Volume I, Issue I July 2020

LAKE SUMTER Children's Advocacy Center

Child Chat

"Dedicated to children and those dedicated to serving them"

From the Editor's Desk

I once had a friend who used to say, " I ain't gonna lie!". He would then proceed to spin outlandish tales that would have made Mark Twain blush. In the interest of more honest disclosure, I must admit that this newsletter is a wee bit self-serving. After all, we at the Center realize the impor–tance of getting our name out into the community and effec-tively stamping our "brand" on our trauma-informed services. We're hoping then that this quarterly newsletter shall facil-itate just that purpose. Still, I must admit that the writer in me wishes to educate, inform and entertain you in the process. So, we'll mix some human interest with our infor-mation to spice things up a little. I sincerely hope that you will take something useful from each issue. For now though, I just want you to take with you that our staff brings a special passion to their work with children (and "I ain't gonna lie" about that!). We promise to educate and inform you with each issue of this letter, and maybe, just maybe, we'll entertain you, too! And, just remember, when it's all said and done, we're always and uncondi-tionally about the children!

Sobering Facts

- 5 children every day die from child abuse.
- There are 2.9 million reported cases of child abuse in the U.S. each year.
- 68% of child sexual abuse cases are per-petrated by a family member.
- 14% of all men and 36% of all women in prison were abused as children.
- In a recent survey 80% of 21-year-olds who were abused as children met criteria for at least one DSM-5 psychiatric disorder.

STOP CHILD ABUSE!
Call
1-800-96-ABUSE

"Seeking Truth, Healing Wounds, Instilling Hope"

About 25 years ago a group of caring citizens in Lake County had an idea: to create a regional compre-hensive services center that would meet the needs of child survivors of abuse. It was truly an idea whose time had come. After all, for years DCF caseworkers and local law enforcement officers had escorted traumatized children all the way to Gainesville to receive medical and Child Protection Team (CPT) services. So, after two years of educating, politicking and fundraising, Lake Sumter Children's Advocacy Center (LSCAC) was born.

The early years of the Center were sparing ones, with modest operations in Eustis and later in Tavares. But still, our founders recognized that the mission of healing the physical, emotional and spiritual wounds of abused children was a worthy one. And they re-doubled their efforts to establish a specialized, free-standing children's trauma center. In 2010, they finally realized their dream with the dedication of a new facility at 300 S. Canal Street in Leesburg.

Today, LSCAC offers an extensive array of trauma-informed services to children, including family advocacy, forensic interviews, medical assess-ments, crisis counseling and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). Furthermore, in August 2018 the Center initiated well-received school-based coun-seling services in the Sumter County Schools. The demand for our services continues to grow. In fact, last year, LSCAC served 1,074 children while providing 3,361 total services.

While we shall always lament the circumstances that bring children to our attention, we are gratified that we have the credentials, expertise and experience necessary to meet their needs. And, as we serve our children, we shall always be mindful of our mission of "seeking truth, healing wounds and instilling hope."

Once upon a time, a dream fostered a vision that inspired a plan that generated a program. Once upon a time...Is that not how all great stories begin?

CAC Programs by the Numbers

- There are over 850 CAC programs in the United States.
- CAC programs served 371,060 children nationwide in 2019.
- There are 39 accredited CAC programs serving 57 counties in Florida.
- In 2019 Florida CAC programs served 31,984 children.

The CAC Model: Integrated Child Abuse Services

Lake Sumter Children's Advocacy Center is an accredited member of an extensive network of over 850 child abuse service programs called Children's Advocacy Centers (CAC). To understand what a Children's Advocacy Center is, one must understand what child survivors of abuse would face without one. With-out a CAC, abused children might end up telling the worst story of their lives over and over again, to doctors, police, lawyers, therapists, investigators, judges, and many others. They might have to talk about their traumatic experiences in a police station where they might think they are in trouble. Or, they might be asked the wrong questions by a well-meaning teacher or other adult that could hurt the case against the abuser.

