MULTI-FACETED FAMILY THERAPY FOR PARENT-CHILD CONTACT PROBLEMS
Important Information For Parents and Lawyers

There is consensus among experienced practitioners, supported in the social science literature, that when opting for outpatient therapy, a family therapy approach is preferred for mild and moderate cases of strained parent-child relationships. This includes parent-child contact problems after separation or divorce when the child may have a good reason to reject or resist a parent, when the reason may be unjustified or disproportionate, or in cases with elements of both. Generally speaking, the family therapy is intended to improve the current difficulties within the family, including those related to the parent-child relationships and contact, parenting and co-parenting. Detailed parenting plans, court orders, regular court monitoring and accountability/sanctions for noncompliance are important structural components needed for successful family therapy in parent-child contact problem cases.

Parent-child contact problems, like other relationship problems, are systemic in nature. Consequently, it is not sufficient to limit intervention to only one part of the system, such as individually with either the rejected parent or child, or even with the child and rejected parent in joint sessions. The preferred parent's participation and co-parenting work is essential to the success of the therapy. Siblings may be contributing to the parent-child relationship problem, especially when they are also resisting contact. Therefore, optimally, the family therapy is multi-faceted in that it requires the participation of all family members in various combinations (e.g., individual sessions with the child and each parent, parent-child sessions, co-parenting sessions, and whole family sessions).

Unfortunately, even when court-ordered, some referrals are not suitable for MFFT. Careful screening and intake with the lawyers and the parents at the outset are important to determine if a particular family is suitable for outpatient family therapy. After a preliminary screening call with the lawyers and completion of a brief Parent Referral Form by both parents, a more thorough Clinical Intake Consultation (CIC) is conducted. This involves meetings with the parents and children is suggested to determine suitability given the nature of the compromised parent-child relationships. More severe parent-child contact problem cases regardless of the cause of the problem are unlikely to respond to the family therapy being summarized here, and may require other clinical or legal remedies.

The therapist is not as a custody assessor, arbitrator, mediator, or parenting coordinator. This means the purpose of the family therapy is *not* to determine IF it is in the child's best interests to have contact with a resisted or rejected parent. Rather, in consenting to the family therapy both parents must agree, or the court must order, that it is in the child's best interests to have contact with the resisted or rejected parent irrespective of the reason for the parent-child contact problem, be it justified, unjustified or a combination of both.

Multi-faceted family therapy for parent-child contact problems requires a therapist who has specialized training and considerable experience working with separation/divorce and court involved families. The therapy utilizes interventions consistent with cognitive behavioural and solution-focused therapies. Parent education is a large component of the work. The reciprocal relationship between feelings, thinking and behaviour are fundamental; changing one often changes the other. The therapy can be conducted in the office and in the community.

In some cases, the parents will have obtained a court order for the MFFT or they may have consented to a court order. Notwithstanding there being a court order, once accepted for family therapy, like in any therapy, the parents will be required to provide their informed consent contained in a detailed Family Therapy Agreement. Moreover, parent consent is an fundamental part of the acceptance criteria for MFFT because the therapy requires both parents' participation. It would be wasteful of time and money to begin the therapy only to discover the parent is not agreeing to consent to participate.

It is imperative for the parents, children and any other professionals currently involved with the family to understand what the family therapist can do and not do in their role as therapist. As noted, the role does not include determining whether or not it is in the child's best interest to restore contact with the rejected parent. Nor does the role include making decisions about the parenting time schedule. However, the role does include assisting the family members to implement the parenting time schedule ordered by the court or agreed to by the parents. To more readily accomplish this, and because the therapist is not a mediator, parenting coordinator, assessor or arbitrator, it is preferable for the parents to enter the therapy with an agreed to, detailed and unambiguous parenting plan or court order that includes the regular and holiday/special day parenting time schedule. It is not uncommon for gains to be achieved early on in the therapy, only to be met by *unnecessary* setbacks caused by conflict arising from a lack of clarity or dispute around an upcoming holiday period, for example.

In some exceptional cases, the parents will be unable to agree on an interim parenting time schedule and there will be no court order for one. In these cases, it may be possible at the outset to establish a parenting time schedule phased in over time commensurate with the passage of therapy. (For example, the plan might say, after four (4) weeks of therapy, the parenting time will be _____ and after eight (8) weeks of therapy it will be _____.) In other cases, the parenting time may be limited to the contact during family therapy as deemed appropriate by the therapist for the purpose of the therapy. This latter option, is problematic to the extent that it puts the therapist in a decision-making role about the child's contact with a parent and consequently, may compromise his or her role as therapist. The therapist, however, should be able to decide on smaller issues such as the context of contacts, protocols for transfers, telephone and email, parent-child contact, co-parenting communication and child-related information sharing).

