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Identification and Intervention of Youth with Problematic Sexual Behavior: A Preventative Approach to Adult Sexual Offenses

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Identification and Intervention of Youth with Problematic Sexual Behavior: A Preventative Approach to Adult Sexual Offenses

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Abstract

The largest bodies of research regarding sexual offenses focus on punitive measures and intervention for adult offenders during and post-incarceration. Research concerning the sexual behavior in youth has been increasing over the past 30 years, with studies showing stark differences in recidivism rates between intervention during childhood and adults post-incarceration. As a result of this growing body of research, programs targeting childhood problematic sexual behavior have continued grow, spreading awareness of childhood sexual development and providing effective treatment for youth exhibiting sexual behavior problems. No single entity is responsible for governing or responding to childhood sexual behavior. The purpose of this project is to provide a standardized public health approach to the surveillance, monitoring, and intervention of childhood sexual behavior. The overall goal is to provide youth-facing professionals with the knowledge and skill to identify and appropriately respond to children with sexual behavior problems. The K.A.P.S. Manual for Problematic Sexual Behavior: A Guide to Building Better Futures Through Early Identification and Response to Problematic Sexual Behavior in Children includes modules on childhood development, including sexual development, identifying problematic sexual behavior, levels of responding, and continuing education opportunities.

Keywords: children, youth, sexual development, problematic sexual behavior

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Introduction

Nearly eight billion people inhabit the earth; 400,000,000 of those occupy the United States (United States Census Bureau, 2021). The number of violent sexual crimes has been rising since 2015 with as many as 734,630 completed, attempted, or threatened rapes in 2019 (Morgan & Oudekerk, 2019; Morgan & Truman, 2020). Among individuals 12 years and older in the United States, 463,634 incidents of sexual assault, including rape, are estimated to occur each year (RAINN, 2021). One-third of sexual offenses committed against children are committed by other children (Finkelhorn, Ormrod & Chaffin, 2009). Many entities have attempted to reduce sexual offending with various punishments and treatments post incarceration (Lobanov-Rostovsky, 2017), including residential restrictions (Chajewski & Mercado, 2008), community notification (Freeman, 2012) GPS monitoring (CSOM, 2001; Beck & Travis III, 2004; Beck & Travis III, 2006; Turner & Jannetta, 2007), incapacitation, retribution, and rehabilitation (CSOM, 207; CSOM, 2008). Despite numerous attempts to manage sexual offending, few policies and guidelines are rooted in evidence-based practices (Lobanov-Rostovsky, 2017). However, continued collection and analysis of offender data is still valuable in informing effective sexual offending prevention and response (Wiseman & Lobanov-Rotvsky, 2017). This project aims to view the reduction of adult sexual offending through a preventative lens, beginning in childhood.

Sexual interaction is one of the most evolutionarily engrained and natural components of existence. For humans and an emerging lineup of other animals, sex can be functional and pleasurable serving to satisfy neurobiological and physiological mechanisms (Georgiadis, Kringelbach & Pfaus, 2012). However, violent sexual crimes are fueled by the deviances in the development of the offender (McCabe & Wauchope, 2005) and not nature. Awareness and

understanding of youth exhibiting problematic sexual behavior is not widespread or readily discussed in schools, childcare facilities, or other youth settings. The lack of communication between mental health providers, law enforcement, and the public often leads to unnecessary consequences such as involvement in the legal system, disruption of families, and lifelong stigma (Harris, Walfield, Shields, & Letourneau, 2016).

Requirements such as sex offender registries, public notification, and residential restrictions, collectively known as Megan's Law, extend the availability of criminal history, registry status, and current address to the public (Megan's Law, 1996). The law was enacted in response to the 1994 murder of Megan Kanka to protect children from adult offenders; however, these sanctions are also being used against children for behaviors such as sexting and sharing nude photos of themselves (Berger, 2009). Effects of such practices are compounded through the practice of plea bargaining. More severe sentences are leveraged due to perceptions of youth who are believed to have engaged in sex crimes with specific regard to the individual's gender, identified victim's age, and available treatment for the act in question (Ferguson & Ireland, 2006; Letourneau, Armstrong, Bandyopadhyay & Sinha, 2013; Rogers, Hirst & Davies, 2011). To force these requirements on children inhibits their ability to enroll in schools, play with other children in public parks and shared spaces, and put them at greater risk for victimization.

Just as perception plays a punitive role in sentencing youth exhibiting problematic sexual behavior, research shows that perceptions of children as perpetrators and criminals significantly decreases treatment completion rates and successful reintegration into communities, thereby rendering current measures of responding disproportionate and detrimental to children who have yet to develop the necessary history to warrant such grave measures (Willis, Levenson, & Ward, 2010). In addition, many youths have yet to gain the capacity to fully appreciate the gravity of their actions or may be ignorant of the laws surrounding the behaviors in which they engage (e.g.,

sexting) (Berger, 2009). Clinical trials have shown differences between adult offenders and youth who engage in sexual behavior including behaviors engaged in, motivation, ability to control impulse, and prognosis following treatment (Finkelhorn, Ormrod & Chaffin, 2009; Leppink, Chamberlin, Redden & Grant, 2016). These differences have supported children being viewed as separate populations (SOMAP, 2017). Differences in youth with problematic sexual behavior and adult offenders revealed passing down the same sentences to children which were originally intended for adults is excessive and unconstitutional (Miller v. Alabama, 2012), especially when evidence-based treatment for youth is available. Appropriate responses must include consideration to the youth's chronological and developmental age (Comartin, Kernsmith & Kernsmith, 2014).

Evidence-based intervention for children exhibiting problematic sexual behavior has been shown to extinguish a variety of behaviors and significantly reduce or eliminate recidivism to less than 2 percent (Caldwell & Van Rybroek, 2005; Chaffin, 2008; Leppink, Chamberlin, Redden & Grant, 2016; Masson & Hackett, 2004) compared to the 5.3 percent recidivism rates of adult sexual offenders in a three-year follow up period with 17.1 percent of those being arrested for a violent offense and 24 percent recidivism after a 15 year follow up (Przybylski, 2017.). Successful programs for youth exhibiting problematic sexual behavior implemented an integrated treatment approach which focused on improved parent-child relationships, prosocial relationship skills, stress management, and conflict resolution (Fox, 2013; O'Brien, 2010). Follow up studies found that at 10- and 20-years post treatment youth continued to have significantly lower recidivism rates than those who did not receive treatment (Przybylski, 2015). Youth who repeated behaviors post intervention were found to share risk factors identified in previous research such as early onset of behaviors with longer periods between onset and intervention (Curwen, Jenkins & Worling, 2014; Rich, 2015).

It is the responsibility of professionals to understand, identify, and appropriately refer youth with problematic sexual behavior to developmentally informed evidence-based treatment. Not only will this action improve to health and welfare of the youth involved, but also ensure the wellbeing and order of the communities with which they engage and are a part of.

Statement of the Problem

Research over multiple decades has pointed to risk factors observed in childhood (Simons, 2017) with both biological predisposition and socio-environmental experiences contributing to the patterns of behavior that lead to sexual offending (Craissati & Beech, 2006; Ward & Beech, 2008). Risk factors for sexual victimization were found to be shared with offending populations (Jennings, Zgoba, Maschi & Reingle, 2014) including, but not limited to, childhood experiences of neglect, exposure to violence, and physical abuse (Levenson, Willis & Prescott, 2016). With these bodies of research in mind, this project proposes childhood intervention as a means of prevention for adult sexual offending.

Beginning in utero and continuing throughout the lifespan, sexual development occurs concurrently with physical and cognitive development. As children meet physical and cognitive milestones, certain sexual behaviors can also be expected (Elkovitch, et al., 2009; Friedrich et al., 1991, 1992, 2001; Larsson & Svedin, 2000, 2001; Lindblad et al., 1995; Sandfort & Cohen-Kettenis, 2000). The National Center on the Sexual Behavior of Youth described normative sexual behavior as "natural and healthy" and outlined the characteristics of normative sexual behavior as intermittent and spontaneous, balanced with other interests, is engaged in willingly and playfully, occurs without objection from other children, does not cause feelings of "anger, shame, fear, or anxiety", is not coercive, and decreases with appropriate nurturing intervention and instruction (ncsby.org, a). Exhibitionism (showing sexual body parts to others), voyeurism (attempting to view others' sexual body parts) and poor personal boundaries (sitting too close to

others, hugging, or kissing without asking, and grasping female breasts) are among the most commonly reported sexual behaviors for children (Freidrich, 1998). Normative sexual behaviors such as these occur within their peer groups and with children who are familiar to each other rather than strangers. These behaviors occur among children of the same gender and even with siblings (ncsby.org, a). The previously mentioned normative sexual behaviors are negatively correlated with a child's age, while other behaviors such as sexual interest in others, drawing sexual body parts, sexual language, and interest in the nude human form increase with age and continue to develop and evolve with cognitive, emotional, and physical development (Elkovitch et al., 2009).

