How to Handle a Disclosure

How Should a Victim of Sexual Violence Act?

Hysterical?	Angry?	Crying?	Tired?
Joking Around?	Nervous?	Laughing?	Isolated?
Flippant?	Irate?	Agitated?	Empty?

- There is no **one way** that a victim of sexual violence behaves.
- We all have different coping mechanisms & we all respond to trauma differently.
- Just because someone does not act the way that "a rape victim should," do not disregard their disclosure as attention seeking behavior.

Disclosures

Be an excellent listener. Try not to interrupt the victim or ask too many questions because it may make the victim feel like they are being interrogated.

Tell he/she that you believe them. People rarely make up stories of sexual abuse or rape. It is very important that you acknowledge & support the victim's disclosure because the first contact can significantly help or hurt the victim's healing process.

Contain your own feelings. Try to remain professional. Emotional reactions can make the victim feel guilty for disclosing or cause more feelings of shame.

Acknowledge their trust in disclosing to you. Highlight their courage & strength in taking action in their healing process.

Offer them the appropriate referrals for professional support- Provide them with information about local DV/SA providers & other counseling options.

Be familiar with you organization's policies regarding disclosure of abuse. If your organization does not have one, RCC would be happy to help you develop one.

Dos & Don'ts

Do tell the person that you believe them.

Do offer privacy to disclose. They may approach you in a group setting, so offer to move to a more private area.

Do tell the person that they were right to tell you & that it was brave.

Do tell the person that they are not the only one & that sexual violence happens to others.

Do tell them they are not responsible for what happened & it's not their fault.

Do make necessary referrals such as DSS & RCC.

Do consult your RCC staff members who are available 24/7.

Don't make promises that you can't keep; especially if they ask you to keep the disclosure a secret.

Don't panic or show that you are shocked; remain calm for the victim's sake.

Don't give the impression that you might believe the victim is somehow at fault, e.g. don't ask: "How much had you had to drink?" or "Why did you go over to his/her house?" or "This happened 2 months ago! Why didn't you tell me sooner?"

Don't ask intrusive questions.

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Your Words, Our Image

- Use **person-first language**. You are in a unique position to shape the public image of people with disabilities. Your words can create insensitive, negative images or a straightforward, positive view of people with disabilities.

Don't Say	Do Say
Differently abled, challenged	**Disability**
The disabled	**People with disabilities**
Slow learner	**Person with a learning disability**
Quad	**Person with quadriplegia**
Autistic	**Person with autism**
Mongoloid	**Person with Down syndrome**
Midget	**Person of short stature**
Burn victim	**Burn survivor**
Handicapped parking	**Accessible parking**
Blind	**Visually impaired**
Alcoholic	**Alcohol dependent**
Brain damaged	**Brain injury**
Polio	**Post-polio syndrome**
Confined to a wheelchair	**Uses a wheelchair**
Hare lip	**Cleft lip**
Fit, attack	**Seizure**
Mute, dumb	**Speech disorder**
Birth defect	**Congenital disability**
Mental retardation	**Intellectual disability**
Normal, able-bodied	**Nondisabled**
Deaf-mute, the hearing impaired	**Deaf, hard of hearing**

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THE MOST APPROPRIATE LABEL IS USUALLY THE ONE PEOPLE'S PARENTS HAVE GIVEN THEM.

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North Carolina Council on Developmental Disabilities
Building Bridges to Community

The Rape Crisis Center of COASTAL HORIZONS CENTER, INC.

This handout was developed based on input and/or direct experiences of individuals with atypical speech. Adapted with permission from Disability Services ASAP of SafePlace, Austin, Texas

How to Communicate with People with Atypical Speech

Attitudes:

- Assume that the person with whom you are speaking will be able to understand you, and that you will be able to understand them. The first assumption of many people who have limited experience with those whose speech is atypical is that there will be a problem communicating. Often, this is not the case. Sometimes it depends on what you expect.

- Assume that the person with atypical speech has typical intelligence. Just because a person's articulation is different from what you are accustomed to does not mean that the person has any intellectual difficulty/disability.

- Remember that communication is a partnership. Communicating means that both people are encouraged to express what is on their minds and that both individuals listen and take in what is being said and respond appropriately. Communication between two people is an exercise in turn-taking: each person learns to absorb what is said and then takes a turn being the speaker again. This turn-taking process is usually conducted unconsciously, and is only exposed as a process when one or both individuals have difficulty with their turn. To make this process conscious when first interacting with someone who has atypical speech, remind yourself to speak, wait and listen, and then take your turn again.

- Miscommunication between two people constitutes a communication "breakdown." In a communication breakdown, one person does not understand what the other is saying and the expected ease of the conversation is disrupted. In that moment, both people become aware that there is work to do. The appropriate response to a communication breakdown is an attempt to repair the breech. It is a partnership, so both parties share the work of repairing the communication breakdown. It may be helpful to identify the breakdown out loud to the person and say, "I'm so sorry, but I feel like we're missing each other. Can we start over?"

- Do not speak for someone else even if you are familiar with his or her speech patterns unless you have been asked to do so, or you have an agreement about it. People who are having difficulty understanding may turn to someone they think is easiest to communicate with and literally pass over the person whose speech is difficult to understand. This kind of "speaking for" infantilizes the speaker and it puts a third person into what was intended to be a two-person conversation. It is intrusive. To be a conscious communicator, you may have to say no to someone who is asking you to speak on behalf of a person with atypical speech. They have to do the work themselves. Rather than automatically answering, you might say, "I don't know, ask her."