When either police or child protec-tive services believes a child is being abused, the child is brought to the CAC, a safe, child-focused environ-ment, by a non-offending caregiver or other "safe" adult. At the CAC, the child tells his/her story once to a trained interviewer who knows the right questions to ask in a way that does not re-traumatize the child. Then, a team that includes medical practitioners, law enforcement,

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CAC Model (continued)

mental health professionals, child protective services, prose-cutors, victim advocates, and other professionals make deci-sions together about how to help the child based on the findings of the forensic inter-view. This "Multi-Disciplinary Team (MDT) response" is the central concept of all CACs.

Inside This Issue

Child Quote: *"There can be no keener revelation of a society's soul than the way in which it treats its children."* - Nelson Mandela

Telehealth: Remote Healing in the Days of "Corona"

"[My children] have shared the difficulties in not having those face-to-face interactions with teachers, as well as their peers."

Sorimar Aquino earned her M.S. degree in Clinical Mental Health Counseling from Nova Southeastern University. As a Registered Mental Health Counselor Intern with our Children's Advocacy Center, she provides trauma-focused outpatient therapy services to youths at our Leesburg clinic. Sorimar is equally adept in working with children or adolescents and always brings an infectious enthusiasm to her clinical services. As one of several counselors at LSCAC implementing telehealth during COVID-19, she graciously gives us an inside look at this "remote therapy" medium.

Therapy with traumatized children is a delicate proposition even in the best of times. First, the therapist, who is initially a veritable stranger to the child, must establish rapport and build trust. Now imagine just how difficult trust becomes for a child who has been sexually abused by Dad or Mom. Second, many children—younger children particularly—are not especially prone to verbalizing their feelings, which, by definition, is a necessary precondition of verbal therapy. Third, most children, whether victims of abuse or not, are relatively distractable creatures. They are understandably curious about their environment as they learn and change and grow. Exploring our world is a natural by-product of human development. Fourth, not only do we expect the child to trust, focus and talk, but we ask that child to retrieve painful memories from a dark place in the most remote recesses of the mind that he or she would prefer to eradicate.

And then, as if therapy were not tough enough, along comes coronavirus with its imposed social distancing and compelled isolation. It hardly seems fair—to the therapist or the child. But fairness is a social justice issue, and therapy is therapy…or is it? So, how do we provide therapeutic supports to children in the face of a pandemic, and how effective can our clinical efforts be in the absence of physical proximity with a child? The answers, at least temporarily, lie in the digital phenomenon called telehealth, By now, most of us have at least a vague notion of the principle of telehealth. We know the basic premise is that a medical practitioner or clinician contacts a patient/client through Skype, FaceTime, Zoom or some other soon-to-be-antiquated, garden variety video medium to engage in a medical or clinical exchange. However, while telehealth has been utilized by the medical community for some time with a certain degree of efficacy, this remote approach to services has been far less prevalent among mental health therapists. Consequently, we have considerably less evidence of its efficacy in addressing the needs of those suffering from diagnosable mental health disorders—and perhaps even less in the treatment of traumatized children.

We shall use a structured interview with Sorimar Aquino, an esteemed member of our LSCAC counseling team, to explore the assessed merits and challenges of telehealth as a medium for conducting therapy with child survivors of abuse. We would caution that these are simply one counselor's impressions of the medium based on limited applications with children she has served under the extraordinary conditions wrought by COVID-19. As such, they serve neither as support for nor indictment of the practice of telehealth.

A Telehealth "Q & A" with Sorimar Aquino

Q1: So, I know that your counseling services to children at the Center prior to COVID-19 were face-to-face. What did you have to do to get ready for telehealth?

Once we were made aware that Registered Mental Health Interns could provide telehealth and count the hours towards licensure, we took the "Telehealth for Mental Health Professionals" training.

Q2: It is ironic that children who already had suffered the trauma of abuse have been forced to endure the trauma of the coronavirus. Did any of your children wish to talk to you about COVID-19? If so, were they able to do so through telehealth? What did they say?

"It was a surprise to me when none of my clients talked about their concerns of COVID-19. However, most have mentioned how doing virtual learning has been a huge adjustment they have had to learn. They have shared the difficulties in not having those face-to-face interactions with their teachers, as well as peers."

Q3: Can you actually think of a child for whom telehealth was perhaps more effective than doing face-to-face counseling? If so, what made telehealth better for that child?

"When working with the younger children, I personally don't think telehealth is more effective than face-to-face counseling. I believe it has been beneficial in the aspect of continuing to receive services to address their trauma, as well as stressors that may appear during this time."

