Report of the ATSA Task Force on Children With Sexual Behavior Problems

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EXECUTIVE SUMMARY

The Association for the Treatment of Sexual Abusers (ATSA) Task Force on Children With Sexual Behavior Problems was formed by the ATSA Board of Directors as part of ATSA's overall mission of promoting effective intervention and management practices for individuals who have engaged in abusive sexual behavior. The task force was charged to produce a report intended to guide professional practices with children, ages 12 and younger. Specifically, the task force was asked to address how assessment should be linked to intervention activities, what intervention models or components are most effective, and the role of family involvement in intervention. The task force also addressed a number of scientific and public policy issues concerning children with sexual behavior problems (SBP).

The task force report begins with an introductory section that offers a working definition of children with SBP, reviews existing theory models about the etiology of SBP, and reviews the overlap of SBP with other problems. Research on population subtypes and the relationship of SBP to early sexual abuse and other risk factors is reviewed.

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Authors' Note: Dedication: This report is dedicated to our friend and fellow task force member, Bill Friedrich, who passed away during the final phases of completing this report. Bill's contributions to research and practice in this area, and his contributions to this report, were immense.

Editor's Note: This paper is a task force report written for the Association for the Treatment of Sexual Abusers and has been informally disseminated by that group since its completion in 2006. It was submitted to modified peer review by *Child Maltreatment* (seeking only recommendations of accept or do not accept) and approved through that process prior to its publication here.

Next, the report suggests principles for conducting good clinical assessment of children with SBP, including the role and timing of clinical assessment, the need to take a broad ecological assessment perspective, suggested assessment components and tools, and specific assessment issues. This includes the extent to which assessment of past sexual abuse history needs to be explored when children present with SBP.

The Treatment section of the report begins with a review of the treatment outcome research literature. The body of controlled treatment studies is small but does allow identification of better supported treatment models. A range of treatment issues is addressed, including the role of parents and/or caregivers in treatment and considerations for selecting between group, individual, or other treatment modes. Suggestions are offered for specific treatment components and how these treatment components may be integrated into an overall intervention where there are multiple treatment foci.

The Public Policy section of the report begins by articulating an overarching framework for policy decisions about the subset of more serious or victimizing childhood SBP and offers suggestions for specific policy areas, such as registration and notification, mandatory child abuse reporting practices, policies about removal of children from their homes, policies about segregated versus general placement settings, policies about information sharing, and policies about interagency collaboration. Specific suggestions about removal and placement decisions are offered, with the intent of valuing the needs and rights of other children in the home or community, as well as the welfare of the child with SBP.

The positions articulated by the report are intended to serve as suggested practices and recommendations. The task force strived to ground these recommendations in the best available scientific research, general good-practice principles, and accepted ethical codes. As with any task force report, we believe the suggestions and recommendations in the report should be given due consideration by practitioners and policy makers, but they should not be confused with formal practice standards. Highlights from the report include the following:

- Childhood SBP can range widely in their degree of severity and potential harm to other children. Although some features are common, virtually no characteristic is universal, and there is no profile or constellation of factors characterizing these children.
- Given the diversity of children with SBP, most intervention decisions—including decisions about removal, placement, notifying others, reporting, legal adjudication, and restrictions on contact with other children—should be made carefully and on a case-by-case basis. Because children and their circumstances can change rapidly, decisions should be reviewed and revised regularly.
- Despite considerable concern about progression onto later adolescent and adult sexual offending, the available evidence suggests that children with SBP are at very low risk to commit future sex offenses if provided with appropriate treatment. After receiving appropriate short-term outpatient treatment, children with SBP have been found to be at no greater long-term risk for committing future sex offenses than other child clinical populations (2%-3%). Children with SBP may be at equal or greater risk for becoming future sexual abuse *victims* as sexual abuse *perpetrators*.
- On the whole, children with SBP appear to respond well and quickly to treatment, especially basic cognitive-behavioral or psychoeducational interventions that also involve parents and/or caregivers. Intensive and restrictive treatments for SBP appear to be required only occasionally or rarely.
- Children with SBP are qualitatively different from adult sex offenders. This appears to be a different population, not simply a younger version of adult sex offenders. Public policies, assessment procedures, and most treatment approaches developed for adult sex offenders are inappropriate for these children.
- Policies placing children on public sex offender registries or segregating children with SBT may offer little or no actual community protection while subjecting children to potential stigma and social disadvantage.

INTRODUCTION

Definition of Children With SBP

SBP do not represent a medical or psychological syndrome or a specific diagnosable disorder but rather a set of behaviors that fall well outside acceptable societal limits. The task force defines children with SBP as children ages 12 and younger who initiate behaviors involving sexual body parts (i.e., genitals, anus, buttocks, or breasts) that are developmentally inappropriate or potentially harmful to themselves or others. Although the term *sexual* is used, the intentions and motivations for these behaviors may or may not be related to sexual gratification or sexual stimulation. The behaviors may be related to curiosity, anxiety, imitation, attention seeking, self-calming, or other reasons (Silovsky & Bonner, 2003).

It is important to distinguish SBP from normal childhood sexual play and exploration. Normal childhood sexual play and exploration is behavior

that occurs spontaneously, intermittently, is mutual and noncoercive when it involves other children, and the behavior itself does not cause emotional distress. Normal childhood sexual play and exploration is not a preoccupation and usually does not involve advanced sexual behaviors such as intercourse or oral sex. Some degree of behavior focused on sexual body parts, curiosity about sexual behavior, and interest in sexual stimulation is a normal part of child development. The form of these normal interests and behavior varies across development and across cultures (Friedrich et al., 2001). What is normal behavior for a preschooler may be atypical for an older child and vice versa, and what may be tolerated in one culture may be discouraged in another (e.g., Friedrich, Sandfort, Oostveen, & Cohen-Kettenis, 2000). In determining whether sexual behavior is inappropriate, it is important to consider whether the behavior is common or rare for the child's developmental stage and culture, the frequency of the behaviors, the extent to which sex and sexual behavior have become a preoccupation for the child, and whether the child responds to normal correction from adults or whether the behavior continues unabated after normal corrective efforts. In determining whether the behavior involves potential for harm, it is important to consider the age and/or developmental differences of the children involved; any use of force, intimidation, or coercion; the presence of any emotional distress in the child(ren) involved; if the behavior appears to be interfering with the child(ren)'s social development; and if the behavior causes physical injury (Araji, 1997; Hall, Mathews, & Pearce, 1998; Johnson, 2004).

