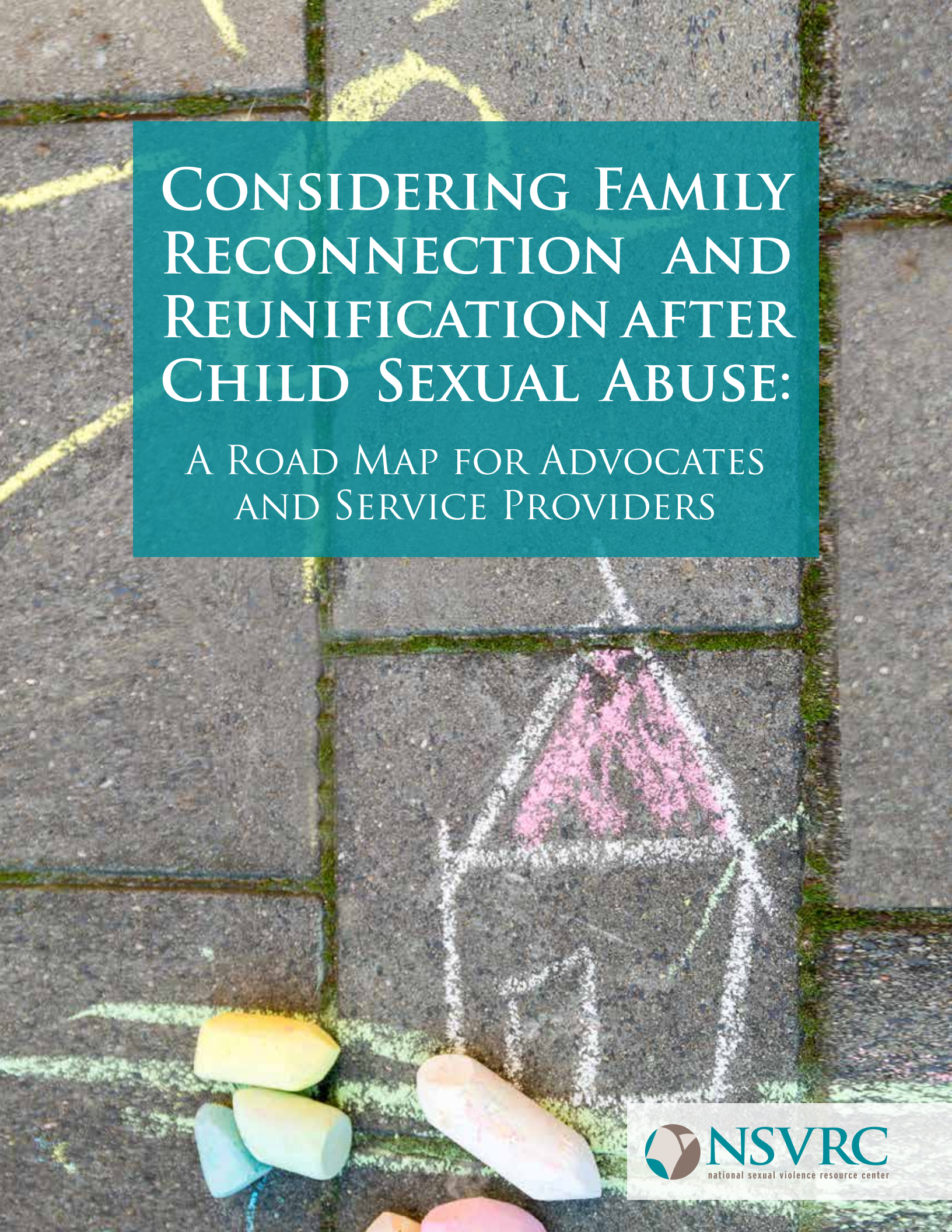


Considering Family Reconnection and Reunification after Child Sexual Abuse:

A Road Map for Advocates and Service Providers

NSVRC
national sexual violence resource center

Suggested citation: Tabachnick, J., & Pollard, P. (2016). *Considering family reconnections and reunification after child sexual abuse: A road map for advocates and service providers.* Enola, PA: National Sexual Violence Resource Center.

©National Sexual Violence Resource Center 2016. All rights reserved.

This project was supported by Grant No. 2011-TA-AX-K023 awarded by the Office on Violence Against Women, U.S. Department of Justice. The opinions, findings, conclusions, and recommendations expressed in this publication are those of the author(s) and do not necessarily reflect the views of the Department of Justice, Office on Violence Against Women.

The content of this publication may be reprinted with the following acknowledgment: This material was reprinted, with permission, from the National Sexual Violence Resource Center's publication entitled *Considering family reconnections and reunification after child sexual abuse: A road map for advocates and service providers.* Also available online at the Lifespan webpage of National Sexual Violence Resource Center website: http://www.nsvrc.org/projects/lifespan/sexual-violence-against-children

Considering Family Reconnection and Reunification after Child Sexual Abuse:
A Road Map for Advocates and Service Providers

TABLE OF CONTENTS

Note From the Authors	1
Introduction	5
Background on Child Sexual Abuse	11
Definitions	23
Guiding Principles and Assumptions	26
Navigating the Road Map of Reunification	28
Outline of the Steps	32
Conclusion	47
Acknowledgments	49
References	51
Resources	57
Appendix A: The Seven Major Risk/Need Factors	59
Appendix B: Family Safety Plan	60
Appendix C: Roles in the Reunification Process	63

Notes

Note From the Authors

Few topics stir up such deeply emotional responses as the sexual abuse of a child. When we began talking about this guide we were met with a range of reactions from anger and fear to a deep appreciation for taking on a project that will provide a thoughtful examination of this important issue, sometimes from the very same people. What we have begun to see is that each reaction is tied to the image that person holds in the moment of who a "sex offender" is, and how fully the person has internalized the widespread and sometimes misleading assumptions and stereotypes about people who have sexually abused a child.

The reactions we have heard to family reunification have tended to be quite different depending on whether an individual's image of the sexually abusive person is that of a child, who is sexually-reactive to his or her own abuse experiences, versus an image of a manipulative adult family member, who has not acknowledged the harm or respected boundaries of the family.

For better and for worse, any professional's rigid commitment to either of these images will influence whether they believe that a given adult, teen, or child who has abused can return to and live safely with their families, in their homes and communities or should be allowed to do so. The complexity of that belief will be an important factor in determining the success or failure of any exploration of the question.

Key to gaining a nuanced and meaningful understanding of this process is for the reader to explore the influences of personal attitudes towards accountability; the impact of child sexual abuse; what's been learned, particularly over the last 35 years, about the dynamics of sexual abuse; and concepts of healing and justice.

Some of you might be asking, "Why should I care?" or "Why should I be involved in this?"

From our own work, it is clear that most people who abuse, even if they are also reported, successfully prosecuted, and sent to jail or prison, will eventually return

to their community, and in many cases to their families. Even when the person who abused a child is held accountable for his or her crime, at some point, the community and his or her family will still need to interact with them in some way. For example, an adult who was sexually abused as a child may seek reconnection either through a clarification session or reunification with the person who abused them, making this issue a part of our approach to victim-centered care.

For the purpose of this guide, we recognize that the concept of family changes for each individual as well as across cultures. Therefore, when talking about reintegration into the family, the discussions of "family" might go beyond the nuclear family to address safety plans for the larger extended family or "chosen" family or community.

It is critical to acknowledge that for many families, it is not safe to even consider reunification after a child has been sexually abused. It is also true that under certain circumstances, reunification has worked for families, even resulting in more accountability for their behaviors and in a richer, healthier environment for growth, especially if the person who caused the harm is/was a child or teenager.

Successful reunification is possible when there are resources available to help monitor the process; if enough time has passed for deeper acknowledgment of the pain as well as practical safety plans for everyone; and if there are people within the family and larger community network to ensure that safety plans are established and maintained. Some level of reintegration may actually be the most healing path for the family.

This guide is not a "how to" manual nor an endorsement of reunification, but rather a tool to begin a discussion that we hope will be useful for sexual assault advocates who want to understand the process, learn about the resources and knowledge needed to make it work, and explore whether/when this process makes sense for a particular family and situation.

Finally, and most importantly, we want to give our heartfelt thank you to the individuals, families, advocates, and other professionals who have shared their experiences with us, fully recognizing that even the concept of family reunification after sexual abuse can be a difficult one for many people to think about. As authors, we know that we could not have done this work without these painful and sometimes hopeful stories in mind.

And we want to thank our own families and partners for their insights, love, humor, and support throughout this writing and editing process.

Warmly,
Joan Tabachnick and Peter Pollard

Notes

Introduction

"Why should I care?"

When one in four girls and one in six boys have been sexually abused before the age of 18, (Dube et al., 2005) it's clear that child sexual abuse is a reality that many families across the country have had to face.

As recently as the 1970s, sexual abuse of children was widely believed to be a rare occurrence. Over the last 35 years, society's awareness and understanding about the impacts of sexual abuse and the potential for healing has grown enormously. When families acknowledge the sexual abuse of a child, they usually deal with a combination of emotions from anger, loss, and fear to the confusion resulting from the disruption of some of the closest relationships surrounding that child. Families are most likely also facing increasingly

complex questions of separation, reporting, court procedures, prosecution, sentencing, community and family reactions, and economic insecurity.

It can be difficult for many people to fully take in the fact that the successful and safe integration of the adult or youth who sexually abused back into a community means that every child and community is safer. This is the ultimate goal for every professional working towards community safety, whether they are victim advocates, sex-offender treatment providers, probation or parole officers, or child-protective-services case managers.

Most of these same professionals would also agree that family reunification is not the ultimate goal for every case. In fact, reunification should **only** be considered if safety can be maintained for everyone in the family, especially with the safety of the child who was victimized at the center of the discussion.

Ideally, as part of the healing process, the family will develop a structured way to acknowledge and discuss how

A NOTE ABOUT LANGUAGE

How we talk and think about the dynamics of sexual abuse and those involved can have profound effects on how we approach the work.

With that in mind, this document will use "person-first" language to honor the various ways people self-identify and to emphasize that a behavior or experience does not define the whole person. Descriptions of someone's behavior such as "the person who sexually abused a child," "the child who was sexually abused" or the "child who was harmed" are used rather than defining an individual by their actions or what happened to them (e.g. offender, abuser, or victim, survivor.)

Describing someone as a "person" first, whose life has been affected by a behavior or experience, avoids defining them solely by that experience. It asks us to consider that people can change, heal and grow, and develop new, healthier identities. Person-first language demands hope.

While this document is primarily for sexual assault advocates, much of this information can also be useful to many other service providers. When the document refers to sexual assault advocates and other professionals, this includes clinicians, probation officers, child protection service workers, and others who may work with children who were sexually abused.

they will manage those disruptions, the harm the abuse has caused, and the impact on everyone who has been affected — a process that, when done formally, is sometimes called "clarification" (Schladale, n.d.).

Sooner or later, if the person who sexually abused a child is also a member of the family, questions will arise about what that person's future relationship, connection, and interaction with different family members will be. The process of "reunification" involves developing and implementing terms for deciding how or whether to restore those relationships. For a more detailed discussion, see the section on page 23 entitled "Definitions: Family Clarification, Reconnection, and Reunification."

For many years social policy emphasized a "simple," single solution to this complex issue, encouraging families to react responsibly and report sexual abuse when they suspect a child has been harmed. While an important first step for some families, professionals now also acknowledge that most cases of child sexual abuse are never reported (Hanson et al., 2002) and even when reported, only a small percentage of these cases are successfully prosecuted (Stroud, Martens, & Barker, 2000).

Taking this process a step further, research shows that most adults, adolescents, or children who have sexually abused a child will eventually return to their community and often to their family (Wickland & DeMichele, 2008).

Therefore, families and communities who have had the courage to face child sexual abuse find that reporting is only one step in a much longer journey. These same families and communities must also face the difficult questions and decisions of how best to connect with the adult, teen, or child who sexually abused, if at all; how best to support the child who was harmed; and if appropriate, consider what kind of family process is possible and safe for the child and family. These are especially difficult questions if the person who abused a child is a child or teen him/herself, needing family support and supervision to live safely in a home or community.

> Coming forward, being honest, and accepting the truth has enabled my family to get the help we needed, especially [for my two children].
>
> — Mother of a child who abused and a child who was abused

In cases where the sexual abuse has been reported and substantiated, the family will often be involved with the child welfare system. Ideally, this means that the family may have more access to resources and support from professionals who have some experience in working with this issue.

Added stressors may include increased costs for getting to and from appointments,

missed work, increased childcare needs, placement of a child in foster care, and other changes, for which assistance may or may not be available. The kind of resources and the access to resources for a family will differ from state to state, and even within the state. Searching out these qualified resources may be a necessary step for the family, and a process sexual assault advocates and other service providers can help family members navigate.

However, the system also must address mandates, which often include a guideline to at least consider family reunification. According to the Adoption Assistance and Child Welfare Act of 1980 and Adoption and Safe Families Act of 1997, states must "prioritize reunification of removed children to their biological parents and if that is not possible or safe, the timely pursuit of other permanency options" (Connell et al., 2009, p. 219).

Research shows that the majority of children removed from their families are reunified with a parent, relative, or guardian, often within one year of their removal (Connell et al., 2009; Harper, 2012). Therefore families who have had the courage to report child sexual abuse may also need to face the system's pressures and the difficult questions surrounding family reunification, and hopefully, in this case, with the resources and support to safely explore these decisions.

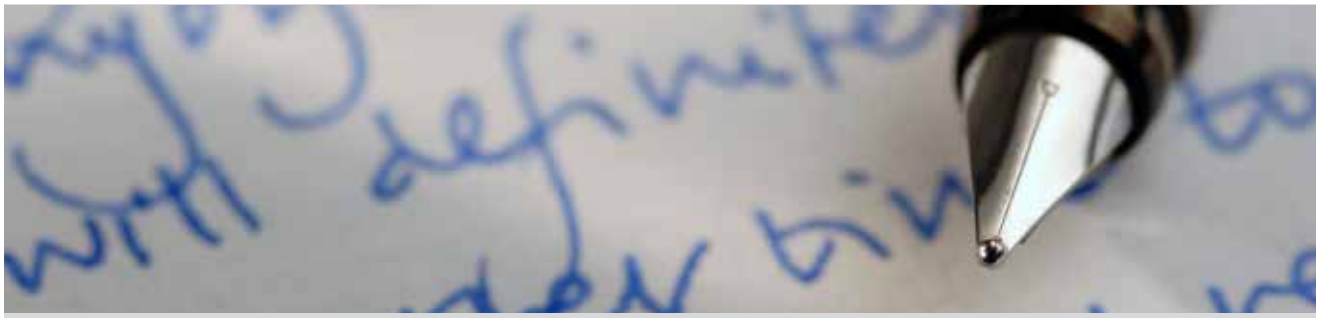
Finally, although this discussion will be focused around situations where the sexual abuse has been reported and substantiated, and the families are now in the process of considering clarification or reunification in some form, it is clear that the majority of child sexual abuse is never reported.

Therefore, the majority of families are facing the same questions of safety, but without acknowledging what happened or having the outside resources to help guide a process of confrontation. The research also supports the fact that most people who are reported are also released and return to the community and have some connection to their families or extended families (Stroud et al., 2000; Wickland & DeMichele, 2008).