Additional goals for the family therapy include:

- fostering overall healthy child adjustment;

- restoring, developing or facilitating adequate parenting and co-parenting functioning and skills;
- assisting parents to resolve relevant parent-child conflicts;
- developing family communication skills and effective approaches to problem solving;
- assisting parents to fully understand their child(ren's) needs for healthy relationships with both parents and the negative repercussions for the child(ren) of a severed or compromised relationship with a parent in their young lives and as adults;
- restoring or facilitating contact between the child and the resisted/rejected parent
- assisting the parents and child(ren) to identify and separate each child's needs and views from each parent's needs and views;
- working with each family member to establish more appropriate parent-parent and parent-child roles and boundaries;
- correcting child(ren)'s distortions and providing more realistic perceptions reflecting the child's actual experience with both parents;
- assisting the child(ren) to differentiate self from others, and to be able to exercise age-appropriate autonomy; and,
- assisting parents to distinguish valid concerns from overly negative, critical, and generalized views relating to the other parent.

Multi-faceted family therapy may differ from other more traditional individual and family therapies. For example, the therapist is permitted to use his or her discretion in sharing information obtained from one family member with another. Often, many professionals are involved with families experiencing parent-child contact problems, such as the CAS, OCL, other therapists, physicians and teachers. Ensuring coordinated services is essential to successful treatment. Accordingly, one requirement of the therapy is for current, and in some cases the previous professionals, to exchange information as required. As noted, the court's oversight of family therapy is imperative; the therapist may provide status updates or progress reports to the lawyers and court when necessary.

Experienced clinical and legal professionals agree the longer a parent-child contact problem exists the worse it can become and the harder it may be to remedy. Initial delays are common as parents and their lawyers struggle to agree to the terms in the Family Therapy Agreement. Even once the therapy gets started, delays related to scheduling and other reasons can occur. These delays may indicate the family relationship difficulties are too severe for the family therapy approach. As the therapy progresses, children and parents may find the work challenging. The parents may struggle with implementing the parenting time schedule previously agreed-to or court ordered. However, while noting it can be stressful, it is usually best to attempt to problem solve any issues that may arise, instead of avoiding these, because parent and legal conflicts, delays or significant gaps between sessions are likely to increase the associated stress and anxiety and exacerbate the strained parent-child relationships.

Often, our attempted solutions can become or exacerbate the problem. It is not helpful to continue with an approach that is proving to be ineffective and which may well be exacerbating the problems. It is for this reason that careful monitoring of any progress is important. A status conference in court or with the lawyers is one way to monitor progress.

If the identified therapy goals are not being met to some extent within 60 to 90 days of the therapy beginning, careful consideration needs to be given to additional court support or legal remedies, in an effort to prevent the contact problem from becoming worse with the passage of time.

While parents may have different views about the causes or reasons for their child's reluctance or refusal to have contact with a parent, both parents must be committed to being part of the solution. The family therapy requires not only a commitment of effort, but also of time expended both in the weekly sessions and in between sessions reviewing educational material and completing homework. Often, more than one session per week of the various family members will be necessary, particularly in the first 6 to 12 weeks.

Because after school hours are usually preferable to a child missing school or a parent missing too much work, the distance to the therapist's office and the time needed to travel there, often in rush hour, needs to be considered. Finding an experienced therapist with specialized training reasonably close to the children's school or residence is preferable to lengthy travel at the end of the day when the children are fatigued and may have other activities and lessons they would prefer to be doing.

Multi-faceted family therapy delivered on an outpatient basis does not provide a quick fix. Please keep in mind that steps forward coupled with a step or two backwards often characterizes good and sustainable change. This should be expected as a normal part of the process and provides an opportunity to learn from and correct mistakes.

Appendix A from: Fidler, B.J., & Bala, N. (2020). *Concepts, Controversies and Conundrums of "Alienation": Lessons Learned in a Decade and Reflections on Challenges Ahead. Family Court Review, 58*(2), 576-603.