In contrast to normative sexual behavior, problematic sexual behavior has been defined as "developmentally inappropriate or potentially harmful behavior that involves the use of sexual body parts" (Chaffin et al., 2008; Shawler et al., 2018)" and have been found to be associated with "early, age-inappropriate exposure to sexual behavior or knowledge (Bonner *et al.*, 1999; Friedrich *et al.*, 1991, 1992, 2003). Friedrich *et al.* (1991, 1992, 2001)" (as cited in Elkovitch et al., 2009). Problematic sexual behaviors include, but are not limited to, repetitive non-intrusive behaviors such as seeking out others who are nude and showing private parts to others frequently. While problematic sexual behaviors differ from normative ones, behaviors that fall into the problematic category are not strictly dichotomous. Some normative sexual behaviors can start at as normative and become problematic, such as self-touch that leads to physical harm to the genitals or occurs in public places. Other behaviors may be developmentally expected but are illegal due to the youth's age (sexting or sending and receiving nude photos of themselves and intimate partners) or illegal by statute (sexual contact with animals). Developmentally inappropriate problematic behaviors include genital, digital, or object penetration of self or others' sexual body parts. Other problematic sexual behaviors include those that are without

consent (groping and rubbing), aggressive sexual contact or penetration, and sexual contact that is accomplished through coercion (ncsby.org, b).

Cultural, religious, social, and family value differences often come into play when caregivers report problematic sexual behaviors. Guidelines for identifying problematic sexual behaviors from The National Center on the Sexual Behavior of Youth set forth guidelines for identifying problematic sexual behavior to help differentiate normative and problematic sexual behavior. Problematic sexual behavior occurs more frequently than normative sexual behavior. It occurs between children of wide chronological age or developmental ability, or between children of disparate strength, authority, or size (ncsby.org, b). As with normative sexual behaviors, problematic sexual behaviors are commonly among children who are related or are known to each other (Snyder, 2000). Problematic sexual behavior is associated with intense feelings of anger, anxiety, or fear and can cause physical or emotional harm or potential harm to a child. It does not respond to common parenting strategies of instruction to cease behaviors or supervision. Finally, sexual behavior is problematic if it involves aggression, threats of harm (physical, social, or another kind), coercion, or physical force (ncsby.org, b).

While multiple interventions for youth exhibiting sexualized behaviors exist, few are developed for children. Of those developed for youth, a handful are empirically supported: PSB-CBT (Problematic Sexual Behavior-Cognitive Behavioral Therapy) is an evidence-based model (Jenkins, Grimm, Shier, van Dooren, Ciesar, & Reid-Quiñones, 2020; Carpentier, Silovsky & Chaffin, 2006) serving youth ages three-years to 17-years and 11-months and emphasizes youth being viewed and treated as children by all involved (e.g., caregivers, law enforcement, judicial officers, social workers, treatment providers, etc.). PSB-CBT is comprised of psychoeducation, behavior management, and skill building at a developmentally appropriate level: PSB-P (preschool, ages 2-6), PSB-S (school age, ages 7-13), and PSB-A (adolescent, ages 14-17:11).

Each of the 18 modules for PSB-S addresses a new topic while reviewing and building on previous learned information and skills (Swisher, Widdifield, Silovsky, 2013). PSB-A adds a module addressing the legal ramifications of breaking sexual behavior rules as an adolescent and later as an adult and emphasizes the parent-child relationship more than skill accumulation (Bonner, Chaffin, Pierce, Swisher, Schmidt, & Walker, 2009).

Other successful evidence-based intervention models can be combined with PSB-CBT to address co-occurring challenges. PCIT-PSB combines the attachment or child-directed interaction (CDI) phase and discipline or parent-directed interaction (PDI) phase of Parent-Child Interaction Therapy with the modules of PSB-P to address behaviors associated with attention-deficit hyperactivity disorder (ADHD), oppositional defiant disorder (ODD), or other behavior concerns, as well as any problematic sexual behaviors the child is exhibiting (Shawler, Bard, Taylor, Wilsie, Funderburk & Silovsky, 2018). Children who experience stressful and traumatic events (e.g., natural disasters, witnessing domestic violence, sexual abuse, etc.) react in a variety of ways. They may withdraw, have nightmares, and even display behaviors outside the typical development of their age group. Sexual abuse can lead to the development of problematic sexual behavior; however, other types of traumatic events can result in atypical sexual behaviors (Szanto, Lyons & Kisiel, 2012). Including adaptations for PSB in trauma services allows children to overcome their trauma symptoms as well as decreases risk for future victimization and further problematic sexual behavior (Allen, 2018; Silovsky, Hunter, & Taylor, 2009).

Research on the number of children with problematic sexual behavior is limited, as is widespread awareness and appropriate response to childhood sexual behaviors (Elkovitch, Latzman, Hansen & Flood, 2009; Ey, McInnes & Rigney, 2017). A standardized manual for the surveillance, screening, and early intervention of youths' exhibiting problematic sexual behavior would provide detailed insight into normative sexual development, as well as the characteristics

of youth with problematic sexual behavior, its etiology and resolution, and a detailed guide for surveying, screening, and connecting children to appropriate intervention as a means to prevent future adult sexual offending.

Purpose

The purpose of this project is to create a public health manual that provides a standardized response to youth with problematic sexual behavior grounded in foundational knowledge of child development and evidence-based practice. The overall goal is to provide guidelines to youth-facing professionals for surveying, assessing, and responding to youth with problematic sexual behavior in order to increase awareness of childhood sexual development and apply that knowledge to intervene early and prevent future offending. The K.A.P.S. Manual for Problematic Sexual Behavior: A Guide to Building Better Futures Through Early Identification and Response to Problematic Sexual Behavior in Children provides a walkthrough of the proposed guidelines with step-by-step examples for responding.

Creation of Manual

Data for the manual is based on prior research studies concerning youth with problematic sexual behavior and research which utilized the CBT-PSB protocol. The K.A.P.S. Manual for Problematic Sexual Behavior: A Guide to Building Better Futures Through Early Identification and Response to Problematic Sexual Behavior in Children includes units on child development including sexual development, problematic sexual behavior, surveillance and screening of sexual development, responding to problematic sexual behavior, referring youth to treatment, and information regarding continuing education opportunities.

Limitations

As of July 2022, The K.A.P.S. Manual for Problematic Sexual Behavior: A Guide to Building Better has not been disseminated to law enforcement, child welfare agencies, schools,

childcare agencies, pediatricians' offices, mental health clinics, or other youth-facing entities.

This manual is not intended to supersede existing processes outlined by any state's governing bodies regarding response to youth with problematic sexual behavior. It is intended to provide guidelines which incorporate the foundational understanding of childhood development, such that surveillance, assessment, and intervention pathways may be grounded in evidence-based practices and provide significant decreases in adult offending through prevention. The components of the manual are intended to be used as a whole, however individual components such as the child development milestone sheets may be disseminated individually to support the dissemination of knowledge to families and other youth-facing professionals.

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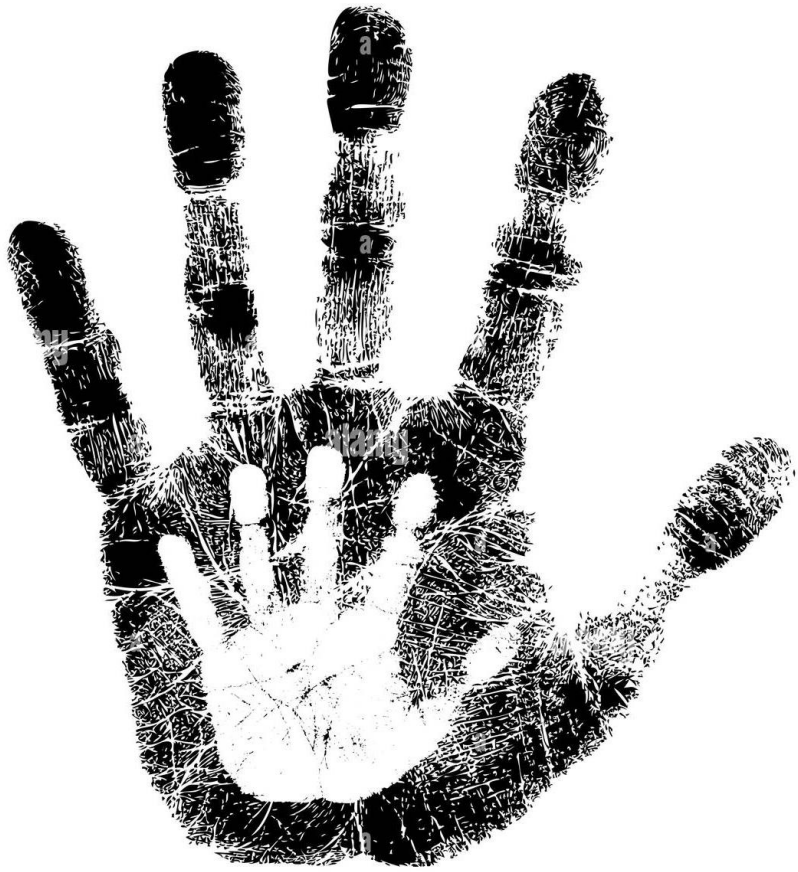
KNOWLEDGE, **A**TTITUDE, **P**ERCEPTION, **S**KILLS for PROBLEMATIC SEXUAL BEHAVIOR



Response Manual, 1st Edition
Heather R. Martin

A GUIDE TO BUILDING BETTER FUTURES THROUGH EARLY IDENTIFICATION AND RESPONSE TO PROBLEMATIC SEXUAL BEHAVIOR IN CHILDREN

Purpose

The K.A.P.S. for Problematic Sexual Behavior manual is intended as a reference document for Oklahoma law enforcement, civil servants, and professionals with preschool and school-age facing responsibilities. It contains requirements for surveillance and screening and responding to problematic sexual behavior. It is intended to complement existing efforts to promote the whole health of Oklahoma children and families, as well as support Oklahoma's ongoing efforts to ensure every child receives evidence-based intervention within an appropriate timeline to ensure the child's optimal success and reduce overall recidivism in adolescence and adulthood.