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Actions:

- If you do not understand what someone has said, be honest about it. If you pretend to understand but do not, there is a noticeable shift in the equality of the interaction, and it signals a certain level of disconnection. People who have lived many years with atypical speech usually know when someone is pretending to understand, primarily because it changes the nature of the interaction by reducing the intelligibility of the conversation and creating emotional distance. Pretending to understand can result in the other person feeling embarrassed, angry, frustrated, and/or alienated.

- Tell the individual you have not understood what has been said. There is no "fault" in these situations, and there is no "right" way to feel about any communication breakdown. The focus needs to be on repairing the breakdown, and the first step is to acknowledge that you did not understand.

- Once you have admitted that you do not understand, wait for the individual to attempt to repair the breakdown. Most people who have atypical speech patterns have years of experience repairing communication breakdowns and they will employ any number of strategies to help you understand. You may not need to do anything more than admit you have not understood

Strategies for Effective Communication in Priority Order:

For those situations where effective communication requires more than a simple repetition, you and the person with atypical speech can employ any of the following strategies:

- **Wait:** Communicating with an individual who has difficulty with speech is complicated, so take your time. Decoding speech patterns that your ears are not trained for can take a little time. Listen to the whole sentence or phrase. Wait for a second and try to relax. Let the conversational context help you.

- **Repeat:** Simply repeating the sentence or thought may be enough. There are times, though, when repeating is not going to help because the speaker is not going to be able to change the way a specific word is pronounced. If repeating does not work, move on to another strategy.

- **Rephrase:** Ask the individual to try and express the same thought using various words. Often, the misunderstanding hinges on one or two words in a sentence.

- Identify which part of the sentence or thought was misunderstood: If you know most of the phrase or sentence that has been spoken and can identify which part(s) are unclear, you might try repeating back to the individual what you know has been said, and asking him/her to focus on finding a way to understand just the part you did not get. This has two functions: it lets the person with atypical speech know that you are still actively participating in the conversation and that you want to understand, and it also reduces the amount of repair that has to happen.

If the previously-mentioned strategies are not effective, consider the following:

- **Spelling:** Once you have located the word(s) you do not understand, ask the individual to spell for you. It usually just takes the first few letters of the word to clear up the confusion.

- **Writing:** You can ask him or her to write it down, or you can write down what you thought they said, and you can give each other feedback.

- **Guess:** Ask what the topic is and/or ask for a context in which you might better understand or "guess" – this can be really funny! And it can break the tension as long as the person with atypical speech knows that you are trying.

Other Accommodations

- Speech to Speech Relay (STS) is a service mandated by the Federal Communications Commission that enables people with a speech disability to use their own voice, voice prosthesis, or communication device to make a phone call. In an STS call, the speech of one person is relayed to the other by a communication assistant in a three-way call environment. Call 7-1-1 and request "Speech-to-Speech" to place a call or visit www.speechtospeech.org for a list of toll free numbers throughout the United States.

- Assistive or Adaptive Technology: The individual may use assistive or adaptive technology such as a communication board or electronic device with speech output. If this is the case, ask the person which mode of communication he/she prefers to use. Some individuals will prefer to use their own speech. Keep questions and responses short and simple. The person may have to spend more energy using the device to communicate. Ask the person with atypical speech if he/she prefers both parties to communicate in written form. The person may want to read your responses rather than hearing them. Be patient and wait. The person with atypical speech using assistive technology may require several minutes to communicate.

- Keep in mind that augmentative communication devices may be withheld and/or broken by perpetrators in an attempt to silence the individual who relies on them. In addition, some perpetrators may attempt to "speak for" the individual in an attempt to prevent a survivor from speaking out. Other perpetrators may refuse to program augmentative communication devices to further prevent disclosure. When interacting with individuals who may use these types of communication supports, be aware of this dynamic and include it in any safety planning that you may offer. In addition, discuss checking in periodically just to make sure that the communication device is being used to relay the person's intended message, not that of a perpetrator.

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Adapted from Identifiers of Caregiver Abuse by the Disability Services of ASAP of SafePlace, Austin, Texas.

Identifiers of Caregiver Abuse

Some forms of abuse may be subtle, but are still hurtful and disrespectful. The following is a list of possible identifiers of abuse inflicted by a caregiver or a person with a disability. The listing and the examples provided are not all-inclusive as there are many other specific forms of abuse.

Coercion and Threats

- Threatening to: hurt the individual, their child(ren), pet, or service animal; withhold basic support and rights; terminate relationship and leave the person unattended; report noncompliance with a service program; use more intrusive equipment; institutionalize the individual; take children away; or medicate the person
- Coercing the person to have sex without consent
- Using consequences and punishments to gain compliant behavior
- Pressuring the person to engage in fraud or other crimes

Intimidation:

- Raising a hand or using other looks, actions, gestures to create fear
- Destroying property
- Mistreating service animal(s) and/or abusing pet(s)
- Displaying weapons
- Providing personal care in a rough manner
- Driving recklessly

Emotional Abuse:

- Punishing or swearing at the person
- Refusing to speak and ignoring requests

- Ridiculing the person's disability, culture, traditions, religion, size, and/or personal tastes

- Enforcing a negative reinforcement program or any behavior program to which the person does not consent

