



# Children with Sexual Behavior Problems:

Research on best practices, current systems, and policy and practice recommendations to improve Minnesota's ability to provide early identification and intervention services

June 2017

*This document was supported by a grant from Raliance, a collaborative initiative to end sexual violence in one generation, made possible through a commitment from the National Football League (NFL). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the NFL.*



# Acknowledgements

We are grateful for the financial support of Raliance, a collaborative initiative to end sexual violence in one generation, made possible through a commitment from the National Football League (NFL). Their crucial support provided the time and resources to delve into this topic.

We would also like to give special thanks to Joan Tabachnick, a nationally recognized expert in child sexual abuse prevention, for her guidance throughout this project including reviewing multiple drafts of the literature review. We are also very grateful to Jane Silovsky and Jimmy Widdifield from the National Center on the Sexual Behavior of Youth (NCSBY), part of the Center on Child Abuse and Neglect (CCAN) in the Department of Pediatrics of the University of Oklahoma Health Sciences. With their students, they provided extensive guidance, shared additional research, and reviewed multiple drafts of the literature review. Thanks also to Johnanna Ganz who provided critical guidance in developing the executive summary.

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Special thanks to these partners who assisted us in distributing our survey to professionals who work with children:

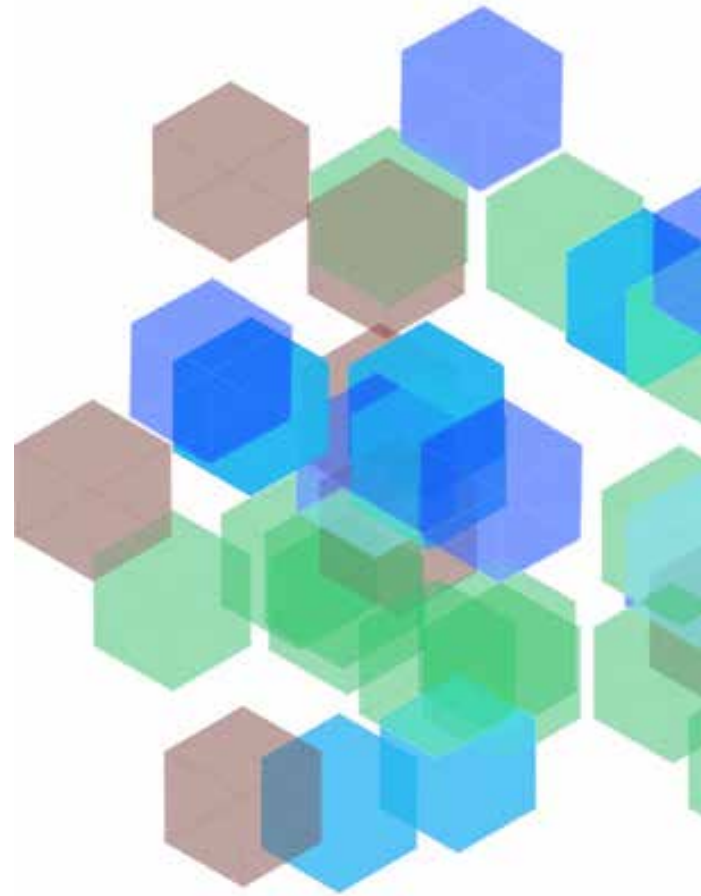
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Special thanks to these individuals for sharing their expertise in working with children with SBPs:

- Stacey Christensen, Clay County Child Protection Services
- Alyse Dalen, West Central Regional Juvenile Center - Pathways Program, Moorhead
- Shaun Dean, Hubbard County Family Services Collaborative
- Stephen Johnson, Mille Lacs Academy, Onamia
- Miranda Lillo, First Witness, Duluth
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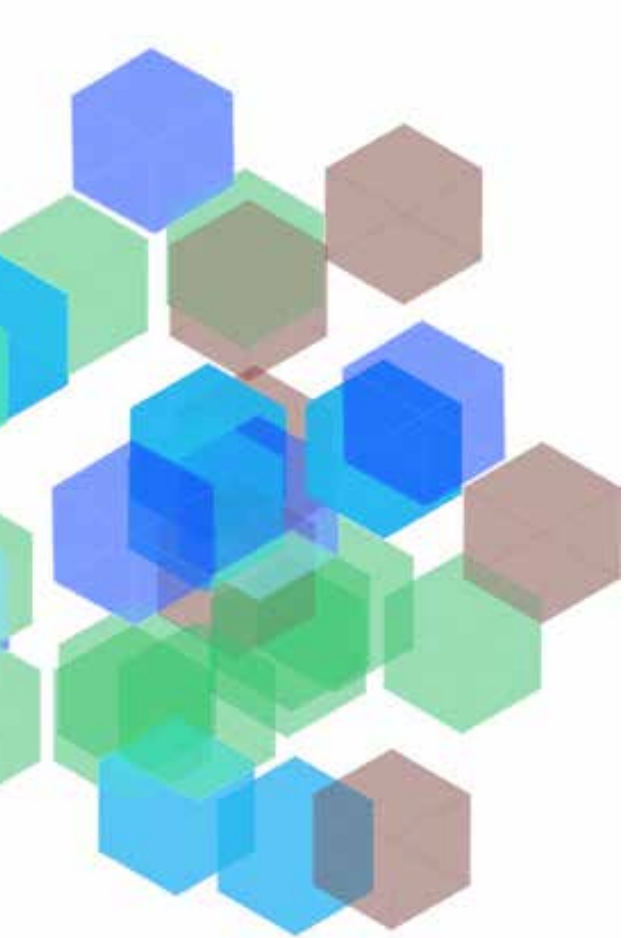
Thanks to these individuals whose input and expertise helped guide this project:

- Cordelia Anderson, Sensibilities Prevention Services, Minneapolis, MN
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- Gayle Kelly, MN Head Start
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- Kelly Monson, Children's Cabinet Program Manager, Governor's Office
- Joanne Mooney, Children's Trust Fund, MN Department of Human Services
- Scott Parker, Supervisor, Child Development Services, Minnesota Department of Human Services
- Debbykay Peterson, Early Childhood Screening; MN Parents Know, Early Childhood Services, MN, Department of Education
- Stephanie Trilling, Boston Area Rape Crisis Center, Boston, MA
- Emily van Schenkhof, lobbyist for Kids First (the CAC Coalition and Prevent Child Abuse-- Missouri chapter), Kansas City, MO



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## Children with Sexual Behavior Problems: Executive Summary

MNCASA has a long history in efforts to prevent the perpetration of sexual violence, including understanding and addressing the risk factors for perpetration of sexual violence and improving how Minnesota responds to and manages known sex offenders. This specific project grew out of our interest in better understanding the connections between responses to children’s sexual behaviors, including behaviors that are concerning or problematic, and the development of future sexual behavior problems (SBPs) in children, youth and adults.

We specifically wanted to know what’s working, as well as what is not working, in Minnesota’s current systems for identifying children with SBPs. This project aims to explore where the gaps are and what holds the best hope for improving our ability to provide early identification and intervention for children showing signs of SBPs. Our ultimate goal is reduce the likelihood of children and youth engaging in problematic or harmful sexual behaviors.

**This project aims to explore where the gaps are and what holds the best hope for improving our ability to provide early identification and intervention for children showing signs of sexual behavior problems (SBPs).**

For the purpose of this project, we are utilizing the Association for the Treatment of Sexual Abusers (ATSA) definition of SBPs: children ages 12 and younger who initiate behaviors involving sexual body parts (e.g. genitals, anus, buttocks, or breasts) that are developmentally inappropriate or potentially harmful to themselves or others.

## Methodology

This project collected information and data in multiple forms. To facilitate the process, we identified a set of guiding questions at the onset of the project and then chose five data collection methods to answer our guiding questions (for details refer to Report #1). These methods included exploratory interviews with key informants, a scan of the empirical literature, a web-based survey of professionals who work with children, investigative interviews with professionals who work with children with SBPs, and story gathering. Data for this project were collected between August 2016 and May 2017.

**The overall objective was to identify three to five policy or practice changes that would**

- **improve the early identification of children with SBPs,**
- **increase access to services for children with SBPs, and**
- **reduce the likelihood of children and youth engaging in problematic or harmful sexual behaviors.**

## Key Findings from Literature Review

To provide a solid background in best practices for addressing children with SBPs, we conducted a literature review of the latest research on incidence, identification, assessment, treatment, and policies for children with SBPs. This provided an empirical basis for our work to better understand how well Minnesota is doing in effectively identifying and intervening with children showing signs of SBPs. For detailed results, see Report #2.



## Summary of findings:

- It is difficult to estimate the incidence or prevalence of children with SBPs because **there are not widely agreed upon definitions** of what behaviors are considered problematic or harmful and because **no one system is charged with responding** to reports of children engaging in concerning or problematic sexual behaviors.
- **Sexual behaviors in children are common and determining whether sexual behaviors are problematic involves comparing the child's behaviors to developmentally-expected or normative sexual behaviors.** This requires a base understanding of what is “normal” or developmentally expected which is influenced by the attitudes, beliefs, values, and culture of the adults in the child's life. It is important to note that the intention of children engaging in concerning or harmful sexual behaviors may not be sexual but could be out of curiosity, anxiety, a need for affection, self-soothing, etc.
- While the presence of sexual behaviors in children is often thought to be a sign that a child has been sexually abused, **research shows there are multiple pathways to developing SBPs;** not all of which include having been sexually abused. Child maltreatment, coercive or neglectful parenting practices, being exposed to sexually explicit media, living in a highly sexualized environment, and exposure to family and community violence are risk factors for developing SBPs.
- **Most children who are sexually abused do not develop SBPs.**
- **Most adult offenders do not report having childhood SBPs.**
- Research shows that when children with SBPs receive **appropriate treatment,** they are at no greater risk than the general population to grow up to be adolescent or adult offenders.

## Key Findings from Survey of Professionals Who Work with Children

To better understand the knowledge and experience of professionals who work with children, MNCASA surveyed them about their experiences, policies, interest in training, and ideas for how to improve the identification and response to children showing signs of concerning or inappropriate sexual behaviors. For detailed results, see Report #3.

## Summary of findings:

- Our survey confirmed that **parents and other colleagues view professionals who work with children as resources on differentiating between children's developmentally expected sexual behaviors and sexual behaviors that are concerning or problematic or early signs of a child developing SBPs.** One out

of three have been asked a question related to childhood sexual behavior by a parent/guardian and one in four have been asked by a co-worker. One in five have observed a child engaging in behaviors involving sexual body parts.

- While survey respondents expressed confidence in their ability to differentiate between children’s developmentally expected sexual behaviors and behaviors that are potentially harmful to themselves or others, two-thirds of them also indicated they would be interested or very interested in training that covered how to recognize and respond to these behaviors.
- Survey respondents were least confident in their ability to supervise a child with SBPs, refer children with SBPs to effective treatment, engage parents or caregivers in addressing their child’s sexual behaviors, and refer a child for an assessment of their sexual behaviors. **They also expressed interest in training on how to interact with children and their parents about children’s sexual behaviors.**
- **The majority of professionals who work with children either didn’t have or were not aware of written policies, procedures, or protocols for how to respond to an incident in which a child is engaging in inappropriate or harmful sexual behaviors either alone or with another child.** When they had policies, the policies most often addressed reporting to someone external or internal to the organization, when and what to communicate with parents/ caregivers, and how to respond to the child.



## Key Findings from Interviews with Professionals who Work with Children with SBPs

To better understand the current state of response for children showing signs of SBPs, MNCASA interviewed clinicians who work directly with children with SBPs along with those to whom reports may be made. We wanted to understand how many calls or referrals they receive for children with possible SBPs, how they work with children with SBPs (where appropriate), and their sense of how well Minnesota is doing in identifying, assessing, and treating children with SBPs as well as what services or resources they would like to see for children with SBPs. For detailed results, see Report #4.

### Summary of findings:

- In our interviews with professionals working with children with SBPs (including state administrators, county child protection workers, child advocacy centers, residential treatment and out-patient treatment providers) we learned that

there is still a lot of stigma associated with SBPs which impacts how **easily** and effectively parents and professionals are able to identify and respond to children with SBPs. While **the research emphasizes the need to approach children with SBPs as children first** and underscores the effectiveness of short term treatment for children reducing their likelihood of future SBPs, many professionals continue to approach children with SBPs as “sex offenders” rather than as children engaging in inappropriate sexual behaviors.

- We learned that **there is no clear process or procedure for where to report a child who is engaging in concerning or harmful sexual behaviors** and that many different systems (including social services, law enforcement, medical providers, child protection, probation, and school staff) all come into contact with children with SBPs and yet here is no one system charged with responding to or even tracking reports of children with SBPs. This results in great variations, county by county, to reports of a child with possible SBPs.

- Professionals who work with children need guidelines for how to treat behaviors as serious, educate about treatment being available, help set up effective supervision, and create protective environments. Without these guidelines, **there is a tendency to either over-react or under-react resulting in children not receiving the help they need.**



- **There are disparities across the state in terms of access to effective treatment for children with SBPs.** Not all providers have specific training on children with SBPs and not all use evidence based treatment methods. Not all parts of the state have easy access to professionals who specialize in working with children with SBPs.
- Interviewees stressed the need for access to information and resources for professionals and parents and the need to make it safe and easy for parents to reach out for help. **They also said that there is a need for better understanding of child sexual development and children’s sexual behaviors.** This is not provided as part of their professional training but should be. Training should cover how to identify behaviors, understanding SBPs, understanding treatment, and where to refer children and families for help.



## Policy and Practice Recommendations

The ultimate objective of this research project was to identify three to five policy or practice changes needed to support the early identification of children with SBPs and their access to effective services. Based on our findings, we make these recommendations:

- 1. Make specialized training on best practices for identifying and responding to children’s sexual behaviors readily available to all professionals who work with children and families.** This training needs to address the myths about children’s sexual behaviors and share the message of hope that with treatment, children are at no greater risk to grow up to be sexually abusive. A key element of this training should be how to effectively engage parents in discussions of and treatment for their child’s SBPs. Ideally this training would be incorporated into the educational requirements for students as well as offered as part of on-going professional development or as a requirement for licensure.
- 2. Develop consistent guidelines and protocols for tracking and responding to children’s sexual behaviors, including sexual behaviors between children.** Ideally, all children would receive an assessment by a qualified professional who would make recommendations to address any SBPs and any safety risks the child poses to others.
- 3. Create written policies professionals who work with children can access on how to respond to a child showing concerning or problematic sexual behaviors, when and what to communicate to parents/caregivers, and how to refer a child for an assessment.**
- 4. Develop an educational campaign that can be used to raise awareness about children’s sexual development and SBPs.** This could be done by providing resources during well child doctor visits, sharing handouts at school open houses, etc. This effort would go a long way in reducing the stigma and fear that gets in the way of effective response to children showing early signs of SBPs.