Typical Behaviors, Perceptions and Beliefs of Children & Parents in Alienation Cases [1] [2]

Child
• Inconsistent behavior, including degrees of resistance, in the presence of the favored parent as opposed to when that parent is absent;
• Inconsistency between what is *stated or alleged* about rejected parent and how child *behaves* with rejected parent;
• Inconsistent behavior with the rejected parent (e.g. defiant, hostile) while may behave well with other adults;
• Opinion of each parent is rigid, one-sided, all good or all bad; idealizes one parent and devalues the other; refusal or reticence to consider alternate views, explanations;
• Weak, trivial, frivolous, unelaborated, false and irrational reasons to justify dislike, hatred, resistance or rejection of one parent;
• Revision of history to eliminate or diminish any positive memories of experiences with rejected parent; may report negative events with the rejected parent that could not possibly be remembered (before child is 3 or 4 yrs);
• Stories are repetitive and lacking in detail and depth;
• Use of "borrowed scenarios" – descriptions adopted from the favored parent or aligned family members;
• Report mimics that of siblings rather than own actual experience;
• Reactions and perceptions unjustified or disproportionate to rejected parent's behaviors;
• Talks openly and without prompting about rejected parent's perceived shortcomings;
• Claim they are fearful, but are aggressive, confrontational, even belligerent;
• Calls rejected parent by their first name;
• Badmouths or extends hatred to rejected parent's extended family or even pets of rejected parent (hatred by association); may extend to vilification of rejected parent; unrelenting campaign of denigration, hatred;
• Lack of guilt or ambivalence regarding cruelty or unkind behavior towards rejected parent;
• Anger at rejected parent for perceived abandonment, even though rejected parent seeks relationship;
• Speech about rejected parent is brittle, a litany; obsessed; has an artificial quality; affect does not match words; no conviction; uses adult language; has a rehearsed quality;
• Denial of hope for reconciliation; no acknowledgement of desire for reconciliation
• Reflexive support of favored parent in the parental conflict

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[1] This Table relies on previous reviews of the literature (e.g., Baker, 2005; Baker & Darnall, 2006; Cartwright, 2006; Garber, 2007, 2011; Johnston, Walters & Olesen, 2005; Kelly & Johnston, 2001). This Table has been adapted from earlier versions, including in Fidler, Bala, Birnbaum & Kavassalis, 2008; Fidler, Bala, & Saini, 2013, and Fidler & Ward, 2017).

[2] Behaviors listed in this table are not differentiated by level or severity. While these are typical behaviors, all of them will not be present in every case.

- "Independent thinker phenomena" – child claims these negative views about the rejected parent are their own, and not the favored parent's beliefs;
- Distorted perceptions and beliefs go unchallenged by favored parent;
- Expresses worry for preferred parent, desire to care for that parent; or, defensive denial child is indeed worried about parent:
- Acts to appease, or avoid rejection or withdrawal of attention by or love from favored parent:
- Role corruption or reversal with favored parent, child triangulated (e.g. parentification, adultification, infantilization):
- Internalizing (eg., anxiety, phobic reactions, depression, low self esteem behavior problems;
- Externalizing (aggressive to people or objects, or other acting out bullying, oppositional behavioral problems):
- May appear to function adequately in other environments than with rejected parent (eg., school, social), but tends to have difficulty interpersonally).

Favored Parent (and possibly Alienating Parent)

- Makes statements or demonstrates behavior indicating separation is experienced as humiliating;
- Badmouthing, denigrating of other parent's qualities, parenting, involvement with child;
- Believes or portrays other parent as dangerous (harmful, angry, mean) or sick; convinced of harm or abuse by other parent, despite absence of evidence; especially concerning if there are repeated unfounded allegations of sexual, physical and/or emotional abuse despite independent investigations do not support;
- Believes or implies other parent never really loved or wanted the child;
- Portrays self as parent who was the only "real" or involved parent;
- Believes other parent is not "worthy" of relationship with the child or has abandoned child;
- Acts fearful and/or suspicious of other parent in front of child; instills fear and rejection of other parent:
- Fosters dependency on and need for protector of child in favored parent;
- Withdrawal of love and approval: love of favored parent is conditional on the child not showing love or positive feelings for other parent;
- Minimizing actual and symbolic contact with other parent (eg., no or removal of photos or other reminders of other parent in the home):
- Insists that the child has the right to make decisions about contact; tells the child: "It's up to you."
- Refuses to talk directly to parent; refuses to be in same room or close proximity; does not let rejected parent come to door to pick up child;
- Rarely talks about the other parent to the child; uninterested in child's time with other parent after contact; gives a cold shoulder, silent treatment, or is moody after child's returns unless child expresses dissatisfaction about the contact;
- Refusal to hear positive comments about rejected parent; quick to discount child's good times as trivial and unimportant;
- Intercepts calls and messages from rejected parent;

