Strategies for Identifying and Assessing Children With Sexually Abusive Behavior Problems

Part One: Two Curriculum Modules

By

Lucinda A. Rasmussen
San Diego State University
Title IV-E Child Welfare Stipend Project

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CALSWEC PREFACE

The California Social Work Education Center (CalSWEC) is the nation’s largest state coalition of social work educators and practitioners. It is a consortium of the state’s 18 accredited schools of social work, the 58 county departments of social services and mental health, the California Department of Social Services, and the California Chapter of the National Association of Social Workers.

The primary purpose of CalSWEC is an educational one. Our central task is to provide specialized education and training for social workers who practice in the field of public child welfare. Our stated mission, in part, is “to facilitate the integration of education and practice.” But this is not our ultimate goal. Our ultimate goal is to improve the lives of children and families who are the users and the purpose of the child welfare system. By educating others and ourselves, we intend a positive result for children: safety, a permanent home, and the opportunity to fulfill their developmental promise.

To achieve this challenging goal, the education and practice-related activities of CalSWEC are varied: recruitment of a diverse group of social workers, defining a continuum of education and training, engaging in research and evaluation of best practices, advocating for responsive social policy, and exploring other avenues to accomplish the CalSWEC mission. Education is a process, and necessarily an ongoing one involving interaction with a changing world. One who hopes to practice successfully in any field does not become “educated” and then cease to observe and learn.

To foster continuing learning and evidence-based practice within the child welfare field, CalSWEC funds a series of curriculum sections that employ varied

research methods to advance the knowledge of best practices in child welfare. These sections, on varied child welfare topics, are intended to enhance curriculum for Title IV-E graduate social work education programs and for continuing education of child welfare agency staff. To increase distribution and learning throughout the state, curriculum sections are made available through the CalSWEC Child Welfare Resource Library to all participating school and collaborating agencies.

The section that follows has been commissioned with your learning in mind. We at CalSWEC hope it serves you well.
INTRODUCTION

This curriculum was supported by a grant from the California Social Work Education Center (CalSWEC). It provides theoretical knowledge and practice skills necessary for social work practice with children who have sexual behavior problems. The knowledge and skills presented address the CalSWEC priority area of child development and the following specific CalSWEC competencies:

- Student understands and is sensitive to cultural and ethnic differences of clients. (1.1)
- Student can develop relationships, obtain information, and communicate in a culturally sensitive way. (1.4)
- Student considers the influence of culture on behavior and is aware of the importance of utilizing this knowledge in helping families improve parenting and care of their children within their own cultural context. (1.5)
- Student can distinguish diagnostically between the traditional culturally based disciplining and child-rearing practices of cultural and ethnic families and those of the dominant society and will be able to differentiate "culturally different" from "abusive" behavior. (1.10)
- Student understands that child abuse and neglect are presenting symptoms of social and family dysfunction. (2.1)
- Student is able to assess the interaction of individual, family, and environmental factors which contribute to abuse, neglect, and sexual abuse, and identifies strengths which will preserve the family and protect the child. (2.2)
- Student recognizes and accurately identifies physical, emotional, and behavioral indicators of child abuse, child neglect, and child sexual abuse in child victims and their families. (2.3)
- Student accurately assesses the initial and continuing level of risk for the abused or neglected child within the family while ensuring the safety of the child. (2.9)
- Student works collaboratively with foster families and kin networks, involving them in assessment and planning and supporting them in coping with special stresses and difficulties. (2.19)

- Student is aware of his or her own emotional responses to clients in areas where the student's values are challenged, and is able to utilize the awareness to effectively manage the client-worker relationship. (3.6)

- Student assesses family dynamics, including interaction and relationships, roles, power, communication patterns, functional and dysfunctional behaviors, and other family processes. (3.7)

- Student understands crisis dynamics, identifies crises, and conducts crisis intervention activities. (3.8)

- Student has knowledge of how clients are nonvoluntarily referred to Public Child Welfare. (3.10)

- Student knows and demonstrates appropriate parenting strategies. (3.16)

- Student assesses family from a person-in-environment perspective. (3.17)

- Student understands children's developmental needs and how developmental level affects a child's perception of events, coping strategies, and physical and psychological responses to trauma. (4.1)

- Student understands the process of human sexual development and behavior. (4.3)

- Student understands the potential effects of child abuse and neglect on child/adult development and behavior. (4.4)

- Student understands the significance of attachment, separation, and loss issues across the life span. (4.7)

- Student understands the interaction between environmental factors especially in terms of racism, poverty, violence, and human development. (4.8)

- Student understands the impact of adult/parental psychopathology on child development and on family functioning. (4.10)

**RATIONALE FOR THE CURRICULUM MODULES**

The commission of sexual offenses by adolescents and young children is increasingly recognized as a disconcerting social problem. The best available estimates from crime reports and victim surveys indicate that at least 30% of cases of child sexual
abuse and 20% of all rapes are perpetrated by adolescents (Barbaree, Marshall, & Hudson, 1993; Davis & Leitenberg, 1987; Finkelhor, 1996). Histories of adult sexual offenders have indicated that sexually abusive behavior develops over time and often begins in latency and early adolescence (Abel, Mittelman, & Becker, 1985; Groth, Longo, & McFadden, 1982). Clinical work with children has confirmed that even young children may exhibit sexually abusive behavior (Burton, Rasmussen, Bradshaw, Christopherson, & Huke, 1998; Cunningham & MacFarlane, 1991, 1996; Isaac, 1986; Johnson, 1988, 1989).

Over the past 25 years, enhanced public awareness of child sexual abuse resulted in increased reporting of sex offenses, including those committed by adolescents and children. Coordinated efforts of treatment professionals in various locations throughout the nation helped develop comprehensive treatment services for juvenile sexual offenders (Bengis, 1986; California Department of the Youth Authority, 1986; Michigan Adolescent Sexual Abuser Project, 1988; National Task Force on Juvenile Sexual Offending, 1988, 1993; New York Governor's Task Force on Rape and Sexual Assault, 1990; Utah Governor's Council on Juvenile Sex Offenders, 1990). In 1993, the National Task Force on Juvenile Sexual Offending reported, "Whereas there were about 20 programs identified nationally in 1982, there are now over 800 specialized treatment programs serving sexually abusive youth" (p. 5).

Along with the proliferation of treatment programs, research concerning adolescent sex offenders flourished (Davis & Leitenberg, 1987; National Task Force on Juvenile Sexual Offending, 1988, 1993). In the late 1980s, clinicians and researchers...
began to identify another abusive population: children 12 years of age or younger who were sexually abusing other children. Literature concerning this topic has emerged over the past decade (Araji, 1997; Bonner, Walker, & Berliner, 1991-1996; Burton et al., 1998; Cantwell, 1988; Cunningham & MacFarlane, 1991, 1996; Friedrich & Luecke, 1988; Gil & Johnson, 1993; Gray, Busconi, Houchens, & Pithers, 1997; Gray & Pithers, 1993; Hall, Mathews, & Pearce, 1998; Johnson, 1988, 1989; Johnson & Berry, 1989; Lane, 1997a, 1997b; Pithers, Gray, Busconi, & Houchens, 1998; Rasmussen, Burton, & Christopherson, 1992; Ryan, 1997a). Much of this research has shown that many young children who display sexually abusive behavior problems are victims of abuse themselves (Cunningham & MacFarlane, 1991; 1996; Bonner et al.; Burton et al., 1998; Friedrich & Luecke; Gray et al., 1997; Johnson, 1988, 1989).

Practitioners who provide treatment to victims of child sexual abuse must recognize that at least some of those victims may go on to develop sexually abusive behavior. It is therefore important that MSW students who work with abused children obtain specialized knowledge in identifying and assessing children and adolescents who display sexually abusive behavior, as well as gain practice skills in appropriate intervention strategies. The curriculum presented in these modules provides this specialized knowledge and teaches practical skills in assessment, therapeutic engagement, and treatment planning.

The topic of sexually abusive children is especially relevant to the public welfare competencies listed above. For example, students need to understand that child sexual abuse perpetrated by children or adolescents is a presenting symptom of "social and

family dysfunction" (Competency 2.1). They need to know how to assess "interaction of individual, family, and environmental factors" that contribute to sexually abusive behavior in children and adolescents (Competency 2.2). They need to recognize and accurately identify the "physical, emotional, and behavioral indicators of child abuse" perpetrated by children and adolescents (Competency 2.3), assess when children are at risk to act out sexually (Competency 2.9), assess whether the sexual behaviors exhibited are developmentally appropriate (Competency 4.3), and identify the potential acute and long-term effects on the victims when children molest other children (Competencies 4.4, 4.7, and 4.8).

The topic of sexually abusive children also relates to the competencies which stress understanding and accurate assessment of family dynamics and parenting skills, both in biological and foster families (Competencies 2.19, 3.7, 3.8, 3.10, 3.16, 3.17, and 4.10). Working with sexually abusive children and their families challenges students to be aware of their own values and manage their emotional responses (Competency 3.6). Assessment and intervention with sexually abusive children and their families must be culturally sensitive (Competencies 1.1, 1.4, 1.5, and 1.10) and reflect an accurate understanding of child development (Competencies 4.1 and 4.3).

During their first year in social work practice courses, MSW students typically acquire knowledge and skills in interviewing, assessment, and treatment planning. They are introduced to a few practice theories and models, including the generalist intervention model, crisis intervention, case management, and other intervention models. In their second year, MSW students typically focus more specifically on

advanced interviewing skills and learn intervention strategies and techniques. This curriculum manual complements the second-year course of study by providing specialized assessment strategies and therapeutic engagement techniques to address a clinical population with special needs--children who have sexual behavior problems. In their field placements, many MSW students are seeing troubled families with abuse issues, including families with children or adolescents who have offended sexually. It is imperative that MSW students are prepared to address the needs of these youth. This curriculum manual will help students gain the knowledge and skills needed to assess these youth and their families, engage them in treatment, and formulate a treatment plan that addresses their needs. Emphasis is placed on the beginning phases of the helping process: engagement and assessment. Discussion of intervention strategies to guide the middle and ending phases of treatment is beyond the scope of this curriculum.

Through this curriculum, MSW students may gain knowledge of the adverse effects of child sexual abuse and other types of child maltreatment on child development and learn how impaired child development can lead to sexual behavior problems in children. They will be exposed to specific skills they can employ in practice to identify and assess children with sexual behavior problems and their families and engage them in treatment. Students also will be challenged to identify their personal feelings related to working with sexually abusive youth, increase their self-awareness of cultural and countertransference issues, develop self-care strategies to guard against burnout and vicarious traumatization, and maintain appropriate professional boundaries.

This curriculum is derived from a current review of research literature pertaining to effects of child sexual abuse, inappropriate sexual behaviors in children, and juvenile sexual offending. The primary emphasis is on identification and assessment of sexual behavior problems in children. Instructors who teach courses or give training related to adolescent sexual offending may wish to use this manual as a supplemental resource and access additional resources as primary instructional materials. Resources on adolescent sexual offenders are included in the Resource List to be presented in Part 2 of the curriculum. This curriculum does not address issues pertaining to identification, assessment, and treatment of adult sexual offenders, nor does it address treatment issues pertaining to adults who were molested as children.

LEARNING OBJECTIVES

Knowledge Objectives

• Develop knowledge of the acute and long-term effects of child sexual abuse on children's cognitive, emotional, and behavioral functioning.

• Develop knowledge of normal sexual development in children and factors that differentiate age-appropriate from sexually abusive behavior (e.g., differences in power, misuse of authority [intimidation], manipulation, and coercion).

• Distinguish among and be able to critically apply clinically and empirically derived methods for classifying types of children with sexual behavior problems.

• Develop a working knowledge of theories explaining the etiology of sexually abusive behavior problems (e.g., post-traumatic stress disorder and reenactment of prior victimization, traumagenic dynamics of sexual abuse, sexual abuse cycle, Trauma Outcome Process).

• Develop knowledge of research literature on commonly observed characteristics of child abuse victims and children with sexually abusive behavior problems.

• Develop a working knowledge of dysfunctional family dynamics often displayed when family members exhibit sexually abusive behavior.

• Distinguish among and be able to critically choose strategies to assess cultural factors and discriminate culturally appropriate behavior from sexually abusive behavior problems.

• Distinguish among and be able to critically apply psychodynamic, social learning, cognitive-behavioral, and family systems theories in completing biopsychosocial assessments of children with sexual behavior problems.

• Develop knowledge of steps involved in formulating treatment plans for children with sexually abusive behavior problems and their families and selecting intervention modalities (i.e., individual therapy, group treatment, and family therapy).

• Use crisis intervention to identify, assess, and manage high risk factors in children with sexually abusive behavior problems.

• Distinguish among practice models used in intervention with children with sexually abusive behavior problems (e.g., psychodynamic approach, client-centered therapy, cognitive-behavioral therapy, play therapy, and family systems approaches) and critically apply these models in engaging children and families in treatment.

• Develop knowledge of ethical dilemmas related to social work values, confidentiality, professional boundaries, and countertransference in social work practice with sexual abuse victims, children with sexual behavior problems, and their families.

Values Objectives

• Develop awareness of personal feelings related to sexual issues (e.g., age-appropriate sex play among children and sexually abusive behavior).

• Develop awareness of diversity (i.e., race, culture, ethnicity, gender, sexual orientation, class, religion, and disability) in social work practice with sexually abused children, and children with sexual behavior problems and their families.

• Develop awareness of factors that personally impact clinicians who treat sexual abuse victims and children with sexual behavior problems.

• Develop self-awareness of personal issues related to sexual abuse, including countertransference, vicarious traumatization, and ethical dilemmas (i.e., conflicts between personal values and social work values).

Skills Objectives

- Develop skill in synthesizing assessment information, determining case conceptualizations, formulating treatment goals, and selecting intervention modalities and strategies for children with sexually abusive behavior problems and their families.

- Develop skill in using various practice models to engage child victims of abuse and children with sexually abusive behavior problems in treatment (e.g., crisis intervention, client-centered therapy, cognitive-behavioral therapy, play therapy, and Trauma Outcome Process approach).

- Demonstrate skill in implementing appropriate self-care strategies to deal with countertransference and vicarious traumatization reactions to the therapeutic issues presented by sexually abused children and children with sexually abusive behavior problems and their families, problem-solve and resolve ethical dilemmas, maintain appropriate professional boundaries, and prevent burnout.

Note to instructors: Experiential exercises performed in class may be used to evaluate whether students are acquiring the practice skills demonstrated in this curriculum. Learning experiences in students' Field Practicum offer greater opportunities for students to apply these skills to actual client situations. It may be best, therefore, to evaluate the above "Skills Objectives" in Field Practicum.

CONTENT OF CURRICULUM

The complete curriculum consists of four modules. Part One includes Modules I and II. Part Two includes Modules III and IV and will be published later. Each module contains learning objectives (related to knowledge, values, and skills), suggested readings, an outline of the specific issues addressed in the module, and suggestions about how the module can be taught in the classroom and in field practicum. Teaching techniques for presenting the material contained in each module are presented, including small group discussions, role-plays, videos, case vignettes, and experiential structured exercises. Each module may require two or more class or training sessions to complete.

The first three modules focus on theory. Module I discusses the effects of sexual abuse trauma on young children. This module sets the stage for later modules in describing the adverse effects of sexual abuse trauma and the role of past victimization experiences in motivating sexual acting out. Current research literature is presented, and affective, cognitive, and behavioral effects are reviewed. Two practice models that explain the effects of abuse (i.e., post-traumatic stress disorder and traumagenic dynamics of sexual abuse) are discussed and compared. An integrative treatment model, the Trauma Outcome Process, is introduced.

Module II discusses childhood sexual development and reviews research on sexual behavior problems in children. Experiential exercises are used to enhance students' awareness of their sexual values. Research findings about normative sexual development in children are presented. Criteria are described for differentiating sexually abusive behavior problems from age-appropriate sex play. Current clinical and research methods used to classify types of children with sexual behavior problems are reviewed and discussed.

Module III reviews current literature identifying the individual characteristics and family dynamics of children with sexually abusive behavior problems. Selected theories that provide explanations for the development of sexually offending behavior are presented, compared, and analyzed. Students have an opportunity in this module to critically think about and identify internal and external risk factors that may contribute to children developing sexual behavior problems.

Module IV focuses on assessment and engagement strategies for social work practice with children with sexually abusive behavior problems and their families. This module discusses how a multidimensional biopsychosocial assessment can be tailored to identify the specific needs and therapeutic issues of sexually abusive children and their families. It emphasizes the need to address the unique aspects of each client's family dynamics and cultural background. Students are challenged to become aware of the influences of their own family dynamics and culture on the way they view the world, and to learn ways to communicate effectively with individuals of different cultures. Sensitivity to all aspects of diversity (i.e., race, culture, gender, sexual orientation, age, religion, and disability) is emphasized.

The assessment module also discusses the application of specific practice theories and models in the assessment and engagement phases of intervention with sexually abusive children. Students learn how to use crisis intervention to assess and manage the high-risk factors inherent in the treatment of these children. The module discusses the process of using practice theories to interpret and understand clinical observations and assessment data, make DSM-IV diagnoses, and formulate appropriate treatment plans for children with sexually abusive behavior problems. Intervention strategies from specific practice models (e.g., psychodynamic approach, client-centered therapy, cognitive-behavior therapy, play therapy, family systems approaches) are introduced. Specific strategies for engaging sexually abusive children and their families in treatment and establishing therapeutic rapport are demonstrated.

and discussed. Students are given opportunities to practice conceptualizing cases, formulating treatment plans, and implementing practice skills.

Module IV also includes a discussion of case management issues, emphasizing the importance of integrating different treatment modalities (i.e., individual therapy, group therapy, family therapy, psychoeducational classes on parenting, and supervision issues) and accessing needed resources for sexually abusive children and their families. A systems approach is proposed which entails applying family systems concepts and case management strategies to help clients identify and access needed resources. Students are exposed to strategies for helping parents of sexually abusive children increase supervision in their homes, enhance safety of all family members, and prevent additional incidents of sexually abusive behavior.

Module IV concludes with a discussion of the ethical and personal issues frequently encountered in providing sexual abuse treatment. Ethical dilemmas that may arise when treating sexually abusive children and their families are presented. The difficulties of maintaining professional boundaries and guarding against vicarious traumatization are discussed. Students are encouraged to identify their own countertransference issues related to working with sexual abuse issues, particularly issues pertaining to sexual values or to past traumatic experiences. Strategies for addressing personal issues, maintaining professional boundaries, taking care of self, and preventing burnout are presented. Students are given the opportunity to thoughtfully consider and formulate goals related to professional boundary and personal issues.

APPLICATION OF CURRICULUM TO CLASSROOM AND FIELD SETTINGS

The curriculum is written for instructors of second-year MSW students and to trainers of clinicians. It is assumed that the students or workshop participants\(^1\) who are exposed to this curriculum already have beginning-level knowledge and skills related to assessment and intervention of child sexual abuse victims and their families. The curriculum teaches specialized skills and is too advanced for first-year MSW or undergraduate social work students.

Instructors may use the curriculum as a resource manual for a semester-long course on social work practice with sexually abusive youth. A suggested syllabus with a course outline is included in Appendix A. The instructor may need to condense the material presented in the modules in order to cover the suggested topics within the time constraints of an academic semester. Two PowerPoint presentations to accompany Modules I and II can be found online where this curriculum was located.

The modules may also be used to supplement the course content of other courses.

The assessment module (Module IV) is particularly appropriate for second-year social work practice courses. The theory modules (Modules I, II, and III) may be used in social work practice courses (as part of a discussion of practice theories/models) or in human behavior (HBSE) electives (as part of a discussion on child development or child abuse issues). The material on professional use of self in Module IV may be integrated...

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\(^1\)To avoid the use of repetitive language, participants will be referred to throughout this manual as students.

into both theory and practice courses, or used to supplement courses on law, ethics, and values.

Alternatively, the curriculum may be presented as separate training modules in classroom, field agency, or workshop settings. Separating the curriculum into manageable segments allows for more comprehensive discussion of each topic. It also facilitates more active student involvement in experiential activities such as role-plays, analysis of case vignettes, and self-awareness exercises. Students will benefit most from this course by participating in the experiential exercises, which are designed to increase awareness of their feelings, attitudes, and values concerning sexual abuse issues. Class size is particularly important. When possible, instructors should limit the number of students in the class to approximately 16. Keeping the class size small allows for greater in-depth discussion of the content of the course and facilitates student involvement in the experiential exercises.

Assigned readings are provided for each module. Students should come prepared to each class or training session having read the assigned readings. Instructors should expect students to actively participate in discussions of the readings and to demonstrate critical thinking in analyzing the course material and applying it to clinical practice. Instructors may present the material from the required readings through lectures (with accompanying PowerPoint presentations, or handouts), class discussion, Socratic questioning, or dividing the class into small discussion groups. Experiential exercises, such as role-plays, self-awareness exercises, or analysis of case vignettes, can further illustrate the material presented in the readings.
Academic and field instructors should carefully monitor student responses to the experiential exercises. If a student shows an intense response to a particular exercise, the instructor should meet privately with him or her, help the student identify the personal issues that were triggered by the exercise, and discuss alternatives for addressing those issues. It may be necessary to refer the student to appropriate therapeutic resources. In any case, it is critical that instructors stress to students the need to resolve personal issues pertaining to sexual abuse, trauma, or loss. Resolving one's own personal abuse issues is a critical prerequisite for doing therapeutic work with sexually abusive children and their families.

Suggested written assignments are provided in the proposed syllabus in Appendix A. These assignments may be required for students in an academic course, or may be supplemental follow-up exercises for participants in training workshops. Pre- and posttests will be included in Part Two (Modules III and IV). Instructors of academic courses may wish to draw upon the questions in the pre- and posttests when designing midterm or final examinations. Alternatively, if the manual is being used in providing agency training workshops, instructors may wish to use the pre-/posttests as a measure to evaluate the effectiveness of the training.

TEXTBOOKS AND READINGS

There are four required textbooks for the course. These textbooks are considered among the best currently available on assessment and intervention with children with sexual behavior problems, juvenile sexual offenders, and their families. In addition, instructors may recommend a fifth textbook (Lukas, 1993). The Lukas text is a

practical, hands-on resource to help students engage clients in treatment, assess high risk factors, and complete a mental status exam and biopsychosocial history.


A number of journal articles and chapters in edited books are also suggested as required readings for students. Instructors may wish to arrange to place these readings on reserve at their university’s library, or contact publishers to obtain permission to distribute the articles or chapters to students.

Instructors may choose to select additional readings to supplement those suggested in this curriculum. The suggested readings for each module are listed below:

**Module I**


- Trauma models - Traumagenic Dynamics Model, Post-Traumatic Stress Disorder (pp. 123-125, 128-129)


- Chapter 1 - Prior Traumatization (pp. 9-20) and Sexual Abuse Cycle (pp. 25-26); Chapter 2 - Trauma Outcome Process (pp. 31-33, 45-49).

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**Module II**


Introduction (pp. xxvi-xli), Chapter 1 - Identifying, labeling, and explaining children's sexually aggressive behaviors (pp. 1-46).


Chapter 1 - Sexually abusive behavior problems: Definitions and current knowledge (pp. 1-28).


Chapter 1 - Childhood sexuality (pp. 1-20), Chapter 2 - Age-appropriate sex play versus problematic sexual behaviors (pp. 21-39), and Chapter 3 - Sexual behaviors: A continuum (pp. 41-52).


BEGINNING THE TRAINING:
THE INITIAL CLASS SESSION

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LEARNING OBJECTIVE

To create interest in the course, establish rapport with students, and set course expectations.

READING ASSIGNMENTS


MATERIALS NEEDED

• Quiz (Pretest)
• Course Syllabus (or handout listing purpose of course and learning objectives)
• Overheads and overhead projector, or computer with slide projector and PowerPoint presentation
• Easel stand and pad, or chalkboard
• Magic markers, or chalk

RATIONALE

The introduction to the course may best be accomplished by making it a separate class session. Some instructors may wish to combine the introduction with Module I; however, it is important to remember that the various tasks of beginning a course usually take a good amount of time. These tasks include introducing the instructor and class members, establishing ground rules, reviewing the purpose of the course and learning objectives, setting expectations and course requirements, and attending to housekeeping items (e.g., breaks, food, beverages, location of restrooms, etc.). Scheduling an introductory session allows completion of these tasks without taking time
away from essential content areas or interfering with in-depth discussion of the course material covered in Module I. It also allows students to consider their reasons for taking the course and to establish goals before beginning the learning process.