REPORT #1

## Children with Sexual Behavior Problems: Research on Best Practices for Identifying and Providing Early Intervention Services

# Methodology

We first identified a set of guiding questions and then identified five data collection methods to generate information to answer our guiding questions (refer to Table 1). These methods included exploratory interviews with key informants, a scan of the empirical literature, a web-based survey, investigative interviews, and story gathering. Data for this project were collected between August 2016 and June 2017.

## Exploratory Interviews with Key Informants

Nineteen individuals agreed to participate in semi-structured interviews (primarily by phone) during the fall of 2016 (refer to Table 1 for the guiding questions addressed). We selected these individuals because of their:

- knowledge of different service providers for children in Minnesota (i.e., child care, Head Start, social services, mental health services, public health services, early childhood screening, early childhood education, etc.);
- recognized expertise in childhood sexual behavior, including the identification of problematic behaviors, assessment, treatment, and/or policies;
- knowledge and experience in working on this issue in another state; and/or
- recommendation from another key informant.

Each interview was documented in an interview write-up. The interview contents were then organized into 11 topical areas, noting the name and affiliation of the respondent.

These topics included language and definitions; resources (both people and documents) for more information; the Minnesota context; Minnesota data regarding sexual behavior problems (SBPs) in children; available prevalence data nationally or in other states; policy options to consider, other state models and approaches; identification, assessment, and treatment considerations and practices; connections to pornography; advice about the study design and methods; and ideas for products.

## Literature Review

We identified candidate documents through web-based searches of university and college library databases, including Minnesota State University’s database and through recommendations by key informants. Using the following criteria we selected 42 documents to review:

- Document provided a synthesis/review of the empirical literature or is based on empirical data,
- Document was published in the past 10 years (earlier only if we think it is a “must” to include),
- Document was geared to the different sectors/professional disciplines concerned with the sexual behavior of young children.

Key steps in the review process included (a) creating an inventory of documents, (b) abstracting information by source for each key guiding question; (c) creating documents to display the information by major topic (refer to Table 1 for a list of the guiding questions addressed); and (d) synthesizing the information and presenting it in a report organized by guiding question.



In our preliminary scan of the literature we noted that in 2006 the Association for the Treatment of Sexual Abusers (ATSA) Task Force on Children with Sexual Behavior Problems published a comprehensive report intended to guide professional practices with children, ages 12 and under. This report provided us with a working definition of children with SBPs, a synthesis of the research regarding the relationship of SBPs to early sexual abuse and other risk factors, the principles of good clinical assessment of children with SBPs, and a review of the treatment outcome research literature. A

section of the ATSA report is devoted to public policies, which answered questions about the risk children with SBPs pose to other children and the community, discussion of registration, public notification, and mandatory reporting, placement decisions, and interagency collaboration. We therefore viewed this document as a starting point (not wanting to duplicate their work) and made a conscious effort to search out documents published after 2006 or those that addressed guiding questions not covered in the report.

Our initial review of the literature was completed during the summer and early fall of 2016. Once the initial literature review was written, we circulated it to four national experts on children with SBPs to get their input on the accuracy of the literature review and on any key areas that were missing from the report. Based on their input, we reviewed another 10 documents.

## Web-based Survey

A total of 1,022 individuals responded to a web-based survey between February and March 2017 (refer to Table 1 for the guiding questions addressed). MNCASA distributed the survey link to eight statewide organizations who were then asked to send an e-mail to their contacts with a link to the survey. The survey was intended for practitioners in Minnesota who work with or on behalf of children. Respondents reported their primary work settings as:

- Childcare (64%)
- Head Start/Early Head Start (9%)
- Primary health care (e.g., pediatrician, family practice physician, nurse practitioner, etc.) (7%)
- School (6%)
- Home visiting (4%)
- Advocacy program (3%)
- Public Health (3%)
- Foster care (0.1%)
- Other (6%)

Eighty-three of the 98 counties or tribal lands in Minnesota (85%) included at least one respondent. The largest concentration of respondents (44%) were from six counties (Anoka, Dakota, Hennepin, Olmsted, Ramsey, and St. Louis). Only 41 (4%) of the respondents indicated they did not work directly with children.

## Investigative Interviews

Twelve individuals were interviewed by telephone using a structured set of questions in winter and spring of 2017 to further explore the availability of services for children

with SBPs in Minnesota (refer to Table 1 for the guiding questions addressed). A sample of 13 of agencies was drawn from Minnesota directories of Children’s Mental Health & Family Service Collaboratives and Children’s Therapeutic Services & Supports. Additional interviewees were selected because they were recommended by another interviewee. The types of organizations included County Child Protection Services (3), Child Advocacy Centers (2), out-patient providers (4), residential treatment (2), and other agencies serving children and families (2).

Each interview was documented in an interview write-up. The contents of each interview were then organized into five topical areas, noting the affiliation of the respondent. These topics included the type and range of involvement with children with SBPs, treatment models/curricula used, opinions regarding quality of Minnesota’s services for children with SBPs, additional services and resources needed in Minnesota, and additional thoughts.



## Story Gathering

MNCASA also gathered stories from the field in spring of 2017, adapting a method called the Story Approach first described by Rick Davies and Jess Dart<sup>1</sup>. The following steps were followed in gathering and selecting stories:

1. As part of the on-line survey, respondents were asked if they had a story they would be willing to share. Sixty-two people indicated they did and 59 people provided contact information.
2. In March, 2017, we sent an e-mail to all people who indicated they had a story they were willing to share. They were given the option of completing an on-line story form, writing their story by e-mail, or sharing their story by telephone. Five people shared their story via the on-line form and one person responded by e-mail.
3. In the submission form, the storyteller briefly told the story and the characteristics of the child involved without including identifiable information.
4. One person initially reviewed all the stories, sorting them into three categories: (a) stories that included a clear focus on SBP; (b) stories where the identification, assessment, or treatment of SBP was unclear or questionable; and (c) stories that did not involve a SBP with a child under the age of 13.
5. The stories that remained in category b were then reviewed by MNCASA staff who reviewed each story using the following criteria:
  - Does the story address children with SBPs?
  - Is the story understandable/clear?
  - Is this a story that would help people learn something about SBPs?
  - Does the story involve a sub-population of interest?
  - Does the story articulate something useful, beneficial, detrimental, and/or challenging about SBP?

A total of 6 stories submitted by 6 individuals from Minnesota were reviewed and considered. Of these, four were recommended for inclusion based on the criteria noted above.

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<sup>1</sup> Davies, R.J. & Dart, J. (2005). The most significant change (MSC) technique: A guide to its use. Downloaded from [www.clearhorizon.com.au](http://www.clearhorizon.com.au)

Table 1. Guiding questions and sources of data

GUIDING QUESTION		KEY INFORMANTS	LITERATURE REVIEW	WEB-BASED SURVEY	INVESTIGATIVE INTERVIEWS
<b>1.0</b>	<b>DEFINITIONS</b>				
1.1	How are SBPs in children defined?		X		
1.2	What are the commonly used terms?	X			
1.3	How does the definition vary by age?		X		
1.4	Do definitions of developmentally expected behaviors vary culturally?	X	X		
<b>2.0</b>	<b>INCIDENCE</b>				
2.1	What is the prevalence rate for children with SBPs in Minnesota?	X			
2.2	What is the prevalence rate for children with SBPs nationally?	X			
2.3	What types of data, if any, does MN collect on SBPs?	X			
2.4	What types of data, if any, does MN have access to related to this issue?	X			
2.5	How are other states measuring incidence?	X	X		
2.6	What are sources of data?	X	X		
2.7	What evidence connects childhood SBPs related to incidents of perpetration later in life?		X		
2.8	What evidence connects viewing of pornography as a child to the development of SBPs?		X		
<b>3.0</b>	<b>IDENTIFICATION AND ASSESSMENT</b>				
3.1	What are the known factors associated with incidence of SBPs?		X		
3.2	What distinguishes normative sexual development vs. SBPs, and how does it differ?		X		
3.3	What resources are available to facilitate identification and assessment of SBPs in children?		X		
3.4	How are professionals prepared to identify/ assess/ respond/ treat children with SBPs?		X	X	
3.5	What are best organizational practices for early identification for children with SBPs?	X	X		

Table 1. Guiding questions and sources of data continued

GUIDING QUESTION		KEY INFORMANTS	LITERATURE REVIEW	WEB-BASED SURVEY	INVESTIGATIVE INTERVIEWS
3.6	What are best administrative practices for early identification for children with SBPs?	X	X		
3.7	What are best legislative/policy practices for early identification for children with SBPs?	X	X		
3.8	What are the patterns in who identifies children with SBPs?	X	X		X
3.9	What are barriers to recognizing SBPs?	X	X		X
<b>4.0</b>	<b>TREATMENT</b>				
4.1	What treatment services are available for children with SBPs? What additional services and resources are needed in Minnesota?	X			X
4.2	What evidence based treatments are available for children with SBPs?		X		X
<b>5.0</b>	<b>ESTABLISHED PRACTICES FOR EARLY INTERVENTION OF SBPS</b>				
5.1	What are established organizational/administrative practices for early intervention services?	X	X		
5.2	What are established legislative/policy practices for early intervention services?	X	X		
<b>6.0</b>	<b>PRACTITIONER EXPERIENCES</b>				
6.1	What types of interactions do practitioners have with children's sexual behavior?			X	
6.2	What do practitioners do after observing a concerning behavior?			X	
6.3	What types of written protocols, policies, or procedures do agency have?			X	
6.4	How confident are practitioners in their abilities to deal with problematic sexual behaviors of children?			X	
6.5	What barriers do practitioners face in responding effectively?			X	
6.6	How interested are practitioners in training regarding sexual behaviors in children? What types of training would be helpful?			X	





REPORT #2:

## **Children with Sexual Behavior Problems: Research on Best Practices for Identifying and Providing Early Intervention Services**

# **Literature Review**


## **Purpose**

This report summarizes findings from a focused review of the literature to answer several questions related to

- How sexual behavior problems (SBPs) in children are currently defined,
- What is known about the incidence of SBPs among children under the age of 12 in Minnesota and nationally,
- Evidence-based practices associated with the early identification, assessment, and treatment of SBPs in children, and
- Policies that support the early identification of children with SBPs and access to effective services with a goal of ultimately reducing the likelihood of children and youth to engage in problematic or harmful sexual behaviors.

The information presented here is intended to inform subsequent work of the Minnesota Coalition Against Sexual Assault (MNCASA), including:


1. Design of a survey of stakeholders to understand the current gaps in knowledge and practice across Minnesota;

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2. Gathering of stories from parents and professionals to capture in rich detail the current gaps in identifying and providing early intervention services to children with SBPs; and
  3. Articulation of three to five specific recommendations for changes in policies and practices.

**This research report provides an overview of the latest research on incidence, identification, assessment, treatment, and policies.** This will inform the next steps of our project where we will delve more deeply into Minnesota specific opinions and experiences through interviews, surveys and by collecting stories to better understand the experiences of children and their families who are struggling with SBPs.

While the details are provided in this report, we wanted to draw your attention to a few overarching themes and patterns from this literature review:

- **All efforts to address children with SBPs must start from recognizing them as children first.** Applying methods (for assessment, treatment, supervision, etc.) designed for adolescents or adults is inappropriate and potentially very harmful. Labeling children or youth as sex offenders or perpetrators is particularly harmful because research shows that using the label “juvenile sex offender” inaccurately impacts public perception of the likelihood of SBPs to continue into adolescence and adulthood and results in more severe public policy consequences. Labels can also influence the child’s future behaviors.
- Both in Minnesota and nationally, it is difficult to calculate the prevalence of children who are identified as having possible SBPs. **There is no consistent, widely agreed upon definition of what behaviors are considered problematic or harmful** and concerning behaviors exist along a continuum which makes it hard to determine when behavior has crossed from being concerning to being problematic or harmful. There are also multiple systems (including child protection, child advocacy centers, law enforcement, juvenile justice, etc.) that can be involved, depending on the specifics of the incidents. These barriers result in there being no credible, comprehensive source of data and suggests **the need for a clear, rational, and agreed upon method to collect data.**
- **Sexual behaviors exist along a continuum** from inappropriate (e.g. rubbing genitals without regard to place or people) to problematic (e.g. looking, showing or touching) to abusive (using force or coercion). SBPs include behaviors a child engages in alone in addition to behaviors involving other children. It is important to note that the intention or motivation for the behaviors may not be sexual but could be out of curiosity, anxiety, a need for affection, self-soothing, etc.
- **Determining specific behaviors that are problematic requires a base understanding of what is “normal”** or developmentally expected which is impacted by the attitudes, beliefs, values, and culture of the adults in the child’s life. It is important to recognize how these factors impact what parents or caregivers view as problematic. It is equally important for therapists to be



aware of their own attitudes, beliefs, values and culture in order to provide treatment in the context of the child's family's attitudes, beliefs, values and culture.

- **There are multiple pathways to developing SBPs.** The presence of SBPs is enough to raise the question of the child having been sexually abused but it is not enough to conclude that the child has been sexually abused.
- **Factors known to increase the likelihood** of developing SBPs include: child maltreatment, coercive or neglectful parenting practices, being exposed to sexually explicit media, living in a highly sexualized environment, and exposure to family and community violence.
- SBPs often are associated with and need to be considered in relation to other presenting problems including Conduct Disorder, Attention Deficit/Hyperactivity Disorder, Oppositional Defiant Disorder, trauma related disorders, social skills deficits, and learning and sensorimotor strengths and concerns. **Clinical decision making and treatment planning should integrate addressing these along with the child's strengths and protective factors.**
- With appropriate treatment, research suggests that **children with SBPs can respond to evidence based treatment** with low risk for future SBPs.
- **Effective treatment and intervention strategies are available** and include these components: Cognitive-Behavioral Therapy, behavioral parent training, caregiver involvement in treatment modules on teaching rules about sexual behaviors and boundaries, using behavior management, sex education, abuse prevention, and self-control with the youth.
- Professionals who work with children (e.g. childcare providers, Head Start teachers, school social workers, school nurses, health care professionals, etc.) should have training in differentiating between developmentally expected sexual behaviors in children of various ages and behaviors that are concerning, harmful, or abusive. **These professionals can play an important role with parents** by incorporating guidance on children's sexual behaviors into their regular communication with parents.
- Policies should address both the developmental and social needs of the child with SBPs with the needs of other children. **Decisions about safety planning, living situation, etc., should be individualized** to match the specific level of risk for that child to harm themselves or others with their behaviors as well as the level of stress and support in the family and environment.
- In the rare cases when children's sexual behaviors require a criminal justice response, **adjudication decisions should be applied in a manner consistent with responses to other problematic behaviors** such as assault or theft.