Current Efforts

Oklahoma State Department of Health's Whole School, Whole Community, Whole Child (WSCC): https://oklahoma.gov/health/wscc---oklahoma-state-department-of-health.html

Oklahoma Office of Juvenile Affairs Community Based Services Division Placement and Reintegration: https://oklahoma.gov/oja/community-based-services/community-based-services-division.html

National Center on the Sexual Behavior of Youth – OJA partnership: https://ojjdp.ojp.gov/tta-provider/national-center-sexual-behavior-youth

National Center of the Sexual Behavior of Youth: https://ncsby.org/content/about-us

Service Questions – Contacts

For questions regarding training and implementation of K.A.P.S. for Problematic Sexual Behavior please contact Heather R. Martin, M.A., LPC, (405)271-5700.

Table of Contents

Overview

K.A.P.S. for Problematic Sexual Behavior refers to a response model focused on the integration and understanding of physical, cognitive, emotional, and sexual development of preschool and school-age children. The K.A.P.S. for Problematic Sexual Behavior response model utilizes an inter-disciplinary approach to identify and respond to preschool and school-age children exhibiting problematic sexual behavior in a developmentally appropriate manner in order to promote the public good and prevent future sexual offenses in adolescence and adulthood.

Continuous communication and collaboration are imperative to ensure effective identification, response, and intervention by all key supports in the child's life, including school, law enforcement, case workers, behavioral health providers, and other individuals interfacing with the youth.

K.A.P.S. for Problematic Sexual Behavior is designed to assist youth facing professionals and civil servants in identifying and responding to preschool and school-age children exhibiting problematic sexual behavior; and further public health and safety by connecting children exhibiting problematic sexual behavior and their families to appropriate supports and remove barriers which may otherwise prevent engagement in necessary effective evidence-based services to ensure the rehabilitation and continued prosocial behavior of the individual and the communities with which they engage.

Why an Interdisciplinary Approach?

"Professionals and family are charged with promoting safety and addressing the needs of all the children (the youth with PSB, child victims, siblings, and others) in the context of the family, school, and community." -ncsby.org

Children interact with many adults who are responsible for guiding their development and experiences, such as, but not limited to:

- Caregivers
- Teachers
- School Administrators
- After School Program Leads
- Primary Care Physicians

Children exhibiting problematic sexual behavior will interact with additional adults who are also responsible with their continued education and development.

- Law Enforcement
- Forensic Interviewers
- Social Workers
- Behavioral Health Providers
- And Others

K.A.P.S. for Problematic Sexual Behavior is intended to develop awareness and advocate for integration and coordination of law enforcement, educators, social workers, primary care, behavioral health, and youth services to promote the surveillance and screening, intervention, and support of preschool and school-age children exhibiting problematic sexual behavior.

Each component of the K.A.P.S. for Problematic Sexual Behavior promotes developmentally appropriate surveillance and screening of preschool and school-age children to ensure future prosocial behavior and increase public health. Surveillance and screening, intervention, and support is delivered through an interdisciplinary team to comprehensively address the social, developmental, and legal aspects of problematic sexual behavior in preschool and school-age children.

Specially trained team members will serve as points of contact throughout each step of the process for preschool and school-age children exhibiting problematic sexual behavior and their families.

The goals of K.A.P.S. for Problematic Sexual Behavior are to ensure processionals:

- Gain knowledge of sexual development, effective intervention, and potential outcomes.
- Identify preschool and school-age children with problematic sexual behavior early.
- Have a dedicated consultant to offer guidance and support throughout the intervention process.
- Enhance public safety.

Why a Developmental Approach?

"Many children with developmental delays or behavior concerns are not identified as early as possible. As a result, these children must wait to get the help they need to do well in social and education settings (for example, in school, at home, and in the community)" (Center for Disease Control and Prevention, 2021).

Early identification and intervention of disorders occurring in development are critical to ensuring the health and wellbeing of children. Current surveyed conditions which affect a child's immediate and long-term development include hearing, vision, language, intellectual ability, **and behavior** (Lipkin & Macias, 2020). Pediatricians, childcare agencies, and schools routinely survey children's development as it relates to developmental stages. Each stage coincides with a set of abilities or milestones that develop in a predictable sequence at specific ages. During each stage of development, children will acquire new skills and build on the mastery of previously achieved skills. (Lipkin & Macias, 2020; Scharf, Scharf & Stroustrup, 2016). Screening of these milestones assesses four domains: cognitive, motor (fine motor and gross motor), language, and social-emotional. Deviation from these milestones may indicate a child's trajectory towards typical versus atypical development (Misirliyan & Huyn, 2020). Those exhibiting problematic sexual behavior warrant expedient and specific surveillance due to the nature of the behavior and the risk such behavior poses to the community should the behavior persist.

K.A.P.S. for Problematic Sexual Behavior Curriculum

K.A.P.S. for Problematic Sexual Behavior training is intended for professionals in youth-facing service positions, such as law enforcement, educators, childcare providers, social workers, behavioral health professionals, youth program leads, and others. Core components of K.A.P.S. for Problematic Sexual Behavior are as follows:

- Assess pre- and post-training knowledge, attitudes, perception, and skills concerning preschool and school-age children exhibiting problematic sexual behavior.
- Develop and enhance knowledge, attitudes, perception, and skills regarding physical, linguistic, psycho-social, and sexual development of preschool and school-age children.
- Develop and enhance knowledge regarding effective evidence-based interventions for preschool and school-age children with problematic sexual behavior.
- Develop skills to survey, screen, and respond to preschool and school-age children exhibiting problematic sexual behavior and their families in a variety of settings.
- Develop a working knowledge of the referral process to link preschool and school-age children and their families to effective evidence-based interventions and support.
- Promote and provide continuing education and support for professionals interfacing with preschool and school-age children exhibiting problematic sexual behavior and their families.

K.A.P.S. Core Components

Knowledge: the factual understanding an individual possesses concerning the risk factors, characteristics, presentation, and intervention of youth with problematic sexual behavior.

Attitude: the way an individual thinks or feels about youth who exhibit problematic sexual behavior, which can assist or hinder in the identification and referral process.

Perception: the level of awareness and accurate or inaccurate predisposition an individual has towards children exhibiting problematic sexual behavior.

Skills: an individual's level of ability to appropriately and effectively survey, screen, and respond to youth exhibiting problematic sexual behavior.

K.A.P.S. for Problematic Sexual Behavior Units

Pre-/Post-K.A.P.S. Assessment

Development and Y-PSB

Response and Evidence-based Intervention

Referral Process

Continuing Education

K.A.P.S. Pre-/Post-Assessment

The Knowledge, Attitude, Perception, Skill (K.A.P.S.) assessment is designed to capture a snapshot of an individual's preparedness to effectively survey, screen, and engage with a preschool or school-age youth exhibiting problematic sexual behavior (Y-PSB). Anything less than a score of 100 percent indicates a need for further training by the individual completing the assessment.

K.A.P.S. Pre-/Post-Assessment

The assessment below is designed to identify an individual's knowledge, attitude, perception, and skill regarding engagement with youth with problematic sexual behavior (Y-PSB). Please read each question carefully and answer to the best of your understanding. To accurately assess your current level of understanding, please complete the assessment before researching characteristics or treatment of Y-PSB.

Circle your answer for each question. Do not erase. If you would like to select a different answer than the one you initially chose, cross out your answer and circle the one you wish to keep. An example is below.

Example: H_2O is the scientific notation for water. (True) ~~(False)~~

1. Almost one-third of sexual assaults against children under the age of 12 are committed by other children.

   True False

2. Children exhibiting problematic sexual behavior who engage in evidence-based treatment such as cognitive behavior therapy for problematic sexual behavior (CBT-PSB) have been found to have recidivism rates of less than 2 percent.

   True False

3. Experiencing and/or witnessing physical abuse and domestic violence has been found to increase risk for development of problematic sexual behavior in children.

   True False

4. Teaching children rules regarding sexual behavior and consent, abuse prevention, and sexual development at a developmentally appropriate level has been found to decrease problematic sexual behavior in children.

   True False

5. Most children with problematic sexual behavior have been sexually abused.

   True False

6. Typical sexual development includes self-touch in infancy and early childhood.

   True False

7. Children who engage in problematic sexual behavior will sexually offend as adults.

True False

8. Most children with problematic sexual behavior will require intensive long-term therapy.

True False

9. Play therapy is an effective intervention to decrease problematic sexual behavior.

True False

10. Behavior-management parent training has been found to have the greatest success in eliminating problematic sexual behavior in children.

True False

11. Children exhibiting problematic sexual behavior should not be allowed to live with other children until treatment is completed.

True False

12. One indication that a child's sexual behavior is problematic is that the behavior continues after repeatedly being told to stop.

