to return to his mother.

At the age of eight a compact disc was taken to the local police station near where the aunt and uncle lived with a note that the boy was John. On the CD, John was recognized as the victim of sodomy by an adult male and oral-genital contact by a woman. An investigation ensued. Neither the man or woman could be identified but it was determined that the man on the CD was not the same person who John had identified as molesting him when he was five. The pictures on the CD were of John at about three years old. Many of the pictures were in dark rooms with only a single light bulb. John often looked very drowsy or drugged.

As this information came out, and John was re-questioned about his earlier disclosure about molestation, he was very forthright about discussing the person who molested him. Now living separate from his aunt and uncle, he also acknowledged that the man stayed around his aunt and uncle’s house, but said that he did not have any sexual contact with him again. John remembered three instances of oral/genital contact with the man. He said that the man was his very good friend and that he missed him. He said that the man was always very nice to him and didn’t ever hurt him. He had no memories of not being forthright with Child Protective Service’s and the Police. He remembered telling his mother about the oral-genital contact. John had no conscious memory of the sexual abuse portrayed on the CD.

While John’s behavior had always been somewhat physically intrusive with all adults, the intrusive behavior became sexualized after the disclosure of the sexual abuse on the CD and discussion of the sexual abuse at his aunt and uncle’s house. At times he would pounce on his mother and try to hump her as if simulating intercourse. He would also be all over her, trying to kiss her on the neck and face, and trying to touch her breasts. This would happen at home, in stores, and in the home of friends.

John entered therapy due to the sexual abuse on the CD, his lack of understanding that sexual contact by adults to children is abusive, and his uncontrolled sexual behavior with his mother. In assessing for dissociative phenomena, his mother was able to indicate that there were many times when John appeared to “space out.” This was often under times of stress at home and at school, and
also sometimes when he was playing. John’s memory for recent and distant events was very spotty. His ability to handle conflict or heightened emotions was very poor. It would either send him into a rage, he would “space out,” or he would want to go to sleep. He had very intense mood swings and could be physically overpowering to his mother at times of rage whereas generally he was a gentle child.

In working with John around the sexual behaviors, he indicated that he would get sexual feelings in his body and then would find himself jumping on his mother and humping her. It wasn’t until she would yell at him to get off that he would become aware that he was on top of her. He said there was a gap in his memory between the sexual feelings and being on top of her mother. In thinking about his thoughts when he got the sexual feelings, he realized to his horror that he wanted to penetrate her anally. He said he knew it was not all right to want to be sexual with your mother but that the urges just swept over him. He said he didn’t know where he got the thoughts and urges and did not want to have them.

John’s use of dissociation to try to block the unacceptable thoughts and sexual urges for contact with his mother was quite receptive to behavioral interventions. After cataloging the sexually intrusive behaviors, the touching of his mother’s breasts was selected as the target behavior to extinguish first. This was selected as it was the most frequent, happened in many locations, and was very distressing to his mother and others who observed it. After practice between John and his mother in the therapist’s office, John was gently and consistently made aware by his mother when he was touching, or attempting to touch, her breasts, either with his hands, his face, his head, the top of his head, or his forehead. When this was brought to his attention, his mother would gently say “no,” take hold of his hand and put it by his side. When John wanted to and it was appropriate, they played rock, paper, scissors in order to establish appropriate physical contact that was playful and enjoyable to both of them. After three weeks of work on this intrusive sexual behavior it ceased completely. Each time there was a court hearing that related in any way to the sexual abuse charges, there would be a re-emergence of the behavior, but to a lesser degree.

It is likely that the unconscious strivings were the result of sexual abuse by the man and woman shown on the CD and “his friend.” John remained unable to remember anything about the
abuse when he was three, perhaps due to it’s unacceptable nature and/or that he was in a drugged state when it occurred and he therefore did not have access to it at a conscious level.

The above examples include children who were dissociative. However, it should be noted that most children with sexual behavior problems do not dissociate when engaging in the problematic sexual behaviors.

