AMERICAN ACADEMY OF CLINICAL SEXOLOGISTS

AT MAIMONIDES UNIVERSITY

# CHILDREN WHO MOLEST OTHER CHILDREN: A GROWING TREND

A DISSERTATION SUBMITTED TO THE FACULTY OF THE AMERICAN ACADEMY OF CLINICAL SEXOLOGISTS AT MAIMONIDES UNIVERSITY IN PARTIAL FULFILLMENT OF THE REQUIREM ENTS FOR THE DEGREE OF DOCTOR OF PHILOSOPHY

BY

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DISSERTATION APPROVAL

This dissertation submitted by Lorraine A. Mitchell has been read and approved by three faculty members of the American Academy of Clinical Sexologists at Maimonides University.

The final copies have been examined by the Dissertation Committee and the signatures which appear here verify the fact that any necessary changes have been incorporated and that the dissertation is now given the final approval with reference to content, form and mechanical accuracy.

The dissertation is therefore accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

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# ABSTRACT

This paper explores the fact that children are by their very nature, sexual beings. The paper attempts to focus on the recent sexual abuse hysteria and discredit those who label children as sexually reactive and future perpetrators. Studies are included which provide therapeutic intervention for these children.

Exhibiting non-coercive sexual behaviors does not make children dysfunctional, sexually reactive or future sexual predators. In fact, children who are labeled as sexually reactive are no different from other children and no more likely to become sexual perpetrators. These children are being labeled during their formative years with no proof that they will sexually offend or reoffend in the future.

Society is putting this population at an unfair disadvantage and is actually assisting in the development of their future abusive behavior. By isolating, stigmatizing and labeling these children while in their formative years, does not give them the opportunity to interact with their peer group, causing them to miss out on dating and seeing how healthy relationships operate. Children have varied sexual practices unlike adults whose sexual practices have become a habit. It should be noted that it takes years for an individual to develop a habit and it would take years to shape a child into having sex with younger children.

The Juvenile Justice System is doing these children a great political injustice by labeling them as sex offenders as early as 18 months old. These children are being forced to carry the label of sexual perpetrator throughout their lives when they may not in fact be deserving of this label. It appears that due to society's sexual hysteria, a witch-hunt has been launched on our children, one which society will come to regret.

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CHAPTER 1

## Introduction

Today, there is a new trend of children, those who molest other children. Attempts are made to show how the children are naturally sexual beings and that sexuality is a part of our nature. Exhibiting non-coercive sexual behaviors does not make children dysfunctional, sexually reactive or future sexual predators.

This paper attempts to show that children who are labeled as sexually reactive are no different from other children and no more likely to become sexual perpetrators. These children are being labeled during their formative years with no proof that they will sexually offend in the future. Children have varied sexual practices unlike adults whose sexual practices have become a habit. It should be noted that it takes years for an individual to develop a habit and it would take years to shape a child into having sex with younger children. For example, an adult who smokes cigarettes starts off with mild cigarettes, then as time goes by the cigarettes get stronger until he's maybe smoking marijuana and other more potent substances. So it is with children. They do not have definite sexual practices while they are young; these practices take time to develop. A 30 year old man has definite sexual practices, e.g., he prefers 6 year old females. It took time for him to develop his "taste."

Research shows that these children more than likely will grow up and never offend again. There is no sufficient evidence to prove that these children will go on to become sexual offenders. The chances are they may grow up to become criminal offenders (trust, property, substance, burglary or domestic abusers) and never violate anyone sexually in their lifetime. Society is putting this population at an unfair

disadvantage and actually assists in the development their future abusive behavior. This is done by isolating, stigmatizing and labeling these children while they are in their formative years. By not allowing these young people to interact with their peer group they miss out on dating and seeing how healthy relationships should operate. Instead they are left confused, vulnerable and forced to interact with and form bonds with younger children. It should also be noted that juvenile sex offenders have numerous issues such domestic violence, lack of male role models, lack of social skills and lack of peer interaction during their formative/teenage years.

The Juvenile Justice System is doing these children a great political injustice by labeling them as sex offenders as early as 18 months old. They are causing these children to carry the label of sexual perpetrator throughout their lives when this may not be the case. It appears that due to sexual hysteria in our society that a witch-hunt has been launched on our children, one which society will come to regret.

Several studies are included which provide therapeutic intervention for these children.

CHAPTER 2

## The Making of Sexually Reactive Children

This new field of social science study is concerned with preadolescent children who exhibit sexually aggressive behaviors towards other children. Sexually aggressive children are defined as those who are twelve and younger, who exhibit patterned behaviors of sexuality (which are too advanced for their ages) in conjunction with aggression (force, coercion, secrecy) towards other more vulnerable children (West, 1999). Araji (1997), argues against comments written in, Coming to Understand Them (West, 1997), especially that sexually aggressive children are produced in homes where physical violence and sexual abuse can be extreme. Aggression, anger, conflict, neglect and little support are common. Children are exposed to sexualized adult behaviors which may range from poor sexual boundary maintenance to genital contact and even intercourse. These children in turn exhibit coercive sexually aggressive behaviors towards other children. In a study conducted by Gray, Busconi, Houchens, and Pithers (1997), they found that many abusers were themselves abused. The study consisted of 72 children who had engaged in sexual misconduct with other children, and they determined that 95% of the children for whom maltreatment data could be collected had been sexually abused. In addition, 48% had suffered physical abuse. Pithers, Gray, Busconi, and Houchens (1998) also conducted a study exploring the family characteristics of 6 to 12 year olds who had engaged in problematic sexual behavior. In general, the parents of these children established an insecure attachment to their children and rejected those characteristics they found disappointing. In addition, the parents exercised little supervision, which contributed to the sexual acting-out behavior and reduced the chance

that this behavior would stop. Significant levels of sexual abuse in the extended family were also identified. Both sexual abuse victims (72% of the extended families had at least one sexual abuse victim) and sexual abuse offenders (62% of the extended families had a least one additional sexual abuse offender) were found.

In a study comparing offenders who had been abused with offenders who had not, Hunter and Figueredo (2000) noted that adolescent offenders with or without a history of molestation are more likely to demonstrate high levels of pessimism and hopelessness and lower levels of self-sufficiency when compared to a matched group. In addition, multiple molestations at an early age were identified as a risk factor for becoming a juvenile sexual offender.

**Juvenile Sexual Offenders**

Juvenile sexual abuse offenders represent a large segment of the population of sexual offenders. In fact, juvenile sexual abuse offenders are responsible for 20% to 30% of the rapes and 30% to 60% of the child molestation cases in this country, with an alarming rise in the 6 to 12 year old range (Social and Rehabilitation Services, 1995).

Araji (1997), also argues that a "culture of denial" refuses to see children as capable of initiating aggressive sexuality and this inhibits adequate social service responses. Yet she argues that the physical abuse and aggression towards children may be more salient in explaining these behaviors than sexuality per se. She reviews the variations in system response across the United States which include legal responses such as charging children who demonstrate "culpability" with a sexual crime or sexual harassment; developing social service responses such as tools for identification,

education and psychotherapy for children and their families, and developing community responses with training for schools, the media and other service providers.

**Sexual Abuse Hysteria**

The "sexual hysteria" movement of the 1990s where a six year old boy gets suspended from school for kissing a six year old girl on the cheek demonstrates how societies or subcultures define sexuality in relation to children and this is extremely problematic. As the adult culture in the United States is struggling over the nature and definition of sexual harassment, sexual consent, and even what constitutes sexual behaviors (President Bill Clinton did not consider oral sex with an intern real "sex"), to take on the task of dealing with sexuality and aggression in small children becomes daunting indeed. Further, are children "aggressors" or "victims?" Are they to be protected or prosecuted by social systems? What are children's rights and who is considered a "child" now? This is topic which requires richer sociological analysis, (West, 1997).

**Young Children and Sexual Behavior Problems**

Over the past two decades, the incidence and ramifications of sexual behavior problems in childhood have increasingly come to the attention of professionals in the child maltreatment and children's mental health fields and more recently in the juvenile justice system (American Academy of Child Adolescent Psychiatry, 1999; Department of Social and Health Services, 1992, National Task Force on Juvenile Sexual Offending, 1993). Children as young as 3 years of age have been found to exhibit sexually intrusive acts against other children such as fondling and oral sodomy (Freidrich & Luecke, 1988, 1989). Due to the rise in children with sexual behavioral problems a number of treatment

programs designed for this population have rapidly increased, and many of these specialized sexually behavioral treatment programs treat children as young as 3 and 4 years of age (Araji, 1997; Freeman, Longo, Bird, Stevenson, & Fiske, 1994). Demonstrating sexual behavior problems as a young child may be associated with problems of adjustment and development, including socialization difficulties, increased risk of victimization, and care-giver relationship difficulties, which can lead to disruptions in the child's residential placement (Araji, 1997). Recognition of the need to treat children who exhibit inappropriate sexual behaviors is growing, and there is an increased concern that if left unchecked or untreated these problems may graduate into criminal sexual offending (Bonner, Walker, & Berliner, 1999). There is little evidence to support this concern. To date, research on problematic sexual behaviors has focused on young children (12 and younger) and on adolescents who have already committed serious sexual crimes (Silovsky & Niec, 2002). The clinical research picture contains little information on adolescents whose sexual behavior problems have not reached the level of criminal offending.

The goals of the study conducted by Letourneau, Schoenwald & Sheldow (2004) were to describe the characteristics of a sample of youth, ages 5 to 19, with non-criminal sexual behavior problems and to evaluate treatment outcomes for this group. In order to provide a context for the study, researchers briefly reviewed extant research on the characteristics of young children (ages 3 to 12) with sexual behavior problems and on adolescent sex offenders. Chaffin, Letourneau, and Silovsky (2002) defined problematic sexual behaviors occurring in childhood as those occurring with unexpected frequency, in coercive contexts, or between youth in different age groups and as those that resist

intervention, interfere with development, and/or are associated with emotional distress (p.208). The study found that in general, children with sexual behavior problems are a highly heterogeneous group with few characteristics that distinguish them from other children (Chaffin, et. al., 2002). Research identified some individual and family factors that are characteristic of such children as summarized.

**Factors that Characterize Children with Sexual Behavior Problems**

***Individual factors***. Several individual factors have been examined in the literature on children with sexual behavior problems and adolescent sex offenders including gender, age, abuse history, and comorbid psychiatric problems. Few of these characteristics distinguish children with sexual behavior problems from other groups. Even gender, a robust factor that characterizes adolescent sex offenders fails to distinguish children with sexual behavior problems. Age appears differentially related to child sexual behavior problems and adolescent sexual offending (Ageton, 1983; Alexander, 1999; Pastore & Maguire, 2000; Worling & Curwen, 2000). Research on sexual behavior problems in children ages 6 to 12 suggests that age is negatively correlated with frequency of inappropriate sexual behaviors (Bonner et. al., 1999; Friedrich, et. al., 1991, 2001). The limited data on adolescent sex offenders suggest younger adolescents (13 to 15) are no more likely than older adolescents (16 to 18) to commit sexual crimes (Ageton, 1983). The severity of sexual crimes does appear to increase with age, however, as older teenagers are more likely to commit crimes involving penetration and overt force (Barbaree, Hudson, & Seto, 1993).

A personal history of sexual abuse is characteristic of children with sexual behavior problems and adolescent sex offenders. It is unclear whether a history of

physical abuse or neglect is another risk factor for inappropriate sexual behavior (Bonner et. al., 1999; Friedrich et. al., 1992). In a small study of preschool-aged children, physical abuse and witnessing domestic violence were related to inappropriate sexual acting out, but this was not the case in a study that compared children (ages 6-12) referred for sexual behavior problems with a group of children referred for other problems (Bonner et al., 1999). For adolescents, however, a history of physical abuse appears to be a clear risk factor for adolescent sexual (and nonsexual) offending (Becker, 1998; Benoit & Kennedy, 1992; Davis & Leitenberg, 1987; Milloy, 1994).

Children with sexual behavior problems are likely to exhibit additional internalizing and externalizing behavior problems. Relative to other delinquent youth, adolescent sex offenders appear to have fewer violence and attention-related problems (Kempton & Forehand, 1992). Relative to non-delinquent youth, adolescent sex offenders are more likely to demonstrate internalizing problems such as anxiety (Blaske et. al., 1989; Jacobs, Kennedy, & Meyer, 1997; Kempton & Forehand, 1992).

***Family factors***. The most robust family correlate of child sexual behavior problems is family sexuality, defined as family nudity and opportunities for children to view sexual intercourse. Family sexuality has not been systematically assessed with samples of adolescent sex offenders. Family risk factors for adolescent sex offenders parallel risk factors for other delinquent youth. These risk factors include parental violence and abusive parenting. In particular, physical abuse by fathers has been related to increased sexual aggression whereas maternal bonding appears to decrease sexual aggression ((Ageton, 1983; Becker, 1998; Benoit & Kennedy, 1992; Koyayashi, Sales, Becker, Figueredo, & Kaplan, 1995)). Additional family disruptions such as long-term

unemployment, death, or divorce also distinguish delinquent from nondelinquent youth. Delinquent youth (sexual and nonsexual offenders) are more likely to perceive more negative labeling from parents than non-delinquent youth. In addition, family factors such as low parental monitoring; ineffective, harsh, or inconsistent discipline; and family conflict are known predictors of delinquency in youth. It is highly probable that these family factors may well be involved at least for delinquent youth that commit sex offenses (Blaske et. al., 1989; Borduin, Henggeler, Blaske & Stein, 1990).

***Peer factors***. The influence of peer factors in the development of sexual behavior problems in children has not been examined, but evidence suggests associations between such factors and adolescent sex offending. Clear support for the influence of delinquent peers on adolescents who acknowledged committing criminal sexual behavior was found. However, one study suggests the influence of peers may differ for subgroups of adolescent sex offenders. Specifically, some offenders with much younger victims may spend free time with younger children rather than with same-aged peers delinquent or otherwise, (Ageton, 1993; Milloy, 1994).

***School factors***. It is unclear whether child sexual behavior problems are related in any way to school related problems. Poor school achievement and the need for specialized school services were suggested by data in one study that lacked a comparison group but were not found in a study comparing children with sexual problems; both groups had average scholastic achievement. Poor school functioning characterizes delinquent youth in general and delinquent youth who commit sex offenses ((Pithers, Gray, Busconi, & Houchens, 1998).

**Definition of Problematic Sexual Behavior in Children**

Sexual behavior in children is defined as problematic when it:

(a) occurs at a greater frequency or at a much earlier age than would be developmentally expected;

(b) interferes with children's development;

(c) occurs with the use of coercion, intimidation, or force;

(d) is associated with emotional distress (in the child with sexual behavior problems or other children involved); and/or

(e) reoccurs in secrecy after intervention by caregivers. This definition includes both sexually aggressive behaviors (use of force or coercion) and intrapersonal sexual behavior problems (e.g., excessive masturbation) that does not involve other children. Due to the young age of the children, age difference between children is not required for the sexual act to be considered a sexual behavior problem. Thus, this definition includes acts that would not be labeled as "sexually abusive," (adapted from Hall, Mathews, Pearce, Sarlo-McGarvey & Gavin, 1996).

**Labeling Children with Inappropriate Sexual Behaviors**

In some of the literature, children who demonstrated inappropriate sexual behaviors were given a variety of labels e.g., sexually reactive children, sexual offenders, children who molest, child perpetrators. More recent conceptualizations of these children have used the term "children with sexual behavior problems: (children with SBP) as it more clearly describes the behavior without assigning a negative label to the child (Araji, 1997; Bonner, Walker, & Berliner, 1999; Gray & Pithers, 1997). "Perpetrator," "offender," and related terms when used with children with SBP are not only legal

malapropisms but also potentially detrimental to children's developing self-concept (Chaffin, Letourneau, & Silovsky, in press).

There are many questions that need to be asked when it comes to sexually aggressive children such as:

(1) What is "normal" child sexual behavior?

(2) What term(s) should be used to label children exhibiting sexual behavior problems?

(3) Is child sexual behavior which looks the same as adult sexual behavior really the same?

(4) What role does the family and environment play in developing, sustaining or inhibiting problematic sexual behavior?

(5) Should treatment for the child or protection of others be our primary concern?

(6) Should treatment focus primarily on the child's own victimization issues or on his/her perpetration behavior?

