

## **TDMHSAS BEST PRACTICE GUIDELINES**

### ***Children with Sexual Behavior Problems***

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Nationally, increasingly younger children are coming to the attention of schools, courts, and social service agencies for sexual behavior problems. While Tennessee law, state policy and mental health practice originally geared for adult offenders have been modified in part for minors who commit sexual offenses, they do not differentiate between the behavior of older minors and children 12 and under that are experiencing sexual behavioral problems. However, research has shown that the assessment and treatment needs of children ages 12 and under who have sexual behavior problems are different from the assessment and treatment needs of adolescents who offend sexually. These differences must be taken into account when working with this population of children. It is also important to note that problematic sexual behaviors are only a small part of a child’s behavior and should not overshadow the view of the whole child.

The co-occurrence of victimization, trauma, and inappropriate sexual behavior by young children accounts for an undeniably high number of cases of children 12 and under who have sexual behavior problems. However, not all children who are sexually abused develop sexual behavior problems, and not all children who exhibit inappropriate sexual behavior are victims of childhood sexual abuse. Therefore, inappropriate sexual behavior is not in and of itself “diagnostic” for a history of abuse or sexual trauma.

#### ***I. Definition of Children with Sexual Behavior Problems (CSBP)***

Child sexual behavior problems are a set of functioning behaviors that fall outside acceptable societal norms. It is not a diagnostic category. Generally CSBP are defined as children 12 and younger who initiate behaviors involving sexual body parts that are developmentally inappropriate or potentially harmful. The intention and/or motivation of the behaviors may or may not be related to sexual gratification. These behaviors can be related to other factors such as curiosity, anxiety, imitation, attention seeking and/or self-calming. Sexual behaviors can be self-focused or involve other children (Chaffin, M., Berliner, L., Block, R., Johnson, T. C., Friedrich, W. N., Louis, D. G., et al., 2006).

## ***II. Healthy vs. Problematic Sexual Behavior in Children***

When considering sexual behavior in children under the age of 12 it is essential to distinguish between behavior that is healthy and that which is considered problematic. Elements to consider include:

- Healthy sexual play and exploration occurs spontaneously, intermittently, is mutual and non-coercive, not causing emotional distress.
- Children engage in healthy sexual behavior because it is pleasant and they are curious. Sexual exploration is part of social development and information gathering about issues such as gender roles and behaviors, how bodies look alike and are different.
- Healthy sexual behavior is not a preoccupation. It generally comes out of a place of curiosity and exploration.
- Healthy sexual behavior does not usually involve advanced sexual behavior, such as intercourse or oral sex.
- When making distinctions between healthy and problematic sexual behavior it is important to be sensitive to developmental stage and cultural norms.
- Other factors to consider when distinguishing between healthy and problematic behavior include:
  - Frequency – problematic sexual behavior occurs more frequently and is likely to interfere with normal childhood activities.
  - Whether the child responds to correction by an adult. Generally, children engaging in sexual behavior within the healthy range are responsive to redirection by adults. It is important to note that children with developmental disabilities may respond less quickly and therefore require additional redirection. When caught, children engaging in healthy sexual behavior may show embarrassment, but usually not more negative emotions such as shame or anxiety.
  - Age/developmental difference of children.
  - Use of force (self/others), intimidation or coercion.
  - Presence of emotional distress.
  - Interference with social development.

### **Healthy Sexual Behavior**

### **Problematic Sexual Behavior**

<ul style="list-style-type: none"> <li>• Comes from a place of curiosity</li> <li>• Behavior is spontaneous and mutual</li> <li>• Behavior involves positive affect</li> <li>• Behavior is responsive to redirection</li> <li>• Involves children in similar age/developmental range</li> <li>• Low Frequency</li> </ul>	<ul style="list-style-type: none"> <li>• Behavior seems to be a preoccupation</li> <li>• Engaging in advanced sexual behavior or knowledge</li> <li>• Behavior seems planned/targeted or is coercive</li> <li>• Behavior is emotionally distressing</li> <li>• Behavior is unresponsive to redirection</li> <li>• Inappropriate age/developmental range between children</li> <li>• Behavior is frequent or obsessive</li> <li>• Behavior interferes with social development</li> <li>• Behavior disrupts functioning</li> </ul>
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For most children with sexual behavior problems, it is not necessary to conduct extensive, broad range assessments across many sessions. It is important to determine at the very beginning whether the referral for an assessment of sexual behavior is appropriate. Evaluators can make this determination at the time of the referral by requesting collateral data to support existence of inappropriate sexual behavior and by helping the referring party to clarify referral questions.