- Keeping the individual awake

- Treating the person like a child or servant

Isolation:

- Controlling access to friends, family, neighbors, telephone, television and/or other forms of media

- Limiting employment or educational opportunities

- Discouraging contact with a case manager, advocate, or other service providers

- Determining living arrangements
- Locking the person in a room

Minimize, Justify, and Blame

- Denying or making light of abuse

- Denying physical and/or emotional pain of people with disabilities

- Justifying rules that limit autonomy, dignity, and relationships

- Excusing abuse as behavior management or caregiver stress

- Blaming the disability for the abuse

- Saying that the person is not credible

- Justifying that no one else would want to have sex with the individual or be willing to take care of the individual

Withhold, Misuse, or Delay Needed Supports

- Using medication to sedate the person for convenience

- Ignoring equipment safety requirements

- Breaking or not fixing adaptive equipment
- Refusing to use or destroying communication devices
- Using equipment to torture an individual

Economic Abuse

- Using a person's property and money without their permission
- Stealing money or personal items
- Using property and/or money as a reward or punishment program
- Making financial decisions for the person without their consent or permission
- Limiting access to financial information and resources

Caregiver Privilege

- Taking action without the individual's consent
- Making unilateral decisions
- Defining narrow, limiting roles and responsibilities
- Providing care in a way to accentuate the person's dependence and vulnerability
- Giving an opinion for the person as if it were that person's opinion
- Denying the right to privacy
- Ignoring, discouraging, or prohibiting the exercise of full capabilities

Non-Profits and the Americans with Disabilities Act of 1990

The Americans with Disabilities Act (ADA) of 1990 prohibits discrimination and ensures equal opportunity for persons with disabilities in non-profit facilities, State and local government services, and public accommodations. The 2010 Amendments to ADA includes detailed guidance to help nonprofits fulfill their obligation to offer full and equal access to persons with disabilities. Specifically, ADA states that:

- Nonprofits cannot discriminate against individuals on the basis of disability in the full and equal enjoyment and benefit of goods and services offered to the public.
- If your organization's goods and services cannot be accessed by individuals with disabilities as they are by the general public, then you must provide ways that are separate and/or different and just as effective as those provided to others.
- Nonprofits must ensure effective communication with people who have disabilities relating to vision, hearing, and speech as long as it does not impose an undue burden on their organization. You may need assistive communication devices, vision or hearing aids, large-print brochures, and/or qualified interpreters to be available. Each individual should make a request and your organization can determine if it's appropriate.
- Communication accommodations must be accessible, timely, and protective of the privacy and independence of the individual requesting the accommodation. There can be no extra charge imposed on individuals with disabilities to cover the cost of these measures.
- If providing an accommodation imposes an undue burden on your organization, you must seek alternatives that ensure effective communication to the maximum extent feasible.
- Accommodations must be provided to individuals in the most integrated setting appropriate to their needs. Accommodations cannot be excluded through false safety regulations or eligibility screening restrictions.
- To improve communication with individuals having cognitive disabilities, train your staff to rephrase and simplify concepts with demonstrations, providing information clearly, one topic at a time, keeping remarks short, and reducing distractions and noise.
- Nonprofits must remove architectural barriers when it is "readily achievable" to ensure access from approach points such as parking into the building, to the areas where services are offered, and to restrooms. When such access is not readily achievable, nonprofits must provide alternative methods (e.g., having personnel available to assist such individuals) until barrier removal is achieved.

For details of these regulations, see: www.ada.gov
The ADA Information Line is (voice) 800-514-0301 and 800-514-0383 (TTY)

Under the ADA, a disability is a physical or mental limitation that substantially impairs a major life activity such as seeing, hearing, walking, breathing, thinking, and/or performing activities of daily living. Trauma stemming from PTSD often qualifies as a disability. Persons with disabilities are encouraged to pursue personal, social, employment and/or family responsibilities to the extent their limitations interact with social and environmental factors.

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Mandated Reporting

NC Department of Social Services Reporting Law

Statute

North Carolina N.C. Gen. Stat. § 108A–102(a) – (b)

(a) Any person having reasonable cause to believe that a disabled adult is in need of protective services shall report such information to the director.

(b) The report may be made orally or in writing. The report shall include the name and address of the disabled adult; the name and address of the disabled adult's caretaker; the age of the disabled adult; the nature and extent of the disabled adult's injury or condition resulting from abuse or neglect; and other pertinent information.

Reporting to DSS-Reporting Law

- WHO MUST REPORT?
  Any person who has reasonable cause to believe that a person with a disability is in need of protective services.
- WHAT DOES THAT MEAN?
  If there is **suspicion** that someone is being abused (sexually, physically, financially, or verbally), neglected, or exploited.
- WHAT IS ABUSE?
  "Willful infliction of physical pain, injury, or mental anguish: unreasonable confinement; willful deprivation by a caretaker or services necessary for mental or physical health."
- WHAT IS NEGLECT?
  "Living alone and being unable to provided necessary care for physical and mental health; failure of caretaker to provided necessary services."
- In situations of stranger assault, DSS will usually not screen these reports in, unless there is a supervision issue.

Making a Report

- WHAT MUST BE INCLUDED IN THE REPORT?

  Information given by the reporter ideally including name, address, age of the individual with a disability; name and address of the caretaker; extent of injury, abuse, neglect, exploitation; or any other pertinent information.