Therefore, nearly all families who have faced sexual abuse in some way must also consider these same questions of creating a safety plan for children, setting clear boundaries around everyone, establishing consequences for behaviors that cross those boundaries even in minor ways, developing a process for confronting these behaviors, and finally implementing a process to hold individuals accountable for their behaviors. This guide provides information and resources that relate to all of these situations.

Focus of this Guide

The focus of this guide is to offer an overview for sexual assault advocates and other service providers about navigating the structured processes of family clarification, reconnection, and reunification. The guide explores the key differences between adults who have sexually abused, and adolescents and children with sexual behavior problems. This guide will also consider differences



SELF-AWARENESS

As you read through this guide, listen to and examine your own personal attitudes towards sexual abuse; clarification; the benefits and risks of reconnection and reunification; accountability; healing; and justice. Take a minute to consider each question and write down your responses.

1. Do you believe or think that children who have been abused (or later in life as teens or adults) should have a say about what happens to their family after sexual abuse?

_____

_____

_____

2. Do you believe or think that a child, adolescent, or adult can learn to live safely in their community or in their family after they have sexually abused someone?

_____

_____

_____

3. Do you think reunification is good in all cases? Why or why not?

_____

_____

_____

4. What could be some of the possible outcomes of reunification of the family, good and bad?

_____

_____

_____

between abuse perpetrated within the family versus outside of the family.

This document concentrates primarily on situations where abuse was reported to police or child protective services, and where the person who sexually abused a child was prosecuted and found guilty. However, it is crucial to remember that for many families, no report will have been made and/or there will have been no arrest, court case, or state intervention.

Yet, such families face (or overlook) the same issues and questions that will arise in any formal reunification process, including establishing effective boundaries, safety, and the possibility of future harm. When a report has not been made, families may not have the support, experience, and additional accountability provided by professionals involved in reunification, increasing the risks for all. Although this guide cannot address all the complexities of those situations, some of the tools offered here may be helpful to families who are interested in creating a safety plan and developing the skills to adequately implement that plan.

Crucial considerations when contemplating the possibility of reconnection, clarification, and reunification (Gilligan & Bumby, 2005; Harper 2012) include:

- whether the adult, youth, or child who abused has learned to recognize and control his or her impulses and behaviors;
- the family's ability and commitment to supporting and reinforcing that change;
- the possible risk of re-victimization;
- and the effectiveness or availability of the child welfare and judicial systems to supervise families before, during, and after reunification.

This guide is not an endorsement of clarification, reconnection, or reunification for every situation or a recommendation for all families. However, regardless of the outcome of the decision-making process, it will provide insights into the questions that need to be asked and information about the resources and tools available for any family or sexual assault advocate working with the individuals and families affected by sexual abuse.

Background on Child Sexual Abuse

How Child Sexual Abuse Impacts Our Community

Child sexual abuse is an issue that many adults in the United States have or will have to face in their lifetime. This may include surviving child sexual abuse or knowing someone who was sexually abused as a child, knowing someone in their family, and/or knowing someone who sexually harmed a child.

Here are some basic facts about child sexual abuse and those who commit it. What do we know?

- One in four girls and one in six boys have been sexually abused before the age of 18 (Dube et al., 2005).
- Over 40% of women who reported being raped reported being raped before the age of 18, with about 28% experiencing first rape between 11–17 years old and about 12% experiencing first rape at age 10 or younger (Breiding et al., 2014).
- Over 20% of male victims who reported being offended against were made to penetrate someone else before the age of 18 (Breiding et al., 2014).
- One study found that over 38% of African Americans, almost 50% of Caucasians, and over 40% of Latinas reported experiencing childhood sexual abuse (Postmus, 2015).
- Of the total child sexual abuse reports made to child protective services in 2008 nationally, 6.8% were African American, 5.2% were American Indian or Alaska Native, 6.6% were Asian, and 8.3% were Hispanic children (U.S. Department of Health and Human Services, 2010).
- In a study of seven Native American tribes, 24% of men and 31% of women experienced childhood sexual abuse (Koss et. al., 2003).
- In a study of 152 lesbian, bisexual, or two-spirit American Indian/Alaska Native women, 76% reported sexual contact when they were younger than 18 with someone who was 5 or more years older (Lehavot, Walters, & Simoni, 2010).
- 29% of sampled child sexual assault victims were assaulted by someone 17 years old or younger (Finkelhor et al., 2008).
- Majority (90%) of children do not disclose sexual abuse while they are still children (London, Bruck, Ceci, & Shuman, 2005).
- Thirty-four percent (34%) of people who sexually abuse children are family members and fifty-nine percent (59%) are known to the victim (Snyder, 2000).
- The majority of people who sexually abuse children are male (Snyder, 2000).
- Thirty to fifty percent (30–50%) of those who sexually abuse children are themselves children or teens (Barbaree & Marshall, 2006; Finkelhor, Ormrod, & Chaffin, 2009).

No community can say "it just doesn't happen here." Studies indicate that children and their families are affected by sexual abuse across different cultures, ethnicities, economic classes, etc. (Goldman, Salus, Wolcott, & Kennedy, 2003).

It is also known that systems may respond differently depending upon a multitude of individual and familial identities, including race, ethnicity, gender, socio-economic status, sexual orientation, immigration status, language, and other characteristics. Each of the factors, alone or in combination, can have a profound influence on how the circumstances around

the abusive interactions are viewed, and on the outcomes of any interventions (Kreiger, 2003).

Recognition of differences and the willingness of service providers to understand and to accommodate the effects of past experience will play a major role in a family's positive engagement with the system response (Malley-Morrison & Hines, 2007). It is important to make sure services are accessible (incorporating cultural practices, beliefs, language, etc.) to families, as well as to recognize historical oppression that serves as a barrier for many communities to move forward with reporting and participation in formal legal action. Oftentimes, the legal system moves forward without the cooperation of the family, so allowing choice and accommodations for the family can be key to successful reconnection and/or reunification.

Harm Caused by Child Sexual Abuse

Child sexual abuse is an intensely personal and often life-changing form of harm. For the purposes of this document, child sexual abuse is defined as:

When an adult, adolescent or other child exposes the child to sexual acts or behavior, including: sexual acts that involve penetration, touching the child's breasts or genitals, making a child touch another person's breasts or genitals, and both voyeurism and exhibitionism. In addition, other forms of child sexual abuse may include: showing a child pornography or using a child in the production of pornography, child sexual exploitation such as trafficking or child prostitution, and internet-based child sexual abuse, such as creating, depicting, and/or distributing sexual images of children online; or stalking, grooming, and/or engaging in sexually explicit behaviors with children online (National Sexual Violence Resource Center [NSVRC], 2011).

The impact of child sexual abuse can include complex and frequently profound short- and long-term physical, psychological, behavioral, and societal consequences on the child throughout his or her life. Other factors, including physical, developmental, or mental health conditions; accompanying experiences of physical abuse, emotional abuse, and neglect; exposure to domestic violence and substance abuse in the home; and loss of a parent may also induce additional trauma responses in a child (Felitti & Anda, 2009). As research explores the impact of trauma from sexual abuse, the consequences of that trauma may be felt immediately or unfold over time. It is impossible to completely differentiate these consequences because each can affect the others.

For example, trauma can affect a child's growing brain and create cognitive delays or later emotional difficulties (Child Welfare Information Gateway, 2013; Felitti & Anda, 2009). However, not all children who have been sexually abused will experience long-term health consequences, but families may want to be aware that a child's risk for being harmed may have increased, especially if the situation is ignored.

As the trauma may increase risk, this vulnerability can be decreased by adding in a number of "protective factors" within the child or within his or her family or community. According to the Centers for Disease Control and Prevention, protective factors are "individual or environmental characteristics, conditions, or behaviors that reduce the effects of stressful life events; increase an individual's ability to avoid risks or hazards; and promote social and emotional competence to thrive in all aspects of life now and in the future" (CDC, 2009, p. 3). Protective factors include a positive attachment to an adult or family, higher self-esteem, emotional regulation, humor, and independence. The addition of protective factors may also lessen the long-term impact of abuse and increase a child's potential to overcome their traumatic experience (Goldman et al., 2003).

With the influence of enough protective factors, emerging research has shown the incredible resiliency in children and how often so many children grow up to live healthy and productive lives (Center for the Study of Social Policy, n.d.; Shaffer, 2012).

Cultural Considerations

"Awareness and knowledge of how age, gender, race, ethnicity, national origin, religion, sexual orientation, disability, language, and socioeconomic status are crucial dimensions to an informed professional understanding of human behavior and … skills necessary to work effectively and ethically with culturally diverse individuals, groups, and communities" (Hansen, Pepitone-Arreola-Rockwell, & Greene, 2000, p. 653). Culturally diverse perspectives about family and community need to be understood and honored when approaching the complex issue of child sexual abuse. Culturally relevant approaches may result in more families reaching out and getting the help they need.

Recognizing Historical Oppression

For families who are members of a marginalized group or community, interaction with the system can trigger caution — especially when that system is not culturally diverse or relevant to families seeking help. Decisions about reporting abuse, cooperating with criminal proceedings, or building trust with well-meaning service providers may clash with entrenched defenses against expectations of oppression (Fontes & Plummer, 2010).

For some cultural groups, including Native American and African American, there is a direct link between a legacy of sexual abuse and their historic experiences. For example, well into the 20th century, Native American children were forcibly separated from their families by the U.S. government and placed in boarding schools, where they experienced physical abuse, sexual abuse, and experienced forced assimilation and labor (Smith, 2007). The treatment of African Americans by the government systems over centuries, and more recently even through the foster care systems, where African American children are far more likely to be placed into foster care, has also created a deep distrust of

the very systems they are told to reach out to for help and intervention (Lau et. el., 2003). The long-term impact of those physical, emotional, and sexual traumas continue to affect Native American and African American communities today (Smith, 2007; Wyatt, 1992).

Other cultural communities offer different challenges and opportunities for professionals and advocates alike. For instance, some cultures such as Latin@[1] families value a larger extended family and tend to prioritize the family collective over the individual (Falicov, 1998). In some Latin@ families, keeping the family together may be such a top priority that makes separating any of the members (removing the child or the person who offended) incomprehensible (Kimber Nicoletti, personal communication, March 31, 2014). In these cases, if reporting is linked to family members leaving, families may be much less likely to report.

In many Latin@ families shame is a powerful concept used to control others' behavior (Falicov, 1998). Shame is used by cultures to reinforce rigid cultural norms. A family's sense of shame because of immigration status, language skills, etc. can also be a barrier to building a relationship with service providers (Fontes, 2007) and seeking services. Shame surrounding sexual violence extends to a child's family as well. Parents may not want to disclose abuse because of fear of shame of not being able to protect their child or because discrimination faced by Latin@s by service professionals also limits reporting (Fontes, 2000).

In some Native American communities, when someone sexually abuses another person, their behaviors are seen as the result of not only their individual actions, but of the larger community letting that person down; when one person falls, all community members fall (Strong Oak, personal communication, March 31, 2014). In these cases, the responsibility of the larger community offers opportunities for system-wide changes and while the individual is held accountable, the family and community can be involved as part of the protective solution.

1 We use the "@" symbol to represent the feminine and masculine versions of words and to promote gender inclusion.

LANGUAGE INTERPRETERS

A practical and immediate need (and legal obligation through Title VI of the Civil Rights Act of 1964 if receiving federal financial assistance [Fontes, 2005, p.54]) would be to provide a language interpreter to families who do not speak English. When working with Deaf clients, an American Sign Language interpreter is required under Title III of the Americans with Disabilities Act of 1990 (1991). A best practice would be to offer language interpreting to any bilingual or multilingual family, even if they speak English. Often, especially when discussing traumatic events, people feel most comfortable speaking in their native language (Fontes, 2009).

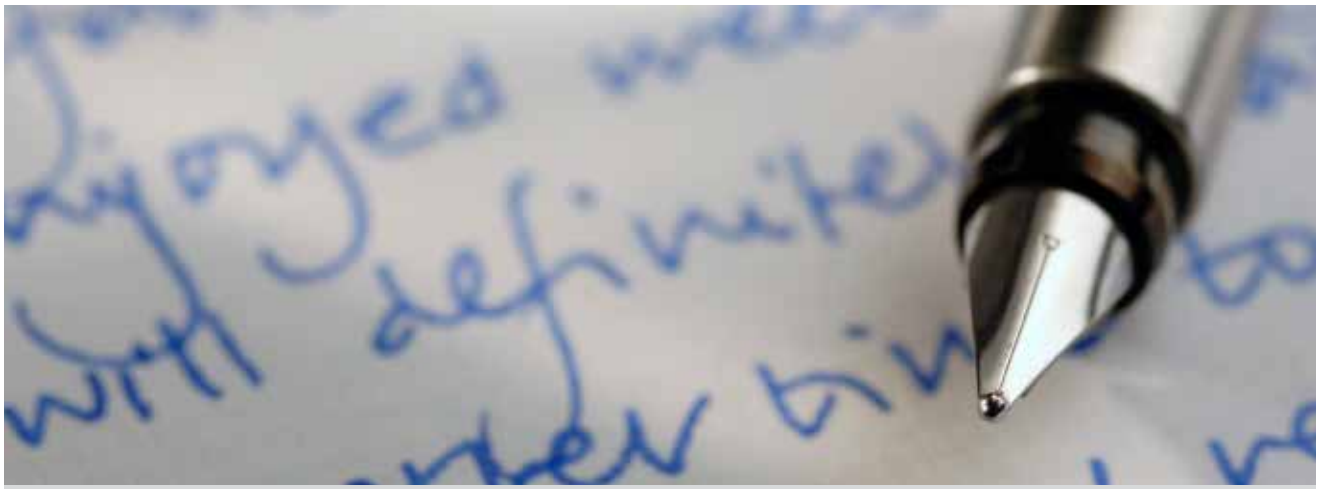
These examples illustrate how individuals in various populations may view seemingly protective interventions, such as reporting to law enforcement, involvement of child protective services, and seeking medical care, as potentially more harmful than helpful due to a mistrust of authority based on their experiences of historical oppression. What may be viewed as resistance or neglect by an outsider may in fact be a reflection of a client's caution based on misunderstood differences in cultural norms and values or experiences of past (or historical) discrimination (Fontes and Plummer, 2010). Recognizing how historical trauma and oppression may influence families can help sexual assault advocates reinterpret resistance and understand the importance of alleviating concerns by fully informing the family of each step in the process and what to expect as possible outcomes.

When working with diverse communities, families may also respond more favorably when their family traditions, worldviews, and strengths are recognized and incorporated into service provision. Culturally relevant approaches could include diverse staff that reflect the family's traditions, as well as approaches that address the unique needs of the family and its culture and traditions. Some examples include incorporating faith, singing, prayer, and inclusion of elders and extended family members (Waites, Macgowan, Pennell, Carlton-LaNey, & Weil, 2004).

For some families, becoming involved with law enforcement and in the child protective system can be a shaming experience for parents because they were not "good parents"; only "bad parents" get questioned by the authorities (Fontes, 2005). An awareness of the unique ways that shame is used in many cultures to reinforce unhealthy behaviors will be critical to effectively working with families and communities that come into contact with the current system.