True False

13. Teaching impulse control decreases problematic sexual behavior.

True False

14. If a child does not admit to having exhibited problematic sexual behavior, they will not be successful in reducing problematic sexual behavior.

True False

15. Children exhibiting problematic sexual behavior are children first.

True False

Development and Y-PSB

Developmental Milestones (0-5)

The CDC updated their published milestones in early 2022 in an effort to survey American children with expectations more consistent with their global peers (CDC, 2022). A reference guide of those milestones is provided on the pages that follow.

Social-Emotional: Social-emotional development encompasses a child's expanding understanding and management of their emotions, as well as their ability to develop cooperation with others, express empathy, and utilize moral reasoning.

Cognitive: Cognitive development refers to a child's ability to receive and process information, maintain attention to a task, solidify and store memories, understand and appropriately interact with their surroundings, create, and to develop, execute, and accomplish planned processes.

Language: Language development details a child's ability to communicate with those around them. It includes phonology (creating sounds), pragmatics (communicating with verbal and non-verbal cues), semantics (understanding word rules to decipher what words mean), and syntax (applying grammar and building sentences).

Motor: Motor development includes physical ability [fine motor (buttoning buttons, cutting with scissors, coordination of the hands and eyes) and gross motor (large movements such as running, jumping, skipping, and walking)] and growth.

Developmental Milestones: 2 Months

Social-Emotional

- Calms down when spoken to or picked up
- Looks at your face
- Seems happy to see you when you walk up
- Smiles when you talk to or smile at them

Cognitive

- Watches you as you move
- Looks at a toy for several seconds

Language

- Makes sounds other than crying
- Reacts to loud sounds

Motor

- Holds head up when on tummy
- Moves both arms and both legs
- Opens hands briefly

Adapted from CDC Milestones https://www.cdc.gov/ncbddd/actearly/milestones/index.html

Developmental Milestones: 4 Months

Social-Emotional

- Smiles on their own to get your attention
- Chuckles (not yet a full laugh) when you try to make them laugh
- Looks at you, moves, or makes sounds to get or keep your attention

Cognitive

- If hungry, opens mouth when they see sees breast or bottle
- Looks at their hands with interest

Language

- Makes sounds like “oooo”, “aahh” (cooing)
- Makes sounds back you talk to them
- Turns head towards the sound of your voice

Motor

- Holds head steady without support when you are holding them
- Holds a toy when you put it in their hand
- Uses their arm to wing at toys
- Brings hands to mouth
- Pushes up onto elbow/forearms when on tummy

Adapted from CDC Milestones https://www.cdc.gov/ncbddd/actearly/milestones/index.html

Developmental Milestones: 6 Months

Social-Emotional

- Knows familiar people
- Likes to look at theirself in a mirror
- Laughs

Cognitive

- Puts things in their mouth to explore them
- Reaches to grab what they want
- Closes lips to show they doesn't want more food

Language

- Takes turns making sounds with you
- Blows "raspberries" (sticks tongue out and blows)
- Makes squealing noises

Motor

- Rolls from tummy to back
- Pushes up with straight arms when on tummy
- Leans on hands to support theirself when sitting

Adapted from CDC Milestones https://www.cdc.gov/ncbddd/actearly/milestones/index.html

Developmental Milestones: 9 Months

Social-Emotional

- Is shy, clingy, or fearful around strangers
- Shows several facial expressions, like happy, sad, angry, and surprised
- Looks when you call their name
- Reacts when you leave (looks, reaches for you, or cries)
- Smiles or laughs when you play peek-a-boo

Cognitive

- Looks for objects when dropped out of sight (like their spoon or toy)
- Bangs two things together

Language

- Makes different sounds like “mamamama” and “babababa”
- Lifts arms to be picked up

Motor

- Gets to a sitting position by theirself
- Moves things from one hand to their other hand
- Uses fingers to “rake” food towards theirself
- Sits without support

Adapted from CDC Milestones https://www.cdc.gov/ncbddd/actearly/milestones/index.html

Developmental Milestones: 12 Months (1 Year)

Social-Emotional
- Plays games with you, like pat-a-cake

Cognitive
- Puts something in a container, like a block in a cup
- Looks for things they see you hide, like a toy under a blanket

Language
- Waves “bye-bye”
- Calls a parent “mama” or “dada” or another special name
- Understands “no” (pauses briefly or stops when you say it)

Motor
- Pulls up to stand
- Walks, holding on to furniture
- Drinks form a cup without a lid, as you hold it
- Picks things up between thumb and pointer finger

Adapted from CDC Milestones https://www.cdc.gov/ncbddd/actearly/milestones/index.html

Developmental Milestones: 15 Months (1 Year 3 Months)

Social-Emotional

- Copies other children's play, like taking toys out of a container when another child does
- Shows you and object they like
- Claps when excited
- Hugs stuffed doll or another toy
- Shows you affection (hugs, cuddles, or kisses you)

Cognitive

- Tries to use things the right way, like a phone, cup, or book
- Stacks at least two small objects, like blocks

Language

- Tries to say one or two words besides "mama" or "dada", like "ba" for ball or "da" for dog
- Follows directions given with both a gesture and words. For example, they give you a toy when you hold out hand and say "give me the toy"
- Points to ask for something or to get help

Motor

- Takes a few steps on their own
- Uses fingers to feed themself some food

Adapted from CDC Milestones https://www.cdc.gov/ncbddd/actearly/milestones/index.html

Developmental Milestones: 18 Months (1.5 Years)

Social-Emotional

- Moves away from you, but looks to make sure you are close by
- Points to show you something interesting
- Puts hands out for you to wash them
- Looks at a few pages in a book with you
- Helps you dress theirself by pushing arm through sleeve or lifting up foot

Cognitive

- Copies you doing chores, like sweeping with a broom
- Plays with toys in a simple way, like pushing a toy car

Language

- Tries to say three or more words besides “mama” or “dada”
- Follows one-step directions without gestures like giving you the toy when you say, “Give it to me.”

Motor

- Walks without holding on to anyone or anything
- Scribbles
- Drinks form a cup without a lid and may spill sometimes
- Feeds herself with her fingers
- Tries to use a spoon
- Climbs on and off a couch or chair without help

Adapted from CDC Milestones https://www.cdc.gov/ncbddd/actearly/milestones/index.html

Developmental Milestones: 24 Months (2 Years)

Social-Emotional

- Notices when others are hurt or upset, like pausing or looking sad when someone is crying
- Looks at your face to see how to react to a new situation

Cognitive

- Holds something in one hand while using the other hand; for example, holding a container and taking the lid off
- Tries to use switches, knobs, or buttons on a toy
- Plays with more than one toy at the same time, like putting toy food on a toy plate

Language

- Points to things in a book when you ask, like "Where is the bear?"
- Says at least two words together, like "More milk"
- Points to at least two body parts when you ask them to show you.
- Uses more gestures than waving and pointing, like blowing a kiss or nodding yes

Motor

- Kicks a ball
- Runs
- Walks (not climbs" up a few stairs with or without help
- Eats with a spoon

Adapted from CDC Milestones https://www.cdc.gov/ncbddd/actearly/milestones/index.html

Developmental Milestones: 30 Months (2.5 Years)

Social-Emotional

- Plays next to other children and sometimes plays with them
- Shows you what they can do by saying "Look at me"!
- Follows simple routines when told, like helping to pick up toys when you say, "It's clean-up time."

Cognitive

- Uses things to pretend, like feeding a block to a doll as if it were food
- Shows simple problem-solving skills, like standing on a small stool to reach something
- Shows they know at least one color, like pointing to a red crayon when you ask, "Which one is red?"

Language

- Says about 50 words
- Says two or more words, with one action word, like "Doggie run"
- Names things in a book when you point and ask, "What is this?"
- Says words like "I", "me", or "we"

Motor

- Uses hands to twist things, like turning doorknobs or unscrewing lids
- Takes some clothes off by themself, like loose pants or an open jacket
- Jumps off the ground with both feet
- Turns book pages, one at a time, when you read to them

Adapted from CDC Milestones https://www.cdc.gov/ncbddd/actearly/milestones/index.html

Developmental Milestones: 36 Months (3 Years)

Social-Emotional

- Calms down within 10 minutes after you leave them, like at a childcare drop off
- Notices other children and joins them in play

Cognitive

- Draws a circle when you show them how
- Avoids touching hot objects, like a stove, when you warn them

Language

- Talks with you in conversation using at least two back-and-forth exchanges
- Asks "who", "what", "where", or "why" questions, like "Where is mommy/daddy?"
- Says what action is happening in a picture book when ask, like "running", "eating", or "playing"
- Says first name, when asked
- Talks well enough for others to understand, most of the time

Motor

- Strings items together, like large beads or macaroni
- Puts on some clothes by themself, like loose pants or a jacket
- Uses a fork

Adapted from CDC Milestones https://www.cdc.gov/ncbddd/actearly/milestones/index.html

Developmental Milestones: 48 Months (4 Years)

Social-Emotional

- Pretends to be something else during play (teacher, superhero, dog)
- Asks to go play with children if none are around, like "Can I play with Alex?"
- Comforts others who are hurt or sad, like hugging a crying friend
- Avoids danger, like not jumping form tall heights at the playground
- Likes to be a "helper"
- Changes behavior based on where she is (place of worship, library, playground)

Cognitive

- Names a few colors of items
- Tells what comes next in a well-known story
- Draws a person with three or more body parts

Language

- Says sentences with four or more words
- Says some words from a song, story, or nursery rhyme
- Talks about at least one thing that happened during his day, like "I played soccer"
- Answers simple questions like "What is a coat for?" or "what is a crayon for?"

