

**CHILDREN WITH SEXUAL BEHAVIOUR PROBLEMS:  
CURRICULUM FOR PARENTS AND EDUCATORS**

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## **Abstract**

The issue of child sexual abuse and the disturbing trend of sexual offending of children by children is causing alarm among many parents and educators. The study of children with sexual behaviour problems is a new and developing field. Information on normative sexual behaviour in children, definitions and classifications of inappropriate sexual behaviours, assessment, and treatment of children with sexual behaviour problems, is now emerging in the research literature.

This curriculum is designed for parents and educators who are seeking current information and helpful perspectives regarding children with sexual behaviour problems.

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The issue of sexual abuse began to emerge in the public's awareness over two decades ago. Much has been learned in the past twenty years about the sexual abuse of children by adult offenders. Researchers have been investigating and analyzing the many aspects of child sexual abuse, including its prevalence, dynamics, causes, effects, and treatment. In the early 1980s, a new category of offender was identified, the adolescent sex offender. Social workers and therapists began to acknowledge that particular behaviours constituted sexual abuse, even if they were committed by adolescents. In more recent years, an alarming and controversial phenomenon has come to light, sexual offending of children by children.

The study of sexual victimization and perpetration by children is in its infancy. Clinicians and researchers are grappling with definitions and classifications, determining abusive versus consensual acts, clarifying normal and abnormal sexual behaviour in children, developing assessment tools, and examining treatment approaches. While research on children with sexual behaviour problems is beginning to be published in professional journals and in specialized texts on the subject, relatively little information has been disseminated to the general public.

In recent years our society has been inundated with news reports about the sexual molestation of children by adult males. Although reports of adolescent and child offenders rarely come to media attention, parents and educators are beginning to voice their concerns and question the intrusive

sexual behaviour of some children. Child therapists are responding to an increasing number of requests for information and advice regarding developmentally appropriate sexual behaviour for children.

## **Rationale For The Curriculum**

Child sexual abuse is a widespread problem that will touch the lives of many children. The effects of sexual abuse are substantial, not just in terms of its prevalence and impact on victims and families, but also because of its long term social costs. Children are entitled to be protected from sexual abuse and threat from harm. To ensure the safety of children, adults who live with and work with children need to be educated about sexual abuse issues.

Parents and educators are in positions to teach children about sexual abuse prevention. Sexual abuse can occur very early in a child's life and parents may be the only adults who are in the position to recognize the danger signs of sexual abuse and ensure the safety of the youngster.

Some parents are opposed to public school instruction in sex education and prefer to educate their own children in sex education matters. In order to impart accurate and useful prevention information about child sexual abuse, parents need access to current information. The difference between appropriate and inappropriate sexual behaviours needs to be discussed openly by parents so that children receive two very clear messages, that they can say

“no” and that certain behaviours are unacceptable. It is crucial that children be given accurate and useful information so that they can understand the risk of abuse and how to protect themselves.

The most serious omission in discussions of sexual abuse relates to the topic of offenders. Many parents only talk to their children about the possibility of abuse by strangers. The issue of abuse by family members or other children goes largely unmentioned. Most children are not sufficiently informed about the possibility of sexual abuse by other children.

Many parents are uncomfortable speaking to their children about sexuality and sexual abuse. This discomfort may result in the failure to address these serious concerns. Some parents feel that they lack knowledge, vocabulary, and experience in speaking about sexual matters. Parents need to be aware of the possible consequences of not safeguarding their children with adequate information. Unless a parent or educator is armed with clear, concise, and accurate information, the topic becomes even more difficult to discuss. Parents and educators are important sources of information on child sexual abuse from whom children can learn protection and personal safety.

This curriculum provides accurate, research based information on the issues of sexual abuse and children with sexual behaviour problems. It is designed for parents, educators, and other adults who work with children in either a professional or a volunteer capacity. Parents of children who have experienced sexual abuse and/or are manifesting symptoms of sexual



behaviour problems will have a particular interest in this course. The topic of sexual abuse and the issue of children with sexual behaviour problems is controversial and highly sensitive. It is anticipated that some of the adult participants in the course will have had prior personal experience with sexual abuse. Statistics confirm the widespread prevalence of sexual abuse and research identifies familial and intergenerational patterns of abuse. In addition to having concerns about their own children or other children, some adult participants may be coping with their own anxieties and fears related to abuse.

## **Literature Review**

The major themes and issues that emerge in the literature are as follows: the problem, the extent of the problem, the effects of child sexual abuse, the debate over labelling and classifying, childhood sexuality, problematic sexual behaviours, theories on sexual offending, psychological profiles of children with sexual behaviour problems, family environments, assessments, treatment, parent training and community education.

The study of children with sexual behaviour problems is a new and developing field, consequently there is limited research available on some topics. To provide a greater understanding of some issues I have drawn upon and included research on adolescent and adult sex offenders.

## **Why Be Concerned?**

Some children coerce, intimidate, or force other children by threats or physical harm to comply with their sexual requests. Sexually aggressive children exhibit the following behaviours: genital fondling, exhibitionism, voyeurism, public masturbation, oral sex, simulated or attempted intercourse; digital, penile, or object penetration of the vagina or anus. Children as young as four years of age have been referred to treatment for their sexual behaviour problems. Johnson's (1989) research on female child perpetrators included 13 girls, ranging in age from 4 to 12, with the mean age of 7.5 years.

Concerned parents fear that children with sexual behaviour problems will develop chronic and persistent offending behaviours. At the present time there are no longitudinal studies identifying or describing a progression from childhood sexual behaviour problems to adolescent or adult sexual offending. Research findings based on retrospective data do indicate that many sex offenders began offending in adolescence or childhood. McGrath (1990) determined that 30% of adults convicted of sex crimes began offending before they were 9 years old (as cited in Cantwell, 1995). In his research, Abel (1982) found that 50% of the adult sex offenders began offending in adolescence (as cited in Perry & Orchard, 1992). Cantwell (1995) states that adolescent sex offenders often begin their sexual aggression in earlier childhood. She notes that offenders who are seven years old or younger are not uncommon. Lane

(1995) identifies that some young offenders and parents of some young offenders have reported an onset of sexually abusive behaviour as young as four or five years of age. Johnson (1993) reports that some adolescent sex offenders recall offending at three or four years of age.

There is concern that the severity of the offending behaviour may escalate if treatment is unavailable or if the offender is not apprehended. Longo and Groth (1983) report that 35% of the incarcerated sex offenders in their study indicated that they progressed from compulsive masturbation, exhibitionism, and voyeurism as youths to more serious sexually aggressive behaviours (as cited in Perry & Orchard, 1992). Abel, Mittelman and Becker (1983) found that offenders often progress from less intrusive to more intrusive or less coercive to more coercive behaviour over time (as cited in Ryan & Lane, 1991).

The reinforcing nature of sexual activity presents a challenge for parents and therapists who attempt to redirect children away from particular sexual behaviours. Physical pleasure combined with feelings of power and control can entice children to repeatedly engage in unacceptable sexual behaviours. It is an unfortunate but well known fact that one sex offender can victimize many innocent children. Johnson's (1989) study of female children who molest other children revealed that the average number of victims of the child perpetrators was 3.3, with a range of 1 to 15 victims. She cautions that the figures may be low due to the reluctance of many children to disclose

information about molestations for which they have not been caught. In a study of convicted sex offenders, 99 men admitted to over 8000 sexual contacts with 959 children (Weinrott & Saylor, 1991; as cited in Bagley, Wood & Young, 1994). In "Child Sexual Abuse Prevention: What Offenders Tell Us", Elliott (1995) interviewed 91 adult sex offenders about their offending behaviours. The findings related to the number of victims included: 70% of the men had committed offenses against one to nine children, 23% had committed offenses against 10 to 40 children, 7% had committed offenses against 41 to 450 children. Freeman-Longo and Wall (1986) report that 53 adult sex offenders committed approximately 25,757 sex crimes (as cited in Shaw, 1994). The above figures highlight the alarming and frightening risk that untreated sex offenders pose to children, families, and communities.

Gil and Johnson (1993) report that police officers have noticed a gradual and steady increase in the number of referrals involving children with problematic sexual behaviours and children who molest. Some school districts have also felt the impact of the growing problem. Cantwell (1995) relates that parents of victimized children are suing school districts when they can show that the schools knew other children to be perpetrators, and thus potential threats. In 1992, a Texas court awarded a child-victim molested by a five-year-old classmate over \$11 million, citing the daycare's negligence in protecting the child (Gil & Johnson, 1993).

## Extent Of The Problem

Canadian statistics related to the incidence of sex-related offenses committed by children (4 to 12 years of age) are unavailable. Youth 12 years of age and older come under the provisions of the Young Offenders Act and thus there is a possibility that charges could be laid and trends observed. In Best Practice Issues and Suggested Practice Standards in Working with Children with Sexual Behaviour Problems, Wachtel (1996b) states that sexual abuse cases require a substantial probability of conviction before charges are laid. This means that proceeding with charges is unlikely where the victimized children do not appear to be capable witnesses. As a result of this, many adolescents, especially those who abuse very young children or siblings, are not charged. If they are not charged, treatment is not mandated.

Shaw (1994) compiled information on 32 preadolescent and adolescent sex offenders in Southern Ontario. The ages of the offenders ranged from 9 to 18 years. One hundred and nineteen offenses were committed by the 32 males. The most frequently occurring behaviour was touching or fondling, with a total of 53 different occurrences committed. The second most frequently committed act was vaginal penetration, with 20 occurrences, followed by anal sex with 11 occurrences. Exposure and masturbation each had a frequency of nine, oral sex occurred four times and lastly, invitation to sexual touching occurred two times. Thirty-two offenders committed forty-five offenses either

using violence or aggression to control the victim. The number of years difference between the perpetrators and their victims ranged from one year to eleven years. Sixty of the victims were female and 28 were male.

In 1987, Mathews (as cited in Berry, 1992) reported that 25% of all sex crimes committed in Canada are perpetrated by adolescents. On the basis of reports made to the Children's Aid Societies in Ontario in 1989, Troeme (as cited in Berry, 1992) estimated that of the 6,000 substantiated cases of child sexual abuse, juveniles committed at least 1,500 of those sexual assaults.

In their Literature and Resource Review of Youthful Sexual Offenders: A Comprehensive Bibliography of Scholarly References, 1970-1992, Openshaw, Graves, Erickson, Lowry, Durso, Agee, Todd, Jones, and Scherzinger (1993) relate that the incidence of reported sex-related offenses committed by preadolescents and adolescents has been increasing at an unprecedented rate over the last decade. According to the United States Department of Justice the incidence of sexual offenses perpetrated by minor-age males continues to grow at the rate of nearly ten percent per year. Lakey (1994) reports that treatment centers for child and adolescent sex offenders in the United States mushroomed from 20 in 1982 to 650 in 1993. Openshaw et al. (1993) conducted an extensive search of the literature related to youthful sex offending and their study affirmed the growing interest in the field. The researchers located nine articles published in the 1970s and 171 articles published during the 1980s.

## **Effects Of Sexual Abuse**

Why should parents and the community at large be concerned about sexual abuse? There is a significant amount of research establishing the serious short-term and long-term effects of sexual abuse. From her clinical work with sexually abused children, Gil (1991) sees the manifestations of the abuse expressed internally and externally. She finds that children who exhibit internalized behaviour tend to be isolated and withdrawn. They attempt to handle the abuse by themselves. These children frequently appear withdrawn, depressed, over-compliant, hypervigilant, and anxious. They may dissociate, lack spontaneity, develop phobias, experience sleep disorders, engage in self-mutilation, and make suicide attempts. Children with externalized manifestations engage in behaviour directed towards others; they exhibit outward expression of their emotions. Gil finds these children can be aggressive, destructive and hostile; provocative, sexualized; violent, sometimes torturing, or killing animals. Sexualized behaviours, including masturbation and sexual acting out, are among the most common behavioural sequelae.

The trauma of sexual abuse may progressively accumulate as the individual matures through later developmental stages. Immediate or short-term effects may impede normal progression through later developmental stages, resulting in long-term impact from the sexual abuse. The study of adult survivors of child sexual abuse provides a longitudinal perspective on the

lasting effects of the abuse. Research studies (Browne & Finkel, 1986; Gelinias, 1983; as cited in Downs, 1993, Gil & Johnson, 1993) show long-term effects include: chronic anxiety, anxiety attacks, low self-esteem, behavioural and social problems (prostitution, alcoholism, substance abuse), somatic disorders, emotional disorders, eating disorders, problems in interpersonal relationships, sexual dysfunction, revictimization, sexual aggression, and suicide.