A FIRST NATION'S RESTORATIVE APPROACH

The Hollow Water First Nation in Manitoba faced a devastating epidemic of sexual abuse in their community. In this community, three out of four tribal members were sexually abused and it was estimated that one in three sexually harmed another in the community. Virtually no individual was unaffected by the sexual abuse. Based upon traditional practice of circle dialogues and other healing rituals, this First Nation created the Community Holistic Circle Healing (CHCH) project. Each circle was created in response to a case that came forward and encouraged the entire community to take responsibility for keeping a compassionate yet watchful eye on the person who abused, maintaining full support for the child who was sexually abused, and helping to bring about changes in everyone's relationships to minimize the risk of future abuse. The ten-year evaluation of the CHCH program captured its remarkable success. Of 107 individuals who sexually abused and chose to participate in the program, only two reoffended (Couture, 2001). This 2% sexual re-offense rate was dramatically lower than what the community originally confronted when reporting and prison were the only options for the family and community (Tabachnick & Klein, 2011).



SELF-AWARENESS

When you hear "sex offender" what images and feelings come to mind? Do you think of a... "Monster," "Perp," "Rapist," "Sexually Violent Predator," or a "Dirty Old Man"? Or do you picture a seven-year-old who was sexually abused and is now acting out that abuse on another child? Write down your feelings and images and compare these to what you think you know about the adults, adolescents, and children who have sexually abused.

RECIDIVISM

Recidivism data is dependent on subsequent reports of sexual abuse. Given that sexual violence is a highly under-reported crime, there are questions about the accuracy of recidivism studies related to sexual offenses. However, even with that limitation, follow-up studies have consistently shown rates of sexual offense recidivism for both adults and adolescents convicted of sexual offenses are significantly lower than is commonly believed. Rates vary based on the type of sexual offense(s), the age at release, and other factors. Recidivism rates tend to diminish steadily the longer an individual lives offense-free in the community, and as a person ages. Recidivism rates for adults who have been convicted of sexually abusing a child range from 13% to 35% (after 15 years) and about 7% for adolescents (after five years) (ATSA, 2014; Miner et al., 2006; Waite et al., 2005).

What we know about people who sexually abuse

Individuals view the world and think about creating safety through the multiple lenses imparted by upbringing; family, religious and cultural values; positive or negative experience with authorities; and personal histories of trauma and safety. No one, including service providers, law enforcement, faith leaders, and community members, is immune from biases. Self-awareness about those biases can play a crucial role in providing respectful and effective interventions.

How children, adolescents, or adults who abuse are viewed through those lenses can deeply affect how service providers approach the options and choices that might be possible for a family. How sexual violence against children is defined and framed can influence how people understand and respond to the complex dynamics of this issue.

For example, "child sexual abuse" is used to describe behaviors as diverse as voyeurism (a "peeping Tom") as well as a violent rape.

The term "sex offender" is used to describe a wide variety of people who abuse, from an abuse-reactive child to a well-respected adult in the community. It is important to acknowledge that language can hinder a person's full understanding of child sexual abuse. Therefore, we need to embrace the complexities that surround this issue. Some may assert that they know with certainty "how all sex offenders will act," and mistakenly provide a standard profile for all the sex offenders in the community.

REACTIVE BEHAVIORS

Nearly all children have some reaction to their experience of being sexually abused, sometimes immediately, and sometimes years later. It is important to stress that most children who are sexually abused do not react by going on to sexually abuse others, (ATSA, 2014) a fact that is in sharp contrast to incorrect "common wisdom" about "cycles of abuse." Especially for males, the inaccurate but widely held fear that boys who were sexually abused will be seen as doomed to become abusive poses a serious barrier to seeking help.

That said, research also shows that a significant majority of children and adolescents who do engage in sexually abusive behavior with another child were themselves physically, sexually, or emotionally abused and/or neglected. (ATSA, 2014; Prentky, Harris, Frizzell, & Righthand, 2000). Not surprisingly, trauma of any kind heightens a child's risk for reactions that may harm others. But a risk is in no way a likelihood of behaving abusively.

For professionals working with children and adolescents, there are special considerations for treatment, for their families, community, and school, as well as the juvenile courts.

In treatment, the recommended research-based approach emphasizes the strengths of the adolescent or child as well as the strengths and challenges within the family, while addressing the specific skills and safety controls needed to maintain a safe environment for the child who was harmed and for the youth who abused (Prescott, 2006). As such, treatment will vary based on the age or developmental stage of the child or adolescent who sexually offended. (See special considerations for children and teens who offend.)

Families often need to be reminded that a child or teen that has sexually abused and completes a developmentally appropriate treatment program will, in nearly all cases, learn to live a healthy and productive life (Alexander, 1999; Caldwell, 2002). For parents where both the child who was abused and the child who was abusive are in the same family, the issues of clarification and reunification are much more complicated. These parents may also have a strong desire to keep all members of their family together, which increases the pressure to consider family reunification (Harper, 2012).

What causes people to sexually abuse a child?

Where experts agree and what the research supports is that there is no "one-size-fits-all" approach to understanding the individuals who sexually abuse children. People who sexually offend are as diverse as any other population (Association for the Treatment of Sex Offenders [ATSA], 2014). No reasons justify sexual abuse of a child and there are no simple explanations.

Characteristics of adults who have sexually abused can include wide differences in age, intellectual development, criminal background, and attitudes towards sexuality and sexual arousal — no single factor distinguishes adults who sexually abuse. People who sexually harm a child may do so for multiple reasons. Generally, a complex interplay of emotional, situational, developmental, and psychological factors, which may include intimacy deficits, loneliness, anger, stress, sexual attraction to children, desire for control, and other issues are believed to contribute to an individual's motivation to sexually abuse (ATSA, 2014).

Special Consideration for Adolescents and Children Who Have Sexually Abused

How a child experiences sexual abuse, and any long-term effects, may have no relation to the motivation or intent of the person who sexually abused her/him. Still, the reasons an adolescent may interact sexually with a child are even more diverse and follow different patterns of behavior than adults might follow (Longo & Prescott, 2005). As might be expected, sexual experimentation plays a bigger role in adolescents' abusive behavior with children than with many adults, and consequently, the approaches to intervention and treatment should reflect such differences (e.g., we cannot assume that a 13-year-old who has touched the genitals of a younger sibling will grow up to be a serial sex offender).

It is important to remember that developmental stages around social and cognitive awareness mean that the reasons a pre-teen or younger child may sexually abuse another child are very different and likely to be even more varied than is the case for adolescents. When a young child engages in sexually harmful behaviors, the causes may relate much more to a reaction to their own experience of abuse, curiosity, and/or experimentation (Miner et al., 2006).

Notes

Definitions

Family Clarification, Reconnection, and Reunification

For the purposes of this guide, clarification, family reconnection, and family reunification are very different phases in a much longer process to assure family safety.

Even when a serious betrayal has occurred, the basic human instinct is to restore connection with someone who has played a significant role in one's life (McCullough, 2008). For those outside the family, and often for non-offending family members, the shattered trust inherent in the abusive interactions may be the dominant, if not sole focus. However, the child who was abused may remember the betrayal in a more complex context of a rich, often-nurturing relationship with a parent, sibling, or relative. Over time, the urge to regain the positive aspects of the relationship (with a hope of the abusive elements being absent) can remain strong. The result may be ambivalent feelings, rather than outright rejection of the abusive family member.

In the age of social media, the opportunity to initiate reconnection in small ways and even over the objection of legal or familial authorities is difficult to eliminate. Acknowledging the

urge for reconnection and establishing a clear safety plan to manage any interest in restoring the relationship is a critical part of any family safety plan.

Family Clarification

Family clarification refers to the process designed for family members to talk about the harm caused and the impact on everyone within the family system (Schladale, n.d.). The process is conducted under the supervision of professionals who can facilitate the acknowledgment and/or apology from the person who committed sexual violence, discuss the needs of the child who was harmed, the needs and capacity of the family, and consider the options for any safe contact. The clarification process will change dramatically depending upon the age of the child who has been harmed; the age of the adult, adolescent, or child who caused that harm; and the reactions and the capacity of the family members who have been affected and have a role to play in keeping the family safe in the future.

Family Reconnection

As mentioned earlier, there is often a powerful instinct to reconnect, even after harmful interactions. After a clarification process, the family (or portions of the family) may want to consider new ways to safely connect. Decisions about how to interact as a family should involve professionals and others outside of the family as a safety net.

Ideally, family reconnection is a process of determining under what prescribed circumstances this contact should occur. The process should be developed within the parameters of a clear safety plan. The ability of family members to understand the value of the plan and to effectively supervise the process, and of professionals to monitor each step, is essential to success and the safety of everyone involved (Gilligan & Bumby, 2005; Schladale, n.d.).

Family Reunification

Formal family reunification is an in-depth process where all professionals involved (see page 35 for visual of people involved) with the family and family members work together to consider the type and degree of contact that might be possible with a child, adolescent, or adult who has sexually abused (Child Welfare Information Gateway 2011). Reunification should only be considered if everyone agrees they want to try this and the professionals agree that it would be a positive decision for everyone in the family. If there is not consensus on this, then the family and professionals should consider other options.

When a person sexually abuses someone outside of the home, the family reunification process may not include a child who was sexually abused but should address other potentially at-risk children who may or may not live within that home. When reunification involves both the abusive child and the child who was harmed, additional conditions may be applied (Gilligan & Bumby, 2005).

REUNIFICATION FACTORS

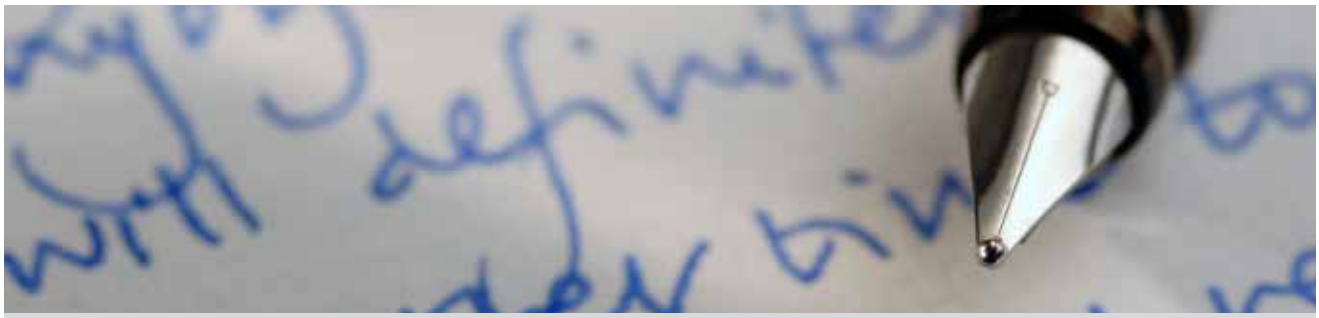
Here a few examples that outline potential factors that come into play when considering reunification:

- An eight-year-old is sexually abused and acts out the abuse on a younger (five-year-old) sibling. Regardless of whether or not the eight-year-old is initially removed from the home, as part of treatment for everyone involved, the family will need to find a way to viably live together by developing a safety plan to ensure the five-year-old's safety and to establish healthy boundaries for the eight-year-old.
- A father sexually abuses a boy while coaching, goes to prison, and wants to return to his family (no young boys live in the home).
- A 14-year-old with intellectual disabilities acts out in school and is reported for trying to touch younger children in the bathroom, and the family (with younger children at home) is hesitant about whether they can care for and supervise the teen as he/she gets older.
- A parent of two young children is concerned about an uncle in the family with a prior history of sexually abusive behaviors and how to establish safe boundaries for everyone attending an upcoming family reunion.

Guiding Principles and Assumptions

Every professional working in this field brings a unique set of assumptions and principles to their work. When facing a particularly difficult situation or a controversial conversation about a topic like family reunification, it is essential to articulate the principles underlying one's approach to this work. Below are a set of foundational assumptions and principles used to guide this publication:

- ***Every member of the community deserves to be safe:*** This is true for the child who was harmed, the child's family members, the adult or youth who abused, his or her family members, and the people surrounding them all.
- ***Acknowledge the harm caused to everyone:*** Acts of sexual abuse damage the closest relationships of the person who abused and the person who was abused. If the abuse has been perpetrated within the family, the loss of trust, intimacy, support, acceptance, and love is felt by each individual member of the family (Gilligan & Bumby, 2005; Schladale, 2014).
- ***Use a trauma-informed approach:*** Professionals and organizations working with the family should modify the way they conduct business based upon a full understanding of how the child who is abused might understand what has happened to them (The National Sexual Assault Coalition Resource Sharing Project & National Sexual Violence Resource Center [RSP & NSVRC], 2013; Washington Coalition of Sexual Assault Programs [WCSAP], 2012).
- ***Follow current best practice standards:*** Professionals must follow research-based processes, and the intervention must be delivered by knowledgeable providers (ATSA 2005).



SELF-AWARENESS

What principles and assumptions do you bring to this work? What would you add to this list?