If instructors do decide to combine this introductory session with Module I, they should schedule a break at the end of the introductory material prior to beginning Module I content. In either case, whether the introduction is a separate session or combined with Module I, the purpose of the initial class session is to:

- Assess students’ current state of knowledge about children with sexually abusive behavior problems.
- Help students identify what they already know about sexually abusive children and their families.
- Activate a desire within students to learn more about children with sexually abusive behavior problems and their families.
- Clearly state the purposes and learning objectives of the course.

Tell students what to expect in the course (e.g., number and length of class sessions, time of breaks, textbooks and other reading assignments, examinations, written assignments, etc.).

TEACHING SUGGESTIONS

A. Beginning the Course

A short written quiz may be used to assess students' current knowledge about children with sexually abusive behavior problems. The quiz may be placed on students’ desks prior to their arrival. Students may complete it while waiting for class to begin. An example of the Pretest will be published in Part 2.

Begin the course with an introduction that stimulates interest and motivates students to engage in the learning process. An interesting introduction can attract students' attention, set the stage for the material to follow, and create an atmosphere conducive to learning. Present information that shows why juvenile sexual offending
and sexually abusive behavior committed by young children constitute a critical social problem. The following statistics taken from Chapter 2 in the Ryan and Lane text may be useful in communicating the extent of the problem:

- The National Center on Child Abuse and Neglect (NCCAN, 1987) reported that in 1986, there had been an estimated 2.25 million cases of child abuse reported and over 1.5 million cases confirmed. The reported cases indicated an incidence rate of 2.5 children per 1,000 annually, for a tripling of reported incidence since 1980. By 1993, reports for child protection investigators increased to 3 million annually, but the reported rates of child sexual abuse remained stable (Snyder, Sickmund, & Poe-Yamagata, 1996).

- Juveniles are responsible for approximately 30% of sexual offenses against children (Finkelhor, 1996).

- Retrospective studies of sexual abuse victims indicated that teenagers perpetrated approximately 57% of the reported cases of sexual abuse of male children (Rogers & Tremaine, 1984; Showers, Farber, Joseph, Oshins, & Johnson, 1983).

- Research on adult sexual offenders indicates that about 50% admit beginning sexually deviant behavior in latency or adolescence (Abel et al., 1985). These researchers reported that their sample of 240 adult offenders, who were guaranteed confidentiality, reported an average of 581 attempted or completed acts against an average of 380 victims per offender.

- The Uniform Data Collection System of the National Adolescent Perpetrator Network reported that the majority of juveniles in its sample of 1,600 were referred for first offenses. However, the average number of victims per offender was seven, indicating that many unreported offenses had occurred (Ryan, 1988; Ryan, Miyoshi, Metzner, Krugman, & Fryer, 1996).

Introduce yourself and present your professional experience, particularly your experience in the area of sexual abuse treatment and treatment of juvenile sexual offenders.

Ask class members to introduce themselves to one another by identifying who they are and briefly commenting on their past experiences in sexual abuse treatment. The instructor may help class members to begin to get to know each other by asking them to share some aspect of their personality or life experience that can be a strength or an asset when working with sexually abused or sexually abusive children and their families.
B. Case Vignettes of Children with Sexual Behavior Problems

**Present** the following case vignettes (or others from your experience):

- **Megan, age 11**, is in foster care because she was sexually abused by her grandfather and her mother's boyfriend. An 8-year-old foster sister reported Megan got in bed with her and rubbed her vagina.

- **Tony, age 10**, is attention-deficit disordered and physically aggressive toward other children. His mother is a drug user. He was removed from his home due to chronic neglect. He denies any history of sexual abuse. His foster parents caught him performing oral sex on his 7-year-old foster brother.

- **Alicia, age 8**, was sexually abused by her father and by her teenage sister. She masturbates excessively and has tried to touch the private parts of younger children at school.

- **Jason, age 9**, was placed in foster care after he molested several children in his neighborhood and two of his siblings. He threatened his victims and committed penetrative offenses—including oral sex, anal sex, and inserting objects in the rectums of the other children. He was sexually abused at age 5 by a male teenage babysitter.

- **Ray, age 8**, and **Bobby, age 6**, are brothers in a family of eight children. All the children were placed in foster care after it was discovered that the older children were molesting their younger siblings. The older children were placed in residential treatment, while Ray and Bobby were placed together in the same foster home. Last week, the foster mother caught the boys trying to hump each other.

- **Robin, age 11**, was placed in foster care after she molested her two younger brothers. Robin's foster parents became concerned when they found her playing games in a shed with a group of 6-year-old neighborhood children. Robin claimed, "All we were doing was playing hide and seek."

- **Aaron, age 10**, was placed in foster care after he sexually molested his 3-year-old sister. He told his caseworker that he did it because he heard voices inside his head telling him to touch her. One morning when Aaron's foster mother came into his room to wake him for school, she found him letting the family dog lick his penis.

**Ask** students if the case vignettes reminded them of any children or adolescents to whom they have provided direct services. **Survey** the students and determine how many are currently providing therapy or case management in their field placements to children with sexual behavior problems or to juvenile sexual offenders. **Allow** students to briefly discuss how the children or adolescents they have seen are similar to the case vignettes.

Review the written quiz and briefly discuss the answers. Take note of any questions that most students answered incorrectly as these questions may indicate content areas that may require more focus in the training. Remind students that they already have some knowledge of children with sexual behavior problems and juvenile sexual offenders. Emphasize that the course will help correct misconceptions they may have had, increase their knowledge of children with sexual behavior problems and juvenile sexual offenders, and provide new skills that they can use in practice.

C. Review of Purpose of the Course, Learning Objectives, and Course Expectations

(Slide 3) Discuss the purpose, learning objectives, reading assignments, and written assignments of the course. A suggested syllabus is presented in Appendix A, which includes the written assignments. Part Two (Modules III and IV) will include examinations that may be used to test students' comprehension of the course material.

Cautions: Keep the introduction to the course relatively brief. Although it is important to immediately create an atmosphere where students can feel free to make comments, limit their discussion to brief comments and emphasize that more time will be provided for discussion in future class sessions.
MODULE I

EFFECTS OF CHILD SEXUAL ABUSE TRAUMA

LEARNING OBJECTIVE

Develop knowledge of the potential acute and long-term effects of child sexual abuse on children's emotional, cognitive, and behavioral functioning.

READING ASSIGNMENTS


Chapter 1 - Prior traumatization (pp. 9-20) and Sexual abuse cycle (pp. 25-26); Chapter 2 - Trauma Outcome Process (pp. 31-33, 45-49).


MATERIALS NEEDED

- Handouts
- Overhead transparencies and overhead projector, or lap-top computer with projector and PowerPoint presentation
- Easel stand, pad, and markers; or chalkboard and chalk

RATIONALE

Many juvenile sexual offenders and children with sexual behavior problems have been sexually abused themselves. In order to provide effective treatment to sexually abusive children and adolescents, a clinician must have knowledge of the effects of sexual abuse as well as the dynamics of sexually abusive behavior. This module provides students with information about the emotional, cognitive, and behavioral symptoms commonly displayed by sexually abused children. It presumes that students already have some basic knowledge about child sexual abuse.

Several research studies on the effects of child sexual abuse are reviewed and analyzed. Two models that explain the trauma of sexual abuse (i.e., the post-traumatic stress disorder model and the traumagenic dynamics of sexual abuse model) are presented. The relationship of these models to broader theoretical perspectives (i.e., psychodynamic and social learning) is discussed. An integrative model for victim and offender treatment, the Trauma Outcome Process, is then introduced, but will be discussed in greater depth in Module III. The three models presented in this module give students a basic conceptual framework for understanding the effects of sexual abuse trauma on young children, particularly the development of sexual behavior problems in response to victimization experiences.

I. Effects of Child Sexual Abuse: Clinical Impressions
   A. Emotional Effects of Child Sexual Abuse
   B. Cognitive Effects of Child Sexual Abuse
   C. Behavioral Effects of Child Sexual Abuse

II. Research on the Effects of Child Sexual Abuse
   A. Overview of Research
   B. Symptoms of Sexually Abused Children
   C. Intervening Variables Affecting Severity of Symptoms
   D. Behavior Problems of Sexually Abused Children

III. Conceptual Models for Sexual Abuse Treatment
   A. Overview of Practice Models
   B. Post-Traumatic Stress Disorder (PTSD)
   C. Traumagenic Dynamics of Sexual Abuse: Definition and Overview
   D. Traumagenic Dynamics: Traumatic Sexualization
   E. Traumagenic Dynamics: Betrayal
   F. Traumagenic Dynamics: Stigmatization
   G. Traumagenic Dynamics: Powerlessness
   H. Traumagenic Dynamics: Summary and Practice Implications
   I. Introduction to the Trauma Outcome Process
   J. Group Activity

CONTENT

I. Effects of Child Sexual Abuse: Clinical Impressions
   Once you have established rapport with the students and outlined the course expectations, begin presenting the course content by discussing the effects of abuse on young children. Inform students that the information you will present in this session focuses on sexually abused children in general and is not specific to children with sexual behavior problems.

   Ask: From the experiences you have had in your field placements in providing services to sexually abused children, what are some of the common feelings, thinking processes, and behaviors which are often displayed by the children who have been sexually abused?

   List students' answers on the chalkboard under three headings: emotional, cognitive, and behavioral.

A. Emotional Effects of Child Sexual Abuse

Make sure you obtain a comprehensive list of the emotional effects of sexual abuse. Feelings on the list may include fear, anger, hurt, shame, guilt, embarrassment, rejection, stigmatization, betrayal, powerlessness, abandonment, etc.

As feelings are listed, ask students to share case examples of how the above feelings may be manifested.

B. Cognitive Effects of Child Sexual Abuse

Cognitive effects on the list may include distractibility, concentration problems, cognitive distortions, and dissociative thought processes.

Stress that sexual abuse and other trauma can disrupt the child's "worldview" (Finkelhor, 1988) or "cognitive schemas." Cognitive schemas can be defined as "personal constructs for organizing reality" (Epstein, 1985, cited in McCann & Pearlman, 1990). A person's worldview will affect his or her response to trauma. Refer students to this statement in Chapter 9 in Ryan and Lane (1997): "The degree to which the victimization is dissonant with the individual's view of the world may affect the level of trauma, as well as the method of coping" (p. 158).

Point out that disruptions in cognitive schemas often result in cognitive distortions consisting of negative self-perceptions and unrealistic beliefs. Ask students to think of case examples that illustrate distorted thinking processes. Refer students to the section in Chapter 9 in Ryan and Lane (1997) that gives examples of distortions victims may have about sexuality. (Victims may perceive that their bodies are different and permanently damaged ["damaged goods"]. In response to the "pairing of fear and guilt, pain and pleasure," the victim's thought processes may "incorporate the perpetrator's own distorted rationalizations" [Ryan, 1997, p. 160]).

C. Behavioral Effects of Child Sexual Abuse

Behaviors on the list may include sleep disturbance, nightmares, eating disorders, bed wetting, defecating outside the toilet or soiling, social withdrawal, depression, lack of self-confidence, poor peer relationships, anxiety, self-destructive behavior, suicidal behavior, running away, aggression, cruelty to animals, poor personal boundaries, pseudomature behavior, excessive masturbation, sexual acting-out behavior, confusion of sexual preference, etc. (Gillespie [1991] provided a comprehensive list of behavior problems of sexually abused children.)
Ask students to be as specific as possible about the behaviors displayed by the sexually abused children with whom they have worked. Encourage them to share their clinical experiences in working with these children.

II. Research on the Effects of Child Sexual Abuse

A. Overview of Research

Present: Tell students that research on the effects of sexual abuse on young children confirms many of the clinical impressions they have shared.

Until recently, literature on the impact of child sexual abuse consisted disproportionately of retrospective studies of adults. For example, the conclusions of a widely cited review (Browne & Finkelhor, 1986) were based on only 4 studies of children, compared with 23 studies of adults.

In the past decade, a number of studies have concentrated specifically on assessing the impact of abuse on children. Kendall-Tackett, Williams, and Finkelhor (1993) reviewed 45 studies of child victims of sexual abuse (all victims were age 18 or younger). This review and other studies provided data about negative effects commonly seen in sexually abused children.

B. Symptoms of Sexually Abused Children (Kendall-Tackett et al., 1993) Review (Slides 4 & 5)

Sexually abused children had more symptoms than nonabused children.

The most frequent symptoms displayed by sexually abused children were fears, post-traumatic stress disorder (PTSD), behavior problems, sexualized behaviors, and poor self-esteem. No one symptom characterized most sexually abused children. For preschoolers, the most common symptoms were anxiety, nightmares, general PTSD, internalizing, externalizing, and inappropriate sexual behavior.

For school-age children, the most common symptoms included fear, neurotic and general mental illness, aggression, nightmares, school problems, hyperactivity, and regressive behavior.

For adolescents, the most common behaviors were depression; withdrawn, suicidal, or self-injurious behaviors; somatic complaints; illegal acts; running away; and substance abuse. Symptoms that appeared prominently for more than one age group were nightmares, depression, withdrawn behavior, neurotic mental illness, aggression, and regressive behavior.

Ask: What can you conclude about the symptoms of sexually abused children from Kendall-Tackett's review of the research? (Discuss student responses. Make sure that students understand that there is no single specific syndrome that characterizes children who have been sexually abused and no single traumatizing process.)

Present: The affective, cognitive, and behavioral effects reviewed above are symptoms that can be anticipated in sexually abused children. Caution students to be very careful in making interpretations or conclusions based on clinical observations of children's symptoms. Emphasize that one cannot conclude that a child has been sexually abused purely on the basis of the presence of symptoms. A particular combination of symptoms may indicate the existence of a number of different problems. Sexual abuse is only one possible factor that may have contributed to a child showing symptoms. Symptoms can result from exposure to stressors that have nothing to do with sexual abuse (e.g., other types of traumatic events, major losses). Ask: What evidence is needed before a clinician can reasonably suspect that sexual abuse has taken place? (Statements by a child reporting sexual abuse, or reports by an individual who has actually witnessed sexual abuse taking place.)

C. Intervening Variables Affecting the Severity of Symptoms (Kendall-Tackett et al., 1993): (Slide 6)

Molestations that included a close perpetrator (relative or friend); a high frequency of sexual contact; a long duration; the use of force; and sexual acts that included oral, anal, or vaginal penetration resulted in a greater number of symptoms for victims.

Lack of maternal support at the time of disclosure and a victim's negative outlook or coping style also led to increased symptoms. The influence of age at the time of assessment, age at onset, number of perpetrators, and time elapsed between the end of abuse and assessment were not clear from the studies reviewed.

Challenge students to think critically about the Kendall-Tackett et al. review, to analyze the results, and to express their opinions. For example, you might ask:

- Think about what you know about the dynamics in families in which abuse takes place. Why do you think that being molested over a long period of time by a perpetrator who is a close friend or relative may result in a greater number of symptoms than a single incident of abuse by a stranger?

Can you think of case examples that illustrate how lack of support by a parent at the time of disclosure resulted in increased symptoms in the victim?

Kendall-Tackett et al. did not find any clear indication that age at the time of the onset of the abuse or the disclosure of the abuse related to the severity of symptoms. What do you think? Which is more traumatic---to be sexually abused as a very young child, or to be sexually abused when older?

D. Behavior Problems of Sexually Abused Children

Present: Mannarino, Cohen, and Gregor, (1989) compared 94 sexually abused girls ages 6-12 with 89 clinical controls and 75 normal controls on several measures (i.e., Children's Depression Inventory [CDI], State-Trait Anxiety Inventory for Children [STAIC], the Piers-Harris Children's Self-Concept Scale, and the Child Behavior Checklist [CBCL parent version D]).

(Slide 7)

- Results of the STAIC A-Scale showed that abused subjects were significantly more anxious than both control groups.

- On the CBCL, the sexually abused girls and clinical controls were significantly more pathological on the internalizing and externalizing scales, the total behavior problems scale, social competence scale, and 7 of 9 subscales.

Point out: This study focused on sexually abused girls only. Ask: If boys had been included in the study, what do you think the results would have shown? (Students should recognize from their readings [Chapter 9 of the Ryan and Lane text] that sexually abused boys typically show more externalizing behavior problems than sexually abused girls do.)

Dubowitz, Black, Harrington, and Verschoore (1993) completed a follow-up study of 93 prepubertal children evaluated for sexual abuse and 80 nonabused children matched on age, gender, and race. The CBCL was completed at intake by the parents of all children, and again 4 months later by 45% of the parents of the abused children.

(Slide 8)

- The sexually abused children had significantly more behavior problems than the comparison children, including depression, aggression, sleep and somatic complaints, hyperactivity, and sexual problems.

- At follow-up, only those children who had externalizing behavior in the clinical range improved significantly.

• At intake, children who verbally disclosed their abuse to the evaluator had significantly more behavior problems than children who indicated by their doll play that they had experienced abuse.

• At follow-up, children who had abnormal physical findings had significantly more behavior problems.

• There were no significant differences found on the other intervening variables that were examined (i.e., type of sexual abuse, relationship of the perpetrator, likelihood of abuse, therapeutic services).

**Ask**  students to analyze the results—why might children who were more verbal about their abuse to the evaluator have more behavior problems than children who indicated by their doll play that they had experienced abuse? Why would children with abnormal physical findings show more problems in their behavior?

Hibbard and Hartman (1992) assessed 81 alleged sexual abuse victims with 90 nonabused comparison subjects on the parent report of the CBCL and compared their problem behaviors. *(Slide 9)*

• The sexually abused group displayed significantly higher mean total behavior problems (internalizing and externalizing) than the comparison group.

• The sexually abused group showed more impaired social interactions, withdrawal, and sexual problems.

Wells, McCann, Adams, Voris, and Ensign (1995) completed a structured parent interview on three matched samples of prepubescent females: 68 from a sexual abuse clinic in which a perpetrator confessed, 68 seen at the same clinic who did not have a perpetrator confession, and 68 who were selected for nonabuse. *(Slide 10)*

• Parents of girls in both sexual abuse groups reported increased sleep problems, fearfulness, emotional and behavioral changes, concentration problems, and sexual activity and knowledge.

• The sexual abuse group in which the perpetrator confessed showed significantly more self-consciousness, nightmares, and fear of being left alone than the alleged sexual abuse group with no perpetrator confession.

**Ask:** How do you explain these findings? What can you conclude about perpetrator confession? Why would sexually abused children whose perpetrator confessed be more anxious than those children whose perpetrator

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did not confess? (Discuss students’ responses. Point out that children whose perpetrator confessed may be more involved with the legal system than those children whose perpetrator did not confess. They may also have experienced additional trauma [e.g., break-up of their family, lack of support from their nonoffending parent or siblings, stigmatization from family or friends]).

Mennan and Meadow (1994) examined levels of depression, anxiety, and self-worth in a sample of 75 girls, ages 6-18 recently identified as sexually abused. Subjects were compared against standardized norms on three measures: the Children's Depression Inventory (CDI), the Revised Children's Manifest Anxiety Scale (RCMAS), and the Self-Perception Profile for Children. (Slides 11 & 12)

- Subjects had higher levels of anxiety and depression and lower levels of self-worth than normal samples.
- The interaction between the identity of the perpetrator and force was significantly related to levels of depression and self-worth. Force was related to a less serious impact when the father was the abuse perpetrator and more serious with a non-father perpetrator.
- The interaction between the identity of the perpetrator and whether the child was removed from the home was significantly related to anxiety. Those removed from the home had significantly higher anxiety when abused by a non-father figure.

Ask: Why were sexually abused children who were abused by their father less depressed and less anxious than those who were abused by a non-father perpetrator? (Discuss student responses. Challenge students to think critically about the differences between intrafamilial and extrafamilial sexual abuse.)

Tong, Oates, and McDowell (1987) completed a follow-up study on 37 girls and 12 boys who had been sexually abused an average of 2.6 years previously. Each subject was matched with a child not known to have been sexually abused. Both groups were assessed on the CBCL (parent, teacher, and youth self-reports) and the Piers-Harris Self-Concept Scale. (Slides 13 & 14)

- CBCL parent and teacher reports showed a significantly higher proportion of the sexually abused children scored in the clinical range when compared with the control group children.

• The sexually abused girls had significantly lower self-esteem than the control group girls did. There was no difference in self-esteem between the control and sexually abused boys.

• Data gathered through interviews with the parents showed that 76% of the sexually abused children were thought to be less confident than before their abuse. The parents reported that 30% of the children had fewer friends, 20% were more aggressive, 24% showed increased sexual awareness, 28% had behavior problems as reported by teachers, 17% had repeated a year of school, and 17% had deteriorated in their school work.

**Summarize by asking:** What might be some practice implications of studies that conclude that sexually abused children often show behavior problems? *(Sexual abuse has long-term consequences for victims. Children suspected of being sexually abused should receive an assessment of their psychological status and careful follow-up in order to watch for behavior problems and intervene as soon as possible.)*

### III. Conceptual Models for Sexual Abuse Treatment

**A. Overview of Practice Models**

**Present:** Now that we have an understanding of the effects of sexual abuse on young children as documented by clinical observations and by empirical research, let's turn our attention to a discussion of practice models that explain why these particular effects occur.

**Ask:** What is a practice model? How is a practice model different from a practice theory?

**List** students' responses on the chalkboard under two headings: practice model and practice theory. **Discuss** their responses and bring out the concepts included in the following definitions *(Slides 15 & 16)*:

"A practice model is a set of concepts and principles used to guide certain interventions...a model is not tied to a particular explanation of behavior...Most often, a model develops out of actual experience or experimentation" (Sheafor, Horejsi, & Horejsi, 1997, p. 51).

"A practice theory...offers both an explanation of certain behaviors and broad guidelines about how those behaviors can be changed" (Sheafor et al., p. 51).

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**Summarize** by clarifying that practice models are more specific explanations of certain phenomena and are usually based on broader practice theories or practice perspectives. Give examples: the psychosocial treatment approach is based on psychodynamic theory; cognitive-behavioral models are based on behavioral (social learning) theory; the client-centered model is based on humanistic theory.

**Present:** Two models that are frequently used to explain the effects of abuse are the post-traumatic stress disorder (PTSD) model and the traumagenic dynamics of abuse model. Both of these models are useful in understanding the effects of child sexual abuse on young children. PTSD was a well-known model when Finkelhor (1988) proposed another model, the traumagenic dynamics of sexual abuse, as an alternative explanation for the immediate and long-term effects of sexual abuse.

**Present:** The PTSD model is based on psychodynamic theory, while the traumagenic dynamics model is based on social learning theory. **Ask:** What are the differences between psychodynamic and social learning theories? (Psychodynamic theory emphasizes the role of internal psychological processes, while social learning emphasizes the role of learning, conditioning, or modeling.) (Slide 17)

**B. Post-Traumatic Stress Disorder (PTSD)**

**Inform** students that sexually abused children often display symptoms of post-traumatic stress disorder (PTSD). Define PTSD: (Slide 18)

The person experienced, witnessed, or was confronted with an event that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others. The person's response involved intense fear, helplessness, or horror. Note: In children, this may be expressed instead by disorganized or agitated behavior (American Psychiatric Association [APA], 1994, p. 427).

**Present:** The concept of PTSD was first formulated to explain the effects of trauma on adults, particularly the trauma of war. It was later applied to explain the effects of different types of trauma on children, including natural disasters, violent crimes, exposure to a violent death of a loved one, and sexual abuse.

**Present:** The DSM-IV lists three categories of PTSD symptoms: (Slide 19)

- Intrusiveness involves ways in which "the traumatic event is persistently reexperienced" (APA, 1994, p. 428).
"Numbing of general responsiveness" involves ways in which individuals may persistently "avoid stimuli associated with their trauma" (APA, 1994, p. 428).

Increased arousal refers to physiological responses, often to cues associated with the traumatic event.

Ask: What symptoms do sexual abuse victims display that could be considered as reexperiencing their trauma?

List students' responses on the chalkboard. Make sure their list includes as many of the symptoms in the DSM-IV as possible: (Slides 20 & 21)

"The traumatic event is persistently reexperienced in the following ways:

- Recurrent and intrusive distressing recollections of the event including images, thoughts, or perceptions. Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
- Recurrent distressing dreams of the event. Note: In children, there may be frightening dreams without recognizable content.
- Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). Note: In young children, trauma-specific reenactment may occur.
- Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
- Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event" (APA, 1994, p. 428).