(7) Should children with sexual behavior problems ever be considered to be criminally responsible for their behavior, i.e., are children (12 and under) capable of criminal intent?

These questions have not been answered, and the issues arising from them are far from being resolved. Considerable disagreement still exists among practitioners, as well as in the general community, concerning the most appropriate way to address problematic sexual behavior in children (Araji, 1997).

CHAPTER 3

## Understanding the Sexual Behavior of Children in Care

The following information introduces the concerns about inappropriate and abusive sexual behavior amongst children and young people in care. The Children were divided up into four groups:

***Group I*;** natural and healthy sexual play;

***Group II;*** sexually-reactive behaviors

***Group III;*** children who mutually engage in a full range of adult sexual behaviors

***Group IV;*** includes children who molest other children

If one was to ask a group of teachers, school counselors, or social workers, if they think children today express more sexual behaviors than they did a generation ago, they would most likely say "yes". Documenting such an increase, however, would be impossible, because, until recently there has been no reliable collection of data about the number and types of sexual behaviors in which children engage; even now, such research is in its infancy (Cavanagh Johnson, 2001).

All of us can point to certain sociological factors that may be contributing to changes in sexual behaviors, including children's access to wider television programming, adult videos, and communications facilities that provide on-line and telephone sexual experiences for callers. Without an established base of research, however, how are parents, teachers, and counselors able to determine when children's sexual behaviors fall within an acceptable range of sexual behaviors, or when they may require intervention and treatment?

Many professionals continue to argue that intervention around sexual issues is never required for children that all sexual behaviors of children are, by their very nature, benign and uncomplicated. However, a growing body of research largely based on two specific populations, children who have been sexually abused and children who have used some kind of coercion or pressure to force other children into sexual behaviors is causing many professionals to rethink that argument. Many professionals who work with children are aware of contemporary studies that suggest that increased sexual behaviors may be an indication that a child is being, or has been sexually molested. Increasing evidence also points to the fact that it is important to evaluate young children who are coercing other children into unwanted sexual behaviors; research on adult offenders has revealed that many offenders began their coercive sexual behaviors in elementary school and increased the number and violence of their sexual behaviors during adolescence. Such findings indicate that there may be danger in just hoping that children will grow out of coercive sexual behaviors (Cavanagh Johnson, 2001).

It has also been found that overreacting to children's sexual behaviors can also have negative consequences; it could cause them to feel ashamed and self-conscious about a natural and healthy interest in their bodies and sexuality.

It is also important to note that adults who work with children often assume that they "just know" whether a child's sexual behavior is natural and healthy. However, what they are generally using in making their evaluations are just sets of internal, and largely unconscious, intuitive guidelines, which have been drawn from their own sexual experiences as children, their parents' attitudes, their religious beliefs, and other aspects of their personal histories and cultures.

Such preformed guidelines may actually reveal more about the adult evaluator than the child in question. Individual standards for evaluation, not surprisingly, vary widely: some adults think that any behavior of a young child relating to sexuality is unacceptable, while others accept a wide range of sexual behaviors among children. Professionals who work with children need practical data-based guidelines to determine when a child's sexual behaviors are within acceptable limits and when they are causes for concern.

While research data on childhood sexuality is still in the pioneering stages, there is enough information to establish some important observations about the sexual behaviors of children 12 years of age and younger. In looking at the continuum of sexual behaviors, it is important to remember that:

1. There is no single standard for determining normal sexual behaviors in all children, since there are individual differences due to the development level of the child and due to the amount of exposure the child has had to adult sexuality, nudity, explicit television, and videos. Parental and societal attitudes and values, as well as the child's peer group and living conditions, exert additional influences on the types and range of the child's behaviors. A set of guidelines, nonetheless, may provide a base-line by which children's sexual behaviors can be somewhat objectively evaluated by this time, and may help target potential problems.

2. The sexual behaviors of a child represent only one part of their total being. Sexual behaviors should not be used as a sole criterion for determining whether a child has a significant problem as will be shown in the Initial Assessment.

## A Continuum of Sexual Behaviors

Professionals who work with children need to have perspectives on the full spectrum of childhood sexual behaviors, from the wide variety of what are perceived to be age-appropriate healthy activities to patterns that may be unhealthy or pathological and may require attention and/or treatment.

***Group I:*** includes children engaged in natural and healthy childhood sexual exploration;

***Group II*****:** is comprised of sexually-reactive children;

***Group III*****:** includes children who mutually engage in a full range of adult sexual behaviors; and

***Group IV*****:** includes children who molest other children.

This continuum of sexual behaviors applies only to boys and girls, aged 12 and under; who have intact reality testing and are not developmentally disabled. Each group includes a broad range of children, some are on the borderline between the groups, and some move between the groups over a period of time (Cavanagh Johnson, 2001).

## The Initial Assessment

The initial assessment, to determine where on the continuum the child may fall, includes:

1. An evaluation of the number and types of sexual behaviors of the child.
2. A history of the child's sexual behaviors.
3. Whether the child engages in sexual activities alone or with others.
4. The motivations for the child's sexual behaviors.
5. Other children's descriptions, responses, and feeling sin regard to the child's sexual behaviors.

6. The child's emotional, psychological, and social relationship to the other children involved.
7. Whether trickery, bribery, physical or emotional coercion is involved.
8. The affect (levels of feelings) of the child regarding sexuality.
9. A thorough developmental history of the child, including abuse and out-of-home placements.
10. Access and careful reading of protective services' reports, court reports, and probation documents (if applicable).
11. An assessment of the child's school behaviors, peer relations, behaviors at home, and behaviors when participating in out-of-home activities, such as day care or recreational programs.
12. A history of each family member; the overall family history, and an evaluation of the emotional and sexual climate of the home. Assessment of these areas helps to determine whether the child falls into Group I, II, III, or IV.

If the child falls into Groups II, III or IV, a thorough evaluation to assess the treatment needs of the child, and the family, will be necessary. It is recommended that assessments should be completed by a mental health professional who specializes in child sexual abuse. While the child may not have been sexually abused, the sexual behaviors demonstrated in these groups may be indicative of previous or current sexual abuse.

**Group I: Natural and Healthy Sexual Play**

Normal childhood sexual play is an information gathering process. Children explore, visually and through touch, each other's bodies (for example, play doctor), as well as trying out gender roles and behaviors (e.g., play house). Children involved in such explorations are of similar age and size, are generally of mixed gender; are friends rather than siblings, and participate on a voluntary basis ('I'll show you mine if you show me yours!"). The typical feeling level of these children, in regard to sexually-related behaviors, is light-hearted and spontaneous. In natural sexual play or exploration, children often are excited, and they feel and act silly and giggly. While some children in Group I may feel some confusion and guilt, they do not experience feelings of shame, fear, or anxiety, (Cavanagh Johnson, 2001).

The sexual behaviors of children who are engaged in the natural process of childhood exploration are balanced with curiosity about other parts of their universe as well. They want to know how babies are made and why the sun disappears; they want to explore the physical differences between males and females and figure out how to get their homework done more quickly, so they can go out and play. If children are discovered while engaged in sexual play and are instructed to stop, their sexual behavior may, to all appearances, diminish or cease, but it generally arises again during another period of the child's sexual development.

The range of sexual behaviors in which children engage is broad; however, not all children engage in all behaviors: some may engage in none, and some may only engage in a few. The sexual behaviors engaged in may include; self-stimulation and self-exploration, kissing, hugging, peeking, touching, and/or the exposure of one's genitals to

other children, and, perhaps, simulating intercourse, (a small percentage of children, 12 or younger, engage in sexual intercourse). Because of this broad range of possible sexual behaviors, diagnosing a child on sole basis of their sexual behaviors can be misleading. Although children who have sexual problems usually manifest more varied and extensive sexual behaviors than Group I children, their behaviors may, in some cases vary only in degree.

**Group II: Sexually-Reactive Behaviors**

According to Cavanagh Johnson, 2001, Group II children display more sexual behaviors than the same-age children in Group I; their focus on sexuality is out-of-balance in relationship to their peer groups; and they often feel shame, guilt, and anxiety about sexuality.

Many children in Group II have been sexually abused; some have been exposed to explicit sexual materials; and some have lived in households where there has been too much overt sexuality. Young children, who watch excessive amounts of soap operas or television and videos, and who live in sexually explicit environments, may display a multitude of sexual behaviors. Some parents, who themselves may have been sexually and/or physically victimized, express their sexual needs and discuss their sexual problems openly with their young children. This can over-stimulate and/or confuse their children. Some children are not able to integrate these experiences in a meaningful way. This can result in the child acting out his or her confusion in the form of more advanced or more frequent sexual behaviors, or heightened interest and/or knowledge beyond that expected for a child of that age. The sexual behaviors of these children often represent a repetition compulsion or a recapitulation (often unconscious) of previously over-stimulated

sexuality or sexual victimization. The time between the sexual over-stimulation and the sexual behaviors is close, and often overlaps or is contiguous.

Behaviors of Group II children include: excessive or public masturbation, overt sexual behaviors with adults, insertion of objects into their own or other's genitals, and talking about sexual acts. Such sexualized behavior may be the way the child works through his or her confusion around sexuality. After being told that their sexual behaviors need to be altered, Group II children generally acknowledge the need to stop the behaviors and welcome help. The sexual behaviors of this group of children are often fairly easy to stop, as they do not represent a long pattern of secret, manipulative, and highly charged behaviors, such as those seen among child perpetrators in Group IV.

**Group III: Extensive Mutual Sexual Behaviors**

Group III children have far more pervasive and focused sexual behavior patterns than Group II children, and they are much less responsive to treatment. They participate in a full spectrum of adult sexual behaviors, generally with other children in the same age range, (oral and anal intercourse, for example), and they conspire together to keep their sexual behaviors secret. While these children use persuasion, they usually do not force or use physical or emotional coercion to gain other children's participation in sexual acts. Some of these children however, move between Groups III and IV, i.e. between mutually engaging in sexual behaviors and forcing or coercing other children into sexual behaviors.

One of the striking differences between Group III children and the children in other groups is their affect or emotional level – or more precisely, their lack of affect – around sexuality. Group III children do not have the light-hearted spontaneity of sexually

healthy children, the shame and anxiety of sexually-reactive children, or the anger and aggression typical of child perpetrators. Instead, they display a blasé, mater-of-fact attitude toward sexual behaviors with other children – as one explained, "This is just the way we play".

It might be more accurate to say that sexual interaction is the way Group III children try to relate to their peers. As for relating to grownups, most Group III children expect only abuse and abandonment from adults. Other group III children have been sexually abused, in a group, by one or more adults, and continue the sexual behaviors experienced with the other children after the abuse by the adults has stopped. Other children in Group III are siblings who mutually engage in extensive sexual behaviors as a way of coping in their highly dysfunctional families.

All Group III children have been sexually and/or physically abused and/or have lived in highly chaotic and sexually charged environments. Through these experiences their understanding of relationships has become skewed; distrustful of adults, chronically hurt and abandoned, and lacking in academic and social success. These boys and girls use sexuality as a way to make another child a friend – even briefly. Few of these children report any need or drive for sexual pleasure or orgasm, and although their "What's the big deal?" attitude may have the appearance of sophistication, it conceals significant emotional vulnerability. Their sexual actives appear to be their attempts to make some kind of human connection in a world which is chaotic, dangerous, and unfriendly (Cavanagh Johnson, 2001).

**Group IV: Molestation Behavior**

Many professionals involved with the care and protection of children find it difficult to believe that children 12 years and younger can molest other children. Evidence that they an, and do, is found not only in a growing group of studies and journal articles, but in FBI reports and newspaper clippings. In one recent case, a fourth grader was sexually assaulted by several students in the bathroom of her local public school. The incident occurred at a small country school in Vermont which serves just 150 children, from kindergarten through fourth grade. The perpetrators of the sexual assault against the little girl were all her age or younger. Two 10-year-old boys from the girl's class initiated the attempted rape, and three other boys watched or helped to hold the struggling victim while her attackers tried to penetrate her. One of these boys was eight years old and the other two were six years old.

This small town incident is just one example of a nationwide in crease in reports of sexual offences by prepubescent children that have taken the system by surprise. Last year, in the state of New York, "juvenile court prosecutors handled 270 cases of sexual crimes involving children 12 years old and younger – more cases than in the 13-to 15 year-old range. Commenting on the statistics, Peter Reinharz, supervisor of the sexual crimes prosecution unit, noted that the age drop meant that the unit was dealing with "eight, nine, ten-year-olds committing rape (and) sodomy. The identified victims are usually other children (Cavanagh-Johnson, 2001).

Only a few treatment programs have been established for these child perpetrators, but preliminary findings on children in Group IV have been published. As a group they have behavior problems at home, and at school, few outside interests, and almost no

friends. These children lack problem-solving and coping skills, and demonstrate little impulse control. Often, they are physically and sexually aggressive. In preliminary findings on child perpetrators, no one – parents, teachers, or peers – described any member of the group as an average child.

The sexual behaviors of Group IV children go far beyond developmentally appropriate childhood explorations or sexual play. Like the children in Group III, their thoughts and actions are often pervaded with sexuality. Typical behaviors of these children may include (but are not limited to) oral copulation, vaginal intercourse, anal intercourse and/or forcibly penetrating vagina or anus of another child with fingers, sticks and/or other objects. These children's sexual behaviors continue and increase over time, and are part of a consistent pattern of behaviors rather than isolated incidents. Even if their activities are discovered, they do not, and cannot, stop without intensive and specialized treatment (Cavanagh-Johnson, 2001).

A distinctive aspect of Group IV children is their attitudes toward sexuality. The shared decision making and lighthearted curiosity evident in the sexual play of children in Group I is absent; instead, there is an impulsive, compulsive, and aggressive quality to their behaviors. These children often link sexual acting out to feelings of anger (or even rage), loneliness, or fear. In one case, four girls held a frightened, fighting and crying 18-month-old child while another girl felated him. The girls (all age six to eight) each took a turn. The little boy required extensive medical attention as a result of penile injuries.

While most of the case studies in this group are not physically violent, coercion is always a factor. Child perpetrators seek out children who are easy to fool, bribe, or force into sexual activities with them. The child victim does not get to choose what the sexual

behaviors will be, nor when they will end. Often the child victim is younger and sometimes the age difference is as great as 12 years, since some of these children molest infants. On the other hand, some child perpetrators molest children who are age-mates or older. In sibling incest with boy perpetrators, the victim is typically the favorite child of the parents. In other cases, the child is selected due to special vulnerabilities, including age, intellectual impairment, extreme loneliness, repression, social isolation, or emotional neediness. Child perpetrators often use social and emotional threats to keep their victims quiet: "I won't play with you ever again, if you tell", this is a powerful reason to keep quiet if the child victim already feels lonely, isolated or even abandoned at home and at school.

Even the bathroom games sometimes seen in Group I children are markedly different from the disturbed toileting behaviors common in Group IV. Some children who molest other children habitually urinate and defecate outside the toilet on the floor, in their beds, outdoors, etc.) While many Group I children may mildly resist changing underwear, some children in Group IV will wear soiled underpants for more than a week or two and adamantly refuse to change. Some constantly sniff underwear. Many of the children regularly use excessive amounts of toilet paper (some relate wiping and cleaning themselves to masturbation) and stuff the toilet until it overflows day after day. The children continue these disturbed toileting patterns even if their families have severely punished them for their behavior. While Group IV children often obsessively focus on toileting and sexual activities, the natural and healthy sexual curiosity and delight of young children in their bodies is absent. Instead, they express a great deal of anxiety and confusion about sexuality. Many Group IV children say they act out sexually when they

feel jumpy, funny, mad (angry) or bad. Yet, after engaging in sexual behaviors, most report that they feel worse (Cavanagh-Johnson, 2001).

Most child perpetrators who have been studied have been victims of sexual abuse themselves, although the sexual abuse generally has occurred years before the children began molesting other children. All of the girl perpetrators (females represent about 25% of child perpetrators) and about 60% to 70% of the boy perpetrators have been molested. All of the children live in home environments marked by sexual stimulation and lack of boundaries, and almost all of the children have witnessed extreme physical violence between their primary caretakers. Most parents of Group IV children also have sexual abuse in their family histories, as well as physical and substance abuse.