  Reporting can be done anonymously but professionals **should not** report anonymously. If someone reports anonymously, their information will not be shared with the alleged perpetrator or the victim. A letter will be sent to the reporter stating how DSS will proceed with the report.

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Power & Control Wheel

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Adapted from the National Center on Domestic and Sexual Violence

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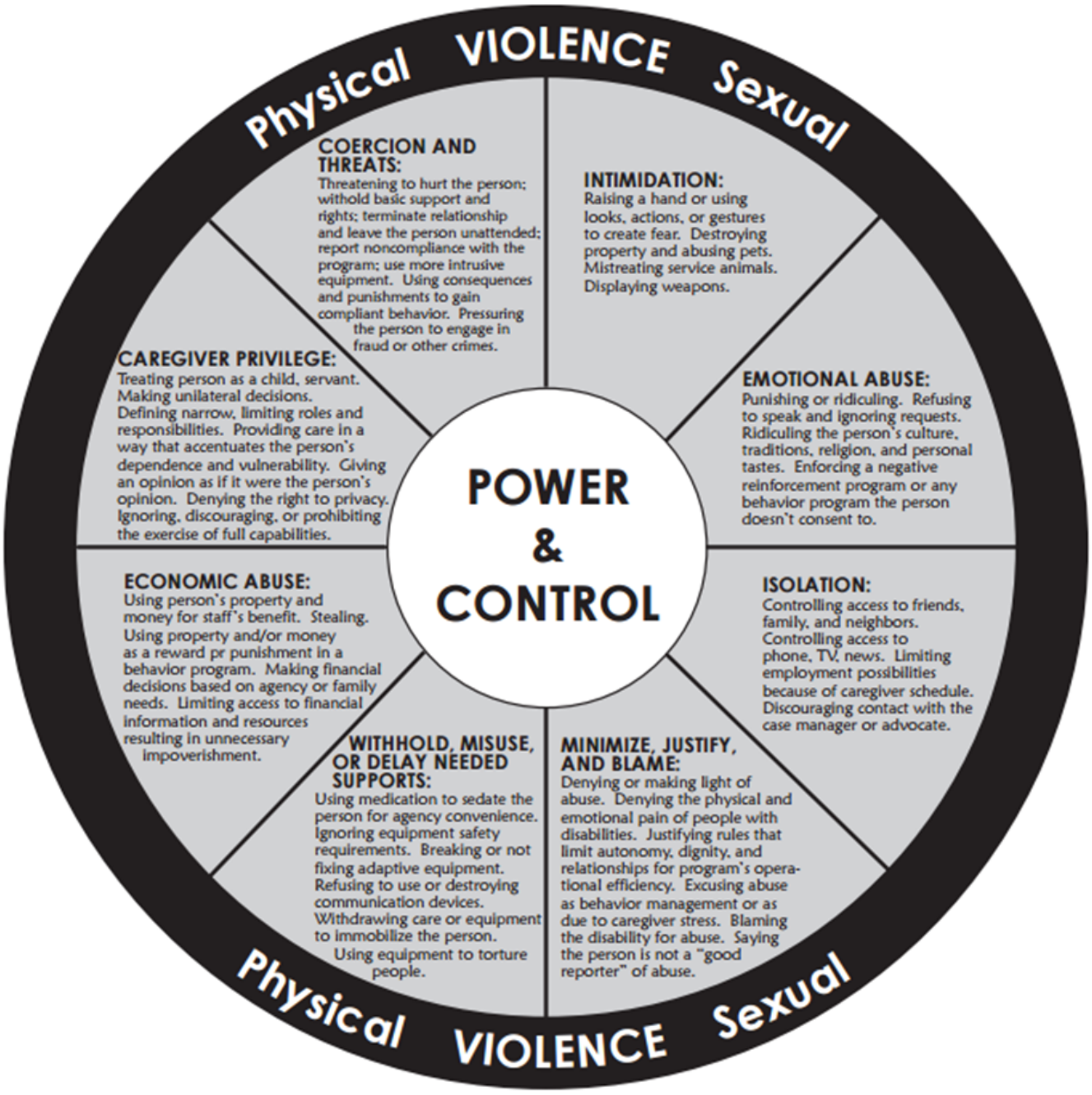
Power & Control Wheel: Individuals with Disabilities and Their Caregivers