**Children Who Engage in Extensive, Mutual Sexual Behaviors**

Often distrustful, chronically hurt and abandoned by adults, children in this group relate best to other children. In the absence of close, supportive relationships with adults, they use their sexual behaviors to connect with other children. Children who engage in extensive, mutual sexual behaviors use sex as a way to cope with their feelings of abandonment, hurt, sadness, anxiety, and often despair. They do not coerce other children into sexual behaviors but find other similarly lonely children who will engage in sexual behaviors with them. Almost all of these children have been sexually and emotionally abused and neglected and look to other children to help meet their emotional needs and their need for physical contact.

Children in this group were previously sexually-reactive children. Children do not go from natural and healthy sexual behaviors to extensive, mutual sexual behaviors. First, they become confused and overwhelmed by the overt and covert sexuality to which they are exposed. Then, some come to use sex as a coping mechanism against their pain, despair, disillusionment, and lack of adult attachment figures (Johnson, 1988, 1999, 2000). The following vignette illustrates this coping mechanism.

Raul was five and Maria was four when they were left in a room with a drunken older man. They were frequently left by their drug-addicted mother in motel rooms with people they didn’t know. On this night it was late when they were left and Raul and Maria tried to go to bed on some blankets that they arranged on the floor. The drunken man in the bed was snoring very loudly. At one point during the night he woke up came toward them and yanked Maria up from the floor and put her into the bed with him. He pulled down her pants and tried to put his erect penis in her vagina. She screamed because it hurt and she didn’t want him to do it. Raul got up and yelled at him and told him to stop. The man hit Raul
which caused him to tumble to the side of the room where he hit his head. The man then let go of Maria, took another drink, and fell asleep. Raul and Maria tried to get out the door to leave, but couldn’t. Unfortunately the man woke up again, and again tried to rape Maria. Raul was again unable to stop him, instead he yelled and then cried, begging him to not hurt his sister.

Clinging to each other for safety, the children went to sleep exhausted from the terror of the previous night. They were awakened by Child Protective Services and the police who interviewed them and removed them to foster care. From that time forward Raul and Maria engaged in simulating intercourse. As each foster parent found the children engaging in the sexual behavior they were placed in another home. At the fifth foster home treatment was sought.

They were brought to a treatment program for children who molested other children and their victims. After being in treatment for a short period of time, it became evident that Maria did not feel she was being molested, nor did Raul feel that he was molesting her. Maria said that she didn’t want to tell people when she and Raul were engaging in sexual behavior with one another, because everybody got mad at Raul and punished him. She said, “It’s not Raul’s fault. I like to do it too.” The children clearly felt safe when they were engaging in the sexual behavior, and did not see it as bad or wrong. Somehow, the desperate clinging to one another during the terror they felt in the motel room became their way of coping with their pain, sorrow and loneliness in foster care. They clung to each other when they felt most desperate and lost. There was no description by the children of sexual arousal or pleasure, only of emotional togetherness that gave them a sense that they were connected and therefore could survive.

As the therapists understood the fears of annihilation and desperation in the children and that the sexual behavior was a way of coping with these feelings, they helped them with alternative behaviors that attached them to their caregivers. When the children felt the emotional safety and physical security of loving, caring, containing and understanding adults, the sexual behavior dropped away. Each remained the others’ closest and most trusted friend, but they were able to transfer their dependency needs onto trusted adults who cared for them. At six and seven years old there were no more concerns about Maria and Raul’s sexual behavior.
Children Who Molest

The sexual behaviors of children in this category are frequent and pervasive. A growing pattern of sexual behavior problems is evident in their histories and intense sexual confusion is a hallmark of their thinking and behavior. Sexuality and aggression are closely linked in the thoughts and actions of these children. Unless the other child is too young to understand, children who molest use some type of coercion to get other children to participate in sexual behaviors. Bribery, trickery, manipulation, or emotional or physical coercion is generally used. Physical force is neither commonplace nor necessary as the children’s victims are selected due to vulnerabilities, including developmental delays, social isolation, and emotional neediness. The victims may be older, younger, or the same age as the child who molests.