Motor

- Catches a large ball most of the time
- Serves themselves food or pours water, with adult supervision
- Unbuttons some buttons
- Holds crayon or pencil between fingers and thumb (not fist)

Adapted from CDC Milestones https://www.cdc.gov/ncbddd/actearly/milestones/index.html

Developmental Milestones: 60 Months (5 Years)

Social-Emotional

- Follows rules or takes turns when playing games with other children
- Sings, dances, or acts for you
- Does simple chores at home, like matching socks or clearing the table after eating

Cognitive

- Counts to 10
- Names some numbers between 1 and 5 when you point to them
- Uses words about time, like “yesterday”, “tomorrow”, “morning”, or “night”
- Pays attention for 5 to 10 minutes during activities. For example, during story time or making arts and crafts (screen time does not count)
- Writes some letters in their name
- Names some letters when you point to them

Language

- Tells a story they heard or made up with at least two events. For example, a cat was stuck in a tree and a firefighter saved it
- Answers simple questions about a book or story after you read or tell them
- Keeps a conversation going with more than three back-and-forth exchanges
- Uses or recognizes simple rhymes (bat-cat, ball-tall)

Motor

- Buttons some buttons
- Hops on one foot

Adapted from CDC Milestones https://www.cdc.gov/ncbddd/actearly/milestones/index.html

Sexual Development

Children explore their sexual health through play – it is natural, healthy, and expected (NCSBY, b).

Sexual development begins in utero and occurs concurrently with social-emotional, cognitive, language, and motor development into adolescence (Campbell, Mallappa, Wisniewski & Silovsky, 2013). Just as cognitive and physical markers are predicted to present themselves as a child develops, expected sexual behaviors also emerge (Mesman, Harper, Edge, Brandt & Pemberton, 2019; NCSBY,c).

Sexual Behavior: Sexual behaviors are behaviors involving body parts considered to be "private" or "sexual", including but not limited to the breasts, buttocks, and genitals; such behaviors are considered by many professionals to be typical and not harmful.

Problematic Sexual Behavior: Problematic sexual behaviors are child-initiated behaviors involving body parts considered to be "private" or "sexual", including but not limited to the breasts, buttocks, and genitals and are outside developmentally anticipated behaviors and/or are potentially harmful to the child or other children they engage in these behaviors with – behaviors may be self-focused (e.g., excessive self-stimulation) or involve other children (e.g., touching other children's sexual body parts, or sexual intercourse); problematic sexual behaviors are behaviors that are considered non-normative, unacceptable to society, and may impair functioning.

Multiple state and national entities have outlined the stages of sexual development to assist in clearly differentiating between normative and atypical or problematic sexual behavior in preschool and school-age children (Planned Parenthood, 2017; Minnesota Coalition Against Sexual Assault, 2017; Mesman et al, 2019; National Child Traumatic Stress Network, 2009). Characteristics of normative and problematic sexual behaviors are below.

Normative Sexual Behavior

- Occur spontaneously and intermittently
- Are not the sole focus of children's play, the interest in sex play is balanced by other interests and activities
- Involve children who are willing to engage in OR are generally lighthearted and playful
- Are agreed upon (that is, no child is objecting to the behavior
- Do NOT cause any of the children involved strong uncomfortable feelings such as anger, shame, fear, or anxiety
- Often decrease with appropriate caregiver intervention when the child receives nurturing instructions to stop the behaviors
- Occurs among children of similar age and developmental ability
- Occurs among children familiar with one another – not strangers

A list of normative sexual behaviors and knowledge by age group are listed on the pages that follow.

Sexual Development: Birth-2 Years (Infants)

Behaviors:

- Curiosity and exploration of own body parts, including genitals
- Self-touch of genitals in private and public settings
- Not bothered by own nudity
- Genital reactivity (e.g., infant erection)
- Learn behaviors associated with different genders

Knowledge:

- Vague understanding of differences between male and female genders.
- Vague understanding of pregnancy
- Aware of adults kissing and cuddling

Encouraging Healthy Sexual Development:

- Use anatomical (doctor's) names for body parts (e.g., penis, vagina, etc.)
- Explain basic differences in male and female anatomy
- Provide simple responses to questions about bodies and bodily functions
- Give basic information on appropriate ways to interact with peers (e.g., personal space)

Adapted from MNCASA (2017), NCSBY (a), and Planned Parenthood (2017).

Sexual Development: 2-4 Years (PreSchool Children)

Behaviors:

- Intermittent self-stimulation in public or private settings (general a soothing behavior and not for sexual pleasure)
- Engage in playful exploration of peers genitals (e.g., showing, peeking)
- Ask questions about bodies, bodily functions, how babies are made
- Curious about adult bodies and how they are different
- Continued comfort with nudity (remove own clothes or diapers)
- Begin using slang or made-up words for anatomy and bodily functions (e.g, boobies, pee-pee, fart, etc.)

Knowledge:

- Can identify own gender
- Can identify gender differences based on cultural factors such as hairstyle, body shape/size, and clothing.

Encouraging Healthy Sexual Development:

- Provide simple responses to questions about reproduction
- Explain differences between private and public settings, and appropriate versus inappropriate
- Differentiate between wanted and unwanted touching (consent)
- Begin teaching boundaries (e.g., asking for permission to hug or kiss a friend, peer, or unfamiliar adult, can say no to hugs and touching from others)

Adapted from MNCASA (2017), NCSBY (a) , and Planned Parenthood (2017).

Sexual Development: 4-6 Years (Young Children)

Behaviors:

- Intentional touch genitals in private, and occasionally in public
- Physiologically capable of experiencing orgasm
- More aware of difference in body differences
- Imitate dating behavior such as holding hands and kissing
- Able to learn that genital exploration is to be done in private
- Talk about genitals, use sexual slang or "swear" words with or without understanding of their meaning

Knowledge:

- More cognizant of gender differences and gender roles, though they may play or act in ways generally associated with multiple roles.

Encouraging Healthy Sexual Development:

- Allow space for discussions around gender identity and expression
- Explain the existence of multiple sexual orientations (e.g., girls and boys who like each other, girls who like girls, and boys who like boys, etc.)
- Teach self-stimulating behaviors are to be done in private
- Continue providing simple responses to questions regarding sexuality, reproduction and body differences/changes
- Explain person rights and responsibilities regarding bodies and sexuality (e.g., your body belongs to you, consent means we ask first and respect "no", all people deserve respect, etc.)

Adapted from MNCASA (2017), NCSBY (a) , and Planned Parenthood (2017).

Sexual Development: 7-12 Years (School-Age Children)

Behaviors:

- Puberty begins.
- Increased need/requests for privacy and independence
- Begin understanding social norms around self-stimulation and may engage in behaviors in private
- Sex play such as "Truth or Dare" and "Spin the Bottle"
- Watch/listen to sexual content in the media (e.g., music on the radio, television shows with PG13/Teen or higher ratings
- Begin developing sexual orientation
- Experience sexual attraction to peers and desire for romantic partners/relationships
- Increased curiosity about adult bodies
- Mood swings

Knowledge:

- Understand pregnancy and birth
- Aware of adult sexual behaviors
- Basic understanding of puberty
- Accuracy of knowledge may vary based on informal and formal information (e.g., media, peers, caregivers, etc.)

Encouraging Healthy Sexual Development:

- Provide accurate information about puberty and body changes
- Discuss social-emotional aspects of puberty – validate needs and emotions
- Provide age-appropriate regarding sexuality and sexual behavior
- Promote understanding of consent and boundaries in friendships and other relationships.

Adapted from MNCASA (2017), NCSBY (a), and Planned Parenthood (2017).

Problematic Sexual Behavior

No clear separation exists between normative sexual behavior and sexual behavior that is problematic; sexual development occurs on a continuum, spanning from expected, to concerning, to problematic (NCSBY, b).

Problematic Sexual Behavior

- Self-stimulation which causes physical harm or damage, is excessive, occurs in public in spite of intervention.
- Non-intrusive and repetitive behaviors (e.g., preoccupation with nudity, secretively viewing others while they are naked or undressing, repeatedly showing others their private parts, viewing pornography, or using sexual language).
- Touching others' private parts without permission or consent (e.g., rubbing or poking).
- Sexual contact outside developmental expectation or that may be illegal (e.g., digital-, oral-, genital-genital contact involving penetration).
- Distributing sexual images produced by themselves or other youth (e.g., physical or digital photographs, videos, or texting).
- Sexual contact with animals.
- Sexual contact that is coercive or aggressive
- Sexual contact that involves penetration.

Problematic Sexual Behavior: Risk Factors

Preschool and school-age children exhibit problematic sexual behavior as a response to a variety of ecological risk factors (Allen, Thorn & Gully, 2015, Allen, 2017).

In the list below, the factors which pose the highest risk towards a child developing problematic sexual behavior have been marked with an asterisk.