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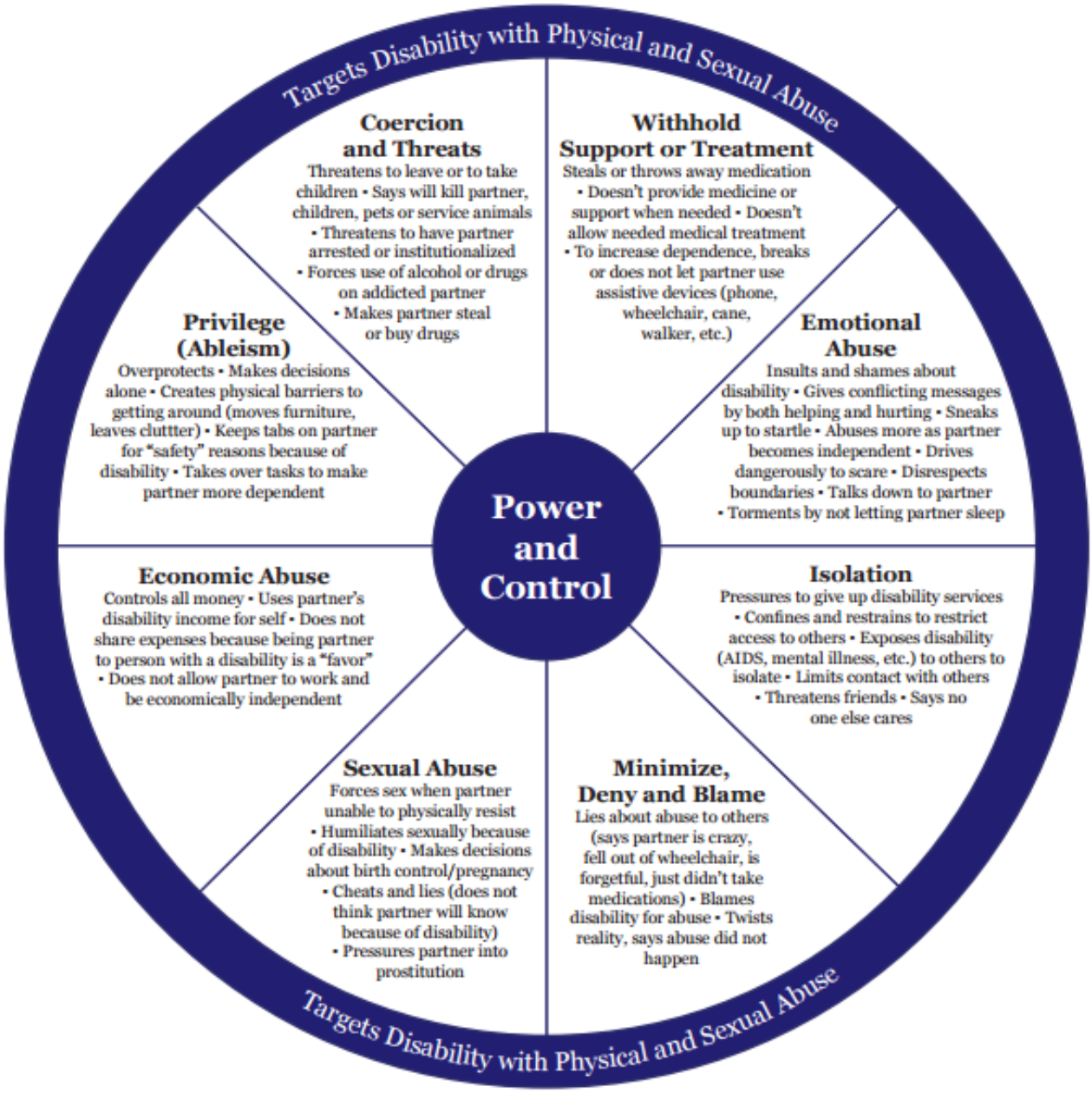
Power & Control Wheel:

Individuals with Disabilities in Partner Relationships



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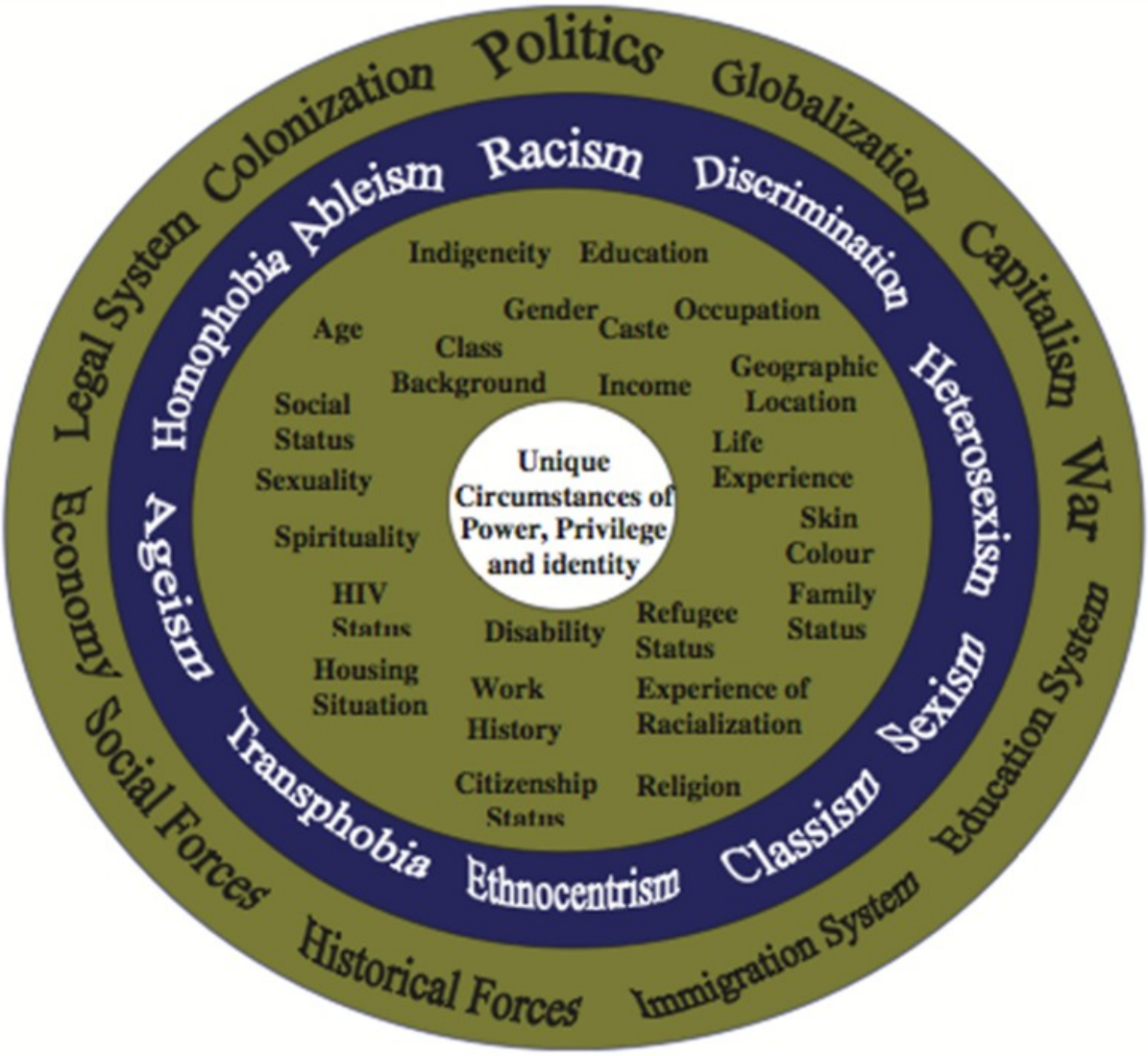
Intersectionality of Oppression