# How are SBPs defined and how do they vary by age and culture?

## Summary Comments:

SBPs in children are broadly defined as behaviors that are developmentally inappropriate or harmful either to the child or to others. Sexual behaviors in children are common and determining whether sexual behaviors are problematic involves comparing the child's behaviors to developmentally-expected or normative sexual behaviors. Most researchers place sexual behaviors along a continuum from natural and healthy childhood sexual play to behaviors that are concerning, problematic or harmful to self and others. There is more agreement on what behaviors are abusive than on what behaviors are developmentally expected, particularly in children older than 10.

Challenges exist because there is no definitive definition or understanding of what is normative sexual development. There is recognition that what is normative varies by age, developmental trajectory, and by culture. Since these definitions can be used to determine future implications for children in terms of child welfare, mental health, and juvenile justice, it is important to work toward empirically derived knowledge based on children of many different cultural backgrounds.

***Sexual behaviors in children are common and determining whether sexual behaviors are problematic involves comparing the child's behaviors to developmentally-expected or normative sexual behaviors.***

There are also a variety of phrases used to describe SBPs (including harmful, intrusive, aggressive, etc.) The term children with sexual behavior problems or problematic sexual behaviors is preferred because it separates the child well-being from the problematic behaviors. Using labels such as perpetrators or sex offenders, isn't appropriate and doesn't recognize that most children who have SBPs do not continue these behaviors as adolescents or adults. In addition, labels such as "juvenile sex offender" trigger beliefs in the intractability of SBPs that research doesn't support and leads to greater public support for policies like registration and public notification.

## Definitions of SBPs

In 2006, a national taskforce formed by the Board of Directors of the Association for the Treatment of Sexual Abusers (ATSA) broadly defined sexual behavior problems in children as:

**Children ages 12 and younger who initiate behaviors involving sexual body parts (i.e., genitals, anus, buttocks, or breasts) that are developmentally inappropriate or potentially harmful to themselves or others.** (Chaffin, Berliner, Block, Friedrich, Johnson, Friedrich, Louis, Lyon, Page, Prescott, & Silovsky, 2006, p. 3)

SBPs may involve behaviors that are entirely self-focused (e.g., excessive masturbation) or behaviors that involve other children, including showing or looking at private parts, fondling, or penetration. Sexual behaviors vary in the degree of mutuality or coercion as well as the potential for psychological or physical harm of one child by another. **Sexual behaviors are viewed as developmentally inappropriate when they (1) occur at a greater frequency or at a much earlier age than would be developmentally or culturally expected, (2) become a preoccupation for the child, and/or (3) reoccur after adult intervention/corrective efforts.** (Allen, 2017; Elkovitch, Latzman, Hansen, & Flood, 2009; Kellogg, 2010; Latzman & Latzman, 2015)

From research with a variety of cultures, sexual acts that are intrusive (e.g., insertion of finger or object in another child's vagina or rectum), planned, or involved aggression were not reported to occur in normative, nonclinical samples (Silovsky, Swisher, Widdifield, & Turner, 2013; Swisher, Silovsky, Stuart, & Pierce, 2008).

## Commonly used terms

There are a wide variety of terms used regarding the sexual behavior of children, some more descriptive and less stigmatizing than others. Some agencies suggest using the phrase **“sexually reactive children”** in place of sexual behavior problems (SBPs) in order to address concerns in the field about labeling children as sex offenders (Tabachnick, personal communication, August 2016). However, because the phrase “sexually reactive” has been used to describe children and adolescents with SBPs as a result of traumatic experiences, care must be taken to not automatically assume that children who have SBPs have been sexually abused themselves (Kellogg, 2009; Kellogg, 2010; Latzman & Latzman, 2015).

Other terms or phrases used include: **“harmful sexual behavior,” “sexually intrusive behavior,” “sexually aggressive,” “sexual acting out,” “sexually abusive behavior,” and “interpersonal (behaviors that involve other children) or non-interpersonal (behaviors that are entirely self-focused) sexual behavior problems.”**

A number of phrases attach labels to children: “perpetrators,” “children who molest,” “prepubescent offenders,” “victim-perpetrators” (Village Counseling Center). In particular, use of “sex offender” or “sexual abuser” to refer to children under the age

of 10 who exhibit SBPs is widely discouraged in the field to differentiate children from adult sex offenders who engage in sexual activities for gratification of their own sexual needs (Russell, 2014). **Most young children who display sexually inappropriate behaviors do not follow these adult patterns or grow up to continue these behaviors as adolescents or adults** (Russell, 2014).

Terminology derived from adults can stigmatize children, overemphasizing the potential threat they pose to society resulting in policies or practices that isolate children with SBPs. Research has found that using the term **“juvenile sex offender”** is associated with people overestimating the probability that these youth will continue their behavior as adults and leads to greater support for policies such as registration, public notification, and social networking bans (Harris & Socia, 2016).

Alternatively, the terms **“sexual play”** and **“sexualized behaviors”** are generally used to label developmentally appropriate behaviors or normative sexual behaviors among children. (Kellogg, 2010; Village Counseling Center).

## Normative sexual development

Children’s sexual development and behaviors are influenced by their social world (DeLamater & Friedrich, 2002). Children display a wide range of sexual behaviors yet few comprehensive empirical studies are available regarding the sexual behavior of children. In U.S. culture, childhood sexuality has competing meanings. It is variously understood as natural curiosity, a sign of sexual abuse, or a symptom of a sex-offender in the making (Martin, 2014).

**In U.S. culture, childhood sexuality has competing meanings. It is variously understood as natural curiosity, a sign of sexual abuse, or a symptom of a sex-offender in the making.**

**Yet, sexual behaviors in children are common, occurring in 42 to 73 percent of children by the time they reach 13 years of age** (Kellogg, 2009). Developmentally appropriate behavior that is common and frequently observed in children includes trying to view another person’s genitals or breasts, standing too close to other persons, and touching their own genitals (Campbell, Mallappa, Wisniewski, & Silovsky, 2013; Kellogg, 2010; Russell, 2014). Sexual behaviors observed in young children include self-stimulation, “playing doctor” or touching another’s genitals, exposing one’s genitals, talking about bodies or sexuality, and kissing or imitating adult sexual behaviors (Hornor, 2004).

While there is general agreement about what behaviors are problematic or illegal, **there is a lack of consensus on what is considered normative sexual behavior** at different points in a child’s life (Bonner, 2000; Elkovitch, et al., 2009; Silovsky, et al., 2013). Because SBPs are formally defined and assessed in terms of deviations from societal norms (Carpentier, Silovsky, & Chaffin, 2006), there is a pressing need to broaden the understanding of normative childhood sexual behavior. It is not uncommon for adults to attach “adult” meanings and motivations to children’s

behaviors. Due to adults' life experiences, normative sexual play for children can often be misidentified as concerning behaviors (Russell, 2014).

The type and frequency of normative sexual behaviors vary with the age and development of the child. Infants as young as seven months have been found to touch and play with their own genitals with boys engaging in this more frequently than girls. This touch most often is related to curiosity and pleasure seeking (Silovsky & Swisher, 2008). Beyond infancy, sexual behaviors increase as toddlers become more aware of their body parts, including their genitals, physiologic sensations deriving from their genitals, and gender differences. **In general, sexual behaviors in children two to five years of age are of a greater variety and occur more often compared with sexual behaviors in children older than five years** (Kellogg, 2010; Swisher, et al., 2008). Researchers note that sexual behaviors observed by adults tend to peak between the ages of 3 and 5. After that, children may pick up on social norms and taboos and will avoid engaging in sexual behaviors when they might be observed (Sandnabba, Santtila, Wannas, & Krook, 2003).

## Distinguishing normative sexual development from SBPs

Professionals in the field often view sexual behaviors along a continuum ranging from common sexual play to problematic sexual behavior (Kellogg, 2010; Silovsky & Bonner, 2004). At one end of the continuum is sexual play that:

- Is exploratory and spontaneous;
- Occurs intermittently and by mutual agreement;
- Occurs with children of similar age, size, or development level;
- Occurs with children who know each other;
- Is not associated with high levels of fear, anger, or anxiety;
- Decreases when told by caregivers to stop; and/or
- Can be controlled by increased supervision.

**A majority of adults (66% to 80%) recalled experiencing sexual play at least once and it can occur in children as young as 2 or 3 years old** (Lamb & Coakley, 1993; Larsson & Svedin, 2001; Reynolds, Herbenick, & Bancroft, 2003).

At the other end of the continuum, sexual behavior is considered problematic when it:

- Is frequent, repeated behavior such as compulsive masturbation;
- Occurs between children who do not know each other well;
- Occurs with high frequency and interferes with normal childhood activities;
- Is between children of different ages, sizes, and development levels;
- Is aggressive, forced, or coerced;
- Does not decrease after the child is told to stop the behavior; and/or
- Causes harm to the child or others. Example: a child causes physical injury, such as bruising, redness, or abrasion on themselves or another child, or causes another child to be highly upset or fearful.

Determining where sexual behavior falls on the continuum of typical, concerning, and problematic involves establishing the types of behavior, frequency, duration, emotional responses, and ages/abilities of the children. Use of tools like the **Child Sexual Behavior Inventory** (Friedrich, 1998) are helpful because they provide guidelines for examining the frequency and developmental appropriateness of behaviors at different ages and stages of development.

## Models used for determining SBPs in children

In the past 25 years, researchers have put forward a variety of overlapping conceptualizations of inappropriate sexual behavior among children. In 1991 Toni Cavanaugh Johnson was amongst the first to distinguish **sub-types of problem sexual behavior of children**, emphasizing the age-appropriateness of the nature and frequency of sexual activity by a child or between children and the child's responsiveness to correction by adults (Webster & Butcher, 2012). She clustered children under the age of 13 along a continuum of sexual behaviors:

- Children engaging in natural and healthy childhood sexual play;
- Sexually reactive behaviors – where the child's focus is out of balance compared with their peers;
- Extensive mutual sexual behaviors – where the child may engage in a full spectrum of adult behaviors, generally with age-mates; and
- Molestation behavior – children who harm others through their sexual behaviors.

In 1993, Pithers, Gray, Cunningham, and Lane (Webster & Butcher, 2012) identified **five criteria to determine if a behavior set is normative, problematic or abusive**:

- The extent to which the type of sexual activity is consistent with the child's developmental level;
- The extent to which the children have equal power;
- The extent to which force or intimidation were used;
- The extent to which secrecy was involved; and
- Whether the behavior has an impulsive or obsessive quality.

In 1997, Ryan (Webster & Butcher, 2012) developed a tripartite model which identified the factors of equality, consent and coercion as central to defining a child's sexual behaviors as 'abusive'. Ryan also developed a **four level classification for behaviors**: green flag, yellow flag, red flag and abusive behaviors.

Gerard Webster and Jude Butcher (2012) incorporated these conceptualizations into **a two-pronged typology: Type 1 (healthy) or Type 2 (problem sexual behavior)**. Within Type 1 there are two subtypes:

- Type 1A (normative) in which a child's sexual behaviors are age-appropriate and facilitate psychosexual development, or
- Type 1B (exaggerated) in which the sexual behavior is outside age-related



norms but does not cause harm to any child and is done in such a way that does not unduly expose the child to harsh reactions of others (e.g. unusually frequent auto-erotic activity or interpersonal sexual experimentation).

Type 2 includes three subtypes:

- Type 2A: Sexualized in which the child is psychologically harmed by their own behavior as it is indicative of psychopathology (e.g. a re-enactment of prior trauma).
- Type 2B: Affronting, meaning the child may be at risk of social sanctions as their behavior places them outside societal norms (e.g. engaging in sexual behaviors in the school playground).
- Type 2C: Harmful because the behavior poses a risk of harm to others where issues of inequality, absence of consent, and/or coercion are present.

## Considerations for determining whether a child's sexual behaviors are problematic

**Guidelines for caregivers** (meaning parents and other adults who care for children) advise them to be concerned about a child's sexual behaviors if it: (1) occurs frequently; (2) does not respond to typical parental interventions or strategies; (3) causes physical or emotional harm to any child; (4) involves children of widely differing ages or abilities, such as a 10-year-old child who has sexual behaviors with a 4-year-old child; (5) was initiated with strong, negative feelings (e.g., anger, anxiety); and/or (6) involves any type of coercion, force, or aggression (Campbell, et al., 2013, p. 158).

**Research has demonstrated that within the context of childcare settings, parents and childcare providers interpret and respond to sexual behaviors among children differently** (Martin, 2014). Although adults may routinely find such behaviors "inappropriate," how they further interpreted and reacted to the events is based on their relationship with the child. Parents are more likely to respond under the assumption that their child was the victim (regardless whether the behavior appeared mutual), particularly when the other child is the instigator. Childcare providers, in contrast, are most likely to react to sexual incidents by treating them as another form of misbehavior to be managed by educating children, reporting to parents, and increasing supervision; they rarely invoke a sexual abuse frame for understanding these incidents.

## Impact of environment on developmentally expected behaviors

Children's sexual behaviors are influenced by their social world, including their family environment. (DeLamater & Friedrich, 2002). Family beliefs, attitudes, customs, knowledge, sexual decision making, and risk taking (Herdt, 2004) are part of the family sexual culture and therefore influence the development and behavior of children (Thigpen, 2009). Family nudity is positively correlated to more frequent reported sexual behavior in children. Parents who do not believe child sexuality is normal report fewer sexual behaviors in their children. **Parent attitudes towards**

**sexuality also impact their child rearing practices including responding negatively to and potentially discouraging specific behaviors** (Friedrich, Sandfort, Oostveen, & Cohen-Kettenis, 2000).

