Children With Sexual Behavior Problems

Trainer Guide

Training Developed by Karen Boyd Worley, Ph.D. and Janice K. Church, Ph.D.
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U·A·L·R
School of Social Work

TRAINER OUTLINE

Audience: This training is designed for employees of the Division of Children and Family Services (DCFS), foster parents and any providers who work with the Division.

Organization: The Trainer Guide consists of a training outline with exercises, copies of the Participant Manual for the trainer's use, trainer resources including PowerPoint presentations (in some training modules), a manual for participants, and handouts. Since this training may be presented to a diverse audience, every effort has been made to include a variety of exercises, handouts and material to enable the trainer to tailor the training to a specific group.

Areas to Emphasize: This training needs to emphasize realistic safety precautions for children with sexual behavior problems. It should also emphasize basic knowledge of normal sexual development in order to assess when sexual behaviors become problematic.

Time:
This training is set up for three hours. Modify exercises depending on the group size and the amount of time available.

CHILDREN WITH SEXUAL BEHAVIOR PROBLEMS
TRAINER OUTLINE

COA Requirements

- G7.1.05.b
- G7.1.05.c
- G7.2
- G7.3.01
- G7.3.07.c

Competencies Addressed

- 103-1
- 203-2
- 203-4
- 203-9
- 203-14

The materials for this workshop were provided by Dr. Karen B. Worley and Dr. Janice K. Church with the Family Treatment Program of the University of Arkansas for Medical Sciences (UAMS). The materials are used with permission.

Objectives: Participants will

- Understand the developmental nature of sexual behaviors.
- Know the range of normal sexual behaviors and be able to identify behaviors that are of concern.
- Know strategies for managing children with sexual behavior problems.
- Be able to develop a realistic safety plan for children and adults in homes where there is a child with sexual behavior problems.

Materials:

- Handouts 1 –
- Whiteboard or flipchart setup for each small group
- Name tents (use stickers on the backs of the name tents for easy movements into small group work)
- Participant Manual

I. Introductions

A. The trainer should introduce him/herself to the group. Give enough personal information to establish your credibility to teach the material.

B. Depending on group size, conduct an exercise designed to surface participants' hopes and expectations of the workshop. A sample exercise is included in the Trainer Resource section but trainers should feel comfortable in substituting if they have an icebreaker that they prefer.

C. After the ice breaker, refer the participants to the Participant Manual, page 1 (Agenda) and quickly review the workshop agenda.

II. Overview of the Problem

A. Start the next section with a quick knowledge test. Refer participants to the Participant Manual, page 2 (Overview). Ask them to take a few minutes to answer the questions on this page.

B. Lead a discussion to address each of the issues on that page. There is supplemental material in the Trainer Resource section for the trainer to use when preparing for this section of the training.

C. Teaching points include:

1. Sexuality is a normal part of development. There is a large range of normal sexual behavior exhibited by children.

2. Sexual abuse by children is as psychologically damaging as sexual abuse by an adult.

D. Briefly review the Division's policy on Behaviorally Based Reports and Under Age Juvenile Aggressors. The policy is summarized in the Participant Manual, page 3 (Behaviorally Based Reports).

III. Norms for Children's Sexual Behavior

A. Use the information in the Trainer Resource section to lead a discussion of normal vs. abnormal sexual behaviors in children. Participants have this material in the Participant Manual, page 4 (Norms for Children's Sexual Behavior).

B. Learning points include:

1. The actual percentages are less important than the overall trend. For example, it is not unusual for a female child to be shy with men. It is highly unusual for a child to offer to put his/her mouth on the sex parts of an adult.

2. Ask the class members to share any experiences where they have worked with children who are exhibiting the more concerning behaviors.

C. Move from this discussion to the two different typologies set out in the Participant Manual on page 5-7, (Typologies for Sexual Behavior Problems in Children).

D. Opinions Exercise

After reviewing the materials on norms for sexual behaviors and the different typologies, take the opportunity to conduct an exercise to let participants practice applying the information.

Purpose:

This exercise is designed to provide an opportunity to apply the information presented on normal sexual behavior.

Materials:

This exercise requires the Opinion Survey on pages 8-10 in the Participant Manual.

Methodology:

1. Either divide the large groups into smaller groups or leave them in the small groups from the earlier exercises.

2. Ask the groups to look at the materials on pages 8-10..

3. Instruct each small group to complete these questions and be ready to discuss their answers. If time is running short, shorten the number of questions the groups need to answer.

4. Each group should note any area where the group members did not reach consensus on the answer.

5. Allow about 10 minutes for groups to complete their work.

6. Call time. Go through the answers with groups alternating on providing the answers. (There is a cheat sheet for trainers in the Trainer Resource section.)

Processing

Summarize this exercise with Handout 2, Red Flags.

IV. Safety Planning

A. Refer participants to Participant manual, pages 11-12 (Range of Interventions).

B. Use this material to cover the types of behaviors which require intervention. This material not only reinforces the answers to the Opinion Survey but also sets the stage for a discussion of safety planning. The intervention will be the safety plan. The safety plan should be incorporated as part of the case plan for the child and family.

C. Conduct a short listing exercise to elicit the group's ideas and thoughts about safety planning in sexual abuse cases. Ask the following question: "What should be included in the safety plan for a family where there is a child with sexual behavior problems or where child sexual abuse is occurring?"

1. List all answers on the whiteboard.
2. Ask for clarification if necessary.
3. Point out who is the target of the intervention – for example is the victim child the one who is receiving misplaced attention/intervention. An example would be the case where an eight year old female has been sexually abused by her 13 year old brother. The intervention recommended to the family was to lock the eight year old in her room so that her brother could not gain access. (the room had no window and no other means of escape in case of fire, illness, etc.
4. Move from the listing exercise into a review of the safety planning tips on page 13 - 14.

D. Review the safety planning tips in the Participant Manual on page 13 - 14 (Safety Planning). After the review, look at the sample safety plan format in the Participant manual on page 15, (Sample Safety Plan).

E. Conclude this section of the training with a case scenario. Since participants are already in small groups, use the existing groups in order to save time.

1. Refer participants to page 16, and ask them to look over the scenario.
2. Using the information provided about safety planning, direct the group members to answer the questions at the end of the scenario and be prepared to share their thoughts with the larger group.
3. Allow sufficient time for participants to read, discuss and answer the questions.
4. Call time. Review the questions. Consider asking one group to respond to the first question, another group to the second question, etc.
5. Facilitate a discussion to assess the degree of consensus among the groups on the questions. Reinforce answers that address victim-centered responses.

V. Treatment Issues – Assessment and Intervention

Material has been included in the Participant Manual, pages 16 -24 related to assessment of children with sexual behavior problems and suggestions for picking a therapist. Cover this material if time allows. If there is not time, ask participants to look it over for future reference.

Pass out evaluations, encourage participants to complete one, thank them for attendance and dismiss the class.

CHILDREN WITH SEXUAL BEHAVIOR PROBLEMS

Curriculum for MidSOUTH Training

Materials provided to MidSOUTH by:

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INTRODUCTORY ICEBREAKER

Purpose:
The purposes of the ice breaker are to provide an opportunity for participants to get to know one another and to surface expectations of the workshop.

Materials:
This exercise requires a copy of Handout 1 and either a pen or pencil for each participant.

Methodology
1. Divide the group into smaller groups of 4-5 members.

2. Pass out Handout 1 – Getting to Know You – to group members.

3. Ask group members to introduce themselves to each other, using the questions on the Handout.

4. As the groups are completing the introduction exercise, remind each group to pick a recorder. Direct the recorder to write each group member's expectations and hopes for the training on the whiteboard or flipchart.

5. Depending on how many people are in attendance, decide whether to have each group introduce themselves or whether to go immediately to the listing exercise that summarizes this exercise.

6. Give the groups a few minutes for introductions. Then, ask the recorder for each group to share the group's expectations for the class.

Processing
As the groups list the things they would like to get out of the workshop, reinforce those ideas that will be covered. If there are hopes and expectations that are out of the scope of the workshop, point these items out. Offer to meet with that participant at break or after the workshop to provide resources that might help them get the answers they are seeking.