- Innermost circle represents a person's unique circumstances.
- Second circle from inside represents aspects of identity.
- Third circle from the inside represents different types of discrimination/isms/ attitudes that impact identity.
- Outermost circle represents larger forces and structures that work together to reinforce exclusion.

Note it is impossible to name every discrimination, identity, or structure. These are just examples to help give you a sense of what intersectionality is.

From A Toolkit for Applying Intersectionality by Joanna Simpson, CRIAW/ICREF

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Sexual Violence and People with Intellectual/Developmental Disabilities

A fact sheet with helpful information for respecting and supporting individuals with Intellectual /Developmental Disabilities (IDD).

What do we know about violence and individuals with disabilities?

- Persons with disabilities in NC experience sexual assault at a rate five (5) times higher than persons without disabilities.
- 80% of women and 60% of men with developmental disabilities have been sexually abused.
- Sexual violence can be prevented.
- No two people with disabilities are the same.

Common Questions About Intellectual and Developmental Disabilities

Q - What is a developmental disability (DD)?

A - DD means someone has limitations in three or more of the following areas: self-care, language, movement, self-direction, capacity for independent living, or economic self-sufficiency. The onset of DD is before age 22 and often includes intellectual disability. Examples are: Down syndrome, fragile X syndrome, cerebral palsy, or spina bifida. In North Carolina, DD includes disability caused by a traumatic brain injury at any age.

Q - What is an intellectual disability (ID)?

A - ID means someone has limitations in intellectual functioning (reasoning, learning, solving problems) and in adaptive behavior (the range of everyday social and practical skills). This type of disability usually originates before the age of 18.

Q - What is Autism Spectrum Disorder (ASD)?

A - ASD is considered a developmental brain disorder. Individuals with ASD may have difficulty understanding verbal/nonverbal communication and relating to people, objects, and events. It is often found in combination with other disabilities. ASD affects individuals differently.

1. Centers for Disease Control and Prevention (2010). Behavioral Risk Factor Surveillance System.
2. Hingsburger, D. (2001). *Sexuality and People with Developmental Disabilities*. Mountville: Vida Publishing.

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Values Embraced by the Disability Community

Self-Advocacy — To speak up and assert one's interests, desires, needs, and rights; to make informed decisions and take responsibility for them.

Inclusion — Individuals fully participate in communities, rather than live separated from mainstream society.

Self-Determination — People with disabilities make their own life decisions. The self-determination motto is "Nothing about us without us."

Diversity — The concept of diversity includes acceptance and respect for others. This means understanding that each individual is unique. Diversity involves moving beyond tolernce to celebrating differences.

Using Person-First Language

- Put the person first. *Person with a disability* instead of *disabled person.*
- Say *wheelchair user*, rather than *wheelchair bound*. The wheelchair enables the person to get around and participate in society; it's liberating, not confining.
- It's okay to use idiomatic expressions when talking to people with disabilities. *See you later*, to a person who is blind is acceptable.
- Avoid disempowering words: *victim, sufferer*.
- Avoid outdated terms like *handicapped*, *crippled* and *retarded*.

***Spread the Word to End the Word* is a National Movement (*www.r-word.org)*. Some people still use "mental retardation*",* but most people are offended by the "r" word, even if the person does not intend to be offensive.**

When you are supporting a sexual violence survivor with IDD…

- Acknowledge the individual's emotional state. *You seem upset today...You must be proud...That must be frightening.* Such statements validate the individual's experience, and help to build trust.
- Behavior is one way of communicating. Pay attention to non-verbal cues, over-compliance, resistance, and body language.
- Use more than one way to give information. Include stories, graphics, icons, and other tools.
- Be aware of your environment. Some individuals may feel comfortable pacing, need a small space, or prefer a quiet place away from distractions.
- Use verbal or visual cues when changing topics. If the individual is having difficulty understanding a question, try asking it in a different way.