Discuss the above symptoms by encouraging students to relate case examples of children with whom they have worked who displayed those symptoms. You may also want to relate case examples of your own, such as:

I once worked with Nicole, a 6-year-old girl who was the victim of a violent rape. Each week in therapy she played with a male anatomically correct doll and sucked on its penis. The behavior she showed in her play did not seem consistent with the violent details she had reported about her rape. I informed Nicole's mother of her repetitive play. When her mother questioned her about it, she disclosed that her grandfather was currently

molesting her. Her repetitive play, an intrusive symptom of PTSD, helped us to identify another perpetrator and intervene to stop the abuse and ensure her safety.

Ask: Which symptoms of sexual abuse victims could be considered avoidance or numbing of general responsiveness?

List students' responses on the chalkboard. Make sure their list includes as many of the symptoms listed in the DSM IV as possible: (Slides 22 & 23)

"Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness as indicated by three (or more) of the following:

- Efforts to avoid thoughts, feelings, or conversations associated with the trauma
- Efforts to avoid activities, places, or people that arouse recollections of the trauma
- Inability to recall an important aspect of the trauma markedly diminished interest or participation in significant activities
- Feeling of detachment or estrangement from others
- Restricted range of affect (e.g., unable to have loving feelings)
- Sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)" (APA, 1994, p. 428).

Encourage students to relate case examples of children with whom they have worked who displayed symptoms of avoidance or numbing. You may also want to relate case examples of your own, such as the following:

Andrew was a 7-year-old boy whom I saw in therapy following sexual abuse by a teenage male perpetrator. Andrew's perpetrator used physical force to make him comply. Whenever I asked Andrew about his abuse, he became silent. Sometimes he distracted himself by playing with a toy, but most of the time, he just stared off into space and did not respond.

Ask: Which symptoms of sexual abuse victims could be considered as increased arousal?

List students' responses on the chalkboard. Make sure their list includes as many of the symptoms listed in the DSM-IV as possible: (Slide 24)

"Persistent symptoms of increased arousal (not present before the trauma), as indicated by two or more of the following:

- Difficulty falling or staying asleep.
- Irritability or outbursts of anger.
- Difficulty concentrating
- Hypervigilance

Caution students that they should differentiate between children who show symptoms of increased arousal as a result of experiencing a traumatic event and children who have an impulse disorder, such as attention deficit hyperactivity disorder (ADHD). Note that some children display symptoms of both disorders; they have ADHD and they also have been traumatized and are displaying symptoms of PTSD. Ask students to think of case examples of this dual diagnosis. Present case examples of your own that show the importance of assessing and treating both disorders. You might relate an example such as:

Sam was a 9-year-old boy who recently disclosed sexual abuse by his father. He was diagnosed as ADHD at age 7. He was relatively compliant in school in most circumstances. However, after he began attending supervised visits with his father, he began showing disruptive behavior at school.

Video Option: The video series Understanding Psychological Trauma: Healing Our Children" (CVA Media, 1992) is an excellent resource for this module. Part I of the three-tape series is entitled "Symptomatology" and includes a discussion of symptoms of PTSD. Instructors may wish to use this video to illustrate the preceding discussion of PTSD symptoms.

Present: According to the PTSD practice model, the effects of sexual abuse can be explained in terms of PTSD symptoms. Symptoms of intrusiveness, avoidance, and increased arousal may indicate that a child has experienced a traumatic experience and is reacting to it. However, it is important to remember that symptoms can have many causes. Caution students to be very careful in making interpretations based on clinical observations alone. Corroborating evidence (i.e., statements by the child or direct observations by another individual) are necessary before making definitive conclusions that symptoms of intrusiveness, avoidance, and increased arousal indicate that the child has experienced some kind of traumatic event.

The assigned article by Finkelhor (1988) noted ways in which the PTSD model has contributed to the child sexual abuse field. Ask: What are those contributions (p. 63)? Discuss these points: (Slides 25 & 26)
• PTSD provided a clear label to describe the symptoms that many sexual abuse victims display.

• PTSD model showed that the effects of sexual abuse may be examined in a structured way. **Ask:** How does the PTSD model provide structure to the examination of the effects of abuse? (*It categorizes the variety of symptoms displayed by sexual abuse victims into separate clusters.*)

• PTSD model showed that sexual abuse shares similar dynamics to other types of trauma. **Ask:** For example, how is sexual abuse similar to physical abuse and domestic violence? (*All three types of trauma create anxiety, fear, and a sense of helplessness or powerlessness in the victim.*)

• PTSD model brought new research interest in sexual abuse.

• Research on abuse shows some variation in PTSD symptoms according to type of abuse. For example, Deblinger, McLeer, Atkins, Ralphe, and Foa (1989) found that 29 sexually abused children had significantly more PTSD symptoms indicative of reexperiencing trauma than the physically abused (n = 29) or nonabused (n = 20) control groups. **Ask:** How do you explain these findings? (*Discuss students’ opinions of the differences between sexual abuse and physical abuse trauma.*)

• PTSD model helped bring attention to sexual abuse as a psychological stressor.

• Thinking of sexual abuse as a form of PTSD may help reduce the social stigma often associated with sexual victimization.

Finkelhor (1988, p. 64) also noted some problems with the PTSD formulation. **Ask** students to identify those problems. (*Discuss each of the following points as students mention them): *(Slide 27)*

• PTSD does not adequately account for all symptoms displayed by victims of sexual abuse. PTSD symptoms focus on intrusive imagery, nightmares, and numbness in affect and social relations. Symptoms such as fear, depression, self-blame, and sexual problems are not accounted for in PTSD. Neither are behaviors such as suicide attempts, substance abuse, or revictimization.

• PTSD only accurately applies to some sexual abuse victims. Although it is descriptive of victims who have affective disturbances (e.g., explosion of affect, constriction of affect), it does not describe victims whose symptoms are primarily cognitive and who have cognitive

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disturbances (i.e., distorted beliefs about the self and others, self-blame, sexual misinformation, and sexual confusion).

Finkelhor (1988) stated that the PTSD model is "mostly a syndrome defined by a group of symptoms rather than an explanation of how those symptoms develop" (p. 66).

**Present:** Finkelhor (1988; pp. 66-67) discussed three different explanations of how PTSD symptoms develop. Pynoos and Eth (1985b, p. 38), cited in Finkelhor (1988, p. 66) indicated that PTSD symptoms result from "an overwhelming event resulting in helplessness in the face of intolerable danger, anxiety, and instinctual arousal" (p. 66). **Ask:** What are the problems involved in viewing sexual abuse in this way? *(Discuss students' responses. Make sure the following points are covered):* (Slide 28)

- Much sexual abuse does not occur under conditions of violence. Trauma may result from the meaning of the abuse ("I am being exploited") as much as from physical danger.

- "Sexual abuse may be less of an 'event' than a 'relationship' or a 'situation'" (Finkelhor, 1988, p. 66). Victims may be traumatized by the betrayal of the relationship or by being trapped in the situation, rather than from exposure to an overwhelming event.

**Present:** Horowitz (1976) proposed that PTSD occurs because the mind tries to integrate the experience of a traumatic event into existing "schemata." Until the integration is complete, memories of the event remain active and may interrupt other functioning. **Ask:** What were some of the difficulties that Finkelhor (1988) identified in Horowitz's explanation of how PTSD occurs? *(Slide 29)*

- Although it may explain intrusive and increased arousal symptoms (e.g., nightmares and flashbacks), it does not account for some of the emotions victims feel (e.g., anger, self-blame, worthlessness).

- Integration of feelings and memories associated with trauma can become problematic when sexual abuse victims "overintegrate" by taking "the behavior learned in the abusive situation" and applying it "indiscriminately to other situations where it is inappropriate" (Finkelhor, p. 67).

- Janoff-Bulman (1985) attributes PTSD symptoms to a state of disequilibrium that victims experience when the assumptions that they have about the world are "shattered" by a trauma. **Ask:** Why did Finkelhor (1988, p. 67) state that Janoff-Bulman's explanation did not totally fit sexual abuse? *(Slide 30)*
• Although *shattering of assumptions* may account for some of the cognitive effects of abuse, it does not apply to other symptoms (e.g., sexualized behavior) which are better accounted for by learning or conditioning.

• The premise of shattered assumptions does not apply as well to children as it does to adults.

C. Traumagenic Dynamics of Sexual Abuse: Definition and Overview

**Present:** Finkelhor (1988) proposed the traumagenic dynamics of sexual abuse as an alternative model to explain the effects of sexual abuse trauma. This model proposes four traumagenic dynamics to account for the impact of sexual abuse: traumagenic sexualization, betrayal, stigmatization, and powerlessness. *__(Slide 31)__* It is a cognitive-behavioral model that focuses on the victim's thinking processes, perceptions, and learned behaviors.

**Define** traumagenic dynamics *(Finkelhor, 1988, p. 68)* *__(Slide 32)__*: "A traumagenic dynamic is an experience that alters a child's cognitive or emotional orientation to the world and causes trauma by distorting the child's self-concept, worldview, or affective capacities."

**Discuss** the various terms in the definition (i.e., orientation to the world, worldview, affective capacities).

**Ask:** What are the strengths/advantages of the traumagenic dynamics model *(Finkelhor, 1988, pp. 68-69)?*

• It is comprehensive in suggesting several dynamics to account for the variety of different symptoms.

• It incorporates some elements of the PTSD model, but provides an explanation for other symptoms that do not fit into PTSD (e.g., cognitive symptoms).

• The model is more applicable to children because it describes a *distortion* of assumptions rather than the shattering of assumptions described by Janoff-Bulman (1985).

• The model emphasizes that victims' coping responses can be adaptive to the experience of abuse and its aftermath, but "may be dysfunctional in coping with a world where abuse is not the norm" *(Finkelhor, 1988, p. 69).*

**Present:** The following discussion of traumagenic dynamics is based on Finkelhor, 1988, Table 4.1, p. 73-74:

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D. Traumagenic Dynamics: Traumatic Sexualization

**Define:** Traumatic sexualization refers to "the conditions in sexual abuse under which a child’s sexuality is shaped in developmentally inappropriate and interpersonally dysfunctional ways" (Finkelhor, 1988, p. 69).

**Ask:** What factors contribute to the development of traumatic sexualization? (p. 69, Table 4.1, p. 73) *(Slide 33)*

- The child receives rewards for sexual behavior that is inappropriate to his/her level of development.
- The offender exchanges attention and affection for sex; the child then learns to use sexual behavior to meet his/her own needs and manipulate others.
- The child acquires distortions about genitalia.
- The offender transmits misconceptions to the child about sexual behavior and sexual morality.
- The child learns to associate sexual behavior with negative emotions and memories, making it difficult as an adult to have positive experiences with sex.

**Ask:** What are possible psychological impacts of traumatic sexualization on victims? (Table 4.1, p. 73) *(Slide 34)*

- Increased salience of sexual issues
- Confusion about sexual identity
- Confusion about sexual norms
- Confusing sex with love and care-getting
- Aversion to sex and intimacy

**Ask:** What behaviors displayed by sexually abused children are examples of traumatic sexualization? **List** students' responses on the chalkboard. **Encourage** students to share case examples. *(Student responses should include the behaviors listed in Table 4.1, p. 73) *(Slide 35)*

- Sexual preoccupations and compulsive sexual behaviors (e.g., excessive masturbation; Finkelhor, p. 70 and on Table 4.1, p. 73)
- Aggressive sexual behaviors
- Promiscuity
- Prostitution

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• Sexual dysfunctions
• Avoidance or phobic reactions to sexual intimacy

E. Traumagenic Dynamics: Betrayal

**Define:** Betrayal refers to the discovery of sexually abused children that "someone on whom they were vitally dependent has caused them harm or wishes them harm" (Finkelhor, 1988, p. 70). **Ask:** What are some ways that sexually abused children experience betrayal? **Encourage** students to share case examples. *(Student responses should include the following points)* (Slide 36):

- The child's trust and vulnerability are manipulated.
- The child's expectation that others will provide care and protection is violated.
- The child's well-being is disregarded.
- Nonoffending parents may fail to protect or provide support.

**Ask:** What are some of the psychological impacts that result from the dynamic of betrayal? **Encourage** students to share case examples that illustrate the various impacts (Table 4.1, pp. 74-75). *(Slide 37)*

- Grief, depression
- Extreme dependency
- Impaired ability to judge trustworthiness of others
- Mistrust
- Anger, hostility

**Ask:** What behaviors displayed by sexually abused victims are manifestations of betrayal? **List** students' responses on the chalkboard. *(Make sure the responses include the behaviors listed in Table 4.1, p. 74)* (Slide 38)

- Clinging
- Vulnerability to subsequent abuse and exploitation
- Allowing own children to be victimized
- Isolation
- Discomfort in intimate relationships
- Marital problems
• Aggressive behaviors
• Delinquency

F. Traumagenic Dynamics: Stigmatization

**Define:** Stigmatization refers to "the negative messages about the self--evilness, worthlessness, shamefulness, guilt--that are communicated to the child around the (abuse) experience" (Finkelhor, 1988, p. 70).

**Ask:** What factors contribute to the development of the dynamic of stigmatization? **List** student responses. **Encourage** students to relate case examples. Student responses should include the following behaviors: (Table 4.1, p. 73) *(Slide 39):*

- The offender blame and denigrates the victim.
- The offender and others pressure the child for secrecy.
- The child associates sex with attitudes of shame.
- Others have a shocked reaction to the child's disclosure.
- Others blame the child for the sexual activities.
- The child is stereotyped as damaged goods.

**Ask:** What are some of the psychological impacts that result from the dynamic of stigmatization? **Encourage** students to share case examples from their own practice experience (Table 4.1, pp. 74-76). *(Slide 40)*

- Guilt and shame
- Lowered self-esteem
- Sense of being different from others.

**Ask:** What behaviors displayed by sexually abused victims are examples of stigmatization? **List** student responses. Behaviors listed in Table 4.1, p. 73 include *(Slide 41):*

- Isolation
- Drug or alcohol abuse
- Criminal involvement
- Self-mutilation
- Suicide

G. Traumagenic Dynamics: Powerlessness

**Define:** Powerlessness includes two components: (Finkelhor, 1988, p. 71):

- "A child's will, wishes, and sense of efficacy are repeatedly overruled or frustrated."
- "A child experiences the threat of injury or annihilation."

**Ask:** What factors contribute to the development of the dynamic of powerlessness? (See Table 4.1, p. 74.) *(Slide 42)*

- Body territory is invaded against the child's wishes.
- Vulnerability to invasion continues over time.
- The offender uses force or trickery to involve the child.
- The child feels unable to protect self and halt the abuse.
- The child repeatedly experiences fear.
- The child is unable to make others believe.

**Present:** The powerlessness dynamic includes three clusters of effects (Finkelhor, 1988, p. 76): *(Slide 43)*

- Anxiety and fear (includes inability to control the traumatic event and the PTSD symptoms)
- Impairment in coping skills (includes low sense of efficacy and perception of self as a victim)
- Compensatory responses (includes a need to control or dominate and identify with the aggressor).

**Ask:** What behaviors displayed by sexually abused victims are manifestations of each cluster of powerlessness? **List** student responses. *(Make sure the responses include at least the behaviors listed in Table 4.1, p. 74.) *(Slide 44)*

- Anxiety and fear: nightmares, phobias, somatic complaints, eating and sleeping disorders, depression, dissociation.
- Impaired coping skills: running away, school problems, truancy, employment problems, vulnerability to subsequent victimization.
- Compensatory responses: aggressive behavior, delinquency, becoming an abuser.
H. Traumagenic Dynamics: Summary and Practice Implications

Present: In the traumagenic dynamics model, sexual abuse is "conceptualized as a situation or a process rather than simply as an event" (Finkelhor, 1988, p. 77). The process includes the manipulations the perpetrator uses to accomplish the abuse, the actual abuse, the disclosure of the abuse, and the interventions that take place to help the victim.

The traumagenic dynamics operate during all parts of the process: before, during, and after the abuse.

Ask: How might the traumagenic dynamics be manifested prior to the abuse?

Discuss student responses. Emphasize that children may be either vulnerable or resilient to developing a traumagenic dynamic depending on how nurturing or stable their lives were prior to the abuse. For example, a child who has had a number of significant losses or who comes from an unstable family may have already experienced betrayal from other sources prior to being sexually abused. The sexual abuse may add to a dynamic of betrayal that already existed. Alternatively, a child from a nurturing family who has been given age-appropriate responsibilities may have acquired a well-developed sense of self-sufficiency. This child may be more resilient to the effects of sexual abuse, and the dynamic of powerlessness may be lessened. Ask: How might the traumagenic dynamics be manifested after the abuse? Discuss student responses. Emphasize that much of the dynamic of stigmatization takes place as the child is confronted with the reactions of others who find out about the abuse. Finkelhor (1988) noted that "a child who is relatively unstigmatized by the abuse itself may experience massive stigmatization if blamed by family" (p. 78). The dynamic of powerlessness may be increased by events that happen after the disclosure of the abuse and during intervention. The process of multiple interviews and involvement of multiple agencies in an investigation, as well as separation from family, may increase a sexually abused child's sense of powerlessness.

I. Introduction to the Trauma Outcome Process (Burton et al., 1998; Rasmussen et al., 1992, Rasmussen, in press).

This last section of Module I focuses on introducing the Trauma Outcome Process, an integrative treatment approach for understanding and addressing the effects of victimization (see Chapter 2 of the Burton et al. text; Rasmussen; Rasmussen et al.). The basic premises of the Trauma Outcome Process are presented and described. The Trauma Outcome Process is discussed in more detail in later modules. It is included in Module III as a theoretical explanation for the etiology of sexually abusive behavior. Module IV discusses its use as an
intervention model in assessment, treatment planning, and engaging the child and family in treatment.

Present: Both the PTSD and Traumagenic Dynamics models are useful explanations of the effects of sexual abuse. However, both models focus primarily on the effects of victimization and address perpetration issues only minimally. In their clinical work with children with sexual behavior problems, Burton et al. (1998) identified the need for an integrative practice model that addresses the treatment issues of both victims and offenders. They developed the Trauma Outcome Process as "both an explanation of the etiology of sexually abusive behavior problems and as a treatment approach" (p. 31).

Ask students to recall the definition presented earlier by Sheafor et al. (1997) of a practice model. Have them assess whether the Trauma Outcome Process can be considered a practice model. Students should be able to conclude from having read Chapter 2 of the Burton et al. text and Rasmussen (in press) that the Trauma Outcome Process is a practice model because it "is a set of concepts and principles used to guide certain interventions...is not tied to a particular explanation of behavior...developed out of actual [clinical] experience or experimentation" (Sheafor et al., 1997, p. 51).

Present: Burton et al. (1998) based the Trauma Outcome Process on three premises: (Slide 45)

- The first premise is that "victims of abuse have three possible outcomes in response to trauma. They may:
  - "internalize their emotions and become self-destructive"
  - "externalize their emotions and become abusive"
  - "express their emotions and come to understand and integrate the traumatic experience with their other life experiences" (Rasmussen, in press, p. 14).

- The second premise is that "victims of abuse have some choice as to which of the three behavioral outcomes to pursue" (Rasmussen, in press, p. 15). The choices victims make can be either rational or irrational, depending on the nature of their thinking processes. Ask: Which practice theories does this premise reflect? (Students should recognize from their study of the assigned readings that this premise reflects both cognitive-behavioral and humanistic theories. The focus on having rational thinking processes is a cognitive-behavioral concept, while the focus on awareness of choices is a humanistic/existential concept.)

The third premise is that "the effects of traumatic experiences and efforts to recover from them are dynamic processes" (Rasmussen, in press, p. 15). Ask students to explain their understanding of this premise, based on their study of the assigned readings (Burton et al., 1998, Chapter 2; Rasmussen, in press; Rasmussen et al., 1992). Students should recognize similarities to Finkelhor's traumagenic dynamics model in which sexual abuse is viewed "as a process, rather than simply an event" [Finkelhor, 1988, p. 78). Bring out that Burton et al. emphasized that the three outcomes they describe (self-victimization, abuse, and recovery) are not mutually exclusive. "As motivated by their individual coping responses, individuals who have experienced sexual abuse or other traumatic experiences may choose any or all three options at different times as they recover from the negative effects of their experiences" (Rasmussen, in press, p. 15).

Refer students to the illustration of the Trauma Outcome Process in the Burton et al. text (see Figure 2.1, p. 32) (Slide 46). Present and discuss the Trauma Outcome Process while pointing to each specified area of Figure 2.1. The following description may be used (adapted from Rasmussen, in press):

- **Individual characteristics, family dynamics, and ecological context.** The three rectangles at the bottom of Figure 2.1 represent individual characteristics of the child, the dynamics of the family, and the ecological context (neighborhood and community) in which the child and his or her family are living.

- Each child has a unique combination of individual characteristics, family dynamics, and ecological factors that affect how that child will respond to stress, especially stress related to trauma.

- The individual characteristics of the child and the dynamics of the family interact to determine how a child may respond to a trauma. Resilience or vulnerability to trauma is dependent on the interaction of the child's cognitive and personality strengths and weaknesses, the adaptive or maladaptive dynamics of the family, and resources and deficits in the ecological environment.

- Individual characteristics may include internal factors such as temperament or personality, as well as attributes related to the child's physical, cognitive, emotional, and social development. Family dynamics may include characteristics related to family structure, boundaries, roles, and communication patterns. Family dynamics may contribute to the development of individual characteristics. The ecological context refers to the social and cultural factors associated with the neighborhood and community in which the child and family reside. The ecological context may affect the development of individual characteristics and the

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functioning of the family system. Specific individual characteristics, family dynamics, and ecological factors that may make a child vulnerable to the effects of trauma will be discussed in later modules.

- **Trauma.** "A child's Trauma Outcome Process begins when he or she experiences a traumatic experience" (p. 19). The black jagged burst above the individual and family characteristics in Figure 2.1 signifies an event that was traumatic to the child. In the Trauma Outcome Process, the definition of trauma is not limited to sexual abuse, but includes other types of physical or emotional injury, including physical abuse, severe neglect, witnessing domestic violence, verbal abuse, significant losses, abandonment, accidents, hospitalizations, natural disasters (p. 19).

- **Cognitive and emotional outcomes.** The rectangle above the black burst labeled "Trauma" in Figure 2.1 signifies that trauma affects the child's thoughts and feelings, that it has both cognitive and emotional outcomes. **Ask:** The Trauma Outcome Process focuses on both cognitive and emotional outcomes. How does this compare to the PTSD and Traumagenic Dynamics models? (Students should recognize from their readings and from the previous discussion that the Trauma Outcome Process includes elements of both the PTSD and Traumagenic Dynamics models. The PTSD model focuses on emotional outcomes, the Traumagenic Dynamics focuses on cognitive outcomes, while the Trauma Outcome Process focuses on both emotional and cognitive outcomes.)

- **Trigger.** Directly above the outcomes rectangle in Figure 2.1 is a black jagged burst labeled *trigger*. A trigger signifies a stressful experience that elicits negative feelings (e.g., feeling powerless, controlled, or rejected) or provokes memories of past trauma. Triggers may include sights, sounds, smells, or situations that resemble aspects of a past traumatic event. **Ask** students to give examples of possible triggers that abused children might experience. (Flashbacks and nightmares are obvious answers. You may wish to have students give specific examples of triggers experienced by some of the abused children whom they have seen in treatment.)

- **Awareness and choice.** The central wheel of the diagram (labeled *awareness* on a pentagonal shape in the center of the wheel and *choice* on the outside of the wheel) is the *awareness process*. It consists of senses, thoughts, feelings, wishes or wants, and actions. (Slide 47)
  - As individuals confront feelings elicited by a trigger, they reach the *choice point* of the Trauma Outcome Process. They then make choices about whether to deal with or avoid their feelings. These choices determine which response pattern they will take in the

Trauma Outcome Process (i.e., self-victimization, abuse, or recovery).

- Each choice is a product of their awareness of their body sensations, thoughts, feelings, intentions, and actions. Some people may be more aware of their thoughts and less aware of their body sensations and feelings. Others may be unaware of how their body sensations, thoughts, and feelings affect their intentions and actions. Responsible choices are more likely when all components of awareness are present.