Some children and adults are severely traumatized and damaged by childhood sexual abuse, while others are not. The severity and specific form of the effects vary across individuals (Comte, 1985, as cited in Downs, 1993) and within individuals over time (Friedrich, 1988, as cited in Downs, 1993). What factors mediate the impact of the abuse? Gil (1991) suggests that the severity of the symptoms depend on the following variables: (1) age and developmental level of the child (2) onset, duration, and frequency of the molestation (3) degree of coercion and physical trauma (4) child's pre-existing mental and emotional health (5) relationship to the offender (6) emotional climate of the child's family prior to the abuse (7) parental response to disclosure (8) societal reaction to the abuse - ie. medical, investigatory, legal (9) availability and quality of therapeutic intervention.

Research studies have largely focussed upon sibling incest and perpetration by adults. There is limited research focussing specifically upon the effects of extrafamilial sexual abuse on children when the offender is a child. While some parents may believe that exploitative sexual behaviour initiated by



a child may be less damaging than abuse perpetrated by an adult, many therapists would argue that any sexual offense is traumatic because it represents a violation of emotional and physical boundaries. Initial research (Haugaard & Tilly, 1988; Lorado, 1982, as cited in Kikuchi, 1995) suggests that children who are sexually abused by other children suffer the same types and severity of negative consequences as children who are sexually abused by adults.

### **Labelling And Classifying**

The task of defining and classifying problematic sexual behaviours has been fraught with controversy. In the relatively short period of time that therapists have been working with children who have sexual behaviour problems, a number of terms have been adopted and then later deemed undesirable. Terms such as sexually intrusive, child sex offender, and child perpetrator are considered by some therapists as unnecessarily stigmatizing. Okami (1992) in "Child Perpetrators of Sexual Abuse: The Emergence of a Problematic Deviant Category" is highly critical of labelling a child a sex offender. He questions the validity of operational definitions of "child perpetrator" and highlights the possible negative consequences of such labelling.

The first program developed in the United States in 1985 for children with

sexual behaviour problems was called SPARK (Support Program for Abuse-Reactive Kids). The term abuse-reactive was coined to describe children who have been abused in some way, and are reacting to their early trauma in abusive, aggressive, and inappropriate sexual ways. Abuse-reactive characterizes the child as a victim and implies the need for therapeutic intervention. Some therapists argue that the term minimizes or excuses the abusiveness of the sexual behaviours. The term, children with sexual behaviour problems, has recently been adopted by many therapists. In the past two years in British Columbia, mental health professionals have replaced the label sexually intrusive children with the term, children with sexual behaviour problems. Wachtel (1996b) views the term as minimally stigmatizing, non-alarmist, not uni-causal, and broad in application. Terminology influences the way a child and his/her behaviour are perceived by therapists, educators, parents, and the community. It is quite conceivable that the term, children with sexual behaviour problems, will at some point fall out of favour, and a new term will take its place.

Terms such as child sex offender and child perpetrator are still used by many researchers and writers. Although I personally prefer to use the term children with sexual behaviour problems, when referring to research articles and books, I will accurately reflect the writing of the author by using the terminology that he or she employed.

## Childhood Sexuality

Childhood sexuality is not well understood nor tolerated by adults in our society. In general, adults are uncomfortable with the notion that children are sexual beings, let alone sexual offenders. The discomfort and lack of understanding related to childhood sexuality contributes to the minimization and denial of sexual abuse. Sexually assaultive and aggressive behaviours are sometimes dismissed as childhood curiosity or exploratory stages that will pass with age. Responses such as “boys will be boys”, “he/she was just curious”, “they were playing doctor” can sometimes mask serious exploitative sexual behaviour. Drawing upon her experience in working with tens of thousands of children, teens, parents, teachers, and professionals, Kikuchi (1995) concludes that as a society we are tolerant of sexual abuse between children or adolescents, even when there is a considerable age difference or when some of those involved clearly did not consent to the activity. In her groundbreaking research on “female child perpetrators”, Johnson (1989) states that “most of our society, and this includes mental health professionals, appear to want to deny the existence of young children who are acting out sexually and often aggressively with other children”. Johnson challenges the mental health community to recognize the seriousness of sexual offenses committed by children twelve years of age and younger. Since the publication of her initial findings in 1988 and 1989, an increasing number of therapists, social workers,

teachers, and parents have expressed concern about unusual and inappropriate sexual behaviour in some children.

Researchers (Finkelhor, 1983; Friedrich, 1991; Goldman & Goldman, 1988, as cited in Gil & Johnson, 1993) estimate that 40% - 85% of children will engage in at least some sexual behaviour before 13 years of age. Martinson (1991) in his research on normal sexual development in infancy and early childhood, asserts that very young children have the physiological capacity for sexual experiences and that they express sexual behaviours in a variety of ways. Beginning in infancy, children express curiosity about their bodies and the bodies of others. Martinson reports that genital play and the development of orgasmic abilities occurs during the first year of life. Gil (1993) suggests that normal sexual development is progressive over time and follows suit with physical, emotional, psychological, cognitive, and moral development. Sexual development and the visible expression of childhood sexuality are influenced by the following factors: cultural expectations and norms, religious values, family social and sexual interactions, overt or covert sexual abuse, and nonfamilial interpersonal experiences. In his research on sibling and cousin incest, De Jong (1989) reports that an understanding of normal sexual behaviour in children is essential in determining whether a particular activity is age appropriate, exploratory behaviour, or exploitative.

Comprehensive, research based information on childhood sexuality is relatively scarce. Lindblad, Gustafson, Larsson, and Lundin (1995)

express concern about the lack of epidemiological research on sexual behaviour in children. In evaluations of sexual abuse, knowledge about normal sexual behaviours in young children is required as a baseline for viewing aberrant behaviours. Further research on normal childhood sexual development is called for.

### **Problematic Sexual Behaviour**

Central to the discussion of problematic sexual behaviour in children are two pivotal questions. What is normal sexual behaviour? When is sexual acting out considered abuse? While these questions are contentious, there appears to be growing agreement among most therapists and researchers, as to which behaviours constitute sexual abuse.

In 1988 Johnson began the serious work of defining and describing the population of child perpetrators. She included children in her sample if they met the following criteria: (1) they had acted in a sexual way with another child; and (2) they had used force or coercion in order to obtain the participation of the other child, or the victim was too young to realize he/she was being violated and did not resist the sexual behaviour, or it was an offense such as exhibitionism; and (3) there was an age differential of at least two years; and (4) there was a pattern of sexually overt behaviour in their history.

The criteria of an age differential between the perpetrator and the victim

is frequently used as an indicator that sexual interaction is abusive. A number of researchers (Coffey, Leitenberg, Henning, Turner & Bennett, 1996; Grocke, Smith & Graham 1995; Sermabeikian, 1994; Faller, 1989a; de Jong, 1989) included in their definition of sexual abuse the following criteria: an age differential of at least five years between the victim and the offender. The criteria of a five year age differential was explained in terms of developmental differences (de Jong, 1989). The researchers felt that if sexual contact occurs between children of different developmental levels, it is exploitative.

In his research on adolescent male sex offenders, Worling (1995b) categorized the abuse as an offense against a child if the offender was at least four years older than the victim and the victim under 13 years of age. Worling also included the category of peer-age victims, if the age differential was less than four years.

At the present time, there are no universally accepted criteria available for distinguishing between normal sexual exploration and abusive sexual behaviour. Age discrepancy is one of several criteria used by therapists to determine if sexual activity is abusive. While some therapists and researchers believe that sexual activity between children within the same age group can not be considered sexual abuse, other therapists would definitely disagree. The age discrepancy criterion ignores the fact that children may be the same age and yet be physically, developmentally, and/or emotionally unequal. Johnson (1993) relates that she has treated many children for molesting behaviours who

were the same age or significantly younger than their victims. In addition to age discrepancy, Gil (1993) suggests that therapists assess size difference, difference in status (perhaps one child has authority over the other, ie. babysitter) type of sexual activity, and dynamics of sexual interaction between children.

Cunningham and MacFarlane (1996), therapists and authors of several books on the subject of children with sexual behaviour problems, reviewed the literature on sexually inappropriate behaviour, and concluded that any sexual behaviour involving coercion, threats, aggression, or developmentally inappropriate sex acts between younger children, or where one participant relies on an unequal power base, is considered abusive.

Several classification systems for problematic sexual behaviours in children have been proposed. Friedrich (1991) classified problematic behaviour as sexually inappropriate, sexually reactive, sexually eroticized, or sexually aggressive. Johnson (1993), widely recognized for her work in classifying sexual behaviour, developed a continuum of sexual behaviours, incorporating four broad groups: (1) normal sexual exploration (not problematic), (2) sexually reactive behaviours, (3) extensive mutual sexual behaviours, (4) children who molest.

Johnson views normal sex play as an information-gathering process. She believes that children involved in age-appropriate exploration are of similar size, age, and developmental status. The children voluntarily engage in

lighthearted and spontaneous sexual exploration. The sexual behaviours are limited in type and frequency. Johnson notes that in age-appropriate sex play, children feel excited and silly rather than fearful or anxious. Curiosity related to sexual exploration is balanced by an interest in a variety of childhood activities.

Johnson (1993) describes sexually reactive children as displaying more sexual behaviours than children in group one. Many sexually reactive children have been sexually abused, exposed to pornography, and/or living in a home where there is too much sexual stimulation. Children who have been overstimulated sexually often reenact the sexual behaviour that they have witnessed or experienced. Some children will engage in sexual behaviours with children of a similar age, while others will focus their attention upon their own bodies, masturbating, exposing themselves, or inserting objects into vaginal or anal openings. Sexually reactive children often feel shame, guilt, and anxiety about sexuality. Clinicians find that sexually reactive children usually respond positively to therapeutic intervention.

Children who are involved with extensive mutual sexual behaviours have a more pervasive and focussed sexual behaviour pattern. They participate in the full spectrum of adult sexual behaviours with other children of a similar age. Johnson finds these children lack affect around sexuality and are much less responsive to treatment. She describes these children as having been emotionally, sexually, and/or physically abused, and/or having lived in highly



chaotic and sexually charged environments. In reaction to chaos, abuse, and/or abandonment, these children often turn to sexual activity as a way to cope or connect with others.

Children who have very serious sexual behaviour problems are classified as children who molest in Johnson's continuum of sexual behaviours. These children generally display impulsive, compulsive, and aggressive sexual behaviours that increase over time. They target victims who are vulnerable; children who can be threatened, tricked, or coerced into sexual activity. Children who molest are often physically and sexually aggressive, and typically have behaviour problems at home and in school. Most of these children have experienced or witnessed physical, sexual, and emotional abuse. Their sexually aggressive behaviours are thought to be linked to feelings of rage, loneliness, and fear. Johnson believes that these children are unable to stop their sexual behaviours unless they receive intensive, specialized treatment.

Classification systems are often helpful for therapists as they assess the severity of the problems that the child and family face. While typologies are useful for research and assessment purposes, it is critical that therapists not focus upon labels and classifications but rather on the uniqueness and individuality of each child and his or her family.

## Theories On Sexual Offending

A number of theories have been proposed to explain deviant sexual behaviour in children and adolescents. There appears to be a general agreement among clinicians and researchers that sexual offending is a learned rather than a biological or genetic phenomenon.

Do sexually offending behaviours originate from prior sexual victimization? The cycle of abuse has been examined by many researchers and the results of the findings vary considerably. In her study of female child perpetrators, Johnson (1989) found that 100% of the 13 girls, ages 4 to 13, had been previously sexually abused. Worling (1995b), in "Sexual Abuse Histories of Adolescent Male Sex Offenders: Differences on the Basis of the Age and Gender of their Victim" studied 90 adolescent male sexual offenders. Forty-three percent of the participants reported prior sexual victimization. Briggs and Hawkins (1996) interviewed 84 incarcerated child molesters in South Australia, and discovered that 93% of the child molesters had been sexually abused in childhood. Bagley, Wood, and Young (1994) interviewed 750 males, aged 18 to 27, in Calgary, to study the mental health and behavioural sequels of child sexual abuse. The researchers concluded that the combination of emotional abuse in the respondent's childhood with multiple events of sexual abuse was a relatively good predictor of both poor mental health, and later sexual interest or sexual contact with children.

Prior sexual victimization in childhood is a significant predisposing factor that appears to increase the risk of the development of sexually abusive behaviours. Clearly though, victimization alone does not account for all offending behaviours. Thousands upon thousands of victims of sexual abuse do not go on to become perpetrators.