- No encouragement of calls by child to other parent between contacts; rationalizes that child does not ask;
- Tells child fun things that were missed during the child's time with other parent;
- Arranges conflicting activities; talks about missed activities;
- Indulges child with material possessions and privileges;
- Sets few limits or is rigid about routines, rules and expectations;
- No concern for missed time with other parent;
- Makes statements and then denies what was said;
- Body language and nonverbal communication reveals lack of interest, disdain and disapproval;
- Engages in inquisition of child after time spent with the other parent ;
- Rejected parent is discouraged or refused permission to attend school events and activities;
- Telephone messages, gifts and mail from other parent to child are destroyed, ignored or passed on to the child with disdain;
- Restricts or withholds other parent's access to child related information (about school, activities, health);
- Distorts any comments of child that might justify the accusations about abusive parenting or negative behavior;
- Doesn't believe child has any need for relationship with other parent;
- When child calls during contact with other parent and is quiet or non-communicative, parent wrongly assumes child has been pressured by rejected parent, or concludes child is uncomfortable with rejected parent, thereby confirming evidence of bad parenting, with no appreciation that child is in loyalty conflict or uncomfortable sharing positive experiences with the favored parent;
- Repeats negatives and embellishes or exaggerate negative attributes of other parent;
- Neglects or avoids talking positively about the other parent or child's time with other parent;
- Psychopathology, mental illness, personality disorder or characteristics, substance/alcohol abuse manifest in unfounded allegations of abuse and/or intimate partner violence and/or; abusive/neglectful parenting;
- Delusional false statements repeated to child; distorts history and other parent's participation in the child's life; claims other parent has totally changed since separation;
- Projection of own thoughts, feelings and behaviors onto the other parent;
- Does not correct child's rude, defiant and/or omnipotent behavior directed towards the other parent (or extended family), but would never permit child to do this with others;
- Says other parent left "us," divorced "us" and doesn't love "us;"
- Over-involves or confides in child about the marriage, adult matters and litigation;
- Child required to keep secrets and spy or report back on other parent;
- Overt and covert threats to withdraw love and affection from child unless other parent is rejected;
- Lack of courtesy to rejected parent, manifest directly or indirectly to varying degrees;
- Not permit child to take (or return with) certain clothing, cellphones, toys, etc.;
- "Therapist shopping" for child;
- Relocation for minor reasons and with little concern for effects on child

- Inflexibility around making occasional changes to the schedule to accommodate special events or occasions (eg., weddings, funerals, special birthdays, etc.);
- Changes child's last name without permission of other parent;
- Does not put the other parent's name on school, extracurricular and health forms;
- Moves away without notice or hides child from other parent.

Rejected (Alienated) Parent (Listed behaviors do not reach the level of abuse or warrant the child's disproportionate response or contact refusal. If behaviors reach level of abuse, the correct identification of the contact problem is justified rejection)

- Lax or intermittently rigid or punitive parenting style;
- Outrage at child's challenge to his/her authority;
- Passivity or withdrawal in face of conflict;
- Feelings of helplessness in response to child's dramatically changed behavior;
- Immature, self-centered in relation to child;
- Puts own needs ahead of child;
- Loses temper, angry, demanding, intimidating character traits, but not to level of abuse;
- Counter-rejecting behavior towards child in response to child's rejection;
- Loss of hope that anything or anyone can change the child's new belief system;
- Lacks empathic connection to child;
- Critical or demanding traits, present in marriage, continue and take on new meaning;
- Inept and unempathic pursuit of child, pushes calls and letters, unannounced or embarrassing appearances at school or activities;
- Challenges child's beliefs or attitudes, and tries to convince child otherwise;
- Tells the child they are parroting other parent;
- With child, vents and/or blames other parent for brainwashing child; takes no responsibility for family circumstance;
- Dismissive of child's feelings and negative attitudes;
- Attempts to induce guilt in child;
- May use force to attempt to reassert parental position;
- Mental illness, personality disorder or characteristics but does not manifest to the point of abusive/neglectful parenting.