## Impact of culture on developmentally expected behaviors

There is no evidence to suggest that any ethnic or cultural group is more likely to have children who exhibit SBPs and that generally, the profile of children with SBPs conforms to the proportions of the demographics of the community (HM Government, 2015). Similarly, **there is no evidence to suggest that SBPs are impacted by socio-economic factors.**

While children from lower socio-economic families may be more likely to be identified, this is more likely due to the fact that these children have greater contact with social services (HM Government, 2015).

Western culture tends to view children as innocent and pure, lacking any sexual desires, thoughts, or interests (Heimann et al., cited in Horner 2004). Paradoxically, **in Western culture**

**children are exposed to sexual images on television, in movies, and via the Internet** while their parents are often reluctant to discuss sex with their children at young ages because they believe children aren't sexual and because they are uncomfortable discussing sex and sexuality (Heimann et al., cited in Horner 2004).

The Association for the Treatment of Sexual Abusers (ATSA) definition of childhood SBPs emphasizes the role of culture, noting that sexual behaviors are considered inappropriate when they occur at a greater frequency than would be culturally expected (Elkovitch, et al., 2009). **The cultural and societal context in which children grow up, including family attitudes and educational practices can impact children's knowledge of sexuality and sexual behavior** (Kellogg, 2010; Silovsky, Swisher, Widdifield, & Burris, 2012). Similarly, aspects of culture such as religion, spirituality, social class, historical experiences, customs, race, and ethnicity can impact receptivity and response to treatment for children with sexual behavior problems. The sensitive nature and at times taboo rules around the topics of sexual behavior and children



heightens the importance of cultural congruence in service delivery addressing child SBPs (Silovsky, et al., 2012).

Ford and Beach proposed the notion that culture influences sexual attitudes, beliefs, and practices in 1951. While their research utilizes an outdated framework by differentiating “Western” societies, we include it here to note that the understanding that sexuality varies by culture is well established.

**Sexual behaviors are considered inappropriate when they occur at a greater frequency than would be culturally expected.**

“Most Western societies are classified as “restrictive,” and intentionally impede or limit sexual knowledge and experiences during childhood. Alternatively, higher frequencies of sexual behaviors in children have been found in more permissive social environments where nudity is acceptable, privacy is not reinforced, and exposure to sexualized material is common (as opposed to social environments that reinforce modesty and privacy). Similarly, caregivers’ attitudes towards children’s sexuality have been found to impact children’s sexual knowledge and behavior. For example, caregivers who report a more liberal or relaxed approach to parenting (e.g., family nudity, co-bathing, witnessing intercourse, and co-sleeping) also report higher levels of general sexual behaviors (e.g., self-touch, touching of parental genitals) for their children; and these differences remain after controlling for several other family variables” (Campbell, et al., 2013, p. 158).

## Impact of race and ethnicity on developmentally expected behaviors

Given the low numbers of non-white children in studies used to determine normative sexual behaviors in children, we were interested in available studies that looked at childhood sexual behavior as it occurs within a specific ethnic group.

Thigpen sought to describe the range and frequency of behaviors in a sample of low-income, African American children aged 2 to 12 with no known history of sexual abuse. He determined **African American children display a similarly broad range of sexual behaviors as compared to white children.** African American children show an increase in sexual behaviors for 10 to 12 year olds which can be explained by the earlier sexual maturation of African American children. African American children were also found to engage in less masturbatory behaviors which is consistent with lower levels of masturbation among heterosexual African Americans. Finally, African American parents might be reluctant to report on sexual behaviors in their children out of fear these will confirm long-standing stereotypes about African American sexuality (Thigpen, 2009).

To determine **normative behaviors in Latino pre-school age children,** researchers administered the Child Sexual Behavior Inventory with 188 mothers of pre-school (3-5) age children of Latino ethnicity. Latino mothers reported higher levels of their

children kissing other children, standing too close to people, and being overly friendly and affectionate with adults, touching or trying to touch mothers' breasts, and lower levels of touching their private parts. These differences can be related to common patterns of physical affection, higher levels of breast feeding, and taboos in Latino culture against masturbation (Kenny & Wurtele, 2013).

## What do we know about incidence and the factors that influence it?

**Summary Comments:** It is challenging to accurately estimate the incidence and prevalence of SBPs in children.

For many years, the field believed that SBPs were a reaction to a child's experience of being sexually abused. Current practice is to recognize that the presence of SBPs should raise the concern that a child may have been sexually abused but should not be enough to assume a child has been sexually abused. Similarly, research shows that most children with SBPs are at no greater risk to grow up to be adolescent or adult offenders than the general population when they receive appropriate treatment.

***Research shows that most children with SBPs are at no greater risk to grow up to be adolescent or adult offenders than the general population when they receive appropriate treatment.***

The origin and maintenance of SBPs appears to be due to a combination of individual, familial, social, and developmental factors and children with SBPs are a complex and heterogeneous group. Researchers have identified an extensive list of specific factors that have been found to have a negative impact on the sexual development of children as well as factors that help to mitigate the development of SBPs. Additionally, children with SBPs are more likely to have additional internalizing symptoms (e.g. depression, anxiety, etc.) and externalizing symptoms (e.g. aggression, hyperactivity, etc.). Researchers also noted that exposure to age-inappropriate sexual materials can prompt or modify behaviors in children.

## Prevalence

**Epidemiological data regarding the prevalence of SBPs in Minnesota or nationally have to date not been routinely collected or reported** (Allen & Berliner, 2015; Carpentier, et al., 2006; Silovsky et al., 2013). Factors inhibiting the collection of these data include inconsistent definitions of the behaviors, limited epidemiological and longitudinal research, and fragmented professional responses (Silovsky et al., 2013).

A number of researchers have provided estimates of the prevalence of normative sexual behaviors in children that include children under the age of 12:

- Sexual behaviors in children are common, occurring in 42 percent to 73 percent of children by the time they reach 13 years of age (Kellogg, 2010).
- Somewhere between 40 and 85 percent of children will engage in some sexual behaviors with other children before they turn 18 (Russell, 2014).

Researchers have also provided estimates of the prevalence of children with SBPs:

- Girls are more likely to be referred for services for SBPs during preschool years with boys more likely to be referred during the school age years (Silovsky & Niec, 2002; Bonner, Walker, & Berliner, 1999; Gray, Busconi, Houchens, & Pithers, 1997).
- Approximately 6 percent of children presenting for mental health treatment may display some form of serious SBPs (Friedrich, 2007 cited in Allen & Berliner, 2015).

## Sources of data

We found no information about potential sources of valid and reliable prevalence data in the literature.



## Origins of SBPs

Sexual behavior problems in children do not represent a syndrome or diagnosable condition but rather a continuum of behaviors considered unacceptable by society and that cause impairment in functioning (Carpentier, et al., Silovsky, & Chaffin, 2006, Elkovitch, et al., 2009; Silovsky, et al., 2013). SBPs may be a single-focused problem, part of a trauma-related reaction, a symptom of a disruptive behavior disorder or other clinical concerning condition, or a combination of these (Silovsky, et al., 2013, p. 403). **Researchers further emphasize that the intentions and motivations for these behaviors may or may not be related to sexual gratification or sexual stimulation.** These behaviors may simply be related to curiosity, anxiety, need for affection, imitation, attention-seeking, self-calming, or other reasons (Carpentier, et al., 2006; Silovsky, Niec, Bard, & Hecht, 2007).

## Factors associated with the incidence of SBPs

Children with SBPs are a complex, heterogeneous group, more so than adolescents with SBPs or adult sexual offenders (Elkovitch, et al., 2009). They vary in terms of demographic characteristics, co-occurring clinical issues, and the social environment in which they live (Elkovitch, et al., 2009; Silovsky, et al., 2012).

**Children with SBPs are more likely than children with normative sexual behaviors to have additional internalizing symptoms of depression, anxiety, withdrawal, and externalizing symptoms of aggression, delinquency, and hyperactivity** (Allen, 2017; Kellogg, 2009). In a clinical sample of children six to twelve years of age with sexual behavior problems, the most common co-morbid diagnoses were Conduct Disorder (76 percent), followed by Attention-Deficit/Hyperactivity Disorder (40 percent) and Oppositional Defiant Disorder (27 percent) (Kellogg, 2010).

There are many factors that influence whether a child develops SBPs. (Silovsky et al., 2012; Silovsky, et al., 2013). Contributing factors may include child maltreatment, coercive or neglectful parenting practices, exposure to sexually explicit media, living in a highly sexualized environment, exposure to family violence as well as individual factors and heredity (Bonner, 2000; Chaffin, et al., 2006; Kellogg, 2009; Kenny, Dinehart, & Wurtele, 2013; Kenny & Wurtele, 2013; Silovsky & Bonner, 2003; Silovsky & Bonner, 2004; Silovsky, et al., 2012; Silovsky, et al., 2013).

**Grant and Lundeberg provide an extensive list of specific factors found to have a negative impact on the sexual development of children.** These include “sexual abuse, physical abuse, neglect, medical/health problems, mental health issues, behavioral disorders, learning disabilities, social deficits, high levels of family stress, lack of age appropriate sexual information, disrupted parent-child relationships, exposure to highly sexualized material/information, rigid or overly restrictive family views regarding sexuality, poor family boundaries, overly punitive/permissive parenting, unstructured home environments, parents or other key relationship figures modeling inappropriate sexualized behaviors, etc.” (Webster & Butcher, 2012, p. 23).

## Supportive and protective factors

Factors associated with lower likelihood of developing SBPs include:

- Healthy boundaries supported and modeled;
- Protection from harm and trauma;
- Parental guidance and supervision;
- Healthy friendships;
- Open communication about feelings with a trusted adult;
- Successful experiences/skills;
- Adaptive coping skills (Silovsky, Jenkins, Hill & Dunn, 2016).

## Relationship between childhood sexual abuse and developing SBPs

There has been an evolution in thinking about the link between the experience of being sexually abused and childhood SBPs over the past 20 years. A commonly held historical assumption was that SBPs were exclusively sexually reactive behaviors of children who had been sexually abused. Early research on SBPs focused on examining what types of sexual behaviors were indicative of a history of sexual abuse (Silovsky, et al., 2013).

**Current thinking is that although a significant number of children with SBPs have a childhood history of sexual abuse, most children who have been sexually abused do not develop sexual behavior problems** (Allen, Thorn, & Gully, 2015; Kellogg, 2010; National Center on Sexual Behavior of Youth, 2003, Kendall-Tackett, Williams, & Finkelhor, 1993). Children sexually abused at a younger age, abused by a family member, or whose abuse involved penetration are at greater risk of developing SBPs (Kellogg, 2010).



## Relationship between childhood SBPs and later adult perpetration

**Most adult sexual offenders do not report a childhood onset for their behavior**  
(National Center on Sexual Behavior of Youth, 2003).

Based on a review of available treatment outcome research, the ATSA Task Force on Children with Sexual Behavior Problems stated in their 2006 report:

...the available evidence suggests that children with SBPs are at very low risk to commit future sex offenses, especially if provided with appropriate treatment. After receiving appropriate short-term outpatient treatment, children with SBPs have been found to be at no greater long-term risk for future sex offenses than other clinic children (2-3 percent) (Chaffin, et al., 2006, p. 2).

## Relationship between childhood SBPs and exposure to sexually explicit materials

Persistent exposure to age-inappropriate sexual behavior, knowledge or material (i.e., pornographic pictures and videos) is frequently listed as one of many factors that prompt or modify sexual behaviors among children (Kellogg, 2009; Kellogg, 2010; Latzman & Latzman, 2013).





# What are best practices for assessing children for SBPs?

## Summary Comments:

An assessment is used to evaluate the presence and influence of risk factors as well as protective factors. It can be used to determine if the reported sexual behaviors are problematic. It is not intended to determine facts in a case or to determine culpability. Rather it is a thorough review of the history of the concerning behavior as well as personal and contextual factors to better understand what might have led or contributed to the SBPs. Assessments are not used to predict future behavior but can be used for case management and treatment planning.

It is best practice to use an evidence-based risk assessment tool when available and appropriate. Both risk and protective factors should be assessed. Due to developmental changes in children, an assessment remains effective for no more than a year and significant changes in life circumstances can signal the need for reassessment.

***Assessments are not used to predict future behavior but can be used for case management and treatment planning.***

It is also important to consider the SBPs in the context of other co-existing issues that influence the child's behavior including Attention Deficit/Hyperactivity Disorder, trauma related symptoms, social skills deficits, co-morbid diagnoses, etc.

Practitioners who assess children with SBPs should be knowledgeable about normative sexual development, aware of their own attitudes, values, and beliefs related to sexual behaviors, and understand the factors that differentiate age-appropriate behaviors from problematic behaviors. Additionally, they should have expertise in common childhood mental health and behavior problems including co-morbid problems frequently seen in children with SBPs (e.g. Conduct Disorder, Attention Deficit/Hyperactivity Disorder, child maltreatment, self-control issues).

A limited number of specific assessment strategies exist for children and it is important that practitioners not use adult or adolescent tools or procedures with children. It is also important that they guard against viewing children's behaviors in an adult context.

Assessment reports should address safety planning, treatment, the parent/caregiver/family role in treatment and how to address co-occurring issues. In developing these recommendations, it is important to consider the best interest of the child along with the interests of the family, other children and the community.

## Assessment resources

Sexual behavior is typically assessed via parent report or surveys completed by anyone who knows the child well, using measures originally developed in the early 1990s that have continued to be refined (Kellogg, 2009; Chaffin, et al., 2006). While age and gender norms have been established for many of these tools, questions may need to be adapted for children with disabilities or those from different cultural backgrounds. **Best practices in clinical assessment stress understanding the child's sexual behavior in context** (Kenny & Wurtele, 2013; Silovsky, et al., 2013).

- The **Child Sexual Behavior Inventory** (CSBI) is designed for children ages 2-12 and measures the frequency of both common and atypical behaviors, self-focused and other-focused behaviors, sexual knowledge and level of sexual interest, and planned and aggressive sexual behaviors. This is the only assessment tool that is normed by gender and age.
- The Child Sexual Behavior Checklist (CSBCL) assesses behaviors related to sex and sexuality in children ages 12 and under, including children's sexual behaviors with other children, the presence of problematic sexual behaviors, and environmental issues that can increase problematic sexual behaviors in children.
- The **Weekly Behavior Report** (WBR) tracks week-to-week changes in general and sexual behavior among young children.