There are several theories that attempt to explain why some children who have experienced sexual abuse would develop sexually abusive behaviours. Finkelhor and Browne (1986) believe that sexually abused children are taught and therefore learn to behave in sexually inappropriate ways (as cited in Gil and Johnson, 1993). This concept is based upon learning theory, with the basic tenet that children are taught to respond to specific stimuli in specific ways. It appears that as a consequence of sexual abuse, children are capable of learning both the victim and the offender roles. From her extensive clinical work with adult male sex offenders, Briggs (1995) concludes that child sexual abuse is a learned behaviour and that without treatment it is difficult for offenders to overcome their early conditioning.

Terr (1990) named the repetitive and literal reenactment of traumatic experiences, post-traumatic play. These behavioural reenactments of traumatic experiences are frequently seen in children who have been sexually abused. Some children will attempt to repeat the elements of the traumatic event with other children. The repetition of the trauma may be an attempt to gain mastery over feelings of helplessness, anxiety, and terror. By moving from a passive to

an active role the child attempts to discharge the pain and fear of the trauma memory. Johnson (1989) concluded that the female children in her research on children who molest were not looking for sexual pleasure, but rather for a decrease in feelings of anger, confusion, and anxiety.

Rasmussen (1992) believes that sexually victimized children have three possible responses to their trauma: (1) they can express and work through feelings associated with the trauma to the point of recovery, (2) they can develop self-destructive behaviours (self-victimization), and (3) they can identify with the perpetrator and become abusive with others (as cited in Gil and Johnson, 1993). Although influenced by emotional and social factors, Rasmussen holds that children do make choices about how they respond to their trauma.

Sexual offending behaviour may be in response to heightened sexual arousal. Children who have been sexually abused are often prematurely eroticized, easily aroused, and seek sexual interactions for pleasure. The sexual behaviours may be so gratifying for children that caregivers may find it difficult to redirect them toward socially acceptable interactions. Some abused children have trouble differentiating between affectionate relationships and sexual relationships.

Rasmussen, Burton, and Christopherson (1992) suggest the following five precursors lead to vulnerability to offend sexually: prior traumatization, social inadequacy, lack of intimacy, impulsiveness, and lack of accountability.

Breer (1987) postulates that sexually aggressive behaviours may become addictive as a result of the psychological and physiological reinforcement experienced by the child (as cited in Wachtel, 1992). The addiction model identifies the sexually offending behaviour as preplanned, self-reinforcing, compulsive, and secretive.

Johnson (1993) determined that highly sexualized environments can produce feelings in children that are consistent with those found in some children who have been sexually abused.

A history of physical abuse has also been identified as a significant factor in the development of sexual offending. In their work with sibling incest offenders, Adler and Schutz (1995) found that 11 of the 12 offenders (92%) in their study had a history of being physically abused by one or both parents. Perry and Orchard (1992) note that research findings indicate that the major predeterminant that adolescent sex offenders share is a history of physical abuse. From her clinical experience, Johnson (1993) has found that many children who molest have been victims of extreme physical abuse. She believes that physical abuse and cruel treatment are important etiological factors in the rage that many of these children feel.

After examining all of the potential contributing factors in the development of a child who molests other children, Cunningham and MacFarlane (1996) conclude that some form of maltreatment or traumatic influence occurred during the early years of these children's lives. Drawing

upon their clinical experience with children who exhibit problematic sexual behaviours, Rudko and Schaubert (1995) identify the following five factors as present to some extent in all of their referrals: (1) violence - physical abuse or witnessed physical abuse of others (2) trauma - both the children and their parents have experienced sexual, physical, or emotional abuse (3) neglect or abandonment (4) sexualized environment - pornography, adults openly engaged in sexual contact, lack of boundaries, or a sexually repressive environment (5) developmental interference - Fetal Alcohol Syndrome, Infants of Substance Using Mothers, Attention Deficit Disorder, and severe learning disabilities. Rudko and Schaubert conclude that numerous factors are at the base of sexual behaviour problems and that the dynamic interplay of these factors are unique for each child and family.

Perry and Orchard (1992) assert that sexual assault is not primarily a sexually motivated behaviour. They believe that it is an abuse of power, related more to aggression and control than to sexual stimulation. From their clinical experience with adolescent sex offenders, Orchard and Perry contend that sex offenders attempt to meet basic emotional, social, and personal needs through assaultive, exploitative sex. Richardson, Loss, and Ross (1988) postulate that sexual offenses are committed for the following reasons: (a) to overpower someone, to be in control; (b) to achieve revenge against someone or the world; (c) to release anger; (d) to scare someone and make him/her feel bad about him/herself; (e) for immediate gratification; (f) to feel wanted; and (g) to

impress someone and feel like someone looks up to you (as cited in Perry & Orchard, 1992).

The current literature suggests that there are several etiologic pathways to sexual offending. Sexually abusive behaviour appears to result from a combination of psychological, physiological, social, and environmental factors. At the present time no single theory completely explains the underlying dynamics of sexual offending. Although many theories have been postulated, few have been systematically tested. Additional research is necessary to empirically explain which factors determine why some children develop sexual offending behaviours.

## **Psychological Profiles Of Children**

### **With Sexual Behaviour Problems**

Most of the available research on children with sexual behaviour problems is based upon children whose behaviour is serious enough to warrant placement in treatment programs. The descriptions of children and families are most accurate for those children who display significant and serious molesting behaviours. For children whose sexual behaviour problems are assessed as less disturbed, the psychological and family profiles may be less accurate.

From her clinical work with children and adolescents, Lane (1995) concludes that young children with sexual behaviour problems are similar to

adolescent perpetrators. She finds that the thinking processes, power aspects, and abusive behaviours are similar between the two groups. Lane states that the children, ages six to ten, exhibit the same lack of tolerance for feelings of helplessness, powerlessness, abandonment, rejection, or humiliation as the adolescent offenders. She finds that children who have sexual behaviour problems have difficulty following directions, asking for help, handling mistakes or failures, and joining in or playing with others. These children also have problems expressing anger, identifying feelings, and resolving conflict.

Fehrenbach, Smith, Monastersky, and Deisher (1986) describe adolescent sex offenders as lonely and socially isolated from their peers; they prefer the company of younger children, they are naive and lack suitable sex education; and they frequently experience disturbed family relations (as cited in Lakey, 1994). Davis and Leitenberg (1987) include feelings of male inadequacy; low self-esteem; fear of rejection and anger toward women; atypical erotic fantasies; poor social skills; history of sexual victimization; exposure to adult models of aggression, dominance and intimidation, as characteristics of adolescent sex offenders. These youth are frequently disruptive in school and many have learning problems, including attention deficit disorder.

In addition to remarking upon the many similarities between the sexually abusive behaviours of young children and the behaviours of adolescent sex offenders, Gil and Johnson (1993) point out some of the differences that exist



between the two groups. They find that children who molest and their parents have more highly disturbed interpersonal relationships and higher levels of family disruption, sexual confusion, and victimization. From their research and clinical experience, they observe that most children who molest have severe oppositional disorder and significant disruptions in their capacity to make meaningful attachments. For children who molest, Gil and Johnson see the sexually abusive behaviours primarily as a vehicle for expressing internalized anger or tension and less frequently for obtaining sexual pleasure.

The female child perpetrators in Johnson's (1989) study had trouble in school academically and socially. Many of the girls had severe learning problems. All of the girls were described as depressed, anxious, and oppositional with adults and authority figures. None of the 13 girls had best friends. Stealing, fire setting, and running away were features of some of the children. Johnson (1993) believes that children who molest prefer to express rage and aggression, rather than experience intense feelings of sadness, loss, and abandonment.

After assessing more than 800 imprisoned male sexual offenders who have abused children, Wallis (1995) determined that offenders come from different family, educational, and socio-economic backgrounds and present diverse psychological profiles. He concludes that sex offenders are not a homogeneous group, either in their socialization, their psychology, or in the situations in which the abuse occurs. Wallis notes that the majority of

perpetrators perceive themselves as powerless. In their research with adult male sex offenders, Briggs and Hawkins (1996) point out that for an overwhelming majority of offenders there was no evidence of psychotic processes.

The information and research data on children with sexual behaviour problems is still emerging. Preliminary findings suggest that children who molest share some similarities in terms of early childhood experiences and resulting behavioural disturbances.

### **Family Environments**

Research findings suggest that family environments play a significant role in the development of sexually abusive behaviours. As Gil (1993) notes, extreme and persistent sexualized and molesting behaviours do not emerge in a vacuum. Therapists frequently find that children with serious sexual behaviour problems have been raised in dysfunctional families with histories of substantial abuse.

Through her research on female children who molest, Johnson (1989) discovered a preponderance of single parent households headed by females. Johnson found that the majority of the mothers had been sexually abused as children, physically abused by one or more men, had a series of unsuccessful relationships with men, were depressed, had extremely low self-esteem, and

were unable to keep themselves or their children safe. Most of the girls in Johnson's study did not know where their fathers were. All of the girls had been previously sexually abused. The abuse was considered very serious in that the frequency was high, it occurred over an extended period of time, and the perpetrators were trusted parents, relatives, or friends (fathers, mothers, uncles, neighbours). Johnson learned that when each child disclosed the victimization, none of the parents/caretakers believed the child or responded by assuring the child's safety. These children had no nurturing, stable mother or father figures in their lives.

Adams, McClellan, Douglass, McCurry, and Storck (1995) report that family dysfunction, including problems with lack of structure, marital instability, poor parenting, and substance abuse, is commonly experienced by youth who have sexual behaviour problems. In their research on juvenile sexual offending, James and Neil (1996) conclude that sexually abusive behaviour arises in a setting of dysfunctional families with a history of abuse. Among the youth in their study the researchers discovered high rates of emotional and behavioural problems combined with substantial histories, in the majority of cases, of neglect, emotional, physical, and sexual abuse. Researchers (Adler & Schutz, 1995; De Jong, 1989; Johnson, 1989) report high percentages of sexual victimization histories for the parents of offenders. Adler and Schutz (1995) view sibling incest as "the tip of the iceberg" with regard to family dysfunction and intergenerational patterns of abuse.

Ray, Smith, Peterson, Gray, Schaffner, and Houff (1995) studied 15 children who coerced, intimidated, or forced other children by threats of physical force to comply with their sexual requests. The researchers found that the children had been raised in chaotic, violent, and abusive homes. All of the children had been sexually abused and the majority of them had been in and out of foster homes.

In their research with convicted adult male sex offenders, Briggs and Hawkins (1996) compared 84 incarcerated men to 95 male nonoffenders who were sexually abused in childhood. The researchers found that the incarcerated men were more socially disadvantaged than the nonoffenders and they had received less physical affection and more physical beatings and verbal abuse as children than the comparison group.

Ryan (1991) sees that following common characteristics in the families of juvenile sex offenders: emotional impoverishment, lack of appropriate affect, dangerous secrets, distorted attachments, and a history of disruption in care. Baird (1991) finds that most families of adolescent sex offenders have inherent degrees of minimization, rationalization, and denial of the adolescent's behaviour. Families play a critical role in the lives of children. Further empirical research is necessary to more accurately determine which family variables influence the development of sexual offending behaviours.

## **Assessment**

Several structured assessment inventories have been developed to help therapists assess the extent and the range of sexual behaviours shown by a child. Friedrich (1992) created a 36 item measure that assesses a wide variety of sexual behaviours (as cited in Gil & Johnson, 1993). Johnson (1992) developed the Child Sexual Behaviour Checklist as an assessment tool for therapists who work with sexualized children. The Child Sexual Behaviour Checklist contains an inventory of 150 behaviours related to sex and sexuality in children 12 years of age and younger. The behaviours range from natural, healthy childhood sexual exploration to severe sexual disturbances. The inventory of sexual behaviours is thorough. The opportunity to view the range of inappropriate sexual behaviours on the checklist helps parents to put their concerns in perspective.

The Child Sexual Behaviour Checklist is an excellent assessment tool to use with parents. The explicit questions on the checklist provide an opportunity to discuss very private but critically important issues with each parent. Topics such as the use of pornography, nudity, and adult sexual activity in the home are included in the checklist. While there is no guarantee that parents will be completely honest in their responses, nevertheless the issues are raised and the therapist gains information from body language, intonation, and affect, in addition to the verbal responses. Although standardized norms

for the Child Sexual Behaviour Checklist are currently not available, Johnson (1993) has found that children who molest show far higher numbers of sexual behaviours than nonabused children.