SBP may include behaviors that are entirely self-focused or behaviors that involve other children. Behaviors involving other children may vary in the degree of mutuality or coercion, the types of sexual acts, and the potential for harm. The most concerning SBP cases involve substantial age or developmental inequalities; more advanced sexual behaviors; aggression, force, or coercion; and harm or the potential for harm. In this report, the task force will address SBP in a broad sense, with additional attention to more aggressive and abusive sexual behaviors directed toward other children.

Incidence and Prevalence

No population-based figures are available on the incidence or prevalence of SBP in children. By definition, most of the behaviors involved are fairly rare, which is borne out by the available data on the incidence rate of nonnormative sexual behavior in children (Friedrich et al., 1991; Friedrich et al., 2001). Recent decades have seen an increase in the number of children with SBP who have been referred for child- protective services, juvenile services, and treatment in both outpatient and inpatient settings (Burton, Butts & Snyder, 1997). It is not known whether this represents an increase in the incidence of such behaviors, changing definitions of problematic sexual behavior, increased awareness and reporting of what has always existed, or some combination of these factors.

Origins of Sexual Behavior Problems in Children

The origins of SBP in children are not clearly understood. Early theories emphasized sexual abuse as the predominant, if not sole, cause of sexual behavior problems in children. Children who have been sexually abused do engage in a higher frequency of sexual behaviors than children who have not been sexually abused (Friedrich, 1993; Friedrich, Trane, & Gully, 2005), and sexual abuse histories have been found in high percentages of children with SBP (Friedrich & Luecke, 1988; Johnson, 1988). The last decade of research suggests that many children with broadly defined sexual behavior problems have no known history of sexual abuse (Bonner, Walker, & Berliner, 1999; Silovsky & Niec, 2002). Current theories emphasize that the origins and maintenance of childhood SBP include sexual abuse as well as familial, social, economic, and developmental factors (Friedrich et al., 2001; Friedrich, Davies, Feher, & Wright, 2003). Contributing factors include maltreatment, substandard parenting practices, exposure to sexually explicit media, living in a highly sexualized environment, and exposure to family violence (Friedrich, Davies, Feher, & Wright, 2003). Hereditary also may be a contributing factor (Langstrom, Grann, & Lichtenstein, 2002). For some children, SBP may be one part of an overall pattern of disruptive behavior problems (Friedrich, 2007; Friedrich et al., 2003; Pithers, Gray, Busconi, & Houchens, 1998), rather than an isolated or specialized behavioral disturbance.

Typology

Children with SBP are quite diverse in the types of sexual behaviors performed and also in personal demographics, familial factors, socioeconomic status, maltreatment history, and mental health status. Children with SBP are perhaps more diverse than adolescents with SBP and adult sex offenders. For example, whereas adolescent and adult sex offenders are predominantly male, there are a substantial number of young girls as well as young boys among children with SBP (Johnson, 1989; Silovsky & Niec,

2002). No distinct SBP profile for children exists, nor is there a clear pattern of demographic, psychological, or social factors that distinguish children with SBP from other groups of children (Chaffin, Letourneau, & Silovsky, 2002).

Attempts have been made to construct SBP subtypes based on types of SBP involved (Bonner et al., 1999). To date, findings suggest that there are not qualitatively different sexual behavior subtypes but rather simply ranges of overall SBP severity and intensity. Children with more intense SBP tend to have more comorbid mental health, social, and family problems (Hall, Mathews, Pearce, Sarlo-McGarvey, & Gavin, 1996). Efforts to derive clinically distinct subtypes have yielded empirical clusters with substantial overlap, suggesting that there may not be distinct taxonomic subgroups (e.g., Bonner et al., 1999; Pithers et al., 1998).

ASSESSMENT

Assessment Purpose and Timing

The focus of this section is on clinical assessment of children with SBP. Clinical assessments are primarily useful for informing intervention and treatment planning. Where child welfare or juvenile justice authorities are involved, clinical assessments may properly aid in formulating official dispositional recommendations and case plans. However, clinical assessments should not be confused with official investigations into whether or not an alleged behavior actually occurred, and consequently, clinical assessments may not be relevant for official proceedings focused on determining whether or not a particular act was committed.

Case-by-Case Assessment and Decision Making

The task force believes that individual assessment should play a foundational role in intervention decisions and actions. This includes determining whether or not there is a need for intervention or treatment; recommending the types of intervention or treatment that are needed; recommending intervention priorities; and offering input into decisions about child removal, placement, or family reunification. As noted in the policy section of this report, the task force endorses assessment-driven, case-by-case intervention planning and decision making for all children with SBP.

Assessor Qualifications

Clinical assessments should be conducted by degreed, mental health professionals who are licensed appropriate to their discipline and according to local laws. The task force recommends that assessors have expertise in the following areas:

- Child development, including typical sexual development and behavior.
- Differential diagnosis of childhood mental health and behavioral problems.
- Specific familiarity with common problems seen among children with SBP, including nonsexual disruptive behavior problems, learning disorders and developmental issues, attention deficit hyperactivity disorder (ADHD), child maltreatment, child sexual abuse, trauma, and posttraumatic stress–related problems. Familiarity with conditions that may affect self-control, such as hyperactivity and childhood bipolar disorder, may be important.
- Understanding environmental, family, parenting, and social factors related to child behavior, including the factors related to the development of sexual and nonsexual behavior problems.
- Familiarity with the current research literature on empirically supported intervention and treatment approaches for childhood behavior and mental health problems.
- Cultural variations in norms, attitudes, and beliefs about child rearing and childhood sexual behaviors.