There is an impulsive and aggressive quality to many of the behaviors—including sexual behaviors—of children who molest. Generally, these children have problems in all areas of their lives. There is a progression for these children from healthy sexuality to sexually-reactive behaviors to molesting behaviors. Some of these children progress through all three groups prior to molesting (Johnson, 1988, 1999, 2000).

The following vignette concerning Eric provides a picture of a child who molests other children. His family background is replete with abuse and neglect, the modeling in his home gives a very distorted view of the place of sex in relationships, and emotional, physical and sexual violence is associated with all aspects of his family life.

At nine years old Eric had forcibly penetrated the vagina of his five-year old sister with his penis on a minimum of three occasions. On the first occasion Eric’s sister, Suzie, told her mother. Eric’s mother beat him up and told him she’d kill him, if he did it again. Although his mother knew that Eric had great hostility towards his sister and had sexually abused his sister, she used Eric as a babysitter. It was on these occasions and others that Eric would physically terrify and sexually abuse his sister.

Both children witnessed their father, Stan, beat up their mother and heard him raping her on many, many occasions. The children’s father would repeatedly go into a drunken rage and emotionally and physically batter their mother accusing her of laziness, stupidity and infidelity. Eric was the scapegoat of both his mother and his father. His sister could do no wrong; Eric could do nothing right. His father physically and emotionally abused him from the
time he was very small. Both parents neglected Eric. Stan justified his behavior toward Eric in the same way he justified his violence towards his wife. He didn’t like Eric’s behavior or attitude and he was stupid and lazy.

Eric grew up fearing, hating, and desperately wanting his father to love him and his mother. He always felt confused about his mother. At times she would try to protect him from his father’s wrath, and at other times she would stand by and say nothing while he was being beaten by his father. Eric learned not to trust anyone for emotional solace and physically safety.

Eric’s mother, who was very dependent on Eric’s father financially and emotionally, submitted to him sexually to keep the children from being homeless. Her anger at her husband became focused on Eric. When Eric entered the treatment program at nine, his mother could not even differentiate between Eric and his father. She would say, “He is just like his f__king father.” While all of the negative projections from the father landed on Eric, Eric’s mother could only see good in his sister. His sister was actually a very misbehaved and spoiled five-year old child “who got away with everything,” thereby increasing the anger Eric felt toward her.

After Eric entered the treatment program it was determined that he had not been sexually abused, in any “hands on” way. But witnessing the physical aggression that often had sexual overtones, and hearing and feeling the sexual aggression toward his mother, Eric had paired the sex and anger that constantly surrounded him into a coping mechanism. When angry, confused, or when feeling emotionally hurt or abandoned, Eric used both physical and sexual aggression towards his sister to quell the feelings. His mother’s strong projection onto him of being “just like his f__king father,” was another strong catalyst for his hostile and sexually aggressive behavior as Eric played out the role assigned to him. While Eric was extremely angry at his mother for not protecting him, he was also angry at her for being victimized for so long by his father. While he was somewhat verbally and physically abusive to his mother, he took out the bulk of his anger and confusion at his mother and father on his sister. While many children who are angry at their parents might be emotionally and physically aggressive toward the favored sibling, Eric—with his father’s model of hurting with sex—used sexual, emotional and physical methods to hurt his sister.
With two years of clinical interventions with Eric and his mother and sister, they were able to live together in peace and harmony. There were no reported abusive sexual behaviors by Eric to his sister or anyone else.

The continuum of sexual behaviors as described above or elsewhere (Hall, Mathews, & Pearce, 1998; Pithers et al., 1998b) permits differentiation between children who molest and children with less serious sexual problems. This is essential in today’s environment, as being mislabeled as a child who molests can mean:

- Removal from home
- Not being allowed to be alone with other children
- Not being allowed to attend regular classes in school
- Not being able to play freely in the neighborhood
- Being placed in therapy as an “offender”
- Not being allowed visits with the “victim” for an extended period of time
- Being put on a list of sex offenders

The term “sexual offender” is among the most highly charged labels in our culture. It can define a child’s future employment and devastate his or her sexual development. Many children who are mislabeled also struggle to comprehend how their sexual behavior can fit the heinous crime of sexual offending (Chaffin & Bonner, 1998). Megan’s Law calls for the public notification of sex offenders (Freeman-Longo, 1996). States handle this notification process idiosyncratically (Freeman-Longo, 1996). By 1997, 19 states had mandated public notification of adjudicated juveniles who have sexually offended (Matson & Lieb, 1997). In Texas in 1999, there was a ten-year old on the list of registered sex offenders. His name and address were listed on the Internet (Johnson, 2000).