Q4: Are there children with certain clinical presentations who in your opinion would derive greater benefit from telehealth?

"Yes, I believe for those children who have not experienced an extensive history of trauma. Perhaps it is better for those who experience anxiety and can focus more on learning coping skills and relaxation techniques."

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Child Chat

Telehealth Q & A *(continued)*

Q5: I am thinking it would be difficult to work with younger kids through telehealth, given a therapist's typical reliance on toys and games to stimulate children's participation. Do you have any "tricks of the trade" you wish to share?

"I have found that books have worked very well to encourage the children to participate more, as I have them draw something related to the story. I have had a child host a tea party with me at the end of session. She grabbed her tea party supplies and held a cup up to the screen for me to drink. That was pretty entertaining!" :)

Q6: I know that "show rates" can always be challenging with outpatient counseling services. How did your counseling attendance rate with telehealth compare with your attendance rate with face-to-face services?

"When we first began doing telehealth, my services decreased. Some opted to not participate in telehealth, while others forget to log in every week at their scheduled time. And, finally, with kids that are in the foster care system, being put into a different placement and waiting to get the ball rolling again can be challenging."

Q7: What did you like best about utilizing telehealth as a medium for counseling?

"What I liked best would be that I was still able to provide therapeutic services to my clients."

Q8: What were the biggest challenges you faced in utilizing telehealth?

"I would say the biggest challenge has been learning to redirect the younger children via telehealth, getting them to focus on the intervention and teaching relaxation skills. What makes it challenging is they have distractions around them, such as their toys, siblings coming into the room and tantrums online."

Q9: How do you think the kids felt about receiving counseling through telehealth? Did any of them comment on it? If so, what did they say?

"I think for them at first it was a little weird, as it was for me too. Some of my kids have said that they can't wait to come back and get to play games with me again, and others look forward to do arts and crafts together. So many of the clients enjoy coming into the office because they know it is their own time to talk about what is on their minds, knowing there is no judgment. They consider it their safe place."

Q10: What was your biggest "take away" from utilizing telehealth?

"I would say my biggest take away would be that it definitely helps during this difficult time by keeping everyone safe while still addressing their mental health needs."

Q11: On a scale of 1 to 10, with 10 being the most favorable score, how would you rate your telehealth experience and why?

"That is a tough one. I would say I rate it a 5, because my clients are still able to receive services and there is no sudden interruption in the therapeutic process. However, the down side of telehealth for me would include the issues that arise when using technology. It can cause such an interruption when either the client or myself are "lagging", when the volume stops working or when the connection is bad. In addition, the distraction that may be surrounding the client, such as pets, other people in the home and even their toys, can be problematic. Sometimes, caregivers simply forget about the appointments due to their new schedules and the adjustments they have been having to make. It all can become quite overwhelming!"

"[T]he biggest challenge has been learning to re-direct younger children via telehealth….they have distractions around them, such as their toys, siblings coming into the room and tantrums online."

A Tip from the Counselor's Corner

TF-CBT is an evidence-based practice that LSCAC counselors utilize with children suffering from PTSD. You can identify the essential elements of TF-CBT if you remember the word **PRACTICE**:

P = Psychoeducation

R = Relaxation

A = Affective Modulation

C = Cognitive Coping

T = Trauma Narrative

I = In Vivo Exposure

C = Conjoint Trauma Narrative

E = Enhancing Safety

**** For more information on TF-CBT, please "stay tuned" for our October issue.***

"Amy": A Child Protection Team Success Story

"Amy nursed a pair of broken glasses and fiddled with an untied shoelace. The chair in which she was sitting swallowed her meager shape. She curled her slight body into its yawning frame to make herself as small as possible…."