Assessment Areas and Scope

Scope of assessment. The scope of a clinical assessment may vary from case to case. In other words, the breadth and complexity of the assessment and the amount of assessment resources consumed will vary. The task force believes that for most cases, it is unnecessary to conduct broad-ranging assessments with extensive testing across many sessions. Rather, in many cases, the necessary assessment information can be obtained from review of background materials, taking a basic behavioral and psychosocial history from parents or caregivers, a basic assessment interview with the child, and administration of a few simple assessment instruments. This can be accomplished in a limited number of assessment sessions, and often in a single session. In cases where there are complicated diagnostic issues, more extensive assessments are warranted.

Assessing context, social ecology, and family. The family environment and social ecology are key areas in assessing all childhood behavior problems, including SBP. Children's behavior may reflect their environment, and changes in environment often are necessary for sustained changes in behavior. Current and future environmental context may be more influential than individual child factors or the child's individual psychological makeup. Consequently,

assessment should include a focus on current and future contextual factors both inside and outside the home, including the following:

- Quality of the caregiver–child relationship, including the level of positive adult caregiver engagement with the child
- Adult caregiver capacity to monitor and supervise behavior
- Caregiver warmth and support shown toward the child
- Presence of positive or negative role models and peers in the child's social environment
- Types of discipline, limits, structure, or consequences applied; the level of disciplinary consistency; and the child's response
- Emotional, physical, and sexual boundary violations in the home
- Availability of opportunities for inappropriate behavior
- Extent and degree of sexual and/or violent stimulation in the child's past and current environment
- Exposure to, and protection from, potentially traumatic situations
- Cultural factors of the home and community (including racial, ethnic, religious, socioeconomic, etc.)
- Factors related to resilience, or strengths and resources that can be developed

Effective interventions for childhood behavior problems usually include working directly with and through parents or other adult caregivers in the child's social ecology. Ecologically focused assessment is critical for guiding which goals and strategies will be pursued with key adults in the child's life. In addition, the social ecology of the extended family, neighborhood, school, and other social environments directly affects children's behavior and should be included in the assessment. For example, an ecologically focused assessment of a case might suggest that negative peer influences contribute to the child's sexualized behavior. In this event, it might be important to assess what adult resources are available to steer the child away from his or her negative peers, to promote involvement with different peers, and to supervise peer interactions more closely. Similarly, an ecologically focused assessment might identify exposure to sexually explicit online material as a stimulus triggering SBP. In this event, it might be important to assess what sorts of limits, restrictions, or monitoring might be applied to eliminate this influence. Ecologically focused assessment strives to identify not only problems and factors that trigger or maintain SBP but also strengths and resources that might be marshaled to overcome the problems. For example, a child who genuinely wishes to please significant adults may respond well to interventions emphasizing positive reinforcement and praise. Family, extended family, peer, community, and school strengths should be examined. Ecologically focused assessment also integrates information about permanency planning for children in state's custody. If the child is currently in foster care, but the long-term plan is reunification with his or her biological family, assessment and treatment planning will focus on both homes.

Assessing broad psychological and behavioral status. Good assessment of children with SBP includes a broad assessment of general behavior and psychological functioning, as well as a specific assessment of problematic sexual behavior. In some cases, SBP may be the dominant concern. In other cases, assessment may indicate that SBP is a secondary or lower priority. Combining a broad assessment of general functioning with a specific assessment of sexual behavior makes prioritization possible. A number of nonsexual problems have been described among children with SBP, including externalizing behavior problems (e.g., ADHD, oppositional or aggressive behavior), internalizing problems (e.g., posttraumatic stress disorder symptoms, depression, or anxiety), developmental and learning problems, and adverse environments (e.g., physical abuse, neglect, or exposure to violence). Because a significant number of children with SBP have histories of abuse or trauma, assessing for problems commonly related to abuse or trauma may be especially important. Common abuse or trauma-related problems may include posttraumatic stress disorder, other anxiety disorders, and depression. Depending on the case, other general assessment procedures, such as assessment of intellectual or learning functioning, may be appropriate. Less often, children with SBP may present with serious neuropsychiatric conditions, such as bipolar disorder, with symptoms of behavioral disinhibition and socially inappropriate sexual behavior. As a general assessment principle, common explanations for behavior involving more prevalent conditions and more everyday explanations should be considered prior to entertaining explanations based on rarer conditions.

Assessing sexual behavior and contributing factors. Obtaining a clear, behavioral description of the sexual behaviors involved, when they began, how frequently they occur, and how and whether they have progressed or changed over time is a core assessment component. It often is informative to sequence the sexual behavior history chronologically, and if possible, juxtapose this chronology with key events in the child's life. Multiple information sources are

important to creating a complete picture of the SBP, including information provided by the child, by parents or caregivers, by teachers, or by other child(ren). This information may be directly obtained or drawn from official investigation reports, records, or prior evaluations.

An important area of assessment is determining the extent to which the pattern of SBP is self-focused, other-directed, planned, aggressive, or coercive. For example, SBP that are self-focused, such as excessive childhood masturbation, may suggest a very different intervention plan from SBP that involve use of force with other children. If the SBP involved other children, it is important to determine how the behavior was initiated, the degree of mutuality involved, and whether the behavior was planned or impulsive, and whether it involved use of force or aggression to overcome any resistance. These factors are critical in assessing the extent of supervision and restriction needed to protect other children. The sexual behavior history should include attention to prior efforts or lack of efforts made by parents or caregivers to correct the behavior, and the child's response to these efforts. In particular, it may be important to assess for corrective efforts that have shown some degree of success, as this may offer insight into key elements of an effective intervention plan.