## **Treatment**

Gil (1993) states that some children with sexualized behaviours grow out of the problematic behaviours, respond to limit setting from their parents, develop more appropriate ways of exploring their sexuality, and learn to use their own internal controls to contain inappropriate behaviours. For children who remain unresponsive to limit setting and whose sexualized behaviours continue to be inappropriate and problematic, professional treatment becomes necessary. There is general agreement among researchers and therapists that early identification and treatment of sexual abuse is critical. Intervention with potential offenders at an early stage may prevent the development of chronic and persistent behaviours and thus prevent further victimization and the needless suffering of many children.

Should children with sexual behaviour problems be viewed as victims or offenders? How these children are seen determines the type and direction of their therapy. In their research on the differences and similarities in the theoretical perspectives and practice issues of five groups of child protection workers who work with juvenile sex offenders, Sanders and Ladwa-Thomas

(1997) found that the issue of whether juvenile abusers should be seen primarily as victims or perpetrators produced the greatest diversity of opinion.

The philosophy of the individual therapist or the treatment centre determines how children are treated. Ray, Smith, Peterson, Gray, Schaffner, and Houff (1995) point out that the trend in the recent past has been to treat sexually aggressive youth as victims, especially younger children, but more recent trends emphasize accountability, behaviour management, and cognitive restructuring, regardless of the age of the perpetrator. Many treatment interventions for adolescents and children with sexual behaviour problems have been adopted from programs for adult sex offenders. The basic principles of offense-specific treatment are the same for adults, adolescents, and children, with modifications for developmental abilities. Sermabeikan and Martinez (1994) point out that the assumption that sexual offending has been learned, observed, or experienced leads to the development of treatment interventions that provide offenders with opportunities to learn how to stop abusive sexual behaviour and to learn socially acceptable ways of expressing sexuality.

Many therapists (Cohen & Mannarino, 1998; Taylor, 1995; Cunningham & MacFarlane, 1996; Johnson, 1993) believe that victim-centered treatment approaches are not effective in reducing problematic sexual behaviour. These therapists adopt a directive, structured, cognitive-behavioural approach to treatment. Treatment for victims is often nondirective, permissive, and focussed upon expression of feelings. Kendal (1991) describes the techniques and goals

of cognitive-behavioural therapy as directed toward remediating children's deficiencies and correcting their distortions in cognitive processing of events (as cited in Cunningham & MacFarlane, 1996). Through individual and/or group therapy, children are taught to manage their own behaviour. Therapeutic activities provide opportunities for children to gain increased awareness of their thoughts, feelings, and behaviours that lead to the offending behaviours. They are taught thought stopping techniques to interrupt their thoughts as they contemplate inappropriate sexual behaviours. The children are expected to take personal responsibility for their sexual behaviour and increase their control over impulsive behaviour.

In 1995, British Columbia's Child and Youth Mental Health Services coordinated a Provincial Consultation Group On Children Under Twelve With Sexual Behaviour Problems. The group's task was to provide advice on policy development, clinical practice, research, and training. Borrowing heavily from the 1993 Revised Report from the United States National Task Force on Juvenile Sexual Offending, the consultation group produced a document entitled Best Practice Issues and Suggested Practice Standards in Working with Children with Sexual Behaviour Problems (Wachtel, 1996). The authors suggest that treatment should be offense-specific and directed by the therapist. The goals of therapy are to manage and reduce or extinguish the problematic sexual behaviours and enhance positive functioning.

For most therapists the major focus of treatment for children with sexual



behaviour problems is to prevent reoffending. Many researchers (Cunningham & MacFarlane, 1996; Rudko & Schaubert, 1995; Henley, 1995) view the family as playing a central role in the therapeutic change process. Sexual behaviour problems do not occur in isolation from family dynamics and interactions. Family dynamics either contribute to the continuance or the elimination of the problem. Cunningham and MacFarlane (1996) believe that sexual victimization and perpetration by children are family problems. Acknowledging the profound influence that families have upon children's lives, these researchers recognize the importance of including family therapy in the treatment plan for children with sexual behaviour problems. Rudko and Schaubert (1995) view the family as the best structure from which and in which change can occur. They engage and support the family in creating a solution to the family's problem. They believe that family treatment is crucial and must be mandated. As many families of children who have serious sexual behaviour problems are dysfunctional and tend to be resistant to intervention, an authoritative mandate for treatment is necessary to ensure that these families continue to participate in treatment. Henley (1995) states that inter-generational work may be necessary to heal unresolved issues between the parents and grandparents of the child who is expressing the sexual behaviour problems.

Johnson (1993) recommends that during family sessions the sexual behaviour problem should be stated matter-of-factly and there should be clarity and openness about the child's problematic sexual behaviours. All of the family

members need to understand the seriousness of the problem and what they can do to help the child stop the abusive behaviours.

Parents need to be educated to provide adequate supervision of their child to ensure community protection. Participation in psychoeducational programs is critical as it teaches parents many new skills, including how to positively support their child and how to identify antecedent indicators of sexual offending.

In addition to individual and/or family therapy, many therapists incorporate group therapy as a component of their treatment for children who have sexual behaviour problems. Some therapists (Gil & Johnson, 1993) view group therapy as the pivotal component of effective treatment. Group therapy provides children with the opportunity to develop much needed positive interactions with peers. Johnson (1993) believes that the greatest learning comes from being with other children and learning new ways to interact with them. On the other hand, Friedrich (1993) states that sexually reactive children are behaviourally more reactive in group settings, therefore he does not recommend group therapy as a treatment intervention. He believes that expecting appropriate group behaviour is premature, and often retraumatizing for many children who have failed peer experiences. During group process children learn the difference between sexually abusive and nonabusive behaviours, why their sexual behaviours are unacceptable, and how their behaviours effect others. They gain problem management skills and learn

strategies to interrupt and control sexually abusive behaviours. The element of secrecy related to sexual offending is addressed in group sessions as children are expected to openly discuss their problematic sexual behaviours. The relatively low cost of group therapy is an alternative for some parents when treatment is not free of charge.

After completing psychoeducational programs, some parents become motivated to participate in more intensive therapy. Many treatment centers require parent participation in adult group therapy. The parent groups focus upon a variety of topics including: identification and expression of feelings, child and parent victimization issues, sex education, supervision, offending behaviours, family and marital dynamics, conflict resolution, stress reduction, communication, and parenting skills.

Ideally there should be a continuum of treatment interventions for children who have sexual behaviour problems. In response to the continuum of childhood sexual behaviours, there needs to be a range of interventions. While most children with sexual behaviour problems can be effectively treated in outpatient treatment programs, high risk offenders require secure residential treatment programs.

The research on children with sexual behaviour problems repeatedly reports significant traumatization prior to the emergence of the sexual offending behaviours. Most of these children have experienced and/or witnessed physical, sexual and/or emotional abuse, sexualized environments, neglect, or

abandonment. Their behaviour problems are manifestations of past traumas. While it is essential to assist children in eliminating abusive behaviours and reduce the risk for reoffending, it is also critical to provide therapy for the underlying psychological trauma experienced by most of these children.

Pain and trauma can be temporarily masked, but unhealed psychological trauma does not disappear without effective treatment intervention. Since the origins of much of the inappropriate sexual behaviour appears to be related to issues of abuse and neglect and feelings of sadness, anger, and fear, these deeper issues must be addressed. Children with sexual behaviour problems need to release and resolve emotionally charged memories and traumas.

For many children abuse occurred early in their young lives, often prior to the development of sophisticated verbal skills. In many instances trauma is a visual, auditory, and/or kinesthetic experience and thus needs to be released through modalities other than speech. For children under nine years of age play therapy is an effective treatment intervention. As emotional wounds heal, children begin experiencing an increased sense of self worth and personal mastery. New feelings of adequacy enable children to develop more effective coping skills and outgrow dysfunctional behaviour.

While many different therapeutic interventions are utilized, there is limited data available on the effectiveness of treatment approaches. Therapy programs need to be evaluated and compared. Longitudinal studies of children who have received treatment must be conducted.

## **Parent Training And Community Education**

From their clinical experience, Smith and Monastersky (1987) proposed two primary distinguishing features of families of adolescent sexual offenders: denial of sexual tensions and a paucity of sexual knowledge or education (as cited in Bischof, Stith & Whitney, 1995). Johnson (1989) notes that children who have sexual behaviour problems are raised by parents who have a distinct lack of clarity about sexual issues. None of the parents in her study were able to discuss sexual matters with their daughters at an age-appropriate level. The majority of the parents were virtually unaware of the significant details of both their child's prior sexual victimization and their current sexual offending behaviour. In "Assessing Juvenile Sex Offenders To Determine Adequate Levels Of Supervision", Gerdes, Gourley, and Cash (1995) state that parents' participation in psychoeducational intervention is critical as it enables them to identify the antecedent indicators of risk and establish guidelines for protection. In their study "Parental Involvement In Sexual Abuse Prevention Education", Elrod and Rubin (1993) surveyed 101 parents of children under age seven, in Maryland. Parents were questioned on their knowledge of: the incidence and prevalence rates of child abuse in the United States, the effects of sexual abuse for the child, typical perpetrators, and estimated reporting frequency. These research findings showed: the overall scores on knowledge of child sexual abuse were low, with an average of 41% correct; parents did not have a clear

idea of the widespread nature of sexual abuse and when or what to watch for in children's behaviour or verbal messages; 99% of parents reported obtaining their information about sexual abuse from the media; 92% of parents rated themselves as the preferred educators of their children about sexual abuse. Elrod and Rubin concluded that parents clearly need some assistance, intervention and more realistic training to learn about sexual abuse and how to teach their children, especially preschoolers, about sexual abuse prevention. It would seem reasonable that the more accurate information parents have at their disposal and the more comfortable they feel about delivering information on sexual abuse prevention, the more likely they will be to actually share it with their children.

The British Columbia Provincial Consultation Group on Children Under Twelve with Sexual Behaviour Problems (1996) recommends that in-service training should be offered to teachers and educational professionals about sexually abusive behaviour, dynamics, and therapeutic goals so that schools can make good decisions about when information about such behaviours should be given to police, child protection, or treatment providers. The Provincial Consultation Group suggests that within the educational setting, training should be offered not just to teachers but also to other staff who interact with children, such as teaching assistants, secretaries, school bus drivers, and custodians.

Many research articles on children with sexual behaviour problems

conclude with the recommendation that parental and community education should be incorporated as a prevention strategy (Johnson, 1988, 1989; Elrod & Rubin, 1993; Daro, 1994, Gerdes, Gourley & Cash, 1995). However, a search of available resource materials reveals a lack of educational curricula specifically designed for parents and educators relating to children with sexual behaviour problems.

### **Summary**

The study of children with sexual behaviour problems is a new and evolving field. The theoretical and practical components of the field are still developing and further research is required in a number of significant areas, including the etiology of sexual offending, the effectiveness of treatment approaches, and the normal sexual development of children.

Many mental health professionals, police officers, educators, and parents view the phenomenon of child sexual offending as a serious and growing concern. To reduce victimization and prevent the development of sexually abusive behaviours, proactive approaches are called for. Both victims of abuse and offenders require early identification and intervention. Early intervention may prevent the unnecessary suffering of many children.

Public education programs on sexual abuse awareness and prevention need to incorporate information on young sex offenders. Most prevention

programs for children focus upon stranger and adult perpetrators and do not address the issue of child or family offenders.

Due to the relatively recent inception of this field of study, very little information is available to the general public. Information on topics such as normative child sexual development, “red flag” behaviours, and appropriate treatment interventions need to be communicated to parents, educators, and interested adults who work with children.



# **Children With Sexual Behaviour Problems: Curriculum For Parents And Educators**

## **Course Outline**

### **Session One**

- Overview of course content
- Childhood sexuality
- Normal childhood sexual behaviour
- Sexual behaviour problems
- Controversy over labelling and definitions
- Classifying sexual behaviour problems
- Twenty-one “red flag” behaviours

### **Session Two**

- Definition of childhood sexual abuse
- The Badgely Report
- Short-term effects of sexual abuse
- Physical and behavioural indicators of sexual abuse
- Long-term effects of sexual abuse
- Factors that mediate the impact of the abuse

### **Session Three**

- The development of sexual behaviour problems
- Psychological profiles of children with sexual behaviour problems
- Sexual abuse cycle
- Assessment of sexual behaviour problems

### **Session Four**

- Treatment interventions
- Cognitive-behavioural therapy
- Nondirective play therapy
- Family therapy
- Group therapy
- Guidelines for caregivers

## **Session One**

- Overview of course content
- Childhood sexuality
- Normal childhood sexual behaviour
- Sexual behaviour problems
- Controversy over labelling and definitions
- Classifying sexual behaviour problems
- Twenty-one “red flag” behaviours

## Objectives

The participants will:

1. Examine their personal values and beliefs related to childhood sexuality.
2. Gain an understanding of normal childhood sexual behaviour.
3. Distinguish between appropriate versus inappropriate sexual behaviours.
4. Identify current professional controversies over labelling and definitions.
5. Gain an understanding of how sexual behaviour problems are classified.
6. Recognize “red flag” behaviours of children with sexual behaviour problems.