In gathering information for the assessment, focus should be on the following:

- Context, Social Ecology and Family: Assess the context of the behavior in question as well as family and environmental issues that may be impacting the child. In cases where children are in temporary living situations, the assessment should also focus on environmental needs in the permanent setting.
- Broad Psychological and Behavioral Status: Non-sexual problems including internalizing problems, externalizing problems, developmental issues and adverse environments often exist in children with sexual behavior problems. It is necessary to assess for these issues so that behaviors and presenting problems can be prioritized.
- Sexual Behavior and Contributing Factors: Attempt to identify circumstances under which sexual behavior problems (SBP) seem to occur by obtaining a clear behavioral description of the sexual behaviors in a chronological sequence. Some children might engage in SBP when under stress, when depressed or frightened, when angry, or when reminded about past abuse. Others may engage in the behavior in response to environmental triggers or when there is opportunity.

Relevant information summarized above can be gathered using the following components:

- Review of background and collateral materials. This can include past psychological evaluations and school evaluations.
- Behavioral and psychosocial history as reported by caregiver. This may include:
  - Developmental History;
  - Family History: special attention paid to early development of relationships and environmental context, use of authority/discipline in the home, role of coercion and sexuality in family, manner of expressing affection and personal boundaries, parental history of psychological functioning and past trauma, and how supportive will family be in terms of treatment;
  - Social History – peer relations, social skills;
  - Psychiatric/Treatment History;
  - School History/Intellectual Functioning; and
  - Medical History – includes any current medications, significant medical conditions.
- Child interview - focus on information gathering, including the child's understanding of the negative sexual behavior and laying the groundwork for addressing the SBP. The focus is not to get an admission and the interview should not include pressure the child to disclose.
- Administration of any of the following measures:

- The Child Sexual Behavior Inventory (CSBI) measures the frequency of both common and atypical behaviors, self-focused and other-focused behaviors, sexual knowledge and level of sexual interest
- The Child Sexual Behavior Checklist (CSBCL- 2<sup>nd</sup> revision) lists 150 behaviors related to sex and sexuality in children, asks about environmental factors, gathers details about sexual behavior and lists 26 problematic characteristics of child sexual behavior.
- The Weekly Behavior Report (WBR) tracks week-to-week changes in general and sexual behavior among young children.
- Measures of behavior and emotional symptoms, such as Child Behavior Checklists (CBCL), Behavior Assessment System for Children (BASC), and Trauma Symptom Checklist for Children (TSCC).

Key differences between a psychosexual evaluation completed for an adolescent and an assessment for a child with sexual behavior problems:

- There are typical components of a psychosexual that are not included in a child's assessment, such as sexual history and certain risk measures.
- Standard recommendations such as no contact with children 12 and under are not appropriate in assessments for children.
- Children 12 and under should *never* be labeled as perpetrators or offenders in an assessment.
- Polygraphs or techniques designed to elicit a confession should never be used.
- It should be noted that "level of risk" is not considered a factor in CSBP in the same way it is with adolescent and adult sexual offenders. CSBP are not considered sexual offenders, regardless of whether they have been involved with the legal system or not. Thus, "risk to reoffend" is not a consideration. Increasing structure and supervision in the home and addressing associated child and family treatment needs decreases the "risk" that is present for continued sexual acting out.

Evaluation Recommendations for Children with Sexual Behavior Problems:

- Recommendations should avoid broad statements; rather recommendations should focus on the individual child and family.
- Recommendations should be individualized based on the family circumstances and the age/developmental level of the child.
- Family issues to address should include needed services and supports for family members.
- Recommendations should address issues that are triggers for inappropriate sexual behavior, as well as issues related to boundary needs.
- Recommendations should address the existence of co-occurring conditions or other factors present in the child or family that require treatment attention.
- Specific recommendations related to safety in the home and community for the targeted child as well as any other children in the home should be included. This can include recommendations regarding the development of safety plans and factors that should be addressed in a safety plan, including supervision needs. Factors to consider in development of a safety plan include:
  - Level of awareness of the youth and family regarding the SBPs;
    - Level of understanding on the part of the youth and family that the sexual behavior is problematic;

- Level of understanding regarding the impact of behavior on others on part of child and family;
- Specific recommendations for the school to ensure safety of the child and other children;
- Plan for responding to subsequent incidents of inappropriate sexual behavior; and
- Specific behavior management strategies to reinforce appropriate behavior and reduce negative behaviors.