Good assessment should attempt to identify situations or circumstances under which SBP seem to occur. For example, some children might engage in SBP during times of stress, when depressed or frightened, when angry, or when reminded about past sexual abuse. Others may engage in SBP in response to particular environmental triggers, such as when exposed to sexual stimuli or when engaged in rough and tumble play with other children. Still others may show behavior limited to opportunistic circumstances, such as behavior occurring during sleepovers or when sharing a bed with another child. As a general principle, current and recent factors maintaining SBP, both environmental and emotional, may be more salient than long past or distal factors. In other words, although understanding original causes and the ultimate etiology of the behavior may be informative, assessment-driven recommendations ought to focus more on what *current* factors are maintaining the behavior, what *current* factors are restraining the behavior, and what *future* maintaining or restraining factors may arise. Parents, caregivers, or professionals sometimes presume that assessment must find a specific event that caused the SBP or presume that finding the root cause is necessary for solving the problem. However, in reality, causes for human behavior can involve the interplay of multiple factors and may not be fully knowable. Parents or other professionals should be reassured that finding the ultimate past cause(s) of the SBP is far less important than assessing what current and future factors need to be identified to help.

In cases in which there has been a reduction in SBP because of a dramatic but temporary change in the child's environment (e.g., a child placed in foster care or removed from any contact with other children), long-term maintenance of improved behavior will require assessing not only the child's *current* emotional and environmental circumstances but also the *future* circumstances likely to be involved when the temporary environmental change ends (e.g., when the child returns home or resumes contact with other children). Therefore, good assessment in these cases will include identifying maintaining and restricting factors both in the temporary living environment and in the anticipated future living environment.

Interviewing children about their SBP. Care is needed when interviewing children about the specifics of their SBP. Sensitivity to developmental issues and past trauma history is necessary. The interview atmosphere should be supportive and unpressured. The goal of a clinical interview is information gathering and laying the groundwork for addressing SBP in a calm and matter-of-fact manner. The goal is not to obtain a confession, and clinical interviewers should not use interrogation or pressure strategies with children. Polygraphs or other techniques designed to elicit confessions should not be used with children.

Interviewers should expect that children may be reticent to discuss the subject of inappropriate sexual behavior. Children commonly deny past wrongdoing of any sort when questioned by adults. For some children, discussing sexual behavior may recall upsetting memories. Other children may simply have forgotten about past events or details, especially when intake assessments occur many months after the incident. Failing to admit past SBP during the assessment, even in situations where there is clear evidence that the behavior has occurred, is not necessarily an indication of poor prognosis or being in a pathological state of denial. Assessors may opt not to question children about long-past events or details, events that are clearly upsetting to the child, or may choose not to interview very young children about the specifics of their SBP.

The role of formal testing in assessment. Psychological testing can help estimate the extent and nature of SBP. The Child Sexual Behavior Inventory–III

(CSBI-III; Friedrich, 1997) is designed for children ages 2 to 12 and measures the frequency of both common and atypical behaviors, self-focused and other-focused behaviors, sexual knowledge, and level of sexual interest. Since the development of the third edition of the CSBI, Friedrich (2002) has added four items that assess planned and aggressive sexual behaviors. Age and gender norms are available for the CSBI and can help discriminate between developmentally normal and atypical sexual behavior. None of the four added planned/aggressive items were endorsed by current normative samples. Another measure is the Child Sexual Behavior Checklist (CSBCL–2nd Revision), which lists 150 behaviors related to sex and sexuality in children, asks about environmental issues that can increase problematic sexual behaviors in children, gathers details of children's sexual behaviors with other children, and lists 26 problematic characteristics of children's sexual behaviors (Johnson & Friend, 1995). The CSBCL–2nd Revision also gathers a broad range of information that is useful for assessment and treatment planning. The CSBCL–2nd Revision for children 12 years of age and younger can be completed by anyone who knows the child well (Johnson & Friend, 1995). A shorter instrument appropriate for tracking week-to-week changes in general and sexual behavior among young children is the Weekly Behavior Report (WBR; Cohen & Mannarino, 1997b). All of these assessment tools are useful in several ways. They may help evaluate the extent and nature of the SBP. Normed instruments such as the CSBI may be useful for explaining to parents or others which of a child's sexual behaviors are common and which are atypical. Instruments such as the CSBCL can help assess contributing factors and identify environmental intervention areas. Finally, instruments can be useful for monitoring progress and tracking outcomes (e.g., Cohen & Mannarino, 1997b).

Assessment Issues

Adult and adolescent sexual behavior assessment procedures that are inappropriate for children. Several features of adult or older adolescent sexual behavior assessment have little direct relevance to assessing children. For example, some adult sex offenders have sexual attraction toward children. Sexual attraction toward children is considered deviant for adults. However, this factor has no conceptual equivalent and therefore no relevance when assessing children with SBP. Deviant arousal assessment techniques, such as phallometry, should not be used. Other assessment targets that are relevant for adults or older adolescents, such as deficient victim empathy or patterns of "grooming" behaviors, also may be either irrelevant or qualitatively different among children. What is concerning at older ages, such as concrete moral thinking, may be developmentally normal among children or even young teens. Although children are capable of empathic feelings, the level of abstraction and complexity involved is normally much less than for adults. Similarly, the sorts of sequential planning and deliberation required for "grooming" may be well beyond the cognitive capabilities of young children. Assessors should guard against projecting adult constructs onto children.

How much should assessment focus on sexual abuse history? It is clear that a history of previous or ongoing sexual abuse increases the risk for developing SBP (Friedrich, 1993; Kendall-Tackett, Williams, & Finkelhor, 1993). Consequently, when a child exhibits SBP, it is appropriate for assessors to make direct inquiries into whether or not the child has been, or is being, sexually abused. However, assessors should not presume that SBP, even SBP involving clearly adult-like sexual behaviors, is sufficient to conclude that there has been sexual abuse. Evidence suggests that there probably are multiple pathways to SBP, some of which involve sexual abuse and some of which do not. The task force believes that childhood SBP are sufficient to raise the *question* of sexual abuse but should not be considered sufficient, by themselves, to *conclude* that sexual abuse has occurred.