_____

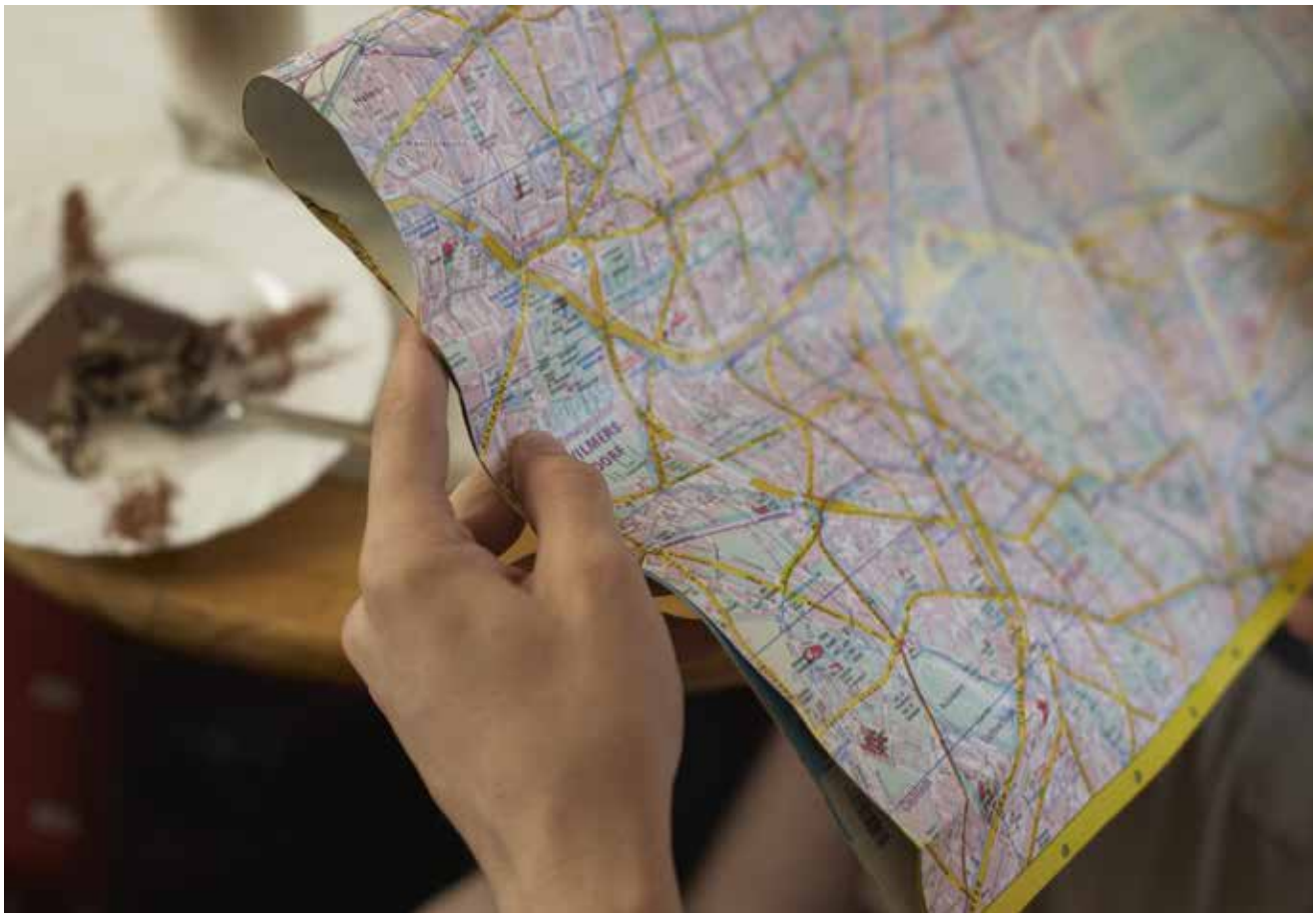
_____

_____

_____

_____

- ***Do no further harm:*** A key best practice is to ensure that a child who is harmed wants to move forward before family clarification and possibly reunification is considered. Depending upon the age of the child, either the child or his/her therapist/advocate should be consulted regularly to ensure there is no further harm caused by any step in the process (Gilligan & Bumby, 2005; Schladale, 2014).
- ***A collaborative approach brings all perspectives to the table:*** It is difficult to hold multiple perspectives in a shifting family dynamic, especially around the issue of child sexual abuse. Most programs encourage a collaborative approach to decision making, involving all key stakeholders from the beginning (Gilligan & Bumby, 2005).
- ***Interventions should be both culturally informed and strengths-based:*** Families need to be recognized for the strengths and unique cultural approaches they bring to their solutions (Appleyard & Osofsky, 2003). A family's/client's/individual's culture can influence every step of the process, even the definition of family and the responsibility families feel for each member of the extended family (Fontes and Plummer, 2010).
- ***Increase the protective factors for the child and the family:*** At each step in the process, consider ways to increase child and family protective factors such as support from a parent or a trusted adult (Appleyard & Osofsky, 2003; Harper, 2012).



Navigating the Road Map of Reunification

Before beginning to step into the process of family clarification, reconnection, or reunification, it is helpful to explore the variety of views of what is meant by "family."

Individuals, communities, and institutions have many different ways to define family, and the explanations of family are often deeply affected by cultural, economic, and social influences. To ensure some cultural sensitivity, asking the family how they define themselves may provide some insight into how to develop a process that resonates for that child and family. A family may define themselves as related by blood, by marriage, and may add individuals who have established strong emotional or community ties as well.

The family might be one-generational (e.g., siblings raising siblings) or intergenerational (e.g., parents and children or grandparents raising grandchildren), and may include both related and unrelated people living in one home. One commonality for most families is that the people who call themselves "family" are making it clear that these people are important in some way to each other. Asking individuals to name the people who are "family" to them

may help to educate everyone involved in the decision about who and what resources are available (Thomas, 2004).

The goal of the family clarification process is to facilitate healing for the child and the family and offer the person who harmed a child the opportunity to take responsibility for his or her actions. Even if many years have passed since the abuse occurred, the clarification process may be a helpful place for healing. When the people involved speak together about what happened and have a chance to discuss the role each person played in the situation, it can offer the person causing the harm a chance to take full responsibility for his or her actions.

The clarification process may also serve as a point of assessment for possible future family contact, interaction, or reunification The ultimate goal of family reunification is healing, as well as preserving the safety of the child, the family, and the public (Gilligan & Bumby, 2005). The driving force for any family reunification effort must begin and end with the best interest of the child, with the focus on the health of the child's long-term adjustment (Gil & Roizner-Hayes, 1996; Hewitt, 2008).

Ideally, the family clarification and possible future reunification should only move forward as a gradual and deliberate process that includes appropriate treatment for the child; for the adult, adolescent or child who abused; and their family members (Gilligan & Bumby, 2005). Reality is often much more complicated — the lack of local resources, court orders in the face of ambiguous findings, pressure from the system, lack of cooperation from key family members, and pressures from extended family or culture may push a family towards reunification, even when some of the family members or professionals are opposed.

For the best outcome, the process should only be considered if the child, the child's therapist, and the child's family are willing to consider the process, and the person who abused has done their work in treatment and is willing to accept responsibility for their actions. If they are, the next question is whether the adult or youth who abused the child, the non-offending parent, and any other responsible caregivers have the ability and the willingness to protect the vulnerable members of the family (Gilligan & Bumby, 2005).

If a family chooses not to enter into any aspect of this process, the professionals working with the adult, adolescent, or child who abused still play a critical role in assisting with housing, social supports, employment, or school, which are all important factors for living safely in the community.

Concerns

There are many legitimate reasons to be concerned for a child or family considering any form of clarification, reconnection, or reunification with someone who has sexually abused a child. General questions that must be considered:

- Will the child be safe?
- Is the child ready for this kind of interaction?

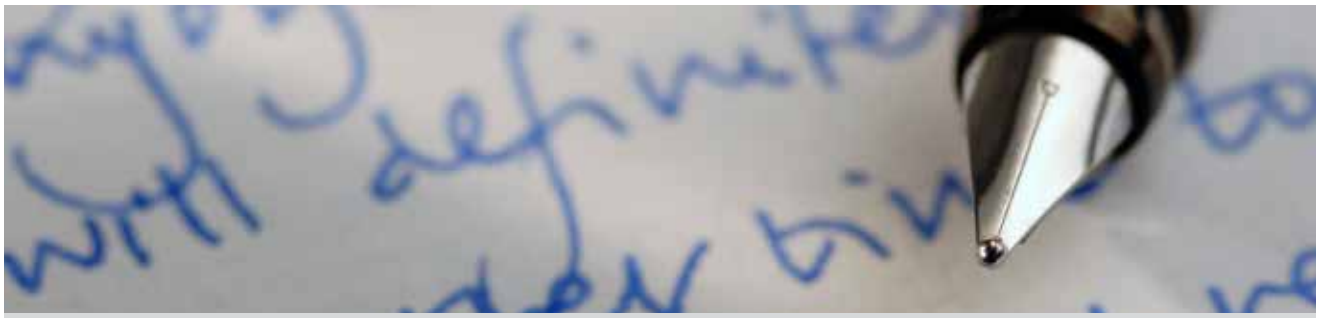
- Do family members have the skills and understanding to supervise ongoing interactions?
- Does the family have the resources to follow through on a safety plan in all aspects of their lives?
- Does the adult, adolescent, or child who did the harm understand the impact of what he or she did and do they have the ability to control their behaviors?

Other concerns about reconnection and reunification, which may be driven by misunderstanding, bias, or fear, rather than thoughtful consideration, must be acknowledged to address reflexive resistance or uninformed insistence. These may include:

- Single-minded desire to punish the person who caused harm.
- Philosophical stance: i.e. "We just do not do that," OR "We must always forgive someone for their transgressions..."
- Belief/fear that creating safety/change is not possible.

Beyond these initial, broad concerns and questions, below is a list of more specific circumstances that would provide strong prohibitions against family reunification or reasons to build capacity before anyone proceeds further.

- **Offender-treatment provider and community supervisor do not give their approval:** Before the clarification or reunification begins, the person who abused should have completed specialized treatment and have the agreement of the treatment provider and community supervisor. Without approval from the treatment provider and community supervisor, reunification will likely fail, and ignoring their concerns is likely to pose an increased risk for the child and his or her family (Cumming and McGrath, 2005; Gilligan & Bumby, 2005; Schladale, n.d.).
- **The caregivers are in denial:** If the caregivers do not believe the offense occurred, they may not have the willingness, skills, and readiness to provide adequate supervision and support, capacity to identify potential risky situations, and/or offer any form of protection (ATSA, 2005; Gilligan & Bumby, 2005).
- **Lack of family capacity:** If key members of the family are currently experiencing untreated psychiatric disorders, substance abuse, domestic violence, or are exposed to other overwhelming stressors, these circumstances may prevent adequate family supervision and compromise the safety of the child. By addressing these issues, the family may be able to pursue family reunification (ATSA, 2005; Cumming & McGrath, 2005; Gilligan & Bumby, 2005).
- **Family minimizes the seriousness or the impact of the abuse:** This kind of family reaction has the potential to negatively affect the child, interfere with the treatment of the person who caused the harm, and create an environment that is not focused on safety (Gilligan & Bumby, 2005; Schladale, n.d.).



SELF-AWARENESS

Social supports such as housing, employment, and social interactions for the person who caused the harm are critical elements in preventing further abuse. Therefore a decision to stop family reunification can put the child, adolescent, or adult who offended at further risk to abuse (Maruna, 2001; Russell, Seymour, & Lambie, 2013; Willis & Grace, 2008; Willis & Johnston, 2012). In these cases, what do you think can be done to ensure that the child who was harmed and the community are safe?

Normalizing the need for all families to create standards of safety, whether involved in a reunification process or not, may make it easier to engage defensive or resistant family members in safety planning. In fact, every family should consider questions of boundaries, safety plans, and how to respond to inappropriate behaviors. Since most child sexual abuse is never reported and most people who abuse eventually return to their communities, many families will face issues related to reconnection, clarification, and reunification, and can benefit from a framework and guidance to make decisions that truly consider the safety of every child, the family, and the entire community.

The following steps are a simplification of what is possible for a family if they have acknowledged the sexual abuse, reported the abuse, the abuse is substantiated, and there are resources available for everyone involved. Although reunification is not always a solution for some families, the steps and the practical advice about protecting the vulnerable child/children will be helpful to every family.

Outline of the Steps

Given the complexity of reunification, a family cannot effectively engage in this process alone. In fact, since child sexual abuse thrives in an environment where families are silenced and isolated, bringing in additional resources and eyes to the family can help to foster safety and communication within the family.

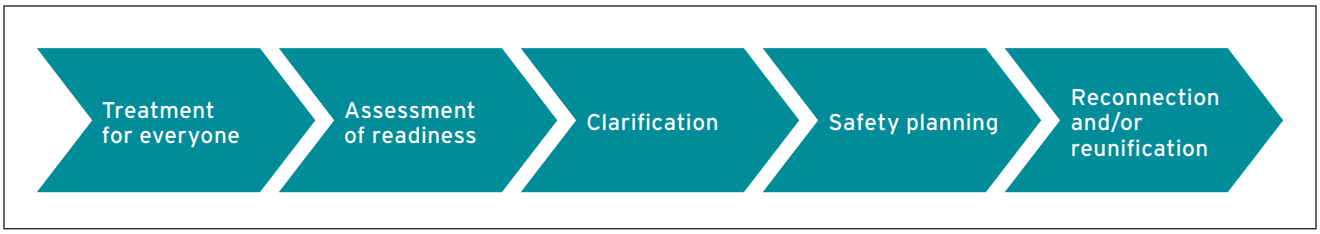
Ideally, the family receives adequate support from the victim advocate, child protection case manager, sex offender treatment provider, family therapist, probation officer, and any other professional working with the family. This should include a thorough understanding of the process, the specific roles of each person, as well as clear and consistent communication throughout the process by everyone involved (Gilligan & Bumby, 2005; Harper, 2012; Thomas, 2004). Ongoing attention to recognizing and addressing the particular practical and cultural needs of a family (i.e., helping with transportation, providing an interpreter, or incorporating culturally relevant practices and

beliefs) can enhance the family's sense of safety, respect, and empowerment and ultimately their willingness to fully engage in the process.

Key to successfully moving through the reconnection and/or the reunification process is being aware of the cultural considerations outlined on page 14. When service providers are proactive and address cultural needs (such as providing a language interpreter or incorporating other culturally relevant practices/beliefs such as faith, religion, or prayer and inclusion of elders), the process outlined below can only be improved. Of course, the empowerment principle of meeting people where they are still applies: asking families what they need throughout the process is imperative.

> Sexual abuse "impacts our community and society like ripples breaking the water's smooth surface"
>
> (Yantzi, 1998, p. 54)

Five Steps towards Reconnection and/or Reunification

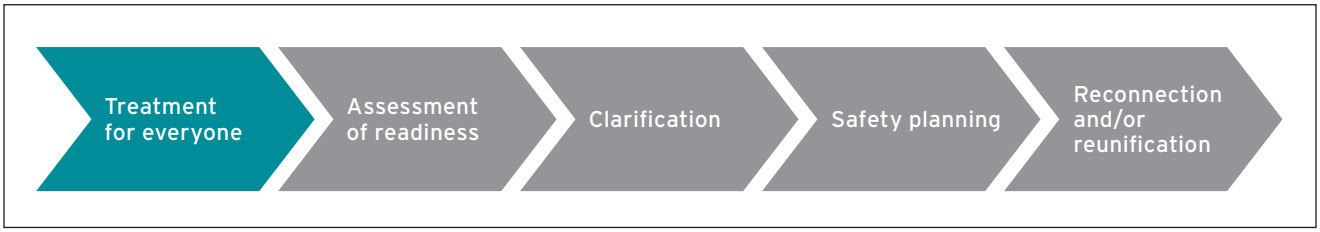


Although the process is complex and may be halted at any time, there are five key steps (Gilligan & Bumby, 2005; Price, 2004):

1. Treatment of the offender, victim, and family
2. Assessment of readiness
3. Clarification
4. Supervised visits in clinical settings and in the community
5. Going home with ongoing supervision for at least the first year

A caution: Even if the process has begun, family reunification should not be implemented in every case. When there is a decision to terminate the process, alternative plans need to be made so that each family member has the opportunity to deal with the feelings of grief, anger, loss, and/or guilt. If the process is discontinued, the child who was abused, family, and the person who abused should have continued access to services. The person who caused the harm should have continued supervision and monitoring to reinforce the no-contact orders and any specialized conditions (Cumming & McGrath, 2005; Gilligan & Bumby, 2005).

Step One: Treatment of Everyone — The child who was abused; the adult, teen, or child who was abusive; and their families.



Once the sexual abuse is reported and substantiated, there are a number of key stakeholders involved in keeping the child and family safe. These stakeholders may include:

- victim advocate
- therapist for the child
- treatment provider for the person who offended
- family therapist
- supervision officer such as probation or parole
- child welfare caseworker
- child who was victimized
- caregivers, the family, and any other responsible adults the family wants to include (Gilligan & Bumby, 2005; Chaffin, n.d.; Schladale, n.d).

Others who may play an important role in the process may include:

- extended family members
- faith community
- school personnel
- coaches
- others who have a role in the care of the family.