- **Ask:** Do sexually abused children make choices about how they are going to respond to their abuse? What factors might determine whether they make a responsible choice? (*The concept of children having choice is likely to elicit some group discussion. Encourage students to express their opinions about whether or not children are developmentally capable of making choices in response to victimization.*)

- **Point out** that Burton et al. (1998) believed that when children encounter trauma or triggers, they experience some or all of the aspects of awareness, and they do make choices about how to respond. They then select one of three possible responses: (a) self-victimization, (b) abuse, or (c) recovery. The *recovery* response of the Trauma Outcome Process represents healthy coping, while the *self-victimization* and *abuse* responses represent maladaptive coping.

- **Present:** Burton et al. (1998) believed that children have the capacity to make some conscious choices, but their ability to choose is affected by factors in their environment.

  A child's ability to make appropriate choices is often dependent on the interaction of his or her individual characteristics, family dynamics, and cultural context. These factors may increase children's vulnerability to experiencing negative outcomes at the time of traumatic experiences and affect their ability to make choices that lead to recovery (Rasmussen, in press, p. 21).

- **Ask:** What did Burton et al., believe was necessary in order for traumatized children to make a responsible choice? (*A sense of safety---remind students: "Children must have a sense of personal safety before they can choose to recover from traumatic experiences" [Rasmussen, in press, p. 22]. "When safety is not present, available choices are often limited to surviving the trauma and protecting oneself" [Burton et al., 1998, p. 48]).
• Ask: How can an abused child be assured of safety? (An abused child’s safety is dependent upon appropriate nurturing and protection by a responsible caregiver and action on the part of the child protective, mental health, and legal systems to assure that the child is protected from further victimization.)

• Recovery. The recovery response in the Trauma Outcome Process represents healthy coping in response to trauma. Point to the recovery wheel on Figure 2.1 and discuss the steps of recovery. In order to heal and recover from the trauma of abuse, an abused child must:

  • Establish a safe environment. Once the child is in a safe environment, it is possible to follow the next steps of the recovery response.

  • Take responsibility for his or her own recovery from trauma. Ask: What can we as clinicians do to help abused children be more assertive in their own healing process? (We can assure children that the abuse was not their fault, but resulted from irresponsible choices of their perpetrator. We can help them to see that although the abuse was not their fault, they have options about how they choose to respond to their abuse. We can help them identify responsible actions they can take to protect themselves from abuse in the future.)

  • Work through feelings of denial and anger. Present: Burton et al. believed that recovery from the trauma of abuse often follows the stages of grieving identified by Kubler-Ross. Review the Kubler-Ross stages: denial, anger, bargaining, depression, and acceptance. Victims of abuse may experience some or all of these stages. Express the feelings associated with the traumatic experience and grieve losses. Present: In order to recover from traumatic experiences, children must have the opportunity to express their feelings about what happened to them. Expressing their feelings allows the children to acknowledge their abuse, tell their story, and go through the grieving process. Telling the story of what happened is often therapeutic. Ask: How can we help abused children to tell their story and express their feelings? (Students should recognize that children often express how they feel by their behavior. Intervention with abused children should provide opportunities for expression of feelings in nonverbal, experiential ways [e.g., play therapy, art therapy]).

  • Integrate the traumatic experience as part of his/her life experiences. Present: Abused children must have sufficient opportunity to express and work through their feelings and tell their

story before they can be expected to accept what has happened and move on. The last step of the recovery response involves coming to an acceptance of the traumatic experience, reconnecting with ordinary life, and integrating what has happened into the rest of the abused child's life experiences. Ask: What can clinicians do to facilitate this process? (Help children to re-engage in the ordinary activities of daily living: school, relationships with friends and family members, and recreational activities.)

- **Self-victimization. Present:** When traumatized children are unable to find safety to deal with their traumatic experiences and are not given the opportunity to express their feelings or grieve their losses, they are likely to respond in maladaptive ways. Children who respond to trauma by hurting themselves in some way are showing a response pattern that Burton et al. (1998) call self-victimization.
  
  - In contrast to the recovery response of expressing and working through feelings, children who choose the self-victimization response may repress, avoid, and hide their feelings. Ask: What may happen when abused children repress their feelings? (Their feelings may keep building up to the point that the children are unable to contain them. They may then release their feelings inappropriately through some kind of maladaptive behavior.)
  
  - **Ask:** How might abused children feel about themselves when they release their feelings through inappropriate behaviors? **Discuss** student responses. Bring out that the process of avoiding, hiding, repressing, and then releasing feelings inappropriately can damage how children feel about themselves and cause their self-esteem to deteriorate.
  
  - **Ask:** How might this process of avoiding, hiding, and releasing feelings inappropriately affect a traumatized child's thinking processes? (Students should recognize from reading Burton et al.'s [1998] writings that children who do not deal appropriately with their feelings often show thinking errors.)
  
  - **Define thinking errors** as "cognitive distortions used to justify hurtful behaviors" (Burton et al., 1998, p. 17). (Slide 48) **Present:** Thinking errors can be externalized (e.g., justifying one's behavior by making excuses or blaming others). However, some children exhibit thinking errors that are directed toward themselves rather than toward others. Traumatized children who exhibit the self-victimization response in the Trauma Outcome Process may feel sorry for themselves or blame themselves for what happened. Their thinking processes are still distorted, but their thinking errors are
internalized. **Ask** students to relate examples of abused children on their caseloads who showed internalized or self-victimizing thinking errors.

- **Present**: Abused children may also exhibit a type of thinking error called *trauma echoes*. **Define** trauma echoes as "thinking errors expressed to them by their own perpetrator(s) that contaminate their own thinking" (Gray, 1989 as cited in Burton et al., 1998, pp. 46-47). *(Slide 49)* For example, children may blame themselves for their own abuse because their perpetrator(s) communicated to them at the time of the abuse "Don't tell anyone about this or you'll be in a lot of trouble," or "You really like me doing this, don't you?" Children may believe what their perpetrator(s) have told them and continue believing it long after the abuse has stopped. Children who display trauma echoes may still think that the abuse was their fault because they didn't try to stop it or because they enjoyed the physical sensations that they experienced. Be sure that students understand the concept of trauma echoes. **Ask** students to relate case examples of children who displayed thinking indicative of trauma echoes.

- **Ask**: What happens if traumatized children do not recognize and correct their trauma echoes and internalized thinking errors? *(Students should be able to respond from their study of the Burton et al., [1998] readings that the children may eventually exhibit self-destructive behaviors.)*

- **Ask**: What are some self-destructive behaviors that abused children might exhibit? **List** student responses. Make sure their responses include at least the following behaviors: social isolation, suicidal gestures, self-mutilating behavior, eating disorders, substance abuse, entering into destructive relationships. **Ask** students to give examples from their practice experience of traumatized children who showed some of these self-destructive behaviors. **Discuss** how self-destructive behaviors may reflect a pattern of avoiding and hiding feelings, allowing the feelings to build up and then releasing the feelings inappropriately through behavior that is hurtful to self.

- **Abuse. Present**: While children who choose the *self-victimization* response hurt themselves, children who choose the *abuse* response hurt others. Like *self-victimizing* children, abusive children may react to traumatic experiences or triggers by avoiding and hiding their feelings and developing trauma echoes and thinking errors. However, instead of becoming self-destructive, their thinking errors are more often externalized and are directed toward others.

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Ask students to name some externalized thinking errors that sexually abusive children may use. List their responses. Show the overhead entitled "Thinking Errors and Corrections." (slide 50) Define and discuss each of the thinking errors listed (e.g., blaming, making excuses, minimizing, lying, assuming, and using anger to control others). Emphasize that children who choose the abuse response often use these thinking errors to justify their behavior, manipulate others, and meet their own needs.

Present: Children who choose the abuse response often have a great deal of anger related to their own abuse. When events in the present trigger memories of past traumatic experiences, they may feel angry. Rather than talk about their anger they may isolate themselves and begin to create get back fantasies. They may go on to plan ways to hurt others and then set up opportunities to offend. Ask: What might happen if these children do not correct their thinking errors or interrupt their get back fantasies and manipulative behaviors? (They may eventually hurt others sexually, physically, and/or verbally.)

Present: Often children who have engaged in the abuse response feel shame about their abusive actions and fear getting caught. However, when another trigger happens, many return to the same response of avoiding and hiding their feelings, using thinking errors, creating get back fantasies, setting up offenses, and doing some type of abusive behavior. Ask: What do you think might happen if children begin to repeat this pattern over and over again? (The pattern may begin to show signs of an addictive process.)

Present: When the abuse response becomes cyclical, it is equivalent to the sexual abuse cycle or assault cycle (Lane, 1997a; Ryan, Lane, Davis, & Isaac, 1987; Ryan, 1989; Stickrod-Gray & Mussack, 1988). The sexual abuse cycle or assault cycle is a conceptual framework in juvenile sexual offender literature that explains how adolescents become involved in sexually offending behavior and why their abusive behavior often increases over time. Students should be familiar with the sexual abuse cycle from their study of the assigned Burton et al. (1998) readings. In this module, it is sufficient to introduce the concept of the sexual abuse cycle. The use of the sexual abuse cycle as an explanation of sexually abusive behavior and as an intervention strategy will be covered in detail in later modules.

● Summarize discussion of the Trauma Outcome Process by emphasizing that it differentiates an adaptive response to traumatic experiences (talking about one's feelings in order to integrate the experiences) from

maladaptive responses (becoming self-destructive or abusive toward others). **Ask** students if they have questions about the Trauma Outcome Process. **Make sure** that participants understand the differences in the three responses (i.e., recovery, self-victimization, and abuse).

**J. Group Activity**

Divide the class into four small groups. Give each group a copy of the *Janet* case vignette (Handout 1).

- Ask the groups to use the PTSD, Traumagenic Dynamics of Sexual Abuse, and Trauma Outcome Process models to identify major concerns in the case. Have them answer the questions that follow the vignette.

- After the groups have discussed the case, bring the whole class back together and have each group report on their answers to the questions.

**Note:** Instructors may use the following guidelines to evaluate if the students have effectively assessed the case and identified the concerns and strengths of Janet and her family:

- The vignette contains information suggesting that Janet has exhibited symptoms of depression, anxiety, and PTSD. She has shown several behavioral problems including an eating disorder, truancy, drug use, physical aggressiveness, and self-mutilation (suicidal gesture).

- There is evidence to suggest all four traumagenic dynamics. She appears to have some traumatic sexualization, at times avoiding age-appropriate contact with boys and at other times being irresponsible in choosing inappropriate locations for sexual activity and failing to take birth control measures. She shows signs of feeling powerless, as shown by her anxiety attacks and the content of her nightmares. She has experienced a sense of betrayal, which continues to affect her relationships with boys her own age. She shows signs of feeling stigmatized, including worrying that her body has been irreparably damaged, feeling acute embarrassment when undressing in the girls’ locker room, and being overly sensitive to criticism by her sister.

- Janet displays emotional, cognitive, and physical symptoms that are indicative of both the self-victimization and abuse responses in the Trauma Outcome Process. She appears to have some trauma echoes of self-blame for her abuse that relate back to some of the thinking errors communicated to her by her perpetrator at the time of the abuse. Although her physically aggressive behavior toward her sister indicates that she has shown the abuse response, the response that best describes her current functioning is self-victimization. This is shown by several self-destructive behaviors including slashing her wrists with a razor, her eating disorder

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(bingeing and purging), marijuana use, and promiscuous sexual activity (sex in the park and at the beach with her boyfriend).

- Janet’s strengths include her ability to survive having been sexually abused and still continue to function, at least to a marginal degree, as evidenced by partial school attendance, established relationships with peers, and participation on the girls’ swim team. Her artistic talent is also a strength as it provides a means whereby she can express herself. Janet’s family appears supportive. She appears to have a strong relationship with her sister, as there are indications that she has confided in her. Her mom appears concerned and caring.

- A lot of information is missing in the case. We do not know why her cousin was able to molest her for such a long period of time without any family members finding out and why Janet did not have enough trust in her family to disclose her abuse. There is no information provided about Janet’s relationship with her dad. We do not know what legal action has been taken now that Janet has disclosed her abuse and whether the perpetrator will be confronted and prosecuted. Little information is given concerning cultural factors, other than that the family is Caucasian and middle class.

(Slide 51)
MODULE II

IDENTIFYING SEXUAL BEHAVIOR PROBLEMS IN CHILDREN

MODULE II
IDENTIFYING SEXUAL BEHAVIOR PROBLEMS IN CHILDREN

LEARNING OBJECTIVES

Develop knowledge of normative sexual development in children;

Increase self-awareness of one's own attitudes, values, and beliefs related to childhood sexuality;

Identify factors that differentiate age-appropriate from sexually abusive behavior (i.e., differences in power, misuse of authority [intimidation], manipulation, and coercion);

Identify methods for differentiating and classifying subtypes of children with sexual behavior problems.

READING ASSIGNMENTS

   Introduction (pp. xxvi-xli); Chapter 1: Identifying, labeling, and explaining children's sexually aggressive behaviors (pp. 1-46).

   Chapter 1: Sexually abusive behavior problems: Definitions and current knowledge (pp. 1-28).


   Chapter 1: Childhood sexuality (pp. 1-20); Chapter 2: Age-appropriate sex

play versus problematic sexual behaviors (pp. 21-39); and Chapter 3: Sexual behaviors: A continuum (pp. 41-52).


**MATERIALS NEEDED**

- Handouts
- Overhead transparencies and overhead projector, or laptop computer with projector and PowerPoint presentation
- Easel stand and pad, or chalkboard
- Magic markers, or chalk

**RATIONALE**

It is important that students have knowledge of normative sexual development in childhood to accurately assess sexual behavior problems in children. They must also know and understand criteria for differentiating sexual behavior problems from normative or age-appropriate sexual behavior. This module explores some of the difficulties involved in defining, labeling, and classifying sexual behavior problems in young children. Research pertaining to normative sexual development and sexually inappropriate behavior in children is reviewed. Current methods of classifying children's sexual behavior problems are presented and discussed.

Discussion of these topics requires that students have awareness of their own attitudes, values, and beliefs pertaining to sexual issues. This module therefore includes an exercise designed to help students gain awareness of their beliefs and values and to understand how their values and life experiences can influence their ability to accurately assess sexual behavior problems in children and provide appropriate interventions.

CONTENT OUTLINE

I. Defining Sexual Behavior Problems: Labeling and Classifying
   A. Incidence and Prevalence of Sexual Offenses Committed by Children
   B. Problems Inherent in Defining and Labeling Sexual Behavior Problems in Children

II. Sexual Development in Children
   A. Practitioner Self-Awareness of Sexual Issues
   B. Explanations of Childhood Sexuality
   C. Research Findings

III. Inappropriate Sexual Behavior in Children
   A. Research Findings
   B. Classification Systems for Differentiating Normal/Normative Sexual Behaviors from Problematic or Abusive Sexual Behaviors
   C. Case Vignettes

CONTENT

I. Defining Sexual Behavior Problems: Labeling and Classifying

   A. Incidence and Prevalence of Sexual Offenses Committed by Children

   **Present:** Begin by discussing the information in the Introduction of the Araji (1997) text concerning the extent of sexually abusive behavior perpetrated by children. **Emphasize:** Although Araji has documented that several states (Washington, Vermont, New York, Oregon, and Rhode Island) report a high incidence of sexual abuse perpetrated by children (Slide 52), there are no statistics available that document the national extent of the problem. According to Gray et al. (1997), who recently published descriptive data from their treatment outcome study

of children with sexual behavior problems in Vermont: “Although the scope of the problem is difficult to measure precisely, the best evidence suggests that child-on-child sexual behavior problems are a source of a substantial percentage of reported child sexual abuse” (p. 260).

Ask students to explain why it is difficult to obtain an accurate estimate of the prevalence of children with sexual behavior problems. Gray et al. (1997) cited the 1988 report of the National Adolescent Perpetrator Network in stating: "Nationally, the prevalence of children with sexual behavior problems is difficult to estimate because such acts are ill defined, often unacknowledged or misperceived, and inconsistently reported" (p. 268).

As students discuss the factors that prevent an accurate identification of children with sexual behavior problems, emphasize that societal denial that children can be involved in sexual behavior inhibits recognition of their sexual behavior problems. Refer students to this citation from the National Adolescent Perpetrator Network (1988) cited by Araji (1997) on page xxviii: "In a society which denies all sexuality in childhood and attempts to repress sexual behavior in adolescence, it is not surprising that we would minimize and deny sexual offending by children" (p. 42).

Ask students to think about their own personal feelings about children having sexual behavior problems and committing sexually abusive behaviors. Encourage them to share their feelings. Closely monitor this discussion and validate any feelings of discomfort by referring students to this statement of Cunningham and MacFarlane (1996):

They [children with sexual behavior problems] make us all uncomfortable—so uncomfortable we've had to deny their existence and/or minimize their behavior until now. We've called their behavior “exploration” or “curiosity” until they were old enough to comfortably call it what it is: sexual abuse of other children (p. viii, cited in Araji [1997], p. xxx).

B. Problems Inherent in Defining and Labeling Sexual Behavior Problems in Children

Present: The issue of sexual abuse perpetrated by young children was not addressed in research literature until the late 1980s. Literature about this topic has grown considerably during this past decade. Refer students to the list of references presented on page xxviii of Araji (1997).
Ask: What terms are used in the literature to describe these children? List student responses on the chalkboard. Make sure the list includes the following terms: children with sexual behavior problems, children with sexually abusive behavior problems, sexually reactive, abuse-reactive, sexually aggressive, sexually abusive, sexualized, child perpetrators, children who abuse, children who molest, and children who sexually act with criminal intent.

Ask: Why have so many different terms been used to describe these children? (Clinicians and caseworkers are hesitant to label young children as sexual perpetrators.)

Discuss each of the above terms and its advantages and disadvantages. Have students compare and analyze the different terms. Use the following questions to facilitate this discussion.

- **Ask:** Which terms show a connection between sexually abusive behavior and past abuse? (Sexually reactive, abuse-reactive, sexualized.)

- **Ask:** What are the disadvantages to using those terms to describe all children who abuse other children? (Some children who sexually abuse other children have not been sexually abused themselves. "Sexually reactive" is not applicable to those children.)

- **Ask:** Which of the above terms clearly describe the abusive nature of the sexual behavior? (Sexually aggressive, sexually abusive, children who molest, children who abuse, children who act with criminal intent.) Point out that these terms clearly put the responsibility for the inappropriate behavior on the child who initiates the inappropriate sexual behavior.

- **Ask:** What are the disadvantages to using these terms to describe all children who abuse other children? (Some children who initiate sexual behavior toward other children are doing so because they are reenacting what was done to them in their own victimization. Although their behavior is abusive, their intent, or motivation is not. Terms such as sexually aggressive, children who molest, children who abuse, and sexually abusive children may put more responsibility on these children than they actually have.)

- **Ask:** Which of the above terms describes the sexual behavior without labeling the child? (Children with sexual behavior problems and children with sexually abusive behavior problems.)

• **Ask:** Which of the above terms label the child? (*Child perpetrator.*) What are possible harmful effects that can result from attaching a negative label to a child? (*The child's self-esteem may be negatively affected, and the child may end up acting in ways that are consistent with the negative label.*)

• **Summarize** the discussion by stating that it is difficult to find a term that accurately and justly describes all children who have committed an inappropriate sexual behavior against another child. Some terms may not stress enough accountability for the inappropriate behavior; other terms may not take into account the intent motivating the child to commit the behavior. Whenever possible, the terms selected to describe these children should describe their behavior without labeling the child.

• **Ask** students to indicate which of the above terms they prefer. You might want to ask for a show of hands for each term. After students have voted, indicate that the terms "children with sexually abusive behavior problems" and "sexually abusive children" will be used in this training course. Although these two terms may not be the best to describe the unique circumstances of each child, the first term (children with sexually abusive behavior problems) describes the behavior without labeling the children. The second term (sexually abusive children) holds the children accountable for the abusive nature of the sexual behavior. Note that the Araji (1997) text states a preference for the term, sexually aggressive children, for similar reasons—it clearly specifies the hurtful nature of their behavior.

II. Sexual Development in Children

A. Practitioner Self-Awareness of Sexual Values

**Begin** the discussion of sexual development in children by stating that sexual issues are often uncomfortable to discuss because they may evoke anxiety or other intense emotional responses. These responses usually relate to one's own life experiences and to values acquired through one's family and cultural upbringing. Remind students that it is especially important for social workers to be self-aware and understand how their own values and life experiences influence their perceptions of emotionally charged issues, such as childhood sexuality.

**Distribute** the *Sexual Values Quiz* (Burton et al., 1998), which asks students to identify and examine their beliefs about various sexual issues (i.e., sexual behavior between children, masturbation, sexual...
orientation, sexual expression between consenting adults, and sexual abuse). The quiz asks students to (a) list their beliefs, (b) determine where they think they acquired the beliefs, (c) note whether their beliefs have changed in the past 10 years, and (d) determine if they are comfortable with their beliefs or if they would like to change them.

- Allow students about 10 minutes to complete the quiz. Have students only consider their beliefs about the first two issues on the quiz (i.e., sexual behavior between children, masturbation).

- When all students have finished, ask the class to discuss their reactions to the quiz. Assure students that you are not asking them to disclose specific details about their answers, but rather to talk about the thoughts and impressions they had as they examined their sexual values related to sexual behavior between children and masturbation.

- Monitor the discussion carefully, and emphasize that although identifying and examining one's beliefs about sexuality is often uncomfortable, it is necessary in order to be prepared to appropriately respond to the concerns about sexuality which clients may have.

Next, distribute the worksheet *Communicating Sexual Values* (Burton et al., 1998, p. 248). Allow students another 10 minutes to complete the worksheet by evaluating the beliefs/values they identified on the Sexual Values Quiz. This worksheet asks students to examine their beliefs/values regarding sexuality, to determine if these beliefs/values are healthy or unhealthy according to the following criteria, and to evaluate if they need to change.

- Healthy values affirm sex as a positive expression of caring and affection between consenting adults, while unhealthy values degrade sex.

- Healthy values help one nurture oneself and affirm the rights of others, while unhealthy values promote deviant, abusive, or violent sexual expression, conceal information, and enable secrecy.

**Divide** the class into the four discussion groups that were established in Module I. Ask each group to discuss their reactions to the process of identifying, examining, and evaluating their sexual beliefs/values related to sexual behavior between children and masturbation. Assure students that they do not need to disclose their personal beliefs and values about the issues if they do not wish to do so. They only need to talk about...
what the process of identifying and examining their values was like for them. Allow about 15 minutes for discussion.

**Bring** the class back together and ask students: "How can the experience we have just had in identifying, examining, and evaluating our values help us when working with children who have sexual behavior problems?" Discuss students' ideas. Point out that being aware of one's values can make a social worker more sensitive to client needs.

**B. Explanations of Childhood Sexuality**

**Tell** students that increasing their awareness of their sexual values is important preparation for studying childhood sexuality. Some authors of the assigned readings for Module II (Araji, Gil & Johnson, Martinson, and Ryan) give explanations of sexual development in children. **Encourage** students to think critically about the concepts presented in the readings and to notice the ways in which their beliefs, values, and biases influence their emotional responses to the ideas expressed by the authors.

**Present:** Children have "capacities for sexual experiences and interactions and they do express sexual behavior in a variety of ways" (Martinson, 1997, p. 37). Martinson asserted that children's capacities for erotic experience begins very early, during intrauterine development. He stated that the fetus is responsive to touch and speculated that the fetus may engage in auto stimulation before birth. **Ask:** Why might it be difficult for some people to accept Martinson’s assertions about prenatal sexual development? *(Because of denial that children have sexual capacities.)*

**Display** chart of Erikson's stages of psychosocial development *(Slide 53).* **Ask** someone to explain the basic premises of Erikson’s psychosocial theory. *(Individuals progress through certain stages in which they must master specified developmental tasks.)*

**Present:** According to Martinson (1997), there are no inborn, normal stages in a child’s sexual development. However, there are "identifiable capacities and behaviors that appear to contribute to the child's sexual development" (p. 37) and may be expected at each life stage—infancy, preschool, school age, and preadolescent. These capacities/behaviors can be related to the framework of Erikson's psychosocial stages. Sexual behaviors for each age would be expected to be consistent with the characteristics of the specific psychosocial stage.