This group of children is at the highest risk for continuing, and escalating, their patterns of sexually abusive behaviors, unless they receive specialized treatment specifically targeting their acting out. Unfortunately, there are only a handful of any type of treatment programs specifically targeted for children who molest other children. A jury in New York City took just two months to convict a ten-year-old boy of raping a seven-year-old girl, but two years to find a treatment resource for him

Even in an age of sharply limited government funds, increasing resources for children who molest other children are vital. Gene Abel, MD, Director of the Behavioral Medicine Institute in Atlanta, and the author of more than 80 articles on sexual offenders, has hypothesized that the average adolescent perpetrator could be expected to commit more than 300 sexual crimes in his lifetime. Abel noted, “We know that many adolescent perpetrators engaged in deviant sexual behaviors as early as five or six years of age. When there is persistent and consistent pattern of sexually deviant behavior in young

children, early assessment and specific treatment affords the best opportunity to stop the behavior (Cavanagh-Johnson, 2001).

**Conclusion: The Need for Practical Guidelines on Child Sexual Behaviors**

While thorough evaluation needs to be provided by an expert in child sexual behaviors, it is almost always a non-specialist who identifies sand refers a child for evaluation. The persistent and consistent pattern of problem sexual behaviors is usually first noticed by parents, caretakers, and front line professionals, including school teachers, nurses, counselors and social workers. For this reason, all professionals who work with children or families need practical guidelines as to which child sexual behaviors are natural and healthy and which behaviors indicate a need for specialized assessment (Cavanagh-Johnson, 2001).

According to Cavanagh-Johnson, 2001, research on child sexual behaviors also has immediate practice ramifications for anyone teaching sexuality education classes to youngsters.

- First, the families of children in Group II, III and IV verbally or nonverbally communicate in accurate information about sexuality, gender, and reproduction. Accurate information, and a forum in which to ask questions about sexuality, is essential for these children.
- Secondly, the increase in reports on child perpetrators underscores the importance of including information on child sexual abuse in sexuality education classes. Children should be aware that no other person (whether that person is an adult or another child) has the right to force or pressure them into unwanted sexual behavior.

**Signals for Parents, Counselors and Child-Care Workers**

1. The child focuses on sexuality to a greater extent than on other aspects of his or her environment, and/or has more sexual knowledge than similar-age children with similar backgrounds who live in the same area. A child's sexual interests should be in balance with his or her curiosity about, and exploration of, other aspects of his or her life.
2. The child has an ongoing compulsive interest in sexual, or sexually-related activities, and/or is more interested in engaging in sexual behaviors than in playing with friends, going to school, and doing other developmentally-appropriate activities.
3. The child engages in sexual behaviors with those who are much older or younger. Most school-aged children engage in sexual behavior with children within a year or so of their age. In general, the wider the age range between children engaging in sexual behaviors, the greater the concern.
4. The child continues to ask unfamiliar children or children who are uninterested, to engage in sexual activities. Healthy and natural sexual play usually occurs between friends and playmates.
5. The child, or a group of children, bribes or emotionally and/or physically forces other child/children of any age into sexual behaviors.
6. The child exhibits confusion or distorted ideas about the rights of others in regard to sexual acts. The child may contend: "She wanted it" or "I can touch him if I want to."

7. The child tries to manipulate children or adults into touching his or her genitals or causes physical harm to his or her own or other's genitals.
8. Other children repeatedly complain about the child's sexual behaviors – especially when the child has already been spoken to by an adult.
9. The child continues to behave in sexual ways in front of adults who say "no", or the child does not seem to comprehend admonitions to curtail overt sexual behaviors in public places.
10. The child appears anxious, tense, angry, or fearful when sexual topics arise in his or her everyday life.
11. The child manifests a number of disturbing toileting behaviors: plays with, smears feces, urinates outside the bathroom, uses excessive amounts of toilet paper, stuffs toilet bowls to overflow, sniffs or steal underwear.
12. The child's drawings depict genitals as the predominant feature.
13. The child manually stimulates or has oral or genital contact with animals.
14. The child has painful and/or continuous erections or vaginal discharge.

**Studies on Childhood Sexuality and Sexual Behavior**

Childhood sexuality and sexual experiences remain highly controversial and have, apart from the early Kinsey studies, received relatively little scientific attention until recently. The increasing bulk of knowledge and theory on the impact of sexually abusive experiences on children's developing sexuality has led to a demand for contemporary empirical studies on child sexual behavior. Some alternative lines have crystallized, based either on observation of present behavior by adults in different settings or on retrospective questions to adults (Kinsey, Pomeroy, & Martin, 1948; Kinsey, Pomeroy,

Martin, & Gebhard, 1953). First, professionals have observed children playing with anatomically correct dolls in studies designed to discriminate between abused and nonabused children (Koocher, Goodman, White, Sivan, & Reynolds, 1995). Second, investigations have been made on the sexual behavior of clinical samples. Third, parents have been interviewed about their child's sexual behavior or answered questions in observation rating scales about a variety of sexual behavior items. Finally, one line of observational studies has been to ask teachers about behavior at preschools (Larsson & Svedin, 2002; Lindblad, Gustafsson, Larsson, & Lundin, 1995; Lloyd Davies, Glaser, & Kossoff, 2000).

The other main approach has been to study sexual behavior by retrospective interviews or questionnaires to teenagers or adults. In a nationwide sample of 17-year olds in Sweden, Edgardh and Ormstad (2000), and Edgardh (2001) studied adolescent sexual experiences of nearly 2,000 girls and boys in the early 1990s. Although her focus was on consensual adolescent sexuality, the teenagers' experiences of nonconsensual sexual encounters with someone at least 5 years older were also investigated. Edgardh found 2.3% of the boys and 7.1% of the girls to have had such experiences (exhibitionism excluded). The average age at onset was 9 years (SD = 4.3 for boys and 3.9 for girls). Thirty-seven percent of the abused boys and 19% of the abused girls had had their abusive experience with a friend, whereas 5% of the boys and 4% of the girls had had their nonconsensual experiences with an older sibling. Another study in a multicultural high-school setting in Stockholm by Edgardh (2001) revealed that 7.4% reported sexual abuse experiences (2.2% of the boys and 13% of the girls), most of which were peer experience, especially for the boys. In an American study by Haugaard and Tilly (1988),

undergraduate students were asked about their most memorable childhood sexual experience; their reports illustrate which types of experience last in memory into adulthood, but give no data on the frequency of sexual experiences or the range of sexual behaviors. In a later study by Haugaard (1996), also targeted at undergraduates, 59% stated that they had had at least one sexual experience with another child, most of which occurred in the ages between 7 and 12 years. A study of female undergraduates' normative sexual play in childhood found that 85% of the women described a sexual game experience, of which 30% reported that they had been persuaded, manipulated, or coerced to participate. Another 13% remembered that they themselves had been the initiators (Lamb & Conkley, 1993).

Studies from North America of child sexual behavior are frequently cited, but few of these are comparative studies. Goldman and Goldman (1982) compared sexual knowledge among children in four Western societies. They found that 85% of the participating Swedish children said they had received some sex education at school, whereas in the samples from the English-speaking countries, fewer than 40% had had any such education. In Finkelhor's early study of college student's memories of childhood sexual experiences with other children, nearly two thirds described such experiences as occurring before adolescence, although very few of the experiences were revealed to anyone at that time (Finkelhor, 1983). Schoentjes, Deboutte, and Friedrich (1999) conducted a comparative study of Dutch and American children and found no significant differences in their sexual behavior. Larsson et al. (2000) compared a group of Swedish preschool children with an American sample and found that the Swedish children were

reported to show more sexual behavior than the American children. The kinds of behaviors reported from both countries were similar.

Although the above-mentioned studies sketch a framework for contemporary knowledge about childhood sexuality, they do not provide a basis for distinguishing between consensual or nonconsensual sexual encounters between children. The children's feelings about the sexual behaviors they participated in have also not yet been properly explored. The main aim of the paper was to study aspects of young adults' recollections of their sexual experiences before the age of 13, solitary and shared, mutual as well as nonconsensual. Another aim was to study any possible correlation between different kinds of childhood sexual experiences with peers and inappropriate sexual experiences with adults.

The empirical literature on young children with Sexual Behavior Problems (SBP) is particularly scant but supports a relationship between SBP and child sexual abuse. Friedrich and Lueck (1998) studied 22 children (half younger than 7 years old) referred due to SBP. All but 1 of the young children was male. Five of 6 children who had sexually aggressive behaviors had a clear history of sexual abuse; the 6th child was reported to have witnessed sexual violence, but there was no report of direct sexual abuse. Five of six also had a history of maternal absence or neglect.

Further support of the relationship between childhood sexual abuse and SBP is found in the work of Johnson (1988, 1989). The relationship between sexual victimization and demonstrating SBP may be stronger in preschool-age children than in school-age children for boys. In a study of 47 boys with SBP, Johnson (1988) found that 72% of the 4- to 6-year-olds had a history of being sexually abused, whereas 42% of the

7- to 10 year olds and 35% of the 11- and 12-year-olds had such a history. Girls with SBP may be more likely to have a history of child sexual abuse than boys. In a sample of 13 female children with SBP (ages 4 to 12 years), Johnson (1989) found that 100% of the children had a history of child sexual abuse.

Research on the symptomotology of children who have been sexually abused provides additional information about the relationship between sexual abuse and SBP. Kendall-Tackett, Williams, and Finkelhor (1993) conducted a comprehensive review of the research on sexual abuse and found that SBP and post-traumatic stress disorder (PTSD) symptoms were more prevalent in sexually abused children than in clinically referred children without a history of sexual abuse. Of 1,353 children who had been sexually abused (evaluated in 13 different studies), 28% had exhibited SBP (Kendall-Tackett et. al., 1993). The youngest of these children (ages 3-5 years) were noted to have the highest prevalence of SBP (35%). Since this review, a study of 100 sexually abused children (ages 3 to 7 years) by Hall et. al. (, found that 63% of these children demonstrated “interpersonal” sexual-contact that was problematic 1996; Hall, Mathews & Pearce, 1998).

Letourneau, Schoenwald & Ashili, 2004, conducted a study of four randomized trials which tested treatments for children with sexual behavior problems or adolescent sex offenders. Evidence from two trials of treatment for young children with sexual behavior problems suggests these problems respond equally well to a variety of treatments, all of which were relatively short-term (12 to 24 weekly sessions) and all included significant caregiver involvement (Bonner et al.,. 1999; Pithers et al., 1988). It has thus been suggested that caregiver involvement, rather than specific treatment

methods, may be an essential component in the treatment of children with sexual behavior problems (Caffin et al.,. 2002; Pithers et al., 1998).

To summarize, the risk profile for children with sexual behavior problems provided by the research study conducted by Letourneau, Schoenwald & Ashili, 2004, is one of boys and girls who are likely to have been sexually abused and/or to have witnessed family sexuality, who are likely to have comorbid internalizing and externalizing behavior problems, and who are likely to respond well to relatively short-term treatment that includes caregivers. The risk profile for adolescent sex offenders is very similar to that of other delinquent youth. The study found that adolescents who commit sex offenses are usually boys who may have been sexually or physically abused, associate with deviant peers, have significant school problems and have serious problems within the family (Ageton, 1983; Jacobs et. al., 1977; Lewis, Shanok, & Pincus, 1979; Milloy, 1994).

The study conducted by Letourneau, Schoenwald & Ashili, 2004, also examined the nature of sexual behavior problems in a group of youth (ages 5 to 19) referred to community clinics for treatment of serious antisocial and other externalizing behavior problems. In the sample, sexual behavior problems were defined largely by their frequency (e.g., masturbates too often) or inappropriateness (e.g., public masturbation) and do not include other relevant behaviors (e.g., aggressive sexual behavior directed toward others). Outcome data both descriptive and immediate post treatment, on these youth was compared with data on youth from the same sample who did not have sexual behavior problems. Because there is almost no published research on the non-criminal sexual behaviors of non-offending adolescents, Letourneau, Schoenwald & Ashili, 2004,

had few a priori hypotheses. However, based on their review of extant literature on children with sexual behavior problems and on adolescent sex offenders, they hypothesized that, in their clinical sample of children and adolescents, that those with non-criminal sexual behavior problems would be characterized by higher rates of sexual and physical abuse and by higher rates of internalized problems relative to youth without sexual behavior problems.

As noted earlier, there is a growing concern that youth with sexual problems may be at risk for engaging in sexual crimes, and indeed, adolescent behaviors previously viewed as misbehavior have recently been criminalized in many states (Caldwell, 2002). Lacking recidivism follow-up data, the study presented by Letourneau, Schoenwald & Ashili, 2004, cannot address whether non-criminal sexual behavior problems represent a risk factor for future criminal sex acts; prospective studies are needed to address this concern. However, data from this study that youth in the high Sexual Behavior Problem group may have more in common with their younger counterparts (i.e., children ages 3 to 12 with sexual behavior problems) than with adolescent sex offenders. Specifically, relative to youth in the no-SBP group, youth in the high-SBP group included a much higher percentage of girls, were significantly younger (by less than 1 year), were less likely to have substance use problems, and had higher rates of social problems. If delinquent youth with sexual behavior problems are more similar to children with sexual behavior problems than to adolescent sex offenders and if these youth respond well to home based treatment, then criminalizing sexual behaviors previously viewed as misbehavior may be an unnecessarily harsh course of action to take. Likewise, when inappropriate sexual behaviors occur in the context of other externalizing behavior

problems that warrant referral for treatment, individual oriented, specialized, sexual behavior-focused treatment may be unwarranted (Letourneau, Schoenwald & Ashili, 2004). Emphasis should be placed on identifying inappropriate sexual behavior and treating those behaviors within the context of family therapy that is effective with other juvenile delinquents may be sufficient for the amelioration of such sexual behavior problems. In order to determine whether specific treatment for sexual behavior problems in children and adolescents with additional behavior problems would result in faster or more complete amelioration of systems further rigorous, randomized clinical trials need to be conducted.

**Developmental Progression of Sexual Behavior Problems to Sexual Offenses**

Treatment for young children with SBP has been conceptualized as secondary prevention, with the hopes of preventing the development of a pattern of sexually inappropriate behaviors that would lead to sexual offending behaviors in adolescence and adulthood (Cantwell, 1998; Pithers & Gray, 1998; Ryan, 2000). Retrospective research with adult sexual offenders has suggested that a subgroup of offenders report an early onset of sexual activities. Based on retrospective research and clinical work with children with SBP, Ryan, Lane, Davis, and Isaac (1987) proposed that SBP may be learned at an early age and progress throughout childhood, adolescence, and adulthood. If there were such a developmental progression, young children with SBP would be expected to present with behaviors, family composition, demographic factors, and social history similar to school-age children with SBP.

Two recently conducted federally funded projects provided the most comprehensive data on school-age children with SBP. The definition of SBP for these

studies was consistent with the one provided earlier in this paper. Bonner et al. (1999) evaluated 201 children from 6 to 12 years old with SBP. The children's SBP was classified into one of three groups in an SBP typology: sexually inappropriate (20%), sexually intrusive (37%), and sexually aggressive (43%). Demographic, social history, and adjustment evaluation results indicated that the majority of the sample was male (63%), the sample was ethnically similar to the Oklahoma City and Seattle areas (76.6% Caucasian, 12% African American, and 5% Native American), and the sample lived with biological parents (68%), foster parents (13%), and alternative relative caregivers (15%). On the Kauffman Brief Intelligence Test the mean Composite score was 94.96 (SD = 12.67) and mean Vocabulary Scale score was 95.5 (SD = 14/51), both of which fall in the average range. An assessment of child maltreatment history found that 48% reported to have a sexual abuse history, 32% a physical abuse history, 35% an emotional abuse history, and 16% a neglect history. Forty-one percent were reported to have no known history of child maltreatment. Emotional and behavioral symptoms were reported in the clinical to borderline range on the Child Behavior Checklist (Total score, M = 67.05, SD 10.86; Externalizing Scale score, M = 66.67, SD = 11.29; and Internalizing Scale score, M = 62.37, SD = 12.21). Caregivers reported significantly greater levels of parenting stress on the Parenting Stress Index (M = 265.88, 90th percentile, SD = 49.51) than the caregivers in the control community sample of children without known SBP (M = 234.43, 65th percentile, SD = 33.66) (Bonner et al., 1999).