*Areas of caution* related to the assessment of CSBP:

- Interviewers should be sensitive to developmental issues and past trauma when interviewing children. The atmosphere should be supportive and pressure to reveal information *should not be applied*. Interviewers should expect children to be reluctant to reveal the truth and details about events may be upsetting to the child.
- *It is important to note that admission of engagement in the sexual behavior, or lack thereof, is not a factor that is related to risk.*
- Adult and adolescent assessment tools are inappropriate for children and should not be used
- While children who exhibit sexual behavior problems might have a history of sexual abuse, evidence suggests that there are other pathways to sexual behavior problems. Therefore, while it is appropriate to question whether or not the child has been sexually abused, it is inappropriate to assume that SBP definitively indicates past sexual abuse.
- Assessment of a child's sexual behavior problems *should not be considered valid beyond one year* from the time that the evaluation was conducted. Developmental factors, environment, and status change over time. Therefore, assessment recommendations that are specific to SBP should not be considered later in the child's life. The assessment should give more weight to recent events and issues.
- Restrictions addressed in safety plans should not last forever. After a period of time that is designated on the safety plan, if no inappropriate sexual behaviors occur the safety plan should be revisited and the child should be allowed more freedom and restrictions relaxed. The goal of a safety plan to is to provide support around resolving the problem behavior, not punishment.

#### ***IV. Factors that may contribute to sexual behavior problems***

The family environment is key in assessing and treating child sexual behavior. The following factors, including familial, social and economic, have been identified as being related to child sexual behavior problems and thus they should be considered when assessing a child's needs:

- History of physical and/or emotional abuse, neglect, exposure to domestic violence, and disruptions in care (i.e., placement in foster care, incarcerated caretakers, caretaker with mental or severe physical illness that impact care);
- Exposure to sexually explicit media (i.e., TV, magazines, web) and sexual violence;
- Living in a highly sexualized environment (i.e., parental arguments about sex, sexual language, exposure to adult sexuality) or homes with poor boundaries and little privacy (i.e., no locks on bathrooms or family members don't knock, bodies are inspected or discussed (over age 6), children are expected to kiss or hug people they don't like, exposure to nudity);
- Children are expected to meet an emotional need of a parent: in role of substitute partner to include sleeping in the same bed or hearing about the parent's problems;
- Children live in places where sex is paired with aggression;

- Children are hormonally or physically different from other children;
- Limitations or disruptions in the quality of caregiver relationship related to engagement and attachment;
- Adult capacity to supervise and opportunities for inappropriate behavior;
- Positive and negative role models and peers;
- Types of discipline and structure;
- Cultural factors;
- Resiliency;
- Poverty;
- Single parents with little education;
- Excessive stressful life events; and
- Sexual victimization within the extended family.

Additionally, it is important to note that while children who have been sexually abused do engage in higher frequency of sexual behaviors than children who have not been sexually abused, children who have no history of sexual abuse also engage in problematic sexual behavior. Child sexual behavior problems can occur as part of an overall pattern of disruptive behavior, in addition to being isolated or specialized.

## ***V. Evidence Based Treatment***

### ***SBP Outcomes Research***

Several studies have emerged examining a variety of interventions and treatment modalities, including individual, group, family, and play therapies, some of which target SBP directly and others indirectly. Emerging evidence-based treatments designed to primarily target SBP are largely group interventions that use cognitive behavioral therapy (CBT) and are time-limited (Chaffin et al., 2006). Following is a summary of significant findings related to treatment of CSBP's:

- More structured programs demonstrate improved SBP in comparison to less structured interventions. For example, compared to a play therapy group (Bonner, Walker, & Berliner, 1999), children randomly assigned to a CBT group demonstrated fewer sex offense arrests at 10-year follow-up (Carpentier, Silovsky, & Chaffin, 2006). Additional studies looking at CBT format interventions found improvements with this population. (Pithers, Gray, Busconi, & Houchens, 1998).
- Interventions with preschool children are especially effective, as demonstrated by Silovsky and colleagues (2007) who successfully treated children ages 3-7 and their caregivers in a group program. Interventions targeted at preschool-age children resulted in the biggest changes, perhaps because parent practice elements like behavior management are better implemented at that age.
- Interventions that target traumatic stress with SBP as a secondary symptom have also demonstrated improvements in children with SBP. Comparisons of Sexual Abuse Specific (SAS) Cognitive Behavior Therapy (CBT) with Nondirective Supportive Therapy (Cohen & Mannarino 1998, 1996) have consistently demonstrated more improvements of SBP's in the

SAS CBT groups. Trauma-Focused CBT has also improved SBP relative to supportive therapy (Deblinger, Stauffer, & Steer, 2001).

- St. Amand and colleagues (2008) conducted a meta-analysis of 11 treatment outcome studies evaluating 18 specific interventions for SBP in young children. They limited their review to studies of children between ages 3 and 12 and to short-term outcomes, given the dearth of long-term outcome studies. Several characteristics of treatment were examined, including specific practice elements rather than whole treatment models (e.g., cognitive coping vs. TF-CBT); treatment type (CBT, play therapy); treatment modality (individual, group, family); and therapist approach (directiveness, limit setting, and use of modeling/practice). The analysis indicated that overall, the degree of change in SBPs following treatment is .46, a medium effect size statistically but a substantial amount clinically, indicating that treatment does work with a heterogeneous group of children (St. Amand et al., 2008).
- Treatment modality (individual vs. group) is less important than specific practice elements (St. Amand et al., 2008).

### ***Recommended Practice Elements***

#### ***Parent Components***

Family/Caregiver involvement in treatment is key. This includes biological parents, foster care or kinship care parents, and any other current or potential future caregivers. In some cases, it will be appropriate for therapists to work directly with surrogate caregivers, such as day care staff or teachers, depending on where the SBP occurs. Research has identified specific elements to be included in successful interventions (Chaffin et al., 2008). Parent/caregiver components include:

1. Developing and implementing a safety plan, which includes:
  - a. A supervision and monitoring plan
  - b. Communicating the plan with other adults in the child's life
  - c. Modifying the plan over time as needed
2. Education about healthy sexual development and how it differs from SBP
3. Developing privacy and sexual behavior rules for the child
4. Education about factors that contribute to and maintain SBP
5. Sex education and how to discuss with children
6. Parenting strategies to improve the relationship with the child
7. Supporting child's use of self-control strategies
8. Modeling appropriate physical affection and building relationship
9. Guiding the child toward positive peer groups

#### ***Child components***

The following child components of successful intervention have been identified:

1. Recognition of the inappropriateness of the sexual behavior and apologizing for that behavior. This is **not** the same as an admission of past behaviors as a requisite for treatment.

2. Education and practice of boundaries and rules about sexual behavior
3. Age-appropriate sex education
4. Coping skills and self-control strategies
5. Sex abuse prevention and safety skills
6. Improving social skills

Relapse prevention, abuse cycles, and other practice elements that are derived from adult and adolescent sex offender treatment protocols are **not** recommended for children with sexual behavior problems.

### ***Co-Occurring Conditions and Developmental Level***

**Co-occurring conditions are very high among children who are physically and sexually abused,** so it not surprising that children with SBP, who often may be victims of abuse, have other conditions that require treatment.

- Treatments that target traumatic stress symptoms such as Post Traumatic Stress Disorder (PTSD) are also effective at reducing SBP (Cohen, Deblinger, Mannarino, & Steer, 2004; St. Amand et al., 2008). Which intervention to use as the primary treatment is a clinical decision that will depend on the highest priority issue. A trauma-focused intervention may be indicated for children with severe PTSD symptoms, but if the child does not present with significant internalizing behavior, then an SBP-focused intervention may be more appropriate.
- A more behaviorally-focused intervention may be more appropriate for children with significant externalizing or disruptive behaviors. Because many of the evidence-based interventions for use with children include similar elements as those that are effective with SBP, namely CBT and behavioral strategies, treatments can be integrated successfully.