Inquiring into sexual abuse and trauma history should be done in simple language that the child can understand; should favor open-ended questions; and should assiduously avoid biased, suggestive, or leading questions. Inquiries into the child's abuse history should be made both with the child and with his or her parents and/or caregivers. Inquiry into possible abuse history may or may not lead the assessor to conclude that there is sufficient reasonable suspicion to warrant making a report to the authorities. Assessors should remain cognizant of their legal obligation to report reasonable suspicions of child abuse and should inform parents and/or guardians about reporting obligations when obtaining consent for the assessment and prior to conducting the evaluation. It usually is not advisable for assessors to move beyond clinical inquiry into the more involved task of abuse investigation or forensic interviewing. Reporting reasonable suspicions is a responsibility for assessors. Investigating those suspicions further and conducting formal forensic interviews is the job of child welfare, law enforcement, or other authorities. Mental health professionals may at times be asked to conduct forensic assessment of abuse suspicions, and separate guidelines are available for these

types of assessments. Mixing clinical and forensic assessments creates complications that are best avoided if possible (American Academy on Child and Adolescent Psychiatry, 1997; American Professional Society on the Abuse of Children, 1990).

In some cases, sexual abuse may be suspected, but the official investigation may yield no clear conclusions. This may be distressing to parents or professionals who may presume that the question of abuse must be conclusively answered for the child to be helped. When the facts are inconclusive, parents or professionals may be tempted to turn to poorly supported or concerning methods in their search to find an answer to the abuse question (e.g., overinterpretation of drawings or play, suggestive therapy or interview techniques, profiling, poorly supported truth-detection techniques, etc.). Assessors should resist the temptation to turn to these methods when the facts are inconclusive. Parents can be reassured that providing good intervention services and expecting good outcomes is still possible even if the original causes of the behavior are unclear and even if the facts concerning sexual abuse history are inconclusive.

In some inconclusive cases, the concern is more about the possibility of *ongoing* rather than past sexual abuse. Naturally, ongoing abuse would be a serious concern, both for the child's welfare and for the success of intervention efforts. In these cases, assessors may recommend interventions focused on educating children about sexual abuse, identifying who children might tell if they were being abused, having significant adults support this message, and building support systems around the child (Hewitt, 1999). Where cases have been thoroughly investigated but findings are inconclusive, it is generally a poor practice to keep questioning children over and over about abuse or to keep seeking additional interviews, additional experts, or additional medical examinations.

Temporal factors in assessment. The task force recognizes that children's behavior and status can change over time as the child develops and matures, and as circumstances and the social environment change. Consequently, the validity of any clinical assessment also can change over time. Good child assessment reports often include explicit statements to guard against inappropriate use of the report long after its validity has expired. This is particularly important for assessment of children who have engaged in coercive sexual behavior, given that there is sometimes substantial misinformation about the persistence of sexual offending in children. In particular, when offering recommendations about limiting contact with other children or similarly restrictive interventions, assessment reports should be explicit that these recommendations apply to current circumstances and may not be valid later in the child's life.

In addition to explicating this caveat, other temporal and maturational factors need to be weighed in assessment. As a general principle, behavior occurring recently should be given greater weight than behavior occurring in the distant past. This point is particularly relevant in cases where the inappropriate or abusive sexual behavior occurred in the past, but where a thorough inquiry suggests that the behavior has not repeated itself after an extended period of time. For example, children may be referred for assessment because of SBP that last occurred 1 year or more ago, and it appears the SBP has not reoccurred. In these circumstances, assessment might appropriately give greater weight to the child's more recent desistance than to the child's long-past SBP.

Assessing best interests and welfare of the child with SBP. Assessors strive to make recommendations that consider the best interests of the child along with the interests of the family, other children, and the community. The task force believes that the point at which this balance is appropriately struck will vary with the age of the child being assessed. Progressively younger individuals require progressively greater consideration given to their interests and welfare. For example, whereas an adult sex offender's interests are expected to be subordinated to those of his victim and the community, the best interests of young children with SBP must be considered more carefully and given more weight. Therefore, the task force believes that assessment should include some estimate of how any intervention recommendations or decisions might negatively affect the child. Where questions of removal or placement are involved, or where more restrictive or burdensome interventions are being considered, the assessment should estimate the potential burden this might place on the child and the potential risks to which the child might be exposed. For example, where residential or out-of-home placement is being considered, assessors should evaluate the potential for any negative social, educational, or familial impact on the child, along with evaluating the potential benefits to the child, and the importance of protecting other children and the community. The younger or more vulnerable the child, the relatively greater the weight we should give to that child's best interests and welfare.

TREATMENT

A number of SBP-specific treatments for preadolescent children have been described in the clinical

literature, most developed during the past two decades (Araji, 1997). A small but reasonably rigorous body of SBP treatment effectiveness research has emerged, sufficient to guide recommendations. Beyond the SBP area, there is a large and rich body of research on effective interventions for child behavior problems in general, and this literature offers additional guidance.

SBP Treatment Outcome Research

Two randomized trials have been conducted specifically focusing on children with SBP. Bonner et al. (1999) randomly assigned children with SBP either to a 12-session, psychoeducational, cognitive-behavioral group treatment program (CBT) or a 12-session play therapy group. Short-term reductions in SBP and nonsexual behavior problems were found among children in both treatment groups. At 10-year follow-up, sex offense arrest and child welfare sexual abuse perpetration report outcomes were significantly in favor of the CBT condition (Carpentier, Silovsky, & Chaffin, 2006). Children randomized to CBT had significantly lower rates of sex offense arrests or sex abuse perpetration reports (2%) than children randomized to play therapy (10%). Children with SBP who received CBT had approximately the same rate of future sex offenses (2%) as a clinic comparison group of children diagnosed primarily with ADHD or behavior problems, but with no history of SBP (3%). Thus, the 12-session CBT approach not only performed better than play therapy but resulted in future sex offense rates that were both extremely low in absolute terms and no different from those of a general clinic population. This suggests that risk for future sexual offenses can be reduced to baseline levels with appropriate short-term treatment. The 12-session CBT protocol used in the study involved teaching children simple sexual behavior and boundary rules, involving parents or caregivers in monitoring and supervision activities, and teaching children basic impulse control skills.

