Children with Sexual Behavior Problems (SBP)

Typically, children with sexual behavior problems (SBP) are those under 12 years of age or younger and who demonstrate developmentally inappropriate or aggressive sexual behavior such as excessive masturbation and coerced or forced sexual acts upon other children. Although the word "sex" is used to describe these children, their motivation for their behaviors may be unrelated to sexual gratification. Sexual behavior between children is considered problematic when the behavior:

1. Interferes with the child's social or cognitive development;
2. Occurs with coercion, intimidation or force;
3. Occurs at a high frequency;
4. Is associated with emotional distress;
5. Occurs between children of significantly different ages or developmental abilities;
6. Repeatedly occurs in secrecy after adult intervention.

Although some sexual play among children is not harmful and quite normal, like playing doctor and peering at private parts, these same behaviors can become abnormal and harmful if done aggressively or intrusively.

Although children who have been sexually abused have been found to exhibit more frequent and intrusive sexual behaviors than non-sexually abused children, many do not develop SBP, which is a common misconception. In fact, research has shown that children who have SBP have not necessarily been sexually abused. It appears that sexual behavior problems in children have multiple origins: sexuality within the family, exposure to sexual materials, exposure to familial violence and physical abuse can all contribute to sexual behavior problems. Sexualized behavior Problems due to abuse are very likely related to sexual abuse that was repetitive and/or sadistic in nature.

Children with SBP are different from adolescent and adult sex offenders. Research also indicates that sexual abuse in childhood is not a strong predictor of adolescent or adult sexual offending. Chaffin and Friedrich's research indicates that about 20% of children with SBP go on to commit sexual offenses as adolescent and about 5-15% of adolescent sexual offenders go on to commit sexual acts as adults. Much of that depends on the constructs of the personality. For example, if an adolescent has a pedophiliac interest, this is likely to persist into adulthood. Versus an adolescent with psychosocial deficits (low social skills, depression, anxiety) which has low sexually deviant traits.

Sexual Play vs. SBP

The key differences between children without sexual behavior problems and those who act out sexually are in the manner in which the acts are carried out: exploratory versus aggressive; playful and curious versus coercion and obsession, non-secretive versus secrecy. Professionals in the field

have developed a continuum of sexual behaviors that range from common sexual play to problematic sexual behavior:

Sexual Play

- Is exploratory and spontaneous
- Occurs intermittently and by mutual agreement
- Occurs with children of similar age, size, or developmental level
- Is not associated with fear, anxiety or anger
- Decreases when redirected by an adult
- Can be controlled by increased supervision

Problematic Sexual Behavior

- Is frequent, repeated and compulsive
- Occurs with high frequency and between children who do not know each other well
- Is between children of different ages, sizes and developmental level
- Is aggressive, forced or coerced
- Does not decrease after the child is told to stop the behavior and given consequences
- Causes harm to the child or others

One method used by therapists to assess whether sexual behaviors are developmentally appropriate or cause for concern includes four basic levels:

Frequency of the Behavior;
Intensity of the Behavior;
Duration of the Behavior;
The Situation in which the behavior occurs.

Ordinarily being redirected, ridiculed or even threatened with consequences is enough to stop the behavior in children who are not compulsive. If the sexual behavior is problematic, a referral for mental health services is recommended. Developmentally inappropriate behaviors include direct genital or penetrative contact among preschool and school aged children as well as masturbatory insertion of objects into the anus or vagina.

Assessment

During an interview with a child, the interviewer may ask the child to demonstrate with dolls what boyfriends and girlfriends do together. If the child places the dolls in sexualized positions, the interviewer may follow-up with "What are they doing?" "What parts are touching when they do that?" "How does it make the girl/boy feel?" "Do they kiss someplace else?" "Does the boy put that part anywhere else on the girl?" "How did you learn about that?" It is also important to ask the caregiver about the environment such as exposure to pornographic magazines, videos, the Internet, cable TV; exposure to adult nudity/sexuality in the home; sex education and sexual abuse prevention education; boundaries regarding sleeping, bathing, dressing, toileting; presence of domestic violence in the home; presence of substance abuse in the home; parental history of sex abuse.