The above study found that the sample of young children they used exhibited a particularly high frequency and severity of SBP's. Evidence was found that some young children do exhibit aggressive sexual behaviors, including forcing others to engage in

sexual acts. The children displayed a complex array of other behaviors and emotional symptoms and experienced multiple stressful events, including changes in caregivers and home placements. Many of the children experienced PTSD symptoms, separation anxiety and a remarkable level of depressive symptoms. The study also found that the young children also presented with a wide range of emotional, behavioral, and developmental problems. It remains unclear the extent to which these factors are interrelated as research on treatment for school-age children with SBP has evaluated serves that are focused on the sexual behaviors (Bonner et al., 1999; Gray et al., 1999).

Direct inclusion of caregivers in services is recommended for treatment of behavior problems in young children. Given the level of caregiver stress, group treatment in which the caregiver can also have support from other caregivers who experience similar challenges may be particularly useful when treating young children with SBP. Most treatment programs for children with SBP do include groups for the caregivers. Reducing the SBP, reducing caregiver stress, and improving the quality of the child-caregiver relationship may in turn improve the stability of the child's placement and make a significant impact on the child's long-term adjustment and social relationships (Bonner, Walker, & Berliner, in press).

One must be extremely careful when making statements about the long-term outcome of these children. The results of this study are not consistent with a conceptualization of SBP as a linear progression from early childhood to school age and adolescence. Although a longitudinal design is required to evaluate the developmental trajectory of SBP, by comparing the young children with SBP in the study to samples of older children with SBP, this study offers preliminary data. The majority of the sample

of young children with SBP were female (65%) in contrast to studies of older children in which the majority of school-age children were male (63% in Bonner et. al., 1999; 65% in Gray et al., 1999) and to research with adolescent and adult sexual offenders who were predominately male (Berliner & Elliott, 1966). Furthermore, the results suggest that the present sample of young children had lower verbal abilities than found in school-age samples and were less likely to be living with their biological parent(s). Given these findings and other evidence, the causes and developmental trajectory of SBP are likely to involve multiple complex pathways. Young girls with SBP may be more responsive to environmental factors and reduce these problematic sexual behaviors once reaching school age. Differential identification of SBP for boys and girls may occur for school-age children and adolescents. Furthermore, a subgroup of boys may have a later onset of SBP.

The finding of a relatively low frequency of a history of substantiated sexual abuse was unexpected. Only 38% had a substantiated sexual abuse history. Substantiating sexual abuse in young children is quite problematic due to the secrecy that is predominant in child sexual abuse cases, the lack of physical evidence in many cases, the controversy regarding the memory and veracity of the testimony of preschoolers, and the complicated process of disclosure in children (Berliner & Elliott, 1996, Bross, 1987; Saywitz & Goodman, 1996).

The impact of exposure to violence through witnessing domestic violence or being physically abused appears to be a fruitful area for further investigations. A substantial portion of the sample – 25 (68%) – was exposed to interpersonal violence. The relationship between exposure to violence and problematic sexualized behaviors in

young children remains unclear but may result from a combination of traumatic experiences with exposure to sexualized materials. Furthermore, experiencing physical abuse may increase the likelihood of demonstrating interpersonal SBP in young children who have been sexually abused, perhaps by the impact on feelings of anger and shame and beliefs about use of control with others (Hall et al., 1988). Another potentially critical factor that was not assessed in the current study is child neglect. Childhood neglect has been found to be associated with significant behavior problems, including increased risk of sex crimes as an adult (Widom & Ames, 1994).

The severity and frequency of SBP, as measured by the CSBI, did not differ by substantiated history of child sexual abuse. Given the relatively small sample in the above study, such findings should be tested with further research. The presentation of specific SBP in young children maybe influenced by other factors, such as impulse control skills, environmental controls, and related conditions, such as presence of oppositional defiant disorder, attention-deficit/hyperactivity disorder, PTSD, or other disorders. Typologies of SBP and related problems have been proposed to classify the sexual behaviors and enhance the understanding of the children (Berliner, Manaois, & Monastersky, 1986; Bonner et al., 1999; Hall et al., 1996, 1998; Pithers et al., 1998a).

Demonstrating SBP as a young child has broad implications for the child's social, emotional, and behavioral development and long-term adjustment. Stigmatizing responses from adults, particularly caregivers, may impede these children's developing self-concept. Poor impulse-control skills, other aggressive behaviors, and inaccurate perceptions of social stimuli in some children with SBP further hinder social relationships and cause problems at school (Araji, 1997; Friedrich & Luecke, 1988; Gil & Johnson,

1993; Horton, 1996). In addition poor boundaries and indiscriminate friendliness often found in young children with SBP may place them at increased risk of being victimized. Raising children with SBP is often stressful for the caregiver and may lead to dysfunctional adult-child interactions and disruptions in the child's residential placement. Indeed, in the present study, caregivers reported stress associated with raising these young children with SBP, and many of the children had already experienced changes in their residential placements. Foster parents reported in a national survey that behavior problems demonstrated by the foster child was the primary reason they requested that foster children be placed in another home, with sexualized behavior reported as a specific concern (U.S. Department of Health and Human Services, 1993). Multiple disruptions in the caregiver-child relationship may place the child at risk for continued behavior problems and attachment difficulties. In the above study, many children were already experiencing high levels of separation anxiety. Thus, eliminating problematic sexualized behaviors is considered critical for the long-term well-being of these young children with SBP.

CHAPTER 4

## Stages of Sexual Development

Roughly 10 years ago, children with sexual behavior problems were first recognized as a clinical population having unique needs (Araji, 1997). Concurrently researchers inaugurated studies to differentiate sexual behaviors characterizing healthy and abnormal child development (Friedrich et al., 1989). Over the past 10 years, the number of practitioners offering clinical services to families of children with sexual behavior problems has escalated dramatically (Safer Society Program and Press, 1994), and a standardized measure has been developed that discriminates between expected and atypical sexual behaviors in children (Friedrich, 1995).

For many of us it may be difficult to accept the fact that children can engage in sexual behaviors that might be harmful to others and to themselves. Childhood is supposed to be a time of protected innocence. However, even at a logical level little reason exists to believe that children are less likely to experience problems in sexual development than with any other behavior. The fact that children can engage in sexually problematic behavior is confirmed by two lines of data: (a) scores on an observational rating instrument of children's sexual behaviors and ( b) the proportion of substantiated child sexual abuse in which the perpetrator was less than 12 years old (Pithers & Gray, 1998).

The concept of "child sexuality" has only recently been a topic of research. Historically, Freud's theories and ideas have been important in denying the existence of sexual feelings in children, especially in the so-called latency period between the ages of 6-10. However, Kinsey, Pomeroy, Martin, and Gebhard (1953) already reported about

sexually exploratory behavior in children in the middle childhood (i.e., Freud's latency period). Recent research shows that children explore their world in a sexual way, that this exploration process manifests itself in a different way from that of adults, and that there are large individual differences. It seems plausible to believe that this behavior is determined by different motives than the adult ones and that it has a different function from adult sexual behavior. We believe that the development of sexual scripts is one of the most important functions of these early phases of sexual behavior. Sexual scripts can be considered the blueprints of sexual meaning, which will only be put into practice at a later age.

In the practice of child psychiatry, it is known that certain children deal with sexuality in an atypical, more grown-up way. This is particularly the case in children with externalizing behavior, specifically children who are diagnosed as suffering from oppositional defiant disorder (ODD) or conduct disorder (CD). For a long time sexuality has been a neglected issue, and even though there are grounds for anticipating that some of the aggressive and sexualized boys will exhibit sexually abusive behavior after puberty (Metzner & Ryan, 1995; Ryan, Miyoshi, Metzner, Krugman, & Fryer, 1996). It is also known that sexually abused girls show sexualized behavior, that they often behave in a seductive way, and run the risk of becoming sexually victimized again later in life (Kendall-Tackett, Williams & Finkelhor, 1993); Messman & Long, 1996). One can assume that the development of sexual scripts in these children is disturbed because they were involved in sexual experiences (often including force and violence) that were inappropriate for their age.

**Early Development and Experience**

According to Ehrhardt & Meyer-Bahlburg (1981), children are active and sensual creatures, even before they are born. One of the earliest sensory systems of the human body to function is the skin, which begins to function during the embryonic stage of development. The skin enables the organism to first experience its environment through generalized responses which are all over the body. When the embryo is less than an inch long from crown to rump, and less than six weeks old, light stroking of the upper lip region or wings of the nose has been shown to cause a response, a bending of the neck and trunk. The fetus in the womb is massaged regularly as the mother moves about doing her daily activities (Martinson, 1994). Movement of the fetus in the womb is necessary for the development of bones and joints also helping to increase body weight, nerve and body functioning.

There is currently a great surge of interest in attempting to understand all aspects of childhood and the life of children. Childhood has come to be seen not only as a transitional phase in the life of an individual, but children are seen as constituting a distinctive population group in society with their own interests and needs. Mothers are now recognizing that their infants are responding and engaging in sensuous experiences, even experiences that are being labeled as sexual. Western society, particularly American society are extremely slow in recognizing and conceptualizing that sexual experiences are a part of a child's development, and an aspect that is worthy of study. There is not much literature on the subject and to date parental discussion of child sexual behavior has not been a common practice (Martinson, 1994). There has been very little generation of folk knowledge, age-appropriate sexuality education for children has been

rarely initiated, and child sex research has not been encouraged, rewarded, or funded, except where the subject of child sexual abuse is concerned.

During the last three to four decades there has been an explosion of studies of infant and child development but few studies of child sexual development and experience. Only a few K-12 sexuality education courses have been developed and more than a dozen books of advice to parents on how to deal with the sexuality of their children have been written in the past few years.

**Infants and Self-Stimulation**

During the first year of life infants discover and explore parts of their bodies. This activity is more exploratory than autoerotic. Autoerotism is the technical term used to refer to self-gratification obtained through stimulation of one's own body, especially stimulation one's genitals (Langfeldt, 1990). By five or six months, many infants appear to enjoy pulling their ears or sticking their fingers in them, some even explore their genitals at this age. Levine, 1957 reported that after six months, infants gradually discontinue playing with their ears. Galenson & Roiphe, 1974 reported that most boys begin genital play at six or seven months of age, while most girls begin at ten or eleven months. For their sample of infants, genital play among girls tended to disappear within a few weeks of onset, but boys continued casual play with additional visual and tactile exploration of the genitals starting at about eleven or twelve months of age.

The most important distinction that can be made between genital play and masturbation in infancy is that in the first year of life an infant is not capable of direct-volitional activity required for the behavior we call masturbation (Langfeldt, 1990). Random play with the genitals is therefore a nonspecific activity and should be labeled

genital play and not masturbation. Genital play need not end with the end of infancy as there is physical pleasure to be derived from fondling the genitals. The satisfaction is enough to develop this practice into a habit and touching or holding the genitals is not only associated with erotic pleasuring.

According to Martinson 1994, in the first eighteen months of life genital play is a reliable indicator of the adequacy or inadequacy of mothering. It was found that when the relationship between mother and infant was one in which the mother provided normal physical and emotional care and attention, that genital play by the infant was present in all cases. When it was not provided, genital play was absent (Bonner, Walker, & Berliner, in press).

**Infants and Orgasm**

The greatest autoerotic satisfaction, and certainly the occurrence of orgasm, depends on manipulation of the genitals that is rhythmic and repeated. Rhythmic manipulation with the hand does not occur before a child is approximately two and a half to three years old, probably because small muscle control is not well developed before that (Martinson, 1994). On the other hand large muscle control is well developed and well coordinated as early as six months of age. It is at this time that some infants form a pattern of rocking that is rhythmic and repeated. They rock and bump their heads against the crib with vigor. Once they are able to sit up, additional types of rocking may be observed, all of which appear to bring satisfaction. Some infants sit and sway rhythmically, some life the trunk and pelvis and bounce up and down off the surface they are sitting on. Some do both by elevating themselves up and down and swaying to and fro, giving the appearance of rising as a person does when riding a trotting horse (Levine,

1957). Infants also can be seen elevating to hands and knees and rocking forward and backward, this appears to be the most frequent type of rocking and is not uncommon as early as six to twelve months of age. In other words, infants may discover the pleasure of rhythmic genital sensation through rocking before they have adequate hand and arm small muscle control to masturbate (Martinson, 1992). Rocking in this manner appears to be more satisfying than manual genital play in that infants in genital play can be easily distracted in contrast to infants who rock. Rockers often rock with great vigor and tension and are not easily distracted. Schaefer, 1964, conducted a study of thirty women who reported that at age six they discovered that rocking and rubbing their genitals on bedclothes bunched between their legs was continued until something would happen, something moved, which they guessed was a little orgasm.

Kinsey, et al. (1948) reported that orgasm is not rare among children, both boys and girls, and has been observed in boys of every age from five months on and in infant girls of four months old. To understand the capacity of infants and small children to reach orgasm, we have to first make a distinction between those who stimulate themselves and those who have been stimulated by others. Given the lack of capacity of infants for sustained rhythmic stimulation of their genitals, to determine the capacity of sexual response in infants would require stimulation by persons other than the infant. Kinsey, et al (1948) had access to such data and reported on stimulation to orgasm of male infants less than one year of age as follows:

The behavior involves a series of physiologic changes, the development of rhythmic body movements with distinct penis throbs and pelvic thrusts, an obvious change in sensory capacities, a final tension of muscles, especially of the abdomen, hips, and back,

a sudden release with convulsions, including rhythmic anal contractions followed by the disappearance of all symptoms. A fretful babe quiets down under the initial sexual stimulation, is distracted from other activities, begins rhythmic pelvic thrusts, becomes tense as climax approaches, is thrown into convulsive action, often with violent arm and leg movements, sometimes with weeping at the moment of climax. After climax the child loses erection quickly and subsides into the calm and peace that typically follows adult orgasm (Kinsey, et al., 1948:177).

Kinsey and his colleagues have been castigated for not exposing the persons responsible for stimulating these infants to orgasm. Such behavior would be regarded as child sexual abuse today (Martinson, 1992). Kinsey did report an increase in the percentage of individuals able to reach a sexual climax from 32 percent of boys two to twelve months of age to 57 percent of those two to five years of age and nearly 80 percent of preadolescent boys ten to thirteen years of age (Kinsey, et al., 1948).

**Masturbation**

Masturbation has been largely ignored in books on infant and child development, yet it has long been recognized as a near-universal phenomenon. Roberts, Kline & Ganon, 1978, found in a sample of American parents that 80 to 90 percent believed most children masturbate. Galenson & Roiphe, 1974, utilizing interviews with parents for the first year and direct observation for the second year of life, found that for boys the onset of masturbation proper began at fifteen to sixteen months of age, whereas for girls a pattern of intermittent genital play was observed. Levine, 1957 observed that most of the sexual activity at this young age remained genital play rather than true masturbation. He reported that most children, even through twenty-four to thirty months of age, indulge in

genital play with a certain degree of satisfaction but in most cases without any apparent emotional excitement or increased stimulation. There appears to be a great deal of overlap between genital play and masturbation.

According to Gardner, 1991, all normal children explore their bodies from time to time and do not differentiate between genital the area and other parts. They have to learn from others that touching oneself in that particular area is socially unacceptable, especially in public. Children usually learn by themselves that stimulation of that area can provide pleasures different from those derived from touching other areas. He also states that orgastic capacity is possible at birth, most young children under the age of nine or ten do not stimulate themselves to the point where they reach orgasm. This is a contrary to what many other researchers believe. He does believe that those who do stimulate themselves may very well have been prematurely introduced into the pubital and postpubital levels of sexual arousal. Certainly, such introduction can be the result of sex abuse. But this is not the only reason why a younger child might masturbate to orgasm. In some children it is a tension-relieving device, especially when they grow up in homes in which there has been significant privation and/or stress. In some it can serve as an antidepressant. When a knowledgeable evaluator hears that a child is masturbating, the examiner will make detailed inquiry about the frequency, the time of onset, the circumstances under which it occurs, and whether or not the child masturbates to orgasm. All this information is useful in ascertaining whether or not the masturbation is related to sex abuse. Typically, validators do not make such inquiries. They hear the word masturbation and that is enough to prove that the child has been sexually molested (Gardner, 1991).