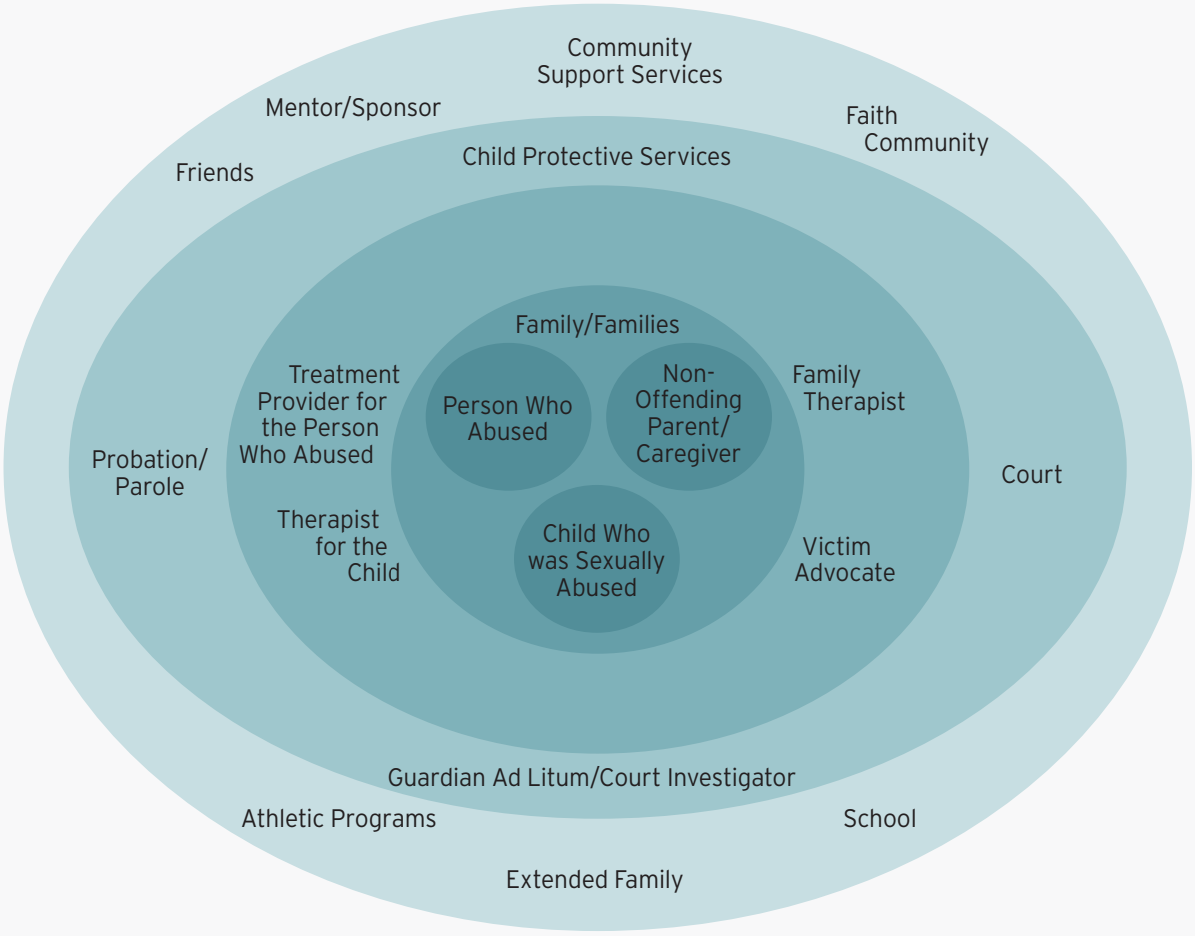
Choosing who needs to be involved and ensuring that each is educated on the issue can be an important step in creating a workable network of support for whatever process is decided upon.

Clear communication across all of these stakeholders creates the safety net needed to implement an effective plan. Collaboration and communication between and among the family and key stakeholders is crucial to the safety of the child, the family, and the community.

The first step in the process is for each member of the family to have access to an assessment of the therapeutic resources available to address the abuse and any related trauma they have experienced. This includes the child who was harmed, the adult or youth who sexually abused that child, and their individual or joint families. The main issues the family system must address are:

- the immediate safety of the child and the family;
- dealing with the effects of sexual abuse;
- and decreasing the risk for the person who offended to sexually abuse again.

KEY STAKEHOLDERS IN REUNIFICATION: THE POWER OF COLLABORATION



Including a family into a collaborative, supportive, and nurturing extended community may offer the best opportunity to assess the wisdom of reunification and ensure the safety of everyone involved.

Every situation will feature a complex array of players — some constantly visible, others mostly in the background, but wielding enormous power and influence. Each will offer their insights, resources, concerns, and strengths through their unique lens and from their particular perspective, determined by their role, their experiences, their beliefs, their values, and their priorities. This unique lens is expressed to others through their own communication style under stress and their ability to express deep emotions.

The challenge for anyone involved in the process of clarification, reconnection, and any effort toward reunification is to carefully consider the strengths each brings to the table and how those strengths can be integrated for the best interests of the child, the family, and the safety of the community.

The family may also have to address other issues that might destabilize the family. For example, access to in-home services, substance-abuse services, and support around interpersonal violence; parenting support, childcare, as well as concrete services such as housing and financial assistance, and transportation will be equally important to healing.

The Child Who Was Sexually Abused: Once immediate safety issues are addressed, therapy for the child who experienced

RIGHTS OF VICTIMS

The rights of the victims of crimes are typically outlined in state statutes and may include victim compensation and restitution, public information about the person who offended, notice of parole conditions, and any violation of these restrictions. Family involvement ensures that they are informed of the process and can be helpful in monitoring the activities of the adult or youth who harmed the child.

sexual abuse can begin. Therapy should address emotional, behavioral, and cognitive reactions to the abuse. This intervention is a chance to address the fears, anxiety, and shame of the child who was sexually abused, as well as any lingering false sense of responsibility that belongs with the person who caused the harm. Although it is not the responsibility of the child to protect themselves, letting the child know of the protective strategies through both family members and professionals lets the child know others are fully engaged to assure that they are safe (Child Welfare Information Gateway, 2013). Therapy should also help the child who was sexually abused learn how to (re)establish trusting and safe relationships.

The Family: The child who was sexually abused and the larger family system participate with a team of advocates, clinicians, and providers specifically trained to address issues of trauma, resiliency, family dynamics, and safety planning related to sexual abuse. The goal is to identify and address various characteristics of the family's interactions — "child and family risk factors" — that were present and may have made the family more vulnerable to the abuse (Gilligan & Bumby, 2005; Farmer, Southerland, Mustillo, & Burns, 2009).

To effectively change the family routines and to eliminate those risk factors, the non-offending guardians and other family members need to address the trauma issues related to the sexual abuse. They also need to explore their feelings about their role in what happened or in failing to prevent it, especially if the person who abused is a member of their defined family. Even if the abused child is not a part of the immediate family of the person who did the harm, these family members will need to confront all of the behaviors that are linked to the abuse patterns and develop healthy alternatives.

Although the problematic characteristics of the family will need to be discussed (e.g., chaotic, unstable environments as well as histories of child sexual abuse), healing, clarification, and reunification will become daunting to the family if the sole focus of the sessions are on the risk factors and problems of the family (Schladale, n.d.). Highlighting strengths like individual family member's courage, insights, past success at changing, commitment to one another's well-being and safety, and willingness to face difficult issues can all contribute to encouraging a sense of hope that healing and safety is possible.

The therapist's and advocate's role is to help the family create a detailed picture of how that family can interact in a healthy, open, supportive, and non-coercive way. By taking this approach, the conversations focus on how change happens and establishes a concrete vision for the future, rather than just discussing how the original problems developed (Miller & Rollnick, 2002; Prescott & Wilson, 2012; Price, 2004).

The Adult, Adolescent, or Child Who Abused the Child: Treatment for the person who abused will vary dramatically depending upon the age and developmental stage of the adult or youth. Treatment is an essential component for any process moving toward a conversation about what has happened in the family. Key to success is the clinician with specialized training to work with these populations and a treatment approach individualized to the risks and needs of that client and family. The resources section will have information on where to find these professionals (see Appendix C).

For adults, the three focus areas are:

1. the safety of the child who was harmed and the safety of the community;
2. a commitment to change;
3. and the development of skills to enable that individual to become a safe, productive member of that community. Information should be continually shared across professions (e.g., probation and parole, polygraph examiners, victim advocate, etc.) with a clear purpose of supporting a safe lifestyle, understanding and changing the factors that led to the abusive behaviors, and holding the individual accountable for both past and current behaviors that create risk for offending.

Treatment typically begins with a detailed assessment of the individual who abused. The purpose of the assessment is to determine where and how to focus treatment interventions. The assessment examines both the static and the dynamic risk factors to re-offend. Static risk factors are characteristics in a person's history that are seen as consistent, habitual, and unchangeable. These might include such things as fixed patterns of violence, multiple victims over time, or victimization of strangers. These risk factors are difficult to address and tend not to exist yet with children and adolescents. Because their "history" is less established, there are many opportunities for children and teens to establish a healthy adult life (Latham & Kinscherff, 2012; Miner et al., 2006; Reitzel & Carbonell, 2006; Waite et al., 2005).

Dynamic risk factors are characteristics, beliefs, or behaviors that are seen as changeable and are often targets for treatment with adults as well as with children and adolescents. These can include weak or non-existent social supports, harmful attitudes about sexuality, and poor strategies related to self-management and responses to stress. When addressed through treatment, risk can be diminished for children, adolescents, and adults (ATSA, 2014).

Treatment with an eye towards clarification will typically include helping the person develop a deeper understanding of the impact of the abuse and supporting them in writing an apology

letter — ensuring that the individual is able to assume full responsibility for their behaviors and the consequences, and does not minimize the abusive act or the harm caused in any way. Current best practice is to examine the individual's risk to abuse and explore what can be done to minimize the risk and increase the protective factors around that individual (see Appendix A for a summary of risk and needs for adults and also page 41 for more information on the apology letter).

SPECIAL CONSIDERATIONS FOR ADOLESCENTS AND CHILDREN WHO HAVE SEXUALLY ABUSED

Adolescence is generally considered the time between the ages of 12 or 13 and 18, a stage of life when an individual transitions from childhood to adulthood, and that is expected to include predictable physical and mental milestones (Mannheim, 2013). Developmentally, there is a growing understanding that the brain is not fully formed until the age of 25 (Miner, 2006; National Institutes of Health [NIH], 2005). While this is important in terms of treatment of young adults, it is not relevant to legal standards of adolescents. "Children" refers to those who have not yet reached adolescence. Some children may enter puberty before adolescence ([NIH], 2014).

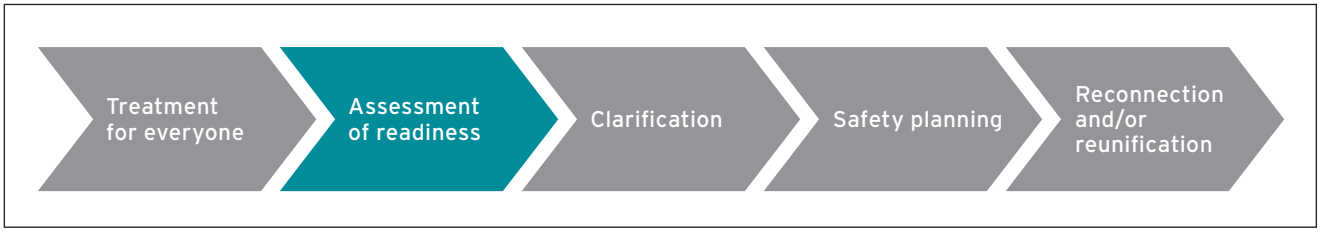
For adolescents and children, treatment will need to include families and guardians who exercise control and supervision over their day-to-day lives. In fact, everything from the initial risk assessment to any reintegration plans will place much greater emphasis on the family environment. Treatment with children and teens that is developmentally appropriate will ultimately have much more chance of success.

Children and adolescents are involved in a constant process of developmental, cognitive, and emotional change, which affects both their understanding and impulse control. Even behaviors that are harmful to others or are seen as deviant may not indicate the existence of fixed or stable tendencies that will persist beyond a given developmental stage (Prentky & Righthand, 2003).

Research has shown that treatment is often effective, especially with youth (ATSA 2014). One research-based approach to treating adolescents who have sexually abused is Multisystemic Therapy for Youth with Problematic Sexual Behaviors (MST-PSB). MST-PSB is a widely used evidence-based model for working with youth with problematic sexual behaviors. Key to its effectiveness is the development of a comprehensive plan tailored to the life, family, school, and environment of each youth in treatment (Borduin, Schaeffer, & Heiblum, 2009).

There are also many more options for youth and their family because the juvenile courts tend to consider options for rehabilitation first rather than exclusively punitive.

Step Two: Assessment of Readiness



Prior to treatment, families rarely have the chance to communicate about the sexual abuse in a healing manner (Schladale, n.d.). The child who was abused and their parent(s) are often told by their attorney to simply not talk about what happened. While that might be invaluable legal advice, this leaves little room for family members to talk about the impact the abuse has had on them.

Under those circumstances, the abused child rarely has had a chance to be fully heard by the family or to hear from others in the family — and especially from the person who abused them — that they are not to be blamed in any way. During the assessment of readiness, the professionals begin to communicate about the status of all members of the family and about how each of their clients have progressed to ensure that the key questions of the family system are addressed collectively *before* any next steps toward reconnection are considered.

Assessment of the Child Who Was Sexually Abused: Depending upon the age and stage of development of the child who experienced sexual abuse, he or she may have more or less involvement in the decisions of where to live, who will be the caregiver, and how much contact to have with the person who caused the harm.

It is essential that those involved in making this assessment fully understand the nuances of complex developmental, emotional, psychological, cognitive, and trauma-related factors involved. For this reason, a clinician who has been trained specifically in working with children who have experienced sexual abuse should direct the assessment (Price, 2004). If no one with those skills is available locally, the provider team should arrange for an ongoing consulting relationship with a specifically trained clinician to help oversee and facilitate the decision-making process and to inform any decisions.

In the assessment of the child who was sexually abused, the therapist, in collaboration with advocates, counselors, caregivers, and other providers, will need to determine if the child has addressed the abuse and related trauma to the extent possible for them. For example, a very young child or infant who was sexually abused will not be able to address the trauma of sexual abuse in the same way an older teenager can. Other key criteria to explore with the child or adolescent

who was sexually abused are whether they (Price, 2004):

- are capable of engaging in direct and healthy communication;
- have freely expressed interest in communicating with the family and/or the person who has perpetrated the sexual abuse;
- and have access to a support system(s) within or outside of the extended family.

There is full agreement in the research that the child who was sexually abused should not be put in the position of deciding whether or not to go forward with any form of clarification because of the pressures that may exist within the extended family.

Assessment of the Family: Attempts at family clarification or reunification are frequently successful or unsuccessful depending upon the parent and/or guardian's ability to maintain the safety plan created for the family. Therefore, the assessment of the family is essential to the decision about whether to attempt a clarification session.

As part of the assessment, the therapist should consider the following of key family members:

- Are they capable of direct and healthy communications?
- Have they been able to talk about the abuse and the related trauma they experienced?
- Do they understand the crucial role they must play in maintaining future safety for everyone?

(National Family Preservation Network, 2009; Price, 2004).

Assessment of the Adult, Adolescent, or Child Who Abused: An essential part of the treatment process is taking on responsibility for the harm caused to the child and the extended family (possibly more than one family if the abuse crosses multiple families). Writing an apology letter is a part of this

COURT-ORDERED REUNIFICATION

It's important to keep in mind that in the majority of situations where a child has been sexually abused, it's likely that there will be no criminal adjudication of a sexual offense. Even with child welfare involvement, without adjudication, family courts may be inclined or feel bound to order reunification. If a parent is arguing for reunification with their own child or the return of a child suspected of abusive behavior, the court may order reunification without the benefit of all or any of the steps outlined in this section. In that instance, a stance made by professionals involved that is supportive of the safety of all involved rather than an adversarial position may allow for the implementation of at least some of the steps.

process for adults or adolescents. It is an approach towards empathy for everyone affected by the abuse and beginning the steps towards healthy engagement.