Other tools for measuring behavior and emotional symptoms mentioned in the clinical literature include: the **Child Behavior Checklist**, the **Behavior Assessment System for Children**, and the **Trauma Symptom Checklist for Children** (TSCC).



## Best practices in identification and assessment

A clinical assessment includes a thorough review of not just the history of the SBPs but also an assessment of the child's behavior and background, including trauma, trauma symptoms and learning problems, the family's history, and the child's developmental and psychosocial history including their individual strengths and their broader social context in the home, school, and community. **The assessment process addresses any needed safety planning and determines when and what treatment services are best suited for the child with SBPs and their family.** Ongoing assessment during treatment provides guidance to family members, professionals and others involved with the child and family when considering discharge from services (Silovsky, et al., 2013).

In conducting an assessment, practitioners will interview the identified child, the child's primary caregiver, and other important figures in the child's life (Chaffin, 2008) to develop an understanding of the child's sexual behavior in context, particularly factors that come to bear on the child's sexual learning and behavior. **Practitioners should therefore assess the sexual beliefs, attitudes, understanding, and customs of a child's family.** In particular, assessments should consider familial perceptions regarding the normalcy of sexual behavior in childhood; primary caregivers who believe sexual behavior is abnormal in childhood may be more likely to allege problematic sexual behavior (Chaffin, et al., 2006; Kellogg, 2009; Kenny & Wurtele, 2013; Russell, 2014).

**Primary caregivers who believe sexual behavior is abnormal in childhood may be more likely to allege problematic sexual behavior.**

Common co-occurring clinical issues should be addressed as part of an assessment of SBPs in children, including (1) disruptive behavior disorder symptoms (e.g., Attention-Deficit/ Hyperactivity Disorder, Oppositional Defiant Disorder); (2) trauma-related symptoms for children who have experienced trauma; (3) other internalizing symptoms; (4) social skills deficits; and (5) learning and sensorimotor strengths and concerns (Silovsky, et al., 2013).

An assessment report should include recommendations for supervision, treatment, the nature of participation of the caregiver(s) in treatment, the involvement of others such as schools and pro-social activities the child may be involved with as well as how co-occurring issues will be addressed (Swisher, et al., 2008). **Assessments remain valid for no more than one year** and, when significant changes in circumstances occur, such as family reunification, changes in treatment, new incidents of SBPs, or challenges in treatment progress, assessments should be conducted more often (Massachusetts Adolescent Sex Offender Coalition, 2015).

The ATSA Task Force on Children with Sexual Behavior Problems highlighted a number of assessment issues in their report (Chaffin, et al., 2006, pp. 11-13):

- **Assessors should guard against projecting adult constructs onto children** (i.e., sexual attraction toward children, deficient victim empathy, and patterns

of “grooming behaviors”). The use of adult and adolescent sexual behavior assessment procedures is inappropriate for children and should not be used.

- Assessors should not presume that SBPs, even SBPs involving clearly adult-like sexual behaviors, are sufficient to conclude that there has been sexual abuse. **Research to date suggests there are multiple pathways to SBPs, only some of which may involve sexual abuse.** Thus, the presence of childhood SBPs is sufficient to raise the question of sexual abuse but not sufficient to conclude sexual abuse has occurred. Inquiring about possible past sexual abuse with the child and with his or her parents/caregivers is appropriate but may not lead the assessor to conclude there is sufficient reasonable suspicion to warrant making a report to the authorities. It is usually not advisable for assessors to move beyond clinical inquiry into the more involved task of abuse investigation or forensic interviewing.
- Child assessment reports often include explicit statements recognizing that children’s behavior and status change over time as the child develops and matures and as circumstances and the social environment change, thereby limiting the report’s long term validity. Interpretations of an assessment should be made with the understanding that children develop, mature, and change rapidly, particularly if provided with evidence based treatment. **Generally, behavior occurring recently should be given greater weight than behavior occurring in the distant past.**
- **Assessors must consider the best interests of the child along with the interests of the family, other children and the community.** Child assessment reports should include some estimate of how any intervention recommendations or decisions might negatively affect the child. If residential or out-of-home placement is being considered, assessors should carefully consider the potential for any negative social, educational or familial impact on the child, along with the potential benefits to the child and the importance of protecting other children and the community.

## Qualifications of professionals

The ATSA Task Force on Children with Sexual Behavior Problems recommended in their 2006 report that assessments of children with SBPs should be conducted by licensed mental health professionals who have expertise in the following:

- Child development (including sexual development and behavior);
- Differential diagnosis of childhood mental health and behavioral problems;
- Co-morbid problems frequently seen among children with SBPs (including Attention Deficit/Hyperactivity Disorder, child maltreatment, child trauma, and conditions that may affect self- control);
- Understanding environmental, family, parenting and social factors related to child behavior, including the factors related to the development of sexual and non-sexual behavior problems;

- The connection between the social environment and other factors that contribute to the development and maintenance of child behavior, including sexual behavior;
- Familiarity with the current literature on empirically supported treatment for childhood mental health disorders and SBPs; and
- Cultural variations in norms, attitudes and beliefs about childrearing and childhood sexual behaviors.

## Patterns and challenges in identifying children with SBPs

**Information used in identifying children with SBPs may come from child self-reports and teacher reports, as well as caregiver reports** (Allen, 2017). The actual interpretation of this information requires a knowledge of normative sexual development in children, a self-awareness of one's own attitudes, values, and beliefs related to childhood sexuality, and an understanding of the factors that differentiate age-appropriate sexual behaviors from sexual behaviors that are problematic.

Challenges in identifying children with SBPs may include:

- Complications that arise in the interpretation and response to children's behaviors when they are perceived as "sexual" due to the **sensitive and taboo nature of the topic of sex and children, strongly held beliefs** about what is appropriate and inappropriate, and **mixed messages** children receive through the media and other aspects of society (Silovsky, et al., 2013);
- Behaviors may not occur or be observed at school; as a result, concerns raised by caregivers (primarily parents) are many times not corroborated by teacher and child reports (Allen, 2017). **This does not make the caregiver's report invalid;**
- Parents and professionals having difficulty in distinguishing between typical sex play and problematic sexual behavior when the behavior occurs among children (e.g., children looking at, showing, or touching each other's genitals) (Silovsky, et al., 2013);
- Although early childhood educators have had training in childhood development, **sexual development is rarely given the attention it deserves** (Kenny, et al., 2013);

Experts caution against conceptualizing children's behavior within frameworks for adult or adolescent sexual offending behaviors, or even adult intimacy (Latzman & Latzman, 2015; Silovsky, et al., 2012). **Origins, motives for initiating and continuing sexual behaviors, and responsiveness to interventions are quite distinct from adult sex offenders** (Silovsky, et al., 2012, p. 402).

# What are evidence-based practices associated with the early identification, assessment, and treatment of SBPs in children?

## Summary Comments:

Evidence-based interventions are available for children with SBPs. When children and their families are provided with short term, structured, family based, SBP-focused, and cognitive behavioral approaches, the long-term prognosis is very good. Children who receive treatment for their SBPs are less likely to repeat the behaviors later in life.

Treatment for children should address basic sex education, sexual behaviors and physical boundaries and teach concrete coping and self-control strategies. As children get older, treatment should include recognizing the inappropriateness of their behavior, safety planning to avoid future behaviors, and apologizing when they break their safety rules. It should also include participation in pro-social activities and other protective factors.

***Treatment for children should address basic sex education, sexual behaviors and physical boundaries and teach concrete coping and self-control strategies.***

The active and full participation of parents and caregivers, including regular attendance at sessions, active participation in services offered, and practicing skills with the child between sessions is most effective. Parents and caregivers should be taught to use behavior management tools to address behavior problems and support the child's use of self-control strategies. They should also learn to address sexual development, safety planning, talking with children about sex, and strategies to build positive relationships.

Research shows that engagement and trust with the clinician (for both the child and caregivers) are key to effective treatment. Clinicians' efforts to understand and respect the cultural beliefs and values of families can aid in retention and increase engagement in treatment. Additionally, a comprehensive treatment approach that directly addresses the SBPs through structured approaches including cognitive-behavioral and psychoeducation increases effectiveness as does the engagement of caregivers in treatment.

## Evidence-based models and practices

**The long-term prognosis of children with SBPs, including children with aggressive sexual behavior, is very good** (Chaffin, et al., 2006; Carpentier et al., 2006). To date, a pattern of results has emerged supporting short-term, structured, family based, SBP-focused, cognitive-behavioral treatment (CBT) approaches (Chaffin, et al., 2006; Carpentier, et al., 2006; Chaffin, 2008). Research on treatment outcomes indicates that when children and their caregivers receive treatment with the components mentioned above, the rates of future SBPs were very low (2 percent) and like those of a comparison group of children with no known previous SBPs (Silovsky, et al., 2013).

The evidence-based practice movement has helped to increase the array of effective interventions that are now available (Allen & Berliner, 2015). Many of these models are based on behavioral and cognitive-behavioral theory and principles that consist of different combinations of comparable treatment practice elements. These elements are discrete clinical technique(s) or strategies used as part of a larger intervention plan (St. Amand, Bard, & Silovsky, 2008). These treatments have been found to be more effective than time (wait periods), play therapy, and nondirective supportive treatment modalities (Silovsky & Swisher, 2008).

The California Evidence Based Clearinghouse for Child Welfare offers an easy to navigate website ([www.Cebc4cw.org](http://www.Cebc4cw.org)) that describes and rates the research evidence for interventions and therapies for children with SBPs who are under the age of 12. **Interventions rated as supported by research evidence or promising research evidence as of September 2016 include:**

- **Children with Sexual Behavior Problems Cognitive-Behavioral Treatment Program: Preschool Program** is a family-oriented, cognitive-behavioral, psychoeducational, and supportive treatment group designed to reduce or eliminate incidents of sexual behavior problems for children ages 3 to 6 years and their parents;
- **Children with Sexual Behavior Problems Cognitive-Behavioral Treatment Program: School-Age Group** is a family-oriented, cognitive-behavioral, psychoeducational, and supportive treatment group for children ages 6-12 years that is designed to reduce or eliminate incidents of sexual behavior problems;
- **Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) [Sexual Behavior Problems in Children, Treatment of]** is a components-based hybrid treatment model that incorporates trauma-sensitive intervention with cognitive behavioral, family, and humanistic principles geared to children ages 3-12 with a trauma history and symptoms;

The Indian Child Trauma Center website ([www.icctc.org](http://www.icctc.org)) describes a treatment program called **Honoring Children, Respectful Ways** that is a cultural adaptation of Problematic Sexual Behavior – Cognitive-Behavioral Therapy model for American Indian/Alaskan Native children ages 3-12 with sexual behavior problems.

## Specific practice principles

Syntheses of the research literature suggest **several underlying principles in the effective treatment of children with SBPs** (Carpentier, et al., 2006; Silovsky, et al., 2007):

1. Treatments need to directly address SBPs and be developmentally sensitive, considering the cognitive, emotional, and behavioral capacities of young children;
2. Behavioral, family-focused, cognitive-behavioral, and psychoeducational approaches appear better than unstructured supportive therapy or unstructured play therapy approaches;
3. Many effective treatments teach impulse-control skills, coping strategies, boundary issues, and work to improve caregiver-child relationships;
4. Effective treatments directly involve the parent/caregiver in treatment; and
5. Effective treatments teach caregivers to use behavior management skills.

Finally, treatment for children with SBPs and trauma symptoms appears to benefit from **blended cognitive behavioral therapy treatments** targeting both traumatic stress symptoms and SBPs, at least for sexual abuse trauma (Carpentier, et al., 2006).

## Practice elements for parents/caregivers

Providing training to parents is an essential element to effective treatment for children with a variety of behavior problems. **Parents are taught to be “co-therapists” for their children and are taught specific skills** to increase their child’s desirable behaviors, reduce their child’s problematic behaviors, improve child-parent interactions, and bring about a positive family atmosphere. Sessions may be conducted with individual parents or with groups of parents.

Training for parents of children with SBPs includes these effective elements: (Chaffin, et al., 2006)

- Developing and implementing a Safety Plan (e.g., for supervision and monitoring and communicating with other adults);
- Providing information about sexual development, normal sexual play and exploration, and how these differ from SBPs;
- Sex education and how to listen and talk with children about sexual matters;
- Parenting strategies to build positive relationships with children and address behavior problems;



- Skills in supporting children’s use of the self-control strategies they have learned;
- Relationship building and appropriate physical affection with children; and
- How to guide the child toward positive peer groups.

## Practice elements for children

Effective treatment approaches for children include a number of common elements (Chaffin, et al., 2006; Carpentier, et al., 2006). For children with SBPs these include:

- Teaching rules about sexual behavior and physical boundaries;
- Providing age appropriate sex education;
- Teaching concrete coping and self-control strategies, including relaxation skills, problem solving skills, or routines to encourage stopping and thinking before acting; and
- Teaching basic sexual abuse prevention/safety skills.

In addition, for children 7 years and older, treatment approaches should directly include **identifying and recognizing the inappropriateness of their actions, planning ways to prevent future acts, and apologizing for rule-violating sexual behaviors** that occurred (Chaffin et al., 2006; Carpentier, et al., 2006).

Finally, treatment elements originally designed for adolescent or adult sexual offenders (confrontation, arousal management, requirements for detailed admission of all behaviors, the exploration of sexual fantasies, relapse prevention, the assault cycle, grooming, compulsivity, or predation) are not considered appropriate for children with SBPs (Carpentier, et al., 2006; St. Amand, et al., 2008).

## Administrative and organizational practices for effective services

Experts have teased out from research a number of practices that practitioners need to address in providing effective services for children with SBPs (Carpentier, et al., 2006). These practices center on (1) choosing the most appropriate treatment modality to fit community and agency needs; (2) consideration of gender, age, and other factors that may affect treatment; and (3) awareness of cultural issues and needs related to implementation of treatment.

**Decisions about treatment modalities should be made based on the results of the assessment.** Treatment can be provided through group or individual sessions or a combination of group and individual/family sessions.

**A critical factor in the provision of group treatment is the clinician's ability to provide structure and support that does not allow opportunities for members to learn inappropriate behaviors from their peers.** Children who have frequent aggressive outbursts that are not readily modified with behavior modification would not be appropriate for a group format. Also, confidentiality may be an issue in a group setting, particularly in smaller communities.

Some advantages of group treatment include:

- Children with similar issues have the opportunity to interact, reducing feelings of isolation and stigma and decreasing negative self-perceptions related to their behaviors;
- Creates a social environment where children can learn and practice prosocial behaviors and social skills modeled by same-age peers.