CONCLUSIONS

There are a myriad of things that we still need to understand about the relationship between sexual abuse and children with sexual behavior problems. It is important to realize that not all children who molest have been sexually abused in a hands-on manner. Approximately one-half to two-thirds of children who molest were sexually victimized in a
“hands-on” way. This should encourage the investigator or treatment provider to assess the children’s environment more closely, not only focusing on hands-on sexual abuse by a sex offender. Not all children who are sexually abused will engage in any problematic sexual behaviors and only a very, very small number will molest other children when they are still children. As an overall strategy it is important to conceptualize children’s sexual behavior along a continuum from natural and healthy to disturbed. Most children who do engage in problematic sexual behaviors are sexually-reactive. Children in the next largest group engage in extensive, but mutual sexual behaviors, and the smallest group is children who molest. It is important to determine which children may molest other children as the consequences are high—for both potential victims of abuse and for children who are inaccurately identified as potential molesters. In some states children can be listed on sex offender registries, and public notification is possible in some states. Careful assessment of problematic sexual behavior is essential to correctly identify and treat all children at risk and to identity the very small number who potentially may harm others.

REFERENCES


Chapter 13

Working With the Cycle: Self-Destructive Behavior and CARESS

We should always be looking for ways to give clients those alternative “lifejackets,” offering strategies that provide the same, albeit healthier, positive outcomes that their self-destructive behaviors yield. Given the fact that standard safety contracts can often exacerbate the problem, asking our clients to simply refrain from their destructive behaviors will usually backfire. Hospitalization, although occasionally necessary for clients who cannot maintain stabilization and become a true danger to themselves, should be considered a last resort. Gratz and Chapman (2009) concur that “there is no evidence that hospitalization is better than outpatient treatment.” They further state, “hospitalization for self-harm really isn’t necessary; it’s like using a wrecking ball to hammer a nail.”

A better way to intervene at this part of the cycle is to introduce the concept of CARESS—Communicate Alternatively, Release Endorphins and Self-Soothe. As we have already discussed, CARESS is an alternative to standard safety contracts that eliminates the power struggle between us and our clients. CARESS is specifically designed to help clients achieve, in healthier ways, the same positive gains they get from self-destructive behaviors. Most clients are tuned in to the fact that self-destructive behaviors ameliorate tension and anxiety, and quell the re-surfacing of painful memories and affect.
They may be less aware, however, of the fact that punitive, harmful acts are a form of meta-communication and the destructive behaviors are representative of their pain narratives. When we target this part of the cycle it is important to introduce a psycho-educational piece that focuses on the dynamics of meta-communication as well as re-framing the behavior as both a re-enactment and re-storying of prior traumatic experiences. CARESS allows our clients to share their pain more productively, while simultaneously giving them creative ways to short-circuit uncomfortable affective states and move towards an experience of feeling soothed.

As an important aside, although I have never encountered this personally in my work, it is worth acknowledging that you may come across a client who feels triggered by the word “CARESS.” By definition, it means an embracing, soft touch—something we want clients to feel comfortable doing for themselves. It is meant to be a reparative alternative to self-punishment. If however, the word connotes something unsafe, particularly for sexual abuse survivors, you can modify the contract to stand for “CARES,” and still maintain all three essential components.