## Childhood Sexuality

Childhood sexuality is generally not well understood nor tolerated by adults in our society. Many people are uncomfortable with the notion that children are sexual beings. Nevertheless, children do experience sexual feelings, and they often express these feelings in a variety of ways. Until recently, very little information or research existed on the normal sexual development and sexual behaviour of children under twelve years of age. The concern regarding sexual behaviour problems has prompted researchers to begin documenting the stages of normal sexual development in children.

In his research on sexual development in infancy and early childhood, Martinson (1991) determined that very young children have the physiological capacity for sexual experiences. Martinson reports that genital play and the development of orgasmic abilities occurs during the first year of life.

### **Suggested Activities:**

Participants complete a questionnaire on values, attitudes, and feelings regarding sex and sexuality.

### **Resources:**

Johnson, T. (1995). Treatment exercises for child abuse victims and children with sexual behaviour problems. Pasadena, California: T. C. Johnson.

## **Normal Childhood Sexual Behaviour**

From an examination of available literature and empirical data and through consultation with professionals, parents, and child care providers, Johnson (1994) developed categories of behaviours related to childhood sex and sexuality. These categories describe behaviours which are within the natural and expected range, behaviours which raise concern, and behaviours which require immediate assessment and intervention.

### **Natural And Expected Behaviours Related To Sex And Sexuality In Preschool Children**

- Touches or rubs own genitals when diapers are being changed, when going to sleep, when tense, excited, or afraid.
- Explores differences between males and females, boys and girls.
- Touches the genitals, breasts of familiar adults and children.
- Takes advantage of opportunity to look at nude persons.
- Asks about genitals, breasts, intercourse, babies.
- Erections.
- Likes to be nude. May show others his/her genitals.
- Interested in watching people doing bathroom functions.
- Interested in having/birthing a baby.
- Uses "dirty" words for bathroom and sexual functions.

- Interested in own feces.
- Plays doctor inspecting others' bodies.
- Puts something in the genitals or rectum of self or other for curiosity or exploration.
- Plays house, acts out roles of mommy and daddy.

### **Natural And Expected Behaviours Related To Sex And Sexuality**

#### **In Kindergarten Through Fourth Grade Children**

- Asks about genitals, breasts, intercourse, babies.
- Interested in watching/peeking at people doing bathroom functions.
- Uses “dirty” words for bathroom functions, genitals, and sex.
- Plays doctor, inspecting bodies.
- Boys and girls are interested in having/birthing a baby.
- Shows others his/her genitals.
- Interest in urination and defecation.
- Touches or rubs own genitals when going to sleep, when tense, excited, or afraid.
- Plays house, may simulate all roles of mommy and daddy.
- Thinks other sex children are “gross” or have “cooties”. Chases them.
- Talks about sex with friends. Talks about having a girl/boy friend.
- Wants privacy when in bathroom or changing clothes.
- Likes to hear and tell “dirty” jokes.

- Looks at nude pictures.
- Plays games with same-aged children related to sex and sexuality.
- Draws genitals on human figures.
- Explores differences between males and females, boys and girls.
- Takes advantage of opportunity to look at nude child or adult.
- Pretends to be opposite sex.
- Wants to compare genitals with peer-aged friends.
- Interest in touching genitals, breasts, buttocks of other same-aged child or have child touch his/hers.
- Kisses familiar adults and children. Allows kisses by familiar adults and children.
- Looks at the genitals, buttocks, breasts of adults.
- Erections.
- Puts something in own genitals/rectum due to curiosity and exploration.
- Interest in breeding behaviour of animals.

### **Behaviours In Preschool Children Which Raise Concern**

Johnson (1994) sees the following behaviours in children who are overly concerned about sexuality, who lack adequate supervision, or live in sexualized environments, and in children who have been, or are currently being sexually abused. When a child shows several of these behaviours, a consultation with a professional is advised.

- Continues to touch or rub genitals in public after being told many times not to do this.
- Continuous questions about genital differences after all questions have been answered.
- Touches the genitals or breasts of adults not in the family. Asks to be touched himself/herself.
- Stares at nude persons even after having seen many persons nude.
- Keeps asking people about genitals, breasts, intercourse, babies, even after parent has answered questions at age appropriate level.
- Continuous erections.
- Wants to be nude in public after the parent says “no”.
- Interest in watching bathroom functions does not wane in days/weeks.
- Boys interest in having/birthing a baby does not wane after several days or weeks of play about babies.
- Continues to use “dirty” words at home after parent says “no”.
- Smears feces on walls or floor more than one time.
- Frequently plays doctor after being told “no”.
- Puts something in the genitals or rectum of self or other frequently or after being told “no”.
- Humping other children with clothes on.



## **Behaviours In Kindergarten Through Fourth Grade Children Which Raise Concern**

Johnson (1994) sees the following behaviours in children who are overly concerned about sexuality, who lack adequate supervision, or live in sexualized environments, and in children who have been, or are currently being sexually abused. When a child shows several of these behaviours, a consultation with a professional is advised.

- Shows fear or anxiety about sexual topics.
- Keeps getting caught watching or peeking at others doing bathroom functions.
- Continues to use “dirty” words with adults after parent says “no” and punishes.
- Frequently plays doctor and gets caught after being told “no”.
- Boy keeps making believe he is having a baby after month/s.
- Wants to be nude in public after the parent says “no” and punishes child.
- Plays with feces. Purposely urinates outside of toilet bowl.
- Continues to touch or rub genitals in public after being told “no”.  
Masturbates on furniture or with objects.
- Humping other children with clothes on. Imitates sexual behaviour with dolls or stuffed toys.
- Uses “dirty” language when other children really complain.
- Sex talk gets child in trouble. Romanticizes all relationships.

- Becomes very upset when observed changing clothes.
- Keeps getting caught telling “dirty” jokes. Makes sexual sounds, e.g. moans.
- Continuous fascination with nude pictures.
- Wants to play games with much younger or older children related to sex and sexuality.
- Draws genitals on one figure and not another. Genitals in disproportionate size to body.
- Confused about male/female differences after all questions have been answered.
- Stares/sneaks to stare at nude persons even after having seen many persons nude.
- Wants to be opposite sex.
- Wants to compare genitals with much younger or much older children or adults.
- Continuously wants to touch genitals, breasts, buttocks of other child or children. Tries to engage in oral, anal, vaginal sex.
- French kissing. Talks in sexualized manner with others. Fearful of hugs and kisses by adults. Gets upset with public displays of affection.
- Touches/stares at the genitals, breasts, buttocks of adults. Asks adult to touch him/her on genitals.
- Continuous erections.

- Puts something in own genitals/rectum frequently or when it feels uncomfortable. Puts something in the genitals/rectum of other child.
- Touching genitals of animals.

## **Sexual Behaviour Problems**

### **Behaviours In Preschool Children Which Require Professional Help**

Johnson (1994) sees the following behaviours as indicative of a child who is experiencing deep confusion in the area of sexuality. The child may or may not have been sexually, physically, and/or emotionally abused. The level of sex and/or aggression in the child's environment may be overwhelming to the child. Consultation with a professional who specializes in child sexuality or child sexual abuse is recommended.

- Touches or rubs self in public or private to the exclusion of normal childhood activities.
- Plays male or female roles in an angry, sad, or aggressive manner.  
Hates own or other sex.
- Sneakily touches adults. Makes others allow touching, demands touching of self.
- Asks people to take off their clothes. Tries to forcibly undress people.
- Asks strangers questions about genitals, breasts, intercourse, babies, after parent has answered. Sexual knowledge too great for age.

- Painful erections.
- Refuses to put on clothes. Secretly shows self in public after many scoldings.
- Refuses to leave people alone in bathroom, forces way into bathroom.
- Displays fear or anger about babies, birthing, or intercourse.
- Uses “dirty” words in public and at home after many scoldings.
- Repeatedly plays with or smears feces after many scoldings.
- Forces child to play doctor, to take off clothes.
- Any coercion, force, pain in putting something in genitals or rectum of self or other child.
- Simulated or real intercourse without clothes, oral sex.

### **Behaviours In Kindergarten Through Fourth Grade Children**

#### **Which Require Professional Help**

Johnson (1994) sees the following behaviours as indicative of a child who is experiencing deep confusion in the area of sexuality. The child may or may not have been sexually, physically, and/or emotionally abused. The level of sex and/or aggression in the child's environment may be overwhelming to the child. Consultation with a professional who specializes in child sexuality or child sexual abuse is recommended.

- Endless questions about sex. Sexual knowledge too great for age.
- Refuses to leave people alone in bathroom.

- Continues use of “dirty” words even after exclusion from school and activities.
- Forces child to play doctor, to take clothes off.
- Displays fear or anger about babies or intercourse.
- Refuses to put on clothes. Exposes self in public after many scoldings.
- Repeatedly plays with or smears feces. Purposely urinates on furniture.
- Touches or rubs self in public or in private to the exclusion of normal childhood activities. Masturbates on people.
- Humping naked. Intercourse with another child. Forcing sex on other child.
- Uses bad language against another child’s family. Hurts opposite sex children.
- Talks about sex and sexual acts habitually. Repeatedly in trouble with regard to sexual behaviour.
- Aggressive or tearful in demand for privacy.
- Still tells “dirty” jokes even after exclusion from school and activities.
- Wants to masturbate to nude pictures or display them.
- Forces others to play sexual games. A group of children forces child or children to play.
- Genitals stand out as the most prominent feature on drawings of human figures. Drawings of intercourse, group sex.
- Plays male or female roles in a sad, angry, or aggressive manner. Hates

own or other sex.

- Asks people to take off their clothes. Tries to forcibly undress people.
- Hates being own sex. Hates own genitals.
- Demands to see the genitals, breasts, buttocks of children or adults.
- Manipulates or forces other child to allow touching of genitals, breasts, buttocks. Forced or mutual oral, anal, or vaginal sex.
- Overly familiar with strangers. Talks or acts in a sexualized manner with unknown adults. Physical contact with adult causes extreme agitation to child or adult.
- Painful erections.
- Any coercion or force in putting something in the genitals/rectum of other child. Anal and/or vaginal intercourse. Causing harm to own or others genitals or rectum.
- Sexual behaviours with animals.

### **Suggested Activities:**

Prior to teaching information on normal sexual behaviours and sexual behaviour problems, have participants brainstorm ideas on sexual behaviours that seem normal and abnormal for different age groups of children.

Large group discussion on multicultural differences related to normal and abnormal sexual behaviour in children.

## **Controversy Over Labelling And Definitions**

Terms or labels describing children who display inappropriate sexual behaviours have changed several times since the inception of the field. The terms, child sex offender and child perpetrator are now deemed as unnecessarily stigmatizing by many therapists and thus are used less frequently. Abuse-reactive children, sexually intrusive children, and sexualized children are terms that many therapists once adopted, but now use less often. At the present time, the term, children with sexual behaviour problems is gaining acceptance among many mental health professionals.

The criteria of age differential between the offender and the victim is frequently used as an indicator that sexual interaction is abusive. Some therapists and researchers believe that behaviours can only be classified as sexually abusive if there is an age differential of at least five years between the victim and the offender. These professionals believe that sexual contact is exploitative if it occurs between children of different developmental levels. Other therapists do not adopt the age discrepancy criterion because they recognize that children may be the same age and yet be physically, developmentally, and/or emotionally unequal. Many researchers and therapists view any behaviour involving coercion, threats, aggression, or developmentally inappropriate sex acts between younger children, or where one participant relies on an unequal power base, as abusive.

## **Classifying Sexual Behaviour Problems**

Several classification systems for problematic sexual behaviours in children have been proposed. Friedrich (1991) classified problematic behaviour as sexually inappropriate, sexually reactive, sexually eroticized, or sexually aggressive. Johnson (1993), widely recognized for her work in classifying sexual behaviour, developed a continuum of sexual behaviours, incorporating four broad groups: (1) normal sexual exploration (not problematic) (2) sexually reactive behaviours (3) extensive mutual sexual behaviours (4) children who molest.