OVERVIEW OF THE PROBLEM

Are Children Really Sexual Beings?

Blue text + possible discussion questions.

The following statements are based on research (Ryan, 2000) in which professionals working with child abuse issues were surveyed.

1. There is more sexual activity by and among prepubescent children than the concept of latency suggests.

2. Children engage in a wide range of sexual behaviors. Can anyone give an example that they have witnessed with their own children?

3. The emergence of sexuality, experience of sexual arousal, early exploration of body, and interpersonal body relationships occur primarily outside the family with peers.

4. Much of the sexual behavior of children occurs in a climate of secrecy, without opportunity for adult observation or intervention. Why do you think this is true?
   Adults' discomfort with looking at children as sexual beings
   Children pick up on the parental attitude that sex is a taboo subject.

5. Children make value judgments about early sexual experiences that are related to their emotions and beliefs about the behavior. So , if you shame your child for touching his or her genitals, how might this affect the child's beliefs about sexual behavior?

Impact of Child on Child Sexual Abuse

A study by Shaw, Lewis, Loeb, Rosado, & Rodriguez (2000) compared emotional and behavioral responses of children who have been sexually victimized by juveniles 17 years of age and younger compared to child victims of adults 18 years of age or older. Compared 51 children molested by children with 143 children molested by adults. Parents provided information using demographic form, Achenbach's Child Behavior Checklist, and the Family Assessment Measure. The child was given the Family Assessment Measure and Trauma Symptom Checklist. The clinical completed the Parental Reaction to Incest Disclosure Scale.

1. **No differences were found between the two groups for the type of sexual abuse, penetration, or the use of force.** Children molested by children were younger and more likely to be males who were abused in a school setting, home, or a relative's home by a sibling or a non-related male.

2. Children molested by children endorsed **clinically significant sexual preoccupations** and manifested **borderline clinically significant symptomatology.**

3. Children victimized by other children manifested elevated levels of **emotional and behavioral problems and were not significantly different from those who had been sexually abused by adults,** so that the impact of sexual abuse by children should not be minimized.

Policy of the Division of Children and Family Services

Behaviorally Based Reports

- Children (usually very young) who are acting out sexually with inanimate objects, with animals, or upon themselves.
- The behavior is out of the range of normal childhood sexual behaviors.
- There has been no verbal disclosure of abuse.
- These reports are referred by the Hotline to DCFS for assessment for supportive services.
- If during the assessment there is a disclosure of sexual activity, the assessor MUST make a report to the Hotline and the report will be investigated by CACD.

Under-Age Juvenile Aggressor

- A report is received by the Hotline alleging behavior by a child under the age of ten that - if true - would result in the child being named as an offender if he or she was 10 years of age or older.
- The child is acting out sexually with other children in a manner that has elements of force and/or compulsion.
- The report will be assessed by DCFS under the same requirements as any other assessment - time frames, required interviews, etc.
- If the report is found to have merit:
  - Worker selects the "Alleged Juvenile Aggressor - Under Age Ten" in the Role In Referral Select box on the Abuse Neglect Screen in Referral or Investigation in CHRIS.
  - Worker selects "**Exempt from Finding (Underage Juvenile Aggressor)"** as the individual finding in the Investigation Findings screen in CHRIS.
  - Worker selects an overall finding for the investigation of true.

Crimes Against Children Division/Division of Children and Family Services Agreement

Reports containing information that children age 9 and under are behaving in a developmentally inappropriate sexual manner, but do not contain allegations of sexual abuse or name an offender will not be registered as child maltreatment, but will be referred to DCFS for an assessment of the family's need for services.

If the assessment results in an allegation of child sexual abuse as defined by statute and protocol, the DCFS worker will make a report to the Child Abuse Hotline and, if accepted, be investigated by CACD.

This policy makes it necessary for DCFS workers to be well-grounded in normal sexual behaviors. And, while it is outside the scope of this workshop, this policy would also necessitate that DCFS workers be skilled forensic interviewers as they will be doing some of the most difficult interviews there are (very young children in a family system where no one is ready to acknowledge the problem).

The opportunity may arise to discuss best practice with regard to assessments of behaviorally based reports. Some county offices are dealing with this issue by sending the family a letter and asking if there is a need for services. They only initiate contact if the family responds to the letter. This is not only bad practice in terms of leaving a potentially vulnerable child at risk. It also clearly does not meet the intent of the legislation, although it may meet a strict interpretation of policy.

NORMS FOR CHILDREN'S SEXUAL BEHAVIOR

It is critical to understand what is normal or expected behavior in children in order to evaluate problematic sexual behavior.

1. Wide range of "normal" sexual behavior (Gil, in Johnson and Gil, 1993)

a. Ages 0-4: Limited peer contact, self-exploration, self-stimulation, disinhibition

a. Ages 5-7: Increased peer contact, experimental interactions

b. Ages 8-12: Increased peer contact, experimental interactions, disinhibition/inhibition

2. Use of the Child Sexual Behavior Inventory

a. Frequency of Sexual Behavior Among Non-Abused 2-12-Year-Olds

Common Behaviors	***Percent Endorsement***
Shy with men	64.5
Boy-girl toys	53.9
Walks around house in underwear	52.9
Scratches crotch	52.2
Touches sex parts at home	45.8
Walks around nude	41.9
Undress in front of others	41.2

b. **Frequency of Sexual Behaviors Among Non-Abused 2-12-Year-Olds**

Uncommon Behavior	Percent Endorsement
Puts mouth on sex parts	.1
Asks to engage in sex acts	.4
Masturbates with object	.8
Inserts object in vagina/anus	.9
Imitates intercourse	1.1
Sexual sounds	1.4

Friedrich, W.N., Grambach, A., Broughton, D., Kruper, H., & Bielke, R.L. (1991). Normative sexual behavior in children. Pediatrics, 88.

TYPOLOGIES FOR SEXUAL BEHAVIOR PROBLEMS IN CHILDREN

Children's Sexual Behaviors from Normal to Disturbed

Typology developed by Toni Cavanagh Johnson, Ph.D.
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Normal

- Few to many sexual behaviors
- Intermittent
- In balance with other interests; can start and stop at will
- Silly/giggly. Perhaps parental or religion-induced guilt
- All types of interpersonal relationships
- Similar age peers, friends or siblings
- No coercion, but request or teasing: mutual
- Secret
- Spontaneous/planned
- When discovered, shy, embarrassed, run and hide
- Curiosity/exploration, be like friends, mimic what has been seen. Sexual stimulation.
- Sometimes education of parents and/or children regarding sex and sexuality/values clarification

Sexually-Reactive

- Several problematic sexual behaviors
- Intermittent to frequent
- Out-of-balance with other aspects of life
- Anxious, shameful, guilty, fearful, confused
- May be isolated, unsure, wary in interpersonal relationships
- Similar age play-mates or living companion
- Often no discussion prior to behavior occurring. If discussion, no coercion
- May be observable
- May approach sibling, accessible children, possibly adults
- Spontaneous/impulsive/planned
- May be surprised when discovered (if dissociated at time of sexual behavior) or upset and confused or afraid.
- Anxiety reduction, posttraumatic stress reaction, to reduce confusion, deal with sexual over stimulation, decrease physiological arousal. Sexual stimulation.

- Recent or ongoing sexual abuse, emotional abuse, pornography history of sexual abuse in family, or overtly sexual lifestyle in home.
- Self understanding, make sense of overwhelming experience with sexuality, sex education, parent education and support, treatment plan to modify sexual behaviors

Extensive mutual sexual behaviors

- Many adult like sexual behaviors
- Ongoing
- Pervasive need for reassurance through sexual contact
- Needy, confused, sneaky, "What's the big deal?" attitude
- Distrusts adults as caregivers/ expects to be hurt, unattached rely on sexual relationship for emotional strength. Vulnerable to victimization by adult due to neediness and confusion. Sexual stimulation.
- Similar age living companion
- Agreement from peer at conscious or unconscious level
- Non-coercive
- Mutual sibling incest or willing children. Sex may become a stable aspect of relationship
-
- Coping mechanism to decrease isolation or loneliness or neediness. Decrease boredom or depression. Decrease physiological arousal. Sexual stimulation
- Sexual and/or emotional and/or physical abuse. Abandonment, neglect, extramarital liaisons of parents, inadequate early bonding, sexually abused in a group, lack of adult attachments, continuous out of home placements.
- Denies or blames other child or does not see problems with the sexual behavior.
- Increase attachment to adults for emotional and dependency needs, self understanding, make sense of overwhelming experience with sexuality, sex education, parent education and support, treatment plan to modify sexual behaviors.