Another issue to consider in any treatment for children is the child's developmental stage and level of cognitive and emotional functioning.

- Younger children and those with developmental delays are much less likely to be able to cognitively process certain concepts and are less emotionally mature. For these children, more concrete behavioral strategies that focus on simple rules and behavior plans are indicated. Role playing, practicing, and reinforcing appropriate behaviors are effective strategies.
- Young children with SBP are more impulsive than compulsive. Therefore traditional adult offender strategies, such as changing cognitive distortions, improving cognitive coping skills, or learning about the abuse cycle, are not likely to be effective.

### ***VI. Reporting Inappropriate Sexual Behaviors in Children 12 and Under***

There are multiple factors to consider when making a report regarding sexual behavior problems with children. Reporting is most appropriate where both of the following conditions are true:

- Behavior that has involved significant harm or exploitation. Where the sexual behavior has caused significant distress or harm; OR a child has used physical and/or emotional coercion (can include bribes and/or threats) to gain the compliance or reduce the resistance of another child; OR where the age or developmental difference between the children indicated substantial inequality; **AND**
- Serious or persistent behavior. The sexual behaviors are of an advanced nature such as 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 behavior of a less advanced nature that persist despite efforts to correct them or admonitions to stop.

If there are reasonable suspicions that the child may have experienced prior or ongoing maltreatment, or where parents or caregivers are neglecting to provide sufficient supervision or care, reporting requirements may be triggered.

Typical or normative sexual play and exploration between children, as outlined earlier, does not merit a report to law enforcement or child welfare authorities. Even SBP that may warrant consulting a professional may not always merit a report to the authorities (Chaffin, et al, 2006).

The law in Tennessee requires anyone who suspects abuse to report it to the Department of Children's Services or local law enforcement. More specifically:

- Professionals who work with children in organizations that are responsible for the care of children (i.e. child care center's or programs, schools or educational enrichment type settings, mental &/or behavioral health providers, clinics, hospitals and residential care faculties) as defined in statute 71-3-501 and 37-5-501
- Or-
- Relatives, neighbors or community members who have concerns about possible child abuse, which a referent may suspect with a child who presents SBP, they are responsible to report their concerns of possible abuse to: Juvenile Court, Department of Children's Service, Sheriff in the county where the child resides, or Chief law enforcement officer in the county where the child resides; as outlined in statute 37-1-605.

### ***VII. Supervision and Monitoring***

It is important to develop, implement and communicate supervision and monitoring plans for children with sexual behavior problems across systems.

- Most children with SBPs can remain in their home or foster home with other children without problematic sexual behavior. However, children who continue to exhibit highly intrusive or aggressive sexual behavior despite treatment and close supervision should not live with other young children until this behavior is resolved.
- Most children can attend public schools and participate in school activities without jeopardizing the safety of other students. Children with serious, aggressive sexual behaviors may need a more restrictive educational environment.
- A behavioral plan to decrease the child's problematic sexual behaviors should be developed with full participation of the caregivers and the child. The plan requires full participation of both and must be clear regarding acceptable behaviors.

- Depending on the level and type of sexual behavior problems, the child may need to be supervised while with other children; not sleep in the same room with another child; not sleep in the same bed with other children or adults at any time; not be left to care for other children, even for a short time; all bathroom activities should be done separately from other children and adults; adults and children should not walk around without clothes on; caregivers should not have sexual intercourse when the child is in the home; and if a child who has previously engaged in sexually inappropriate behavior is living in a home with other children the other children should be told. Motion detectors and buzzers can be used if needed to alert caregivers of the child leaving the bedroom at night.
- The home environment must provide a healthy sexual environment and encourage healthy boundaries by developing healthy rules.
- Some children with sexual behavior problems will require notification of the school and after care providers. All professionals working with the child should be in monthly communication to assure that there is a coordinated treatment plan on which all team members agree.
- All decisions and goals should be made with the child, whenever possible.
- If the child with SBP's remains at home, it is strongly advised to have an open CPS case with authority. When parents and children have to go to therapy without the authoritative incentive of CPS or probation, attendance may be sporadic or nonexistent.
- Some children with SBP's are put on probation. If the child is on probation the terms of the probation should be understood by all of the members of the treatment team.

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