**Providers must consider the age and gender of children participating in group settings** (Carpentier, et al., 2006). In a group situation, experts recommend considering the maturity, verbal skills, and social skills of the child, in addition to their chronological age before placing a child in a group setting. Additionally, consideration of cultural norms about mixed gender groups for children of various ages needs to be considered.



## Other treatment practice considerations

For children 10 and under, treating a mixed-group of boys and girls has advantages. For example, the children's natural school and community environment typically includes children of both genders, thus a mixed gender group is reflective of the everyday life of the child. **Teaching appropriate boundaries and behavior in this group facilitates generalization to everyday life.** A mixed-group format also assists children in learning social skills in a structured environment with supervised interaction. Positive peer interactions are helpful for children who may have experienced social problems. Importantly, some particularly sensitive topics (such as sex education) can be done separately with each gender group if this appears warranted and more culturally appropriate. Logistically and financially, mixed gender groups are typically more manageable for agencies, as separate gender groups would require considerably more resources in personnel, space, etc.

For children who are 10-12 years of age, mixed gender groups can still be appropriate with careful consideration of who is in the group and who is joining the group. For example, it wouldn't be appropriate to add one girl to a group of all boys. In some cultures, mixed gender groups would not be appropriate once a child reaches puberty.

**Consideration of the child and family's cultural values, beliefs, and norms are of foremost importance in the provision of any mental health and social services.**

**Co-therapists can be advantageous when conducting group therapy for children with SBPs.** Therapists can be more flexible and actively involved by using the support and shared leadership to complement each other's strengths, and social interactions of group members are more readily observed and behavior problems more efficiently managed.

Consideration of the child and family's cultural values, beliefs, and norms are of foremost importance in the provision of any mental health and social services. Race, ethnicity, religion, spirituality, socioeconomic factors, and other cultural factors can strongly impact individuals' and families' receptivity and response to treatment of child SBPs. **Due to the sensitive nature of the topic, it is important that clinicians are knowledgeable about the family's and community's beliefs, values, traditions, and practices concerning sex;** including the spoken and unspoken rules about public and private behavior, relationships, intimacy, and modesty. Beliefs about the appropriateness of children touching their own private parts and about masturbation tend to be strongly held and directly impact receptiveness to treatment. The involvement and retention of families in services is enhanced when they feel clinicians understand and respect their cultural beliefs and values (Carpentier, et al., 2006).

# What is effective for public policy?

## Summary Comments:

The state of current policies and practices regarding children with SBPs is limited. To fully understand the scope of childhood SBPs, access to accurate data compiled using clear and consistent definitions is needed. To date, there is not a designated agency responsible for collecting and maintaining this data. Furthermore, there is not a unified response to identify and treat children with SBPs, leaving many families without support and care.

Public policy should embrace a public health perspective to address children with SBPs through community collaboration and should emphasize public safety, family well-being, and child development for the child with SBPs as well as the children with whom they engaged in the behavior. Areas for policy include prevention and education, early identification, a collaborative community response, and an emphasis on evidenced-based treatment.

*Areas for policy include prevention and education, early identification, a collaborative community response, and an emphasis on evidenced-based treatment.*

The trend to segregate children with SBPs is concerning. Decisions should be made on a case-by-case basis and, except in cases with the most egregious, harmful behaviors, children with SBPs should not be segregated. Segregation can lead to unnecessarily excluding children from needed services as well as needlessly label and stigmatize them.

Decisions about how much information to share with schools or similar settings need to consider the individual child's risk for SBPs in those settings. State laws should also be consulted. In Minnesota if a youth is adjudicated for certain crimes (including sex offenses) the dispositional information must be shared with the child's school district (Reference MS 260B.171 Subd. 3).

## Cautions about policies

**Many policies developed for adult sex offenders, such as registration and community notification, are considered by experts to be inappropriate for children,** because children's behaviors change with development and research suggests that with treatment they are at low risk for future SBPs (Chaffin, et.al., 2006).

## Labeling

**Research has found that using language that labels children carries a ripple effect that impacts the child's future behaviors** and influences public policies and practices related to prosecution, sentencing, supervision, and treatment (Harris & Socia, 2016). Policies that label children as sex offenders, deviant, perverted, predator, or perpetrator or variants on these terms are inappropriate, especially when that label is likely to influence that child's future behavior and how others will perceive him or her throughout their life. Such labels risk creating a self-fulfilling prophecy and unwarranted social burden for children, their siblings, and their families.

## Registration and public notification

Although the applicable ages, offenses and conditions under which juveniles are required to register varies by state, several jurisdictions adjudicate children as young as age 8 or 9, and some include young children with SBPs on public sex offender registries (Chaffin, et al., 2006). Registering children and publicly labeling them as sex offenders for life risks a number of significant harms ranging from educational discrimination to ostracism to vigilantism according to the ATSA Task Force (Chaffin, et al., 2006).

## Accurate data

National and state level data on the incidence, prevalence and frequency of types of sexual behaviors in children and youth would be very useful for better understanding and responding to the extent of SBPs in children. **This would require clear consistent definitions of types of sexual behaviors** along with determining who would be responsible for collecting and maintaining this data given that there are multiple pathways for identifying and responding to children with SBPs (Silovsky & Swisher, 2008).

## Prevention and education

**Professionals who work with children need access to education and training about normative sexual behaviors for different ages** so they are knowledgeable and can be a resource to parents or caregivers. Professionals can also proactively be a resource by providing guidance to parents as is currently done by pediatricians on health topics such as "back to sleep", car seat safety, bicycle safety, etc. This guidance should be provided during well child visits and be adjusted based on the age and developmental level of the child. By proactively addressing sexual development and behaviors in children, parents and caregivers will have a resource for asking questions or raising concerns about their child's behaviors (Finkel, 2012; Palusci, 2012).

Professionals need education that dispels myths about children with SBPs and

informs them of the availability and effectiveness of assessment and treatment.

**They also need to be coached to provide clear, accurate, unbiased and respectful communication** and support that conveys the seriousness of the child's behaviors while reassuring parents and caregivers that help is available for both the child and their family and that parents and caregivers play a crucial role in helping their child address SBPs (Silovsky, et.al, 2016).

## Other practice considerations

Protocols for how best to approach sexual behavior, particularly in early childhood classrooms, should be generated collaboratively among a diverse group of early childhood educators, administrators, and parents, so as to meet the needs of the young children and families they serve (Kenny, et al., 2013). These policies, for example, might cover how to respond to behaviors and how best to approach parents if an issue arises.

## Mandatory Reporting

Mandatory reporting laws require workers in a number of professions, including health care, social services, psychological treatment, child care, education, corrections, law enforcement and clergy, to report suspected child maltreatment. As of 2017, Minnesota mandated reporting law defines sexual abuse as when "certain persons" subject a child to an act of sexual contact or penetration or threaten the same.

"Certain persons" are defined as:

- A **"person responsible for the child's care"**-- a person functioning within the family unit with responsibilities similar to a parent or guardian OR a person outside the family unit with duties of the child's care such as school employees and other short-term caregivers such as babysitters, counselors, or coaches.
- A **"significant relationship"**—an immediate or extended family member, or an adult residing in the same home
- A **"position of authority"** - a person acting in the place of a parent, or having the responsibility for the health, welfare, or supervision of a child, even briefly.

Note: Adults are not the only people who can be considered "certain persons." Youth in the roles identified above can be considered "certain persons."

## Responding to children with SBPs

When unsure about whether to make a report about sexual behaviors in or between children, the **ATSA Task Force** (Chaffin, et al., 2006) **recommends reporting when both of the following conditions are true:** (1) the behavior has involved significant harm or exploitation, and/or (2) the behavior is persistent or serious (e.g., oral-genital contact or penetration, penile-anal contact or penetration, penile-vaginal contact or penetration, digital contact or penetration of the rectum or vagina; or other sexual

behaviors of a less advanced nature that persist despite efforts to correct them or admonitions to stop).

Additionally, **reports are warranted in situations in which the parents or caregivers were informed of ongoing abusive sexual behaviors and failed to intervene or protect the children.** In some cases, reporting can be helpful for securing resources and support for addressing the child's behaviors (Chaffin, et al., 2006).

## Investigating reports of children with SBPs

In 2015, Missouri passed legislation that specifically stated that child protection would utilize a family assessment and services approach to all reports about a person under the age of 14 alleged to have committed sexual abuse against another child, no longer limiting their response to actions committed by a person responsible for the care, custody or control of the child (similar to Minnesota's "certain persons" limits). From September 2015 to June 2016 this resulted in 3,886 reports that were assessed for potential services (Emily van Schenkhof, Missouri Kids First, personal correspondence, Fall 2016).

**No one system is charged with responding to all children with SBPs.** In fact, in some situations no public agency is officially charged with responding. Some of these families will receive services through a private children's mental health provider. Others fall through the cracks when child protection screens a case out as not meeting criteria or law enforcement determines the child is too young so they refer them to Social Services, or the child advocacy center has a policy to only provide services to the child who has been victimized. This results in children and families falling through the cracks, not receiving services and also not being counted.

## Collaborative response

The National Children's Alliance's 2016 fact sheet "**Where to Begin: CACs and Youth with Problematic Sexual Behaviors**" stresses the need for a collaborative response that engages the many professionals and systems who work with children and families (including child care providers, school personnel, child protective services, law enforcement, mental health agencies, medical professionals and others).

The ATSA Task Force broadly defines good public policy as promoting appropriate treatment, where assessment suggests it is needed, and collaboration among involved agencies, authorities and providers, including parents and other caregivers as well as the child, where developmentally appropriate, during all phases of the process. Additionally, **policies should ensure that there is a focus on keeping other children safe while supporting the child with SBPs** through effective interventions and safety planning that allows them to overcome their challenges and achieve positive outcomes (HM Government, 2015).

## Addressing stigma

**Families of children with SBPs face considerable social stigma, rejection, and isolation.** Providing support and skills to parents can reduce the emotional responses (e.g. intense fear, shock, denial, guilt, shame and self-blame) that can negatively impact children (Hackett, 2002, cited in HM Government, 2015).

## Placement decisions

**Children with SBPs do not require automatic out-of-home placement,** even in cases where a child has sexually victimized another child in the same home (Chaffin, et al., 2006). This decision requires case-by-case assessment. Out-of-home placement should be considered for those cases where retaining children in the home is not viable either because it would cause harm or significant distress to other children, because of acute needs for treatment or protection (e.g., seriously suicidal children) or because caregivers are not providing an adequate environment (e.g., serious neglect) (Chaffin, et al., 2006).

**If placement is required, priority should be given to the least restrictive, closest to home placement, where family involvement in treatment can be accommodated.** The protective capacity of the proposed caregivers should also be a key consideration when contemplating the out of home placement of a child (Chaffin, et al., 2006). The ATSA Task Force (2006) laid out the following principles to guide decision-making about removing a child with SBPs:

1. Where the presence of the child with SBPs in the home is causing current, serious distress to other children, and/or where the other children would be significantly relieved to be separated from the child with SBPs; or
2. Reasonable, less restrictive efforts have failed to curtail serious SBPs; or
3. Where, despite efforts, caretakers are unable or unwilling to provide a healthy and stable home environment or to exercise even a minimally sufficient intervention or safety plan in the home, and the child persists in aggressive or advanced sexual behavior with other children; or
4. Exceptional circumstances in which there may be risks or behavior so extreme or potentially harmful to self or others that attempting a less restrictive solution is not reasonable and placement should be immediately considered.

When out-of-home placement is involved, less-restrictive alternatives, such as foster care, should be considered first.

**Long-term placement in an institution or residential facility, particularly facilities that aggregate children with behavior problems, should be considered a last resort** (Chaffin, et al., 2006).

The ATSA Task Force recommendations regarding out-of-home placements also discourage foster homes, agencies and facilities from forming policies excluding children with SBPs, as a class, from their services. The idea that children with SBPs, as a class, must be placed only in segregated SBPs or sex offender facilities may unnecessarily



exclude these children from needed services and impose needless placement and service disadvantages. **It also may needlessly label and stigmatize children.** This policy is especially problematic when children are excluded from services based on long-past SBPs that have not reoccurred.

## Information sharing with placements

When a child with sexual behavior problems is placed out-of-home, it is good policy to fully inform the placement about all of the child's needs and problems, including SBPs (Chaffin, et al., 2006). **Foster and kinship caregivers, as well as residential staff, should be educated about children with SBP before a child is placed in their care.** Often, it may be wise to share some more limited information with other children in the home, in a way that does not stigmatize the child, but informs the other children. For example, the family could develop a family safety plan that addresses all safety issues, rather than singling out the child with SBPs. This can be done jointly with all of the children and caregivers present.

## Information sharing with schools

Decisions about notifying schools about a child's SBPs should be based on an individual assessment. **The ATSA Task Force recommendations indicate that notifying schools about all cases of SBPs is unnecessary,** especially where the behavior problem has not previously occurred in school settings, where the child is receiving help for the problem, and where the behavior is not persisting. Conditions for which it is appropriate to inform school personnel include:

- Cases where children are assessed as posing a high risk, or
- Where the SBPs have occurred in school or school-like settings, or
- Where serious SBPs are persisting, or
- If required by state law (Minnesota law requires school districts be notified of juvenile dispositions in certain crimes including sexual offenses. [MS 260B.171 Subd 3]).

Any formal process for informing other children at school about the child's SBPs is usually unnecessary, risks stigmatization and **may violate the child and family's right to privacy.**

## Legal response and culpability

**Laws generally articulate an age below which children cannot be found legally culpable regardless of their behavior.** The ATSA Task Force recommends that in adjudication decision-making processes, children with SBPs should be treated the same as children of similar ages who may have engaged in other problematic behaviors (e.g., assault, theft). The Task Force report noted that in some cases, adjudication may be helpful in securing needed services, protecting communities, or as an appropriate response to particularly egregious behavior.