Pithers and Gray (1993) and Pithers et al. (1998) randomly assigned 115 children with SBP, ages 6 to 12, and their families, to 32 sessions of either expressive therapy or a relapse prevention–based group program. Both group programs, including the expressive therapy, were psychoeducational, structured, CBT types of models. However, the relapse prevention model, which was adapted from adult sex offender treatment, focused on identifying relapse factors and building a prevention team, whereas the expressive approach was limited to education about sexual behavior rules, boundaries, emotional management, understanding the effects of sexual abuse, and teaching problem solving and social skills (Araji, 1997). Midway through the program, children in both groups had improved, and a subgroup of children with serious traumatic stress symptoms improved more with relapse prevention treatment (Pithers et al., 1998). Ultimately, at follow-up, improvements were seen in both groups, and the groups did not significantly differ (reported in Bonner & Fahey, 1998).

Other studies, primarily of sexually abused children, also have tracked SBP outcomes. In a randomized trial studying treatments for sexually abused children with traumatic stress symptoms, several of whom also had SBP, Cohen and Mannarino (1996, 1997a) tracked changes in SBP over time. Children randomized to a gradual-exposure-based CBT, including a brief component focused specifically on managing SBP, were compared with children assigned to individual nonspecific supportive therapy. Both treatment conditions included caregivers in the therapy. The CBT cases demonstrated significant SBP reductions from pre- to posttreatment, whereas the nonspecific supportive therapy group did not. Improvements were maintained at 1-year follow-up (Cohen & Mannarino, 1997a). Furthermore, six children who received nonspecific supportive therapy had persistent SBP and were consequently removed from that arm of the study and provided with CBT, after which their SBP improved (Cohen & Mannarino, 1997a).

Silovsky and colleagues used a waitlist control design to evaluate a 12-week CBT group treatment program for preschool children with SBP (Silovsky, Niec, Bard, & Hecht, 2007). Participants were evaluated weekly throughout wait and treatment periods. Significant time effects and an increased rate of SBP symptom reduction related to treatment were found among children with the highest initial rates of SBP. In other words, SBP tended to improve with the passage of time, perhaps related to basic caretaker or child welfare interventions (e.g., increased supervision, reduced contact with other children), but the rate of improvement of the children with the highest frequency of SBP became more rapid once the short-term psychoeducational CBT treatment was initiated. Similarly, Stauffer and Deblinger (1996) tracked SBP among children in CBT treatment for sexual abuse–related traumatic stress symptoms and noted greater reductions during treatment compared to during a waitlist period and found that these reductions were maintained at 3-month follow-up. Pre-to-post–reductions in SBP also have been reported among children in outpatient psychotherapy treatment with a specific SBP focus (Friedrich, Luecke, Beilke, & Place, 1992).

Several general conclusions might be drawn from this body of research. First, it appears that improvement in SBP is the rule over time, at least when some sort of detection and adult intervention is provided. Second, it appears that focused treatment helps, and some types of treatment work better than others. In particular, where structured, SBP-focused CBT approaches that include parent and/or caregiver involvement have been tested, they have been found to work better than unstructured supportive therapy or unstructured play therapy approaches. This includes findings at both short-term and long-term follow-up and findings for both general parent-reported SBP and for long-term official sexual offense outcomes. Third, it appears that blended CBT treatments targeting both traumatic stress symptoms and SBP can be successful in helping both problems in cases where both are present.

Finally, examining the details of these studies suggests that good results can be obtained for a broad range of children with SBP using short-term outpatient CBT treatment approaches. Across studies, good outcomes in short-term outpatient CBT treatment have been found for children with highly aggressive versus less aggressive SBP and for girls as well as for boys. Benefits have been reported among populations with significant trauma, varying levels of comorbid problems, and varying levels of family problems. Although short-term outpatient CBT treatment may not be the best option for each and every child with SBP, the findings do suggest that short-term outpatient CBT approaches, with appropriate parent or caregiver involvement, can be expected to yield excellent and durable results in most cases. Given these findings, and the fact that short-term psychoeducational CBT is a low-burden and low-risk intervention, short-term outpatient CBT treatment should be considered the first-line treatment for SBP except in unusually severe cases or cases with very severe comorbidities (e.g., children who are acutely suicidal).

Other types of SBP treatments and treatment settings are less well studied than outpatient CBT. For example, there currently are no controlled outcome studies testing interventions for children placed in inpatient or residential settings. Behavioral parent-training or family therapy approaches, which may be promising considering their track record with child behavior problems in general, have not been tested specifically for SBP. However, it does appear that less structured and less goal-directed therapies, such as nondirective play therapy or nonspecific supportive therapy, are not the best choices for children with SBP.

Parent/Caregiver Involvement in Treatment

It is important to note that both the clinical and research literatures emphasize parent involvement in treatment (Friedrich, 2007; Johnson, 1989, 2004; Silovsky et al., 2006). This includes biological parents, foster or kinship care parents, or other caregivers, with consideration given to including both current caregivers and likely future caregivers. In some cases, the home environment actively contributes to the development and maintenance of the child's SBP. To effectively intervene, the home environment must be stabilized and contributing factors managed. In other cases, the home environment may not have contributed to the problem, but parents/caregiver involvement in treatment still may be critical for providing support and for implementing day-to-day aspects of the intervention plan.

Most of the better child behavior problem treatments examined to date in the effectiveness literature have included an active parent component. Some are primarily parent-focused or parent-mediated approaches, such as parent skill training, whereas others involve parents as partners in the treatment (Brestan & Eyberg, 1998; Deblinger & Heflin, 1996; Hembree-Kigin & McNeil, 1995). In general, child behavior problem treatments are most effective when they (a) use a focused, goal-directed approach and (b) teach parents, teachers, or other caregivers to use practical behavior management and relationship improvement skills (Patterson, Reid, & Eddy, 2002). The parenting and behavior management skills taught in these treatments share much in common, including instruction in how to give clear behavioral directions to children; attending to positive child behavior; use of specific labeled praise for desired behavior; using time-out with younger children; use of logical and natural consequences with older children; and promoting parental consistency, warmth, and sensitivity. Among parents of children with SBP, parent involvement may additionally include establishing supervision plans and creating a safe, nonsexualized environment for the child. A number of approaches might be considered for fostering parent involvement in treatment. Joint dyadic sessions, regular parent collateral sessions, and in-home or family therapy modalities are possibilities. The group therapy approaches used by Bonner and colleagues (1999), Pithers and Gray (1993), and Pithers et al. (1998) in randomized trials both included active parent involvement in the children's group and/or in a regular parent's group.