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General Communication Tips

- **Speak in clear sentences.** Use simple words and concepts. Break a complex idea down into smaller parts**.**
- **Use precise language with simple words.** When possible, use words that relate to things you both can see. Avoid directional terms—*right/left, east/west*. Ask *who, what,* or *where* questions. *When* and *how* questions may be difficult to answer.
- **Speak directly; make eye contact** if possible before speaking. Say the person's name often.
- **Don't use "baby-talk" or talk down to the person.** Remember that adults—unless you are informed otherwise—can make their own decisions. Be aware of your voice tone and inflection.
- **Be prepared to use a variety of questions**: yes/no, either/or and open-ended questions. Individuals may be eager to please and tell you what they think you *want* to hear.
- **Be patient; allow the person to take time as needed.** It can be difficult for individuals to make quick decisions. Be encouraging, rather than correcting; don't speak for the person.
- **Signs with visual cues** can help individuals find their way around a facility or answer questions.
- **Use hand gestures and notes,** if helpful.
- **Don't pretend to understand** if you're having difficulty doing so.

Tips for Communicating with People on the Autism Spectrum

- **Use a calm, even voice tone.** Visual supports and gestures are helpful**,** especially in times of stress.
- **Be careful not to startle people.** Approach the individual slowly and quietly.
- **Avoid physically touching** the person if possible**.**
- **Use short, direct instructions.** *Tell me two places you go to feel safe.* Narrow choices to two or three.
- **Give the individual enough time** to respond before you repeat instructions.
- **Do not try to stop an individual's repetitive behaviors,** such as flapping hands or pacing, as these behaviors may be the person's way of calming him/herself.
- **Offer a break,** which can be helpful to reduce anxiety.
- **Remember not to take behaviors personally.** If the person has a lack of eye contact or speech, this may not mean disrespect.

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THIS FACT SHEET IS PROVIDED BY:

North Carolina Council on Developmental Disabilities

North Carolina Coalition Against Sexual Assault (NC CASA)

Carolina Institute for Developmental Disabilities (CIDD), UNC

It's time ... to talk about it! Talk early, talk often. Prevent sexual violence.

An overview of healthy childhood sexual development

Understanding healthy childhood sexual development plays a key role in child sexual abuse prevention. Many adults are never taught what to expect as children develop sexually, which can make it hard to tell the difference between healthy and unhealthy behaviors.

When adults understand the difference between healthy and unhealthy behaviors, they are better able to support healthy attitudes and behaviors and react to teachable moments. Rather than interpret a child's actions with an adult perspective of sex and sexuality, adults can promote healthy development when they understand what behaviors are developmentally expected at different stages of childhood. They are also better equipped to intervene when there are concerns related to behavior or abuse.

Understanding childhood sexual development

Sexuality is much more than sex – it's our values, attitudes, feelings, interactions and behaviors. Sexuality is emotional, social, cultural, and physical. Sexual development is one part of sexuality, and it begins much earlier in life than puberty. Infants and children may not think about sexuality in same way as adults, but they learn and interpret messages related to sexuality that will shape their future actions and attitudes. For example, when a three year old removes their clothes in front of others, a parent may tell him or her that "*being naked is okay at bath time, or in your room, but not while your cousins are here.*" The child is learning that there are times when it is OK to be naked and times when it is not.

Sexuality is emotional, social, cultural, and physical. Sexual development is one part of sexuality, and it begins much earlier in life than puberty.

Children are constantly learning social norms and what is expected or appropriate in interactions and relationships. There are healthy and common expressions of sexuality that children are likely to show at different developmental stages. Often adults want to know which behaviors are appropriate and indicate healthy childhood sexual development. The information below addresses common behaviors that represent healthy childhood sexual development as well as what knowledge and skills are appropriate for children at each stage (National Child Traumatic Stress Network, 2009; The Society of Obstetricians and Gynaecologists of Canada, 2012).

It's time ... to talk about it! Talk early, talk often. Prevent sexual violence.

Healthy childhood sexual development		
Stage of development	Common behaviors	Encouraging healthy development
Infancy (Ages 0-2)	• Curiosity about their body, including genitals • Touching their genitals, including masturbation, in public and in private • No inhibitions around nudity	• Teach correct names of body parts, such as penis and vagina • Explain basic information about the differences between male and female anatomy • Help children begin to understand how to interact respectfully with peers of the same age • Provide very simple answers to questions about the body and bodily functions
Early Childhood (Ages 2-5)	• Occasional masturbation. This usually occurs as a soothing behavior rather than for sexual pleasure. It may occur publicly or privately. • Consensual and playful exploration with children of the same age. This could include "playing house" or "playing doctor." • May ask questions about sexuality or reproduction, such as, "Where do babies come from?" • May show curiosity in regard to adult bodies (e.g., wanting to go to into the bathroom with parents, touching women's breasts, etc.) • Continued lack of inhibition around nudity. May take-off their diaper or clothes off • Uses slang terms for body parts and bodily functions	• Provide basic information about reproduction (e.g., babies grow in the uterus of a woman) • Encourage a basic understanding of privacy and when things are appropriate and inappropriate • Explain the difference between wanted and unwanted touch. For example, a hug that is welcome and positive versus one that is unwelcome and uncomfortable. • Teach children about boundaries. Let children know that their body belongs to them and that they can say no to unwanted touch.

It's time ... to talk about it! Talk early, talk often. Prevent sexual violence.