### **Group I - Normal Sexual Exploration**

- Normal childhood sex play is an information-gathering process.
- Children explore each other's bodies visually and tactilely (e.g., playing doctor). Sex play is on a voluntary basis.
- Children are of similar age and size, generally of mixed sex, more often friends than siblings.
- Children feel lighthearted, excited, and silly.
- Curiosity related to sexual exploration is balanced by an interest in a variety of childhood activities.
- If children are discovered in sex play and instructed to stop, the sexual behaviours generally diminish or cease.



**Group II - Sexually Reactive**

- Children display more sexual behaviours than children in group one.
- Many sexually reactive children have been sexually abused, exposed to pornography, and/or living in a home where there is too much sexual stimulation.
- Children may reenact traumatic experiences related to their abuse.
- Children may engage in sexual behaviours with children of a similar age or focus their attention on their own bodies, masturbating, exposing themselves, or inserting objects into vaginal or anal openings.
- Children often feel deep shame, intense guilt, and pervasive anxiety about sexuality.
- Children do not force others into sexual behaviours.
- Children usually respond positively to therapeutic intervention.

**Group III - Extensive Mutual Sexual Behaviours**

- Children have been emotionally, sexually, and/or physically abused and/or lived in highly chaotic and sexually charged environments.
- Children are generally distrustful of adults, lack academic, or social success, and may use sex to make a "friend".
- Children participate in the full spectrum of adult sexual behaviours with children of a similar age.
- Children use persuasion, but usually do not use force or physical or emotional coercion to gain other children's participation in sexual acts.

- Children show a lack of affect about their sexual behaviour.
- Many children are in foster, group, or residential settings.
- Children turn to sexual activity as a way to connect with others and cope with chaos, abuse, and/ or abandonment.

#### **Group IV - Children Who Molest**

- Sexual behaviour may include oral copulation, vaginal intercourse, anal intercourse, and/or forcibly penetrating the vagina or anus of another child with fingers, sticks, and/or other objects.
- Children's thoughts and actions are pervaded with sexuality.
- Children generally display impulsive, compulsive, and aggressive sexual behaviours that increase over time.
- Children generally target vulnerable and younger victims; children who can be threatened, tricked, bribed, or coerced into sexual activity.
- Children frequently have behaviour problems at home and at school, have few outside interests, and almost no friends.
- Children lack problem solving and coping skills and demonstrate little impulse control.
- Most children have experienced or witnessed physical, sexual, and emotional abuse.
- Sexually aggressive behaviours may be an attempt to decrease intense feelings of rage, loneliness, and fear.

## Twenty-One “Red Flag” Behaviours

In response to requests from mental health professionals, parents, teachers, physicians, school and public health nurses, Johnson (1993) developed a list of 21 “red flags” regarding children’s sexual behaviours. These include:

1. The children engaged in the sexual behaviour do not have an ongoing mutual play relationship.
2. Sexual behaviours which are engaged in by children of different ages or developmental levels.
3. Sexual behaviours which are out of balance with other aspects of the child’s life and interests.
4. Children who seem to have too much knowledge about sexuality and behave in ways more consistent with adult sexual expression.
5. Sexual behaviours which are significantly different than those of other same-aged children.
6. Sexual behaviours which 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 behaviours which occur in public or other places where the child has been told they are not acceptable.
9. Children’s sexual behaviours which are eliciting complaints from other children and/or adversely affecting other children.
10. Children’s sexual behaviours which are directed at adults who feel uncomfortable about receiving them.
11. Children (four years and older) who do not understand their rights or the rights of others in relation to sexual contact.
12. Sexual behaviours which progress in frequency, intensity, or intrusiveness over time.
13. When fear, anxiety, deep shame, or intense guilt is associated with the sexual behaviour.
14. Children who engage in extensive, persistent mutually agreed upon adult-type sexual behaviour with other children.
15. Children who manually stimulate or have oral or genital contact with animals.
16. Children who sexualize nonsexual things, or interactions with others, or relationships.

17. Sexual behaviours which cause physical or emotional pain or discomfort to self or others.
18. Children who use sex to hurt others.
19. When verbal and/or physical expressions of anger precede, follow, or accompany the sexual behaviour.
20. Children who use distorted logic to justify their actions.
21. When coercion, force, bribery, manipulation, or threats are associated with sexual behaviours.

## **Session Two**

- Definition of childhood sexual abuse
- The Badgely Report
- Short-term effects of sexual abuse
- Physical and behavioural indicators of sexual abuse
- Long-term effects of sexual abuse
- Factors that mediate the impact of the abuse

## Objectives

The participants will:

1. Examine definitions of child sexual abuse.
2. Review Canadian statistics on child sexual abuse (The Badgely Report).
3. Identify possible short-term effects of child sexual abuse.
4. Recognize physical and behavioural indicators of sexual abuse.
5. Identify possible long-term effects of child sexual abuse.
6. Describe internalizing and externalizing post abuse behaviours.
7. List the factors that mediate the impact of the abuse.

## **Definition of Child Sexual Abuse**

When the majority of people think of sexual abuse they conceive of an adult abusing a child. Most definitions of child sexual abuse include a reference to the age differential between the offender and the victim. The following definition of child sexual abuse is taken from The Standing Conference on Sexually Abused Children in London (1984):

Any child below the age of consent may be deemed to have been sexually abused when a sexually mature person has, by design or by neglect of their usual societal or specific responsibilities in relation to the child, engaged or permitted the engagement of that child in any activity of a sexual nature which is intended to lead to the sexual gratification of the sexually mature person. This definition pertains whether or not this activity involves coercion by any means, whether or not it involves genital or physical contact, whether or not initiated by the child, or whether or not there is discernible harmful outcome in the short term.

The British Columbia Inter-Ministry Child Abuse Handbook (1988) defines child sexual abuse as:

Sexual exploitation of a child, whether consensual or not, including touching of a sexual nature, sexual intercourse, or any other

behaviour that a reasonable observer would conclude is behaviour of a sexual nature toward a child.

**Suggested Activities:**

Participants examine several definitions of child sexual abuse. Highlight the similarities and differences between the definitions. Note whether or not these definitions apply only to adult offenders.

## **The Prevalence Of Sexual Abuse**

### **The Badgely Report**

In 1980, the federal government of Canada established a special committee to look into the matter of child sexual abuse. The Committee of Sexual Offenses Against Children and Youth (The Badgely Committee) released its report in 1984. Their findings confirmed that child sexual abuse in Canada is a problem of major proportions. The Badgely Report revealed the following:

- One in two females and one in three males have been victims of one or more unwanted sexual acts at some time during their lives. These acts include exposure, sexual threats, sexual touching, sexual assault, or attempted sexual assault.
- Approximately four in five of these unwanted sexual acts were first committed when the victims were children or adolescents.



- 9.2% of female victims and 11.9% of male victims who reported abuse were under the age of seven years.
- 29.4% of female victims and 27.1% of male victims who reported abuse were between the ages of seven and eleven years.
- Four in every 100 females have been raped.
- Two in every 100 young people have experienced completed acts or attempts of unwanted penetration by a penis, by fingers, or by objects.
- Acts of genital exposure constitute the largest single category of sexual offenses committed against children. These cases are often followed by some form of sexual assault.
- Three in five sexually abused children have been threatened or physically coerced by their assailants.

These statistics illustrate the widespread prevalence of child sexual abuse.

Most statistics do not account for abuse perpetrated by adolescents or children.

### **Short-Term Effects of Child Sexual Abuse**

With research findings confirming that child sexual abuse is prevalent within our society, it is critical that parents and professionals be able to recognize the physical, behavioural, and emotional indicators that signal child abuse is occurring or has occurred. While some children are able to immediately report the abuse, many children are not in a position to ask for

help. The British Columbia Ministry of Attorney General (1995) published the following information on the medical, physical, behavioural, and emotional indicators of child sexual abuse.

### **Medical / Physical Indicators**

- \* redness, soreness, or itchiness in the genital or anal area
- \* bruising, bleeding, or infections in the genital or anal area
- \* difficulty walking, sitting, urinating
- \* torn, stained, or bloody clothing
- \* sexually transmitted diseases
- \* eating and sleeping problems
- \* anal fissures or trauma

### **Emotional / Behavioural Indicators** **Preschool Children**

- \* complaints about abdominal pain without physiological cause
- \* fear of a particular person, location, or activity
- \* destroying toys, stuffed animals
- \* excessively clinging behaviour
- \* excessive masturbation
- \* regressive behaviour
- \* bed wetting, soiling
- \* fear of dark
- \* nightmares

### **Emotional / Behavioural Indicators** **School Aged Children**

- \* somatic complaints without physiological reasons
- \* sudden drop in school performance, truancy
- \* excessive preoccupation with sexual activity
- \* memory or concentration disturbances
- \* wearing numerous layers of clothes
- \* refusing to remove clothing
- \* running away from home
- \* depression, fear states
- \* night terrors
- \* fire setting

Additional possible emotional / behavioural indicators of child sexual abuse may include the following:

- undue anxiety and crying
- irritability and short-temperedness
- extreme shifts of moods / emotions
- pseudomature or seductive behaviour
- sexualized or bizarre drawings or essays
- abnormal lack of energy, tired all of the time
- lack of trust, particularly with specific people
- overly compliant behaviour, unusually obedient
- poor peer relationships or inability to make friends
- withdrawal from people, physical contact, and regular activities
- detailed and age-inappropriate understanding of sexual behaviour
- unusual statements or statements that make sense only in a sexual context

### **Internalized And Externalized Manifestations Of Abuse**

Therapist and author, Gil (1991) finds that children who are sexually abused often display internal or external manifestations of the abuse.

#### **Internalized Behaviour**

- Children who exhibit internalized behaviour tend to be isolated, withdrawn, depressed, over-compliant, hypervigilant, and anxious.

- These children attempt to handle the abuse by themselves.
- They may develop phobias, dissociate, lack spontaneity, experience sleep disorders, engage in self-mutilation, and make suicide attempts.

### **Externalized Behaviour**

- Children with externalized manifestations engage in behaviour directed toward others; they exhibit outward expression of their emotions.
- These children can be aggressive, hostile and destructive; provocative, sexualized; violent, sometimes torturing or killing animals.

### **Suggested Activities:**

Prior to teaching information on the possible indicators and effects of sexual abuse have participants explore the question of how trauma may show in children's behaviours.

Examine the concept that males and females may or may not deal with trauma in different ways.

Show videos on sexual abuse.

### **Resources:**

Building Blocks: Empowering Families Against Child Sexual Abuse (53 minute video). For parents and caregivers of children aged two to twelve years.

1996 Building Block Productions, Suite 307 630 Seaforth Street, Victoria, British Columbia, V9A 3R7.

Good Things Can Still Happen (21 minute video). An animated film for

therapists and other professionals to use with sexually abused children ages six to twelve. National Film Board Of Canada.

## **Long-Term Effects Of Child Sexual Abuse**

Child sexual abuse has been linked to problems in psychosocial functioning from infancy to adulthood. The trauma of sexual abuse may progressively accumulate as a child matures through later developmental stages. The study of adult survivors of child sexual abuse provides a longitudinal perspective on the lasting effects of the abuse. Research studies (Browne & Finkelhor, 1986; Gelinias, 1983; as cited in Downs, 1993; Gil & Johnson, 1993) studies show long-term effects include:

- chronic anxiety
- anxiety attacks
- low self-esteem
- eating disorders
- chronic illnesses
- somatic disorders
- emotional disorders
- problems in interpersonal relationships
- behavioural and social problems (e.g. prostitution, alcoholism, substance abuse)
- multiple personality disorder
- sexual dysfunction
- sexual aggression
- revictimization
- memory loss
- suicide

## **Factors That Mediate The Impact Of The Abuse**

The research findings substantiate the claim that the consequences of sexual abuse in childhood can be devastating, debilitating, and long lasting. There is no doubt that some children and adults are severely traumatized and damaged by childhood sexual abuse. While some individuals are severely effected by sexual abuse, it is clear that others appear to be less effected. Therapists and researchers (Gil, 1991; Green, 1993) have identified a number of factors that appear to mediate the impact of the abuse. The severity of the symptoms depend upon the following variables:

- age and developmental level of the child
- onset, duration, and frequency of the molestation
- degree of coercion and physical trauma
- relationship to the offender
- child's pre-existing mental and emotional health
- emotional climate of the child's family prior to the abuse
- parental response to the disclosure
- societal reaction to the abuse - i.e. medical, investigatory, legal
- availability and quality of therapeutic intervention

### **Suggested Activities:**

Present scenarios of child sexual abuse and examine how the factors that mediate the impact of the abuse might effect each child in the scenario.