The apology letter is typically reviewed multiple times by the therapist of the person who is writing it, the treatment group, and selected family members, to suggest revisions and to ensure that it actually does address the issues and needs that have been raised by the child who was harmed and the family. The letter is only shown to the child who was abused after it is reviewed and approved by that child's therapist, who will determine if/when the child is ready to hear and understand the process.

As part of the assessment, the therapist should determine the following (Bumby and Gilligan, 2005; Price, 2004):

- whether there is a deep understanding of the harm caused;
- the ability to put the child's needs above their own;
- a true motivation to rebuild and restore a relationship with the child as well as with the extended family;
- skills to accept the boundaries of others;
- a willingness to follow a family safety plan;
- and acceptance of the responsibility for the abuse as well as for restitution of the harm caused.

APOLOGY LETTER

Key components of an apology letter can include (Chaffin, n.d; Price, 2004):

1. Responsibility: full detailed admission and acceptance of responsibility
2. Boundaries: discussion of the safety plan with rules and limits and why they are important
3. Empathy: explanation of the abuse and demonstration of an understanding of the harm caused to the survivor
4. Commitment: willingness to prevent future abuse

Restitution may include paying for the child's therapy or apologizing to the extended family about the harm and trauma he or she created.

Even if everyone is not ready for the next step, it is sometimes helpful for a selected family member to begin the clarification process with the adult, teen, or child who caused the harm. From a safety point of view, it is helpful to the family of the person who abused to be very involved in treatment. Seventy-seven percent of adults participating in sex offender treatment involved families as part of the support system, and, obviously, for adolescents and children it will be even higher (McGrath, Cumming, Burchard, Zeoli, & Ellerby, 2010).

Step Three: Clarification

The clarification process begins with the adult, adolescent, or child in treatment for abusive behaviors; it then progresses to an apology letter, and then if appropriate, may move towards a highly structured and facilitated clarification session.

Why is clarification important to the child and the family? The session is a chance for the child and family members to openly discuss the sexual abuse that occurred and lessen the self-blame a child may be placing on him/herself.

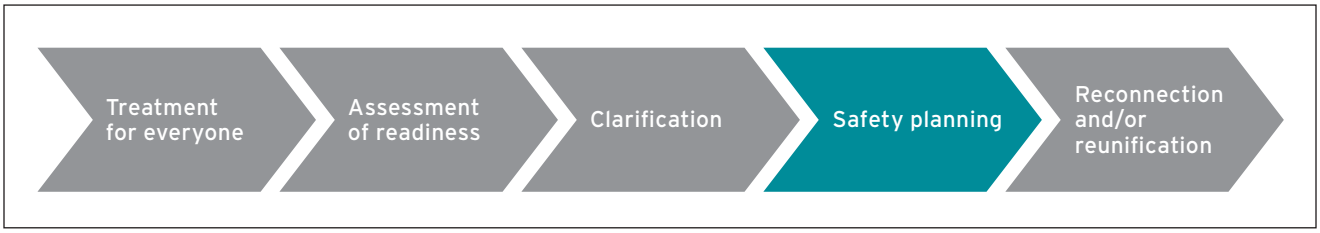
For the session to be successful, the person who abused must accept full responsibility for the abuse, assign no blame to the child harmed, and be able to respond to questions honestly, thoroughly, and in a non-defensive manner (DeMaio, Davis, & Smith, 2006; Gil & Roizner-Hayes, 1996; Gilligan & Bumby, 2005; Price, 2004).

Some may be concerned about the potential harm that may occur during the session. After thorough and careful preparation, the key to the success is whether the professionals in the room maintain the boundaries of the situation, fully understand the motivations for the session, and reinforce that the child is not to be blamed in any way.

If at the end of the clarification process, the child, the family, or the person who sexually harmed the child want to explore supervised visits and the professionals involved agree, then the family needs to develop a safety plan.

Caution: All families who choose to engage in the clarification process should not be pressured in any way to move towards supervised visits or reunification. In addition, it is important that all of the professionals agree that reunification is in the best interest of the child, and that there are enough resources to provide ongoing monitoring/supervision of the child and the person who abused by the professionals and the family (Cumming & McGrath, 2005; Gilligan & Bumby, 2005).

Step Four: Creating a Safety Plan for Contact



Creating a Safety Plan for Contact

A comprehensive safety plan is one that recognizes the strengths of the family as well as the risk factors, patterns, and warning signals of abuse and provides concrete boundaries for the family to maintain for everyone's safety. The clarification process is the beginning to helping change both the patterns of communication and the balance of power within the family (Gilligan & Bumby, 2005).

Supervised Contacts/Visits

Ideally, before introducing any form of supervised visits, there should be a full consultation and agreement between the child's therapist, the treatment provider for the person who abused, and the family, as well as other key stakeholders, such as child protective services, probation or parole if they are involved, and any court ordered personnel (Bumby and Gilligan, 2005; Chaffin, n.d.).

The initial family visit should be supervised by a professional trained in working with sexual abuse issues and ideally takes place in a public setting. Before the meeting starts, the professionals should establish clear ground rules and have everyone involved understand how each rule will help and agree to them. All family members should be able to discuss how to firmly and respectfully establish and maintain appropriate limits with the adult, teen, or child who abused.

Even for families with the most sincere intentions, without regular check-ins, it may be easy to slide into old, familiar patterns

SAFETY PLAN

Safety plans create a road map to illustrate new and safe routes for navigating family interactions previously fraught with trauma and abuse (Schladale, n.d.). A safety plan could be developed for any family who wants to be clear about boundaries and safety. It can also serve to begin important family conversations. This appendix provides an overview of what a safety plan might include.

(See Appendix B for details)

of interaction or feel nervous about changed roles and expectations, especially around intervening with any identified risk behaviors. All of these factors create significant challenges for those participating in a supervised visit. Acknowledging that likely discomfort, and including the person whose behavior will be limited in a detailed discussion about how effective interventions can be made respectfully, can lessen the potential for conflict.

At this initial meeting, it is also helpful to review the family's safety plan to ensure that it is fully understood by every member of the family and to highlight the supportive as well as the restrictive intent of the plan. For an adolescent or child who abused, a family outing may provide a structured way to interact and test the ability and willingness for the youth who abused to follow rules and structure. If both children are a part of the same family, these outings also allow for visits without violating the tentative safe haven of home for the child who was abused.

If all goes well with the initial supervised visits and agreement continues, then there is a gradual transition of supervision from a trained professional to a competent and informed family member with regular debriefs with a specialized provider to help address any confusion resulting from the changed roles, routines, and expectations

Home visits, if seen as appropriate, can then be introduced. Ideally, they should be gradual and planned, beginning with a few-hour visit with structured family

activities (e.g., family meetings) to promote communications, boundaries, and attainable goals. Overnight visits, which involve a high-risk period of time, are a significant step and need further structure, clear expectations, and supervision.

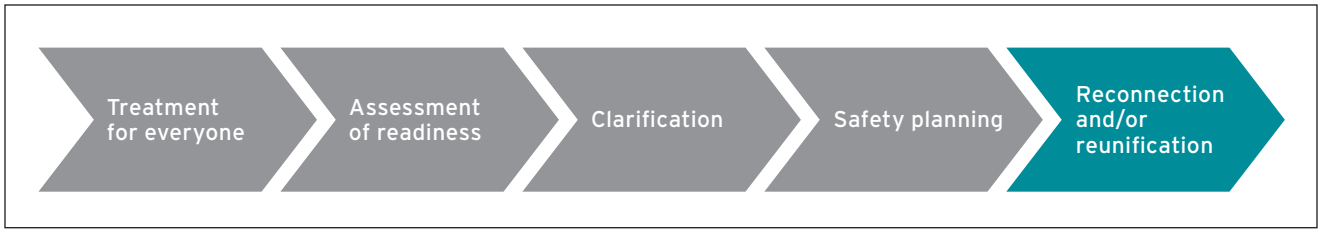
To support the family and to ensure a greater chance of success, there should be ongoing oversight and assistance for the family throughout the process by professionals. Family members, including the person who caused harm, and professionals should have frequent conversations about any "red flags" that were noticed on the visits and how they might be avoided in the future; general debriefs of the visits; and continued conversations about any new situations or any changes within the family.

When Both the Child Harmed and the Child Causing Harm Continue to Live in the Same Home

In some cases, neither the child victimized nor the child who perpetrated the abuse will be removed from the home. The decision to keep both children in the home depends upon many factors including (Chaffin, n.d.):

- the emotional status of the child who was abused;
- whether the teen or older child who abused is in control of his/her behaviors;
- if a reasonable safety plan can be established and reasonably followed;
- whether the parents are competent and able to supervise the behaviors;
- and the impact of removal of either or both children on everyone else within family.

Step Five: Moving towards Reconnection and Family Reunification



As with every other step of the process, family reunification should only proceed when the child who was sexually abused, the family, and all of the key stakeholders agree and understand the risks and benefits of attempting this final stage of the process. At this stage, a comprehensive safety plan should be in place and fully understood and enforced to assure safety for everyone (Gilligan & Bumby, 2005).

In some instances, reunification may include circumstances where family relationships can be restored to a safe and meaningful level without actual reunification within a single household. This would be especially true in a situation where the person who abused the

FAMILY GROUP CONFERENCING

Family Group Conferencing was first widely adopted for youth crime in New Zealand in 1989 because it was considered a close match to indigenous Maori approaches to justice. Since then, this approach has been widely adopted in Australia, Europe, Canada, and parts of the United States. The practice proceeds through five stages: 1) the initial referral, 2) the decision about who should attend, 3) the actual conference, which can last an average of five hours, 4) developing the safety contract, and 5) implementing the plan that will include treatment, in-home supports, and active supervision. In a New Zealand study, families who participated in conferences had half the rate of further child protection involvement of families that received traditional case management (Barbaree & Marshall, 2006; McAlinden, 2008).

child was never a member of the immediate family or has established a network outside of the immediate family that is likely to better support their own positive growth.

Even when everyone agrees and everyone is ready, concerns and challenges will likely arise, especially when adolescents or children who have sexually abused are involved. The goal is not a completely smooth transition, but rather a process where the family is able to raise their concerns, talk openly about problems, and either solve them or seek assistance to resolve the issue. It is actually this ability to recognize and supportively challenge risky behaviors and to work together to find healthy solutions that is one of the most important markers of a change in the family dynamic.

Once the step of family reunification within a single household has begun, it is important to remind the family that the act of moving back into the home is still in many ways the middle of the process. It is essential that ongoing services are maintained after the move for at least the first year of reunification with regular check-ins with the family, continued family meetings to reinforce positive family roles and patterns, and any adjustments to the safety plan as needed. Whether this is a formal or informal process, these check-ins provide an opportunity to review any red flag behaviors and reinforce the positive healthy interactions that are hopefully unfolding.

Caution: As mentioned above, even after family reunification has begun, situations might arise in which there is a decision to terminate the process. If the process is discontinued, it is essential that family, the child and the person who abused continue to access services and that all specialized conditions are met (Cumming & McGrath, 2005; Gilligan & Bumby, 2005).

Conclusion

In the scope of this guide, it is impossible to capture all of the complexities and complications that families face when they experience sexual abuse, whether it is reported or not.

Under ideal circumstances, the sexual abuse has been reported, the person who caused the harm has been held accountable and then engaged in an effective treatment program, each member of the family is willing to face this complex issue, and the child and family members receive effective supports. Although reality is often less than ideal, it can be a useful starting point from which to develop principles to help identify the most effective way forward. This road map prioritizes safety first, offers the possibility of healing, and values a constant consideration of the hazards that might arise.

This explanation of the process should not be seen as an endorsement of family reunification.

Creating safety is not an abstract notion. It takes time to understand what puts someone at risk to abuse, and to identify the protective factors in a given family that reduce that risk. It also demands concrete plans for behaviors that are acceptable and how to respond to behaviors that might be outside of those agreed-upon boundaries.

Hopefully, by breaking down the essential pieces, professionals, and the families with whom they work, will be able to understand the resources needed to maintain safety, both for a child who has experienced sexual abuse and for a child, adolescent, or adult who has sexually harmed a child.

The ideal for family reunification that is described here can be met only if everyone in the family recognizes the harm caused to a child, if the process can be fully supported by the professionals surrounding the family, and if the family's capacity is supported with the necessary resources to move through this difficult time in their lives. Any description of such a process must also offer significant cautions about when this process does not make sense and the many decision points where reunification may be stopped or paused for a significant amount of time. The task of professionals is to always strive toward creating an environment that supports those ideals to the greatest extent possible.

Finally, this guide offers families a sense of hope that healing is possible. Although the effort to achieve a successful family reunification after sexual abuse is difficult and often painful, it is also, at least for some families, a real possibility that can lead to a healthy, happy future.

Acknowledgments

Authors:

Peter Pollard is Communications and Professional Relations director for 1in6, Inc., a national non-profit that supports men who had unwanted or abusive sexual experiences in childhood live healthier, happier lives.

He previously worked for 15 years as a state child-protection social worker and was the Public Education director at Stop It Now!.

Since 2003, he has been the Western Mass. coordinator for SNAP (the Survivors Network of those Abused by Priests) and also works as a group facilitator for an Intimate Partner Violence Education Program and for conflict management groups in correctional facilities.

Peter experienced sexual abuse when he was a child.

Joan Tabachnick is nationally recognized for her expertise in sexual violence prevention and social marketing. Over the past 25 years, she has developed award-winning educational materials and innovative programs for a wide variety of national, state, and local organizations. She has also been asked to participate on national expert panels for a variety of organizations including the Centers for Disease Control and Prevention, National Center for Missing and Exploited Children, Just Beginnings Collaborative, and the Unitarian Universalist Association. Her work includes a National Sexual Violence Resource publication, blog, and online course, *"Engaging Bystanders in Sexual Violence Prevention,"* a book through the Association for the Treatment of Sexual Abusers called *"A Reasoned Approach: The Reshaping of Sex Offender Policy to Prevent Child Sexual Abuse,"*

and program materials for the Enough Abuse Campaign, "*GateKeepers for Kids,*" providing simple prevention guidelines for all youth-serving organizations.

Joan has been the director of NEARI Press and an independent consultant for the last 10 years and prior to that created the programs, helpline services, and authored the founding publications for Stop It Now!. Joan is currently on a fellowship focusing on sexual violence prevention with the Department of Justice SMART Office. Visit www.joantabachnick.com for more information.

Editor: **Jennifer Benner, MPP,** Resource Development Specialist and contributions from **Karla Vierthaler, MPA,** Advocacy and Resources Director

NSVRC thanks the following individuals for their review and contributions:

- **Maia Christopher,** Executive Director for the Association for the Treatment of Sexual Abusers
- **Strong Oak Lefebvre,** President of the Board, Visioning B.E.A.R. Circle Intertribal Coalition, Inc.
- **Kimber Nicoletti,** Director of Multicultural Efforts to end Sexual Assault (MESA) Purdue University
- **Joann Schladale,** Executive Director of Resources for Resolving Violence

About National Sexual Violence Resource Center

Founded by Pennsylvania Coalition Against Rape in 2000, National Sexual Violence Resource Center (NSVRC) identifies, develops, and disseminates resources regarding all aspects of sexual violence prevention and intervention. NSVRC activities include training and technical assistance, referrals, consultation, systems advocacy, resource library, capacity-building, integrating research findings with community-based projects, coordinating Sexual Assault Awareness Month, co-sponsoring national conferences and events, and creating Web-based and social networking resources.