Risk Factors Associated with the Development of Problematic Sexual Behavior:

- Family Modeling of Sexuality *
- Physical coercion by caregivers *
- Physical Abuse
- Emotional Abuse
- Sexual Abuse
- Neglect
- Domestic Violence
- Emotional and Behavioral Dysregulation Disorders
- Impulse Control Problems
- Poor Social Skills

Problematic Sexual Behavior: Guidelines

Normative sexual behaviors may transition into problematic sexual behaviors when the behaviors increase in frequency and do not respond to caregiver intervention (NCSBY, c).

Key characteristics can be observed which assist in the differentiating of expected from problematic sexual behavior (NCSBY-b). Awareness of these guidelines is fundamental to the effective surveillance and screening of problematic sexual behavior in preschool and shool-age children. Guidelines are listed below.

Guidelines: Identifying Problematic Sexual Behavior (NCSBY-b):

- Occur frequently or more frequently than expected
- Take place between children of widely different ages or developmental stages (e.g., 12-year-old with a 4-year-old, or 15-year-old with a 10-year-old).
- Occur between children of different capacity (e.g., disparate physical size and strength or intellectual abilities or position of authority).
- Are associated with strong, upset feelings, (e.g., anger, shame, anxiety, fear)
- Do not respond to typical parenting strategies (e.g., instruction or supervision)
- Involve coercion, force, aggression, or threats of harm

Surveillance and Screening

Developmental surveillance, or monitoring, and screening are common preventative and early intervention strategies implemented by medical providers, educators, welfare workers, and other youth-facing professionals to ensure the healthy development and early access to support for children (CDC-a).

Surveillance: The observation of development over time, including physical, cognitive, language, psycho-social, and behavioral changes in children – can be done by any caregiver, pediatrician, educator, law enforcement, or other youth-facing professional.

Screening: Brief structured interview or questionnaire validated through research designed to detect potential areas of concern or needed support which may indicate a need for further assessment – to be completed by trained professional.

Evaluation: A more formal and in-depth assessment of a child's development involving the use of structured or unstructured interviews of the child and caregiver(s), formal assessment tools such as IQ testing or psychological diagnostic inventories, and observation designed to detect voids, delays, and diagnosable concerns in a child's development.

A chart outlining the detailed components of surveillance and screening for preschool and school-age children with problematic sexual behavior has been adapted from the CDC's Developmental Monitoring and Screening fact sheet and provided on the following page.

	Sexual Developmental Surveillance	**Sexual Developmental Screening**	**Sexual Developmental Evaluation**
Who	YOU – caregivers, pediatricians, teachers, daycare providers, social workers, law enforcement, other care/educational/providers	Healthcare provider, early childhood teacher, other trained professional.	Developmental pediatrician, behavioral health professional, other trained professional.
What	Look for developmentally expected behaviors.	Look for developmentally expected behaviors.	Identify and diagnose problematic sexual behaviors.
When	Preschool to 12 years	Preschool to 12 years	Preschool to 12 years
Why	To help • Guide discussions about a child's development with healthcare and childcare providers • Learn developmentally expected behaviors • Identify concerns early	To determine • If child needs support for appropriate development • If further evaluation is recommended	To determine • If child needs early intervention • If a need for specialized treatment is indicated
How	Free developmental guide provided in this manual.	Formal validated screening tool (CSBI/EOSBI)	Formal assessment (e.g., combined interview, psychological and developmental evaluation, caregiver and other collateral reports)

Response and Intervention

Levels of Responding

Not only has intervention been shown to significantly reduce recidivism among preschool and school-age children exhibiting problematic sexual behavior (Fox, 2013; O'Brien, 2010; Przybylski, 2015), early interventions occurring nearest the onset of problematic sexual behavior were found to be critical in maintaining low recidivism 10- and 20-years post-intervention (Curwen, Jenkins & Worling, 2014; Rich, 2015).

Just as sexual behavior occurs on a spectrum from expected to problematic, responding should also occur on a spectrum from redirection and education to intensive intervention. Though sexual development is healthy and natural, the first time a child is observed to engage in sexual behavior may feel unexpected or be difficult for many adults to understand. It is important that responses to sexual behavior are developmentally appropriate and consistent with the behavior being displayed. The K.A.P.S. for problematic sexual behavior in preschool and school-age children proposes five levels of responding.

- **Level I: Redirection**
- **Level II: Education and Rule Setting**
- **Level III: Enhanced Supervision**
- **Level IV: Enhanced Supervision Across Settings**
- **Level V: Intensive Treatment (CBT-PSB)**

Level I: Redirection

Behavior: Initial behaviors that are developmentally expected but occur at inappropriate times or would be considered inappropriate, concerning, or problematic if the behavior persisted.

Response: Redirect child to activities or conversation unrelated to sexual behavior being exhibited.

Rationale: Sexual behavior is expected at every developmental stage. As children become more aware of relationships and functions of sexual body parts, sexual behavior is expected to evolve; this behavior generally responds to redirection as it stems from curiosity and is exploratory in nature.

Response Examples:

Example 1: 4-year-old child touches own genitals over or under clothes in front of others or in public settings while waiting in a line.

How to Respond:
Approach child with neutral body positioning, bend down to child's level, and state in a neutral even tone "Great job waiting patiently. Remember to keep our hands at our side when we wait in line".

Example 2: 11-year-old child stops at an open bedroom door on their way to go eat breakfast and begins to watch another person getting dressed.

How to Respond:
Approach child with neutral body positioning, pull door closed, and state in a neutral even tone "Time for breakfast. Be sure to eat enough so you will have energy until lunch".

Level II: Education and Rule Setting

Behavior: Repeated developmentally expected behaviors which occur after redirection and would be considered inappropriate, concerning, or problematic if the behavior persisted.

Response: Teach developmentally appropriate information about the body and rules regarding sexual behavior, privacy, and consent.

Rationale: While most developmentally expected sexual behaviors respond to redirection, some behaviors may persist requiring a more direct approach and developmentally appropriate information about sexual behavior including simple social rules and expectations regarding sexual body parts, privacy, and consent.

Private Parts:
Private parts are body parts that people cover with their swim wear. Some people cover all of their private parts like wearing shorts to cover their vulva, penis, and buttocks, and wearing a shirt or top to cover their breasts or chest. Other people choose to cover only their lower private parts.

Sexual Behavior and Privacy Rules:

- All bodies have private parts.
- All bodies belong to themselves.
    - Your body belongs to you; everyone else's body belongs to them.
- No one has the right to look at another person's body or private parts without permission.
- No one has the right to touch another person's body or private parts without permission.
- You can touch your own private parts in private.
- No one has the right to show their private parts to another person without permission.
- No one has the right to use their body or private parts to make other people uncomfortable.
- No one has the right to use language about bodies or private parts to make other people uncomfortable.

Response Examples:

Example 1: 4-year-old child touches own genitals over or under clothes in front of others or in public settings while waiting in a line. The child has been redirected to keep hands at his side in line but continues to touch genitals while in front of others.

How to Respond:
When the child is not part of a group, (e.g., before going outside to play but after other children have left) have the child sit with you at a table of comfortable chair. With neutral body positioning and a calm even tone say "I want to talk to you about how we stand in line. I noticed each time you stand in line, you touch your private parts. Do you know what private parts are?"

If the child answers "yes" or correctly describes private parts, say "that's right. Private parts are the parts of the body that people cover with their swim wear" and continue to teach the sexual behavior and privacy rules.

If the child answers "no" or incorrectly describes private parts (e.g., says "like a secret"), briefly describe private parts by stating "private parts are the parts of the body that people cover with their swim wear, like the buttocks, vulva, penis, and breasts/chest". Then, continue to teach the sexual behavior and privacy rules.

State, the rules in a developmentally appropriate manner say, "there are some rules about private parts that keep everyone safe and healthy that I want you to learn so you can be safe and healthy when you are in line. The **first** rule is that **all bodies belong to themselves**. That means that your body belongs to you and my body belongs to me. The next rule is that **no one can look at another person's private parts**. That means that no one can look at your private parts and you cannot look at other people's private parts. That also means that **no one can show their private parts to another person.** If you are in the bathroom and another person comes in, it is not okay for you to show them your private parts or for that person to show you their private parts. Next**, you can touch your own private parts in private.** This means that if you need to touch your private parts to use the restroom, clean yourself, or for any other reason, you should do it in private like a bathroom or your bedroom. The next rule is, **no one can use their body or private parts to make other people uncomfortable.** That means that people cannot scratch, rub, or touch their private parts in front of others, and they cannot put their body or private parts on others. The last rule is **no one can use their words about bodies and private parts to make other people uncomfortable.** This means that we cannot talk about bodies and private parts with someone who is not one of our trusted adults like a parent, doctor, or teacher."

Give the child the opportunity to tell you which rule they were breaking by touching their genitals in public. Ask, "when you were in line and you touched your private parts, which rule do you think that broke?" If the child answers which rule was broken correctly, say "that's right. You can touch your own private parts in private, but the line is not private so you should keep your hands at your side when you are in line. If you have an itch or need to use the restroom, you can ask to go to the restroom so you can take care of yourself."

If the child answers incorrectly/does not know which rule was broken, say "You can touch your own private parts in private, but the line is not private so you should keep your hands at your side

when you are in line. If you have an itch or need to use the restroom, you can ask to go to the restroom so you can take care of yourself."