Ask: According to the Martinson, and Gil and Johnson readings, what sexual behaviors can be expected of children in Erikson's first stage of development? On the chart, list student responses next to the Trust vs. Mistrust stage (birth to 18 months). Behaviors mentioned by Martinson include:

- Pleasure in response to attachment behaviors initiated by the mother (e.g., "fondling, caressing, kissing, gazing at, looking en face, talking to, and being held close," [p. 39])
- "Ecstatic behavior" (e.g., pelvic thrusting; p. 41)
- Sensuality via sucking, holding, bodily contact (p. 42)
- Genital play (i.e., fingering, pleasurable handling, random exploration; p. 43)
- Rhythmic, pleasure-inducing behavior (e.g., rocking; p. 43)
- Erections, vaginal lubrication, and capacity for orgasmic response (p. 44)

Point out that the sexual behaviors listed are self-focused in nature and are therefore consistent with Erikson's first stage: Trust vs. Mistrust. In this stage, the infant becomes aware of self in relation to the world. An infant who is given appropriate nurturing learns to trust that his or her needs will be met.

Ask: According to Martinson (1997), how is infants' genital play different from masturbation? (The behavior is more reflexive than volitional. "Infants in the first year of life generally are not capable of the direct volitional behavior required for the behavior pattern that we call the masturbatory act [p. 43]...small muscle control is not sufficiently well developed" [Levine, 1957, as cited in Martinson, 1997, p. 44]).

Present: In Erikson's second stage (Autonomy vs. Shame and Doubt, age 18 months to 3 years) the child begins to exercise willful behavior in response to the stimuli in his or her environment. Expected sexual behavior for this age group reflects this willfulness and includes self-exploration and self-stimulation. Martinson (1997) noted that masturbation or "rhythmic manipulation with the hand does not appear to occur until children are approximately 2½ - 3 years old" (p. 44).

Ask: What other sexual behaviors might be expected in 2- to 3-year-old children? On the Erikson chart, list student responses next to the Autonomy vs. Shame and Doubt stage. Behaviors mentioned in the
Readings include: (Gil & Johnson, 1993, p. 26; Martinson, 1997, pp. 45-49):

- Random touching and rubbing of own genitals
- Watching others undress and poking others' body parts
- Showing genitals
- Showing interest in bathroom functions
- Learning sexual vocabulary

**Present:** In Erikson's third stage, Initiative vs. Guilt, age 3 - 5 years, children begin to have more social interaction with each other. Sexual behaviors displayed by preschool-age children would therefore be expected to be more socially oriented and less self-focused. Martinson (1997) noted, "by age three or four, children are beginning to be socialized away from body contact with self as well as with others" (p. 48). Although preschool age children have increased peer contact and may show increased experimental interactions, they would also be expected to show increased inhibition.

**Ask:** What sexual behaviors would you expect to see in preschool age (3 to 5) and school age (5 to 7) children? On the Erikson chart, list student responses next to the Initiative vs. Guilt stage. Behaviors mentioned in the readings include: (Gil & Johnson, 1993, p. 26; Martinson, 1997, pp. 45-49):

- Masturbation (more purposeful and less random than 2-year-old children—in fact Martinson asserted that some preschool children may fantasize when they masturbate (Martinson, p. 47)
- Curiosity about sexual behavior and reproductive processes
- Watching others undress, asking to touch others' genitals
- Inhibitions and requests for privacy
- Telling dirty jokes
- Mimicking grown-up behavior (playing house, imitating adult sexual behavior)
- Showing interest in body functions, playing doctor
- Kissing, holding hands

**Present:** Erikson's fourth stage, Industry vs. Inferiority, age 5 to 11, is the stage that Freud referred to as latency. According to Erikson, in this stage children need to gain a sense of competence or self-esteem. Peer
relationships are very important. Freud believed that sexual urges go underground during latency and are not expressed. However, Martinson (1997) indicated that the concept of diminished sexual activity and interest during latency has been exaggerated. Martinson stated, "Sexual awakening---the beginning awareness of the self as a sexual being and of the opposite sex as potential affectional and erotic partners—is very real for many preadolescents" (p. 49). This "sexual awakening" coincides with the hormonal changes brought about by puberty.

**Ask:** What sexual behaviors would be expected for preadolescent children (ages 8 to 12)? On the Erikson chart, list student responses next to the Industry vs. Inferiority stage. Behaviors mentioned in the readings include: (Gil & Johnson, 1993, p. 26; Martinson, 1997, pp. 49-53):

- Masturbation (which children may learn from each other; Martinson, p. 51)
- Attachments or "crushes," beginning to "date"
- Exhibitionistic behavior (e.g., mooning)
- Kissing, French kissing
- Touching others' genitals, petting
- Dry humping
- Digital or vaginal intercourse, oral sex

**Ask:** How does the sexual behavior of preadolescent children differ from adult sexual behavior? *(Children are primarily motivated by curiosity and, unlike adults, do not understand the potential consequences of their behavior. Martinson noted that "unless eroticized by an older person, most children are more exploratory than goal [orgasm] oriented" [p. 54])*

**Present:** After comparing research from the 1940s, 1960s, and 1980s as well as recent findings on normative sexual development (Friedrich et al., 1991), Martinson (1997) concluded that "children continue to engage in both autoerotic behavior and sexual interactions with peers throughout childhood...It is apparent that children have always been sexual and continue to be sexual" (p. 53). Ask students for their impressions. Do they agree with Martinson's assertion? Have children always been sexual? Or are the children of the 1990s more sexually aware than children in earlier decades? If the students believe today's children are more aware or knowledgeable about sex, ask them to identify factors that may contribute to increased awareness. *(Depiction of

sexual situations and behaviors in movies, videos, TV, and magazines, access to the Internet.)

Summarize the preceding discussion with the following quotation by Eliana Gil: "Two things about childhood sexuality can be said with certainty: (1) sexual curiosity, interest, experimentation, and behavior is progressive over time and (2) sexual development is affected by a number of variables" (Gil & Johnson, 1993, p. 21) (Slide 54). In addition, it is important to remember that a child’s sexual development is an individualized process. Some children will be exposed to much more sexual stimuli than others and will therefore have increased sexual knowledge.

C. Research Findings

Present: It is important to distinguish children’s sexually abusive behaviors from those viewed as normal or normative. Araji (1997) noted that the terms normal and normative are used differently in the research literature (Slide 55). Practitioners and researchers in medicine, psychology, and child development tend to use the term normal, while sociologists, social workers, and professionals associated with the justice system tend to use the term normative. Araji stated that the term normal "frequently describes sexual behaviors that occur as a result of the natural human biological and physiological development process" (p. 2), while the terms normative or appropriate may be used "when sexual behaviors are defined in a sociocultural way--to indicate what is considered the norm in a given society, culture, or group" (pp. 2-3). Similarly, researchers following a developmental perspective frequently use the terms abnormal and pathological, while the terms deviant or criminal are frequently used by researchers following a sociocultural perspective.

Ask: What problems may be created by viewing children’s sexual behaviors from two different perspectives? (The different perspectives may present confusion.)

Present: Araji (1997) stated: "the same sexual behaviors that may be referred to as normal, abnormal, or pathological by writers following a developmental perspective are labeled as normative, deviant, or criminal by those following a cultural or sociological perspective" (p. 3). If students do not mention it, point out that Araji also noted that the various terms present confusion when authors use the terms normal and normative "interchangeably and without definitions" (p. 3). Note that this course will follow a sociocultural perspective and use the term

normative because this perspective is more consistent with the ecological perspective underlying social work practice.

**Present:** One author who has done considerable research on normative sexual development in children is William Friedrich. Both the Araji (1997) and Burton et al. (1998) texts highlight the importance of Friedrich's research. The assigned readings for this module also include two articles by Friedrich and his colleagues: One reported a study on normative sexual development (Friedrich et al., 1991); the other reviewed literature concerning sexual behavior in sexually abused children (Friedrich, 1993).

**Ask:** According to Araji (1997, p. 4), what method did Friedrich and his colleagues use in these studies to differentiate normative from non-normative sexual behaviors? *(They compared children who were known to have been sexually abused with children who did not report sexual abuse.)*

**Ask:** What is the rationale for using the experience of being sexually abused to differentiate normative from non-normative sexual behaviors? *(Discuss the reasons outlined in the Araji text. Make sure that students mention the following.)**(Slide 56):*

- Sexual abuse disrupts the normal course of development.
- Sexual abuse may result in children displaying sexual behaviors that are advanced beyond those expected in children ages birth through age 12.
- Sexually abused children may display compulsive sexual behavior and lack inhibitions associated with normal sexual behavior during latency.

**Ask:** What problems does Friedrich’s method of differentiating normative from non-normative sexual behaviors present? *(It is difficult to accurately identify all children who were sexually abused or to definitively conclude that all sexual behavior problems in children relate to the experience of having been sexually abused. Some children who have been sexually abused may therefore be inadvertently included in normative samples.)* Discuss the problems involved in identifying sexually abused children that were pointed out in the Araji text: *(Slide 57)*

- Some sexually abused children may be afraid or ashamed to report their abuse.
- Some sexually abused children may disclose their abuse to their parents, but their parents may be reluctant to believe them and will therefore deny that their children have been abused.
• Many sexually abused children are abused by a parent.
• The parent does not want to be discovered and will therefore fail to report the sexual abuse of his or her child.
• Some children may be more resilient to the consequences of sexual abuse than others. They may appear normal and are therefore not identified as having been sexually abused.

Summarize: The difficulty involved in accurately identifying sexually abused children is a limitation in Friedrich's research. Nonetheless, his studies do add to empirical knowledge about normative sexual development in children, particularly as it is influenced by the experience of sexual abuse.

Present: Friedrich et al. (1991) used a community-based survey to assess the frequency of sexual behaviors of 880 children, ages 2 to 12, referred to a pediatric clinic who were screened to exclude a history of sexual abuse. (Slide 58) The children were divided into four groups: younger boys and younger girls (ages 2-6) and older boys and older girls (ages 7-12). Ask: What methods were used in this study to assess the frequency of sexual behaviors displayed by each of the four groups of children? (The mothers of the children completed a questionnaire consisting of a demographic data sheet, the Child Sexual Behavior Inventory [CSBI], and the problem behavior portion of the Achenbach Child Behavior Checklist [CBC].) Ask students if they see any potential problems in the ability of the methods used in this study to accurately assess sexual behaviors displayed by children. (Students should be able to critically analyze the methods of the study and respond that a parent’s report of their child’s sexual behavior may not always accurately reflect the actual sexual behaviors displayed by the child. Children who display inappropriate sexual behavior may not do so in front of parents, or if they do, some parents may be reluctant to admit that their child is showing sexual behavior.)

Present: The findings of Friedrich’s study of normative sexual behavior provided data about: (a) the relative frequency of sexual behaviors in a normal sample, (b) the relationship of sexual variables to family variables, (c) the relationship of sexual behaviors to general behavior problems, and (d) the stability of sexual behaviors over time. Ask: What did the study show about the relative frequency of sexual behaviors? (Slide 59)

• Younger children (ages 2 - 6) had a higher frequency of sexual behaviors than older children (ages 7-12).

• Some sexual behaviors were quite frequent (10 of the 35 items were endorsed by more than 20% of the sample and 2 of the 35 items by more than 50% of the sample). Sexual behaviors that were endorsed by a higher frequency of the sample were masturbatory and exhibitionistic behaviors.

• Sexual behaviors that were quite unusual and rarely endorsed included behaviors that were either more aggressive or more imitative of adult sexual behavior. For example, fewer than 2% of the overall sample endorsed the following behaviors: puts mouth on another child/adult's sex parts, asks others to engage in sexual acts with him or her, masturbates with object, or imitates sexual intercourse. Emphasize that Friedrich's study of this normative sample supports the argument that normal sexual development of children includes masturbatory and exhibitionistic behaviors, but does not include sexual behaviors such as oral sex, object insertion, and sexual intercourse.

Ask: What did the Friedrich study show about the relationship of children's sexual behaviors to family variables? (Slide 60)

• Children's sexual behaviors were related to sexual behavior overtly displayed in the family.

• Family nudity was related to greater sexual behavior for older (age 7-12) and younger (age 2-6) children.

• Witnessing sexual intercourse was significantly related to greater sexual behavior in 7- to 12-year-old girls. It was also related to greater sexual behavior in the other groups (2- to 6-year-old boys, 2- to 6-year-old girls, and 7- to 12-year-old boys), but the association was not significant.

Ask: What did Friedrich's study show about the relationship between children's sexual behaviors and other behavior problems as measured by the CBC? (Slide 61)

• Friedrich's sample scored within the expected range for a normative sample on the CBC.

• The mean T scores for all four sample groups were within normal range on both the Externalizing and Internalizing CBC scales.

• The CBC is structured so that approximately 2% of a random sample should score 2 standard deviations above the mean. In Friedrich's sample, 1.5% to 5.7% of the children, depending on age and sex, scored that high on the Internalizing scale, while 2%
to 3.6% of the children reached the level of 2 standard deviations above the mean on the Externalizing scale.

- The mean CSBI score for each of the four age and sex groups positively correlated with the Externalizing and Internalizing scores on the CBC. This correlation was of moderate strength and was highly statistically significant.

**Ask:** How did Friedrich and his colleagues assess the stability of sexual behavior over time? What did they find? *(Slide 62)*

- They had a sample of 70 mothers complete a second CSBI approximately 4 weeks after they completed the initial CSBI.
- The correlation between the mean value of the CSBI at Time 1 and at Time 2 was very strong and highly significant, indicating considerable stability of sexual behavior over the 4-week time period.

### III. Inappropriate Sexual Behavior in Children

#### A. Research Findings

**Present:** Friedrich (1993) reviewed several studies that came to the conclusion that children who have been sexually abused have one distinguishing characteristic from comparison groups: they display more sexually inappropriate behaviors. These studies cover the ages 2-18, with the majority focusing on latency age. Sexually abused subjects were recruited from inpatient facilities, outpatient clinics, teaching hospitals, private therapists, and public agencies. Control groups were recruited from the above, as well as from schools, churches, and after-school programs. Methods used in the various studies included record review, parent report, assessing the relationship of abuse variables to sexual behavior, psychological assessment of the child, and direct observation of the child’s behavior in interviews or play settings. Instructors may draw from the following literature review in selecting studies they wish to discuss:

**Present:** Several of the studies mentioned by Friedrich based their conclusion on review of records: *(Slides 63 & 64)*

- Deblinger et al. (1989) conducted a study of PTSD symptoms among children who were hospitalized in an inpatient unit. They found that 29 sexually abused children showed a significantly higher frequency of sexually inappropriate behavior than matched samples of 29 physically abused and 29 nonabused children.

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Gale, Thompson, Moran, and Sack (1988) reviewed community mental health center records for 202 children who were 7 years old and younger (37 sexually abused, 35 physically abused, and 130 nonabused). The sexually abused group showed a significantly higher frequency of inappropriate sexual behavior than the other two groups (i.e., 41% of the sexually abused group displayed sexually inappropriate behaviors, compared to less than 5% of the physically abused and nonabused control groups). More family stress was also noted in both abuse groups.

Goldston, Turnquist, and Knutson (1989) studied 23 behaviors of 195 girls ages 2-18 who had consecutive admissions to three mental health agencies. Sexually inappropriate behaviors were more common among both older and younger sexual abuse victims than in nonabused comparison girls.

Livingston (1987) found that sexually abused children were significantly more likely than physically abused children to have sexual misbehavior as a presenting complaint when admitted to inpatient hospitalization.

Sansonnet-Hayden, Haley, Marriage, & Fine (1987) found sexually abused girls to be more likely to report promiscuous sexual activity than nonabused girls, and sexually abused boys to be more likely to report cross-dressing and sexually aggressive behavior than nonabused boys.

Present: Another set of studies reviewed by Friedrich (1993) used parent rating scales (e.g., CBC, CBSI, and Louisville Behavior Checklist) to identify sexually inappropriate behavior in sexually abused children. These scales have limitations when assessing sexual behaviors in children. For example, although the CBC is widely used in mental health settings to assess children's problem behaviors, its ability to assess sexual problems is limited. Ask students to describe some of the methodological problems that Friedrich identified in studies that used the CBC to assess children's sexual behaviors. Encourage students to refer to examples of the studies reviewed by Friedrich as they discuss these problems. This discussion can give students opportunity to begin to develop skills in reading research and thinking critically about how the methodology used determines the usefulness of the results. Make sure that students cover the following points in their discussion:

- The reliability of parent rating scales such as the CBC depends on parental objectivity and accuracy. As previously discussed, "mothers of sexually abused children vary widely in the accuracy...
with which they report their child's behavior” (Friedrich, 1993, p. 62).

- The subscale on the CBC used to measure sexual behavior is problematic. Six items on the CBC relate to sexual problems in children. These items measure two dimensions of sexual behavior: sexual identity and sexual activity/preoccupation. The Sex Problems subscale of the CBC does not include all six items that measure sexual behavior, while it does include some items that are not related to sexual behavior (e.g., items assessing peer relations and verbal expression).

- Several studies found that sexually abused children scored significantly higher on the CBC Sex Problems scale than nonclinical children. These studies include: (Slides 65 & 66)
  - Cohen and Mannarino (1988) found an elevated Sex Problems scale for 24 sexually abused girls compared to nonclinical norms.
  - Grogan (1988) found significant differences on the Sex Problems scale between small samples of sexually abused and nonabused latency age females.
  - Valliere, Bybee, and Mowbray (1988) found significant differences between two samples of 19 and 28 sexually abused girls and the CBC nonclinical norms, but not between these two samples and local school-based samples.
  - Einbender and Friedrich (1989) found differences on the Sex Problems scale between 46 sexually abused and 46 nonsexually abused girls (ages 6-14) matched on age, race, family income, and family constellation.
  - Mannarino et al. (1989) found differences on the Sex Problems scale for large (N > 90) samples of sexually abused and control latency-age females, but not between sexually abused and psychiatric controls.

- Other researchers used a derived scale consisting only of the six items on the CBC that specifically refer to sexual behavior: (Slide 67)
  - Friedrich, Beilke, and Urquiza (1987) found significant differences on this derived scale between 93 sexually abused children and two comparison groups of 64 children in outpatient therapy and 78 children from a health clinic.
Friedrich, Beilke, and Urquiza (1988) found significant differences on the derived scale between 31 sexually abused boys and 33 oppositional boys ages 3-7 that were matched on demographic variables.

Friedrich and Luecke (1988) found significant differences on the derived scale between sexually aggressive and nonaggressive children.

Kelley (1989) found more sexual behavior in 32 children (ages 4-11) sexually abused in day care centers and 35 children ritually abused in day care than 67 nonabused children.

Another study (Miller, 1981) used the Louisville Behavior Checklist to assess 88 preschool and school-age sexual abuse victims and psychiatric controls. The findings showed that sexual abuse victims differed significantly in their sexual behavior.

Some researchers have developed their own measures for assessing sexual behavior in children: (Slides 68 & 69)

- White, Halpin, Strom, and Santilli (1988) developed 116 sexual abuse sensitive (SAS) items to assess 58 preschool-age children. The sample included 17 children who were known to have been sexually abused, 18 children who were neglected, and 23 nonreferred children. Sexually abused children, particularly boys, scored higher on the SAS items than the neglected or nonreferred children, although the differences were not significant.

- Friedrich et al. (1991) developed the Child Sexual Behavior Inventory and used it to compare a random sample of 276 sexually abused children with 880 nonabused children. The sexually abused children differed significantly on 25 of the 36 items rated. Sexual behavior was found to be directly related to internalizing and externalizing behavior problems on the CBC, which was completed at the same time as the CSBI.

- Hewitt and Friedrich (1990) used the CSBI to study a sample of 105 children who were referred for suspected sexual abuse. The 65 children who had documented evidence of sexual abuse differed significantly on the CSBI than the other children in the sample.

Present: Friedrich's (1993) review also discussed studies that identified correlations between sexual abuse-specific variables and levels of sexual behavior. Ask: Which variables were significantly related to higher levels of sexual behavior? Make sure that students bring out the following studies in their discussion: (Slide 70)

- Number of perpetrators and frequency of sexual abuse (Friedrich et al., 1988; based on sample of 86 children).
- Duration of abuse and family support (Friedrich, 1988).
- Severity of abuse, number of perpetrators, and use of force (Friedrich et al., 1992; Koverola, 1988; based on sample of 50 sexually abused girls).

Present: Friedrich's (1993) review also discussed research using drawings and projective testing in psychological assessment of children's sexual behaviors (Slide 71)

- Some research has indicated that sexually abused children are significantly more likely to draw genitals than comparison children (Friedrich et al., 1991; Yates, Beutler, & Crago, 1985; Hibbard, Roghmann, & Hoekelman, 1987; Cohen & Phelps, 1985).
- Another study (Hibbard & Hartman, 1990) did not find any significant differences.
- Friedrich cited Cohen and Phelps (1985) indicating that the reliability of independent raters in assessing children's drawings can be extremely poor.
- One study (Einbender & Friedrich, 1989) created a sexualization index whose validity was supported by factor analysis. This index combined scores of the CBC sex problems scale with two Rorschach variables (body preoccupation and impulse control). The sexually abused girls scored significantly higher on the measure than nonabused girls.

Present: Observation of the child in clinical interviews is another method for assessing children's sexual behaviors. Friedrich (1993) reviewed research using two methods for assessing children's sexual behaviors: anatomically correct dolls and behavior rating scales: (Slide 72)

- Research using anatomically correct dolls to assess children's behavior included the following studies:

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- Jampole and Weber (1987) found that children showed more sexual behavior with the dolls when the observer left the room.
- White, Strom, Santilli, and Halpin (1986) found that 3-year-old children were most responsive to the dolls.
- Allen, Jones, and Nash (1989) found no differences in doll interaction between sexually abused and non sexually abused preschoolers, all of whom had been emotionally abused.
- Everson and Boat (1990) studied a demographically diverse sample of 223 children ages 2-5 that were screened for absence of sexual abuse. They found that sexual behavior with anatomically correct dolls was nonexistent among 2-year-olds, but relatively common among older children, with 18% of the 5-year-olds displaying suggestive intercourse positioning.

**Ask:** What do these studies of children's behavior with anatomically correct dolls suggest? *Displaying sexual behavior with an anatomically correct doll may be normative for children around the age of 5.)*

- Friedrich & Lui, (1985) used a 10-item scale to rate children's behaviors during an interview. They found that 45 sexually abused children exhibited more interpersonal boundary and sexual behavior problems than a demographically similar sample of children being seen for their first interview. *(Slide 73)*

**Present:** A final method discussed by Friedrich (1993) for assessing children's sexual behaviors is self-report. Friedrich noted that researchers have only recently begun to assess children's sexual behavior by means of self-report. He reported the findings of two studies that used the Trauma Symptom Checklist for Children (TSC-C), an adaptation of the Trauma Symptom Checklist (Briere, 1989) to measure children's sexual concerns. The TSC-C includes scales that assess several dimensions pertaining to the experience of trauma (e.g., depression, anxiety, sleep problems, sexual problems, dissociation). Results of the two studies reviewed by Friedrich included: *(Slide 74)*

- Friedrich and Briere (1990) found that mean values for the 10-item sexual concerns scale of the TSC-C differed significantly between 29 sexually abused inpatients and 17 nonabused inpatients.

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The second study (Lanktree & Briere, 1990) reported that the reliability of the sexual concerns scale of the TSC-C was .62 with a sample of 28 sexually abused children.

**Summarize** Friedrich's review of literature on sexual behavior in children by emphasizing the following points: (Slide 75)

- Empirical research (using parent report, self-report, psychological assessment results, and behavioral observation) demonstrates that sexual abuse is related to increased sexual behavior following the abuse.
- The research reviewed by Friedrich showed that sexually abused children differ not only from nonabused children but also from nonabused children with psychiatric diagnosis. It also showed that sexually abused children differ from physically abused or neglected children.
- "These results hold true when age, sex, and SES differences are either controlled for, or covaried statistically" (Friedrich, 1993, p. 64).

**Ask** students to identify limitations that they see in the literature reviewed by Friedrich (1993). Make sure students emphasize the limitation identified by Friedrich at the end of his article: "the sexually abused children studied represent clinical samples, for the most part, which reduces the generalizability of the findings to non clinically referred sexually abused children" (p. 64).