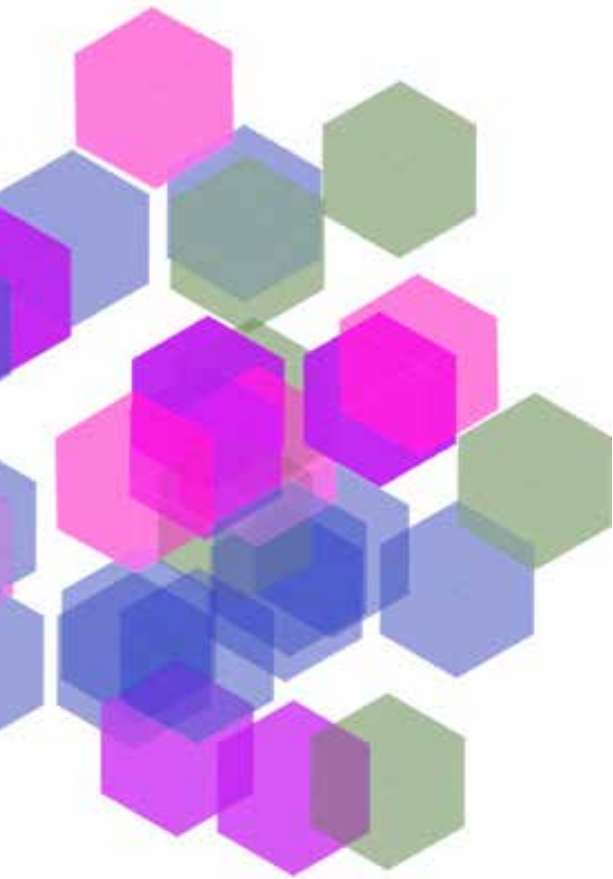
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REPORT #3:

## Children with Sexual Behavior Problems: Professionals who Work with Children

# Survey Findings and Themes

In February and March, 2017 MNCASA invited professionals from across Minnesota who work with children ages 12 and under to complete a web-based survey to better understand their experiences with children's sexual behaviors. The questions asked about their experiences, policies, interest in training, and ideas on how to improve the identification and response to children showing signs of concerning or inappropriate sexual behaviors.

MNCASA worked with statewide organizations in the following sectors to make the survey available to their constituents:

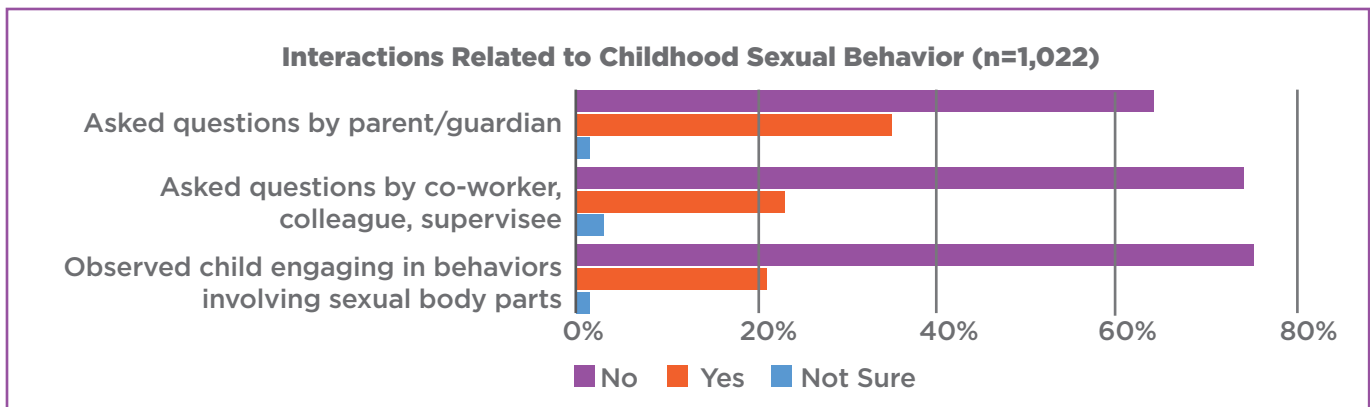
- Child care providers;
- Head Start and Early Head Start teachers and administrators;
- School social workers;
- School nurses;
- Primary health care physicians;
- Home visitors; and
- Domestic violence shelter staff.

MNCASA received a total of 1,022 survey responses. The majority of responses (64%) came from child care providers. One or more of the respondents came from 83 of Minnesota's 98 counties or tribal lands. The largest concentration of respondents (44%) came from six counties (Anoka, Dakota, Hennepin, Olmsted, Ramsey and St. Louis). These counties represent 51% of the population of Minnesota.

## Reported Experience with Sexual Behaviors in Children

This survey found that professionals who work with children are viewed as a resource for determining whether a child’s sexual behavior is “normal”. Approximately **one out of three respondents have been asked a question related to childhood sexual behavior by a parent/guardian** and one out of four respondents have been asked a question by a co-worker.

Respondents were less likely to report they have observed a child engaging in behaviors involving sexual body parts (one out of five).



## Types of parental questions

Respondents indicated that the **most common questions** received from parents center on whether certain behaviors are “normal or not,” “developmentally appropriate,” “weird,” or if the parent “should be concerned.” The child behaviors most frequently asked about include masturbation; “humping” objects; taking clothes off with playmates; showing interest in or touching own genitals, private parts, or breasts; or touching mother’s breast.

Many additional questions received by respondents from parents/guardians are about childhood sexual behavior, generally. Questions such as why children engage in certain behaviors, particularly masturbation or sexual play. **They ask: should children be engaging in these behaviors?**

The types of questions received less frequently asked how a parent should respond to their child’s sexual behavior, the relationship of sexual behavior to abuse, and age-appropriate family behavior (i.e., seeing a parent naked, sleeping and bathing together).

## Types of co-worker questions

Many questions received from co-workers centered on what is “normal,” age-appropriate,” “typical,” or “healthy sexual exploration.” Sometimes the question is framed in terms of **whether the incident “should be reported” or “if it is a sign of possible abuse.”** The child behaviors most frequently cited include masturbation or

touching themselves, wanting to see the body parts of other children, playing doctor, sexual play, or the level of physical affection being shown.

Additional questions received from co-workers are to **“get a second opinion”** about a child’s behavior, discuss whether the staff person should be concerned, what the behavior means, or why a child is engaging in a behavior. Questions also focus on getting advice or direction, brainstorming ideas for responding, or collaborating on determining the best way to handle a situation (e.g., addressing a child’s behavior, handling a discussion with a parent about a behavior the staff person has observed, or how to respond to questions or concerns raised by parents about their child’s behavior).

**Only a few questions received from co-workers asked about resources that address sexualized behavior in children or the services and supports that are available.**

## Actions after Observation of a Concerning Behavior

Upon observing a concerning sexual behavior, a few respondents disclosed that their **first reaction was shock or confusion**. They then talked to a colleague or did nothing. The most common actions involved some pattern of one or more of the following:

- Stopping the behavior, re-directing the child/children, or removing the child from the area calmly and without shaming;
- Having a private conversation with the child about what is appropriate, not appropriate, and why;
- Gathering more information or documentation (through observation of the child, talking with the child, a conversation with parents, or talking with school staff);
- Consulting with a colleague or supervisor to determine the best course of action, if any;
- Notifying the parents and discussing the behavior with them or exploring what is normal/appropriate, or asking them to take the child to a doctor;
- Referring the child for an assessment or conducting an assessment; and/or
- Considering a referral to child protective services or making a referral.

## Agency Written Protocols, Policies or Procedures

**Most respondents noted their agencies do not have written policies or procedures.**

Approximately two in five (38%) respondents indicated their agency has written policies, procedures, and protocols for how to respond to an incident in which a child is engaging in inappropriate or harmful sexual behaviors, either alone or with another child.

Home visitors, childcare, and primary health providers were less likely to have and be aware of policies. Head Start and Early Head Start, school social workers, and school nurses were more likely to have and be aware of policies.



When written policies or procedures exist, they commonly cover:

- Reporting to someone outside of the organization;
- Reporting to someone in the organization;
- When and what to communicate to parents/caregivers; and
- How to respond to the child.

AGENCY WRITTEN PROTOCOLS, POLICIES, OR PROCEDURES (N=959)	
Agency has written protocols, policies, or procedures	Yes = 38%
Content of written protocols, policies, procedures:	
Reporting to someone outside of the organization	71% 258
Reporting to someone in the organization	68% 246
When and what to communicate to parents/caregivers	60% 216
How to respond to the child	52% 188
Referring for an assessment	37% 134
Not sure	9% 33
Other (please specify)	3% 11

## Confidence in Abilities

The confidence level of respondents in taking action varied. Professionals report they are most confident in their ability to:

- Make a report to Child Protective Services;
- Recognize developmentally expected sexual behaviors in children of various ages; and
- Differentiate between developmentally appropriate sexual behaviors in children and sexual behaviors that are potentially harmful to self or others.

Professionals report the least amount of confidence in their ability to:

- Supervise a child who has sexual behavior problems;
- Refer children with sexual behavior problems to effective treatment;
- Engage parents or caregivers in addressing their child’s sexual behaviors;
- Refer children for an assessment of their sexual behaviors; and
- Manage children’s sexual behaviors.

CONFIDENCE IN ABILITIES (N=965)						
Type of Action	Very confident	Confident	Not very confident	Not confident at all	Total	Weighted Average
Make a report to Child Protective Services	45% 428	44% 416	9% 88	1% 13	945	3.33
Recognize developmentally expected sexual behaviors in children of various ages	20% 193	65% 627	13% 125	1% 13	958	3.04
Differentiate between developmentally appropriate sexual behaviors in children and sexual behaviors that are potentially harmful to self or others	21% 202	63% 602	14% 137	2% 16	957	3.03
Manage children’s sexual behaviors	13% 119	48% 453	32% 304	6% 60	936	2.67
Refer children for an assessment of their sexual behaviors	17% 156	41% 383	34% 321	8% 78	932	2.67
Engage parents or caregivers in addressing their child’s sexual behaviors	12% 110	45% 426	35% 324	8% 78	938	2.61
Refer children with sexual behavior problems to effective treatment	14% 133	37% 342	44% 404	14% 127	916	2.36
Supervise a child who has sexual behavior problems	8% 69	35% 316	44% 404	14% 127	916	2.36
<b>Ratings: 4=Very confident; 3=Confident; 2=Not very confident; 1=Not confident at all; not sure responses deleted from analysis.</b>						

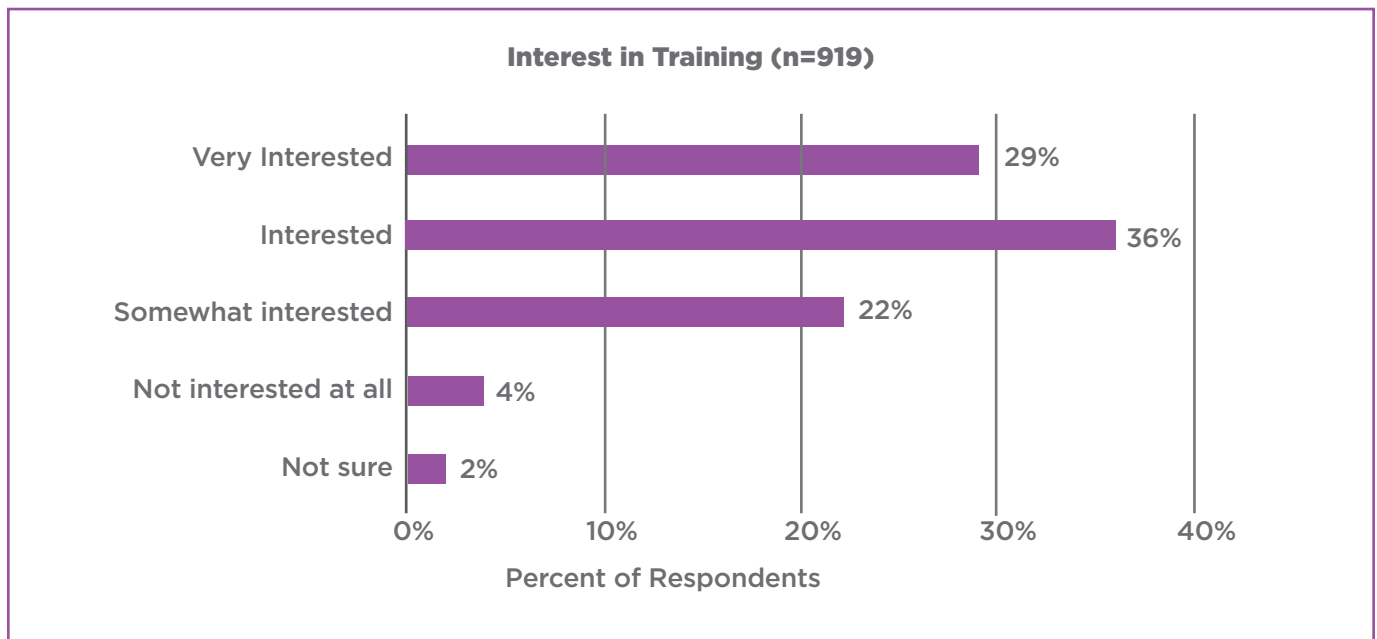
Respondents cited a range of barriers to responding effectively to children with concerning or inappropriate sexual behaviors that cluster in four areas:

1. Their own lack of knowledge, training, or experience in dealing with child sexual behaviors;
2. Parent or provider embarrassment, discomfort or defensiveness in discussing child sexual behaviors;
3. A lack of time or duration of contact with a child, given the role of the respondent; or
4. The rarity of the situation given the respondent's role.

Additional barriers mentioned by a few respondents include the lack of, or ineffectiveness of, resources, the risk of repercussions (i.e., being sued, harming the client relationship), or the needs of children with certain characteristics (i.e., special needs children or children with language barriers).

## Interest in Training and Other Support

The majority of respondents would like to learn more about children with sexual behavior problems. **Two-thirds (65%) of the respondents indicated they would be interested or very interested in training** that covered how to recognize and respond to children's sexual behaviors involving sexual body parts (i.e. genitals, anus, buttocks, or breasts) that are developmentally inappropriate or potentially harmful to themselves or others.



The training topics most frequently mentioned by respondents focus on **differentiating normal/developmentally appropriate sexual behavior from inappropriate or worrisome behaviors.** As part of this type of training, a few respondents mentioned learning how to best respond or address these behaviors,

identifying behaviors that are indicative of sexual abuse, making referrals (including sources) for assessment or treatment, or reporting.

A second training area mentioned frequently centers on **how to interact with children and their parents about these issues**. The types of interactions range from talking to children about their bodies and explaining the differences between developmentally appropriate sexual behaviors and potentially harmful behaviors to approaching children and parents when worrisome behaviors have occurred.