### **Session Three**

- The development of sexual behaviour problems
- Psychological profiles of children with sexual behaviour problems
- Sexual abuse cycle
- Assessment of sexual behaviour problems

## Objectives

The participants will:

1. Identify the major factors that contribute to the development of sexual behaviour problems.
2. Evaluate the role that prior sexual victimization plays in the development of sexual behaviour problems.
3. Describe the key factors that are present in the sexual abuse experiences of children who become sexually intrusive.
4. Recognize common behavioural and emotional characteristics of children with sexual behaviour problems.
5. Identify the components of the sexual abuse cycle.
6. Examine and evaluate assessment inventories and checklists of child sexual behaviours.



## **The Development Of Sexual Behaviour Problems**

At the present time no single theory completely explains the underlying dynamics of sexual offending. There appears to be a general agreement among therapists and researchers that sexual offending is a learned rather than a biological or genetic phenomenon. Sexually abusive behaviour appears to result from a combination of psychological, physiological, social, and environmental factors. Canadian researchers, Hall & Mathews (1996) identify two major factors which contribute to the development of sexually abusive behaviours in children and youth.

- History of childhood victimization (either sexual and/or physical) which was serious in duration, physical intrusiveness, and/or traumatic; and/or
- Problematic “sexual environment” (within the child's home) such as: exposure to explicit sexual material, openly sexual behaviour between family members, sexualization of non-sexual behaviours and issues, and early eroticization or sexualization of the child by the family or primary caregivers.

Hall and Mathews (1996) cite other contributory factors:

- Dysfunctional families with high stress, poor role models, serious conflicts, parental neglect, and problematic attachments.
- Familial boundary problems including problematic notions of privacy (physical and/or informational privacy), intrusiveness into the right's /lives

of others, role reversals with parents, etc.

- Child receiving little or no help/support to deal with issues; no confidante or mitigating positive relationship in child's life.
- Poor social skills in child, especially with peers.
- Child having school problems.
- Poor emotional expression/control within the child and disconnection from feelings.
- Socialization practices that increase likelihood of externalizing sexual issues.
- Societal attitudes that are negative toward females, promote fusion of sexuality and violence, condone violence as a solution to problems, and create inflexible stereotypical gender roles.

Rudko and Schauber (1995) identify three additional factors that are present, to some extent, in children with sexual behaviour problems.

- Physical abuse or witnessed physical abuse of others.
- Sexual, physical, and/or emotional victimization histories of mother and/or father.
- Developmental interference - Fetal Alcohol Syndrome, Infants of Substance Using Mothers, Attention Deficit Disorder and severe learning disabilities.

### **Prior Sexual Victimization**

There are several theories that attempt to explain why some children who have experienced sexual abuse would develop sexually abusive behaviours. Finkelhor and Browne (1986) believe that sexually abused children are taught and therefore learn to behave in sexually inappropriate ways (as cited in Gil and Johnson, 1993). As a result of sexual abuse some children identify with the perpetrator and become abusive of others.

Terr (1990) named the repetitive and literal reenactment of traumatic experiences, post-traumatic play. Some children who have been sexually abused will repeat the elements of the abuse with other children. The repetition of the trauma may be an attempt to gain mastery over feelings of helplessness, anxiety, and terror. By moving from a passive to an active role the child attempts to discharge the pain and fear of the trauma memory. From her work with young females, Johnson (1989) concludes that children who molest are not seeking sexual pleasure, but rather are looking for ways to decrease feelings of anger, confusion, and anxiety.

Some children who have been sexually abused are prematurely eroticized, easily aroused, and seek sexual interactions for pleasure. The sexual behaviours may be so gratifying for children that caregivers may find it difficult to redirect them toward more socially acceptable interactions.

In their research on the development of sexual behaviour problems, Hall and Mathews (1996) explore the perplexing issue of why some sexually abused

children develop sexually intrusive behaviour while other sexually abused children do not. They identify five key factors that are present in the sexual abuse experience of the child.

- Sexual arousal of the child during the abuse
- Sadistic abuse
- Active involvement of the child in the sexual activity
- Child acted in “offender” role during child-to-child sex acts
- Child blames self or is ambivalent about who to blame for the sexual abuse

**Suggested Activities:**

In small or large group discussions, participants brainstorm ideas regarding the development of sexual behaviour problems.

Discuss post traumatic stress disorder.

## **Psychological Profiles Of Children**

### **With Sexual Behaviour Problems**

Most of the available research on children with sexual behaviour problems is based upon children whose behaviour is serious enough to warrant placement in treatment programs. The descriptions of children and families are most accurate for those children who display significant and serious molesting behaviours. For children whose sexual behaviour problems are assessed as

less disturbed, the psychological profiles and family profiles may be less accurate.

Lane (1995) finds that children with sexual behaviour problems often display the following behavioural and emotional characteristics:

- Difficulty following directions and asking for help
- Difficulty handling mistakes or failures
- Difficulty joining in or playing with others
- Problems expressing anger, identifying feelings, and resolving conflict
- Lack of tolerance for feelings of helplessness, powerlessness, abandonment, rejection, or humiliation

Gil and Johnson (1993) find the following characteristics in many children with serious sexual behaviour problems:

- Lack of close friendships
- Depression and/or anxiety
- Oppositional with adults and authority figures
- Theft and fire setting

Hall and Mathews (1996) list the following factors as associated with interpersonal sexual behaviour problems among young sexually abused children:

- Lack of warmth/empathy

- Restricted range of affective expression
- Hopelessness/depression
- Poor internalization of right and wrong
- Blames others/denial of responsibility
- General boundary problems (non-sexual)
- Sexualized gestures and/or frequent or compulsive masturbation

**Suggested Activities:**

Examine case studies of children with sexual behaviour problems.

### **Sexual Abuse Cycle**

The concept of a sexual abuse cycle was developed in 1978 by therapists working at an adolescent treatment centre in Colorado. In their work with juvenile sex offenders, therapists recognized a general pattern common to each sexual abuse incident. An originator of the concept of the sexual abuse cycle, Lane (1991) reports that even though each incident of sexual abuse is unique, relative to the style of the offense, the type of behaviours involved, and the manner of selecting a victim, there are common processes for each. The sexual abuse cycle depicts the repetitive nature of cognitive and behavioural patterns that occur prior to, during, and subsequent to sexually abusive behaviour. Lane describes the cycle as beginning with an event that triggers negative self-perceptions and feelings of helplessness. The adolescent's past

experience and personal view of the world influence his/her perceptions of the event. The initial perception is based on a victim-stance orientation; the adolescent assumes the future will be similar and, thus, unsafe. After attempting to avoid the expected outcomes, he/she attempts to exert power over others in both nonsexual and sexual ways. The response is compensatory in that it counters the perception of inadequacy and helplessness. He/she assimilates the behaviour through a series of thinking errors. The sexual abuse cycle consists of the following components: event ⇒ victim-stance perceptions ⇒ negative perceptions ⇒ avoidance ⇒ power/control seeking ⇒ fantasies ⇒ antecedent behaviours ⇒ sexual assault ⇒ fear of getting caught ⇒ reframing ⇒ event.

Lane believes that sexual abuse behaviours are sexualized expressions of nonsexual needs. The need to feel in control and have power over others is viewed as an attempt to reduce anxiety and manage distressing feelings or thoughts. Specific events that can trigger feelings of helplessness include: abandonment, physical abuse, sexual victimization, rejection, humiliation, loss, alienation, betrayal, death of a significant person or pet, parental divorce, change in environment, and family violence. For some children events or situations such as getting bad grades, being challenged or embarrassed by a peer, parental remarriage, entering a new school, losing a game, or being laughed at, can trigger feelings of powerlessness that are related to past painful experiences.

Understanding the patterns of thoughts and feelings that arise during the sexual abuse cycle is helpful for many parents and children. Awareness of offense-related behaviours and thinking is a necessary first step in many treatment interventions.

**Suggested Activities:**

Use case studies to illustrate the thinking that might occur during the sexual abuse cycle for a child or an adolescent.

### **Assessment Of Sexual Behaviour Problems**

Assessment inventories assist therapists in determining the extent and range of sexual behaviours displayed by a child. Friedrich (1992) created a 36 item measure that assesses a wide variety of sexual behaviours (as cited in Gil & Johnson, 1993). Johnson (1992) developed the Child Sexual Behaviour Checklist, an inventory of 150 behaviours related to sex and sexuality in children 12 years of age and younger. The behaviours range from natural, healthy childhood sexual exploration to severe sexual disturbances.

**Suggested Activities:**

Review Johnson's Child Sexual Behaviour Checklist and Friedrich's Inventory.

**Resources:**

Johnson, T. (1995). Treatment exercises for child abuse victims and children with sexual behaviour problems. Pasadena, California: T. C. Johnson. T.



## Session Four

- Treatment interventions
- Cognitive-behavioural therapy
- Nondirective play therapy
- Family therapy
- Group therapy
- Guidelines for caregivers

## Objectives

The participants will:

1. Identify treatment interventions recommended for children with sexual behaviour problems.
2. Describe key components of cognitive-behavioural therapy.
3. Make personal judgements about the appropriateness of victim-centered and offence-specific treatment.
4. Gain an understanding of the philosophy of nondirective play therapy.
5. Explore the goals and function of family therapy.
6. Examine the goals and format of group therapy for children and parents.
7. Generate and evaluate guidelines for educators of children with sexual behaviour problems.
8. Generate and evaluate guidelines for parents of children with sexual behaviour problems.

## **Treatment Interventions**

- Some children with sexualized behaviours grow out of the problematic behaviours, respond to limit setting from their parents, develop more appropriate ways of exploring their sexuality and learn to use their own internal controls to contain inappropriate behaviours.
- For children who remain unresponsive to limit setting and whose sexualized behaviours continue to be inappropriate and problematic, professional treatment becomes necessary.
- Early identification and treatment of sexual abuse is critical. Intervention with potential offenders at an early stage may prevent the development of chronic and persistent behaviours.
- Ideally there should be a range of treatment interventions for children with sexual behaviour problems. Most children can be effectively treated in outpatient treatment programs. High risk offenders require secure residential treatment programs.

### **Victims Or Offenders?**

Should children with sexual behaviour problems be treated as victims or offenders? How these children are viewed determines the type and direction of their therapy. The philosophy of the individual therapist or the treatment centre determines how children are treated.

Ray, Smith, Peterson, Gray, Schaffner, and Hoff (1995) point out that the

trend in the recent past has been to treat sexually aggressive youth as victims, especially younger children, but more recent trends emphasize accountability, behaviour management, and cognitive restructuring. Many treatment interventions for adolescents and children with sexual behaviour problems have been modelled after programs for adult sex offenders.

### **Cognitive-Behavioural Therapy**

Many therapists adopt a directive, structured, cognitive-behavioural approach to treating children with sexual behaviour problems. Cognitive-behavioural therapists believe that children with sexual behaviour problems require help in correcting cognitive distortions, irrational thoughts, and thinking errors.

Goals of cognitive-behavioural therapy:

- children gain increased awareness of their thoughts, feelings, and behaviours that lead to the offending behaviours
- children are taught thought stopping techniques to interrupt their thoughts as they contemplate inappropriate sexual behaviours
- children increase their control over their impulsive actions and learn to manage their own behaviour

In 1995, British Columbia's Child and Youth Mental Health Services coordinated a Provincial Consultation Group On Children Under Twelve With

Sexual Behaviour Problems. The group's task was to provide advice on policy development, clinical practice, research, and training. The consultation group produced a document entitled Best Practice Issues and Suggested Practice Standards in Working with children with Sexual Behaviour Problems (Wachtel, 1996). The authors suggest that treatment should be offense-specific and directed by the therapist. They recommend that the following issues be addressed in treatment:

1. Acceptance of responsibility for behaviour without minimization or externalizing blame
2. Identification of pattern or cycle of abusive behaviour
3. Interruption of cycle before abusive behaviour occurs; control of behaviour
4. Resolution of victimization (sexual abuse, sexual trauma, physical abuse, emotional abuse, abandonment, rejection, loss)
5. Development of victim awareness/empathy to a point where potential victims are seen as people rather than objects
6. Development of internal sense of mastery and control
7. Understanding the role of sexual arousal in sexually abusive behaviour, reduction of deviant sexual arousal; definition of non-abusive sexual fantasy
8. Development of a positive sexual identity
9. Understanding the consequences of offending behaviour for self, victim, and their families
10. Identification and remediation of family issues or dysfunctions which support or trigger offending; attachment disorders and boundary problems in their families
11. Identification of cognitive distortions, irrational thinking, or thinking errors which support and trigger offending
12. Identification and expression of feelings
13. Development of pro-social relationship skills with peers
14. Development of realistic levels of trust in relationships with adults

**Suggested Activities:**

Provide examples of specific treatment exercises used by cognitive-behavioural therapists.