As we have already discussed, when clients become triggered the pre-frontal cortex goes “off-line,” making it impossible to operate from a place of rational or analytical thinking. Therefore, when the urge to cut, purge, or drink kicks in, it is unreasonable to expect they will have the cognitive capacity to turn to healthier coping strategies. With this in mind, it is helpful to encourage clients to create a CARESS box in your office that will be kept in a safe place at home. (If you are working in a residential treatment center, every client should have their own CARESS box. It should be readily accessible and accepted by staff as a viable first-response when a patient begins to act-out). The box is used as a streamlined “container,” holding all the
tools that will be needed to effectively implement CARESS when the self-destructive impulse strikes. We increase the likelihood that they will follow through with the protocol if everything is in one place and clients don’t have to frantically search for their resources.

To enhance their emotional investment in the process, encourage clients to paint, collage, or draw words and images on the box that represent feeling safe, comforted, and soothed. Allow this process to unfold over several sessions, if necessary, continuing to assess for the activation of the parasympathetic system to confirm that their choice of words and images is evoking a calming response.

Of course, when our clients reach this stage of the self-destructive cycle, they are either intensely hypo-aroused (freeze and dissociation) or shifting into hyper-arousal (fight/flight) as they contemplate the destructive act. We now understand that in either of those states, clients are at a grave disadvantage and their capacity to think clearly about acts of self-care has been sorely compromised. This same dynamic holds true during a therapy session: clients can’t process or integrate what we teach them if they are not grounded and present. To this end, the first “C” in CARESS could also stand for “Centering,” before they can move ahead with the protocol.

There are many strategies that can assist clients in re-connecting with the present moment, and they should be practiced in session to help achieve some beginning mastery. This, in turn, will enable them to take greater advantage of the benefits of the CARESS model. Some of these ideas have already been identified as interventions that can be used when addressing the dissociative/analgesic part of the cycle. You can incorporate them here, as well.
As we previously discussed, encourage clients to experiment with the following strategies to evoke a more “centered” state before moving into CARESS: simple breathing exercises while focusing on the sensations of inhaling and exhaling on the body; stating out loud what they see, hear and feel in their current environment; giving clients simple re-grounding phrases to say as a mantra; using tapping, yoga poses, and other simple movements to re-connect with the body; identifying their present location and age. It will not always be possible for clients to start from a more centered place, but don’t let them become discouraged. In many cases “going to the CARESS box” is the conditioned cognition and action step that begins the centering process for them!

Once you have worked on the concept of centering and they have personalized the box, you can begin to process the three stages of the CARESS protocol. You must reiterate that you are not asking your clients to refrain from their self-destructive behaviors. Rather, when they get the urge to act out, before they do, they will first employ the strategies from CARESS. In this way we are trying to re-train their brains to associate the impulse to harm with an automatic CARESS response, rather than their conditioned self-destructive one. CARESS is presented as an alternative option to the coping strategies they’ve been using; the decision to utilize it is always up to them.

As you set the stage for the protocol, focus on the importance of using a timer. This can be an alarm on a clock, cell phone, oven, or egg timer. Each facet of CARESS is deliberately limited to 10-15 minutes so clients never become flooded or over-whelmed by the strategy. Since
they will often be doing CARESS by themselves, the timer becomes an external resource for boundaries and re-grounding, and reassures us that they will not become “lost” in the work.

Clients should set the timer at the start of each CARESS phase. When it goes off, they can either move on to the next phase of the work or re-set the timer for one more cycle. At the end of the second cycle, however, clients are encouraged to move on to the next step. Clients are less likely to need to do their self-destructive behavior when they can successfully incorporate all three phases.

It is helpful to explain the function of each phase of the protocol as you walk your clients through the three parts of CARESS. In this way, clients understand the rationale behind each step and are more likely to try all three components. The actual “contract” is as follows:

C.A.R.E.S.S.

I agree that when I get the impulse to engage in a self-destructive act, BEFORE I do, I will choose to incorporate one behavior from each category below. (Set a timer so you have an external boundary to re-ground you after 10-15 minutes.)

C.A.- Communicate Alternatively (10-15 minutes)

Hurting the body is a way to communicate feelings, thoughts, needs, and unresolved trauma memories. Here are other, less destructive modalities to communicate.

