Responding to Sexual Behavior Problems in Children Twelve and Under

NYS Coalition for Children’s MH Services

NYS Office of Mental Health

Staff Development Training Forum

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Agenda

- Child sexual behavior overview
  - Normal and naturally occurring child sexual behaviors
  - Sexual behavior problems
- Legal issues and placement decisions
- Assessment
  - Referral
  - Helpful tools and instruments
  - Written report
- Intervention
  - Parental response and supervision
  - Treatment
Change in young children’s sexual behavior requires a change in their environment.

Bonner & Silovsky, 2002
Becky and Diane

- Becky, age 11, charged as JD for incident when she was 9 and placed her mouth on younger sister Diane’s vagina
- Diane, age 9, charged as JD for four sexually aggressive incidents with 5 year-old girl
- Diane’s behaviors included humping on top of girl with clothes on, putting finger in girl’s vagina, licking the girl’s vagina, and forced kissing
Sammy

- 9 year-old boy referred by MH
- One known occasion when Sammy bribed 3 year-old neighbor boy to allow him to put penis against child’s buttocks
- From age 4-6 Sammy was sexually abused by 13 year-old male neighbor
- During time of his victimization Sammy attempted sexual behaviors with his older sister and younger half-brother
Niles

• 10 year-old boy referred by Family Court
• On numerous occasions fondled chest, buttocks, and vagina of 4 year-old adoptive sister
• One instance when he inserted toy thermometer in her vagina and the girl told her mother immediately

• Charged in JD petition with Sexual Abuse 1
Johnson & Mitra, 2007

- 339 U.S. child welfare and MH professionals were asked about their childhood sexual behavior
- 72% recalled engaging in solitary sexual behavior prior to age 12
- 73% recalled engaging in sexual behaviors with other children
- 48% reported self-exploration of genitals
- 34% showed private parts to others
- 32% looked at sexual pictures
- 21% masturbated to orgasm
- 16% reported simulated sex with another child
Lamb & Coakley, 1993

- 128 undergraduates at women’s college surveyed regarding childhood sexual games
- 85% described memory of playing sexual game
- Median age 7.5 years at time of incident
- Playing doctor, exposure, experiments in stimulation, kissing games
- Involvement of cross-gender play more likely to have included manipulation or coercion
Normative Sexual Behavior in Children
Friedrich, Fisher, Broughton, Houston, & Shrafton, 1998

• Sample of 1,114 children ages 2-12 with sexual victimization screened out
• Primary female caretakers reported
• Frequency of sexual behaviors peaked at age 5
• Most frequent behaviors: self-stimulation, touching breasts, and exhibitionism
• More intrusive sexual behaviors much less frequent
• Sexual behaviors significantly linked to family violence and high stress families
### Percentage of Male Children Reported by Caregiver to Have Engaged in Sexual Behaviors

*Friedrich, 1998*

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<thead>
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<th>2-5 years</th>
<th>6-9 years</th>
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<td>Touches breasts</td>
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<td>Self-touching in public</td>
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<td>Tries to look at people nude</td>
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<td>6</td>
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<td>Exposing to adults</td>
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## Percentage of Female Children Reported by Caregiver to Have Engaged in Sexual Behaviors

*Friedrich, 1998*

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<td>Self-touching at home</td>
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<tr>
<td>Touches breasts</td>
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<td>Stands too close</td>
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<tr>
<td>Exposing to adults</td>
<td>14</td>
<td>5</td>
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Natural Child Sexual Behaviors = Learning and Exploration

• Copying and mimicking adult behaviors and gender roles (dating, marrying, playing doctor, playing house, touching, looking, humping, etc.)

• Unlike adults, children generally are not seeking emotional connections and intimate relationships through these behaviors, but are exploring, learning, and experimenting

• Most of these behaviors are not driven by the desire for sexual arousal, physical gratification, or orgasm
Normative Sexual Behavior

- Occurs spontaneously and intermittently
- Is mutual and non-coercive when it involves others
- Does not cause emotional distress
- Does not reflect sexual preoccupation
- Usually does not involve advanced sexual behaviors such as sexual intercourse or oral sex

ATSA Task Force Report on Children With Sexual Behavior Problems
(2006)
Natural Childhood Sexual Behaviors

• A child’s sexual exploration that is healthy and natural may result in embarrassment but does not leave deep feelings of anger, shame, fear, or anxiety.

• If discovered in healthy sexual exploration and instructed to stop, the behaviors will generally diminish.

• The feelings children have regarding healthy and natural sexual play are generally light-hearted and spontaneous.

• Usually children engaged in natural sexual behaviors experience pleasurable sensations from genital touching, and some children may experience sexual arousal or orgasm.

Toni Cavanagh Johnson, Ph.D.
Where do children and adolescents get their sexual information?