Training areas mentioned by only a few respondents include **best practices in intervening with children** and the availability of resources to share with parents or refer them to in the community. Individual respondents also qualified their interest in training, saying it would be depend on the level or if it is needed to renew a Minnesota teaching license.

The survey also asked respondents to indicate what else would help them better serve children with possible sexual behavior problems. They again mention **training, but specifically for specialists** (i.e., psychiatrists, psychologists, mental health providers) or the respondent, themselves.



In terms of additional resources, they cite **access to more**

**information** (i.e., a resource guide or fact sheet that reviews age appropriate sexual behaviors, information on best treatment practices, a community resource guide); ease in accessing information (i.e., a single phone number to call with questions or for referral information, a website); or to a lesser extent, service availability (i.e., more services that are competent and confidential in their region).

Two respondents mentioned the need for changes in policies or organizational practices; one citing a need to reduce government interference and the time spent in insurance reporting and the other citing a need for more communication and feedback from abuse evaluation centers. One respondent called for normative change in our society to become more open about discussing children's sexuality.

## Preliminary Recommendations

The survey findings point to four recommendations. First, given the frequency with which professionals observe or are being asked questions about a child's sexual behaviors, **professionals who work with children should have and make staff aware of policies that go beyond when to make a report and to whom. Policies should include how to respond to the child's behavior, when and what to communicate to parents/caregivers, and how to refer a child for an assessment.**

Second, while professionals who responded to our survey expressed confidence in their ability to recognize developmentally expected sexual behaviors in children of various ages and differentiate between developmentally appropriate sexual behaviors in children and sexual behaviors that are potentially harmful to self or others, nearly 2 out of 3 respondents expressed interest in training that also covered how to respond to these behaviors both with the child/children and with their parents. **Professionals identified parent or provider embarrassment, discomfort or defensiveness in discussing sexual behaviors in children as barriers to effectively responding to children with concerning or inappropriate sexual behaviors. Professionals who work with children should have easy access to training regarding children's sexual behaviors, including best practices for responding to behaviors, engaging parents in discussions of their child's sexual behaviors and knowing when, how and to whom to make a referral for further assessment.**

Third, since parents rely on them for guidance on their child's behavior, **education on children's sexual behaviors**, including differentiating developmentally expected behaviors from behaviors that are more concerning or problematic, **should be required for professionals who work with children.**

Finally, since professionals are already receiving questions from parents about children's sexual behaviors, **professionals should also create opportunities to raise parent's awareness and knowledge about children's sexual behaviors** through proactive communication.



REPORT #4:

## **Children with Sexual Behavior Problems: Professionals Working with Children with Sexual Behavior Problems (SBPs)**

# **Interviews Findings and Themes**

From July 2016 to June 2017, MNCASA conducted key informant interviews with 19 professionals from across Minnesota and nationally to better understand current systems, policies, and practices for responding to children with SBPs. The interviews sought their input on:

- the design of our research project;
- the context in Minnesota;
- any available data; and
- potential policy and practice recommendations.

From January to May 2017, MNCASA conducted investigative interviews with individuals at 13 organizations engaged in responding to children with SBPs, including County Child Protection, Child Advocacy Centers, Residential Treatment and Out-patient Service Providers. We also did a brief written survey with seven additional Child Advocacy Centers. The interviews addressed:

- their experience with receiving requests or referrals for help for children with SBPs;
- their work with children with SBPs (where appropriate); and
- their opinions on how well Minnesota does in identifying, assessing, and treating children with SBPs.

## Context: Stigma Impacts Identification and Response

### Stigma

**It is important to note that there is incredible shame and stigma related to children with SBPs**, which can delay identification, assessment, and treatment as well as hamper appropriate response. Interviewees noted the need to reduce the stigma and taboos around the topic of SBPs as well as to **create “safe spaces” where people can go for information, resources, and support**. Treatment providers indicated that Minnesota is starting to do a better job in terms of schools and parents being more open but that we have a long way to go because we tend to “put everyone in the same bucket and label them a sex offender.”

Beliefs impact the way people respond to a child with SBPs. Some providers and families take a “corrections” view of children with SBPs (where children are treated as sex offenders), while others, **more accurately, see SBPs as a multi-causal mental health problem which can be treated with effective interventions**. Since these stigmas impact the ability and willingness to identify and respond to children’s sexual behaviors, they must be addressed.

### Address misconceptions

Several interviewees still approach sexual behaviors in children primarily as a sign that the child has experienced sexual abuse which isn’t always accurate. While sexual abuse should be considered if a child is engaging in concerning or problematic sexual behaviors, there are many pathways to developing SBPs not all of which include having been sexually abused. We also noted that some child advocacy centers will only see the child identified as the victim and there is often difficulty in acknowledging that a child can be both a victim and a child with SBPs. Some clinicians we interviewed suggested **Minnesota is getting better at differentiating developmentally expected sexual behaviors from concerning or problematic behaviors** although there are still professionals who view all sexual behaviors as problematic.

## Practice: Guidelines, Procedures, and Points of Contact

### Lack of consistent protocol

**There is not a clear process or procedure for where to report or refer children with SBPs**, and no one entity is responsible. This is a reflection of the complicated nature of behaviors which include elements of health, child welfare, child protection, etc. When asked what would happen if someone identified a child as possibly having SBPs, interviewees thought most would be referred to County Social Services or

a Health Care provider. They acknowledged many professionals would not know who else to refer someone to, **especially “up north” where resources are scarce.** Treatment providers receive calls or referrals from social services, law enforcement, medical providers, adoptive parents, other social service or mental health providers, corrections, human services, child protection, probation, and school staff.

In Minnesota, Child Protective Services is charged with investigating abuse when “certain persons” are alleged to have abused. These include:

- persons responsible for the child’s care;
- persons in a significant relationships (i.e. immediate family member, or adult residing in the home); or
- persons in a position of authority (i.e. acting in place of the parent or having responsibility for the health, welfare, or supervision of a child, even briefly).

While youth are included in the definition of “certain persons,” this would still exclude many situations where a child is engaging in concerning or harmful sexual behaviors alone or with other children outside of the family. There are no requirements for conducting an assessment in these situations.

Treatment providers noted that when children are acting out within the family, current policies and practices often “tear families apart”. **Too often, families are split up/siloed with no plans for reunifying the family safely.**

## Variations in response

There are variations in how counties respond to a question about a child with SBPs. Some would consider it neglect and would approach it from a “lack of supervision” angle while others might consider it “neglect” for failing to protect a child from danger. There are also **concerns that addressing children with SBPs as neglect can be punitive towards parents.** In some counties, a report would be addressed as a “child welfare” issue rather than a “child protection” issue. **This county by county variability is a concern.** Currently, there are not well defined parameters or protocol for Child Welfare responses, and these are not well tracked or monitored.





**People are concerned with identifying a child because “now what?”** Often cases that are screened out by Child Protective Services are referred to Law Enforcement who respond with “what are we going to do with a 9 year-old?” This can mean nothing is done which was frustrating for everyone. Interviewees also report being told by Law Enforcement “don’t tell me” because they don’t want to have to do anything.

## Need for guidelines

There is recognition that children absolutely deserve an appropriate intervention and yet, without a consistent planned response, **there is a tendency to either over-react or under-react.** Professionals who work with children need guidelines for how to treat behaviors as serious, educate about treatment being available, help set up effective supervision, and create protective environments. They can be an important resource for families by providing education about how children can safely be treated in the community and that an effective response helps both children deemed “victims” and children deemed “perpetrators”.

## Differing systems response to child/child sexual behaviors

Interviewees raised concerns about differing responses from child protection to a child being abused by an adult/caregiver versus by another child. This differential response seems unfair to both children.

## Screening

There are efforts underway in Minnesota to improve collaboration between Health, Human Services, and Education around Health Screening for children who use Medicaid. They use the Ages and Stages screening tool which parents complete and which includes a question about “concerning” behaviors. Currently less than half of all children on Medicaid are being screened using the Ages and Stages and less than 10% get the Social-Emotional Screening. Through an Early Childhood Comprehensive Systems (ECCS) grant, **Minnesota is working to expand “Help Me Grow” to make it easier to connect families to providers of services** including increasing connections to quality services/providers. Minnesota is also trying to increase the data that are available to better understand how systems are working.

Despite the push to do universal screening, **there are counties where there is not even one provider to work with children who have been identified as needing services.** Interviewees were concerned about focusing on screening if we don’t have the capacity to refer children who have been screened to quality, accessible services.

## Quality treatment

While evidence informed curriculum for addressing children’s sexual behaviors exist, it is unclear whether treatment providers are using these curriculum. When asked

about the kind of treatment they provide to children with SBPs, respondents said they provide Safe Boundaries talks, self-created CLImB (Children Learning and Improving Boundaries) program, RIS (Respecting an Individual's Sexuality and Emotions) healthy boundary curriculum, individual and family sexuality therapy, curricula that address boundaries, the Pathways Manual (mentioned by two), the Primary Impact curriculum, and the Good Lives Model. **Only one treatment provider specifically mentioned an evidence based curricula:** Trauma Focused Cognitive Behavior Therapy.

Interviewees noted that not all private practitioners have been trained, and may not provide the best treatment for children with SBPs. They noted a **need to provide guidelines for effective treatment and to help providers understand what “best practices” are** and to make “best practices” accessible to providers, especially for individual providers in private practice who can't necessarily afford to attend trainings.

## Resources: Make it Easier to Get Help

### Access to information

**Interviewees stressed the need for resources for parents and professionals.** One approach that has worked with other sensitive issues such as Fetal Alcohol Syndrome is a multi-pronged approach. This would start with raising awareness, both about children with SBPs and about resources available, then move to screening then to capacity building around recognizing, referring and treating children. The Minnesota Department of Human Services (DHS) has been moving toward providing more resources and guidance to end users like parents, providers, etc. This could be one possible avenue for disseminating information although there are concerns about the accessibility of a source like DHS for a variety of families.

There is high interest in resources for professionals on sexual development, navigating various behaviors, how to help parents navigate, etc. as well as acknowledgement that we need to create safe spaces to talk, think, and reflect. **Professionals and treatment providers specifically mentioned the need for a referral hub/hotline for parents.**

### Need for training

Interviewees acknowledged that **professionals who work with children—including child care providers, mental health providers, health care, and school staff—need a better understanding of child development and children's sexual behaviors.** The lack of required training on sexual development, developmentally appropriate sexual behaviors, and behaviors that are concerning or problematic contributes to over- and/or under-reacting to children's sexual behaviors. Interviewees indicated that **training needs to cover how to identify behaviors, understand SBPs, and where to refer children and families.** These professionals encounter children's sexual behaviors and

receive questions from parents. They can play a key role both with intervening with behaviors but also in bringing this to the attention of parents. These are two different skill sets and training needs to cover both.

Some professionals noted that while sexual behaviors are expected in the population of children they serve, **this was not a topic that was covered in their training or discussed regularly.** When covered, training specifically about children’s sexual behaviors is only a small portion of a training on another topic, such as supervision. For example, the MN Child Care Credential supervision sessions address

- mandatory reporting requirements;
- why some children are more vulnerable to being abused;
- child behaviors that may indicate sexual abuse;
- high risk situations (such as leaving an older child alone with a younger child);
- awareness of the incidence of sexual abuse by the provider’s older child (typically male);
- why this behavior can happen; and
- what to do to prevent and/or deal with an issue if it happens.

**Because these trainings address other information as well as sexual abuse, none of the courses go in-depth on this issue.** This impacts professionals’ confidence in their ability to recognize and respond appropriately to children’s sexual behaviors.

Interviewees also noted it is important to train multi-disciplinary teams (e.g. Law Enforcement, Child Advocacy Centers, juvenile courts, children’s division, etc.) to address myths, best practices, how to intervene and to provide this training across the state.

## Treatment services

Services and resources vary greatly across the state, depending on rural or urban locations. **There is recognition that we need a continuum of services to match the continuum of behaviors.** Concerns were raised about children with SBP being lumped together for treatment in inappropriate ways. We also heard concerns that treatment providers offer a variety of services, but **there is no consistent, evidence-based guidelines for providers.**

Interviewees noted that there are not enough services for children under age 12, while there are more resources for adolescents. This may be the result of older adolescents requiring greater interventions because they did not receive early treatment.

To be effective, services and support need to be provided for caregivers and ALL the children in the home, especially with behaviors between siblings. Interviewees also noted that **insurance plays a large role in treatment for children with SBPs,** because

**There is recognition that we need a continuum of services to match the continuum of behaviors.**

they can determine acceptable treatment practitioners, and because they may limit treatment based on the belief that sexual behavior problems are not mental health problems.

## Preliminary Recommendations

Based on these findings, four recommendations should be considered.

**First, there is a need for specialized training on best practices for identifying and responding to children’s sexual behaviors.** The training needs to address myths about children’s sexual behaviors including the assumption that sexual behaviors are an indication that the child has been sexually abused and the beliefs that children with SBPs go on to sexually abuse as adolescents or adults. By providing this accurate information, professionals who experience a child engaging in concerning or problematic sexual behavior or who receive questions from parents can emphasize the excellent prognosis when children receive evidence based treatment. This can also provide a base for professionals engaging in proactive awareness raising with parents that can help to reduce the stigma surrounding children’s sexual behaviors.

**Second, Minnesota should develop protocols and guidelines for responding to children’s sexual behaviors** so there is consistency both across the state and regardless of whether the situation meets child protective services screening requirements. In developing these, representatives of the many different professionals who come into contact with children with SBPs should be consulted. The developed guidelines and protocols should provide guidance for next steps, including referrals for a screening, versus simply “screening reports out”. This will help to ensure that children receive earlier intervention services.

**Third, Minnesota should work to increase the number and quality of treatment providers who specialize in and utilize evidence based treatment for children with SBPs** so that children from across the state with varying levels of SBPs have access to appropriate and effective treatment.

**Finally, Minnesota should identify and promote national resources (such as Stop It Now!) or create and promote a state resource that can be a referral hub/hotline for parents and professionals seeking resources for children with SBPs.**

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The Minnesota Coalition Against Sexual Assault (MNCASA) provides leadership and resources for sexual assault programs and allies to prevent sexual violence while promoting a comprehensive, socially just response for all victims/survivors. We support, convene, and collaborate with sexual assault programs, advocates, prosecutors, and law enforcement officers to promote a more victim-centered response to sexual violence, and increase effective criminal justice. Our prevention programs take action before someone is harmed, and we work with policy makers and elected officials for laws and programs that fight sexual violence.