- Draw/paint the body part and the injury you’d like to inflict—add words to images
- Draw the emotions that accompany the urge to do something self-destructive
- Make a collage of words/images that capture thoughts/feelings
Write a poem about your feelings

Depict the body part with clay, sculpt the injury

Write a graphic description of doing your self-destructive behavior

Write about what was happening when you felt the urge to do something destructive

R.E.- Release Endorphins (10-15 minutes)

Clients feel better after they engage in a self-destructive act because the brain releases endorphins (naturally occurring opiates) in response to pain/body trauma. Here are other ways to experience the release of endorphins.

- Run up/down the stairs or the periphery of your house/march in place
- Do 100 jumping jacks
- Use a piece of exercise equipment
- Do a part of an at-home exercise tape/ Put on the radio and dance
- Listen to a funny comedian on a CD/video
- Watch a funny movie/TV show
- Watch a YouTube video of a baby laughing or silly pet tricks
- Read something that tickles you
- Hold/stroke and hug a stuffed animal or live pet
- Hug a pillow, rag doll, or a tree

S.S.- Self-Soothe (10-15 minutes)

Clients need to learn new strategies that promote self-care and decrease anxiety from future triggering events. Here are some additional ways to be comforted.
Wrap in a quilt and rock in a rocking chair
Take a warm shower/bubble bath
Light scented candles or oil
Read positive affirmations
Massage your hands with soothing lotion
Listen to a relaxation tape/play soothing music
Slowly blow bubbles to slow down breathing
Call a 24-hour hotline to hear a comforting voice

Let’s explore the contract in more detail, so you fully understand how to process it with your clients.

CA: Communicate Alternatively

This gives clients another way to “show” the pain narrative so it can be witnessed, processed, and transcended. The use of right brain-based creative modalities will make sense to clients once they understand that trauma memories are not stored in the part of the brain that handles language (Broca’s area). In addition, their perpetrator’s injunctions against “telling” have made it impossible for them to simply talk about their experiences. Therefore, they need alternative ways to communicate their narratives, accessing them with the help of modalities that bring information forward from the more primitive parts of the brain.

Clients are empowered to choose which communication strategies feel safest and most comfortable for them since the CARESS model is rooted in the reparative notion of helping
clients retain a sense of control. The options are designed to integrate both right and left hemispheres of the brain, as this will enable clients to best process and work through the material. As clients select the strategies, it helps to write down their choices on a brightly colored index card or post-it note. This can also be placed in the CARESS box as a kind of “cheat sheet” which further reduces our reliance on clients needing to think clearly when triggering has occurred.

One strategy for “CA” incorporates art therapy techniques to “sublimate” harmful urges. Clients can draw or collage the body part they want to injure, along with a visual depiction of the actual injuries. They can also mold the body part out of clay and then use their fingernail to show the injuries. This effectively helps them to visually sublimate the depiction of pain and affect that is often etched onto the skin via cutting, burning, or bruising the body.

You can even encourage clients to draw, paint or collage the “words” and “feelings” they vomit when purging, or the emotions that accompany the desire to drink, drug, starve, gamble compulsively, or sexually act out. This becomes a way for clients to non-verbally articulate and de-code the deeper emotional underpinning of these behaviors. You may feel understandably nervous about encouraging art that depicts self-destructive behaviors or intense feelings, fearing this will cause an exacerbation of the behavior. But I have found that helping clients “show” their pain and communicate their needs and feelings dramatically reduces the desire to actually act on the behavior. Keep in mind that one of our clients’ primary goals is to “tell” their story and have it witnessed, and art-therapy techniques allow them to safely do that.
Although clients are encouraged to use these artistic techniques when they are incorporating CARESS outside of your office, these are strategies that can also be woven into therapy sessions. Clients do, in fact, get the urge to hurt themselves in our offices, particularly when the content of the session is emotionally-charged or threatening. Pay close attention to the subtle ways in which self-injury can be invoked: using innocuous but sharp objects like pens, pencils, paper clips, or fingernails pressed into the palm of a hand, nail biting, or hair pulling. When this occurs, use the “gestalt” moment as an opportunity to teach clients about the sublimation process as an alternative way to communicate.