- Self-touching
- Sexual play
- Observing adults and older children
- Hearing older children, siblings, or adults talking
- Mainstream media
- Pornography
- Sexual victimization experiences
- School
- Parents
Continuum of Child & Adolescent Sexual Behavior Problems

- Sexually reactive or sexualized children
- Children engaged in extensive mutual sexualized behaviors
- Sexually abusive children
- Adolescent sexual offending behavior
A Proposed Sorting Technique

- Developmentally expected
- Interpersonal, unplanned
- Self-focused
- Interpersonal, planned
- Interpersonal, coercive

D. Hall, 2002
Sexually Reactive Children

• Pre-pubescent children who have been exposed to or had direct contact with inappropriate sexual activities, and have thereafter engaged in or initiated sexualized behaviors

• This can include a range of sexual activity, including sexually aggressive or sexually abusive behaviors

• Children ages 11 or younger

• Children ages 12 or 13 can be considered sexually reactive if they appear to be responding to an explicit sexual experience taking place during the previous 12 months

Phil Rich 2006
Characteristics of Problem
Child Sexual Behaviors

- Developmentally incongruent
- Premeditated
- Coercive
- Aggressive
- Obsessive
- Pervasive
- Excessive frequency or duration
Determining If A Child’s Interpersonal Sexual Behaviors Are Abusive

- Consider the child’s age
- Consider the child’s motivation
- Consider the nature of the child’s known sexual behaviors
- Consider the nature of the relationship
- Do the behaviors stop after adult intervention
- Does frequency exclude normal child activities
- Do behaviors cause fear or anxiety in other children
Common Characteristics of Children with SBP

- Other behavioral/emotional problems
  - ADHD, ODD, PTSD, Conduct Disorder, Attachment
- Internalization of symptoms
- Limited coping
- Social and interpersonal problems
- Parent-child relationship problems
- Stressful family/home environment
Basic Intervention Philosophy

Sexualized behavior in young children does not reflect a ‘character defect’ or ‘addictive behavior’

Change in young children’s sexual behavior requires a change in their environment

Children’s sexual self-concept and awareness develops from messages given by their caregivers

Adapted from Bonner & Silovsky (2002)
In Cases of SBP in Young Children

- Formal charges and Court intervention, generally speaking, is the response of last resort.

- The filing of a petition against a young child can be a tool used to help organize and slow down a confusing or chaotic situation.

- Adjudication of a young child may be necessary and helpful in a few, more extreme situations where circumstances require extended external control and structure, or residential placement / out of home care is required.
Incidence of Legally Charged Sexual Abusing in Young Children

U.S. Dept. of Justice Statistics, 2009

- **Children Under Age 10**
  - committed 0% of all reported forcible rapes
  - committed 0% of other reported sexual offenses

- **Children Age 10-12**
  - committed 1% of all reported forcible rapes
  - committed 2% of other reported sexual offenses
The Task Force does not support the differential application of the normal adjudication decision-making process for children with SBP as compared to similar age children who may have engaged in other behaviors that would be serious crimes (e.g. assault, theft). Legal authorities routinely make case-by-case judgments about what steps are necessary when children and youth engage in seriously inappropriate or victimizing behavior, and sexual behaviors should not be a special exception to this rule. In some cases, adjudication may be helpful in securing needed services, protecting communities, or an appropriate response to particularly egregious behavior. However, simply because a child’s behavior was sexual in nature should not suggest any unique adjudication priority.

ATSA Task Force on CSBP, 2006
Placement Decisions

• Most children with SBP can be safely dealt with at home or in community family-based care (relative, foster home).

• In severe cases, residential placement should be considered:
  – Is caregiver unable to provide good supervision?
  – Does child continue with aggressive sexual behavior despite good supervision?
  – Are other children in the home at risk?
• Only 12-15% of prosecuted cases involve any physical evidence.

• Children heal quickly and even in cases where significant physical trauma has occurred there may be no medical evidence after four weeks.

• 1/3 of sexually abused children show no symptoms.

• There is no diagnostic criteria for child sexual abuse. There is no “child sexual abuse syndrome.”

• The determination of sexual abuse requires a skilled forensic interview and a subsequent legal finding.
• Deciding whether or not a child has been sexually abused is not a clinical task, it is an investigative task.

• The purpose of a forensic interview is to gather facts and information to be used in a possible prosecution or adjudication process.

• A clinical assessment will gather and summarize information regarding a child’s problem behaviors and symptoms, offer a framework to explain and understand the behaviors, and recommend possible ways to intervene.
Forensic Interview

• Gather facts, evidence, information about what happened
• Not necessarily concerned with the “why” question
• Results may be used in subsequent prosecution or adjudication process
• Results may also assist in development of clinical assessment

Clinical Assessment

• Gather and organize information regarding a child’s problem sexual behaviors
• Offer a formulation to help explain and understand the origin and course of the behaviors
• Recommendations for supervision, treatment, and placement
Informed Consent

• The child’s parent or guardian should be provided very clear information regarding the purpose for the evaluation, the information to be included in the report, and with whom the information and final report will be shared.