In many cases, it may be appropriate for therapists to work directly with surrogate parents, such as day care staff, neighbors who look after children, or

teachers. In cases where SBP are occurring at school or in similar settings, therapists should strongly consider visiting the day care facility or school, observing the child's behavior and offering teachers and staff clear, concrete, and practical suggestions for supervision and behavior management techniques. For example, a young child with SBP in day care might need to stay near the teacher during nap times, avoid being alone with other children in the bathroom or changing areas, and receive appropriate reinforcement for keeping hands to himself or herself. Teachers and staff can be educated that SBP are not uniquely difficult behaviors to correct and that most children with SBP will desist from the behavior given appropriate guidance, structure, and help (Horton, 1996). Working with schools and day cares may be important for preventing the child from being expelled from these settings, and thereby creating disadvantages and additional family burden.

Treatment Modality—Group, Individual, or Other Modalities

As child sexual abuse was increasingly recognized during the 1980s, victim support groups and group therapy programs grew and became widely synonymous with abuse-focused clinical practice. In line with this history as well as the group approaches historically used with adult and adolescent sexual offenders, many treatments for children with SBP have been group based (Araji, 1997). However, the clinical popularity of group programs should not be misconstrued as implying that they are the sole legitimate or single-best approach. For example, as reviewed earlier, controlled trial benefits have been found using both group and individual forms of short-term CBT. Group treatment offers unique advantages as well as posing unique challenges. One clear advantage of group approaches is their low cost per unit of service. Possible clinical benefits include the opportunity for vicarious learning, reducing a sense of isolation, and any benefits arising from a positive peer culture established within the group. Groups can spur more active discussion of topics and offer the opportunity to observe *in vivo* social interactions and practice new social skills. Group formats described in the clinical and research literatures have not segregated children with SBP by gender and can accommodate both boys and girls of comparable ages. Groups do pose complicated confidentiality issues. Supplemental family or individual sessions may be needed to attend to idiosyncratic or comorbid issues. Therapists' use of effective behavior management strategies are critical to the success of the group; otherwise, the group may have unintended negative effects because of aggregating children with behavior problems and thereby creating negative social models or peer reinforcement of negative behavior. Group approaches may not be the best fit for children with serious behavior problems or with complicated comorbid issues. Group approaches require significant agency or provider effort to develop and maintain, and require a sizeable and consistent referral flow. Thus, groups may be difficult to establish in rural communities or in practices that receive fewer referrals. Long treatment delays should be avoided if possible regardless of modality. The task force believes that practitioners can validly select from a range of modalities, depending on the client and the context. Treatment approach, rather than treatment modality, appears to be the paramount issue.

Treatment Model Selection in the Context of Comorbidity

In many cases, SBP may be one of several treatment priorities. SBP may be either a primary or secondary priority. Given that successful SBP reductions have been found using CBT models primarily focused on SBP, as well as using CBT models where SBP was a secondary focus and traumatic stress symptoms the primary focus, the task force suggests the following approach to treatment selection. In cases where SBP is the main or dominant problem, first consider one of the research-supported short-term CBT protocols designed to treat SBP. In comorbid cases where SBP is a secondary focus, it may be appropriate to consider using a well-supported, evidence-based treatment matched to the highest priority, comorbid problem, and then integrate SBP-focused components. For example, when children with SBP primarily suffer from serious traumatic stress symptoms, trauma-focused CBT should be considered, with added SBP components addressing necessary environmental changes, supervision, and self-control strategies. When SBP are one element of a broad, overall pattern of early childhood disruptive behavior problems, well-supported models such as Parent-Child Interaction Therapy (Brestan & Eyberg, 1998), The Incredible Years (Webster-Stratton, 2005), Barkley's Defiant Child protocol (Barkley & Benton, 1998), or the Triple-P program (Sanders, Cann, & Markie-Dadds, 2003) might be considered, integrated with SBP-specific treatment components. When the primary problem is a chaotic or neglectful family environment, interventions focused on creating a safe, healthy, stable, and predictable environment may

be the top priority. When insecure attachment is a major concern, short-term interventions emphasizing parental sensitivity have been found to be the most effective (Bakersman-Kranenburg, Van Ijzendoorn, & Juffer, 2003). Resources for selecting empirically supported intervention models are available from a number of registries including the Substance Abuse and Mental Health Services Administration (www.modelprograms.samhsa.gov), the American Psychological Association's Division 53 on Child and Adolescent Clinical Psychology (http://www.wjh.harvard.edu/%7Enock/Div53/EST/index.htm), the Cochrane Collaborative (www.cochrane.org), the Crime Victims Research and Treatment Center (http://www.musc.edu/cvc/guide1.htm), or other repositories. Many of the supported models in these registries could easily be augmented to include an SBP focus. Augmentations might include, for example, adding specific instructions for reducing exposure to sexually stimulating media or situations in the home; instructions for monitoring interactions with other children; suggestions for how parents should respond to sexualized behaviors; and teaching children basic touching, sexual behavior, and boundary rules. In multiproblem cases, incorporating some of these basic SBP elements into evidence-based treatments focused on the highest priority problems may be more feasible than adding or "stacking" separate therapies, each targeted at a different problem. In other words, it is possible that *a single integrated* treatment may be preferable to *multiple separate* treatments, especially where SBP are secondary priorities. For example, a child with serious general behavior problems and mild to moderate SBP might do well in a single behavior management therapy, such as behavioral parenting training with some additional attention to sexual behaviors, and not require an additional and separate SBP group therapy program. Implicit in this suggestion is the assumption that competent child therapists do not have to be SBP subspecialists to provide adequate services to many of these youngsters, particularly in cases where SBP are less severe or are a secondary treatment priority. Although the Task Force believes that basic information and skills pertinent to SBP are important, we do not believe that SBP treatment is such a specialized or esoteric area that it should be reserved for only a few subspecialists. Because childhood SBP are not uncommon, the Task Force believes that basic SBP management strategies should be included in routine training for child mental health clinicians, especially those who work with sexually abused children, behavior problem children, or other at-risk groups.