Offer them paper, markers, crayons, colored pencils, etc. and direct them to “draw” what they are thinking, feeling, or wanting to do on their bodies. Koosh balls with elastic strings that can be tugged, or a variety of foam or squishy “squeeze” toys can also be used as alternatives to hurting themselves if the client is unwilling to draw. The idea is to get the behavior “off of the body.” If you are trained in sand narrative work and have a sand tray in your office, this can be another profoundly helpful way to help clients communicate and process the meta-communication of their actions. Along with the classic items we use in sand tray work to help clients explore their feelings and inter-personal relationship dynamics, be sure to have objects that can represent self-destructive behaviors such as: empty, single serve alcohol bottles; a plastic martini glass; a toy toilet; assorted plastic food; band-aids and other first aid items; a fake razor blade and knife; a fake cigarette; money; a pair of dice; etc.

For clients who have “performance anxiety” about using art, you can encourage them to journal, write a poem or song lyric, send themselves an e-mail, or simply talk into a tape
recorder, mini Dictaphone, or leave themselves a message on their voicemail. Regardless of the modality, we want clients to freely express their thoughts and emotions about what they feel compelled to do, or provide information about the nature of the self-destructive behavior. When clients are able to safely communicate by creating a tangible product that can be witnessed and processed—rather than get high, purge, starve, gamble, or leave a cut, bruise or burn on their bodies—the cycle of helplessness and repeated victimization is short-circuited and true healing can begin.

**RE: Release Endorphins**

The rationale behind this phase of treatment is to offer clients additional ways to short-circuit overwhelmingly negative thoughts and feelings through the release of naturally occurring opiates. Remind clients that the reinforcing component of self-destructive behaviors is the release of endorphins through self-mutilation, bingeing and purging, or the temporary “euphoria” elicited by substance abuse, gambling, compulsive shopping, or self-imposed starvation. Although our brains release endorphins in response to intense pain, we can also experience this pleasurable sensation through hugging, laughter, and an intense burst of physical activity.

After the timer has gone off and clients have had the opportunity to give a new kind of “voice” to their pain, moving to this phase of CARESS is a healthier way to short-circuit their upset state. It is again necessary to negotiate with your clients regarding which options they want to try. In this phase of treatment, clients often like a combination of the three strategies, incorporating a few minutes of physical exertion, laughter, and hugging.

When clients want to release endorphins through movement make sure they are physically fit enough to engage in the activity. This is particularly applicable to obese, medically
compromised, or very underweight clients. You should also rule out the possibility that this is an attempt to do “exercise bulimia,” a form of purging that juxtaposes excessive exercise with an insufficient amount of caloric intake. If exercise is a safe option, clients can spend 10-15 minutes doing activities including: jumping jacks; running around the periphery of their home; going up and down the stairs; using a treadmill; putting on music and dancing; following an exercise routine from a DVD; kick boxing or shadow boxing; playing a high impact “motion-control” video game system such as “Wii” or a controller free motion gaming device like “Kinect.”

When possible, the idea is to sustain a high level of exertion to feel the endorphin release. Extensive research has gone into studying the positive effects of exercise on mood. In addition to a sense of empowerment, heightened control over the body, and a feeling of competence, exercise gives us an endorphin “kick,” which serves as a healthy distraction and has a positive impact on thoughts and feelings. The release of endorphins enables long distance runners to endure the grueling physicality and discomfort of the race. This same concept resonates for trauma survivors.

The second option involves laughter, a surefire way to short-circuit untenable affect and thoughts. Although a mere smile can have a positive impact, we want to encourage clients to go for belly laughs. This can be accomplished in a number of creative ways. Clients can cue up a funny scene from their favorite movie, or listen to or watch the stand-up routine of their favorite comedian. I have found that incorporating YouTube videos is a great way to elicit laughter and create a healthy distraction. In addition to the treasure trove of TV and movie clips from the past, clients can search for either “silly pet tricks” or “babies laughing”. These videos invariably make anyone laugh.
Once again, it is important to process these options with clients ahead of time. If there are unresolved issues related to abortion, miscarriage, infertility, the death of a child, or the loss or death of a pet, then these would not be appropriate suggestions. If however, you assess that there is nothing emotionally loaded or potentially triggering about the topics, given the way our mirror neurons work, watching a child dissolve into a fit of laughter will evoke the same response in even the most stubborn clients!