Treatment Implications

According to the National Center on Sexual Behavior of Youth, most children with SBP can live safely with other children as long as appropriate treatment and careful supervision is in place. Many children with SBP can be successfully treated and managed on an outpatient basis while living at home, attending school. However, if the behavior does continue to be highly intrusive or aggressive, despite treatment, the child should be removed until it is resolved. Inpatient treatment should be resorted as an option for unusually severe cases, such as a child with accompanying psychiatric disorders and/or highly aggressive behaviors which recur despite appropriate outpatient treatment and supervision.

Guidelines for Caregivers

- Recognize that due to child's past experiences, he/she needs significant structure and guidance to manage behavior
- Recognize triggers for the SBP which could mean triggering feelings of anger, loneliness, powerlessness, flashbacks, exposure to stimulating material.
- Recognize that physical punishment may reinforce a negative self image and remind the child of past abuse.
- Recognize the need for to experience safe and appropriate physical affection.
- Be aware that even normal situations and routines such as bathing, sleeping, and TV viewing can act as a trigger.
- Understand that mental health treatment cannot be effective without a safe, structured, supportive home environment. Therapy does not just "fix" a child.
- Establish and discuss rules and boundaries for the family regarding bathing (keep doors closed), sleeping (everyone is separate beds), etc. *All children and adults in the home should abide by the boundaries.*
    - Establish clear rules for touching in the home. Adults should request physical contact form children and children from adults.
    - All family members should bathe, toilet, and change clothes in private with the exception of very young children who need assistance.
    - Do not allow the child to assist in bathing or changing other children.
- Discuss how you, the caregiver, will help him/her maintain the rules (limit setting, reminders, etc.)
- Inform the child of consequences (non-physical) for breaking house/family rules.
- Engage in age appropriate activities with the child ("G" rated movies, board games, outdoor activities).
- Be empathic if the child discloses traumatic experiences, but do not probe.
- Share your feelings with the child so as to appropriately model happiness, fear and sadness.
- Encourage good behavior by noticing good behavior.
- Be aware of your own behavior! Closely monitor your own remarks and sexual suggestibility.

Supervision / Behavior Plan

- "Eyes on" contact should be maintained at all times when the child is with other children.
- No sleepovers.

- Never allow children to play behind closed doors
- Identify problem behaviors and attach logical consequences. (if the child masturbates with a toy, he/she loses privilege of playing with that toy).
- Identify what the child is seeking from the sexual behavior and find other ways to meet those needs. For example: if the child is seeking closeness, encourage the child to ask for appropriate affection from caregivers; if the child is acting out angry feelings encourage verbal expression instead. <u>Give praise to positive behavior changes.</u>
- Discuss healthy sexuality (i.e. sexual relationships are best when they are part of a caring relationship and between people who both want it.)

Resources

Arnts, Jeanne. 2004. Center for Child and Family Health – NC. Identifying and Responding to Children with Sexualized Behavior Problems. Prevent Child Abuse North Carolina, Conference on Child Abuse and Neglect.

National Center on Sexual Behavior of Youth. 2004 Fact Sheet: Sexual Development and Sexual Behavior Problems in Children Ages 2-12. The University of Oklahoma Health Sciences Center.

National Center on Sexual Behavior of Youth. 2003 Fact Sheet: Children with Sexual Behavior Problems: Common Misconceptions vs. Current Findings. The University of Oklahoma Health Sciences Center.