• Everyone should be made aware of any pending legal issues, such as whether or not the child is facing potential petitioning to Family Court.

• If there are unresolved legal questions at the time of the assessment referral, some arrangement should be made in the legal system to assure the child and parent that information in the assessment will not be used as an adjudication tool.
The Assessment Referral Process

- The referral is a crucial part of the assessment

- The request for assessment needs to be as clear and specific as possible:
  - Who is the primary referral source?
  - Why now?
  - What specific questions is the referral source seeking to have answered?
  - Who will see the evaluation report and how will the information be used?
The Assessment Referral Process

• **Collateral documentation requested or provided**
  – chronological, detailed summary of problem sexual behaviors
  – legal documentation if appropriate
  – previous evaluations, treatment summary, school records, psycho-social history, medical history, etc.

• **Determine who will participate in evaluation interviews**
The Task Force believes that for most cases it is unnecessary to conduct broad ranging assessments with extensive testing across many sessions. Rather, in many cases, the necessary assessment information can be obtained from review or background materials, taking a basic behavioral and psychological history from parents or caregivers, a basic assessment interview with the child, and administration of a few simple assessment instruments. This can be accomplished in a limited number of assessment sessions, and often in a single session. In cases where there are complicated diagnostic issues, more extensive assessments are warranted.

ATSA Task Force on CSBP, 2006
Child Sexual Behavior Inventory
Friedrich, Fisher, Dittner, et.al. 2001

- Sexual behaviors of 1,114 children screened for SA were compared to 620 sexually abused children, and 577 children in outpatient MH; all children ages 2-12
- Designed to assess children who were sexually abused or suspected of being abused
- Caretaker rates child on 38 sexual behaviors in 9 domains
- Domains include boundary issues, exhibitionism, gender role, self-stimulation, sexual anxiety, sexual interest, intrusiveness, sexual knowledge, voyeurism
- SA children showed greater frequency of sexual behaviors
- SA children had more aversive and stressful living environments
Child & Adolescent Needs and Strengths (CANS)
John Lyons, Ph.D.

- Functioning
- Risk Behaviors
- Mental Health Needs
- Care Intensity and Organization

- Caregiver Capacity
- Strengths
- Characteristics of Sexual Behavior
Anatomical Drawings
Risk Factors for Sexual Aggression
Hall, Mathews, Pearce (1998)

• Checks for presence of 25 factors in five categories regarding child, caregivers, history
  • Sexual abuse experience of child (as victim)
  • Child characteristics
  • Child’s history
  • Parent-child relationship
  • Caregiver characteristics
Issues to Explore During Assessment

- Is there a “sexual climate” in the family?
- Parent-child conflict and attachment issues
- Unresolved sexual abuse, child or parent
- History of physical abuse for child
- History of emotional abuse or neglect, child
- Inadequate monitoring

Friedrich, 2005
General Guidelines for Written Report

• Gather information from multiple sources, and identify sources clearly. Don’t leave the reader of your report asking, “Where did that bit of information come from?”
• Be aware of the limitations and level of reliability of your information, and state reservations clearly.
• Include informed consent from caregivers and if appropriate from the child.
• Identify and briefly describe instruments or measurements used.
• The first goal of the report should be to communicate clearly what you are saying, including answers to the evaluation questions or recommendations offered.
• Avoid vagueness, overstatement, and don’t be afraid to say “I don’t know.”
Suggested Content of Written Report

- Identifying demographics
- Reason for referral, questions to be answered
- Sources of information
- Informed consent
- Official, documented description of problem behaviors
- Mental status and relevant background information
- Family’s current discussion of the problem behaviors
- Summary of needs, strengths, and protective factors
- Answers to referral questions
- Recommendations for placement, supervision, and treatment
Evaluation Questions From Court

• Are Diane’s sexual behaviors representative of normal childhood sexual exploration?

• Has Diane been exposed to age-inappropriate sexual activity?

• Has Diane been sexually victimized?
Talking to Children About Their Sexual Behavior Problem

- Don’t over or under-react. Talk in a calm, matter of fact manner.
- Understand and normalize a child’s curiosity.
- Clearly explain rules and limits.
- Don’t heap shame or guilt on child.
- Talk about healthy touches.
- Teach proper names for body parts.
- Don’t stop showing and modeling affection.
Two Requirements for Good Supervision and Safety Planning

• Caution
• Common Sense
Safety Planning In a Nut Shell

- What are the risks involved in whatever is being proposed?
- What needs to happen to moderate and lessen those risks?
- Are those things possible?