About the Lifespan Project

NSVRC's Lifespan Project is a technical assistance initiative that provides advocates, medical providers, law enforcement, prosecutors, and others with resources and strategies to effectively respond to and support survivors of sexual violence. The Lifespan Project focuses on trauma-informed service delivery, with a particular concern for populations who may fall through the cracks of our systems. For information on NSVRC's Lifespan Project and other publications, visit www.nsvrc.org/projects/lifespan.

©National Sexual Violence Resource Center 2016. All rights reserved.

This project was supported by Grant No. 2011-TA-AX-K023 awarded by the Office on Violence Against Women, U.S. Department of Justice. The opinions, findings, conclusions, and recommendations expressed in this publication are those of the author(s) and do not necessarily reflect the views of the Department of Justice, Office on Violence Against Women.

References

Alexander, M. A. (1999). Sexual offender treatment efficacy revisited. *Sexual Abuse: A Journal of Research and Treatment, 11*, 101–116. doi:10.1007/BF02658841

Americans With Disabilities Act of 1990, Pub. L. No. 101–336, § 2, 104 Stat.328 (1991).

Appleyard, K., & Osofsky, J. D. (2003). Parenting after trauma: Supporting parents and caregivers in the treatment of children impacted by violence. *Infant Mental Health Journal, 24,* 111–125. doi:10.1002/imhj.10050

Association for the Treatment of Sexual Abusers. (2005). *Practice standards and guidelines for the evaluation, treatment, and management of adult male sexual abusers.* Retrieved from http://childonchildsexualabusepreventiontaskforce.homestead.com/atsa_standards.pdf

Association for the Treatment of Sexual Abusers. (2014). *Eight things everyone should know about sexual abuse & sex offending.* Retrieved from http://www.atsa.com/pdfs/Policy/8ThingsEveryoneShouldKnow.pdf

Barbaree, H. E., & Marshall, W. L. (2006). An introduction to the juvenile sexual offender: Terms, concepts, and definitions. In H. E. Barbaree & W. L. Marshall (Eds.), *The juvenile sex offender* (pp. 1–18). New York, NY: Guilford Press.

Breiding, M. J., Smith, S. G., Basile, K. C., Walters, M. L., Chen, J., & Merrick, M. T. (2014). Prevalence and characteristics of sexual violence, stalking, and intimate partner victimization — National Intimate Partner and Sexual Violence Survey, United States, 2011. *Morbidity and Mortality Weekly Report, 63*(8), 1–18. Retrieved from the Centers for Disease Control and Prevention: http://www.cdc.gov/mmwr/pdf/ss/ss6308.pdf

Borduin, C. M., Schaeffer, C. M., & Heiblum, N. (2009). A randomized clinical trial of multisystemic therapy with juvenile sexual offenders: Effects on youth social ecology and criminal activity. *Journal of Consulting and Clinical Psychology, 77,* 26–37. doi:10.1037/a0013035

Caldwell, M. F. (2002). What we do not know about juvenile sexual reoffense risk. *Child Maltreatment, 7*, 291–302. doi:10.1177/107755902237260

Centers for Disease Control and Prevention. (2009). *School connectedness: Strategies for increasing protective factors among youth.* Retrieved from http://www.cdc.gov/healthyyouth/protective/pdf/connectedness.pdf

Center for the Study of Social Policy. (n.d.). *Strengthening families: A protective factors framework.* Retrieved from http://www.cssp.org/reform/strengthening-families/basic-one-pagers/Strengthening-Families-Protective-Factors.pdf

Chaffin, M., (n.d.) *Reintegrating juvenile offenders into the family.* Available from the California Coalition on Sexual Offending: http://www.ccoso.org/library%20articles/04%20Chafin%20-%20adolescents.doc

Child Welfare Information Gateway. (2011). *Family reunification: What the evidence shows*. Retrieved from https://www.childwelfare.gov/pubs/issue_briefs/family_reunification/family_reunification.pdf

Child Welfare Information Gateway. (2013). *Long-term consequences of child abuse and neglect.* Retrieved from https://www.childwelfare.gov/pubs/factsheets/long_term_consequences.pdf

Connell, C. M., Vanderploeg, J. J., Katz, K. H., Caron, C., Saunders, L., & Tebes J. K. (2009). Maltreatment following reunification: Predictors of subsequent child protective services contact after children return home. *Child Abuse & Neglect, 33*, 218–228. doi:10.1016/j.chiabu.2008.07.005

Couture, J. (2001). *A cost-benefit analysis of Hollow Water's community holistic circle healing process*. Retrieved from Public Safety Canada: http://www.publicsafety.gc.ca/cnt/rsrcs/pblctns/cst-bnft-hllw-wtr/cst-bnft-hllw-wtr-eng.pdf

Cumming, G., & McGrath, R. (2005). *Supervision of the sex offender*. Brandon, VT: Safer Society Press.

DeMaio, C. M., Davis, J. L., & Smith, D. W. (2006). The use of clarification sessions in the treatment of incest victims and their families: An exploratory study. *Sexual Abuse: A Journal of Research and Treatment, 18,* 27–39. doi:10.1177/107906320601800103

Dube, S. R., Anda, R. F., Whitfield, C. L., Brown, D. W., Felitti, V. J., Dong, M., & Giles, W. H. (2005). Long-term consequences of childhood sexual abuse by gender of victim. *American Journal of Preventive Medicine, 28*, 430–438. doi:10.1016/j.amepre.2005.01.015

Falicov, C. J. (1998). *Latino families in therapy: A guide to multicultural practice*. New York, NY: The Guilford Press.

Farmer, E. M., Southerland, D., Mustillo, S. A., & Burns, B. J. (2009). Returning home in systems of care: Rates, predictors, and stability. *Journal of Emotional and Behavioral Disorders, 17,* 133–146. doi:10.1177/1063426608327002

Felitti, V. J., & Anda, R. F. (2009). The relationship of adverse childhood experiences to adult medical disease, psychiatric disorders, and sexual behavior: Implications for healthcare. In R. Lanius, E. Vermetten, & C. Pain (Eds.), *The hidden epidemic: The impact of early life trauma on health and disease* (pp. 77–87). Retrieved from http://www.acestudy.org/yahoo_site_admin/assets/docs/LaniusVermetten_FINAL_8-26-09.12892303.pdf

Finkelhor, D., Hammer, H., & Sedlak, A. J. (2008). *Sexually assaulted children: National estimates and characteristics* (NCJ 214383). Retrieved from the National Criminal Justice Reference Service: https://www.ncjrs.gov/pdffiles1/ojjdp/214383.pd

Finkelhor, D., Ormrod, R., & Chaffin, M. (2009, December). Juveniles who commit sex offenses against minors. *Juvenile Justice Bulletin*. Retrieved from the National Criminal Justice Reference Service: http://www.ncjrs.gov/pdffiles1/ojjdp/227763.pdf

Fontes, L. A. (2000). Working with Latino families on issues of child abuse and neglect. *The National Child Advocate, 3*(2), 1–7.

Fontes, L. A. (2005). *Child abuse and culture: Working with diverse families.* New York: NY: The Guilford Press.

Fontes, L. A. (2007). Sin verguenza: Addressing shame with Latino victims of child sexual abuse and their families. *Journal of Child Sexual Abuse, 16,* 61–83. doi:10.1300/J070v16n01_04

Fontes, L. A. (2009, Spring). Interviewing immigrant children and families for suspected child maltreatment. *APSAC Advisor*, 7–11. Retrieved from http://lisafontes.com/articles/Interviewing%20Immigrant%20Children%20APSAC%20Advisor.pdf

Fontes, L. A., & Plummer, C. (2010). Cultural issues in disclosures of child sexual abuse. *Journal of Child Sexual Abuse, 19*, 491–518. doi:10.1080/10538712.2010.512520

Gil, E., & Roizner-Hayes, M. (1996). Assessing family readiness for reunification. In E. Gil (Ed.), *Systemic treatment of families who abuse* (pp. 175–197). San Francisco, CA: Jossey-Bass Publishers.

Gilligan, L., & Bumby, K. (2005). *Key considerations for reunifying adult sex offenders and their families*. Retrieved from Center for Sex Offender Management: http://www.csom.org/pubs/familyreunificationdec05.pdf

Goldman, J., Salus, M. K., Wolcott, D., & Kennedy, K. Y. (2003). *A coordinated response to child abuse and neglect: The foundation for practice*. Retrieved from the Child Welfare Information Gateway: https://www.childwelfare.gov/pubs/usermanuals/foundation/foundation.pdf

Hansen, N. D., Pepitone-Arreola-Rockwell, F., & Greene, A. F. (2000). Multicultural competence: Criteria and case examples. *Professional Psychology: Research and Practice, 31*, 652–660. doi:10.1037//0735-7028.31.6.652

Hanson, R. K., Gordon, A., Harris, A. J. R., Marques, J. K., Murphy, W., Quinsey, V. L., & Seto, M. C. (2002). First report of the collaborative outcome data project on the effectiveness of psychological treatment for sex offenders. *Sexual Abuse: A Journal of Research and Treatment, 14,* 169–194. doi:10.1177/107906320201400207

Harper, B. M. (2012). *Moving families to future health: Reunification experiences after sibling incest* (Doctoral dissertation). Retrieved from the University of Pennsylvania: http://repository.upenn.edu/cgi/viewcontent.cgi?article=1027&context=edissertations_sp2

Hewitt, S. (2008). Therapeutically managing reunification after abuse allegations. *Journal of Child Sexual Abuse, 17,* 17–19. doi:10.1080/10538710701884326

Koss, M. P., Yuan, N. P., Dightman, D., Prince, R. J., Polacca, M., Sanderson, B., & Goldman, D. (2003). Adverse childhood exposures and alcohol dependence among seven Native American tribes. *American Journal of Preventive Medicine, 25,* 238–244. doi:10.1016/S0749-3797(03)00195-8

Krieger, N. (2003). Does racism harm health? Did child abuse exist before 1962? On explicit questions, critical science, and current controversies: An ecosocial perspective. *American Journal of Public Health, 93*, 194–199. doi:10.2105/AJPH.93.2.194

Latham, C., & Kinscherff, R. (2012). *A developmental perspective on the meaning of problematic sexual behavior in children and adolescents*. Holyoke, MA. NEARI Press.

Lau, A. S., McCabe, K. M., Yeh, M., Garland, A. F., Hough, R. L., & Landsverk, J. (2003). Race/ethnicity and rates of self-reported maltreatment among high-risk youth in public sectors of care. *Child Maltreatment, 8,* 183–194. doi:10.1177/1077559503254141

Lehavot, K., Walters, K. L., & Simoni, J. M. (2010). Abuse, mastery, and health among lesbian, bisexual, and two-spirit American Indian and Alaska native women. *Psychology of Violence, 1*(S), 63–67. doi:10.1037/2152-0828.1.S.53

London, K., Bruck, M., Ceci, S. J., & Shuman, D. W. (2005). Disclosure of child sexual abuse: What does the research tell us about the ways that children tell? *Psychology, Public Policy, and Law, 11*, 194–226. doi:10.1037/1076-8971.11.1.194

Longo, R., & Prescott, D. (Eds.). (2005). Current perspectives: *Working with sexually aggressive youth and youth with sexual behavior problems.* Holyoke, MA: NEARI Press.

Malley-Morrison, K., & Hines, D. A. (2007). Attending to the role of race/ethnicity in family violence research, *Journal of Interpersonal Violence, 22*, 943–972. doi:10.1177/0886260507303060

Mannheim, J. (2013). *Adolescent development*. Retrieved from the National Library of Medicine, National Institutes of Health, Medline Plus: http://www.nlm.nih.gov/medlineplus/ency/article/002003.htm

Maruna, S. (2001). *Making good: How ex-convicts reform and rebuild their lives*. Washington, DC: American Psychological Association.

McAlinden, A. (2008). Restorative justice as a response to sexual offending: Addressing the failings of current punitive approaches. *Sexual Offender Treatment, 3*(1). Retrieved from http://www.sexual-offender-treatment.org/1-2008_03.html

McCullough, M. (2008). *Beyond revenge: The evolution of the forgiveness instinct.* San Francisco, CA: Jossey-Bass.

McGrath, R. J., Cumming, G. F., Burchard, B. L., Zeoli, S., & Ellerby, L. (2010). *Current practices and emerging trends in sexual abuser management*. Retrieved from the Safer Society: http://www.safersociety.org/uploads/WP141-Current_Practices_Emerging_Trends.pdf

Miller, W. R., & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change* (2nd ed.) New York, NY: Guilford Press.

Miner, M., Borduin, C., Prescott. D., Bovensmann, H., Schepker, R., Du Bois, R., … Pfäfflin, F. (2006). *Standards of care for juvenile sexual offenders of the International Association for the Treatment of Sexual Offenders. Sexual Offender Treatment, 1*(3), 1–7. Retrieved from http://www.sexual-offender-treatment.org/index.php?id=49&type=123

National Family Preservation Network. (2009). *North Carolina Family Assessment Scale for Reunification: Scale & definition* (v.R2.0). Retrieved from http://www.nfpn.org/Portals/0/Documents/ncfas-r_scale_defs.pdf

The National Sexual Assault Coalition Resource Sharing Project, & National Sexual Violence Resource Center. (2013). *Building cultures of care: A guide for sexual assault services programs.* Retrieved from http://www.nsvrc.org/sites/default/files/publications_nsvrc_guides_building-cultures-of-care.pdf

National Sexual Violence Resource Center. (2011). *Child sexual abuse prevention: Overview*. Retrieved from http://www.nsvrc.org/sites/default/files/Publications_NSVRC_Overview_Child-sexual-abuse-prevention_0.pdf.

Prentky, R., Harris, B., Frizzell, K., & Righthand, S. (2000). An actuarial procedure for assessing risk with juvenile sex offenders. *Sex Abuse: A Journal of Research and Treatment, 12*, 71–93. doi:10.1177/107906320001200201

Prentky, R., & Righthand, S. (2003). *Juvenile Sex Offender Assessment Protocol — II (JSOAP — II): Manual* (NCJ 202316). Retrieved from Center for Sex Offender Management: http://www.csom.org/pubs/jsoap.pdf

Prescott, D. (2006). *Risk assessment of youth who have sexually abused*. Brandon, VT: Safer Society Press.

Prescott, D., & Wilson, R. (2012). *Awakening motivation for difficult changes*. Holyoke, MA: NEARI Press.