Normal Sexual Development by Age

6 years	7 years	8 years	9 years	10 years	11 years	12 years	11-14 years	14-17 years	17-20 years
Has interest in origin of babies and will ask about it.	Is interested in pregnancies	Can understand growth of baby inside mother	Increased awareness of own sexuality	Most know about sexual intercourse	Can understand prenatal growth	Is aware that intercourse occurs apart form conception	Self-exploration and evaluation common	Multiple, plural relationships common	Forms stable relationships and attachment to others
Has an increased interest in opposite sex (i.e. playing doctor) and will explore.	Modest in front of opposite sex	Has a high interest in sex	Majority know about menstruatio n	Slight disinterest in opposite sex	Sees intercourse as "nasty"	Girls slightly comfortable talking about sex	Limited dating	Decisive turn towards sexual orientation	Intimacy involves commitment rather than exploration
Has interest in and awareness of sex differences. Girls may put things between their legs, simulating they have a penis.	Less exploration than at age 6	Asks very searching questions - wants exact information. May look at pictures of nude adults	May discuss sex information with friends	Girls begin to show signs of sexual maturity (rounding contours...)	Are interested in how seed is planted from mother to father - hard to understand	Girls are cognizant of sex matters and may even flaunt their developing form	Limited intimacy	Exploration of "sex appeal"	Preeminence of individual as a dating partner
Both sexes will investigate opposite gender	Can understand that babies come from 2 seeds	Girls more curious than boys about pregnancies conception	Begins sex swearing, sex poems	No sexual maturation apparent in boys	Boys interested in smutty jokes and animal	Boys more interested in sex and may seek info. from	Increased concern about physical appearance	Will experience feelings of "being in love"	

6 years	7 years	8 years	9 years	10 years	11 years	12 years	11-14 years	14-17 years	17-20 years
roles (i.e. playing house)					copulation	magazines, books, etc.			
May show genitals to others but will respond to scolding / re-direction Will be curious about naked adults but not in an aggressive manner. Will look at nude people.	Puts negative labels on toileting behaviors Can distinguish between sexual and non-sexual touching	Is interested in smutty jokes and peeping Decrease in sexual exploration	Boys hesitant to ask questions Some begin pubertal changes	Girls more aware of sex than boys, but less outspoken	Boys experience frequent erections Girls are very aware/ absorbed in their own body changes	Boys have frequent “bull sessions” about sex. Erections and Masturbation common in boys.		Tentative establishment of relationships Feelings of inadequacy common	

Chart adapted from the South Carolina Guardian ad Litem Training Program, 1998.

Abnormal Sexual Behavior

School age and Pre-Adolescence (5 to 12 years)	Puberty and Adolescence (13 to 15 years)
* Lack of interest in other children, emotionally withdrawn	* Apprehension or guilt towards sex education and health
* Excessive sexual stimulation of self/masturbates with objects	* Impulsive or aggressive sexual behavior
* Excessive enuresis or encopresis (or other disturbing toileting behaviors such as smearing feces)	* Sexual preoccupation or promiscuity
* Anxiety over relationships with people	* Poor or absent relationships with peers and/or adults
* Sexual exploration among children of different ages, size and/or developmental level	* Coaxing, bribing, or tricking a individual that is older or younger in age or developmental level
* Continues sexual behaviors in spite of clear redirection	* An ongoing impulsive interest in sexually related activities
* Seductive or sexually responsive toward adults	* Inability to postpone self-gratifications
* Obsessive-compulsive sexual fantasy	* Precocious sexual behaviors
* Excessive sexual exhibitionism and/or eroticism	* Inappropriate touching of self in public
* Puts mouth on sexual parts	* Colitis, menstrual disorders
* Makes sexual sounds	* Inappropriate touching of others
* Simulates adult sexual intercourse (with or with out clothes on)	* Sex is used to gain friendships or to gain stability within relationships
* Refuses to leave people alone while in restrooms	* Self-worth dependent on sexual performance
* Puts objects in rectum or vagina	* Seductive and clingy towards primary care-taker
* Asks or watches others take their clothes off, repeatedly	* Vulnerable to exploitation/allows people to sexually mistreat

School age and Pre-Adolescence (5 to 12 years)	**Puberty and Adolescence (13 to 15 years)**
* Wants to watch movies with nudity or sex	* Uses sexual behavior to reduce tension
* Cannot distinguish between sexual and non-sexual touching	* Self-mutilation, especially genitals and private parts
* Negative feelings about own body	* Exhibits confusion or distorted ideas about the rights of others in regard to sexual behaviors
* Asks to engage in sex acts	

- Adapted from South Carolina Guardian AD Litem Program and work from Toni Cavanagh Johnson, PhD.