Children who molest

- Many abusive behaviors
- Previous, ongoing, and increasing. Behavioral pattern
- Preoccupied by sex, sexualizes contact with people and things
- Anxious, angry, aggressive, confused, rageful
- Antagonistic, very limited social skills and relationships with people of any age, no reliable way to get approval. Some children seem emotionally detached and highly manipulative.
- Younger or older children with a 0 – 12 year age difference

- Threats/bribes/trickery/manipulation. Coercions
- Secret
- Forced sibling incest or vulnerable children. May be directed at adults
- Planned/explosive
- Decrease anxiety, fear, loneliness, anger, and abandonment fears. Reduce confusion, recapitulation of previous physical, sexual, or emotional over stimulation. Hurt others, retaliation. Trauma reaction. Sexual stimulation
- Intense rivalry for attention between sibs, lack of positive emotional relationships, trauma induced neurobiological changes, pairing of sex/anger aggression/anxiety. Sexual and/or emotional and/or physical abuse. Neglect/abandonment. Inherited vulnerabilities, violence in family history, sexualized relationships, sexualized environment in family, poor boundaries, and caretakers with many unmet needs.
- Aggressively and angrily blames other child and/or person who caught them or denies behavior.
- Intensive treatment, skills training. Goals include addressing sexual behavior problems. Intensive treatment of parents, boundary issues, parallel group treatment for children and parents and siblings, family therapy, intense prevention work in family, violence education.

Typology of Observed Sexual Behaviors (Bonner, Walker, & Berliner, 2000)

1. Group I—Sexually Inappropriate Children

   Represents behaviors in which there was inappropriate sexual behavior but not contact with another person. These behaviors included making sexual remarks, gestures, touching or exposing one's self, and the like.

2. Group II—Sexually Intrusive Children

   Composed of behaviors in which the child made sexual contact with another person in an inappropriate manner, but did so only briefly. Behaviors in this group included individuals who ran up to another child and grabbed the child's genitals after which they would retreat and run away; rubbing against another person in a sexually provocative manner; briefly fondling another person but stopping when the other person indicated displeasure; and similar behaviors.

3. Group III—Sexually Aggressive Children

   Involves behaviors in which there was significant or prolonged contact resulting in completion of a sexual act such as oral sex, vaginal or anal penetration, mutual masturbation, and similar behaviors. In most instances, the behaviors in Group III were implicitly and/or explicitly coercive or aggressive.

IDENTIFYING PROBLEMATIC SEXUAL BEHAVIORS

Range of intervention for observable sexual behavior of prepubescent children (Ryan, 2000)

1. Normal/Developmentally Expected

   Genital or reproduction conversations with peers or similar age siblings

   "Show me yours--I'll show you mine" with peers

   Playing "doctor"

   Occasional masturbation without penetration

   Imitating seduction (i.e., kissing, flirting)

   Dirty words or jokes within cultural or peer group norm

2. Requiring Adult Response

   Preoccupation with sexual themes

   Attempting to expose others' genitals (i.e., pulling other's skirt up or pants down)

   Sexually explicit conversation with peers

   Sexual graffiti (especially chronic or impacting individuals)

   Sexual innuendo/teasing/embarrassment of others

Preoccupation with masturbation

Mutual masturbation/group masturbation (although mutual or group masturbation is not uncommon among children, the interaction must be evaluated.)

Simulating foreplay with dolls or peers with clothing on (i.e., petting, French kissing)

3. Requiring Correction

Sexually explicit conversations with significant age difference

Touching genitals of others without permission

Degradation/humiliation of self or others with sexual themes

Inducing fear/threats of force

Sexually explicit proposals/threats including written notes

Repeated or chronic peeping/exposing/obscenities/pornographic interests, frottage

Compulsive masturbation, which includes vaginal or anal penetration

Simulating intercourse with dolls, peers, animals, with clothing on (i.e., “humping”, “hunching”)

4. Always Problematic; Requiring Intervention

Oral, vaginal, or anal penetration of dolls, children, or animals (Concern about behavior with dolls which may be rehearsals for behavior with peers or more vulnerable children)

Forced exposure of other's genitals (Although restraining an individual in order to pull down pants or expose breasts may occur in the context of hazing among peers, it is clearly abusive.)

Simulating intercourse with peers with clothing off

Any genital injury or bleeding not explained by accidental cause

Red Flags Regarding Children's Sexual Behaviors (Cavanaugh-Johnson)

1. The children involved in the sexual behaviors do not have an ongoing mutual play relationship.

2. Sexual behaviors are engaged in by children of different ages or developmental levels.

3. Sexual behaviors are out of balance with other aspects of the child's life and interests.

4. Children seem to have too much knowledge about sexuality and behave in ways more consistent with adult sexual expression.

5. Sexual behaviors are significantly different than those of other same-age children.

6. Sexual behaviors that continue in spite of consistent and clear requests to stop.

7. Children who appear to be unable to stop themselves from engaging in sexual activities.

8. Sexual behaviors that occur in public or other places where the child has been told they are not acceptable.

9. Children's sexual behaviors are eliciting complaints from other children and/or adversely affecting other children.

10. Children's sexual behaviors are directed at adults who feel uncomfortable receiving them.

11. Children (four years and older) do not understand their rights or the rights of others in relation to sexual contact.

12. Sexual behaviors progress in frequency, intensity or intrusiveness over time.

13. Fear, anxiety, deep shame or intense guilt is associated with the sexual behaviors.

14. Children engage in extensive, persistent mutually agreed upon adult-type sexual behaviors with other children.

15. Children manually stimulate or have oral or genital contact with animals.

16. Child sexualizes nonsexual things or interactions with others.

17. Sexual behaviors that cause physical or emotional pain or discomfort to self or others.

18. Children use sex to hurt others.

19. Verbal and/or physical expressions of anger precede, follow or accompany the sexual behavior.

20. Children use distorted logic to justify their sexual actions.

21. When coercion, force, bribery, manipulation or threats are associated with sexual
behaviors.

DEVELOPMENT OF SEXUALLY AGGRESSIVE BEHAVIOR IN YOUNG CHILDREN

- Risk factors in Child
- Risk factors in Parents
- Risk factors in Environment

RECOMMENDATIONS FOR INTERVENTION FOR CHILDREN WITH SEXUAL BEHAVIOR PROBLEMS

- Assessment
- Specialized treatment in some cases
- Safety Planning

CLINICAL EVALUATION

These guidelines are taken directly from Gil and Johnson's Sexualized Children: Assessment and Treatment of Sexualized Children and Children Who Molest.

1. Prior to the Interviews

    a. Review child protective services records.

    b. Review law enforcement records.

    c. Review data from previous therapists.

    d. Review data from previous placements.

    e. Review or obtain historical information about the child's sexual behavior problems, i.e., the types, duration, and progression of severity of the problem.

2. Who Participates?

    a. The parents or primary caregivers.

    b. The sexualized child.

    c. Siblings (using clinical judgment).

3. The Parent Interview

    a. Assess their behavior management techniques, parenting skills, and level of concern about the problem.

        What is their reaction to the child's sexual behavior?

        How are they managing the child?

    b. Assess their ability to provide adequate supervision.

Make no assumptions about the parents' reaction to or interpretation of the child's sexual behaviors or their belief in the seriousness of the child's problem.

c. Begin to assess family dynamics.

Are there divisions of loyalty within the family?
Is there secrecy, hurt, disruption within the family?
What are the parents' feelings about the child?

d. Obtain a standard developmental history (birth to present).

e. Assess the parents' psychological needs and defenses, level of available emotional and psychological resources.