In the late nineteenth century, in both the United States and England, we witnessed a period of excessive preoccupation and Draconian condemnation of childhood masturbation. Unfortunately, physicians, who should have known better, were actively involved in this campaign of denunciation and attempt to obliterate entirely this nefarious practice. Doctors considered it to be the cause of a wide variety of illnesses, e.g., blindness, insanity, and muscle spasm. Various kinds of restraints were devised in order to prevent children from engaging in this dangerous practice. Some girls were even subjected to clitorectomies, so dangerous was the practice considered to be. Some of the altering signs: temper tantrums, bedwetting, sleep disturbances, appetite changes, mood fluctuations, and withdrawal. Obviously, in the hundred years since those sad times, we seem to have gone back full circle. The same list of symptoms that were indicators of masturbation are now considered to be indicators of sex abuse (Gardner, 1991). Legrand et al. (1989) have written a fascinating article describing the similarities between the masturbation hysteria of the late nineteenth century and the sex abuse hysteria of the late twentieth century with a comparison of the lists of "indicators."

Physicians have played an important role in these crazes. Dr. William Griggs of Salem was the first doctor to "diagnose" the children in the Salem witchcraft trials as being possessed by the devil. Doctors were actively involved in the antimasturbation fanaticism of the late nineteenth century. Unfortunately, there are doctors actively involved in the fiasco today. There are physicians who are diagnosing sex abuse in the vast majority of children they examine, utilizing criteria that are generally considered to be within the normal range (e.g., anal "winking" and hymenal tags). There are other

kinds of doctors (Ph.D., psychologists and M.D. psychiatrists) who are serving as validators and therapists and are perpetrating these abominations (Gardner, 1991).

From three years of age and on, children retain some memories of sexual experiences and can recall them. They may be able to report quite clearly on the first time they remember experiencing pleasurable genital sensation, the first time they masturbated, or the first time they had an orgasm. It may not in fact have been the first time, but earlier sexual experiences have been forgotten. The first memories that a child has appear to be those that were highly emotional (Martinson, 1994).

At three years of age most boys who masturbate do so manually by rubbing the penis or by wrapping the fingers around the erect penis and moving the hand. Still, at this age, many boys lie on their stomachs on a flat surface and writhe while engaged in other activity such as watching television. Some raise themselves slightly from the surface and propel themselves forward and backward, rubbing their genitals in doing so, and continue until orgasm is reached. A small number rub themselves against something, for example, a hard pillow, the leg of a chair, a person's leg, or their own stiff forearm and derive satisfaction in that way (Levine, 1957).

In girls, already at three years of age there are manifold varieties of masturbation. These include thigh pressure; rubbing the genitals against a soft toy or blanket; manually stroking the labia and clitoris; and, less frequently, inserting objects into the vagina (Kinsey, et al., 1953; Levine 1957).

Some form of manual manipulation of the genitalia seems to be most common. Kinsey reports on a mother who observed her daughter masturbating.

Lying face down on the bed, with her knees drawn up, she started rhythmic pelvic thrusts, about one second or less apart. The thrusts were primarily pelvic, with the legs tensed in a fixed position. The forward components of the thrust were in a smooth and perfect rhythm which was unbroken except for momentarily pauses during which the genitalia were readjusted against the doll on which they were pressed; the return from each thrust was convulsive, jerky. There were 44 thrusts in unbroken rhythm, a slight momentary pause, 87 thrusts followed by a slight momentary pause, then 10 thrusts, and then a cessation of all movement. There was marked concentration and intense breathing with abrupt jerks as orgasm approached. She was completely oblivious to everything during these later stages of the activity. Her eyes were glassy and fixed in a vacant stare. There was noticeable relief and relaxation after orgasm. A second series of reactions began two minutes later with series of 48, 18 and 57 thrusts, with slight momentary pauses between each series. With the mounting tensions there were audible gasps but immediately following the cessation of pelvic thrusts, there was complete relaxation and only desultory movements there after (Kinsey, et al. 1953).

Among the women interviewed by Schaefer, the earliest reported experience of first orgasm through self-stimulation was at age four. The subject discovered: that pleasure involved in exposing my genital area to the forceful stream of water in the bathtub. My mother seemed to be very angry when she caught me doing this…There is something very repressive about her when she reprimanded me—as though she was holding in something…but it was coming out in anger from her frozen face and stern eyes (Schaefer, 1964).

Three studies of female sexual activity contained data on the practice of self-stimulation in childhood and the number of subjects who attained climax by this means: in Davis, 1929 study, 25 percent to age ten had practiced self-stimulation and 12 percent had attained climax; in Kinsey et al.'s 1953 study, 19 percent practiced to age twelve and 12 percent attained climax; and in Schaefer 1964 study, 43 percent practiced to age twelve and 23 percent attained climax. Among the Schaefer subjects all those who reported self-stimulation before age twelve and who attained climax thereby continued the practice through adolescence and into adulthood whether or not they had been discovered or reprimanded. For the ones who had not achieved orgasm, the pleasure evidently did not outweigh the guilt feelings and other negative pressures osmosed from the milieu (Schaefer, 1964).

Achieving orgasm can be a powerful motivator for girls as well as for boys. I loved it. I knew it was punishable…yet it was enjoyable, so I did it. It was comforting. Once having produced that kind of experience, it was imperative that I experience this, one way or another, each time. Despite the pleasant feeling associated with orgasm, the words that women with masturbatory experiences used to describe the feeling attached to those experiences seemed to Schaefer, (1964) to be guilt, anxiety, and shame. Kinsey, et. al., (1953) also noted that no other type of sexual activity type had worried so many women as masturbation. Masturbation was a good idea in the sense that it was a pleasure…but guilt robbed it of all those good feelings, I think. One subject was told by teachers in her parochial school that "if you touch yourself in your private places, you'll go crazy" (Schaefer 1964).

In some cases a child fails to find masturbating satisfying because of failure to reach orgasm. The failure may be due to negative prior conditioning, ignorance due to lack of knowledge, or failure to discover a technique for effective self-stimulation. In Scandinavia, where child sexual capacity is more widely recognized, preschool teachers, sex educators, and therapists have on occasion instructed children in better masturbatory techniques (Martinson, 1994).

According to Langfeldt (1990), the Norwegian sex therapist, those with serious masturbatory problems may need therapy to learn how to be orgasmic. He asserted that reducing anxiety, changing masturbatory techniques, and being supportive of sex in privacy are the most common effective aspects of the therapy, but that changing masturbatory patterns once they are established is very difficult in both boys and girls, even in small children as young as three to four years of age. He also reasoned that since girls have less stereotypical masturbatory techniques than boys, girls more often develop a masturbatory technique requiring a higher amount of genital stimulation than would be necessary with better technique. The most satisfactory technique of genital self-stimulation, even for small children, appears to be repeated manipulation of a specific rhythmic form that leads to orgasm. Most children who masturbate to climax stop after one orgasm, but some children have several orgasms, (Langfeldt, 1990).

Not all children relax and go to sleep after reaching orgasm. A few appear to be stimulated by the activity. Levine (1957) reported on a three-year-old boy who would masturbate vigorously and end by sitting up alert, bright-eyed, and apparently satisfied and content. Masturbation is recognized as a tension reliever and is often observed among nursery school children. It is unquestionably increased during periods of

emotional tension, but three-year-old children have been so observed to masturbate as an expression of delight and not when tired, stressed, or unhappy.

A child's initial attempts at self-stimulation are inspired in a number of ways. Many discover the possibility of such activity entirely on their own and quite by accident. The great majority of females in the Kinsey et. al. (1953) study learned to masturbate on their own as a result of their exploration of their genitals, but only 28 percent of the boys had discovered masturbation on their own. Most boys hear about it from others. Boys also learn by observing the behavior of other boys or through deliberate instruction given by one of their acquaintances. In the Kinsey sample, 9 percent of the boys had been masturbated by other males before they began to do it by themselves. Similar same-age activity occurs among girls, but it is not nearly as common. Only about 3 percent of the females in the Kinsey et. al. (1953) sample had begun masturbating as a result of the childhood same-sex contacts. According to Kinsey, et al. (1953), some girls wait months and even years after learning about masturbating before they try it themselves. Unlike girls, boys once they have heard about it rarely delay experimenting on their own.

Masturbation is common during childhood, but by no means do all children masturbate. There is no accurate count of the number who do or the frequency of occurrence for those who do (Martinson, 1997). Several studies have dealt with the topic, but lack methodological rigor and consistency making comparisons between the findings of the various studies less useful than one might think. Sears, Maccoby, & Levine (1957) reported that only two fifths of the mothers said they had never noticed their children doing anything that could be referred to as masturbating. In a study

involving 284 boys, Ramsey (1943) reported that 5 percent of those age six and under had had masturbatory experiences, and 10 percent of seven-year-olds had.

There is little doubt that the attitudes of parents influence the attitudes of children toward masturbation. The parents in Berges, et al., 1983 study, indicated rather apologetically that they had never brought up the subject of orgasm with their children. The majority did not think their children had any understanding of what orgasm was. Masturbation is not a topic commonly discussed in sex education material prepared for parents of young children in our society (Martinson 1992).

**Dreams, Fantasies, and Myths**

In order to ascertain the extent of sexual knowledge and sexual experience of children, we need to look at the content of their fantasy world as is revealed in their dreams, stories, and myths. Fantasy activity is universal in human life, and represents the ongoing baseline mental activity of humans. Attending to this internal mental activity is behavior learned early in childhood (Rosenfeld et al., 1982). Dreams occur during sleep, while fantasies occur during waking hours; they are similar enough that fantasies are also called daydreams. It is assumed that sometime in the first year of life, before they begin to speak, children begin to fantasize (Gardner, 1969). In studies of child play it has been found that young children are very comfortable with fantasy and are able to move quickly and easily from reality to fantasy and back again (Martinson, 1992). Children's styles of fantasy are remarkably similar to those of adults, except that fanciful daydreaming appears mostly unique to children (Rosenfeld, et al. 1982).

During or subsequent to genital self-stimulation in the second year of life, both girls and boys frequently make affectional gestures toward their mothers and touch their

mothers' bodies. But such open affection begins to disappear after a few weeks and is replaced by an "inward gaze and a self-absorbed look" that soon begins to occur, indicating that a fantasy feeling-state now becomes a regular part of genital stimulation (Roiphe and Galeson 1981: 252).

Although it might be expected that the fantasy feeling-state accompany genital play and it would show up in the stories young children tell, but it does not appear to be so for American children. American children learn very early in life that they must not talk about sex, at least not in the presence of adults. That is one reason why the subject of sex does not commonly appear in their stories. An inability or unwillingness to use words referring to sex was one of the most striking findings of Conn's play interview study of 200 children four to fourteen years of age (Conn and Kanner, 1947; Kanner, 1939).

In his play interviews, Conn found that sexual fantasies accompanying masturbation—imagining the sight or touch of genitals, buttocks, or breasts, and thoughts of coitus, were reported by a very small number of boys below nine years and by no girls of any age. For example, in the play interviews, the children even as young as four years of age, spoke hesitatingly and without embarrassment of the boy's "thing" and the girl's "thing," but other distinctions had something secret or hidden about them. It was not so much that these children did not know the names of the genitals; in fact, Conn found no less than sixty-one different names for the genitals among 200 children. These words were not spoken by the children because they regarded the names as bad, nasty, or dirty and not to be uttered in the presence of adults. Conn found that children with such inhibitions could hardly be expected to report stories they made up or dreams they had

about sex and sexual activity. Another reason for the lack of stories about sex was limited information and lack of sexual experience. Conn estimated that with more information and/or experience, children's fantasy life would change.

Ames, 1966; Pitcher and Prelinger, 19643 conducted two major studies of the stories told by young children. Ames, 1966 found that in children two to four years of age the predominant theme at every age for both boys and girls was violence. Of fifteen two-year-old boys mean age 2.5), 60 percent of the stories dealt with violence, and for fifteen girls the figure was 68 percent. Other themes in the stories to two-year-olds were: food and eating (boys 14%, girls 27%); sleep (boys 77%, girls 28%); good and bad (boys 0%, girls 21%); possible sibling rivalry (boys 21%, girls 7%); possible castration (boys 14%, girls 0%; and reproduction (boys 0%, girls 7%). None of the group of thirty two-year-olds described stories overtly concerned with anal activity.

Pitcher and Prelinger, (1963) show in their study that 137 two to five-year-olds, eight main themes were found: aggression, death, hurt or misfortune, morality, nutrition, dress, sociability, and crying. Aggression appeared most often, 124 times in 360 stories; hurt and misfortune was the next most frequent theme, appearing eighty-nine times. For boys, aggression tended to be much more violent than for girls. Even at two and three years of age, the boys' calamities involved much violence. Boys reported to Ramsey, 1943 on dream content in which they found themselves with erections on awakening. The dream content contained nonerotic but potentially violent stimuli such as fighting, accidents, and wild animals, falling from high places, giants, or being chased and frightened.

Among Pitcher and Prelinger's two-year-olds, the theme of their dreams was largely concerned with violence of body intactness meaning some part of the body was broken or severed. The interest of this theme, especially among boys would appear to be consistent with fears of castration. However, this theme was almost absent in the stories of three-year-old boys. Gardner, 1969 based his observations on clinical experience and does not believe that castration anxiety is a significant concern for the normal boy, nor is penis envy a preoccupation in the well-adjusted girl. Rather, the healthy child accepts his or her sex and has pride both in the sexual and nonsexual aspects of the self.

In Ames, 1966 studies, the number of stories featuring some kind of violence ranged from a low of 63 percent for boys at two years to a high of 88 percent of boys at three and a half years. The most common theme was aggression. Ames also found boys to be much more violent in their expression than were girls. In general, Ames found spanking to be strong in the early age as well. Ames concluded, "If it should be that they absorb the violence from the culture, then such absorption must be considered a rather universal phenomenon expressing itself as early as two years of age" (Ames 1966:390).

Researchers wanted to find out what were the themes that related to the sensory and sexual experiences of life, intimacy, kindness and eroticism. Ames, 1966 found that though kind of friendly stories were not very common at any age from two to five years old, they sometimes occurred at two and three years of age. Pitcher and Prelinger, 1963 found that girls sometimes referred to love, courtship, and marriage. The girls were more likely than the boys to express emotion and effect around a parental figure, particularly a mother. The boys displayed an extraordinary lack of interaction with either mother or father. Pitcher and Prelinger found that it was rare that the phenomenon of excitement

and of aggression between a man and a woman took placed in the stories. They attributed this in part to the taboo on sexual knowledge for children in the United States and the fact that adults keep most aspects of their own sex life secret. The younger infants appeared at times to make transparent references to the issue of pregnancy in their stories, but the connection of the various details tended commonly to be illogical or poorly motivated. Gardner, 1969 agreed with Ames and Pitcher and Prelinger that the conscious fantasy life of the normal child at this age contains little overt sexual material. But Gardner found that from about age eight and onward, sexual fantasies might take any form know to adults. It may be a phase-specific theme that the culture does not allow or encourage to be more specific and accurate among younger children. But Pitcher and Prelinger, 1963 did not rule out the possibility that manifestations of unconscious or less conscious preoccupation with sexuality are prevalent in many of the stories of young children.

Borneman, 1983 gathered information about the content of forbidden riddles, songs, verses, and games in Austria. He reported what he regarded to be an inordinate number of verses about brother-sister incest and a fair number about parental intercourse, all of them in stories appealing to children between ages six and seven. This may reflect cultural differences in the exposure of children to sexual knowledge and sexual experience, but it more likely reflects a difference in methods of soliciting information from children.

Wormer and Levin, 1967 distinguished between two kinds of erotic fantasies, erotic fantasies in general and masturbation fantasies in particular. Erotic fantasies consist of all types of fantasies of a sexual nature, including those that could become

reality if the person being fantasized about were available as a participant with the one who is fantasizing. Masturbation fantasies, on the other hand, are sometimes of a kind that could not be fulfilled in any reality relationship with another person. In addition, the aim of masturbation fantasy is self-gratification, and the person masturbating may have little or no desire to translate his or her masturbation fantasy into action. In the masturbation history of a healthy person, masturbation fantasies tend to undergo a variety of changes as the person passes through different phases of psychosexual development. First masturbation for young, innocent children is apt to be accompanied by fantasy content that, as described by one young man in the study, is "either very innocent or erotic concepts or very sadistic and violent through ignorance.

Not all persons who masturbate fantasize. In the Kinsey, et al. 1953 sample, just about half of the females reported that fantasies had occurred almost always in connection with most of their masturbating, at least during certain periods of their life, with another 14 percent fantasizing some of the time. For a fair number, masturbation fantasies had not begun until some years after they began to masturbate; fantasies were least common for the younger females. For males, 72 percent had almost always fantasized while masturbating and another 17 percent fantasized some of the time. For some, fantasizing is a necessary concomitant of successful masturbating.