Appendix B

Behavioral Manifestations of Parent and Child Behaviors By Level of Severity in Alienation Cases[3]

Mild

- Usually, younger children, under 8 or 9 years;
- Some parental alienating behaviors (e.g., contact interference, badmouthing), but limited and not in a consistent pattern; likely unwitting and not an effort to prevent child's relationship with other parent;
- Favored parent values child's relationship with other parent, but occasional displays of misguided or justified protective behaviors
- Parents are usually able to cooperate on major and day to day child-related decisions, and parental conflict is limited and co-parenting communication is usually respectful;
- Child values relationship with both parents but displays discomfort (not extended to extended family), or may be mildly or situationally disillusioned, unhappy or angry with one parent;
- Situational and infrequent parent-child relationship strain;
- Few resisting child behaviors at transitions; once preferred parent departs, child resumes comfort level with other parent;
- Contact is occurring combined with minor interruptions of parent-child contact (e.g., late, missed visits, short-lived transition difficulties in presence of preferred parent);
- Duration of interruptions in parenting schedule that was previously agreed or ordered has been relatively brief (e.g., not more than 6 months);
- Parents and child(ren) are generally flexible, but show inflexibility at times;
- Parents are generally to separate their own needs and feelings from those of the child's
- Both parents statements and demonstrated behavior provide indications they are responsive to treatment/education to improve the parent-child relationship and their own parenting; parents can be reassured;
- Parents generally compliant with parenting plan, treatment agreement and court orders

Moderate

- Usually older children, commencing around 8 or 9 years (although in some cases children as young as 4 or 5 can show early signs of becoming alienated, which fall in Mild or Moderate category) ;
- Child may be disillusioned (unhappy about separation, new partner, angry with one parent), not "alienated"
- Difficulties with transitions with child insisting they don't want to go;
- Child takes longer to settle in after transitions than at mild level; guarded and cautious initially;
- Child 's rejection behaiors reemerge in anticipation of returning to favored parent prior to transition back.

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[3] Adapted from Fidler & Ward (2017).

- Child's displays more resistance than at mild level, although reactions are mixed, confused or inconsistent (e.g. before or during transitions, while with rejected parent);
- Some contact is occurring; may be sporadic, infrequent or delayed; pattern of missed opportunities for parent-child contact evident;
- Parents or child generally more rigid but some instances of flexibility;
- Some remnants/indications of warm/loving relationship with rejected parent;
- Parent's overprotection undermines (unwittingly or intentionally) the child's relationship with other parent ;
- More frequent episodic (than in mild cases) parental alienating behaviors (contact interference, badmouthing, undermining, exaggeration, distortion); may be intentional to alienate or may be unintentional (protective);
- Parents able, to some extent, to separate own needs/views from those of the child;
- Favored parent can be reassured at times and to some extent;
- Favored parent may be willing to meet with other parent;
- Favored parent willing to attend (or is attending) treatment, but sporadic and/or with minimal success;
- Co-parenting communication may exist for specific informational transactions but is strained or non-existent for major child-related decisions; parent communication is terse and less civil;
- Parent(s) demonstrate periodic lapses but generally compliant with parenting plan, treatment agreements and/or court orders;
- Parent(s) inconsistently responsive to education and direction.

Severe

- Intrusive and psychologically controlling parenting by favored parent (see Barber, 2002);
- Favored parent may have severe personality disorders or characteristics may be (e.g., paranoid, antisocial, borderline, narcissistic); or even mental illness (psychotic or quasi psychotic thinking, profound emotional dysregulation, extreme or bizarre behavior);
- Favored parent identifies actions as protecting (rights of) child, despite repeated investigations or evidence demonstrating the risk of future harm is improbable;
- Favored parent advances allegations of abuse (emotional, physical or sexual) against the other parent, despite independent investigation (child protection, police or medical) finding no support;
- Eight "alienated child behaviors" present and stronger than in mild or moderate cases
    - Repeated denigration of one parent
    - Lack of ambivalence
    - Child claims to be "independent thinker" but clearly influenced by favored parent
    - Reflexive support for favored parent
    - Absence of guilt about bad feelings of rejected parent
    - Descriptions of poor conduct of rejected parent based on favored parent claims
    - Animosity towards relatives of rejected parent;
- Child threatens to run away or harm self, rejected parent or others;
- Child runs away or exhibits self harm;
- Child acts out or behaves aggressively (towards rejected parent or others, destruction of property);
- Child guarded and hyper-vigilant to perceived threat of rejected parent, despite absence confirmed history of abuse;

Clinical Contraindications/Possible Rule-Outs For Family Therapy for RRD – Outpatient Cases

- ☐ Parent(s) demonstrated unwillingness to participate in intervention, despite contrary statements to others, such as the court, lawyers, therapists, child protection agency.