B. Classification Systems for Differentiating Normal/Normative Sexual Behaviors from Problematic or Abusive Sexual Behaviors

**Present:** The assigned chapter in the Araji (1997) text, *Chapter 1: Identifying, Labeling, and Explaining Children’s Aggressive Behaviors* presents several classification systems for differentiating children's inappropriate sexual behaviors from normative sexual behaviors and for classifying different levels of sexual behavior problems. Most of these classification systems place children's sexual behaviors on a continuum, with normative sexual behavior on the low end and aggressive, coercive sexual behavior on the high end. Emphasize that all of the classification systems reviewed by Araji are based on the clinical practice experience of the various authors. None of the systems have been empirically validated. Ask students how the lack of empirical validation may present problems in accurately assessing children’s sexual behaviors. *(Classification systems may be subjective and lack the objective data*

Introduction the classification systems by describing an early system that was developed by Berliner, Mana iOS, and Monastersky (1986) and Berliner and Rawlings (1991). Berliner et al. "use the term disturbance to reflect sexual behaviors that deviate from those expected as part of normal sexual development, although what is considered normal is not defined" (Araji, 1997, p. 26). The Berliner classification system consists of three levels of severity of sexual disturbances, based on objective behavioral criteria. The categories are inappropriate sexual behavior, developmentally precocious, and sexually aggressive or socially coercive. (Slide 76)

- **Inappropriate sexual behavior:** Typical behaviors include:
  - persistent masturbation; public masturbation; masturbation causing pain or irritations; touching breasts and genitals of others; asking others to touch child's genitals; repeatedly or publicly showing genitals; an excessive interest in sexual material and sexualized conversation, art, or conduct with others; and sexualization of nonsexual situations (Araji, p. 28).

  **Ask:** What criteria did Berliner et al. present for determining if the above behaviors represent psychological disturbances?
  
  (a) the behaviors occur in inappropriate situations, (b) the behaviors interfere with the child's development, (c) a persistence of the behavior remains despite intervention, (d) multiple sexual behaviors are reported, and (e) the behaviors are accompanied by other forms of disturbed behavior such as conduct disorders (Araji, p. 28).

- **Developmentally precocious:** Behaviors include the previously mentioned sexual behaviors, as well as simulated or completed intercourse. **Ask:** What factors distinguish this category? ("behaviors are explicit and intentional, but no coercion is present" and the behaviors "lie outside the range of what would be developmentally appropriate" [Araji, p. 28]). **Ask:** What characteristics did Berliner et al. (1986) suggest must be included in an evaluation to determine if the behaviors are developmentally inappropriate? Araji, 1997 noted the following:

  (a) the child's age, (b) family contacts, (c) information about how the behavior was learned, (d) frequency and persistence of the behavior, and (e) the extent to which the child has
continued access to sexually explicit materials or opportunities to see sexually explicit activity (p. 28).

- **Aggressive sexual contact and socially coercive:** The most severe category in the Berliner classification system consists of children who commit unacceptable, serious sexual behaviors. They use two terms to describe this category. *Aggressive sexual contact* "involves the use of physical force, including injury" (Araji, p. 28). *Socially coercive* "involves the use of threats or social coercion" (Araji, p. 28). Assessment and intervention are always warranted.

- **Ask:** What are the strengths and unique features of the Berliner classification system? Student responses should include the following strengths cited by Araji:
  - It assesses children's sexual behaviors "in reference to the developmental, familial, and interpersonal environments in which they are manifest" (p. 29).
  - It emphasizes the need to determine the "social contexts in which the behaviors occur" (pp. 28-29).
  - Emphasis is placed "on the relationship between sexual and psychological disturbances" (p. 29).

- **Ask:** What are the limitations of the Berliner classification system? *(Normal sexual behavior is not defined.)*

*Note to instructors:* The Araji chapter discusses several classification systems including systems developed by Gil (1993), Burton et al. (1998); Cunningham and MacFarlane, (1996), Pithers et al. (1993) and Ryan et al. (1993). Each of these classification systems can be discussed using a similar lecture/Socratic questioning format as described above for the Berliner classification system. However, the classification systems developed by the various authors can be more effectively presented through the use of active learning strategies. It is therefore recommended that instructors use student discussion groups to present the curriculum content of the other classification systems. Students will discuss an assigned classification system in a small group and determine how to present it to the class. This process is described below.

**Divide** students into the four discussion groups that were established earlier in this course. Assign each group a classification system to discuss, analyze, and present to the rest of the class.

- Assign Group 1 the classification systems developed by Gil (1993) and Burton et al. (1998). These two systems are quite similar. Inform

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Group 1 that they should also consult the Burton et al. text when reviewing their classification system, as their text provides updated information about their system that is not discussed in the Araji review of classification systems.

- Assign Group 2 the classification system developed by Johnson and Feldmeth (1993). Inform Group 2 that they should also consult Chapter 3 of the Gil and Johnson (1993) text, which was the original presentation of the Johnson and Feldmeth continuum of sexual behaviors reviewed by Araji.

- Assign Group 3 the Cunningham and MacFarlane (1996) and Pithers, Gray, Cunningham, and Lane (1993) classification systems. These two systems have similarities and can be analyzed together.

- Assign Group 4 the classification system developed by Ryan et al. (1993). Inform Group 4 that they should also consult Chapter 21 of the Ryan and Lane (1997) text, which includes a discussion of the Ryan continuum of sexual behaviors reviewed in the Araji text.

Allow the groups about 20 minutes to review their assigned classification system and to determine how to present it to the class. The groups should cover the following areas in their presentation: (a) identify the categories in the classification system, (b) describe the criteria for each category, (c) describe the strengths or unique features of the classification system, and (d) identify any limitations to the classification system. (This process was modeled above in the presentation of the Berliner classification system.)

Bring the groups back together and have them present their assigned classification system to the class. Make sure the groups cover the points discussed below for each classification system.

Discussion Group 1: Gil (1993); Burton et al. (1998); Matsuda and Rasmussen (1990); Rasmussen, Burton, & Christopherson, (1992) Classification Systems.

These classification systems are based on social criteria. They were adapted from previous work by Groth and Loredo (1981) and Sgroi, Bunk, and Wabrek (1988) who developed a set of social factors for assessing adolescents' sexually abusive behaviors.

- Gil (1993) identified three social factors that influence sexual development at each stage of development: peer contact, exploration, and inhibition. (Slide 77) Children show different socialization at each stage of development. See Table 1.2 in Araji text (p. 8). (Slide 78)

Preschool children (ages birth - 4 years) have limited peer contact, engage in self-exploratory sexual behaviors, and show self-stimulation and lack of inhibition.

Young school-age children (ages 5-7 years) have increased peer contact, engage in experimental interactions, desire privacy, and show inhibition.

Latency/preadolescent children (ages 8-12) have increased peer contact, engage in experimental interactions, and show varying degrees of inhibition/disinhibition.

- Gil proposed criteria to differentiate age-appropriate sex play from sexually abusive behavior: (Slide 79)
  - Chronological age difference (a 3-year age difference warrants concern).
  - Developmental age difference
  - Size differences
  - Status differences (e.g., babysitter and charge)
  - Type of sexual activity (i.e., view sexual behaviors on a developmental continuum)
  - Dynamics of sexual play or problematic sexual behaviors.

  Sex play is usually spontaneous and includes joy, laughter, embarrassment, and varying levels of inhibition and disinhibition. Problematic sexual behaviors have themes of dominance, coercion, threats, and force. Children involved in these behaviors appear anxious, fearful, angry, or intense. They demonstrate higher levels of arousal. The sexual behaviors may be habitual and become compulsive in nature. The behaviors are not responsive to parental or caretakers' limits or attempts to distract children from engaging in these behaviors (Araji, 1997, pp. 8-9).

- Burton et al. (1998), Rasmussen et al. (1992), and Rasmussen (in press) proposed a classification system that is similar to the Gil system. They proposed four abusive dynamics that distinguish sexually abusive behavior from age-appropriate sex play (Burton et al., 1998, p. 89). These dynamics are: (Slide 80)
  - Power differential - differences in age, size, intelligence, or physical ability.
• Intimidation - using differences in status or authority (e.g., babysitter and charge) to intimidate other children.

• Manipulation - influencing or controlling others' behavior with grooming behaviors such as "verbal persuasion, games, tricks, and bribes" (pp. 8-9).

• Coercion - using threats or force, hiding or covering up sexually inappropriate behavior, demanding victims to remain silent.

• Rasmussen's previous work (Matsuda & Rasmussen, 1990) included a classification system designed to help juvenile court workers in distinguishing types of children who commit sexually abusive behaviors and are referred for court intervention. This system classified children based on their age and motivation for sexual behavior: (Slide 81)

  • Sexually reactive child - "a child age eight and under (usually eight or nine) who displays sexually inappropriate behavior towards another which is often in reaction to his/her own sexual victimization and/or exposure to explicit sexual stimuli" (p. 2).

  • Preadolescent sexual offender - "a child 9 through 12, who displays sexually inappropriate behavior toward another which is harmful and unlawful" (p. 2).

  • Victim-perpetrator - "a child who is reacting to his or her own sexual victimization or exposure to explicit sexual stimuli or both" (p. 2).

  • Delinquent perpetrator - "a child who is not a prior victim of sexual abuse, but because of social inadequacy and personality or behavioral disorders or both, responds inappropriately to normal developmental sexual arousal" (p. 2).

  • Family perpetrator - "a juvenile who displays harmful or unlawful sexually inappropriate behavior against a younger sibling or other child living in his or her home or both" (p. 2).

• Strengths and unique features of the Gil (1993), Burton et al. (1998), Matsuda & Rasmussen (1990), and Rasmussen et al., (1992) classification systems: (Slide 82)

  • Both systems provide a comprehensive list of social criteria to use in assessing children's sexual behaviors and determining whether the behaviors are age-appropriate or sexually abusive.
The Gil system provides specific criteria for differentiating age-appropriate sex play in young children from sexually abusive behavior "by considering both the progressive nature of sexual development and the changes in environmental contacts" (Araji, 1997, p. 7).

The system described by Matsuda and Rasmussen (1990) "is the first of those reviewed thus far to use terms associated with the legal or criminal justice system to describe children who have crossed the boundary from normal to reactive to abusive sexual behaviors" (Araji, 1997, p. 31). It provides guidelines for juvenile justice personnel in their decision-making regarding placement and case management of children who commit sexually abusive behaviors and are referred to juvenile court.

- Limitations of the Gil (1993), Burton et al. (1998), Matsuda & Rasmussen (1990), and Rasmussen et al. (1992) classification systems: (Slide 83)

  - The Gil classification of behaviors expected in age appropriate sex play does not take into account variations in cultural groups. Araji (1997) noted, "using only sexual behavior as a measure of appropriateness [without considering cultural differences] can be misleading" (p. 8). Variations in behavior based on culture can be expected.

  - Burton et al.’s (1998) distinctions between sexually appropriate and inappropriate behaviors of preadolescent children were not clearly delineated in their earlier publication (Rasmussen et al., 1992). They first described sexually aggressive and sexually reactive children as separate types, but then used the term sexually reactive to refer to all children with sexual behavior problems. Their terminology was clearer in their later publication (Burton, et al.) when they defined children who exhibit harmful sexual behaviors as "children with sexually abusive behavior problems."

  - The classification system presented by Matsuda and Rasmussen (1990) used the terms appropriate and inappropriate sexual behavior, but "did not outline what specific sexual behaviors should be included in the appropriate category" (Araji, 1997, p. 29).


This classification system consists of a four-group continuum of sexual behaviors: normal sexual exploration (sex play), sexually reactive behaviors, extensive mutual sexual behaviors, and children who molest. Table 1.3 of the Araji text compares the four groups according to several dimensions provided by Johnson (1997, as cited in Araji, 1997, pp. 12-15). These dimensions include: type of sexual behaviors, intensity of sexual behaviors, sexual arousal, motivation, affect regarding sexuality, response to discovery, planning, coercion, relationship of others involved in sexual behaviors, age difference, interpersonal relationship characteristics, family/environment, possible etiological factors, and treatment. (Note: Instructors may wish to prepare overhead transparencies of Table 1.3 in the Araji text to illustrate Discussion Group 2’s presentation of the Johnson and Feldmeth Continuum.) This continuum is described below:

- **Normal sexual exploration** - Johnson and Feldmeth (1993, pp. 41-42) used the following indicators to determine if sexual behaviors are normal or appropriate: *(Slide 84)*
  - Sexual behavior is an "act of curiosity" (Araji, 1997, p. 10) involving self-exploration and gratification.
  - The children involved in sexual behavior "are similar in age, size, and developmental levels" (Araji, p. 10).
  - All children involved "engage in sex play voluntarily" (Araji, p. 10).
  - "The sex play involves children who have an amicable relationship outside of the sexual interaction" (Araji, p. 10). They generally "do not choose a sibling for sexual exploration" (Araji, p. 17).
  - "The sexual behaviors are limited in terms of types and frequency" (Araji, p. 10).
  - The children involved "are not preoccupied with sexual behavior" (Araji, p. 10).
  - When caught, the children may stop the sexual behavior in front of others, but may continue it in private. They may experience feelings of "guilt and embarrassment" when caught, but "generally do not express deep feelings of anger, anxiety, fear, or shame" (Araji, p. 10).
The children’s sex play is "usually spontaneous and lighthearted" (Araji, p. 10).

- **Sexually reactive behaviors:** Johnson and Feldmeth (1993, pp. 44-47, also cited in Araji, [1997] pp. 10-11) described "sexually reactive" children as follows: (Slide 85)
  - They demonstrate more sexual behaviors than children in the normal sexual exploration group do.
  - "Their focus on sexuality is out of balance in comparison to their age group" (Johnson & Feldmeth, p. 44).
  - Many have a history of sexual abuse and/or live in homes where they are exposed to sexuality through television, pornographic material, or observing sexual activities in their environment. They "have been overstimulated sexually, but cannot integrate these experiences in a meaningful way" (p. 45).
  - They are motivated to engage in sexual behaviors "by anxiety, overstimulation, a desire to understand previously witnessed sexual behaviors" (Araji, p. 16).
  - Sexual activities involve only themselves or other children of similar ages. They may sometimes choose a sibling for sexual exploration (Araji, p. 17).
  - They “do not seek out or use threats or force on their victims" (Araji, p. 11).
  - (Slide 86) Their sexual behaviors "often represent a repetition compulsion or a recapitualization (often unconscious) of previously overstimulated sexuality" (Johnson & Feldmeth, p. 45).
  - Reactions to being caught may be "deep shame, intense guilt, and pervasive anxiety about sexuality" (Johnson & Feldmeth, p. 45).
  - When caught, they "generally acknowledge the need to stop the behaviors and welcome help" (Johnson & Feldmeth, p. 45).

- **Extensive mutual sexual behaviors** - Johnson and Feldmeth (1993, as cited in Araji, 1997, pp. 11, 16) believed that a group of children exist who engage in sexual activities with peers. They described these children as follows: (Slides 87 & 88)
  - They "participate in the full range of adult sexual behaviors (oral copulation, vaginal and anal intercourse, etc.) generally
with other children of the same age range” (Johnson & Feldmeth, p. 47).

- They use persuasion, but not coercion or force to get other children to participate in sexual activity.
- They "are skilled at keeping their sexual activities secret" (Araji, p. 11).
- They may choose siblings for sexual encounters, but there is "no consistent status differential between the children involved" (Araji, p. 17).
- Their affect is distinctive from the other groups of children in Johnson and Feldmeth's continuum. It is not lighthearted and spontaneous, like normal children, shameful and anxious, like sexually reactive children, or angry, like children who molest. "Instead they display a blasé, matter-of-fact attitude toward sexual behavior with other children" (Johnson & Feldmeth, p. 48).
- Most have been sexually abused, and they often come from abusive, dysfunctional environments.
- Many are living in foster care or residential settings. "They have been chronically hurt or abandoned, frequently lack social or academic successes or both, and have a general distrust of adults" (Araji, p. 16).
- They are "motivated by sexual stimulation as well as coping with dependency needs" (Araji, p. 16).
- Many use sex as a "way of making friends or of coping with feelings such as loss, abandonment, fear, loneliness" (Araji, p. 11).
- They are less responsive to treatment than those in the sexually reactive group.

- **Children who molest** - This is the most severe category of Johnson and Feldmeth's continuum. The behavior of these children deviates the farthest from normative sexual behavior. They are difficult to treat and require specialized intervention. Their characteristics include: (Slides 89 & 90)

  - They participate in a full range of sexual behaviors: (i.e., "oral copulation, vaginal intercourse, anal intercourse, and/or forcibly penetrating the vagina or anus of another child with fingers, sticks, and/or other objects" (Johnson & Feldmeth, p. 48).

"Their thoughts and actions are pervaded by themes of sexuality" (Araji, p. 16).

Their sexual behaviors "continue and increase over time and are part of a consistent pattern rather than isolated incidents" (Johnson & Feldmeth, pp. 48-49).

Their sexual behavior has "an impulsive, compulsive, and aggressive quality" (Johnson & Feldmeth, p. 49). They are motivated to participate in sexual behavior "by a need to reduce feelings of fear, anger, or loneliness that have become associated with sexuality" (Araji, p. 17).

Coercion is always present. They seek out younger and more vulnerable children (both siblings and nonsiblings), whom they manipulate and coerce into participating in sexual activity.

They may use "social and emotional threats to keep their victims quiet" (Johnson & Feldmeth, p. 49).

They "seldom express any empathy for their victims" (Johnson & Feldmeth, p. 49).

They may be physically as well as sexually aggressive.

They may have a number of other problems including behavior problems at school, few outside interests, few friends, lack of problem-solving and coping skills, inadequate impulse control, and may show disturbed toileting behaviors (e.g., urinating and defecating outside the toilet; Johnson & Feldmeth, pp. 49-50).

Most have been sexually abused themselves. They come from dysfunctional environments that include emotional abuse, severe and unpredictable punishment by caretakers, sexual stimulation, lack of boundaries, physical violence between their primary caretakers, sexual abuse in the family history, physical abuse, and substance abuse (Johnson & Feldmeth, p. 50).

Strengths and unique features of Johnson and Feldmeth's (1993) continuum of sexual behaviors: (Slide 91)

- It describes the full range of children's sexual behavior problems from normal sexual exploration to coercive and aggressive sexual behavior.

- It is comprehensive in considering several dimensions in classifying different types of children.

Note to instructors: Inform students that Johnson's continuum was initially formulated in 1988, making it one of the earliest

classification systems developed to describe children's sexual behaviors. Johnson is currently conducting research to validate the continuum using the Child Sexual Behavior Checklist (CSBCL) Revised, an assessment measure that she has developed. The measure is a parent report consisting of a list of over 150 sexual behaviors, as well as questions about the child's background (Gil & Johnson, 1993, Appendix B, p. 329).

  - Like all classification systems reviewed in this section of the module, this continuum was derived from clinical practice experience and not from empirical research. It lacks objective validation of the clinically derived categories.
  - The continuum does not apply to all children. Johnson and Feldmeth (1993) cautioned that their continuum "applies only to children 12 and under who have intact reality testing and are not mentally retarded" (Araji, 1997, p. 17).
  - The continuum does not distinctly classify all children. "Some children may be on the borderline of the various groups or, over time, move between groups, or both" (Araji, p. 17).

**Discussion Group 3 - Cunningham and MacFarlane (1996) and Pithers et al. (1993) Classification Systems.**

These two classification systems are similar in using developmental stages to classify sexual behaviors.

- Cunningham and MacFarlane (1996) distinguished the stages of sexual development by age groups: ages 0-5, 6-10, and 10-12 and list normal and abnormal/abusive behaviors for each age group. See Table 1.4 in the Araji text (pp. 18-19). Instructors may wish to reproduce Araji's table on an overhead transparency to aid Discussion Group 3 in presenting this classification system. The characteristics of children in each of the three age ranges are described below:
  - Ages 0-5: the characteristics of normal sexual behavior include: *(Slide 93)*
    - Masturbation as self-soothing
    - Curiosity and exploratory touching self or others (no coercion)

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- Lack of inhibition in sexual behavior
- Interest in bathroom activities of self/others
- Talking about toilet functions
- Exhibiting genitalia
- Responding quickly to adult limit setting and redirection related to sexual behavior

Ages 0-5: the characteristics of abnormal/abusive sexual behavior include: *(Slide 94)*
- Obsessive preoccupation with sexual behavior
- Reenactment of past abuse in current behavior
- Masturbation involving injury to self
- Sexual behavior involving "coercion, threats, secrecy, aggression, violence, or developmentally inappropriate (precocious) acts" (Araji, 1997, p. 18).
- Inequality in age, size, authority, and lack of consent

Ages 6-10: normal sexual behaviors include: *(Slide 95)*
- Masturbation, although more secretive
- Showing interest in others' bodies through games (e.g., playing doctor)
- Comparing penis size
- Interest in sex, sex words, dirty jokes, swearing
- Seeking information about body functions

Ages 6-10: abnormal/abusive behaviors include: *(Slide 96)*
- Sexual penetration
- Genital kissing/oral copulation
- Simulated intercourse

Ages 10-12: normal sexual behavior includes: *(Slide 97)*
- Masturbation
- Sexual behavior with peers (e.g., kissing, fondling, and sexual penetration)
- Sexual activity may be heterosexual or same-sex

- Interest in bodies; looking at published material
  - Ages 10-12: abnormal/abusive sexual behavior includes sexual play with younger children. For any age group, sexual acts between children are considered abusive if they involve any of the following characteristics: (Slide 98)
    - Coercion
    - Aggression
    - Bribery
    - Secrecy
    - Significant age or peer difference
    - Developmentally inappropriate behavior
  
  Cunningham and MacFarlane (1996) also emphasized the importance of informed consent in determining whether a sexual interaction is abusive. They emphasized that a person may comply with a sexual behavior (i.e., passively behave without overt resistance) and cooperate with the behavior (i.e., participate regardless of belief or desire) without giving consent (Cunningham & MacFarlane, as cited in Araji, 1997, p. 20). The National Adolescent Perpetrator Network Task Force, 1988, as cited in Araji, 1997, p. 20), stated that consent includes: (Slide 99)
    - Understanding of the proposed behavior based on age, maturity, developmental level, functioning, and experience
    - Knowledge of societal standards related to the proposed behavior
    - Awareness of alternatives to and potential consequences of the proposed behavior
    - Assumption that agreements and disagreements will be respected equally
    - Voluntary decision
    - Mental competence

  Like Cunningham and MacFarlane's (1996) classification system, the system formulated by Pithers et al. (1993) is based on distinguishing problematic sexual behaviors from those considered developmentally normal.
    - In the Pithers system, normal sexual development consists of three stages: (Slide 100)

- 0-5 years: sexual curiosity, exploratory touching of self and others.

- 6-10 years: curiosity as shown by sexual games (e.g., playing doctor), telling dirty jokes, interest in their own and others' bodies.

- 11-12 years: some masturbation, but peer relationships are the primary focus. Sexual activities involve kissing and touching and "may be with either sex as long as the activity is mutual." Sexual activity with the same gender is not seen as indicating homosexuality" (Araji, 1997, p. 25).

Pithers et al. (1993) asserted that five factors determine whether a child's sexual behaviors are problematic. "Any one factor may or may not represent a sexual behavior problem" (Araji, p. 27). The factors are: (Slide 101)

- Would the type of sexual activities normally be expected at the child's level of development?

- Are the children involved of equal size and age?

- Substantial differences in age, size, IQ, or leadership ability constitute power differences.

- Are sexual activities mutual or coerced? Coercion may take place by intimidation (e.g., aggressive behavior, verbal threats); force; trickery (e.g., fake kindness, self-serving caregiving, threats to "tell on" the victim, games to access victim); bribes (e.g., use of gifts, money, favors, exchange of chores, or play activities), preplanning to take advantage of another, and use of the element of surprise.

- Does the type of secrecy involved fall outside of normal privacy levels? "Privacy is a rightful protection of one's personal space, whereas secrecy suggests that a child is avoiding the consequences of an action he or she knows or senses is wrong or causes harm" (Araji, p. 27).

- Is the behavior compulsive? (Child has no control over his or her behavior)

- Is the child preoccupied with the sexual behavior? (Obsessiveness)

Pithers et al. suggested the following criteria for deciding if a referral to treatment is necessary when a child displays problematic sexual behavior (Gray, 1996, as cited in Araji, 1997, p. 27): (Slide 102)

- The Department of Social and Rehabilitation Services (i.e., Child Protective Services) has substantiated sexual abuse by the child.
- The behavior, if performed by a juvenile, constitutes a sexual crime.
- The problematic sexual behaviors are observable and repetitive.
- The child refuses to comply when prohibited from continuing the sexual behavior.
- The sexual behaviors are coercive.
- The sexual behaviors are intrusive.
- There is a diversity of sexual behaviors.
- The sexual behaviors are "distracted, highly interruptive, and preoccupied" (Araji, p. 27).
- "Adult supervision is unsuccessful in extinguishing the sexualized behaviors" (Araji, p. 27).