**Comparison between the Sexual Life of Children in Sweden and the United States**

As one expert on sexually victimized children wrote, "we know more about sexual deviance than we do about sexual normality… We hardly know how they come to have sexual experience at all." We have "a vast ignorance of the forces governing the development and experience of sexual behavior in general" (Finkelhor, 1979).

One question that has not been seriously considered or asked is: How do children get a sexual life? One answer could be that they appear to get it naturally and unobtrusively by being alert to the many influences around them. But that method is not sufficient in a society where pains are taken to keep as much sexuality hidden from children as possible. In such a society, if we want children to know about sexuality, we need to supplement natural assimilation with instruction (Martinson, 1994).

In their book "Children Sexual Thinking (1982), Goldman and Goldman (1982), provided a "natural environment" on the need for sexual education. They were Australian educators who set out to look for the best in sexual education materials and methods. They developed a system whereby they could determine the value of sexual education programs by interviewing a sample of five- to fifteen-year olds in four countries, Australia, England, Sweden, and the United States. Goldman and Goldman found that children's sexual thinking is not confined to thinking about sexual intercourse and that it embraces a much broader universe of experience than that. Goldman and Goldman used the broadest meaning of sexuality in order to plan and complete their research. They also found that children are sexual thinkers from birth. Children constantly seek for sex information by whatever ingenious method they can with their exploring sexual topics increasing as their age increases. They seek this information until they feel they have a fairly complete set of answers. If they do not get the answers they need they simply invent them. In addition they looked at the fact that children in the United States were the least and the latest to receive sexual education while in Sweden sexual education was provided to children from the first grade, age seven and on. Here they found a natural experiment showing one country with the least and the latest sexual

education, and another country with the earliest sexual education. What differences did Goldman and Goldman (1982) find between children in the two countries?

Results showed that Swedish children were capable of understanding complex biological concepts much earlier than had been believed. They were two or more years ahead in sexual knowledge and understanding than children from the United States. They found that children in the United States were retarded in their sexual knowledge three or more years and were the most retarded of all four countries. Goldman and Goldman were convinced that the American children were inadequately prepared for sexual adulthood. For example, American children up to and including eleven years of age gave nonsexual responses to parent roles in procreation. Many older children knew the facts of sexual joining, but few could put the facts together to make a satisfactory explanation, even by age fifteen. It was noted that only an estimated 10 percent of American high school students receive comprehensive sex education before they graduate from high school today.

In addition they also found that the home was the most cited major source of sex information for children, in the person of the mother. It could be suspected that silence in the school is matched by silence in the home as well. Sears, Maccoby, and Levine (1957) conducted a study in England which bears this fact out. It is amazing the ingenious means mothers utilized to thwart the attempts of their young children to engage in sex play and to ask sex questions. Not one of the parents was completely free and opens in the discussion of sex with their children. One reason for this was the fear that any attention called to the subject of sex might awaken the child to erotic activity. In contrast, the parents in the Berges (1991) study never brought up the subject of orgasm

with their children. The reason being, they did not believe that their children had any understanding of what orgasm was. It is also interesting to note that orgasm is not a topic commonly discussed in books on sex education prepared for parents of children in United States society (Martinson, 1992).

Beginning in the 1800s, U.S. society built a wall around children to protect their innocence and to protect them from their won sexual inclinations. Keeping children sexually innocent became firmly established and has continued to be a feature of American culture. This means that teenagers have to look elsewhere for their final sexual instruction. Their peers are a major source from whom they learn what passion and orgasm is, and the joy, the fear, the excitement of sexuality. They also learn the status that sexuality can bring them.

**Comparisons between Sex Education in the United States and Sweden**

Sweden took a different course than the United States; it introduced sex education in 1942 and made it compulsory in 1956. After further studying its sex education program in the 1970s, Sweden again reduced the age at which each topic was offered to children. Children between the ages of seven and ten learned the difference between the sexes, where babies come from, the father's role in conception, developments before birth, the process of birth, and many other topics. The Swedes were still not satisfied with their program and introduced a more difficult subject of sex education, namely, teaching children the art of loving. They reasoned that sexuality is not a bad habit to be discarded and that sex education is important for a happy life. Therefore, sex is not a secret in Sweden. Sex education is a totally open program based on faith in young people and this faith has caused young people to respond (Goldman & Goldman , 1982).

According to Schwartz, 1993, because young people understand about sexuality at an early age the rate of sexual intercourse is not down but the rates of venereal disease and abortion are. Sweden's abortion rates are lower than the latest figures for Australia, the United States, and England and Wales (Goldman & Goldman 1982).

Engaging in premarital sexual intercourse has become statistically normative for American youth. Fifty-four percent of ninth through twelfth graders and 72 percent of high school seniors have had sexual intercourse (Haffner, 1992). Haffner also estimated 30 percent of sexually active adolescents become pregnant.

Unfortunately, sexual intercourse is a moral issue for some adults, and this is a problem when it comes to sexual education. Sexual education has focused almost grudgingly on helping young people avoid the negative consequences of bad decisions that could lead to contracting sexually transmitted diseases, unplanned and unwanted pregnancies, school dropouts, early marriage, and a life of poverty. However, in contrast, the Swedes see sexuality as a matter of health, not illness, and try to help people accept and enjoy their overall mental and social health and well-being. It is argued that a major source of public schooling should be to teach children how to reason, to question, and to accept responsibility; to teach them how to think, more than what to think. (Martinson, 1994).

**Public Education and Sex Education Curriculum**

Public education has an obligation to present a variety of ideas that reflect the perspectives of the entire community and to address the needs of all pupils, starting in kindergarten (Sedway, 1992). Public education has introduced a K-12 curriculum. On the other side of this issue, there are groups, often referred to as the far right or religious

right, who promote a narrower curriculum. Their curriculum eliminates the discussion of controversial topics, such as birth control, AIDS, and abortion, and focuses almost exclusively on sexual abstinence as the only behavior that can be supported for moral or practical reasons. These groups also are introducing curricula, and they are small but fervent and zealous in their efforts. We can agree with Udery, 1993, who stated that sex research "is not a battle between the forces of good and evil, nor is it a battle based on some misunderstanding that can be made to go away by more communication. On the contrary, it is a genuine and legitimate political battle between two groups and the population who hold diametrically opposed policy views."

For the almost twenty-five years, the attention of scholars in America, and incidentally, most of the research money, has been concentrated on a much smaller but not inconsequential problem, that of child sexual abuse. Unfortunately, the problem appears to be exacerbated by the public's concern over the naiveté of our youth caught up as they are in a much larger political and religious issue, an issue not of their making. Our youth are also being blamed for sexual issues that are not of their making either. For example, we use the perspective of victimology in judging sexual cases. Victimization predicates victims and perpetrators. The perpetrator is a human being who must be segregated from society or otherwise disciplined. We have begun to use this paradigm in dealing with child sexuality and have written it into the law. Behavior that is treated as child sex play in Scandinavia, at least up until 1984 was treated as perpetrator-victim behavior in the United States (Aigner and Centerwall, 1984).

**Effects of Using the Victim and Perpetrator Paradigm**

The following are examples of the effect of the use of the victim and perpetrator paradigm in dealing with children. The state of Minnesota in 1991-92, reported 1,110 cases of sexual harassment and ninety-five cases of sexual violence in its schools, and these were only the cases that were actually reported (Hotakainen, 1993). It is alleged that many more were not reported. More than 1,000 children in the city of Minneapolis alone were suspended or expelled on charges of sexual harassment (Shalit, 1993). Cases such as the following were classified as sexual harassment: telling dirty jokes, spreading rumors about sexual behavior of individual girls, exposing oneself, snapping bras, wearing offensive T-shirts, and yelling sexual innuendoes during sporting events. Cases classified as sexual violence, the more serious cases, included rape, forced fondling and touching, forced oral sex, "depantsing" (removing another's pants as a joke or as punishment), and "sharking" (biting body parts, such as breasts). Punishment for such offenses, besides expulsion, included transfer to another school, writing essays, apologizing, undergoing counseling, and serving time in detention. The attorney general of the state of Minnesota has warned Minnesota children that such behavior can result in costly litigation. Minnesota is viewed as a national leader in fighting sexual harassment. Sue Sattel, a specialist for the Minnesota Department of Education, reported what she regarded as an open-and-shut case of sexual harassment involving a five-year-old boy as predator and a five-year-old girl as victim. She reported, "the boy led the girl into the art resource room. He pulled her pants down. He pulled his own pants down. He jumped on top of her and began to simulate intercourse." Sattel then went on to say "Something very, very serious is going to happen to that little boy" (Shalit 1993). She is right, for this

is a sexual offense in most states. Minnesota's anti-sexual-harassment law covers all children down to and including the kindergarten age. A publication provided by the Minnesota Department of Education, Examples of Hostile Environmental Sexual Harassment, provides a glimpse into what supervisors are looking for on the playground. Here is a partial listing: Sexual gestures (e.g., boys grabbing their groin when a girl passes by); Students "rating" other students; students teasing other students about body development, either overdevelopment or underdevelopment; males bragging about or indicating the size of their penis. Proponents of Minnesota law say tough penalties for offenses like these are the wave of the future, (Shalit, 1993).

Children appear to get a sexual life naturally and unobtrusively by being alert to the many influences around them. Children come to an age when they are concerned about their own identify and how to relate to members of the opposite sex. In the fumbling attempts to relate, they often perform badly. It is a moot question whether such behavior should be handled punitively, with more expulsion and more detention and at younger ages, or whether we should try another perspective, such as teaching the art of loving and the respect for others. (Martinson, 1993).

CHAPTER 5

## Social Responsibility Therapy for Preteen Children

The news media today increasingly airs stories pointing out the lack of social responsibility and multiple forms of abusive youth behavior which consistently continues to tear at the moral fabric of our society and threaten the civil rights, safety and security of our citizens. Social Responsibility Therapy was designed to help develop social responsibility in youth with multiple forms of abusive behavior from multiple cultural backgrounds whose antisocial behavior impacts the future quality of living in our society (Yokley, 2004).

Social Responsibility Therapy is a research-informed treatment that applies best practice procedures to help those with abusive behavior develop a social responsible lifestyle that is no longer harmful to self and others. Social Responsibility Therapy uses a Structured Discovery approach to target five basic types of abusive behavior (i.e., sexual, physical, property, substance and trust abuse) across settings (i.e., treatment, home school, community), and time (i.e., 24 hours a day, 7 days a week). Social Responsibility Therapy also addresses: the target behavior problem (i.e., the referral form of abuse is not usually the only form of abuse); the negative social influence problem (i.e., from peers, partners and parents) and; the dose-response problem (i.e., expanding the agents of change to include significant others at home, school and the community which provides better coverage of the youth's behavior during the day).

Social Responsibility Therapy has a multicultural premise which states, "We are our brother's keeper" and it is our social responsibility to respect diversity by caring for

ourselves, caring for those who grew up with similar cultural influences and caring for those who did not. (Yokley, 2004).

The target behavior problem is a developmental psychopathology/labeling issue, the constricted referral problem and increased relapse risk resulting from not targeting all forms of abuse on the treatment plan). The target behavior is critical because youth can be incarcerated for any type of abuse not just their referral type of abuse. A youth who completed treatment for sexual behavior problems and exhibits no further sexually abusive behavior but gets re-arrested for physically abusive behavior can be considered a sexual behavior treatment success. However, they can not be considered a community safety or cost success because their other forms of abuse behavior continue to make them both a danger to others and a community tax burden.

Social Responsibility Therapy avoids diagnostic labels that diminish responsibility and focuses instead on the severity and impact of the behavior on "{The Abuse Behavior Continuum". Social Responsibility Therapy uses a social learning experience approach to develop appropriate social behavior control and addresses multiple forms of abusive behavior by teaching prosocial alternatives to antisocial abuse.

Social Responsibility Therapy is the most logical treatment approach for parenting youth with abusive behavior as it teaches social responsibility and multicultural values as competing responses to abusive behavior. This makes it easily accepted and integrated into ongoing behavior management by parents. In addition, Social Responsibility Therapy helps the youth and their parents/foster parents understand how the abusive behavior was acquired, what maintained it and how it generalized into other problem areas. One of the strong points of Social Responsibility Therapy is its

supervision protocol. Electronic communication, behavior tracking and monitoring technology are utilized along with twelve basic foster home safeguards and twelve basic community safety/supervision procedures that target the client and negative peer associates. In Social Responsibility Therapy, youth develop a socially responsible, positive lifestyle in three basic program phases: learning social responsibility; maintaining social responsibility and developing a socially responsible lifestyle. The TASC Forensic Foster Care program for youth with multiple forms of abusive behavior was founded in March of 1988 and is currently operating in Ohio and Florida, (Yokley, 2004).

Youth sex offender risk assessment is in its early development stages. There are presently no empirically validated, assessment instruments to estimate the risk of adolescent sexual reoffending. Actuarial risk scales (i.e., with items weighted to develop the best statistical cut off scores between offenders and non-offenders) are not yet available. The field is moving from the subjective clinical interview stage to the use of objective structured protocols based on known re-offense risk factors. The purpose of these protocols is to aid in the systematic review of identified risk factors that been associated with sexual and criminal offending. The documented limits of these assessments allow the "mitigating circumstances" latitude needed for juvenile court judges and human services clinical supervisors to make important decisions balancing the rights of youth to the least restrictive treatment setting and community safety. Currently there are two relatively well developed structured youth sex offender risk assessment protocols in use, (Yokley, 2004)..

**Juvenile Sex Offender Assessment Protocol**

The "J-SOAP-II, which was developed by Prentky & Righthand (1994), is a youth sex offender risk assessment which is still in its early stages of development. There are presently no empirically validated assessment instruments to estimate the risk of adolescent sexual reoffending. Actuarial risk scales (i.e., with item weighted to develop the best statistical cut off scores between offenders and non-offenders) are not yet available. The field is moving from the subjective clinical interview stage to the use of objective structured protocols based on known re-offense risk factors. The purpose of these protocols is to aid in the systematic reviewed of identified risk factors that have been associated with sexual and criminal offending. The documented limits of these assessments allow the "mitigating circumstances" latitude needed for juvenile court judges and human services clinical supervisors to make important decisions balancing the rights of youth to the least restrictive treatment setting and community safety.

The J-SOAP which has had more time for clinical development than the ERASOR, is designed for boys ages 12-18 and may be used to assess re-offense risk for adjudicated or non-adjudicated youth. The original J-SOAP version was developed in 1994 based on literature reviews covering clinical and risk assessment/outcome studies of juvenile sex offenders, adult sex offenders, general juvenile delinquents and mixed populations of adult offenders. The majority (62%) of the original 26 J-SOAP questions tapped static risk factors. The J-SOAP-II has expanded to 28 items with changes made in all four of its scales. An important contribution to the area of juvenile risk assessment was the addition of the "Caveat" section in the J-SOAP-II which clarifies the limits of these assessments. The J-SOAP-II has 12 identified dynamic items (17-28), with the majority

(57%) of its questions tapping static risk factors. J-SOAP-II also consists of the 12 dynamic risk factor items on that protocol should be reassessed at 6 month intervals and sooner if risk-relevant changes have occurred.

**The Estimate of Risk of Adolescent Sex Offense Recidivism**

The ERASOR 2.0 is designed to assist evaluators estimate the risk of a sexual reoffense only for individuals aged 12-18 who have previously committed a sexual assault. The ERASOR 2.0 was developed using an empirically guided clinical judgment approach in a similar fashion to the Sexual Violence Risk-20. The ERASOR 2.0 has 9 identified static items (5-13), with a majority (64%) of its questions tapping dynamic risk factors. All ERASOR 2.0 scales except the "Historical Sexual Interest Scale", which consists of the 9 identified static risk factor items on that protocol should be reassessed at 6 month intervals and sooner if risk-relevant changes have occurred.

The J-SOAP-II and ERASOR 2.0 exhibit some differences on their emphasis of static versus dynamic risk factors (Yokley, 2000).