What is the sexual history of the parent?
Is there any history of sexual abuse in the parent's life?
What is the current level of functioning of the parent?
What is the parent's history of interpersonal relationships?

f. Assess history and level of physical and sexual violence within the family, past and present.

Has the parent sustained abuse from partners?
Have the children witnessed this?
Has physical violence been paired with sexual aggression?
Has physical punishment been used to stop the problematic sexual behaviors of the child?

g. Genogram may be used to assess context of child's development and intergenerational patterns.

History of births and deaths.
History of marriages, divorces, cohabitations.
History of alcohol and drug abuse.
History of incarceration.

h. Assess boundaries within the family.

How do the parents manage the toileting and bathing/dressing of the child?
What are the sleeping arrangements?
What are the parents' views on their own nudity/attire in the child's presence?
What are the parents' sexual behaviors in the presence of the child?

i. Assess religious background of the family.

How morally charged is the issue of sexuality?
What are the parents' beliefs about masturbation?
Are the parents sexually repressed?
Does the religious belief system provide positive aspects to the family's coping?

j. Assess culture and values.

Ethnicity.
Environment/neighborhood.
Socioeconomic level.
Parents' choice of friends and support systems.

4. The Interview with the Sexualized Child

a. Assess the nature of the child's problematic sexual behaviors.

The behaviors the child discloses may be quite different from what the adults know.

"Do you think you have a problem with touching?"
"Even though I know some things about you and the touching, I would like you to tell me in your own words."
"If you feel like you want to say something that is not true, I would rather you tell me you don't want to answer right now."

Where did the behaviors occur, why was that location chosen, where were the parents, and did the child want the other child to keep it quiet?

b. What was the child's motivation for the problematic sexual behavior?

"Any ideas why you…?"
"Kids have told me that they touch other kids:
'cause they want to,
'cause they feel mad or bad or sad,
'cause they like to,
'cause the other kid likes them to do the touching,
'cause it feels good,…."

c. Assess the child's feelings about sexuality.

Group I Children (Normal Sexual Exploration):
giggly or silly about sexuality.

Group II Children (Sexually Reactive):
shame and guilt and anxiety about sex.

Group III Children (Extensive Mutual Sexual Behaviors):
may experience anxiety or guilt, but they may also have a cavalier or ho-hum attitude and do not understand the concern of the adults about their sexual behaviors.

Group IV Children (Children Who Molest):
volatile affect, generally with very aggressive and anxious features (rage, fear, grave sadness, jealousy, extreme loneliness, etc.) associated with sexuality.

d. Who else knows about the problematic sexual behavior?

e. What is the child's desire to change their problematic sexual behavior?

f. Assess denial, misrepresentation, or minimization of problematic sexual behaviors.

g. Assess the child's understanding of others' concerns about their problematic sexual behaviors.

Child may be mirroring sexual behaviors that occur in the home or neighborhood.

h. Assess the child's willingness to accept responsibility for the problematic sexual behavior.

   Generally a high correlation exists between the parents and the child in this regard.

i. What are the child's feelings about the child with whom the problematic sexual behaviors occurred?

   Group IV Children (Children Who Molest) generally do not engage in sexual behaviors with friends, because many have no friends. They often choose someone about whom they have underlying negative feelings.

   "Why did you pick that child?"

j. Does the child have fantasies or daydreams that may propel them to act out sexually and/or aggressively?

k. How does the child feel before and after engaging in the problematic sexual behavior?

l. Has the child witnessed sexual behavior on videos or television or in printed material?

m. Has the child been physically or sexually abused? What was their response to the abuse?

n. Does the child feel that people in their home environment are overly sexual?

o. Where and with whom does the child feel most safe and least safe?

p. Assess the child's developmental and intellectual level.

q. Assess the child's strengths and weaknesses.

"What are some of the things you do best?"
"What are some of the things that make you feel good about yourself?"
"Are there some things about you which you think are not so great?"
"Are there any things you would like to change about you?"
"What is the best thing you ever did? The worst thing you ever did?"
"What makes you feel proudest? What was your biggest disappointment?"

r. Assess other areas of emotional and behavioral difficulty described by the child.

s. Determine the child's perception of their school performance and peer relations.

"Some kids like school, some kids hate school and some kids are kind of in-between. What about you? Do you like school? What is your favorite thing to learn? What is your worst thing to learn? Do you have friends at school?"

t. Assess the child's willingness and ability to connect with the therapist and their suitability for group therapy.

u. Assess for psychiatric disturbances.

v. Assess use of alcohol and other drugs.

w. Assess risk factors.

WHAT TO LOOK FOR WHEN SELECTING A TREATMENT PROVIDER FOR MANAGEMENT OF CHILDREN'S SEXUAL BEHAVIOR PROBLEMS

1. Therapist should be familiar with normal child sexual development.

2. Therapist should be willing and able to work well with both children and their parents.

3. Therapist should be comfortable openly discussing sexual behaviors with youth and parents alike.

4. Therapist should conduct a thorough assessment of therapeutic needs, be flexible and creative in tailoring treatment to specific therapeutic needs, and continue to monitor/evaluate needs over the course of treatment and make modifications in intervention strategies accordingly.

5. Therapist should have skills in cognitive-behavioral therapy, play therapy, social skills training, and self-esteem building.

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SAFETY PLANS FOR CHILDREN WITH SEXUAL BEHAVIOR PROBLEMS

Safety planning and reunification philosophy should be *victim-centered.*

Supervision Conditions:

- Specialized to include conditions that address the issues identified in the assessment process
- Should be incorporated into formal orders and treatment contracts
- May include
    - Restrictions on contacts with other children
    - Restrictions on activities
    - Guidelines for privacy in dressing, using the bathroom within the home
    - No substance abuse or violence in the home
    - Completion of specialized treatment
    - No use of pornography, “R” rated movies, or phone sex lines
    - Limited/monitored use of the internet

Why involve schools?

- Moral dilemma – to tell or not to tell?
- Protect victims in the same school
- Enhance community safety/supervision

How schools can be involved

- Releases signed
- School notified
- School representative involved with treatment/case management team
- School advised of restrictions on behaviors and how to respond
- Schools know who to contact to address questions and concerns
- Schools learn how they can support positive changes and treatment goals
- Confidentiality stressed

Why safety plans?

Protection of the victim
Protection of the community
Protection of the child with sexual behavior problems from the appearance of risk

When is a safety plan needed?

Upon disclosure
Safety planning is an ongoing activity

Who can supervise?

- Responsible adult aware of the child's history and safety plan
- If victim involved in visitation, victim should feel comfortable with this person and be willing to disclose concerns

Reunification/reintegration activities when child with sexual behavior problems has been removed from home because younger/more vulnerable children or victim lives there.

- Initial visits are brief and in a neutral setting
- Move to longer time periods, eventually in home
- Victim impact closely monitored

Safety plan addresses:

- Level of contact with victim and other vulnerable targets
- If contact with victim allowed
- Dressing/bathing/ general dress in the household
- Pornography/movies with sexual or violent content
- No substance use
- No violence in the home
- Sexually abusive youth does not baby-sit; does not assume role of authority over younger children
- Sexually abusive youth does not share a bedroom with a younger or more vulnerable child
- May include mechanical devices such as alarms, motion detectors, or baby monitors.
- Special conditions

Success of community reintegration depends on:

- Victim-focused approach
- Specialized treatment for the child with sexual behavior problems
- Collaborative effort
- Reintegration planning from the beginning
- Ongoing assessment

Safety Plan

Name _____ Date _____

_____ Child will not have any unsupervised contact with other children under any circumstances**. (NO BABYSITTING**. No unsupervised contact with children in the home. No unsupervised play with children in the neighborhood, etc.)

_____ There will be no nudity or partial nudity in the home.

_____ There will be no open displays of sexual behavior by any members of the household.

_____ There will be no pornographic or sexually explicit material in the home.

_____ There will be no viewing of movies or shows depicting sexualized violence or deviant sexuality (no "slasher" films). No sexually explicit and/or violent music lyrics. No unsupervised access to the Internet.