Strengths and unique features of the Cunningham and MacFarlane (1996) and the Pithers et al. (1993) classification systems: (Slide 103)

- Both of these systems take a developmental focus and assess problematic sexual behaviors in the context of sexual behaviors that would be expected normally at each stage of development.
- The Pithers system describes the dynamics of sexually abusive interactions (e.g., power differences, coercion, secrecy), as well as factors that may motivate a child to continue to sexually act out (e.g., compulsiveness and obsessiveness).
- The Pithers system provides specific guidelines for determining when to refer children who display sexualized behavior to treatment.

Limitations of Cunningham and MacFarlane (1996) and Pithers et al. (1993) classification systems: (Slide 104)

- The use of terms in the Cunningham and MacFarlane (1996) classification system is not precise. They "use the terms abnormal and abusive interchangeably" (Araji, p. 17).

- Unlike the Johnson and Feldmeth continuum, the classification systems by Cunningham and MacFarlane and Pithers et al. do not differentiate different types of children.

Discussion Group 4 - Ryan and Blum (1994) and Ryan et al. (1993) typology of problematic sexual behaviors.

Like Johnson and Feldmeth (1993), Ryan et al. present a continuum of childhood sexual behaviors, with normal sexual behavior at one end and highly intrusive sexual behavior at the extreme end. *(Slide 105)*

- Ryan and Blum (1994) described criteria for determining if a child's sexual behavior presents a problem (Araji, 1997, pp. 20-21):
  - Problem for self - the child's sexual behavior puts the child at risk, interferes with other developmental tasks or relationships, is self-abusive, and the child believes the behavior is a problem.
  - Problem for others - the child's sexual behavior makes others uncomfortable, occurs at the wrong time or in the wrong place, conflicts with family and community values, is abusive, or all four.
  - Problematic – *(Slide 106)* the child's sexual behavior involves other children without their consent; the children are not equal; the child pressures or coerces the others.

- Ryan et al. (1993) formulated a typology of children's sexual behavior problems. Instructors may wish to reproduce an overhead transparency of Table 1.5 in the Araji text as an aid to Group 4 when they discuss Ryan et al.'s typology. Araji noted that this typology is "generally consistent with Johnson and Feldmeth's (1993) [Continuum of Sexual Behaviors]" (Araji, p. 21). The categories are:
  - *Normal sexual behavior* includes: *(Slide 107)*
    - Conversations with peers or similar-age siblings about genitalia or reproduction
    - Games (e.g., "You show me yours, I'll show you mine.")
    - Occasional masturbation without penetration

- Kissing, flirting
- Dirty words or jokes within norms accepted by peer group or culture

**Yellow flag behaviors** include: *(Slide 108)*
- Preoccupation with sexual themes
- Attempting to expose others' genitals
- Sexually explicit conversation with peers
- Sexual teasing
- Single occurrences of peeping, exposing, obscenities, pornographic interest, and frottage
- Preoccupation with masturbation
- Mutual masturbation/group masturbation
- Simulating foreplay with dolls or peers with clothing on (e.g., petting, French kissing)

**Red flag behaviors** include: *(Slide 109)*
- Sexually explicit conversation with children of a significant age difference
- Touching others' genitals
- Humiliating others with sexual themes
- Forced exposure of others' genitals
- Threats of force
- Sexually explicit proposals or threats
- Repeated or chronic peeping, exposing, obscenities, pornographic interests, frottage
- Compulsive masturbation/interrupting tasks to masturbate
- Masturbation including vaginal or anal penetration
- Simulating intercourse with dolls, peers, or animals

**No question behaviors** - this category includes the most severe and intrusive behaviors: *(Slide 110)*
- Oral, vaginal, anal penetration of dolls, children, and animals
- Forced exposure of others' genitals

- Simulating intercourse with peers with clothing off
- Any genital injury or bleeding not explained by accidental cause

- Ryan et al. (1993) asserted that type of sexual behavior is only one factor that must be considered when distinguishing normal from problematic sexual behavior. Other factors (consent, equality, and coercion) pertain to the nature of the relationship and interaction of those involved (Slide 111)
  - Consent was defined slightly differently by Ryan et al. (1993) than by Cunningham and MacFarlane (1996). It is based on a person's desires or beliefs and is distinguished from cooperation (participating without regard to desires and beliefs) and compliance (allowing something to happen without resisting, regardless of desires and beliefs). A child can cooperate or comply with an abuser's request without giving consent. Ryan et al. identified four aspects of consent (as cited in Araji, pp. 21-22): (Slide 112)
    - Similar understanding of the proposed behavior (no trickery, misrepresentation, or confusion)
    - Similar awareness of behavioral standards for family, peer group, or community
    - Similar awareness of possible consequences for the behavior
    - Respect for agreement or disagreement without repercussions
  - Equality according to Ryan and colleagues (Ryan, 1991, as cited in Araji, 1997, p. 23) refers to balance of power and control. Indicators of inequality include: (Slide 113)
    - Obvious indicators - age, weight, height, intellectual differences
    - Less obvious differences reflected by labels attached during play (e.g., doctor and patient) and degrees of self-esteem, popularity, and assertiveness.
  - Coercion was defined by Ryan et al. (1993) as "the pressures used to achieve compliance" (Araji, p. 23). Pressures range from privacy, to secrecy, to fear. Privacy reflects a "rightful lack of sharing," while secrecy reflects a "denial of sharing" (Ryan, 1997a, p. 399, as cited in Araji, 1997, p. 23). Secrecy "prohibits
external feedback, allowing sexual abuse to occur or continue or both and protects abusers from the consequences of disclosure” (Araji, p. 23). The continuum of pressure includes (Ryan, Ryan et al., as cited in Araji, p. 23): (Slide 114)

- No pressure
- Use of authority (manipulation, trickery, and peer pressure)
- Use of coercion, threats, and bribes
- Use of physical force or threat of harm

• Ryan et al. (1993) provided guidelines for parents to help them address their children's sexual behaviors. These guidelines include: (Slide 115)
  - Parents may need to "limit, redirect, or educate children about normal or typical behaviors that may occur as children seek an understanding of their bodies, sexuality, and relationships" (Araji, p. 21).
  - Parents should talk to their children about the private nature of sexual behavior and model open communication in discussing sexual development.
  - Parents should promote empathy by talking to their children about "the feelings others have when they are the victims of abusive behaviors" (Araji, p. 21).

• Strengths of Ryan and Blum (1994), Ryan et al. (1993) classification system: (Slides 116 & 117)
  - It combines aspects of all the preceding classification systems. Like the Johnson and Feldmeth (1993) system, it presents a continuum of sexual behaviors. Like the classification systems proposed by Gil (1993), Burton et al. (1998), Cunningham and MacFarlane (1996), and Pithers et al. (1993), it emphasizes the social aspects of the interaction between the children involved in a sexual activity.
  - It explains the dynamics of sexually abusive interactions (i.e., consent, equality, and coercion).
  - It is the only system to include guidelines for parents.

In their initial presentation of their continuum, Ryan et al. did not specify which social factors needed to be present for each of the categories in the continuum. Araji (1997) noted that later writings and presentations by Ryan and colleagues provided additional details about social factors:

- Yellow flag behaviors may be accompanied by any combination of manipulation, including peer pressure, trickery, and secrecy.
- Red flag behaviors and no question behaviors include use of coercion and threats.
- "Any sexual behaviors that involve the use of physical force, violence, or threats must be considered abusive" (p. 24).
- Sexual behaviors committed by children that would be considered illegal for an older person are clearly deviant, potentially harmful, and "should always result in consideration of reporting and referral" (p. 24).

Present: After all four groups have completed their presentations, ask students to discuss the benefits of using a classification system to determine if children's sexual behaviors are within expected developmental norms or are problematic. Emphasize that classification systems are useful in understanding and explaining the diversity of children who have sexual behavior problems and in identifying different levels of severity. Classification systems provide a rational method for distinguishing severely disordered children who commit intrusive and harmful sexual acts from children whose sexual behaviors are less problematic or are normative for their stage of development. Encourage students to evaluate which of the classification systems presented would be the most informative to use when assessing children who are referred to treatment for sexual behavior problems.

Refer students to Table 1.6 on pages 36-37 of the Araji (1997) text, Identifying Characteristics of Children 12 Years of Age and Younger Who Exhibit Sexual Behavior Problems. Note that it is important to be familiar with the characteristics listed by Araji in the table. Module IV will discuss how to use knowledge of the individual characteristics and family dynamics of sexually abusive children to make a comprehensive clinical assessment. Summarize the discussion of classification systems by pointing out that a classification system can be a tool in an assessment for identifying whether the characteristics listed by Araji in Table 1.6 are present in a particular child. Review the characteristics listed by Araji:

• **Characteristics of sexually aggressive behaviors**--Araji emphasized that sexually aggressive behaviors: *(Slides 119 & 120)*
  - Exceed those expected for age of abuser (e.g., oral or vaginal intercourse, forcible penetration of vagina or anus).
  - Involve use of force, coercion, and/or secrecy. Coercion may involve (a) use of physical force or threats to use force or a weapon, or (b) social threats (e.g., bribes, trickery, persuasion, intimidation, peer pressure).
  - Increase over time, become repetitive, obsessive, and/or compulsive. Represent a pattern rather than isolated events.
  - May be planned, calculated, and predatory.
  - May be associated with other antisocial behaviors.
  - Continue despite intervention.
  - May be criminal in nature (*"if the abuser knows the behavior is inappropriate and is associated with negative consequences,"* [Araji, p. 36]).

• **Motives for sexually aggressive behavior**--include needs that: *(Slide 121)*
  - Reduce negative feelings (e.g., fear, anger, loneliness).
  - Gain power and control.

• **Self-control**--sexually aggressive children: *(Slide 122)*
  - Demonstrate little self-control in their sexual behavior.
  - Tend to be impulsive or compulsive in their behaviors.

• **Emotions demonstrated by sexual aggressors**--sexually aggressive children: *(Slide 123)*
  - Demonstrate deep feelings of anger, rage, fear, shame, and loneliness.
  - Associate deep emotions with sex and aggression (Johnson & Feldmeth, 1993; Friedrich 1990, as cited in Araji, p. 37).
  - Lack empathy for victims.

• **Abuser-victim relationship: Equality, power, and control**--sexually aggressive children: *(Slide 124)*
  - Choose victims who appear weaker, more vulnerable, and have differences in age (2-5 years), size, status, intelligence, cognitive development, physical ability, unmet needs, etc.

Choose victims who are siblings, other children living in the home, schoolmates, or friends. Victims may be younger, but the abuser has some type of authority or power over them.

- **Abuse histories**—sexually aggressive children: *(Slide 125)*
  - May have been sexually abused.
  - Usually have been abused in some way—sexually, physically, emotionally, or all three.

- **Environments** of sexually aggressive children: *(Slide 126)*
  - Lack sexual boundaries in the home.
  - May include frequent exposure to pornography.
  - May include parents or caretakers who have substance abuse problems or other parental dysfunctions.
  - Include environments outside the home that are conducive to socializing children into sexually aggressive activities.

- **Treatment outcomes**—Araji noted that sexually aggressive children are more resistant to treatment than other children with sexual behavior problems and need intensive intervention. *(Slide 127)*

**Present:** Araji (1997) included a section in Chapter 2 devoted to a discussion of whether children with sexually abusive behavior problems should be referred to the juvenile justice system. Araji indicated that some treatment programs (e.g., *It's About Childhood*, a treatment program coordinated by Jan Hindeman) consider a sexually abusive child to have committed a criminal act if the child "knows the behavior is inappropriate and associated with punishment (i.e., the child acts with criminal intent)"; [Araji, p. 37]).

- Ask students to consider whether children with sexually abusive behavior problems should be referred to juvenile court for criminal prosecution. This should stimulate a lively debate. Encourage arguments on both sides. Criminal prosecution in juvenile court can hold sexually abusive children accountable for their behavior and ensure that parents comply with treatment. However, young children are ordinarily not viewed as criminally culpable.

- Note to instructors: The Araji text contains several opinions by various professionals in the child abuse field on this issue (e.g., Lucy Berliner, Dave Fowers, William Friedrich, Eliana Gil, Jan Hindman, Lucinda Rasmussen, and Gail Ryan). Instructors may wish to use some of these opinions to reinforce points brought up by the students in their discussion.
A useful quote to summarize the issue about whether to refer children with sexually abusive behavior problems to juvenile court is this statement by Rasmussen (1996, as cited in Araji, 1997, p. 42):

juvenile justice intervention with preadolescent children is only advisable when the philosophy of the local juvenile justice system supports treatment and rehabilitation. If the focus of court intervention is directed more toward imposing negative consequences than treatment, adjudicating a preadolescent child in juvenile court is not helpful and may in fact be detrimental.

Present: The classification systems that have been reviewed were all derived through clinical practice experience. Two recent studies (Hall et al., 1998; and Pithers et al., 1998) have presented empirically derived classification systems for children with sexual behavior problems. Ask: What are the advantages of an empirically derived classification system over a classification system derived through clinical practice experience? (Clinically derived classification systems are subject to bias. Empirical validation provides an objective way to describe the diversity of children with sexual behavior problems and gives data to confirm or disconfirm clinical impressions.)

Present: In an exploratory pilot study, Hall et al. (1998) gathered data from the clinical records of 100 sexually abused children (37 boys and 63 girls) ages 3-7 years who were enrolled in two treatment programs. The study endeavored "to develop instruments for further research (on children with sexual behavior problems) and clinical use and to lay the groundwork for future hypothesis development and testing" (p. 1057). Hall et al. coded data on approximately 350 areas related to the child's functioning and family history, the sexual abuse experience, and treatment outcome. They included in their coding contextual characteristics (e.g., non mutuality, harm/discomfort caused in others or self, complaints by others, differential power, persistence despite limit setting by others, coercion/bribery, force/threat of force, premeditated planning, extensive adult-type sexual behavior). Based on this review, the children were grouped and compared according to their presenting sexual behavior into three groups. Ask: What are the characteristics of these groups? (Slide 128)

- **Developmentally expected sexual behavior** (n = 22)
- **Sexualized behavior** (n = 15): "children who exhibit developmentally problematic sexualized interests and/or behaviors which are exclusively 'self-focused,' that is, no problematic sexual contact/touch" (p. 1050).

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• **Interpersonal problematic sexual behavior** *(n = 62)* - "children who engage in developmentally problematic sexual contact/touch with others, with or without developmentally problematic self-focused/sexualized interests or behaviors" (p. 1050).

- **Present**: Hall et al. (1998) calculated descriptive statistics and cross-tabulations between each variable and the three sexual behavior groups. They then chose 40 variables that showed the largest difference in percentages between the three groups for further statistical analysis. Chi square analyses were conducted on these 40 variables. This bivariate analysis revealed 20 variables that were statistically significant and best distinguished between children with sexual behavior problems and children with developmentally expected sexual behavior. These were:

  - **Sexual abuse experience of the child**: *(Slide 129)*
    - Sexual arousal of the child during the abuse
    - "Grooming" of the child by the perpetrator
    - Sadistic acts by the perpetrator
    - Child was required to watch perpetrator in sex acts
    - Child was required to be "actively involved" in abuse
    - Who the child blamed for the abuse

  - **Child characteristics**: *(Slide 130)*
    - Lack of warmth/empathy
    - Restricted range of affective expression
    - Hopelessness/depression
    - Pseudomaturity
    - Nonsexual boundary problems
    - Appearance of sexualized gestures
    - Frequent or compulsive masturbation

  - **Child's history**: *(Slide 131)*
    - Physically abused
    - Emotionally abused
    - Permanent loss of father
    - Role reversal, inappropriate parent/child roles

  - **Caregiver characteristics--mother shows**: *(Slide 132)*

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- Chronic stress/PTSD symptoms
- Boundary problems
- A history of childhood physical neglect

**Ask:** What can be concluded from the bivariate findings of the Hall et al. (1998) study? *(The following variables increase the risk that a child will develop sexual behavior problems): (Slides 133 & 134)*

- Intense experiences during sexual abuse (e.g., being sexually aroused during the abuse, experiencing sadism from the perpetrator, being forced to participate in sexual activities, having ambivalence about who to blame for the abuse).
- Characteristics such as lack of empathy or feelings of hopelessness and depression
- A history of physical or emotional abuse
- Having a caregiver who reverses parent/child roles, has boundary problems, shows chronic stress or PTSD symptoms, or has a history of neglect

**Present:** Hall et al. (1998) used a logistic regression model to identify factors that were predictive of interpersonal sexual behavior problems. **Ask:** Which variables emerged as most predictive of interpersonal sexual behavior problems? *(Slide 135)*

- Perpetrator's use of sadism during the child's sexual abuse
- Physical abuse history of the child
- Serious emotional abuse history
- Sexual arousal of the child during the abuse. "[The] odds that a child who experienced sexual arousal would go on to engage in problematic interpersonal sexual behavior were more than 15 times higher than a child who had not experienced sexual arousal" (Hall et al., 1998, p. 1053).

**Present:** Hall et al. (1998) also completed a discriminant function analysis to determine if there were critical variables which could differentiate among the three groups and distinguish children who were sexualized (self-focused) from children with interpersonal behavior problems. **Ask:** Which variables were found to be most predictive of group membership? *(Slide 136)*

- Sexual arousal of the child during sexual abuse
- Who the child blamed for the abuse
- The use of sadism by the perpetrator

• Lead students in a discussion of the findings of the Hall et al. (1998) study. **Ask:** What do the findings suggest about risk factors for developing sexually abusive behavior problems? Make sure that the students touch on the following points in their discussion: *(Slide 137)*

- Sexual arousal during sexual abuse is associated with the development of sexualized (self-focused) behaviors and interpersonal behavior problems. Hall et al. (1998) noted:
  - Perpetrators may groom children to experience sexual arousal in order to get the child to actively participate in the sexual behavior with the perpetrator or in sexual interactions involving themselves and other children.
  - Sexual arousal may contribute to the child feeling guilty and ashamed about the abuse, which may cause the child to be reluctant to disclose the abuse.

- Perpetrator sadism may increase the risk of developing sexual behavior problems by the creation of a "trauma bond." The perpetrator creates fear and discomfort, but also relieves the discomfort. Children who experience a trauma bond with their perpetrator may be more at risk to develop sexual behavior problems.

- There was a relationship in the Hall et al. (1998) study between sexual arousal, the pain and discomfort experienced during the abuse, and whom the child blamed for the abuse:
  - Children who experience pleasure and arousal during their sexual abuse may tend to blame themselves and not blame the perpetrator.
  - Children who experience discomfort and pain may tend "to place blame on their abuser, which in turn reduces self-blame" (p. 1055).
  - Children who experience both pain/discomfort and pleasure simultaneously may be ambivalent about whom to blame for their abuse. At times they may blame the perpetrator, at other times themselves.

- Hall et al. (1998) supported their opinion by analyzing the children in their sample: *(Slides 138, 139, 140)*
  - Children with developmentally expected sexual behavior experienced no sexual arousal and no sadism. They did experience some pain, discomfort, and fear. They tended to blame the perpetrator.

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- Children with sexualized (self-focused) behavior were more likely to have been sexually aroused, but experienced less pain, discomfort, and fear and less sadism than children with interpersonal sexual behavior problems. They were either ambivalent about who to blame for their abuse or blamed themselves.

- Children with interpersonal sexual behavior problems endured the most pain, discomfort, fear, and sadism and experienced the most sexual arousal. They were mostly ambivalent about who to blame for their abuse.

  - Hall et al. (1998) noted that children who are actively involved in a sexual interaction may be more self-blaming, less likely to disclose the sexual abuse, and more likely to identify with the offender and continue inappropriate sexual behavior. The following variables place a child at risk for sexual behavior problems: *(Slide 141)*
  - Being groomed by the perpetrator
  - Watching the perpetrator in sexual acts
  - Being actively involved in the sexual abuse

  - Variables that were not statistically significant "may not be the most fundamental variables associated with sexual behavior problems" (p. 1057). These variables included: *(Slide 142)*
    - Physical intrusiveness of the sexual acts
    - Duration of the abuse
    - Nature of the child’s relationship to the offender

  - History of child maltreatment and other environmental factors were important in increasing risk for interpersonal behavior problems. Hall et al. (1998) observed that children with interpersonal sexual behavior problems: *(Slide 143)*
    - Experienced multiple maltreatment experiences (i.e., physical abuse, emotional abuse) at a rate nearly double found in the other two groups.
    - Were more likely to have experienced permanent loss of their father.
    - Had more complete role reversal with their parent or caregiver than children in the other two groups.
    - Frequently had caregivers who "had sustained multiple forms of childhood maltreatment" (p. 1056).
- Were more depressed, less empathic, and showed a restricted range of affective expression.

**Summarize** the Hall et al. (1998) findings: *(Slide 144)*:

- "The family environment of children with interpersonal sexual behavior problems is not only more abusive physically and emotionally, but also the boundaries regarding the rights of others, privacy, sexuality, and autonomy appear to be more problematic" (p. 1056).

- "The nature of the sexual abuse experience itself and the response of that child to that experience" (p. 1056) are critical factors in determining whether a sexually abused child will develop interpersonal sexual behavior problems.

- The family environment may function "as a mediator between the abuse experience, the child's attributions, and later outcomes" (p. 1057).

**Ask:** What limitations do you see in the Hall et al. (1998) study? Students should mention the following: *(Slide 145)*

- The authors of the study coded the data themselves and did not calculate interrater reliability.

- Data gathering was limited by the quality of the record keeping of the treatment programs from which the sample was drawn. The authors experienced difficulty in understanding clinical notes.

- The retrospective nature of the study limits conclusions about cause and effect relationships.

- The authors used a clinical sample that does not necessarily represent all sexually abused children.

- The sample was primarily Caucasian and does not represent more diverse groups of abused children.

- The authors developed the instruments used in the study; standardized measures were not used.

- Males and females were grouped together, preventing an analysis of sex differences.

**Ask:** What implications does this study have for clinical practice? Students should mention at least the following points: *(Slides 146, 147, 148)*

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- Children with sexual behavior problems differ in type and level of sexual behavior displayed, as well as their individual characteristics and environmental influences. This suggests a need for differential assessment and individualized treatment approaches" (Hall et al., p. 1059).

- Interventions with sexually abused children need to focus attention on their physiological and sexual arousal, attributions of responsibility for the abuse, and thoughts and feelings about the abuse experience.

- "Sexual arousal in the child may be associated with self-blame or ambivalence" (p. 1059). Therapists need to create permissive environments in therapy to allow sexually abused children to express their feelings about having been sexually aroused during their abuse.

- Children who exhibit self-focused sexualized behaviors have problems in their functioning and in their family dynamics. They, like children who exhibit interpersonal sexual behavior problems, should receive early therapeutic intervention.

- Family and caretaking variables are important influences.

- Treatment of children with sexual behavior problems should include the family whenever possible. Caregivers should receive therapeutic assistance for their own child maltreatment issues.

- Concise, user-friendly assessment tools are needed by child welfare and mental health workers to assess which sexually abused children are most at risk to develop sexual behavior problems. The five predictor variables identified in the Hall et al. (1998) study may assist in determining risk and referral priorities for treatment.