- ☐ Parent(s) unable to stipulate it is in child's best interests to have parenting time with other parent vs expecting an assessment of what is in the child's best interest (e.g., repeated false/fabricated allegation of maltreatment or abuse, unsubstantiated after child protection investigations).

- ☐ Parent's ability to exercise parental authority to require children to attend therapy

- ☐ Threats/risk to safety (including abduction) of parent, child or therapist.

- ☐ Active substance use disorder in any family member.

- ☐ Diagnosed psychotic disorder, active untreated substance abuse, and/or diagnosed and untreated mental illness (e.g., bipolar, depression).

- ☐ Severe personality disorders (e.g., antisocial, paranoid, obsessive-compulsive).

- ☐ Immediate threat of intimate partner violence and/or a history of intimate partner violence with control-coercive dynamics.

- ☐ Immediate threat of child maltreatment, neglect, or severely compromised parenting.

- ☐ Noncompliance during administrative or clinical intake consultation.

- ☐ Demonstrated, repeated disregard/noncompliance with previous court orders.

- ☐ No interim or permanent parenting time schedule in place, however restrictive or expansive, by order or on consent order, to be implement as one of the goals of the therapy (i.e., may not be occurring at the time family seeks assistance).

- ☐ Children under the age of 8 years of age, who will attend the therapy (exceptions per the discretion of the therapist).

- ☐ Previous efforts at same or similar intervention have failed.

- ☐ Restrictions on therapist's access to information, contact with collateral sources.

- ☐ Active child protection agency investigation (if there is a required by the court or agency to wait for the outcome before initiating treatment).

- ☐ Presence of individual connected with family who is likely to sabotage intervention efficacy before, during or afterwards (e.g., stepparent, new partner, grandparent, other relative).

UNCOMFORTABLE: Things we don't have to like, may not be right, but can't be addressed directly. Can only be addressed through communication between myself, the person, and my counselor. I can talk to my counselor about it but he won't say something unless I want him to or I am with him when he does. I can tell my 'other' parent about it but it's not their role to directly try to change it or control what my parent does.

*Getting Grounded

*getting phone taken away

*parents snooping through my stuff and my phone

*Random questions

*Getting something taken away

*Hearing others argue and cuss

*Being told to clean up and my stuff and it is taken because I didn't.

*Not getting the food I want

*Being blamed

*Seeing someone drink alcohol

*Having nightmares

*Hearing that someone was hit

*Being yelled at

*Hearing one parent or person talk about another parent or person

*Holding on to a bottle of alcohol

*Someone lying about me

*parent threatens to kick you out (1 time)

*Someone bumps into me

*Being touched in private areas for medical reasons by medical professional or parent/guardian (age 10 and under).

UNSAFE: Things that harm us or will harm us, need to be addressed directly with someone I can trust, need to be addressed as soon as possible. My counselor has to tell someone and address it.

*Being hit

*Seeing another person get hit

*Being left alone by myself at home

*My important stuff being destroyed (multiples times)

*Being called mean names (multiple times)

*being threatened to be kicked out (multiple times)

*Not being fed.

*Being in a car when someone has been drinking and they are driving.

*Being given alcohol to drink

*Being threatened to get hurt

*Hearing a parent or someone threaten to hurt another person/parent.

*Someone lying on purpose to be able to have something unsafe happen to me.

*being kicked out of the house/not being able stay at home

*not having a way to contact someone if I or someone else is unsafe

*seeing someone do something to someone else that could harm them

*Someone other than a medical professional, parent/guardian touching me in my private areas for medical reasons (age 10 and under).

*Someone other than a medical professional touching me in my private areas for medical reasons (11-13).

*Someone other than a medical professional touching me in my private areas for medical reasons without my permission and when I tell them to stop (14 and over). A family member touching me in my private areas regardless of permission or not.

*Seeing other people touched in their private areas by older people/adults.

*Seeing someone do drugs that I know are illegal