_____ Child will sleep alone in his/her own bed in his/her own room. Child should not be up after other children and adults have gone to bed.

_____ Child will bathe and change clothes alone behind closed door.

_____ Siblings will not enter child's bedroom for any reason. Child will not enter sibling's bedrooms for any reason. All interactions will be in "public" parts of the house.

_____ Child will not have close physical contact with other children. (Younger children will not be held by patient. No full-body or lengthy hugging with other children.)

_____ Child will not assume a role of authority or supervision over younger children.

_____ There will be no physical violence in the home.

_____ No use of drugs or alcohol in the home other than medications prescribed by physician.

_____ Parents will be informed and in agreement with the whereabouts of child at all times.

Other:
_____
__

_____

Signatures:

_____
_____
Child Parents or Legal Guardian

_____
_____
Therapist Probation Officer or Caseworker

OPINIONS EXERCISE: SEXUAL BEHAVIORS IN YOUNG CHILDREN

Name_____Date_____

Instructions: Some sexual behaviors in young children are normal, expected behaviors. Others require redirection, while still others are of significant concern and raise a red flag. Give your opinion on each of the following by reading the description of the sexual behavior, and then decide whether it is normal, needs redirection, or represents "red flag" behavior. Then write why you think that.

1. A 3-year-old girl likes to peer into the shower while her father is showering.

   Normal _____ Needs redirection _____ Red flag _____

   Why?_____

2. A 5-year-old girl walks in on a teenage boy while he is using the bathroom. She asks to see his penis and he shows it to her. She touches his penis and he doesn't stop her.

   Normal _____ Needs redirection _____ Red flag _____

   Why?_____

3. A 9-year-old boy and his 8-year-old sister agree to have intercourse.

   Normal _____ Needs redirection_____ Red flag _____

   Why?_____

4. Two 6-year-olds "play doctor" together. No force is involved.

   Normal _____ Needs redirection _____ Red flag _____

   Why?_____

5. A 10-year-old boy makes obscene telephone calls to girls he knows from school.

   Normal _____ Needs redirection _____ Red flag _____

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6. A 9-year-old boy fondles a 3-year-old girl.

   Normal _____ Needs redirection _____ Red flag _____

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7. A boy is at the swimming pool and gets an erection. He tries to make sure nobody sees, but several girls notice.

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9. A 7-year-old boy has been molested by his older brother. At school, he talks a 7-year-old girl into sucking his penis.

   Normal _____ Needs redirection _____ Red flag _____

   Why?_____

10. An 8-year-old girl is found sneaking a pornographic video to school in her backpack.

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    Why?_____

11. A 5-year-old masturbates to the point of redness almost daily.

    Normal _____ Needs redirection _____ Red flag _____

    Why?_____

12. A 9-year-old girl writes a sexually explicit note to a boy in her class, telling him she wants to put her mouth on his penis.

    Normal _____ Needs redirection _____ Red flag _____

Why?_____

13. A 2-year-old disrobes at a family gathering and streaks through a crowd of people.

    Normal _____ Needs redirection _____ Red flag _____

    Why?_____

14. A 7-year-old boy pushes another boy in his class into the restroom and attempts to force him to allow anal intercourse.

    Normal _____ Needs redirection _____ Red flag _____

    Why? _____

15. A 4-year-old girl is seen in the bathroom, looking at her labia and vagina with a mirror.

    Normal _____ Needs redirection _____ Red flag _____

    Why?_____

16. A child is seen rubbing the family dog's penis.

    Normal _____ Needs redirection _____ Red flag _____

    Why?_____

17. A 3-year-old takes the clothes off her Barbie and Ken dolls and simulates intercourse and oral sex while make moaning sounds.

    Normal _____ Needs redirection _____ Red flag _____

    Why? _____

Case Example Discussion

A seven-year-old girl named Mary was placed in foster care because her mother was in jail on drug-related offenses. She had previously been bounced from home to home with relatives or friends of her mother's for weeks or months at a time. There is no known report of physical or sexual abuse on this child, but previous reports of neglect.

In the foster home, there are two younger children, a four-year-old girl named Susie, and a five-year-old boy named James. James has had a number of problems with aggressive and oppositional behavior. After Mary's arrival, James' oppositional behavior escalated and he was observed to engage in masturbation in the public rooms of the house and resisted redirection. He became angry when asked to stop this by his foster mother when he was masturbating in the living room while watching cartoons. He blurted out, "But Mary makes my pee-pee hard." Upon further exploration of this matter, the foster mother discovered that Mary had been sneaking into James' bed at night and fondling his penis. Because the foster parent noticed that Susie had been having difficulty getting to sleep at night and because Susie shared a room with Mary, she talked to Susie about this. Susie indicated that Mary would get in bed with Susie at night and rub against her.

After a couple of months, Mary's appointment at the mental health clinic arrived. Mary's therapist expressed concern that, although a baby monitor had been placed in their room, Susie and Mary continued to share the room. The therapist requested that the foster parent and caseworker meet to develop a treatment plan. They discussed whether Mary needed a separate room from the other children or whether it would be better for Mary to be in a different placement with no younger children. Given the difficulties with James' behavior, it was decided that it was too much to expect the foster mother to manage these three young children all in the same home. Mary was moved to another home that had another older, biological daughter of the foster parent.

Mary began participating in regular treatment, slowly disclosing not only her sexual contact with the other children, but also gradually disclosing her own sexual abuse by multiple perpetrators. Mary had particular difficulty in disclosure of abuse by a man who was also violent with Mary's mother. Soon after this disclosure, the foster parent learned that Mary was drawing pictures of sexual acts at school and giving them to boys in her class.

At what point does supervision start?

At what point should the safety plan be implemented?

Who should be involved in the intervention team?

Using an ongoing assessment approach, at what point would the treatment plan be modified?
At what point would the safety plan be modified?

What should be considered in planning visitation between Mary and her mother? Between Mary and any other relatives?

What should be considered prior to reunification activities between Mary and her mother?

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Children With Sexual Behavior Problems

Participant Manual

Training Developed by Karen Boyd Worley, Ph.D. and Janice K. Church, Ph.D.
Associate Professors with the University of Arkansas for Medical Sciences

U·A·L·R
School of Social Work

CHILDREN WITH SEXUAL BEHAVIOR PROBLEMS
Developed for MidSOUTH by:

Karen Boyd Worley, Ph.D.
Associate Professor
University of Arkansas for Medical Sciences

Janice K. Church, Ph.D.
Associate Professor
University of Arkansas for Medical Sciences

AGENDA

I. Overview of the problem

II. Norms for Children's Sexual Behaviors

III. Continuum of Sexual Behaviors

IV. Identifying Problematic Behavior

V. Development of Sexually Aggressive Behavior in Young Children

VI. Recommendations for Management

- A. Safety Planning
- B. Finding a Treatment Provider

OVERVIEW OF THE ISSUES

Please answer the following questions to the best of your ability:

1. Do you think children are innocent of all sexual knowledge unless they have been abused? At what age is sexual behavior normal?

2. How comfortable do you think adults are with the idea of children showing sexual behaviors?

3. Do you think it makes a difference if a child is sexually abused by another child rather than an adult? If so, how? If not, why not?

4. Do you think that a child who exhibits sexual behavior **must** have been abused?

BEHAVIORALLY BASED REPORTS
UNDER-AGE JUVENILE AGGRESSOR REPORTS

Policy of the Division of Children and Family Services

Behaviorally Based Reports

- Children (usually very young) who are acting out sexually with inanimate objects, with animals, or upon themselves.
- The behavior is out of the range of normal childhood sexual behaviors.
- There has been no verbal disclosure of abuse.
- These reports are referred by the Hotline to DCFS for assessment for supportive services.
- If during the assessment there is a disclosure of sexual activity, the assessor MUST make a report to the Hotline and the report will be investigated by CACD.