Gail Ryan, Kempe Center
Components of Good Safety Plan

- Close supervision
- Child bathes and sleeps alone
- Clear privacy and touching rules for family
- Adults model modesty in dress and behavior
- No exposure to sexual media of any kind
- Plan for monitoring child outside home
- Reinforce child’s compliance
- Teach and model healthy, okay touching
Sexual Behavior & Privacy Rules

- No touching other people’s private parts
- No other people touching your private parts
- No showing private parts to other people.
- Touch your private parts only when alone in your room
- Keep safe distance when with friends, family
- Wear clothes when outside the bathroom
- Don’t say sexual words to friends and family
- Keep door closed when changing clothes
The Therapist’s Classic Tools

- Joining
- Listening
- Questioning
- Clarification
- Reframing
- Interpretation
- Validation
- Reflecting
- Direction

- Confrontation
- Use of affect
- Humor
- Self-disclosure
- Role playing
- Paradox
- Expanding system
- Ritual
Ten Year Follow-up Supports Cognitive-Behavioral Treatment for Children with Sexual Behavior Problems
Carpentier, Silovsky, Chaffin
2006

- 135 children age 5-12 with SBP compared to 156 children with no SBP and followed for ten years
- 2% of children in 12-session cognitive-behavior therapy demonstrated further sexual behavior problems
- 10% of children provided group play therapy demonstrated additional problem sexual behaviors
- 3% of control group of general clinic children who had no previous sexual behavior problems demonstrated problem sexual behaviors during 10 year follow-up
Outline of Sample Short-Term Group C-B Treatment

• Session 1: Introductions; information about the group program, i.e. all kids are there for the same problem; model how group sessions will be run; confidentiality and other group rules

• Session 2: Review group rules; definition of “private parts” and sexual behavior rules; sensitivity to abusive experiences of children in the group
Outline of Sample Short-Term Group C-B Treatment

• Session 3 & 4: Review previous material; teaching about feeling identification; learning appropriate anatomical terms; encourage children to disclose when they have broken a sexual behavior rule; avoid using terms “abuse” and “victim”; support and praise children who disclosed; associate sexual rule breaking with feelings
Outline of Sample Short-Term Group C-B Treatment

• Session 5: Review previous material; teaching impulse control with “Turtle Technique,” i.e. stop, go into shell, relax, think about options, choose one, do it

• Sessions 6 & 7: Review earlier material; continue promoting disclosure of examples of when sexual behavior rules were broken; apply Turtle Technique to a variety of situations
Outline of Sample Short-Term Group C-B Treatment

• Session 8: Information about private parts and their functions; sexual abuse prevention principles and what to do if someone tries to break sexual behavior rules

• Session 9: Review previous material; continue to discuss situations when group members have broken sexual behavior rules; apply Turtle Technique to a variety of situations
Outline of Sample Short-Term Group C-B Treatment

• Session 10: Review of information about private parts; teach abuse prevention principles

• Session 11: Review important skills gained over the course of the group, including sexual behavior rules, sex education information, abuse prevention skills, and Turtle Technique; present various scenarios and ask children what they would do
Outline of Sample Short-Term Group C-B Treatment

• Session 12: Quick review of skills learned; opportunity to say good-bye to group and provide structured and guided opportunity for children to express feelings about the group and its ending; providing certificates of completion to recognize participation and achievement; each child allowed to choose a prize from the prize basket.
Silovksy, Bard, St. Amand 2008

- 11 outcome studies analyzed
- 18 different treatment approaches included
- Treatment elements taken from adolescent or adult models (RP, assault cycle) not effective
- Pure CBT or unstructured play therapy not effective
- Treatment elements most strongly correlated with reduction in SBP were parenting skills and teaching of behavior management skills
- Other important treatment elements: sexual rules, sex education
Factors Important in the Treatment of Children with Sexual Behavior Problems

• Treatment should directly address the sexual behavior problem

• Behavioral, family-focused, cognitive-behavioral, and psycho-educational approaches more effective than unstructured supportive or play therapy

• Effective treatment should directly involve the parent or caretaker

• Effective treatment teaches impulse control skills, sex education, coping strategies, boundary issues, and improves parent/child relationships

• Treatment for sexually or other traumatized children needs to blend focus on the trauma symptoms and the sexual behavior problem
Parent-Child Interaction Therapy
Hembree-Kigin & McNeil, 1995

- Assumes treatment progress is significantly tied to addressing parent-child relationship problems
- Increase number of daily positive interactions
- Alter and diminish parents’ negative view of child
- Connect SBP to precipitating events to make it more understandable and seem more solvable
- Teach parents use of praise and corrective phrases
- Instruct parents in limit-setting and consistency
- Therapist uses active coaching with parents
PTSD

Powerful Tough Stuff to Deal With

W. Friedrich, 2005