Circulate workbooks on group and individual treatment strategies.

**Resources:**

Cunningham, C., & MacFarlane, K. (1996). When children abuse: Group treatment strategies for children with impulse control problems. Brandon, Vermont: Safer Society Press.

Johnson, T. (1995). Treatment exercises for child abuse victims and children with sexual behaviour problems. Pasadena, California: T. C.

Johnson. T.

## **Nondirective Play Therapy**

The research on children with sexual behaviour problems repeatedly reports significant traumatization prior to the emergence of the sexual offending behaviours. Most of these children have experienced and/or witnessed physical, sexual and/or emotional abuse, sexualized environments, neglect, or abandonment. Their behaviour problems are manifestations of past traumas.

Therapists have long recognized that play is a language through which children can easily express themselves. Most children, young children in particular, do not have well developed verbal and cognitive abilities and do not

easily communicate their thoughts and feelings through speech. In the familiar and comfortable medium of play, children can express, release, and subsequently resolve intense and deeply held feelings, memories, and traumas. For children under nine or ten years of age, play therapy is a powerful therapeutic approach for the resolution of trauma. As emotional wounds heal, children begin experiencing an increased sense of self worth and personal mastery. New feelings of adequacy enable children to develop more effective coping skills and outgrow dysfunctional behaviour.

**Suggested Activities:**

Provide participants with an opportunity to see and interact with play therapy materials.

Discuss nondirective versus directive approaches to play therapy.

Demonstrate a short play therapy session.

Show videos on play therapy sessions.

## **Family Therapy**

Family dynamics either contribute to the continuance or the elimination of a child's sexual behaviour problems. Due to the fact that families have a profound influence upon children's lives, many therapists believe that parents and siblings of a child with sexual behaviour problems must also be included in a treatment plan. If provided with adequate support and training, families can

play central roles in the therapeutic change process.

Some treatment programs for children with sexual behaviour problems require that families be actively involved in family therapy. Many parents seek therapy voluntarily, while others are court ordered by provincial child protection authorities to participate in treatment. In some cases, children with serious sexual behaviour problems are allowed to remain at home, if the family attends therapy and if they abide by certain conditions set out by child protection authorities.

There are a number of different approaches to family therapy and most therapists are trained in a particular orientation. Some of the major approaches to counselling families include: family systems theory, structural family therapy, strategic family therapy, behavioural family therapy, and conjoint family therapy. While there are differences in philosophies and techniques between the various schools of therapy, some similarities do exist. Family therapists view the family as the most effective context of change. They believe that lasting behaviour changes are more likely to occur if the entire family is involved in the therapeutic process.

During family therapy, the therapist gathers information on each parent and child. Significant life events, developmental milestones, family interactions, strengths, goals, likes, and dislikes of each family member are recorded. Children and parents are provided with opportunities to share their thoughts and feelings on a variety of issues. The therapist gains information on the sexual



behaviour problems and on the family's reaction to these behaviours.

For families whose children display inappropriate sexual activity, the ultimate goal of family therapy is the elimination of the offending behaviours. In order to achieve healthy family functioning, the therapist works with the family to: identify and interrupt family patterns that enable or support the sexual abuse, improve communication skills, increase marital and family strengths, improve relationships between family members, develop conflict resolution and stress management skills, teach appropriate internal and external controls that will assist in relapse prevention.

Rudko and Taylor (1997) suggest that the following goals be included in family treatment:

- Recognize family strengths and forgotten abilities; individual, parental, sibling, and family.
- Enhance positive connections between child and family - situate the problem within the larger knowledge of the child, reduce singular identification with the problem.
- Introduce a story of hope and competence to replace a family story of discouragement and failure.
- Encourage open family communication about the presenting sexual behaviour and solutions for such, address issues of shame, anger, and confusion.
- Assist the family to deal with all situations which may exacerbate family

stress: a) boundaries and roles

b) family hierarchy

c) the marital relationship

d) family violence and aggression

e) substance abuse

f) unresolved abuse of any family member

- Facilitate parent understanding of risk situations for the child.
- Intervene around excessive stimulation in the family environment such as aggression and overt sexuality in adult behaviour or media, and encourage parents to limit such stimulation.
- Develop safety measures at home and in the community which are not punitive or stigmatizing.
- Assist the child to ask for help when needed and parents to respond in non-reactive, supportive ways.
- Encourage parents to help the child utilize the internal controls identified by the child and develop additional controls.
- Explore family, parental, and community values about childhood sexuality and their influence on the development or solution of the problem.
- Encourage parents to enhance their knowledge of sexuality and childhood sexual development and to guide their children towards healthy sexual behaviour and knowledge.

- Reduce isolation; within the family, and between the family and the community.
- Facilitate positive family contact with other systems including school and social service agencies.

**Suggested Activities:**

Present case studies of families in therapy. Examine how each family member can contribute to the change process and to the positive resolution of the sexual behaviour problems.

## Group Therapy

In addition to individual and/or family therapy, many therapists incorporate group therapy as a component of their treatment for children with sexual behaviour problems. Gil and Johnson (1993) view group therapy as the pivotal component of effective treatment. They believe that group therapy provides children with the opportunity to develop much needed positive interaction with peers. Groups generally consist of three or four children and one or two therapists. Johnson (1993) recommends that the following abuse-specific and general goals be accomplished during group treatment:

- Decreasing children's molesting behaviour.
- Increasing children's understanding of their unhealthy associations and beliefs regarding sex and sexuality.

- Increasing children's understanding of natural and healthy sexuality.
- Increasing children's awareness of their own and family patterns that precipitate, sustain, or increase sexually abusive and other non-adaptive behaviours.
- Understanding and integrating feelings and thoughts associated with prior victimization including physical, sexual, and emotional abuse, abandonment, neglect, family breakups, and deaths.
- Helping children observe and assess their own behaviour, be aware of the circumstances preceding their behaviour, and think of the consequences of their behaviours before they act.
- Increasing children's ability to observe and appreciate other people's feelings, needs, and rights.
- Helping children understand their needs and values and develop their own goals and internal resources.
- Increasing children's ability to meet their needs in socially appropriate ways.
- Increasing children's connectedness to others and building internal supports that assist future growth.

Many treatment providers encourage and even expect parents of children with sexual behaviour problems to participate in adult group therapy. By joining group therapy, parents have the opportunity to share and process their thoughts

and feelings, meet other adults facing similar problems, learn from their peers and from the therapist. Gil (1993) suggests that the goals of group therapy for parents include:

- Parental understanding of their children's unique pattern of molesting.
- Parental clarity on their participation in providing external controls (ie., supervision).
- Parental clarity on their participation in assisting their children with internal controls ( e.g., responding when children ask for assistance as part of their prevention strategies).
- Parental cooperation in identifying and addressing high-risk factors for their children.
- Parental ability to maintain open communication with their children regarding molesting behaviours or situations.
- Parental understanding of family dynamics that may contribute to a family climate in which abuse can occur.
- Parental cooperation with all aspects of the children's therapy designed to help them stop the offending behaviour.
- Parental clarity about their thoughts, feelings, and reactions to the child who molests, the child-victim, and other family members.
- Processing of self-esteem, a sense of parental adequacy, and feelings of guilt, shame, or confusion.
- Identifying strengths and weaknesses of the family.

- Identifying strengths and weaknesses of the marital unit.
- Processing conflicts in an open and safe way.
- Decreasing dysfunctional patterns of interaction such as secrecy, collusions among family members, and triangulation.
- Increasing the use of functional patterns of interaction such as open communication, positive conflict resolution, and identifying, expressing, and negotiating needs.
- Increasing the ability to anticipate problems and use internal and external resources to cope with stress factors.
- Recognizing and correcting any and all patterns of interaction that contribute to sexualization of the family environment.

## **Guidelines For Caregivers Of Children With Sexual Behaviour Problems**

Parents, educators, and other caregivers are in positions to provide the necessary support, training, and supervision that children with sexual behaviour problems require. Although the topics of sexual abuse and sexually abusive behaviours are difficult for many adults to discuss, children will not disclose their problems if they suspect that adults will respond with anger, shock, or disgust. If adults are unable or unwilling to listen, children will be reluctant to talk. Children need to know that they will be believed, supported, protected, and

helped.

Caregivers need to encourage and model open and clear communication. If adults remain calm, composed, and compassionate in their communication, children are more likely to share their feelings, problems, or worries. Rudko and Taylor (1997) recommend that caregivers consider the following suggestions when responding to children who display inappropriate sexual behaviour:

- Be direct and calm.
- Put an end to the behaviour.
- Take a break, reflect, make a plan.
- Review appropriate behaviour, touching rules, and agreed upon plans.
- Describe how you think the other person may be affected by the behaviour.
- Encourage expression of feelings ... talking, writing, drawing.
- Re-direct to physical activity where the child can experience a sense of accomplishment.
- Celebrate the child's current successes at controlling the problem and recall past successes.

It is important that caregivers communicate to children that particular sexual behaviours are inappropriate and unacceptable. Rudko and Taylor (1997) offer the following rules for sexual behaviour:

**It is not OK**

- (1) For other people to touch your private parts.
- (2) To touch other people's private parts.
- (3) To touch or show your private parts in front of other people.
- (4) For other people to touch or show their private parts in front of you.
- (5) To do or say sexual things to other people.
- (6) For other people to say or do sexual things to you.
- (7) To make another person keep a secret about sexual behaviour.

Children who repeatedly engage in problematic sexual activity need to know that caregivers will help them to stop the offending behaviours. Caregivers can provide external controls that will reduce the likelihood of sexual misbehaviour, as well as assist children in developing their own internal controls. Berliner and Rawlings (1991) describe external control as: increasing supervision; creating a family environment which reduces the possibility of inappropriate sexual activity; and insuring that caregivers are prepared to respond constructively to misbehaviour. They believe that internal control is achieved by teaching children accurate information about sexual values and behaviour, how to recognize the risks to misbehave, and skills to handle situations appropriately.

Act II Child and Family Services (1995) recommend that caregivers increase external controls until a child develops sufficient internal controls.



They recommend the following guidelines for caregivers:

- Do not leave the child unsupervised with other children for any amount of time.
- All bathroom activities are to be done separately from others (including changing rooms and bathrooms at pools).
- Walking around nude is not appropriate, even for very young children.
- The child should not sleep in the same bed with other children or adults at any time. Ideally, the child should have his/her own bedroom.
- Caregivers should ensure that their own sexual lives are private.
- The child should never be left alone to care for younger children, even for a short period of time.
- The child should not be encouraged to interact with younger children or be put in a situation where they are seen by others to have some authority or power (i.e., teaching younger children to read at school).
- The community and extended family do not need to know all the details of the child's problem. However, anyone who is in regular contact with the child should be aware that the child needs to be consistently supervised for safety reasons.
- Door alarms are frequently necessary (ones which ring only in the caregiver's bedroom). Many children roam at night and may be involved in sexual behaviour during these times, to compensate for feelings of loneliness or abandonment.

- Having the child sleep over at a friend's home or having friends sleep over needs to be discontinued until such time that internal controls are established.

It is critical that children with sexual behaviour problems receive clear and consistent instruction about privacy and appropriate interpersonal behaviour. Children need to know that bathrooms and bedrooms are private places, and that it is inappropriate to enter these rooms when people are bathing, using the toilet, dressing, or sleeping. Caregivers must give clear messages to children about touching one's own private parts and when and where it is acceptable.

Caregivers need to ensure that children with sexual behaviour problems are not exposed to experiences or sexual stimuli that might increase sexual thoughts and behaviours. Children should be restricted from viewing sexually explicit content in magazines, television shows, movies, and music videos. Images of violence and/or sexual aggression may increase sexual feelings or sexual confusion and thus should be avoided. Caregivers need to refrain from displays of sexual behaviour, nudity, or partial nudity in front of children with sexual behaviour problems. Sexual jokes, stories, and language should also be avoided.

Children with sexual behaviour problems need instruction in effective problem-solving. Caregivers should interrupt and redirect children who misuse

their power. Children who use force to handle problems require guidance to problem-solve new solutions for their difficulties. It is important for children to learn how their behaviour affects others. Children need modelling and guidance around the appropriate expression of feelings.

It is crucial that caregivers not ostracize or reject children with sexual behaviour problems. Caregivers should strive to create environments where children receive positive attention, affection, and approval. All children will benefit from therapeutic intervention and most will learn age appropriate sexual behaviours. Caregivers are in a unique position to reinforce positive self concepts and rebuild damaged self-esteem.

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