Example 2: 11-year-old child stops at an open bedroom door on their way to go eat breakfast and begins to watch another person getting dressed. The child has been redirected in the past, but the behavior has continued.

How to Respond:
When the child is away from a group (e.g., before bed or after breakfast when other children have left the room), say "I want to talk to you about privacy. Do you know what privacy means?"

If the child correctly defines or gives an accurate scenario of privacy, continue by saying "Yes. Privacy is when something is for just you and not to be shared with others, like our private parts. Private parts are the parts of the body that people cover with their swim wear, like the buttocks, vulva, penis, and breasts/chest".

Teach the sexual behavior and privacy rules in a developmentally appropriate manner, say "All bodies have private parts and there are some rules about private parts that keep everyone safe and healthy that I want you to learn so you can be safe and healthy too. The **first** rule is that **all bodies belong to themselves**. That means that your body belongs to you and my body belongs to me. The next rule is that **no one can look at another person's private parts** - no one can look at your private parts and you cannot look at other people's private parts. That also means that **no one can show their private parts to another person.** Next**, you can touch your own private parts in private.** This means that if you need to touch your private parts to use the restroom, clean yourself, or for any other reason, you should do it in a bathroom or another private space. The next rule is **no one can use their body or private parts to make other people uncomfortable.** That means that people cannot or touch their private parts in front of others, and they cannot put their body or private parts on others. The last rule is **no one can use their words about bodies and private parts to make other people uncomfortable.** This means that we cannot talk about bodies and private parts with someone who is not one of our trusted adults like a parent, doctor, or teacher."

Give the child the opportunity to state which rule was broken by watching someone dress. Ask, "which rule do you think was broken?" If the child answers which rule was broken correctly, say "correct, no one can look at another person's private parts. If you look at someone's private parts, like standing at their open door, you are breaking a rule."

If the child answers incorrectly or says they do not know which rule was broken, say "no one can look at another person's private parts. Standing at someone's door while they dress or looking at pictures of private parts all break this rule."

Level III: Enhanced Supervision

Behavior: Repeated developmentally expected behaviors which occur after redirection, education, and rule setting or behavior that is considered inappropriate, concerning, or problematic.

Response: Caregivers should practice eyes-on supervision of child during activities where the behavior has occurred in the past, or in situations in which it is reasonable to believe the behavior is likely to occur.

Rationale: Children who require direct accurate developmentally appropriate education regarding their sexual behaviors often also require enhanced supervision to help the child identify problematic behaviors as they arise, as well as the appropriate replacement behaviors that are expected. Enhanced supervision allows for real time intervention as well as enhances the likelihood positive behavior changes will continue - keeping the child exhibiting behaviors and other children around them safe and healthy.

Eyes-on Supervision: A caregiver or other adult responsible for the child must maintain an unobstructed line of sight of the child at all times, except when the child is engaged in activities that are considered private and the child is able to maintain appropriate hygiene without assistance (e.g., using the restroom, bathing, dressing/changing clothes, etc.).

Response Examples:

Example 1: A 5-year-old child engages in self-touch and exploration in front of others. The child has been redirected and educated on rules regarding private parts and appropriate places/times to engage in self-exploration. The child continues to engage in the behavior even when other family members or friends are present.

How to Respond:
When the caregiver sees the child engage in the self-touch behavior in in public (any space that is designated for all to use such as a game room, playground, entertainment room, etc.), the caregiver should approach the child calmly and, in a calm, even-tone name the behavior, and remind child of the replacement behavior that is expected. Say, "Remember, we can only touch our private parts in private. If you need to take care of your body, ask to use a private place like a bathroom".

Example 2: An 11-year-old child removes their clothing exposing their private body parts to a peer they are playing with and asks the peer if they would like to play a naked game. This is the first time the child has engaged in this behavior, but it is still concerning and inappropriate due to the exposure of sexual body parts and asking another child to engage in behaviors with them.

How to Respond:

When the caregiver sees (or learns of) the child engaging in inappropriate sexual behavior, the adult should approach the child calmly, and in a calm, even-tone name the behavior, and educate the child on appropriate and inappropriate play. As the child has engaged in problematic sexual behavior that may be indicative of exposure to or experienced sexual behavior, the child should be supervised closely to ensure the child is following discussed rules and boundaries regarding privacy and sexual behavior, as well as monitored for potential trauma symptoms. If the child does not follow rules about privacy and sexual behavior, the caregiver will be able to respond as the behavior occurs to allow the child to learn the name of the behavior and the rules about that behavior.

Level IV: Enhanced Supervision Across Settings

Behavior: Repeated developmentally expected behaviors which occur after redirection, education, and rule setting or behavior that is considered inappropriate, concerning, or problematic.

Response: Coordinate with teachers, care providers, doctors, activity leaders, etc. to ensure child has eyes-on supervision at all times, especially when engaging with other children. Adults responsible for the child throughout the day should practice eyes-on supervision of child during activities where the behavior has occurred in the past, or in situations in which it is reasonable to believe the behavior is likely to occur. Child must not be allowed to be alone with other children, should not be in charge of other children, and should be under adult supervision at all times, except in private situations such as changing or maintaining personal hygiene practices.

Rationale: Children who require direct accurate developmentally appropriate education regarding their sexual behaviors often also require enhanced supervision to help the child identify problematic behaviors as they arise, as well as the appropriate replacement behaviors that are expected. Enhanced supervision across settings allows for real time intervention as well as enhances the likelihood positive behavior changes will continue - keeping the child exhibiting behaviors and other children around them safe and healthy.

Eyes-on Supervision: A caregiver or other adult responsible for the child must maintain an unobstructed line of sight of the child at all times, except when the child is engaged in activities that are considered private and the child is able to maintain appropriate hygiene without assistance (e.g., using the restroom, bathing, dressing/changing clothes, etc.).

** Many of the behaviors previously discussed may be determined to require across settings eyes-on supervision. Specific behaviors of concerns are those that are repeated, done in secret, and involve other children or animals, and behaviors that could cause harm to the child.

Level V: Intervention

Successful interventions for children exhibiting problematic sexual behavior were found to share an integrated approach encompassing caregiver education on child development and sexual development, behavior management strategies for caregivers and children, prosocial relationship skills including personal boundaries and consent, stress management and emotional regulation, and conflict resolution (Fox, 2013; O'Brien, 2010).

The table below organizes interventions by age group served and are recommended based on their foundations in research, level of successful intervention with low rates of recidivism, as well as adherence to an integrated developmental approach.

Intervention	Age
PSB-P Group	3 - 6 Years
PCIT-PSB	3 - 6 Years 11 Months
TFCBT-PSB	3 - 17 Years
PSB-S Group/Family	7 - 13 Years
PSB-A Group/Family	14 - 18 Years

Each intervention will be discussed in the pages that follow, beginning with the foundational components of Problematic Sexual Behavior-Cognitive Behavioral Therapy model, followed by adaptations to specific evidence-based interventions for trauma TF-CBT) and other behavior disorders in childhood (PCIT).

Problematic Sexual Behavior – Cognitive Behavioral Therapy (PSB-CBT)

The PSB-CBT model is an evidence-based intervention model that provides children and their families with the skills and knowledge needed to "**eliminate problematic sexual behavior and illegal sexual behaviors and improve prosocial behavior and adjustment, while reducing stress and enhancing skills**" (Problematic Sexual Behavior Cognitive-Behavioral Therapy, 2022).

7 Facts about the PSB-CBT

1. Utilizes a cognitive-behavioral and social ecological approach.
2. Is a short-term, community-based outpatient program for boys and girls and their caregivers.
3. Treatment services are provided either in family or group modality with 6-8 youth in a group.
4. Requires active involvement of parents or other caregivers in family therapy sessions or in a concurrent caregivers' group.
5. Referrals to the program come from various community partners including child protective services, juvenile justice, schools, behavioral health providers, and families.
6. Recidivism after intervention is lower 2 percent or less even after 10-year follow up (Carpentier, Silovsky & Chaffin, 2006). Adolescent model shows similar results of 2 percent recidivism for future problematic or illegal sexual behavior – greater success than the national average (Caldwell, 2016).
7. Programs available for adolescents (14-17:11), school-age (7-12 and up to 14), and preschool (3-6).

PSB-Preschool (Ages 3-6)

Treatment Length
90-minute weekly concurrent sessions for child and caregiver(s)
Number of Sessions/Modules
12 Modules
Topics
Supervision and Safety
Behavior Management Strategies
Boundaries
Assertiveness Skills
How to Make Helpful Choices and Follow Rules
Hot to Get Along with Other Children
Support for Families

*All genders attend group together.

PSB-School-Age (Ages 7-12)

Treatment Length
90-minute weekly concurrent sessions for child and caregiver(s)
Number of Sessions/Modules
18 Modules
Topics
Supervision and Safety
Parenting Strategies
Rules about Sexual Behavior
Affective and Cognitive Coping Skills
Self-Control Strategies
Abuse Prevention
Sexual Education
Empathy and Impact of Behavior on Others

*All genders attend group together.