Under-Age Juvenile Aggressor

- A report is received by the Hotline alleging behavior by a child under the age of ten that - if true - would result in the child being named as an offender if he or she was 10 years of age or older.
- The child is acting out sexually with other children in a manner that has elements of force and/or compulsion.
- The report will be assessed by DCFS under the same requirements as any other assessment - time frames, required interviews, etc.
- If the report is found to have merit:
  - Worker selects the "Alleged Juvenile Aggressor - Under Age Ten" in the Role In Referral Select box on the Abuse Neglect Screen in Referral or Investigation in CHRIS.
  - Worker selects "**Exempt from Finding (Underage Juvenile Aggressor)"** as the individual finding in the Investigation Findings screen in CHRIS.
  - Worker selects an overall finding for the investigation of true.

Crimes Against Children Division/Division of Children and Family Services Agreement

Reports containing information that children age 9 and under are behaving in a developmentally inappropriate sexual manner, but do not contain allegations of sexual abuse or name an offender will not be registered as child maltreatment, but will be referred to DCFS for an assessment of the family's need for services. If the assessment results in an allegation of child sexual abuse as defined by statute and protocol, the DCFS worker will make a report to the Child Abuse Hotline and, if accepted, be investigated by CACD.

NORMS FOR CHILDREN'S SEXUAL BEHAVIOR

It is critical to understand what constitutes normal or expected behavior in children in order to evaluate problematic sexual behavior.

1. Wide range of "normal" sexual behavior (Gil, in Johnson and Gil, 1993)

a. Ages 0-4: Limited peer contact, self-exploration, self-stimulation, disinhibition

b. Ages 5-7: Increased peer contact, experimental interactions

c. Ages 8-12: Increased peer contact, experimental interactions, disinhibition/inhibition

2. Use of the Child Sexual Behavior Inventory

a. Frequency of Sexual Behavior Among Non-Abused 2-12-Year-Olds

Common Behaviors	***Percent Endorsement***
Shy with men	64.5
Boy-girl toys	53.9
Walks around house in underwear	52.9
Scratches crotch	52.2
Touches sex parts at home	45.8
Walks around nude	41.9
Undress in front of others	41.2

b. Frequency of Sexual Behaviors Among Non-Abused 2-12-Year-Olds

Uncommon Behavior	Percent Endorsement
Puts mouth on sex parts	.1
Asks to engage in sex acts	.4
Masturbates with object	.8
Inserts object in vagina/anus	.9
Imitates intercourse	1.1
Sexual sounds	1.4

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TYPOLOGIES FOR SEXUAL BEHAVIOR PROBLEMS IN CHILDREN
Children's Sexual Behaviors from Normal to Disturbed

Typology developed by Toni Cavanagh Johnson, Ph.D.
1101 Fremont Avenue Suite 101
South Pasadena, California 91030

Normal

- Few to many sexual behaviors
- Intermittent
- In balance with other interests; can start and stop at will
- Silly/giggly. Perhaps parental or religion-induced guilt
- All types of interpersonal relationships
- Similar age peers, friends or siblings
- No coercion, but request or teasing: mutual
- Secret
- Spontaneous/planned
- When discovered, shy, embarrassed, run and hide
- Curiosity/exploration, be like friends, mimic what has been seen. Sexual stimulation.
- Sometimes education of parents and/or children regarding sex and sexuality/values clarification

Sexually-Reactive

- Several problematic sexual behaviors
- Intermittent to frequent
- Out-of-balance with other aspects of life
- Anxious, shameful, guilty, fearful, confused
- May be isolated, unsure, wary in interpersonal relationships
- Similar age play-mates or living companion
- Often no discussion prior to behavior occurring. If discussion, no coercion
- May be observable
- May approach sibling, accessible children, possibly adults
- Spontaneous/impulsive/planned
- May be surprised when discovered (if dissociated at time of sexual behavior) or upset and confused or afraid.
- Anxiety reduction, posttraumatic stress reaction, to reduce confusion, deal with sexual over stimulation, decrease physiological arousal. Sexual stimulation.
- Recent or ongoing sexual abuse, emotional abuse, pornography history of sexual abuse in family, or overtly sexual lifestyle in home.
- Self understanding, make sense of overwhelming experience with sexuality, sex education, parent education and support, treatment plan to modify sexual behaviors

Extensive mutual sexual behaviors

- Many adult like sexual behaviors
- Ongoing
- Pervasive need for reassurance through sexual contact
- Needy, confused, sneaky, “What’s the big deal?” attitude
- Distrusts adults as caregivers/ expects to be hurt, unattached rely on sexual relationship for emotional strength. Vulnerable to victimization by adult due to neediness and confusion. Sexual stimulation.
- Similar age living companion
- Agreement from peer at conscious or unconscious level
- Non-coercive
- Mutual sibling incest or willing children. Sex may become a stable aspect of relationship
- Coping mechanism to decrease isolation or loneliness or neediness. Decrease boredom or depression. Decrease physiological arousal. Sexual stimulation
- Sexual and/or emotional and/or physical abuse. Abandonment, neglect, extramarital liaisons of parents, inadequate early bonding, sexually abused in a group, lack of adult attachments, continuous out of home placements.
- Denies or blames other child or does not see problems with the sexual behavior.
- Increase attachment to adults for emotional and dependency needs, self understanding, make sense of overwhelming experience with sexuality, sex education, parent education and support, treatment plan to modify sexual behaviors.

Children who molest

- Many abusive behaviors
- Previous, ongoing, and increasing. Behavioral pattern
- Preoccupied by sex, sexualizes contact with people and things
- Anxious, angry, aggressive, confused, rageful
- Antagonistic, very limited social skills and relationships with people of any age, no reliable way to get approval. Some children seem emotionally detached and highly manipulative.
- Younger or older children with a 0 – 12 year age difference
- Threats/bribes/trickery/manipulation. Coercions
- Secret
- Forced sibling incest or vulnerable children. May be directed at adults
- Planned/explosive
- Decrease anxiety, fear, loneliness, anger, and abandonment fears. Reduce confusion, recapitulation of previous physical, sexual, or emotional over stimulation. Hurt others, retaliation. Trauma reaction. Sexual stimulation
- Intense rivalry for attention between sibs, lack of positive emotional sex/anger aggression/anxiety. Sexual and/or emotional and/or physical

abuse. Neglect/abandonment. Inherited vulnerabilities, violence in family history, sexualized relationships, sexualized environment in family, poor boundaries, and caretakers with many unmet needs.

- Aggressively and angrily blames other child and/or person who caught them or denies behavior.
- Intensive treatment, skills training. Goals include addressing sexual behavior problems. Intensive treatment of parents, boundary issues, parallel group treatment for children and parents and siblings, family therapy, intense prevention work in family, violence education. relationships, trauma induced neurobiological changes, pairing of

Typology of Observed Sexual Behaviors (Bonner, Walker, & Berliner, 2000)

1. Group I—Sexually Inappropriate Children

   Represents behaviors in which there was inappropriate sexual behavior but not contact with another person. These behaviors included making sexual remarks, gestures, touching or exposing one's self, and the like.

2. Group II—Sexually Intrusive Children

   Composed of behaviors in which the child made sexual contact with another person in an inappropriate manner, but did so only briefly. Behaviors in this group included individuals who ran up to another child and grabbed the child's genitals after which they would retreat and run away; rubbing against another person in a sexually provocative manner; briefly fondling another person but stopping when the other person indicated displeasure; and similar behaviors.

3. Group III—Sexually Aggressive Children

   Involves behaviors in which there was significant or prolonged contact resulting in completion of a sexual act such as oral sex, vaginal or anal penetration, mutual masturbation, and similar behaviors. In most instances, the behaviors in Group III were implicitly and/or explicitly coercive or aggressive.

OPINIONS EXERCISE: SEXUAL BEHAVIORS IN YOUNG CHILDREN

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   Why?_____

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    _____

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16. A child is seen rubbing the family dog's penis.

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    Why?_____

17. A 3-year-old takes the clothes off her Barbie and Ken dolls and simulates intercourse and oral sex while make moaning sounds.