The third option, hugging, can either stand on its own or be incorporated into the other strategies. It is important to emphasize that we don’t want clients to hug another person. CARESS has to be workable when they are by themselves because they typically are alone when the impulse to do something self-destructive takes over. Wrapping themselves in a blanket and hugging a pillow or stuffed animal, holding a pet, or a doll usually works. Some clients even like to hug trees! The idea is to release that surge of warmth that we feel when we wholeheartedly hug something. This is also a good place to introduce the EMDR butterfly hug: placing the arms across the chest and alternating gentle taps on the upper forearms with the palms of the hands. I also like to introduce the concept of “hugging the inner child,” by inviting clients to hold a soft pillow close to their bodies while visualizing that they are hugging their younger, innocent self.

**SS: Self-Soothe**

Once clients have communicated and successfully short-circuited their negative thoughts and feelings, the timer is re-set and we want the endpoint of their work to be something self-soothing. In truth, they don’t know how to do this in healthy ways, or they wouldn’t be grappling with self-destructive behaviors! In this regard, clients will need your input and suggestions about how to self-soothe appropriately. Again the emphasis is on activities that can be done solo:
clients shouldn’t have to wait for the physical availability of someone else in order to feel better. This might initially feel counter-intuitive, as many survivors can be co-dependent.

Some of the activities that you can suggest might include: taking a warm shower or bubble bath; listening to soothing music; giving themselves a hand massage with their favorite smelling lotion; reading a book of positive affirmations, something spiritual or grounded in the 12 step movement; calling a hotline to talk to an empathic person; meditating; singing a lullaby to themselves; holding and drinking a warm cup of tea or cocoa; “nesting” in pillows and blankets; massaging their temples and wrists with a relaxing scent such as lavender; taking a short walk through a garden; lying on the grass and watching the clouds in the sky; listening to a guided imagery or relaxation tape; watching an inspiring video; or looking through a book of beautiful photography.

It is quite possible that clients will not easily buy into these options as viable, but this is due to the fact that they are foreign and new, not because they are invalid and won’t be effective in time. Invite your clients to choose strategies that they have some curiosity about, and encourage them to hold onto the idea that in a short while these behaviors will resonate and feel more comfortable with practice and repetition.

Once clients have agreed upon several possible behaviors under each of the three categories, make sure they are all written down on an index card. The last step is for clients to gather all of the resources they will need, depending upon what they have chosen to do. This might include: paper; markers; hand lotion; the URL for the video; a soft blanket; the CD of
soothing music, the phone number for the 24 hour hotline, etc. All of the items should be placed in their CARESS box for easy access.

When clients find the courage to try CARESS, it is important to process what worked and what needs to be re-negotiated. Some clients will take to it instantly, doing all three things and reporting a great reduction in self-destructive behaviors. Others will be initially resistant, doing only part of CARESS, or just thinking about it without putting any of it into practice. Our job is to be patient, supportive, and encouraging. We should reinforce the smallest baby steps our clients take towards new behavior, never shaming them when they don’t follow through. Consistently remind them that when they begin to apply it, it will work. Besides, even thinking about or envisioning new behaviors can have a positive impact on our bodies and brains, so reward clients for taking that meaningful first step.

I want to reiterate that there is something deliberately missing from the CARESS model: calling us when they get the impulse to hurt themselves. Many caring and well-meaning clinicians encourage their clients to reach out to them when they want to hurt themselves or are on the verge of relapsing. Although I appreciate the generosity of this gesture, I believe it is a major mistake. It gives clients the subtle message that they need us in order to be okay, which inadvertently creates co-dependency. It also sets up a dangerous and unrealistic expectation about our availability and our boundaries. Clients should not expect us to be on call 24/7 and we shouldn’t be! We want our clients to believe that they have what it takes to heal. CARESS reinforces the notion that everything they need to reconcile their issues exists inside of them.