**Present:** Another recent study (Pithers et al., 1998) developed an empirically derived typology of children with sexual behavior problems. Pithers et al. studied 127 6- to 12-year-old children who were referred for treatment for exhibiting problematic sexual behaviors which were "(a) repetitive; (b) unresponsive to adult intervention and supervision; (c) equivalent to adult criminal violations; (d) pervasive, occurring across time and situations; or (e) highly diverse, consisting of a wide array of developmentally unexpected sexual acts" (p. 386). (Slide 149)
A 2-hour clinical interview was conducted at intake with the children and their parents. The children and their parents completed several standardized measures. Data for the study were gathered from the following measures: **(Slide 150 - construct Table):**

- **Parent Report Measures:** (of children’s behavior)
  - Child Behavior Checklist (CBCL; Achenbach, 1991)
  - Child Sexual Behavior Inventory--Third Edition (CSCI-3) (Friedrich, 1995; Friedrich et al., 1992)
  - Eyberg Child Behavior Inventory (ECBI) (Eyberg & Ross, 1978)

- **Parent Self-Report Measures:**
  - Parenting Stress Index (PSI; Abidin, 1990)

- **Child Self-Report Measures:**
  - Children's Action Tendency Scale (CATS; Deluty, 1979)
  - State-Trait Anxiety Inventory for Children (STAIC; Spielberger, 1973)

- **Teacher Self-Report Measures**
  - Teacher Report Form (TRF)

- **Statistical methods used included the use of cluster analysis multivariate analysis of variance (MANOVA), and analysis of variance (ANOVA).** **Ask:** What is the purpose of cluster analysis and why did Pithers et al. (1998) decide to use it as a statistical method in this study? **(Slide 151)**
  
  - Cluster analysis identifies homogenous groups of cases based on selected characteristics.
  - Variables are selected for cluster analysis based on a theoretical conceptualization about characteristics that might unify or distinguish study participants.
  - Pithers et al. (1998) wanted to "define a taxonomy" or identify distinct types of children with sexual behavior problems" (p. 386). They believed three types of children with sexual behavior problems might exist: nondisordered, highly maltreated and traumatized, and conduct disordered and delinquent.

- **Ask:** What factors were considered by Pithers et al. (1998) in selecting variables to enter into the cluster analysis? **(Slide 152)**
  
  - Extensiveness of maltreatment

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- Level of psychopathology (presence or absence of psychiatric diagnoses, such as post-traumatic stress disorder [PTSD] or oppositional defiant disorder [ODD])
- Extent of nonsexual aggressiveness
- Frequency of sexual activity
- Amount of aggression evident in sexual behaviors
- Intrusiveness of the sexual behavior
- Frequency of delinquent behaviors

**Present:** The cluster analysis performed by Pithers et al. (1998) identified five subtypes of children with sexual behavior problems. (Slide 153) The authors assigned the following descriptive labels to these subtypes: sexually aggressive, nonsymptomatic, highly traumatized, rule breaker, and abuse reactive. **Discuss** the five subtypes. **Refer** students to Table 3 (p. 390) and to the discussion on pages 399-401:

- **Ask:** What were the characteristics of the sexually aggressive subtype? *(Slides 154 & 155)*
  - Males were overrepresented.
  - CBCL: scored borderline clinical on the externalizing score and total score and normal range on the internalizing score.
  - Psychiatric diagnoses included conduct disorder (highest percentage) and attention deficit hyperactivity disorder (ADHD).
  - Had the lowest mean of perpetrators who had abused them sexually or physically.
  - Were the oldest children at the onset of sexual problems.
  - Had the greatest percentage that penetrated their victims and committed the highest percentage of penetrative acts.
  - Used aggression to gain victim submission.
  - Parents considered their behaviors less problematic than their teachers did.
  - Most frequently acted out sexually in settings other than their homes.

- **Ask:** What were the characteristics of the nonsymptomatic type? *(Slide 156)*

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- Females were overrepresented.
- Were within normal range on most measures.
- Were the least likely to be diagnosed with a psychiatric disorder.
- Acknowledged their own sexual abuse, but rarely had been physically abused.
- Had the fewest number of victims.
- Rarely used force in their sexual acts.

**Ask:** What were the characteristics of the highly traumatized type? *(Slide 157 & 158)*

- Males and females were proportionately represented.
- Were younger than any other type.
- CBCL: were in the clinical range on the externalizing score and total score and in the borderline clinical range on the internalizing score.
- Prevalent psychiatric diagnoses were PTSD (highest percentage) and ADHD.
- Had extensive history of child maltreatment, including the highest number of sexual abusers, highest number of physical abusers, and highest total number of abusers.
- Had a shorter interval between their own experience of maltreatment and their first instance of sexual acting out.
- Had the second highest number of sexually abusive acts against others and the highest mean number of victims.
- Did not penetrate their victims.
- Parents reported problems in feeling attached to their children.

**What were the characteristics of the rule breaker type? *(Slides 159 & 160)*

- Females were overrepresented.
- CBCL: had the highest scores on the externalizing, internalizing, and total scores. Also had the highest mean CSBI-3 score.
- Prevalent psychiatric diagnoses were ADHD, ODD, and conduct disorder.

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- Acknowledged their own sexual abuse, had a moderate history of physical abuse, and had the highest percentage of extended families with an additional sexual abuser.
- Had the longest time between their own abuse and the onset of sexual behavior problems.
- Had the most frequent sexualized behavior of any type.
- Used aggression to gain victim submission.
- Rarely used penetration.

**Ask:** What were the characteristics of the abuse-reactive type? *(Slides 161 & 162)*

- Males were overrepresented.
- CBCL: scored in the clinical range on the externalizing, internalizing, and total scores.
- Highest percentage receiving an ODD diagnosis. Other diagnoses were ADHD and conduct disorder.
- A high percentage had been sexually abused and a moderate percentage had been physically abused.
- Had the shortest time period between their first victimization and their first incident of sexual acting out.
- Had the highest number of sexually abusive acts against others.
- Occasionally used aggression, but rarely penetrated their victims.
- May be sexually aggressive children at an earlier stage of development.

**Present:** Pithers et al. (1998) also presented preliminary findings related to treatment outcome. The children were randomly assigned to two treatment conditions: expressive therapy and cognitive-behavioral treatment (modified relapse prevention). **Ask:** After 16 weeks in treatment, which treatment condition was most effective? *(Slides 163 & 164)*

- Highly traumatized children derived significantly more benefit from a cognitive-behavioral intervention (modified relapse prevention) than from expressive therapy (use of metaphors and indirect activities).
A greater percentage of nonsymptomatic and abuse-reactive children showed clinically significant reductions in their sexual acting out behavior from relapse prevention treatment than from expressive therapy.

Sexually aggressive children showed relatively little change after 16 weeks in either treatment condition; some showed deterioration in expressive therapy.

**Ask:** According to Pithers et al. (1998, p. 402), why was relapse prevention a more effective treatment for highly traumatized children than expressive therapy? Remind students that relapse prevention:

(Slide 165)

- Provides a predictable structure in which concepts are stated directly rather than acquired gradually and experientially through indirect methods (e.g., by metaphors and creative activities).
- Helps traumatized children immediately acquire self-soothing behaviors to reduce anxiety and distress.
- Helps improve attachment between parents and children by meaningfully and positively involving parents in helping the child eliminate sexually abusive behavior.
- Helps parents and children create a support network of individuals who are informed about the child's problems, have regular contact with the child and family, and can help the child manage his or her sexual behavior.

**Ask:** What are the contributions of the Pithers et al. (1998) study to research on children with sexual behavior problems? Students should mention that the study:

(Slides 166, 167, & 168)

- Showed it is possible to empirically define subtypes of children with sexual behavior problems with unifying and differentiating characteristics.
- Offered a preliminary comparison between cognitive-behavioral and expressive therapies.
- Showed that children who were described as highly traumatized (i.e., had an extensive history of child maltreatment and showed PTSD symptoms) benefited more from cognitive-behavioral than expressive therapy.
- Showed that parental attachment to children increases potential success in treatment--children whose parents felt more attached to them did better in therapy.

Suggested that "insecure attachment of parents and children may be a potent intervening variable that could explain the link between child maltreatment and adolescent delinquency and adult criminality, including sexual offenses" (Widom, 1995, as cited in Pithers et al. 1998, p. 404).

Emphasized the importance of providing intervention to parents to help them address their own therapeutic issues, improve their coping skills, and improve their ability to provide "caring oversight" to their children (Pithers et al., 1998, p. 406).

**Ask:** What are limitations to this study? (Slide 169)

- The sample sizes in the two treatment conditions were small.
- Conclusions were stated about effectiveness of the therapy after only 16 weeks in treatment.
- Replication of this study with larger, more diverse samples in different geographic locations and cross-validation of the taxonomy are necessary before it can be implemented clinically.

**Summarize** the research section by indicating that new research is emerging that provides empirical criteria for classifying children with sexual behavior problems. Classification systems, if informed by clinical research, can help identify diverse characteristics within the population of children with sexual behavior problems, provide differential assessment data, and aid in individualized treatment planning. Note that Modules III and IV will provide increased knowledge about the characteristics of sexually abusive children and their family dynamics. These modules will help students develop skills in assessing child and family functioning, conceptualizing and understanding each case, and formulating individualized treatment plans with specific short-term and long-term goals.

C. **Group Activity: Case Vignettes.** Divide students into the four discussion groups established earlier. Give each group a set of four case vignettes (Handout 2). Ask the groups to discuss the vignettes and to apply some of the clinical classification systems discussed earlier to the vignettes, or apply the findings of the Hall et al. (1998) or Pithers et al. (1998) to the vignettes. Allow the groups about 20 minutes for this activity. Rotate from group to group to ensure that students understand how to apply the classification systems. Students may use any of the classification systems that have been presented and discussed (i.e., Berliner; Cunningham and MacFarlane; Gil [1993]; Burton et al. (1998); Johnson and Feldmeth (1993); Pithers et al. [1998]; or Ryan et al.). The activity’s purpose is simply to give students an opportunity to think about the classification systems in

a practical sense. The case vignettes presented at the end of the Pithers et al. article may be used. Alternatively, instructors may want to create their own vignettes, or use some of the case vignettes that were adapted from the introduction to the curriculum manual and are described below. Students should make conclusions regarding classification based on the information given in the vignettes. If they lack the necessary information to make a determination, they should note the information that they think they would need in order to make an accurate classification.

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Social Work Practice with Child Sexual Abuse Victims and Youthful Offenders

An MSW Elective Proposal

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San Diego State University
School of Social Work

A. Purpose of Course

This second-year MSW elective builds upon first-year micro practice courses. This course is meant to give social workers the theoretical knowledge and specialized skills necessary for interpersonal practice with child victims of sexual abuse, children with sexually abusive behavior problems, and juvenile sexual offenders. It is designed to be integrated with the Human Behavior elective, "The Psychosocial Development of Vulnerable Children." Whereas the Human Behavior course focuses on identifying and understanding developmental issues pertaining to abused children, this course focuses on developing assessment and intervention skills to enable students to practice with children and adolescents who have experienced or perpetrated sexual abuse. It addresses the topic of child sexual abuse holistically by identifying practice models and teaching skills to be used in micro practice with victims, offenders, and their families.

B. Objectives of Course

1. Knowledge Objectives: Students will have:
   a. Understanding of the potential acute negative effects of child sexual abuse on the cognitive, emotional, and behavioral functioning of abused children.
   b. Understanding of the potential long-term negative impact of child sexual abuse on cognitive, emotional, and behavioral development through the lifespan.
   c. A working knowledge of recent research findings about child victims of sexual abuse, children with sexually abusive behavior problems, and juvenile sexual offenders.
   d. A working knowledge of individual psychopathology sometimes associated with a history of child sexual abuse (e.g., post-traumatic stress disorder, depression, dissociative disorders, personality disorders).

e. A working knowledge of dysfunctional family dynamics commonly displayed in families with members who display sexually abusive behavior.

f. A working knowledge of the interactional dynamics of abusive behavior (i.e., differences in power, misuse of authority, manipulation, and coercion).

g. A working knowledge of adaptive and maladaptive responses to experiencing sexual abuse (e.g., Trauma Outcome Process, sexual abuse cycle).

h. Understanding of etiological theories of sexual assault.

i. A working knowledge of how psychodynamic, social learning, cognitive-behavioral, and family systems theories can be used to assess sexual abuse victims and offenders and to plan interventions.

j. A working knowledge of specific theoretical frameworks used to understand and assess child victims and child and adolescent perpetrators of sexual abuse (e.g., post-traumatic stress disorder model, traumagenic dynamics of sexual abuse model, Trauma Outcome Process model).

k. Understanding of cultural factors that influence the development and perpetration of sexual violence.

2. Skill Objectives: Students are expected to demonstrate their utilization of knowledge with practice skills in the following ways:

a. Demonstrate skill in using various practice models to treat child victims of abuse (e.g., crisis intervention, play therapy, cognitive restructuring, stress inoculation, trauma outcome process model).

b. Demonstrate skill in using various practice models to treat children with sexually abusive behavior problems and juvenile sexual offenders (e.g., sexual abuse cycle model, relapse prevention model, Trauma Outcome Process model).

c. Apply the structural family therapy model to treating families with members who display sexually abusive behavior.

d. Demonstrate skill in implementing appropriate self-care strategies to deal appropriately with the personal impact of working with abuse issues, including managing counter-transference reactions and preventing burnout.

3. Values and Beliefs Objectives: Students will have:
   a. Increased awareness of cultural diversity in social work practice with sexually abused children, children with sexually abusive behavior problems, and juvenile sexual offenders, as it relates to barriers they may encounter and needs they may have as a result of age, gender, race or ethnicity, national origin, socioeconomic class, sexual orientation, religion, or disability.
   b. Increased awareness of factors that personally impact the clinician who treats sexually abused children, children with sexually abusive behavior problems, and juvenile sexual offenders.
   c. Increased awareness of social work values and ethics as they relate to practice with individuals and families who have sexual abuse issues.

C. Textbooks and Readings


D. Suggested Assignments

1. Select a client from your field placement who has sexual abuse issues (i.e., either a victim of abuse or a sexual abuse perpetrator). If the client is a victim, assess the immediate and long-term effects of the abuse on the client's cognitive, emotional, and behavioral functioning. If the client is a perpetrator, assess the abusive interactional dynamics involved in the client's sexually abusive behavior. If the client is both a...
perpetrator and a past victim, discuss the motivating factors that resulted in a victim becoming a victimizer. Identify and discuss the client's family dynamics. From the perspective of a theoretical framework of your choice, discuss the etiology of the client's current sexual abuse issues and the adaptability of the client's responses to past traumatic events. Choose a practice model to address the client's abuse issues and give your rationale for why you chose it. Establish a treatment plan with immediate, short-term, and long-term goals and interventions based on practice theory. Discuss the interventions that you plan to use.

2. Using Minuchin's structural family therapy model, describe and analyze the dynamics of a family with sexual abuse issues with whom you are working at your field placement. Discuss how you would apply intervention strategies from the Minuchin model to address dysfunctional family dynamics, improve family functioning, and decrease the likelihood of continued sexually abusive behavior within the family.

3. Discuss the personal impact that working with clients with sexual abuse issues has on you. Assess your personal strengths and limitations you bring to working with this population. Use the Trauma Outcome Process model to analyze your responses to working with clients with sexual abuse issues. Formulate and describe a plan for self-care to deal with countertransference reactions and prevent burnout.

E. Course Outline

Week 1 Immediate and Long-Term Effects of Child Sexual Abuse: Research Findings About Child Sexual Abuse Victims

Week 2 Development of Sexually Offending Behavior: Research Findings About Children With Sexually Abusive Behavior Problems, and Juvenile Sexual Offenders

Week 3 Individual Psychopathology as Sequelae to Sexual Abuse: Acute Effects

Week 4 Individual Psychopathology as Sequelae to Sexual Abuse: Chronic Effects and Long-Term Impact

Week 5 Family Dynamics of Families with Sexually Abusive Members

Week 6  Etiology of Sexually Abusive Behavior

Week 7  Assessment and Treatment Contracting With Sexually Abused Children

Week 8  Intervention Strategies and Treatment Techniques With Sexually Abused Children

Week 9  Assessment and Treatment Contracting With Children With Sexually Abusive Behavior Problems

Week 10 Intervention Strategies and Treatment Techniques With Children With Sexually Abusive Behavior Problems

Week 11 Assessment and Treatment Contracting With Juvenile Sexual Offenders

Week 12 Intervention Strategies and Treatment Techniques With Juvenile Sexual Offenders

Week 13 Intervention Strategies and Treatment Techniques With Families With Sexually Abuse Issues

Week 14 Managing Transference and Countertransference and Preventing Therapist Burnout in Social Work Practice With Clients With Sexual Abuse Issues

CASE VIGNETTE: JANET

Janet is a 15-year-old Caucasian female. She currently resides with her parents and her older sister Susan (age 17). The family is middle class and is well connected to their neighborhood and community. Janet's father is an accountant and her mother is an elementary school teacher. Janet has been referred for outpatient therapy after spending 3 weeks in an inpatient unit following a suicide attempt in which she slashed her wrists with a razor.

Janet was sexually abused from the age of 9 through age 12 by Bob, a teenage male Caucasian cousin who is 6 years older than she is. Bob came to live with her family when she was 9 years old. Janet's mother is Bob's aunt. Bob's mother sent him to live with her sister and husband because she could not control his delinquent behavior (he was caught burglarizing neighbors' houses on three occasions and was frequently truant from school). Bob resided with Janet's family for 4 years. He began molesting Janet about 2 months after he moved in with the family. There were numerous incidents over a 3-year time period. Most of the incidents took place in the family's garage when Janet and Bob were the only family members home.

In the first several incidents, Bob fondled Janet's vagina. At first, he used bribes (i.e., gifts of candy, costume jewelry, movie tickets, etc.) to manipulate Janet to participate in the sexual activities. When Janet was 10, Bob forced her to give him oral sex. There were several incidents of oral sex over the next 2 years. He always told Janet, "I know you like this, just as much as I do. I wouldn't do it if you didn't like it so much." As his sexual behavior became more and more intrusive, Bob threatened Janet

to not tell anyone about the abuse and told her he would beat her up if she told. On the evening of her 11th birthday, Bob locked Janet in one of the cars in the garage and penetrated her vagina. Afterwards, he took a rifle out of his uncle's gun cabinet, showed it to Janet, and told her he would kill her if she told anyone. Then he told her, "No one will believe you anyway, even if you tell. They'll know you just led me on." This incident ended up being the last time Janet was sexually abused by Bob, as he joined the Army about one week later.

Janet did not disclose her sexual abuse until her recent hospitalization. Over the past 3 years, Janet has experienced a number of different emotional and behavioral problems. During her Junior High School years, Janet frequently overslept and refused to go to school. The school finally referred her to truancy court because of her excessive absences. Her mood was often sad and morose. To cope with her sadness, Janet began to eat large amounts of food and gained about 30 pounds within a year. After that, she began to purge herself after she binged in order to try to lose weight.

When she was 14, Janet began dating two boys at her school. She soon broke off with both of them and told her sister Susan, "I just don't trust them. I don't trust any guys. All they want is sex." (But neither boy had made sexual overtures.)

Janet started her periods a little later than many girls, just before her 15th birthday. Her mom scheduled a physical for Janet after she had her first period. She was puzzled when Janet absolutely refused to go see her doctor for a physical. Janet later confided in her sister, "There's something wrong with my body and I don't want the doctor to see it."

During Junior High, Janet had two close girlfriends with whom she did activities like going to the mall and watching movies. Janet enjoyed the art class she took in 8th grade and began doing some pencil sketches and painting with watercolors. She also enjoyed swimming and tried out for the school's girls swim team. However, she dropped out after a few weeks because she felt embarrassed to undress in front of the other girls in the locker room.

When Janet began high school, she began to experiment with marijuana. She began dating another boy and this time became sexually involved. Her boyfriend was into several drugs and Janet often skipped school in order to smoke marijuana with him and have sex. They were reckless in their sexual activities, often choosing to have sex in the park or at the beach and failing to use any type of birth control.

Two weeks before her hospitalization, Bob came home on leave from the Army to see the family. When her parents announced that Bob was coming for a visit, Janet began to experience episodes of panic attacks in which her heart pounded and she could barely breathe. One of the most severe attacks occurred one morning when she went out in the garage to get some clothes out of the dryer. She went into the garage and then suddenly she felt like she was smothering and couldn't breathe. Her mom found her curled up next to one of the cars gasping for air. After her mom helped her inside and calmed her down, Janet kept saying over and over again, "I can't do anything about it! " When her mom asked, "About what?" Janet just shook her head and sobbed.

Bob arrived and stayed in the home for 2 weeks. Although she was never alone with him, Janet constantly felt on edge. She had two nightmares the first week. In one nightmare, she awoke screaming and realized she was dreaming about being locked in a car and feeling the body of a teenage boy lying on top of her. In the other nightmare, she was running away from Bob but couldn't get away. Finally he caught her and started hitting her and she awoke.

On the morning that Bob left, the family walked him to his car. He gave everyone a hug. When he hugged Janet, he whispered in her ear, "It's good to see you, sweetie. You always did come on to me."

That afternoon, Janet got into a huge fight with her sister, Susan. They were arguing about a dress that Janet wanted to borrow from Susan. Susan told her she didn't want her to wear the dress because "You won't take care of it. You never think of anybody but yourself." Something triggered inside of Janet and she began screaming at Susan. She struck Susan in the face, then grabbed a broom handle and began hitting her with it. Their mother came in and managed to break up the fight and sent Janet to her room and told her to spend the rest of the afternoon and evening thinking about what she had just done. That was the night that Janet slashed her wrists with a razor. She was hospitalized that evening. One week later, she disclosed to her individual therapist that Bob had molested her.

DISCUSSION QUESTIONS

1. What emotional, cognitive, and behavioral symptoms has Janet shown in response to her abuse?

2. Which of Finkelhor's traumagenic dynamics is applicable to Janet? Support your opinion with specific evidence from the vignette.

3. How does the Trauma Outcome Process model apply to Janet? Which of the three responses best describes her current functioning?

4. What strengths do you see in Janet and in her family?

5. What other information do you need to make an accurate assessment?

SUGGESTED VIGNETTES

• Tony, age 10, has been diagnosed with ADHD and has shown physically aggressive behavior toward other children. He has an extensive history of maltreatment, including physical abuse and chronic neglect. He denies any history of sexual abuse. His mother is a drug user. He was removed from her care last year and placed in foster care. His foster mother caught him performing oral sex on his 7-year-old foster brother. His victim later told the foster mother that Tony had promised him candy and baseball cards for participating in the sexual activity. Tony also threatened to hurt him if he told.

• Alicia, age 8, was placed in foster care after she was sexually abused by her father and by her teenage sister. She masturbates excessively and repeatedly tries to touch the private parts of younger children. She also talks a lot about sex to other children. Her foster mother noticed that she often seems to be spaced out or daydreaming. Once her foster mom asked her what she was thinking about when she was daydreaming. Alicia replied, "Sex."

• Jason, age 9, was recently accepted at a residential treatment facility for behaviorally disordered children. He molested several children in his neighborhood and two of his siblings. He threatened his victims and committed penetrative offenses—including attempting to insert his penis in the vagina or anus of his victims and inserting objects into his victims' rectums. When he was 5 years old, he was sexually abused by a male teenaged babysitter. His parents have a history of marital conflict, including domestic violence, which Jason has occasionally witnessed.

• Zac, age 8, and Bobby, age 6, are brothers in a family of 9 children. The children were placed in foster care after it was discovered that the older children were molesting their siblings. The older children were placed in residential treatment, while Zac and Bobby were placed together in the same foster home. The foster mother recently caught the two boys performing oral sex on each other.

• Robin, age 11, was referred for treatment after her parents found out she had been molesting her two younger brothers. She has been in therapy about 3 weeks. This week, the parents reported to their therapist that Robin had been playing games in a shed with a group of 6-year-old children. The children told their parents that the game involved showing and touching private parts. Robin denied any sexual play took place and said, "All we were doing was playing hide and seek."

• Aaron, age 10, was referred to treatment after he sexually molested his 3-year-old sister. Aaron told his therapist that he did it because he heard voices inside his head telling him to touch her. His mother reported to the therapist that when she came into his room the previous day to wake him for school, she found him letting the family dog lick his penis.

• Trevor, age 9, was brought to treatment by his parents after he was caught hiding in the girls’ rest room at school and trying to watch girls urinate. Trevor’s parents reported several previous incidents where he had tried to look up girls’ skirts.

• Mary, age 10, was referred to treatment for sexually abusing a 4-year-old boy she had been babysitting. Mary pulled down her pants, undressed the boy and forced him to put his penis on her vagina. She told him not to tell anyone or she would hurt him really bad. The boy told his mother. Mary was previously sexually abused by a teenage uncle.

• Jeremy, age 5, was brought to treatment by his mother. She stated she found Jeremy and his best friend, Paul, also age 5, in a closet together touching each other’s penises. She said that as far as she knew, Jeremy has never been abused by anyone.

• Eddie, age 8, performed oral sex on his younger sister, age 5. She disclosed the abuse to her mother. Eddie denied any history of sexual abuse. However, he had been physically abused by his stepfather. He also had gained access to some X-rated videos in his parents’ bedroom and had watched them when they were not home.