PSB-Adolescent (Ages 13-17:11)

Treatment Length
90-minute weekly concurrent sessions for child and caregiver(s)
Number of Sessions/Modules
18 Modules (6-12 Months)
Topics
Supervision and Monitoring
Family Negotiation and Communication Skills
Healthy Sexual Behaviors
Taking Responsibility for Own Problematic Sexual Behaviors
Impact of Behaviors on Others
Applicable Sex Laws
Self-control Strategies
Community Safety

*Typically, youth are court-ordered or have court oversight for their illegal sexual behavior within this age group.

*All genders attend group together.

Parent-Child Interaction Therapy for Problematic Sexual Behavior (PCIT-PSB) (Ages 3-6:11)

PCIT is an evidence-based model targeting behavioral problems in young children. PCIT is conducted in two phases, Child-directed Interaction (CDI) and Parent-directed Interaction (PDI).

Phase One - CDI focuses on strengthening the parent-child relationship through learning and implementing research-based skills to help child feel calm, secure in their relationship with their caregivers, and confident in themselves.

Desired Outcomes Phase One:

- Decreased frequency, severity, and/or duration of tantrums
- Decreased activity levels
- Decreased negative attention-seeking behaviors (such as whining and bossiness)
- Decreased parental frustration
- Increased feelings of security, safety, and attachment to the primary caregiver
- Increased attention span
- Increased self-esteem
- Increased pro-social behaviors (e.g., sharing and taking turns).

Phase Two – PDI focuses on empowering caregivers to manage challenging behavior while maintaining their own emotional regulation and providing a consistent approach to discipline that will increase the child's ability to accept limits, comply with caregiver directions, respect rules, and demonstrate appropriate prosocial behavior.

Desired Outcomes Phase Two:

- Decreased frequency, severity, and/or duration of aggressive behavior
- Decreased frequency of destructive behavior (e.g., breaking toys on purpose)
- Decreased defiance
- Increased compliance with adult directions
- Increased respect for house rules
- Improved prosocial behavior
- Increased caregiver emotional regulation and confidence during discipline

When combined with the additional components of PSB-CBT for Preschool-Age children, PCIT becomes an effective evidence-based intervention to address challenging behaviors in childhood, as well as eliminating problematic sexual behavior (Shawler, Bard, Taylor, Wilsie, Funderburk & Silovsky, 2018).

Treatment Length
60-minute weekly concurrent sessions for child and caregiver(s)
Number of Sessions/Modules
12-20 (4-6 Months)
Topics
CDI (Child-directed Interaction) and PRIDE Skills
PDI (Parent-directed Interaction) and Listening and Minding
Supervision and Safety
Behavior Management Strategies
Boundaries
Assertiveness Skills
How to Make Helpful Choices and Follow Rules
Hot to Get Along with Other Children
Support for Families

*PCIT-PSB is a family therapy model involving the child and primary caregiver.
*Sibling sessions can be added to address challenging behavior and PSB.

Trauma-Focused Cognitive-Behavioral Therapy for Problematic Sexual Behavior (TFCBT-PSB) (Ages 3-18)

TF-CBT is an evidence-based intervention designed to support children, adolescents, and their caregivers to overcome traumatic experiences, such as sexual and physical abuse, domestic violence, community violence, natural disasters, and other life disruptions.

Reactions to Trauma:

- Inability/unwillingness to recall traumatic details
- Intrusive thoughts
- Emotional and physical numbing
- Inattentiveness, hyperactivity, excesses fidgeting
- Sleep disruptions (unable to fall asleep, unable to stay asleep, refusing to sleep, nightmares, excessive sleep).
- Rapid changes in mood
- Depression
- Anxiety
- Low-self esteem
- Mistrust of others
- Substance use (prescription, illicit, alcohol, other)
- Self-harm (cutting, strangling, allowing others to hurt them, etc.)
- Suicidal ideation
- Sexual acting out and other unsafe behaviors

Impacts of Symptoms/Behaviors:

- Increased risk of problems in school
- Increased risk of social isolation
- Increased risk of peer conflicts
- Increased risk of developmental delays
- Increased risk of future victimization or hardship

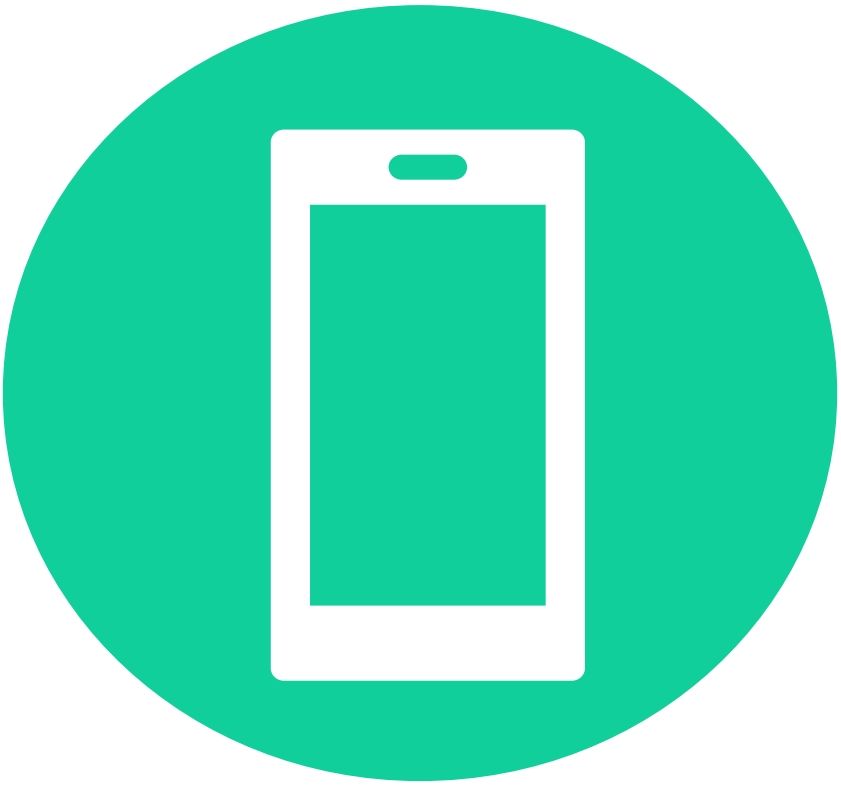
TF-CBT is an effective evidence-based intervention to address traumatic experiences, as well as eliminating problematic sexual behavior (oklahomatfcbt.org, 2006). One key component is to provide an opportunity for the child to discuss details about their trauma in a supportive environment.

TF-CBT supports caregivers by giving them skills to:

- Own their feelings about the child's experience
- Manage behavior and promote healthy communication
- Prepare to hear and supportively respond to trauma narrative

Treatment Length
60-minute weekly individual, caregiver, and conjoint sessions
Number of Sessions/Modules
12-16 Sessions (4-6 Months)
Topics
Psychoeducation and **P**arenting
Relaxation
Affect Management
Cognitive Coping
Trauma Narrative
In Vivo Exposure
Conjoint
Enhancing Safety
Sexual Behaviors (for PSB)

Referral Process



ATTENTION: Each state provides its own policies, regulations, and guidelines regarding problematic sexual behavior and children. No one organization, state or federal, oversees the handling of cases involving youth with problematic sexual behavior. Please follow your state's policies and procedures. The following proposed guidelines are intended to help inform the referral and intervention process and to provide a guide towards positive change in identify and intervening with youth with problematic sexual behavior.

1. Survey and Assess.
    a. Using the tools/checklists provided in the manual, make an assessment as to where the behavior may be coming from (developmental vs. environmental) – this does NOT mean conducting a forensic interview if you are not qualified. You are asking yourself purely based on your observation or the information reported to you. Law enforcement, child advocacy centers, and protective services may have other processes they need to complete that you asking further questions may interfere with.
2. Determine is behavior is expected or problematic.
    a. Using the characteristics discussed in the PSB module, determine whether the characteristics of the behavior(s) are expected or problematic.
3. Match behavior to the appropriate level of responding (Level I – V).
    a. Using the Levels of Responding guidelines, choose the appropriate level of response.
4. Connect youth and family to appropriate services (education vs. intervention).
    a. When indicated, connect the child and family to an interventionist (e.g., behavioral health professional in their area).
5. Determine whether your role will be intermediary (survey, assess, respond, and connect) or ongoing (support person/staff throughout intervention and monitoring post intervention).

Continuing Education

Continuing Education

Enhancing one's knowledge and professional growth are universally viewed as both positive and necessary. This is especially true in youth-facing professions such as teaching, protective services, law enforcement, faith-based leadership, behavioral and mental health, etc. As our knowledge on development and learning/rehabilitation increases, so does our ability to work with and effectively respond to youth with problematic sexual behavior. Routine surveillance, assessment, and appropriate responding allows us to intervene early and prevent future problematic sexual behavior and adult sexual offenses.

Opportunities for Continuing Education:

https://www.ncsby.org/events

- Research articles
- Trainings
- Conferences
- Other events

Along with keeping up with the most up-to-date information regarding youth with problematic sexual behavior, it is important to know who the professionals are who are qualified to intervene or provide treatment. The link provided below is not an exhaustive list of qualified professionals; however, it does contain contact information for providers who have been trained by the National Center on Sexual Behavior in Youth and met qualification standards to provide PSB-CBT. There may be other qualified professionals in your area that are not listed here.

Qualified PSB-CBT professionals (United States)

https://psbcbt.ouhsc.edu/Find-a-Provider/List-of-Providers

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