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    Why?
    _____

Range of Intervention for Observable Sexual Behavior of Prepubescent Children

1. Normal/Developmentally Expected

   Genital or reproduction conversations with peers or similar age siblings

   "Show me yours--I'll show you mine" with peers

   "Playing "doctor"

   Occasional masturbation without penetration

   Imitating seduction (i.e., kissing, flirting)

   Dirty words or jokes within cultural or peer group norm

2. Requiring Adult Response

   Preoccupation with sexual themes

   Attempting to expose others' genitals (i.e., pulling other's skirt up or pants down)

   Sexually explicit conversation with peers

   Sexual graffiti (especially chronic or impacting individuals)

   Sexual innuendo/teasing/embarrassment of others

   Preoccupation with masturbation

   Mutual masturbation/group masturbation (although mutual or group masturbation is not uncommon among children, the interaction must be evaluated.)

   Simulating foreplay with dolls or peers with clothing on (i.e., petting, French kissing)

3. Requiring Correction

Sexually explicit conversations with significant age difference

Touching genitals of others without permission

Degradation/humiliation of self or others with sexual themes

Inducing fear/threats of force

Sexually explicit proposals/threats including written notes

Repeated or chronic peeping/exposing/obscenities/pornographic interests, frottage

Compulsive masturbation, which includes vaginal or anal penetration

Simulating intercourse with dolls, peers, animals, with clothing on (i.e., “humping”, “hunching”)

4. Always Problematic; Requiring Intervention

Oral, vaginal, or anal penetration of dolls, children, or animals (Concern about behavior with dolls which may be rehearsals for behavior with peers or more vulnerable children)

Forced exposure of other’s genitals (Although restraining an individual in order to pull down pants or expose breasts may occur in the context of hazing among peers, it is clearly abusive.)

Simulating intercourse with peers with clothing off

Any genital injury or bleeding not explained by accidental cause.

SAFETY PLANNING

RECOMMENDATIONS FOR INTERVENTION FOR CHILDREN WITH SEXUAL BEHAVIOR PROBLEMS

- Assessment (by trained professional)
- Specialized treatment in some cases
- Safety Planning

SAFETY PLANS FOR CHILDREN WITH SEXUAL BEHAVIOR PROBLEMS

Safety planning and reunification philosophy should be *victim-centered.*

Supervision Conditions:

- Specialized to include conditions that address the issues identified in the assessment process
- Should be incorporated into formal orders and treatment contracts
- May include
    - Restrictions on contacts with other children
    - Restrictions on activities
    - Guidelines for privacy in dressing, using the bathroom within the home
    - No substance abuse or violence in the home
    - Completion of specialized treatment
    - No use of pornography, “R” rated movies, or phone sex lines
    - Limited/monitored use of the internet

Why involve schools?

- Moral dilemma – to tell or not to tell?
- Protect victims in the same school
- Enhance community safety/supervision

How schools can be involved

- Releases signed
- School notified
- School representative involved with treatment/case management team
- School advised of restrictions on behaviors and how to respond
- Schools know who to contact to address questions and concerns
- Schools learn how they can support positive changes and treatment goals
- Confidentiality stressed

Why safety plans?

Protection of the victim
Protection of the community

Protection of the child with sexual behavior problems from the appearance of risk

When is a safety plan needed?

Upon disclosure

Safety planning is an ongoing activity

Who can supervise?

- Responsible adult aware of the child's history and safety plan
- If victim involved in visitation, victim should feel comfortable with this person and be willing to disclose concerns

Reunification/reintegration activities when child with sexual behavior problems has been removed from home because younger/more vulnerable children or victim lives there.

- Initial visits are brief and in a neutral setting
- Move to longer time periods, eventually in home
- Victim impact closely monitored

Safety plan addresses:

- Level of contact with victim and other vulnerable targets
- If contact with victim allowed
- Dressing/bathing/ general dress in the household
- Pornography/movies with sexual or violent content
- No substance use
- No violence in the home
- Sexually abusive youth does not baby-sit; does not assume role of authority over younger children
- Sexually abusive youth does not share a bedroom with a younger or more vulnerable child
- May include mechanical devices such as alarms, motion detectors, or baby monitors.
- Special conditions

Success of community reintegration depends on:

- Victim-focused approach
- Specialized treatment for the child with sexual behavior problems
- Collaborative effort
- Reintegration planning from the beginning
- Ongoing assessment

SAMPLE SAFETY PLAN

Name: _____ Date: _____

_____ Child will not have any unsupervised contact with other children under any circumstances**. (NO BABYSITTING**. No unsupervised contact with children in the home. No unsupervised play with children in the neighborhood, etc.)

_____ There will be no nudity or partial nudity in the home.

_____ There will be no open displays of sexual behavior by any members of the household.

_____ There will be no pornographic or sexually explicit material in the home.

_____ There will be no viewing of movies or shows depicting sexualized violence or deviant sexuality (no "slasher" films). No sexually explicit and/or violent music lyrics. No unsupervised access to the Internet.

_____ Child will sleep alone in his/her own bed in his/her own room. Child should not be up after other children and adults have gone to bed.

_____ Child will bathe and change clothes alone behind closed door.

_____ Siblings will not enter child's bedroom for any reason. Child will not enter sibling's bedrooms for any reason. All interactions will be in "public" parts of the house.

_____ Child will not have close physical contact with other children. (Younger children will not be held by patient. No full-body or lengthy hugging with other children.)

_____ Child will not assume a role of authority or supervision over younger children.

_____ There will be no physical violence in the home.

_____ No use of drugs or alcohol in the home other than medications prescribed by physician.

_____ Parents will be informed and in agreement with the whereabouts of child at all times.

Other:

_____

_____

__

Signatures:

_____ _____
Child Parents or Legal Guardian

_____ _____
Therapist Probation Officer or Caseworker

Case Example Discussion

A seven-year-old girl named Mary was placed in foster care because her mother was in jail on drug-related offenses. She had previously been bounced from home to home with relatives or friends of her mother's for weeks or months at a time. There is no known report of physical or sexual abuse on this child, but previous reports of neglect.

In the foster home, there are two younger children, a four-year-old girl named Susie, and a five-year-old boy named James. James has had a number of problems with aggressive and oppositional behavior. After Mary's arrival, James' oppositional behavior escalated and he was observed to engage in masturbation in the public rooms of the house and resisted redirection. He became angry when asked to stop this by his foster mother when he was masturbating in the living room while watching cartoons. He blurted out, "But Mary makes my pee-pee hard." Upon further exploration of this matter, the foster mother discovered that Mary had been sneaking into James' bed at night and fondling his penis. Because the foster parent noticed that Susie had been having difficulty getting to sleep at night and because Susie shared a room with Mary, she talked to Susie about this. Susie indicated that Mary would get in bed with Susie at night and rub against her.

After a couple of months, Mary's appointment at the mental health clinic arrived. Mary's therapist expressed concern that, although a baby monitor had been placed in their room, Susie and Mary continued to share the room. The therapist requested that the foster parent and caseworker meet to develop a treatment plan. They discussed whether Mary needed a separate room from the other children or whether it would be better for Mary to be in a different placement with no younger children. Given the difficulties with James' behavior, it was decided that it was too much to expect the foster mother to manage these three young children all in the same home. Mary was moved to another home that had another older, biological daughter of the foster parent.

Mary began participating in regular treatment, slowly disclosing not only her sexual contact with the other children, but also gradually disclosing her own sexual abuse by multiple perpetrators. Mary had particular difficulty in disclosure of abuse by a man who was also violent with Mary's mother. Soon after this disclosure, the foster parent learned that Mary was drawing pictures of sexual acts at school and giving them to boys in her class.

Discussion Questions:

At what point does supervision start?

At what point should the safety plan be implemented?

Who should be involved in the intervention team?

Using an ongoing assessment approach, at what point would the treatment plan be modified?

At what point would the safety plan be modified?

What should be considered in planning visitation between Mary and her mother? Between Mary and any other relatives?

What should be considered prior to reunification activities between Mary and her mother?

CLINICAL EVALUATION

These guidelines are taken directly from Gil and Johnson's <u>Sexualized Children: Assessment and Treatment of Sexualized Children and Children Who Molest</u>.

1. Prior to the Interviews

    a. Review child protective services records.

    b. Review law enforcement records.

    c. Review data from previous therapists.

    d. Review data from previous placements.

    e. Review or obtain historical information about the child's sexual behavior problems, i.e., the types, duration, and progression of severity of the problem.