Healthy childhood sexual development		
Stage of development	Common behaviors	Encouraging healthy development
Middle childhood (Ages 5-8)	• Continued use of slang words, "potty humor" or jokes to describe body parts and functions • Deeper understanding of gender roles. May act in a more "gendered" manner as expected behaviors and norms associated with gender are learned (e.g., girls may want to wear dresses). • Sex play or activities that explore sexuality and bodies may occur with same- and opposite-sex friends • Masturbation. Some children may touch their genitals for the purpose of pleasure. This happens more often privately rather than in public.	• Promote a solid understanding of gender and how children experience their gender identity. Children who identify as transgender or gender non-conforming will experience this also, but can face confusion and may need increased support from adults. • Explain the basics of human reproduction, including the role of vaginal intercourse. • Talk about the physical changes that will occur during puberty. • Explain that there are different sexual orientations such as heterosexual, homosexual, and bisexual. • Teach that masturbation is something that occurs in private. • Educate on personal rights (e.g., "your body belongs to you") and responsibilities (e.g., treat boys and girls equally) related to sexuality.

Healthy childhood sexual development		
Stage of development	Common behaviors	Encouraging healthy development
Late childhood (Ages 9-12)	• As puberty begins an increased need for privacy and independence is often expressed. • Interest in relationships. May want to have a girlfriend or boyfriend. • May express curiosity about adult bodies. This could involve the child trying to see people naked or undressing or involve looking for media (such as TV, movies, websites, and magazines) with sexual content. • As social norms around masturbation become clearer. Masturbation will likely occur in private.	• Provide ongoing information about the physical aspects of puberty and changes in their body. • Educate children on the social and emotional aspects of puberty. Help to normalize the new emotions and needs that they may be experiencing. • Provide age-appropriate sexuality information and basic information about sexual behaviors and sexually transmitted infections, etc. • Encourage critical thinking and build the skills to differentiate fact from fiction in media images and representations of sexuality. • Support them in understanding they have both rights and responsibilities in their friendships and relationships. Encourage characteristics of healthy friendships and relationships.

Adolescence and ongoing development

As children progress into adolescence, signs of development become more pronounced and the need for accurate information about sexuality and sex continues. In addition to more detailed questions about sexuality and sexual health, young adults are often in need of support in finding accurate sources of information and resources. Additionally, adults can support youth as they navigate cultural and social messages about sexuality and gender shared though media and often reinforced by peers.

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Healthy childhood sexual development and child sexual abuse prevention

Discussing sexual development within the context of child sexual abuse prevention can cause discomfort and raise tough questions. Conversations about children and sexuality are often seen as taboo. Thus, education, including accurate information about childhood sexual development, is rare. This leaves the media and pop culture, which often hyper-sexualize or exploit children, as the primary information source for both adults and children.

It is important to recognize that many adults had little or no sexuality education growing up, and may have been given negative messages as children about their own sexual development. This can cause adults to see behaviors that are typical and developmentally expected of childhood sexual development as a problem. Discomfort can also occur for adults if they interpret a child's behaviors through an adult perspective. For example, a four-year-old who wants to shower with a parent may simply be curious about different bodies, while a parent may interpret this curiosity as overly sexual.

Childhood sexual development is a challenging topic. With more knowledge, comfort and skills, adults can better understand and support healthy development and recognize signs of unhealthy or abusive behaviors in both youth and adults. For parents, community members and persons working in sexual violence prevention, assessing one's comfort level is a great first step in determining what information and skill are necessary for a stronger understanding of healthy childhood sexual development. All adults in the community can be powerful allies and advocates in preventing child sexual abuse.

When is behavior a concern?

Remember that behavior falling within healthy childhood sexual development should exhibit the following characteristics (National Child Traumatic Stress Network, 2009):

- Children are being playful and/or curious, not aggressive or angry.
- Play involving sexuality (i.e. playing Doctor, "Show me yours/I'll show you mine") should be with a child of a similar age and developmental level, not with a much older or younger child.
- When adults ask children to stop or set limits around inappropriate behaviors they listen.
- The behavior does not cause physical or emotional harm to the child or others.

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Parents & caregivers can:

Develop positive and open communication around topics of sexuality. Create a dynamic where your children know they can come to you for accurate information and guidance that reflects your values without shaming.

Model respectful boundaries when it comes to touch and affection. Don't coerce children to give hugs or other displays of affection when they don't want to. Teach them that they have a right to have boundaries around their personal space and body from a young age and that they have a responsibility to respect the boundaries of others. Empower children to seek help when something feels uncomfortable to them.

All adults & community members can:

Challenge unhealthy norms. When you see or hear an unhealthy norm in either children or adults, in action, say something. Explain what is concerning about the norm and share a healthy alternative. Emphasizing safety, equality and respect as the standard is key to ending oppression and violence.

Be an engaged bystander. If you perceive it to be safe and you see something that is of concern, trust your instincts, and do or say something about it. Everyone has a responsibility to protect children from sexual violence. Active bystanders make an impact, and it's critical to speak up so institutions, policies, and laws can be changed to prevent harm.

Advocates, educators & professionals can:

Engage adults in addressing the issue. Help adults in the community better understand their roles in preventing child sexual abuse. Create opportunities in outreach and programming for dialogue and skill-building on this issue.

Act as resource. Parents and other community members need support and information on topics of childhood sexual development and child sexual abuse prevention. Provide connections to books, curricula and other resources that may help expand knowledge and comfort.

References

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