Price, D. M. (2004). Rebuilding shattered families: Disclosure, clarification, and reunification of sexual abusers, victims, and their families. *Sexual Addiction & Compulsivity, 11*, 187–221. doi:10.1080/10720160490903701

Postmus, J. L. (2015). Women from different ethnic groups and their experiences with victimization and seeking help. Violence Against Women, 21, 376–393. doi:10.1177/1077801214568254

Reitzel, L. R., & Carbonell, J. L. (2006). The effectiveness of sex offender treatment for juveniles as measured by recidivism: A meta-analysis. *Sexual Abuse: A Journal of Research and Treatment, 18*, 401–421. doi:10.1177/107906320601800407

Russell, G., Seymour, F., & Lambie, I. (2013). Community reintegration of sex offenders of children in New Zealand. *International Journal of Offender Therapy and Comparative Criminology*, *57*, 55–70. doi:10.1177/0306624X11426132

Schladale, J. (n.d.). *A collaborative approach for family reconciliation and reunification with youth who have caused sexual harm*. Retrieved from Resources for Resolving Violence, Inc.: http://resourcesforresolvingviolence.com/publication3.pdf

Schladale, J. (Ed.). (2014). *Service description: New Hope Carolinas Psychiatric Residential Treatment Facility.* Retrieved from http://www.newhopetreatment.com/pdf/new_hope_plan_for_clinical_services.pdf

Shaffer, A. (2012, Winter). Child maltreatment: Risk and resilience in ages birth to 5. *CW360°*, 12–13. Available from the University of Minnesota, Center for Advanced Studies in Child Welfare: http://cascw.umn.edu/wp-content/uploads/2014/01/CW360-CEED_Winter2012.pdf

Smith, A. (2007). *Soul wound: The legacy of Native American schools.* Retrieved from Amnesty International USA: http://www.amnestyusa.org/node/87342

Snyder, H. N. (2000). *Sexual assault of young children as reported to law enforcement: Victim, incident, and offender characteristics* (NCJ 182990). Retrieved from the U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics: http://bjs.ojp.usdoj.gov/content/pub/pdf/saycrle.pdf

Stroud, D. D., Martens, S. L., & Barker, J. (2000). Criminal investigation of child sexual abuse: A comparison of cases referred to the prosecutor to those not referred. *Child Abuse and Neglect, 24*, 689–700. doi:10.1016/S0145-2134(00)00131-9

Tabachnick, J., & Klein, A. (2011). *A reasoned approach: Reshaping sex offender policy to prevent child sexual abuse*. Retrieved from the Association for the Treatment of Sexual Abusers: http://www.atsa.com/sites/default/files/ppReasonedApproach.pdf

Thomas, J. (2004). Family intervention with young people with sexually abusive behavior. In G. O'Reilly, W. L. Marshall, & A. Carr (Eds.), *The handbook of clinical intervention with young people who sexually abuse* (pp. 315–342). Danvers, MA: Psychology Press.

U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2010). Child maltreatment 2008. Available from http://archive.acf.hhs.gov/programs/cb/pubs/cm08/cm08.pdf

U.S. Department of Health and Human Services, National Institutes of Health. (2005, September). Teen brains: Still under construction: Parents play important role. *News in Health*, 3. Retrieved from http://newsinhealth.nih.gov/pdf/NIHNiH%20September05.pdf

U.S. Department of Health and Human Services, National Institutes of Health, National Library of Medicine. (2014). *Child development*. Retrieved from http://www.nlm.nih.gov/medlineplus/childdevelopment.html

Waite, D., Keller, A.,McGarvey, E. L., Wieckowski, E., Pinkerton, R., & Brown, G. L. (2005). Juvenile sex offender re-arrest rates for sexual, violent nonsexual and property crimes: A 10-year follow-up. *Sexual Abuse: A Journal of Research and Treatment, 17*, 313–331. doi:10.1177/107906320501700305

Waites, C. Macgowan. M. J., Pennell, J., Carlton-LaNey, I., & Weil, M. (2004). Increasing the cultural responsiveness of family group conferencing. *Social Work, 49,* 291–300. doi:10.1093/sw/49.2.291

Washington Coalition of Sexual Assault Services. (2012). *Creating trauma-informed services: A guide for sexual assault programs and their system partners*. Retrieved from http://www.wcsap.org/sites/wcsap.huang.radicaldesigns.org/files/uploads/resources_publications/special_editions/Trauma-Informed-Advocacy.pdf

Wickland, C., & DeMichele, M. (2008). *Strategically monitoring sex offenders: Accessing community corrections' resources to enhance law enforcement capabilities*. Retrieved from the International Association of Chiefs of Police: http://www.theiacp.org/portals/0/pdfs/IACPinfoguideFINAL.pdf

Willis, G. M., & Grace, R. C. (2008). The quality of community reintegration planning for child molesters: effects on sexual recidivism. *Sexual Abuse: A Journal of Research and Treatment*, *20,* 218–240. doi:10.1177/1079063208318005

Willis, G. M., & Johnson, L. (2012). Planning helps: The impact of release planning on subsequent re-entry experiences of child sex offenders. *Journal of Sexual Aggression*, *18*, 194–208. doi:10.1080/13552600.2010.506576

Wyatt, G. E. (1992). The sociocultural context of African American and White American women's rape. *Journal of Social Issues, 48*(1), 77–91. doi:10.1111/j.1540-4560.1992.tb01158.x

Yantzi, M. (1998). *Sexual offending and restoration*. Waterloo, ON: Herald Press.

Resources

Websites:

Association for the Treatment of Sexual Abusers
http://www.atsa.com

Center for Sex Offender Management
http://www.csom.org

Child Welfare Information Gateway: Family Reunification
https://www.childwelfare.gov/permanency/reunification

Resources for Resolving Violence
http://resourcesforresolvingviolence.com

Safer Society Foundation, Inc.
http://www.safersociety.org

Stop It Now!
http://www.stopitnow.org

Support for Families Who Are Considering the Reunification Process

Darkness to Light: End Child Sexual Abuse
Child Sexual Abuse Prevention for Parents and Individuals
http://tinyurl.com/qgd7o2z

PARENTtalk
http://www.stopitnow.org/parenttalk

Other Useful Documents

For a summary of best practices for family reunification, when the adult who abused has been convicted of that crime, see "Key Considerations for Reunifying Adult Sex Offenders and their Families":
http://www.csom.org/pubs/familyreunificationdec05.pdf

For an overview of a reconciliation and possible family reunification process when an adolescent sexually abuses a younger child, see "A Collaborative Approach for Family Reconciliation and Reunification with Youth Who Have Caused Sexual Harm":
http://resourcesforresolvingviolence.com/publication3.pdf

For more information on providing culturally relevant services, see:
Fontes, L. A. (2005). *Child abuse and culture: Working with diverse families.* New York, NY: The Guilford Press.

Appendix A

The Seven Major Risk/Need Factors[2]

Major risk/ need factor	Indicators	Intervention goals
Antisocial personality pattern	Impulsive, adventurous pleasure seeking, restlessly aggressive and irritable	Build self-management skills, teach anger management
Procriminal attitudes	Rationalizations for crime, negative attitudes towards the law	Counter rationalizations with prosocial attitudes, build up a prosocial identity
Social supports for crime	Criminal friends, isolation from prosocial others	Replace procriminal friends and associates with prosocial friends and associates
Substance abuse	Abuse of alcohol and/or drugs	Reduce substance abuse, enhance alternatives to substance use[3]
Family/marital relationships	Inappropriate parental monitoring and disciplining, poor family relationships	Teaching parenting skills, enhance warmth and caring
School/work	Poor performance, low levels of satisfactions	Enhance work/study skills, nurture interpersonal relationships within the context of work and school
Prosocial recreational activities	Lack of involvement in prosocial recreational/ leisure activities	Encourage participation in prosocial recreational activities, teach prosocial hobbies and sports

2 The table in Appendix A is from Risk-need-responsivity model for offender assessment and rehabilitation 2007-06 (p. 6), by J. Bonta and D. A. Andrews, 2007, Ottawa, Canada: Public Safety Canada. Copyright 2007 by Her Majesty the Queen. Reprinted with permission. Available at http://www.publicsafety.gc.ca/cnt/rsrcs/pblctns/rsk-nd-rspnsvty/index-eng.aspx

3 According to the authors of this document, Joan Tabachnick and Peter Pollard, it may be necessary for people who have sexually offended to participate in a drug and alcohol treatment program to address any addiction issues.

Appendix B

Family Safety Plan

Given the diversity of families, the complexity of family dynamics, the full range of family resources and developmental differences in the individuals who have sexually abused, each family's safety plan must be constructed for that particular family. There is truly no "one-size-fits-all" approach to family safety.

However, there are some consistent guidelines that can be followed to create a safety plan for any family. In fact, these safety plans could be considered by any family, whether or not they have faced sexual abuse experienced by and/or caused by a family member. By understanding what puts a child at risk to be abused or what may put an adult, teen, or child at risk to sexually harm a child, the family can establish clearer boundaries, set consequences for crossing those boundaries, and choose to pull in additional resources to keep everyone in the family safe.

Establishing Family Oversight

The first step of the Family Safety Plan is to identify who will be involved in creating and maintaining the family's safety plan. Participants may include the family members who understand what happened in the family and what needs to change, and professionals with expertise to share and who are working with the family such as therapists or probation/parole officers. The group may also invite other key members of the extended family or community such as a school counselor, religious leader, or childcare provider in a position to encourage and monitor the family's safety plan who are fully aware of what happened.

After the group has been created, they will need to clarify each person's role to ensure the family's success. For family reunification, success means that no more sexual harm is caused by any member of the family and no one is sexually harmed by any member of the family. Everyone is critical because each member of the group has access to different information and may have more or less authority. Ideally, one person will coordinate implementation of the safety plan, provide stability to the process, and ensure that every concern is discussed, followed up, and resolved.

EXAMPLE

A family member may see a violation of a safety plan, but not have the authority to do anything other than confront the person about his or her behaviors. The probation officer might not see the violation, but could act on that information if the family member knows how to communicate that information. The group process ensures that this information is shared and known by everyone.

Imagining Goals

Before creating a safety plan, every member should be educated about healthy sexual behavior and healthy sexual development as well as the warning signs for sexually abusive behaviors. In general, the adults surrounding the vulnerable child as well as the person who abused need to take the lead by opening conversations about healthy relationships, healthy sexual behaviors, and what are sexually abusive behaviors. These conversations can help ensure that everyone connected to the family, either directly or indirectly, understands what happened and what needs to be done to maintain safety in the community.

Once the basic information is shared, the family should discuss future family goals and be sure to incorporate these goals into the plan. The goal-setting process helps the family imagine what is possible and also helps to define success for that family. If safety is truly a goal, then a family member speaking up about their concerns and the family deciding to NOT continue family reunification would be considered success because the goal of safety is reinforced.

Creating Guidelines for Behavior Change

The process of creating a safety plan identifies clear family guidelines for personal privacy and behavior. These should be discussed and reinforced with every adult, teen, and, when appropriate, child who is a part of the family.

A critical step in the safety plan process is creating clear guidelines for the individual who sexually abused a child. The guidelines should be based upon a thorough risk assessment conducted by a qualified professional with input from all members of the family. These guidelines will vary, depending upon the risk that the adult, teen, or child poses to children they harmed in the past. If the abuse was perpetrated outside of the family and there are no vulnerable children within the home, then the specific criteria will be quite different from a situation where the abuse occurred within the family. If the abuse was perpetrated by a child or an adolescent, the guidelines again will be quite different from the guidelines set for an adult.

Sample Criteria for an Adolescent

Sample criteria for an adolescent who sexually abused a younger child may include the following guidelines. These guidelines should include what can be done as well as what cannot be done (Chaffin, n.d., p. 4.):

- Absolutely no babysitting.
- No "roaming" the house at night when adults are asleep.
- No explicitly sexual materials in the home, especially those depicting sexual violence.
- Specified safe people for the adolescent to talk with if concerned about a situation.
- Supervised, no-contact, prosocial activities for the adolescent to engage in.

Sample Criteria for an Adult

Sample guidelines for an adult who committed a sexual offense may include (Cumming & McGrath, 2005, p. 125–126):

- Maintain a written journal of all visits and debrief all visits with appropriate professional.
- Always position oneself within eyesight of an adult.
- Never be alone with a child for any reason.
- Always knock if a door is closed.
- Always tell someone if any guideline is broken.

Appendix C

Roles in the Reunification Process

Person	Role in the Reunification Process
Victim advocate	• Communication with multiple parties. Most influential for victim needs. May have wide influence and credibility. • Some victim advocates may have advanced degrees and clinical training to bring to collaborations on clinical recommendations. • May be actively involved in making non-clinical assessments and recommendations (e.g. legal, placement, who should be included, etc.), supporting families in identifying and accessing a range of possible options and resources.
Parent/caregiver of the child who experienced sexual abuse (adoptive parent/ guardian; CPS)	• Custodial role and may be in position to approve or disapprove treatment options or contact decisions. • May be actively involved in making non-clinical assessments and recommendations. • Key role in supervision.
Therapist for the child who experienced sexual abuse	• May be actively involved in making clinical and non-clinical assessments and recommendations. • Work with the child through the clarification, reconnection, and reunification process. • Ongoing assessment of child's well-being.
Child who experienced sexual abuse	• May be able to make decisions on reunification, depending on age and emotional state. • May be actively involved in making non-clinical assessments and recommendations. • Potential confusion regarding the child's ambivalence between their wishes and what is in their best interest.

Person	Role in the Reunification Process
Person who abused	• Decide to participate in the reunification process. • May be actively involved in making non-clinical assessments and recommendations. • May continue to have strong influence on both victimized child and non-offending parent(s).
Attorney for person who abused	• Depending on age of client, the attorney may make decisions based on perception of "best interest" of client. • May have an important role in negotiating participation in non-clinical assessments and use of findings. • May have an important role in influencing client's participation in assessments and use of findings.
Treatment provider for person who acted abusively	• May be actively involved in making clinical and non-clinical assessments and recommendations.
Child-welfare caseworker	• May have custodial role and be in position to approve or disapprove treatment options or contact decisions. • May be actively involved in making clinical and non-clinical assessments and recommendations. • Dual mandate safety of child and family preservation and significant influence over trajectory of process and level of external leverage. • Makes decisions in terms of supervision and contact.
Family therapist	• May be actively involved in making clinical and non-clinical assessments and recommendations.
Birth parents/ Alternative caregivers for adolescent/child who sexually abused	• May have custodial role and be in position to approve or disapprove treatment options or contact decisions. • May be actively involved in making non-clinical assessments and recommendations. • Key role in supervision.

Person	Role in the Reunification Process
Extended family members	• By invitation, may be actively involved in making non-clinical assessments and recommendations. • May exert strong influence on family members, including child who was victimized and person who acted abusively.
Faith leaders	• By invitation, may be actively involved in making non-clinical assessments and recommendations. • May have strong influence with multiple parties. • May promote perspectives along a continuum of forgiveness to condemnation for abusive behavior.
School personnel (including coaches, teachers, etc.)	• May be actively involved in making clinical and non-clinical assessments and recommendations. • May have role in funding of treatment program/facility. Sometimes raise confusing issues about how much to disclose info regarding abuse vs. safety. • May have supervisory role.
Judge	• Ultimate determinations in court-involved issues and situations, especially where custody is involved. • Will receive and act on all clinical recommendations and assessments. • May decide on some elements but not all aspects of the situation.
Supervision officer/probation or parole	• Operating in response to judicial direction and review regarding terms and conditions of probation, release, and violations. • May be actively involved in making non-clinical assessments and recommendations. • Strong influence over possibility to execute reunification.
Prosecutor	• Determine charges. Decisions about prosecution negotiate outcome of judicial process subject to judicial review. • Significant influence over trajectory of process and level of external leverage.

Notes

Notes