- The J-SOAP-II may be slightly better suited for a forensic evaluator conducting a one time risk assessment for juvenile court or human services recommendations during pre-sentence investigation or placement determination of the initial level of treatment care.
- The ERASOR 2.0 may be slightly better suited for a treatment program therapist conducting repeated risk assessments during treatment to evaluate treatment progress and determine when a recommendation for step down to a less restrictive treatment setting is appropriate.

**Social Responsibility Therapy Treatment Components**

1. **Stopping Abusive Behavior:**
    - By developing self-control and social-emotional maturity as competing responses to abusive behavior.
2. **Understanding Abusive Behavior:**
    - Including the Abuse Development Triad on how abusive behavior was acquired, maintained and generalized.
3. **Developing Prosocial Behavior:**
    - Including assertiveness, empathy, age-appropriate social interaction ability and emotional restitution.

**Abusive Youth: Who are these people?**

- Abusive youth typically have a history of juvenile court involvement, counseling and placement failure.
- Most youth abusers are multiple abusers
    - The referral type of abuse is not usually the only type of abuse.
    - Many youth abusers exhibit more than one type of abuse on "The Abuse Behavior Continuum" that requires treatment (i.e., sexual, physical, property, substance and trust abuse) (Yokley 1996).

**Understanding Abusive Behavior through the Abuse Development Triad**

- Helps abusers, treatment staff and caretakers understand how abusive behavior was:

  - Acquired through, **The Chain of Events that led to abuse**

  - Maintained – by Stress-Abuse Cycle and

- Generalized (to other problems) – by the Anatomy of Social Maturity Components

- In order to help interrupt further abuse behavior
- **"**If you don't know where you came from you're doomed to return there."

Note, the Abuse Development Triad includes cognitive contributors to abuse formulated by Albert Bandura, Samual Yochelson and Stanton Samenow.

**The Chain of Events that led to abuse**

Describes four basic factors or links in a chain which help explain how the initial abuse behavior was acquired. In other words, what led up to it, what were the primary contributing factors?

**Link 1: Past Permanent Problems** which consist of biopsychosocial disadvantages, abuse, neglect, rejection and other predisposing factors that could not be controlled. In summary, Past Permanent Problems are predisposing historical factors associated with the development of abuse.

**History of Being Abused:**

- The childhood experience of sexual abuse has been associated with juvenile sex offending, (Fenrenbach, et. al., 1986; Kahn and Chambers, 1991).
- Vampire Syndrome – Approximately 80% of adult pedophiles were molested as children, (Yokley, 2003).
- 19% to 81% of adolescent sexual abusers were previous victims of sexual abuse, (Becker, Kaplan, Cunningham-Rathner & Kavoussi, 1986).
- 75% of female street prostitutes were raped as children, (Yokley, 2002).

- Childhood experiences of being physically abused, being neglected, and witnessing family violence also have been independently associated with sexual violence in juvenile offenders, (Yokley, 2002).
- 75% of violent adolescent sex abusers report having been physically abused compared to 29% of other delinquents (Yokley, 2002).

**History of Witnessing Abuse:**

- There is a strong relationship between being abused by parents and/or witnessing aggression between parents and battering an adult partner.
- 79% of violent juveniles were exposed to extreme violence in their family.
- This was true for only 20% of less violent juveniles.
- Only 1 of the 14 juveniles sentenced to death in the United States was not physically abused as a child.
- 12 were exposed to extreme violence in the home, (Yokley, 2002).
- Males who observed parents attack each other were three times more likely to have assaulted their wives, (Yokley, 2002).

It is important to note that the abusive experiences of juvenile sex offenders have not consistently been found to differ from those of other juvenile offenders. For example, 44-47% of chemical abusers were victims of incest.

Other factors such as family instability, disorganization, and violence have been found to be prevalent among juveniles who engage in sexually abusive behavior. 59% of adolescent sex offenders come from families with serious problems and 38% of those homes evidence sexual deviation. Parental conflict, poor parental supervision, neglect, separation from parents and lack of parent affection are predictors of juvenile

delinquency. Marital discord and parent hostility directed towards the children appear to play a role in the development of adolescent conduct disorder. Many juvenile sex offenders have experienced physical and/or emotional separations from one or both of their parents (Yokley 2002).

He also found that the effects of inadequate parenting are far stronger on later delinquency, than was marital discord. Also a lack of appropriate supervision, neglect and parental rejection are associated with the seriousness of a child's delinquency. Recollection of paternal rejection is a strong contributor to an abusive personality. It was found that over one third of the mothers and half of the fathers of adolescent sex offenders were judged to be rejecting. 60% of parents are indifferent and 32% are hostile/rejecting of their delinquent youth.

**Link 2: The Chain of Events that led to abuse: Low Self-Efficacy and Social Maturity:**

Feeling ineffective, incompetent and helpless, low self-confidence, social-emotional immaturity, e.g., lacking honesty, trust, loyalty, concern, responsibility, self-control and empathy are all examples of low self-efficacy (Yokley 2002). Juveniles with low self-efficacy show signs of learned helplessness depression.

Research repeatedly documents that juveniles with sexual behavior problems have significant deficits in social competence which lead to involvement with deviant peers that afford an alternative means of self-enhancement. Inadequate social skills, poor peer relationships, and social isolation are among the difficulties identified by juvenile sex offenders. Research found that 46-65% of adolescent sex abusers evidence serious social isolation. This is significantly higher than the 17% of juvenile delinquent controls who are loners. 86% of adult rapists and 74% of adult child molesters report few or no friends

as youngsters. Adolescents with conduct disorder and depression also experience interpersonal difficulties with family and peers.

Pathological social immaturity and character disorder reflect deficits in honesty, trust, loyalty, concern and responsibility and criminal pride. Many youth sex offenders suffer from "pan immaturity" in emotional/social adjustment (Yokley, 1993). Aggressive or hostile adolescents are more likely than their non-aggressive peers to believe that aggressive behavior enhances their self-esteem and helps them having a negative image among their peers.

**Link 3: High Risk Situations:**

High risk situations are situations that set the occasion for, increase the risk of or trigger abuse behavior. Compensation situations, (feeling "one down" makes you want to be where you feel "one up"). High risk situations include people, places and things that allow or trigger abuse behavior such as associating with other abusers or victims; being in a place that sets the occasion for abuse or where abuse has occurred in the past; experiencing abuse trigger emotions. 18-36% of substance abusers report relapses associated with social pressure, e.g., "I have to use to get acceptance from other users". Marital and relationship problems are common with abusers and involve sexual, physical and substance abuse. Abusive youth have to stay away from control and power situations, situations that trigger emotions, pornography and substances (Yokley, 1993).

**Link 4: Maladaptive Thinking:**

Cognitive distortions which support abuse behavior are thoughts, beliefs, attributions and perceptions which disinhibit self-control or set the occasion for abuse. Cognitive distortions such as blaming the victim are associated with sexual reoffending

juveniles. Cognitive distortions biases and errors are correlates of both adolescent conduct disorder and depression. Cognitive distortions (i.e., attitudes, attributions, thoughts and irrational beliefs) that mediate emotional arousal and behavior choices are one of the most widely accepted factors in partner aggression (Yokley, 1993).

Maladaptive thinking examples:

- Justifying actions based on feelings:
    - Batterer's example: "she made me angry" is the most common excuse for violence heard when (battering) men first enter counseling.
- Failure to put self in the place of others:
    - Incest child molester example: "I did it to relieve myself at the time", "There was not love, no feelings, there was no nothing – it was just sex and that's all it was" and "it was mechanical. I just wanted to have a blow job. There were no feelings or anything like that".
- Depersonalization of the abuse victim:
    - Viewing others as objects not human with feelings.
    - Objectifying is also seen in depersonalization of the abuse victim with devaluing words.
    - Justifying raping them because they were prostitutes and deserved it.
- Blaming the abusive behavior on circumstances:
    - Blaming the responsibility for the abusive behavior on provocation by the victim.

- 31% of convicted rapists present their victim as not only willing but the aggressor, a seductress who lured them, unsuspecting into sexual action
- 30% of incest child abusers suggest that their daughter actually initiated the activity but none of their daughter concurred (Yokley, 1993).

- Comparing the abuse to more serious violence:
  - Batterer feels that because he is less violent than the man who beats a woman with his fists because he only slapped her with an open hand. Rapists who detest child molesters and alcoholics who detest drug addict.
- Minimizing and Normalizing abusive behavior
  - "It was just a mistake and I only did it one time".

  Normalizing abusive behavior – depicting the abusive behavior as a common or a socially acceptable occurrence.

  - "All my friends are doing sexual things to girls at parties so why shouldn't I?
  - "It's OK to use drugs", "Everybody gets high"

**Link 5: Fall and Relapse:**

The gratification reaction:

- After eating the entire box of donuts Jane felt terrible. In giving into her urge she let herself down and began to think what others would say. As she drove home she considered lying to cover up the fact that she did not feel like eating

dinner with the family. She failed herself again and felt depressed, disappointed and afraid others would notice.

- The gratification reaction sets the occasion for Negative Coping (e.g., lying and entering into the Stress-Abuse Cycle.

Why Abusers with extensive treatment experience continue to need staff guidance

1. Because social immature abusers have not developed enough honesty, trust, loyalty, concern and responsibility to succeed on their won and
2. Staff have developed enough social maturity to succeed on their own and
3. Social maturity can only be acquired through social learning experiences taught by the socially mature and reinforced through practice.

In summary, it is important that professionals and parents are able to understand the difference between a sexually reactive child and one who could be considered a sexual offender. This knowledge will save a child a lifetime of stigmatization and labeling as a sexual offender, when in fact they were innocently experimenting with the idea of sex and were not engaging in criminal activity.

As mentioned earlier in this paper, childhood sexuality begins very early in life, with some notable professionals stating as young as 12 months old. Sex and sexuality are, to a large degree, learned behavior. Society must therefore keep in mind that children will experiment with their sexuality and with sexual behavior towards other children. Children today live in a sexually saturated society and begin to learn about sex and sexuality from a diverse set of informational sources: television, parents, peers, music, self-exploration, babysitters, and so forth.

It is very important for parents and professionals to understand the concept of presexualization. Presexualization refers to a child who has been sexualized prematurely in life. Nearly all of the adult and adolescent sex offenders' studies have been pre-sexualized. Presexualization can take various forms such as, being overtly or covertly sexually abused, being exposed to pornography, and witnessing adult sexual behavior in the home, are among the most common forms of presexualization. It is important to emphasize that being pre-sexualized, however, does not necessarily imply that the child is or will become a sexual offender. Rather, it may indicate that the child may act out what he/she has been exposed to. This is what we call a sexually reactive child.

A sexually reactive child, for example, may be best illustrated in the following scenario. Tommy is a 9-year-old male, who was exposed to video pornography at the age of 3 onwards. Because his mother had a substance abuse problem, he would be cared for by his mother's sister. His aunt would have boyfriends come over the house regularly, and would engage in sexual intercourse. Though the door to the bedroom was closed, Tommy hearing strange noises found a crack in the door and witnessed the sexual activity. At first Tommy felt very strange, he thought his aunt was being hurt and he felt scared. After witnessing the sexual activity a number of times, he began to feel what we may call "horny" or sexually excited. He began to masturbate at the age of 6 by rubbing his penis on pillows and against the bed. One day, when Tommy was 9, he was left along for the day with his 8 year-old female cousin. They began to play various games together. Tommy noticed a sexual scene on a television soap opera, and became sexually aroused. He then asked his cousin if she wanted to

try something he had seen his aunt do in the past. The female cousin agreed, and Tommy got on top of her and began to "hump" her. While they were doing this, Tommy's aunt came in and witnessed what Tommy was doling. She was so upset and confused, that she phoned the police. The police entered a report, and Tommy and his aunt were referred to a sexual abuse/offender clinic in a nearby town.

Is Tommy sexually reactive, or a sexual offender? Many untrained people may erroneously state that Tommy is a sexual offender. He asked his cousin to partake in the activity. He initiated the activity. It appeared to be an advanced act of carnal knowledge.

Let's re-examine his story for clarification of the facts. Tommy was prematurely exposed to various sexual activities by witnessing his aunt having sex with numerous men, and by viewing pornography. At first he became scared, but then he became eroticized. He began to masturbate at a young age, most likely thinking about what he witnessed. The day of the incident, Tommy's sexual arousal was triggered by witnessing a love scene from a television program, and wanted to try what he had seen with his female cousin. No penetration occurred, and the act was unsophisticated.

Again, Tommy would be considered a sexually reactive child. If Tommy is treated like a "sex offender" by his family and by professionals, he will develop an increasingly higher level of shame over his behaviors and himself. This shame will not facilitate change for him, as he cannot understand that what he did was "wrong". This shame will affect Tommy's life in a number of disastrous long term ways.

Some of the differentiating signs between a sexually reactive child and a sexual offender are the following:

- Did there appear to be a conscious knowledge of sex and sexual behavior, or was the behavior triggered by external stimuli?
- How sophisticated was the incident?
  - Did penetration occur?
  - Was it a planned out offense?
  - Did the child/adolescent have a goal in mind (i.e., ejaculation)?
- How many times has the child/adolescent engaged in such behavior?
  - Is this likely the first, second, or third incident, or
  - Has the child/adolescent exhibited this behavior for an extended period of time?
- Does the child/adolescent make up a deliberate lie to cover their tracts, so to speak? or
  - Does the child/adolescent appear greatly confused and ashamed over the incident?
- Does the child/adolescent typically hang around with or associate themselves with children significantly younger than themselves (i.e., Tommy was 9, are all his playmates 5 and 6?).

These are just a few of the differentiating data that may separate a sexually reactive child from a sexual offender.

It is extremely for professionals and parents to note that much of the shame and psychological damage that occurs, not only with child victims of sexual abuse, but also

with sexually reactive children, stems from the reactionary behaviors of adults. For example, in Tommy's case, his aunt phoning the police may have created a significant trauma in his life that may have created more problems and difficulties for him. Parents and adults should attempt to remain calm in the presence of the children, and phone a specialist or mental health professional immediately. Parents should talk to the child, without expressing anger, and inquire about where the child learned the behavior. During this time the parents should also discuss how many times this may have occurred. It would not be appropriate to punish, hit, or whoop the child, as the child may not have known what he/she was doing wrong. This would only result in an intense level of shame which will carry over for years to come.

CHAPTER 6

# Conclusion

As social workers, therapists and childcare workers, care must be taken not to become caught up in the sexual hysteria hype which is being created by the current mass media. Society today is inundated with sexually explicit material every where we look. Nothing is hidden from our children; sex is all around them, on the TV, in magazines, on billboards, advertisements, movies and video games. Boys are even secretly watching their parents' pornographic videotapes, another example of the effects on children of their exposure to the sexual stimuli that surrounds them.

Today, movies allow their viewers to witness sexual acts, the only restriction being that one cannot observe a penis going into a vagina. (Penises and vaginas not involved in the act of copulation are still permissible.) Those interested in viewing this aspect of a sexual encounter can easily find theaters showing X-rated movies or view pornographic home videotapes. Accordingly, both parents and children have their sexual titillation easily available.

With regard to the containment of sexual urges stimulated by external stimuli, there is a continuum (as is true for most things in this world). At the one end of he continuum are those people with very powerful suppressive (conscious) and repressive (unconscious) psychological mechanisms, with the result that they are able to block from conscious awareness their titillation. However, they may have to resort to the utilization of various complex psychological mechanisms that allow release (symbolically or vicariously) without conscious awareness that pent-up sexual needs are being gratified. At the other end of the continuum are those who are driven to seek every possible sexual

gratification because of the bombardment of stimuli that they are continually being exposed to. Children are no exception to this principle. A newborn infant can be brought to orgasm if an adult chooses to masturbate the child (a practice which is not recommended). Obviously, the greater the intensity of the stimuli, the greater the frequency; the greater the excitation, and the greater the likelihood of acting out. In the world in which we live, the ubiquity of sexual stimuli is causing many children- even those at the highly suppressed end of the continuum, to exhibit sexual interest and excitation. And providing a false sex abuse allegation is one possible and increasingly available route for release (Gardner, 1991).

Compounding the difficulty of identifying children with sexual behavior problems, most American child protective services agencies are not legally empowered to investigate or intervene when sexual behavior problems are identified in children, unless the child first came to their attention as a possible victim of some form of maltreatment (e.g., neglect on sexual, physical, or emotional abuse). In Vermont, if a child under age 10 is found to have acted abusively, the Child Protection Services Agency cannot intervene with the maltreating child. This lack of power differs dramatically from the legal mandate that Child Protection Services Agencies function as therapeutic referral services for children with sexual behavior problems; these agencies are bereft of the ability to provide follow-up even if the family has requested it (Cantwell, 1988). Thus, relatively few records about children with sexual behavior problems are maintained within Child Protection Services Agencies or any other agency.