Holly Sharlow *earned her Bachelor's Degree in the field of Human Services from Saint Leo University in San Antonio, Florida. She commenced employment with the Lake Sumter Children's Advocacy Center in September of 2010 and has served as the Team Coordinator for the Lake/Sumter Child Protection Team (CPT) program since the end of 2017. Holly is a steadfast advocate and dedicated champion for children. She has indicated that what she enjoys most about her position is "doing anything and everything possible to help keep children and the community safe." We kindly thank Holly for contributing the accompanying "CPT Success Story."*

Note: *The LSCAC Child Protection Team (CPT) conducts forensic interviews with child survivors of physical abuse, sexual abuse and/or severe neglect. In some cases an interview occurs the very day of a child's victimization—at a time when that child is most vulnerable and suffering inexpressible pain. With utmost compassion and sensitivity, the interviewers extract crucial information from the child regarding the alleged trauma event. That information, combined with physical evidence collected in the course of the child's obligatory medical examination, supports Law Enforcement, DCF and the State's Attorney Office in their respective decision-making in the case. The case of "Amy" (named changed to preserve confidentiality), the subject of the following article, is illustrative of the exemplary collaborative efforts of CPT and counseling at LSCAC. Amy's courage serves as enduring inspiration to us all.*

Amy was five years old when she first visited the Lake Sumter Children's Advocacy Center. She was tiny, timid and soft-spoken. She hid discreetly in the protective shadow of her mother. Amy was visiting the Child Protection Team to address allegations of sexual abuse by a family member with whom she reportedly was very close. Amy's mother, a military veteran, was interviewed and waxed tearful as she discussed her shock, horror and disgust upon hearing her daughter's disclosure of sexual abuse by this trusted individual. In turn, Amy displayed a decided disinclination to separate from her mother to submit to her forensic interview. During her interview, Amy nursed a pair of broken glasses and fiddled with an untied shoelace. The chair in which she was sitting swallowed her meager shape. She curled her slight body into its yawning frame to make herself as small as possible as she commenced quietly to tell her story. Amy proceeded to convey in halting, diffident words what was done to her. She appeared to be emotionally conflicted , stipulating that she did not want the alleged offender to get in trouble. After a torturous interview, Amy received a standard medical evaluation immediately followed by crisis counseling.

Approximately one year later, after Amy had engaged in trauma-focused counseling, CPT received a call from Law Enforcement indicating that the little girl had more to disclose about her sexual abuse. Amy, now six years old, returned to the Lake Sumter Children's Advocacy Center, to undergo a second interview. This time she appeared significantly more confident than during her first visit with CPT. Amy managed to articulate terminology for her body parts and for the sexual acts in which she was forced to participate. Her voice was louder, and her tone more assertive. Amy sat erectly in her chair. It was apparent Amy's therapy was helping her process what happened. When asked why she did not discuss the particulars of this second interview during her first visit to CPT, Amy reiterated she did not want the perpetrator to get in trouble and that she was scared to tell about everything. Amy expressed concern about her mother's feelings, saying she did not want her to be sad. Ultimately, Amy indicated that telling about all that had happened to her was the right thing to do, so this person [the perpetrator] could "get help."

Another year passed, and Amy finally got her day in court. She, now seven-years-old, testified in her trial. A trusty therapy dog provided by the court lay comfortingly beside her. Although she must have been terrified, Amy presented self-assuredly and confidently, offering compelling testimony about her victimization in front of her malfeasant relative and a jury of strangers. CPT experts also attended court and provided further testimony and corroborative evidence. Amy's case culminated with the alleged perpetrator being convicted of multiple sex crimes. As a consequence he was sentenced to a series of life terms—at least partially because of the testimony of a brave little girl who found her voice.

"Success" is a term that means different things to different people, depending on the situational context. In Amy's case we would conclude that she enjoyed a successful outcome for several reasons. First, Amy received legal justice with her perpetrator's conviction and incarceration. Second, Amy and other children in the community are now spared further harm with this individual off the streets. Third, Amy's "wish" that this person would receive help was granted with the realization that the offender is incarcerated in a facility that offers counseling and rehabilitative services. Fourth, and perhaps most importantly, the healing that Amy evidenced in her changed demeanor after TF-CBT provides hope for her successful growth and development throughout her formative years. Sadly, many children (and adults, too, for that matter) who suffer trauma never get the chance to address those critical wounds, and thus often perpetuate the insidious cycle of intergenerational abuse. The last time we spoke with Amy, she indicated that she "would like to work with children" one day to help them get through situations like hers. Perhaps one day Amy will be living testimony to the power of "paying it forward." For now, at least, she can simply be a child and relish the toys and games and frivolities that comprise the rightful domain of childhood.