2. Who Participates?

    a. The parents or primary caregivers.

    b. The sexualized child.

    c. Siblings (using clinical judgment).

3. The Parent Interview

    a. Assess their behavior management techniques, parenting skills, and level of concern about the problem.

        What is their reaction to the child's sexual behavior?

        How are they managing the child?

    b. Assess their ability to provide adequate supervision.

        Make no assumptions about the parents' reaction to or interpretation of the child's sexual behaviors or their belief in the seriousness of the child's problem.

    c. Begin to assess family dynamics.

Are there divisions of loyalty within the family?
Is there secrecy, hurt, disruption within the family?
What are the parents' feelings about the child?

d. Obtain a standard developmental history (birth to present).

e. Assess the parents' psychological needs and defenses, level of available emotional and psychological resources.

What is the sexual history of the parent?
Is there any history of sexual abuse in the parent's life?
What is the current level of functioning of the parent?
What is the parent's history of interpersonal relationships?

f. Assess history and level of physical and sexual violence within the family, past and present.

Has the parent sustained abuse from partners?
Have the children witnessed this?
Has physical violence been paired with sexual aggression?
Has physical punishment been used to stop the problematic sexual behaviors of the child?

g. Genogram may be used to assess context of child's development and intergenerational patterns.

History of births and deaths.
History of marriages, divorces, cohabitations.
History of alcohol and drug abuse.
History of incarceration.

h. Assess boundaries within the family.

How do the parents manage the toileting and bathing/dressing of the child?
What are the sleeping arrangements?
What are the parents' views on their own nudity/attire in the child's presence?
What are the parents' sexual behaviors in the presence of the child?

i. Assess religious background of the family.

How morally charged is the issue of sexuality?

What are the parents' beliefs about masturbation?
Are the parents sexually repressed?
Does the religious belief system provide positive aspects to the family's coping?

j. Assess culture and values.

Ethnicity.
Environment/neighborhood.
Socioeconomic level.
Parents' choice of friends and support systems.

4. The Interview with the Sexualized Child

a. Assess the nature of the child's problematic sexual behaviors.

The behaviors the child discloses may be quite different from what the adults know.

"Do you think you have a problem with touching?"
"Even though I know some things about you and the touching, I would like you to tell me in your own words."
"If you feel like you want to say something that is not true, I would rather you tell me you don't want to answer right now."

Where did the behaviors occur, why was that location chosen, where were the parents, and did the child want the other child to keep it quiet?

b. What was the child's motivation for the problematic sexual behavior?

"Any ideas why you…?"
"Kids have told me that they touch other kids:
'cause they want to,
'cause they feel mad or bad or sad,
'cause they like to,
'cause the other kid likes them to do the touching,
'cause it feels good,…."

c. Assess the child's feelings about sexuality.

Group I Children (Normal Sexual Exploration):
giggly or silly about sexuality.

Group II Children (Sexually Reactive):

shame and guilt and anxiety about sex.

Group III Children (Extensive Mutual Sexual Behaviors):
may experience anxiety or guilt, but they may also have a cavalier or ho-hum attitude and do not understand the concern of the adults about their sexual behaviors.

Group IV Children (Children Who Molest):
volatile affect, generally with very aggressive and anxious features (rage, fear, grave sadness, jealousy, extreme loneliness, etc.) associated with sexuality.

d. Who else knows about the problematic sexual behavior?

e. What is the child's desire to change their problematic sexual behavior?

f. Assess denial, misrepresentation, or minimization of problematic sexual behaviors.

g. Assess the child's understanding of others' concerns about their problematic sexual behaviors.

Child may be mirroring sexual behaviors that occur in the home or neighborhood.

h. Assess the child's willingness to accept responsibility for the problematic sexual behavior.

Generally a high correlation exists between the parents and the child in this regard.

i. What are the child's feelings about the child with whom the problematic sexual behaviors occurred?

Group IV Children (Children Who Molest) generally do not engage in sexual behaviors with friends, because many have no friends. They often choose someone about whom they have underlying negative feelings.

"Why did you pick that child?"

j. Does the child have fantasies or daydreams that may propel them to act out sexually and/or aggressively?

k. How does the child feel before and after engaging in the problematic sexual behavior?

l. Has the child witnessed sexual behavior on videos or television or in printed material?

m. Has the child been physically or sexually abused? What was their response to the abuse?

n. Does the child feel that people in their home environment are overly sexual?

o. Where and with whom does the child feel most safe and least safe?

p. Assess the child's developmental and intellectual level.

q. Assess the child's strengths and weaknesses.

> "What are some of the things you do best?"
> "What are some of the things that make you feel good about yourself?"
> "Are there some things about you which you think are not so great?"
> "Are there any things you would like to change about you?"
> "What is the best thing you ever did? The worst thing you ever did?"
> "What makes you feel proudest? What was your biggest disappointment?"

r. Assess other areas of emotional and behavioral difficulty described by the child.

s. Determine the child's perception of their school performance and peer relations.

> "Some kids like school, some kids hate school and some kids are kind of in-between. What about you? Do you like school? What is your favorite thing to learn? What is your worst thing to learn? Do you have friends at school?"

t. Assess the child's willingness and ability to connect with the therapist and their suitability for group therapy.

u. Assess for psychiatric disturbances.

v. Assess use of alcohol and other drugs.

w. Assess risk factors.

WHAT TO LOOK FOR WHEN SELECTING A TREATMENT PROVIDER FOR MANAGEMENT OF CHILDREN'S SEXUAL BEHAVIOR PROBLEMS

1. Therapist should be familiar with normal child sexual development.

2. Therapist should be willing and able to work well with both children and their parents.

3. Therapist should be comfortable openly discussing sexual behaviors with youth and parents alike.

4. Therapist should conduct a thorough assessment of therapeutic needs, be flexible and creative in tailoring treatment to specific therapeutic needs, and continue to monitor/evaluate needs over the course of treatment and make modifications in intervention strategies accordingly.

5. Therapist should have skills in cognitive-behavioral therapy, play therapy, social skills training, and self-esteem building.

HANDOUT 1

GETTING TO KNOW YOU

1. What is your name?

2. What is your job title (FSW, Supervisor, Foster Parent, Community Provider, etc)

3. The title of this workshop is Children with Sexual Behavior Problems. If I could learn just three things during this presentation they would be (expectations and hopes for the workshop):

a.

b.

c.

HANDOUT 2

Red Flags Regarding Children's Sexual Behaviors (Cavanaugh Johnson)

1. The children involved in the sexual behaviors do not have an ongoing mutual play relationship.

2. Sexual behaviors are engaged in by children of different ages or developmental levels.

3. Sexual behaviors are out of balance with other aspects of the child's life and interests.

4. Children seem to have too much knowledge about sexuality and behave in ways more consistent with adult sexual expression.

5. Sexual behaviors are significantly different than those of other same-age children.

6. Sexual behaviors that continue in spite of consistent and clear requests to stop.

7. Children who appear to be unable to stop themselves from engaging in sexual activities.

8. Sexual behaviors that occur in public or other places where the child has been told they are not acceptable.

9. Children's sexual behaviors are eliciting complaints from other children and/or adversely affecting other children.

10. Children's sexual behaviors are directed at adults who feel uncomfortable receiving them.

11. Children (four years and older) do not understand their rights or the rights of others in relation to sexual contact.

12. Sexual behaviors progress in frequency, intensity or intrusiveness over time.

13. Fear, anxiety, deep shame or intense guilt is associated with the sexual behaviors.

14. Children engage in extensive, persistent mutually agreed upon adult-type sexual behaviors with other children.

15. Children manually stimulate or have oral or genital contact with animals.

16. Child sexualizes nonsexual things or interactions with others.

17. Sexual behaviors that cause physical or emotional pain or discomfort to self or others.

18. Children use sex to hurt others.

19. Verbal and/or physical expressions of anger precede, follow or accompany the sexual behavior.

20. Children use distorted logic to justify their sexual actions.

21. When coercion, force, bribery, manipulation or threats are associated with sexual behaviors.