Fortunately, even in the absence of a legal mandate, several Child Protection Services Agencies have opened their case files to examine the number of substantiated

cases of child sexual abuse that are the result of other children's misbehaviors. In 1991, Vermont's Child Protection Services Agency held 135 open cases on children and adolescents whose records demonstrated that they had engaged in sexually abusive behaviors against others. Of the 135 youths, 51 (37.8%) were between 6 and 12 years old. These 51 children were responsible for 13.2% of all child sexual abuse cases substantiated in Vermont in 1991. It must be noted that 36 of the 51 children (70.6%) were known victims of sexual abuse before the onset of their own sexual behavior problems (Gray & Pithers, 1993).

Currently more than 40% of known child abusers in Vermont are under age 20 (Social and Rehabilitation Services, 1995). In 1994 alone, in a state with fewer than 640,000 residents, more than 125 children were sexually abused by a child less than 14 years old, with one third of these abuses being performed by a child less than 10 years old. Reported sexual abuse performed by children under the age of 14 has increased 300% within the last 10 years in Vermont (Gray, et al. 1997).

Utah has yielded data remarkably similar to that of Vermont. In Utah, 43% of all sexual abuse perpetrators are youths under age 18 with 18% being youths less than 13 years old (Utah Governor's Council on Juvenile Sex Offenders, 1990). In Washington, two case file reviews have been conducted to determine how many children with sexual behavior problems are in state custody (Office of Children's Research, 1992). In both reviews, the daily census ranged between 650 and 700 children.

The limited information available from Child Protection Services Agencies is powerfully confirmed by juvenile court data. Between 1980 and 1995, juvenile arrests for

general crimes committed by children ages 12 and younger increased 24%. In dramatic contrast, the arrest rate for children less than 12 years old has escalated 125% for sex offenses (excluding rape) and 190% for forcible rape. Of all juvenile arrests for children under age 12, 18% are for sex offenses (excluding rape), and 11% are for forcible rape. Because children of this age constitute only 9% of all juvenile arrests, the proportion of their arrests resulting from sexually abusive behaviors must be psychologically staggering to anyone whose heart holds compassion for children (Butts & Snyder, 1997).

The relationship between child maltreatment and adult criminality has been the topic of speculation for many years. It is now clear that although most maltreated children do not engage in criminal acts as adults, childhood maltreatment is associated with increased risk of arrest for a variety of antisocial behaviors, including sex crimes, throughout adolescence and adulthood. Juveniles who were maltreated during childhood have a higher rate of criminal arrests (26%) than juveniles not abused as children (16.8%). Even in adulthood, abuse survivors have a significantly higher rate of criminal arrest (28.6%) than adults who were not abused during childhood (21%). Sexual abuse was not associated with any greater degree of criminality in adulthood than other forms of child maltreatment. Thus, any form of maltreatment increases the risk of adult criminality (Widom & Ames, 1994).

Using odds ratios (i.e., calculating the odds that a person who has experienced a certain event as a child will engage in a specific behavior as an adult), it was found that sexually abused children were 4.7 times more likely than nonabused children to be arrested for a sex crime as an adult. Physically abused children were 4.1 times more likely than nonabused children to be arrested as an adult for a sex crime. Physically

abused children were 7.6 times more likely than nonabused children to be arrested for rape or sodomy. The similarity in the odds ratios of adult arrest rates for a sex crime across types of childhood maltreatment suggests that the etiologically significant factor in the emergence of abusive sexuality is exposure to trauma, not a unique associate of sexual victimization. Data from a study conducted by Widom 1995 suggests that childhood maltreatment is a distinct criminological factor. However because maltreatment does not function as a criminogenic factor in all children, it may be vitally important to define the debilitating factors that promote antisocial conduct and the protective factors that foster a prosocial adaptation by maltreated children.

The families of these abused children possess exactly the characteristics associated with parents of early-onset conduct disordered youth. Research on children with sexual behavior problems has shown that they can make clinically and statistically significant change after only 16 weeks of specialized treatment. Taken together, these data demonstrate the need to respond to families of children with sexual behavior problems and the ability to do so effectively.

Given these findings, state legislatures of Child Protection Service Agencies must be charged with creating the conditions that permit a meaningful response to the families of children with sexual behavior problems. Statutes need to be revised to enable children who have engaged in problematic sexual behavior to receive services that are demonstrably effective. Child Protection Service Agencies must work to provide services to families in a manner that is not experienced as primarily coercive and faultfinding, but as a method of building on a family's strengths to promote an abuse prevention lifestyle. Should society neglect to quickly provide effective services to these

children and families, the available research demonstrates that there is an increased likelihood that they will require much more costly services after delinquency hearings or criminal trials.

Clinical experience with adult sex offenders has shown that the collaborative efforts of health care and probation professionals result in more favorable outcome than the isolated effort of either profession alone. For children with sexual behavior problems, although the professional partnerships differ, the same principle holds. Effective treatment of these children and their families must involve collaboration among treatment providers, school personnel, Child Protection Service workers, and other social services agencies. Through this collaborative support, the children and family will be given the greatest opportunity to demonstrate an abuse prevention lifestyle day by day.

**Respond to Individuals not Stereotypes**

Within the current social climate, it seems that when an individual has engaged in a sexually abusive behavior, he or she is permanently branded a perpetrator and considered les than human. We seem to have lost sight of the fact that even though sex offenders have engaged in inhumane acts, they possess al the qualities and potential found among people who have not engaged in sex offenses: hatred and love, cowardice and courage, coldness and compassion. In some American states, the social misperception of sex offenders has led to imposition of some criminal sanctions that appear, at least to us, to be quite inhumane themselves (e.g., mandatory castration or “two strikes” legislation). Given that the children with sexual behavior problems have a mean of two victims, we are grateful that no one has attempted to extend “two strikes”

legislation on them. From this perspective, it may be time to rethink legislation that automatically imposes a sanction exclusively on the basis of a predetermined number of victims or convictions. Such social policies ignore one of the most defining elements of American society: recognition that everyone is an individual. Sentencing practices for adult sex offenders and dispositions for juvenile abusers should fully consider each individual's strengths and weaknesses, as well as the needs of their victims.

We are particularly concerned that the tendency to dehumanize adult sexual offenders not be extended to children with sexual behavior problems. Childhood is a time of boundless potential. It is the responsibility of adults who care for children to take measures to ensure that the potential of childhood is nurtured into a strong sense of personal ethics and social responsibility of adulthood. When society identifies children who are engaging in behaviors destructive to others and themselves, it must fulfill its social contract to act responsibly and provide interventions that will inspire these children to become adults with a strong sense of personal ethics. Labeling these children in a manner that even remotely implies that they may have lifelong problems with sexual assaultiveness (e.g., child sex offenders) and that denies their potential to make amazing contributions to the social good is simply wrong and should never be done.

In an era when society has recognized the importance of conserving precious natural resources, all of us must also recognize that children are the most precious resource in our world. Everyone must accept the challenge of demonstrating respect for the preciousness of children, place value in nurturing their boundless potential, and work to alter conditions that impair it. When harm has already been done, resources must be

dedicated to reclaim the hope for a better future offered by every child's life. The loss of one child's ability to nurture unlimited dreams for their future, limits society as a whole.

Finally, because child maltreatment has reached epidemic proportions in America, it may be time for governmental agencies, such as the Centers on Disease Control and Prevention, to demonstrate leadership in supporting implementation of health promotion strategies to prevent child abuse. Such efforts have yielded positive results with other risk behaviors (e.g., smoking cessation or seat belt use).

**APPENDIX I**

**The Abuse Behavior Continuum: Selected Abuse Examples**

## Primary Area of Impact

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| ABUSE IMPACT SEVERITY | **Abuse of Self** | **Abuse of Self and Others** | **Abuse of Others** |
|---|---|---|---|
| | Compulsive Injury of Self<br>Food Abusers<br>(binge, purge, starve)<br>Nicotine Abusers | | |
| | (Single) | Workaholics<br>(with partners and family) | |
| | (Self-destructive relationship dependent type) | Codependents<br>(Abuse behavior enablers) | |
| | (Compulsive deviant masturbation) | Sexual Compulsives<br>(Unprotected sex, affairs) | |
| | (Single Shopaholics) | Money Abusers<br>(Compulsive Gamblers) | (Embezzlers, Credit Fraud) |
| | (Single alcohol and drug abusers) | With partner/family)<br>Substance Abusers<br>(Alcohol and drug abusers with partners/family) | (Drunk drivers, drug dealers) |
| | | Responsibility Abusers<br>(Work Neglecters) | (Child Neglecters) |
| | | Trust Abusers<br>(Partner cheating) | (Professional con artist) |

## Abuse Behavior Continuum (Cont'd)

Verbal Power Abusers

Property Abusers

Physical Abusers

Sexual Abusers

Contract Killers

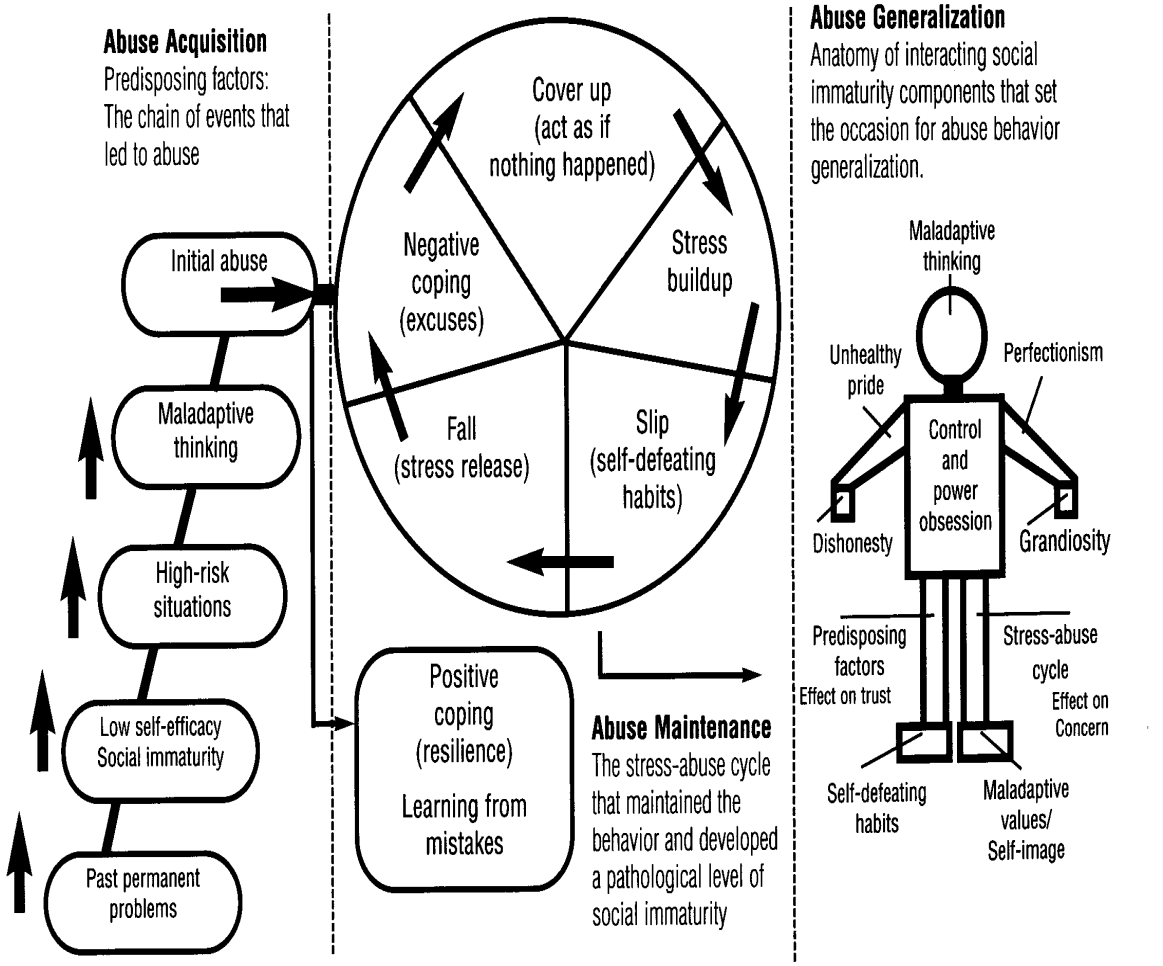
Lust Murderers,

Serial Killers

Compulsive Injury of Others

**APPENDIX II**

**Figure 1- The Abuse Development Triad:**
**How Abuse was Acquired, Maintained & Genelalized to Other Forms**



## DEFINITIONS

### Sexual Behavior Problems (SBP)

Children with sexual behavior problems engage in developmentally expected sexual acts; however, they also engage in more unexpected and intrusive acts than other children.

It understandably may be difficult to accept that children can engage in sexual behaviors that might be harmful to others and to themselves. Childhood is supposed to be a time of protected innocence. However, even at a logical level, little reason exists to believe that children are less likely to experience problems in sexual development than with any other behavior. Fortunately, one need not rely solely on logical analysis. The fact that children can engage in sexually problematic behavior is confirmed by two lines of date: (a) scores on an observational rating instrument of children's sexual behaviors and (b) the proportion of substantiated child sexual abuse in which the perpetrator was less than 12 years old.

The national prevalence of problematic sexual behavior in children is difficult to estimate. Criteria for identifying problematic sexual behavior in children are defined imprecisely (e.g., differences in stature or sophistication). Given the use of vague criteria for defining problematic sexual behaviors in children, it cannot be surprising that such behaviors are often misperceived or reported inconsistently. Because a highly normed measure (i.e., the Child Sexual Behavior Inventory-3) now exists that distinguishes the extent to which children engage in developmentally expected and unexpected sexual behaviors, it may be a preferable strategy for health care professionals to begin using this

measure to objectively define the existence of behavioral problems (National Adolescent Perpetrator Network).

**Oppositional Defiant Disorder (ODD)**

The essential feature of Oppositional Defiant Disorder is the recurrent pattern of negativistic, defiant, disobedient, and hostile behavior towards authority figures that persists for at least 6 months and is characterized by the frequent occurrence of at least four of the following behaviors: losing temper, arguing with adults, actively defying or refusing to comply with the requests or rules of adults, deliberately doing things that will annoy other people, blaming others for his or her own mistakes or misbehavior, being touchy or easily annoyed by others, being angry and resentful, or being spiteful or vindictive. To qualify for Oppositional Defiant Disorder, the behaviors must occur more frequently than is typically observed in individuals of comparable age and developmental level and must lead to significant impairment in social, academic, or occupational functioning (American Psychiatric Association, 2000).

**Conduct Disorder (CD)**

The essential feature of Conduct Disorder is a repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated. These behaviors fall into four main groupings: aggressive conduct that causes or threatens physical harm to other people or animals, nonaggressive conduct that causes property loss or damage, deceitfulness or theft, and serious violations of rules. Three or more characteristic behaviors must have been present in the past 6 months. The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning. Conduct Disorder may be diagnosed in individuals who are

older than 18 years but only if the criteria for Antisocial Personality Disorder are not met. The behavior pattern is usually present in a variety of setting such as home, school, or the community.

Children or adolescents with this disorder often initiate aggressive behavior and react aggressively to others. They may display bullying, threatening, or intimidating behavior; initiate frequent physical fights; use a weapon that can cause serious physical harm (e.g., a bat, brick, broken bottle, knife, or gun); be physically cruel to people or animals; steal while confronting a victim (e.g., mugging, purse snatching, extortion, or armed robbery); or force someone into sexual activity. Physical violence may take the form of rape, assault, or, in rare cases, homicide.

The most current conceptualization of conduct disorder has proposed two distinct subtypes that linked by their developmental pattern and course: early-onset life persistent and adolescent-limited. The early-onset type is marked by onset of behavior problems before age 10, including physical aggression and disturbed relationships with peers. This type is more likely to have pervasive conduct problems that persist into adulthood, becoming antisocial personality disorder (American Psychiatric Association, 2000).

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