Developmental Considerations in Treatment Planning

Cognitive and social aspects of child development have several important intervention implications. Young children's cognitive development limits their repertoire of coping strategies. For example, young children may touch their own genitals as a self-soothing behavior during times of stress (White, Halpin, Strom, & Santilli, 1988). This is far more common among younger than among older children. Younger children may not yet have the ability to use more sophisticated cognitive coping strategies. Consequently, young children may need to be redirected to alternative coping mechanisms that are simple and concrete rather than attempting to teach them cognitive coping strategies. Young children's cognitive development also limits the types of cognitive processes involved in initiating and maintaining sexual misbehavior. Young children with SBP are far less able than adults to engage in complex cognitive processes such as planning, grooming, or rationalizing. Thus, typical adult sex offender treatment concepts such as learning about a cycle of sexual behaviors or correcting elaborate cognitive distortions are far less applicable, if not inappropriate, for young children. Children have shorter attention spans and more limited impulse control. In contrast to some adult sex offenders, childhood SBP are more likely to be impulsive rather than compulsive.

Young children do not yet posses the cognitive maturity or the ability for emotion regulation that would allow them to use self-understanding to improve emotional and behavioral self-control. Rather, young children's cognitive abilities are better suited to understanding simple rules about behavior. For example, young children can be taught concrete rules about sexual behavior (e.g., "Don't touch other children's private parts") and learn to follow these rules, although they may be unable to understand the more abstract reasons why the rule is important. Similarly, because young children learn better by demonstration, practice, and reinforcement, rather than by discussing abstract concepts, interventions may need to emphasize showing children appropriate behaviors, having them practice these behaviors, and consistently reinforcing these behaviors across settings. Among older children with SBP (10-12 years old), some abstract principles along with basic rules may be included, but the levels of abstraction are still well short of those applied with adults and teenagers.

SBP-Focused Treatment Components

The successful CBT treatment programs tested in the research literature have included a number of common components. For children, these include the following:

1. *Identifying, recognizing the inappropriateness of, and apologizing for rule-violating sexual behaviors that occurred.* This component is often omitted with very young children (e.g., younger than 7 years). This component should not be misinterpreted as a requirement that the child admit or acknowledge past behaviors as a prerequisite for treatment.
2. *Learning and practicing basic, simple rules about sexual behavior and physical boundaries.* Teaching sexual behavior and boundary rules should not imply that all forms of human sexuality, touching, or close physical contact are wrong and lead to trouble. It may be important to emphasize which behaviors are acceptable and distinguish these from which behaviors are against the rules.
3. *Age-appropriate sex education.*
4. *Coping and self-control strategies.* This may include teaching relaxation skills, problem- solving skills, or routines to encourage stopping and thinking before acting.
5. *Basic sexual abuse prevention/safety skills.*
6. *Social skills.*

Components for parents or caregivers include the following:

1. *Developing and implementing a safety plan.* This includes the following:

   a. *A supervision and monitoring plan,* especially monitoring interactions with other children. The level of supervision and monitoring should fit the individualized case assessment.
   b. *Communicating with other adults* (such as day care personnel or extended family) about supervision needs. Again, the extent communication with others that is needed will vary according to the individualized case assessment.
   c. *Modifying the safety plan over time.* Safety plans should be modified according to improvements in the child's behavior. Regular modification of the safety plan reinforces the child for increased self-control and decreased SBP and focuses the child on the attainment of behavioral goals.

2. *Information about sexual development, normal sexual play and exploration, and how these differ from SBP.*
3. *Strategies to encourage children to follow privacy and sexual behavior rules.*
4. *Factors that contribute to the development and maintenance of SBP* and how to maintain an environment that is not overly sexually stimulating for the child.
5. *Sex education and how to listen and talk with children about sexual matters.*
6. *Parenting strategies to build positive relationships with children and address behavior problems.* This component can include learning and practicing skills, such as play skills, redirection, giving clear directions, use of labeled praise, use of time-out and logical or natural consequences, application of consistent rules and discipline, and so forth.
7. *Supporting children's use the self-control strategies they have learned.*
8. *Relationship building and appropriate physical affection with children.*
9. *Strategies to guide the child toward positive peer groups.*

The emotional quality of the parent–child relationship also may be important to address, with a focus on enhancing supportive, positive, and mutually enjoyable interactions. Finally, many caregivers of children with SBP have high levels of parenting stress and limited support systems. One advantage of the group approaches is the opportunity to receive support from other parents and to be able to discuss aspects of their child's SBP frankly with a support group.

PUBLIC POLICY

General Policy Considerations for Children With SBP

Do children with SBP pose a risk to other children and the community? Childhood SBP are not rare, especially among children with behavior problems in general, among young children exposed to sexual stimuli in their environment, and as reactive behaviors among children who have been sexually abused. The range of behaviors involved is broad in terms of severity and potential to cause harm. Some SBP involve little or no victimization of others, but SBP can range up to and include behaviors that parallel serious and aggressive sex offenses. Public policy is most appropriately concerned with the subset of children who engage in the most serious and victimizing behaviors. We will primarily concern ourselves in this section with policies that address these most serious cases.

Some have argued that sexual behavior in childhood directly leads to adult sex crimes. Although some adult offenders report a childhood onset to their sexual aggression, we should avoid the logical fallacy of reasoning backward and assuming that all or most children with SBP are therefore on a path toward serious sexual aggression. Prospective data are required for estimating long-term risk to the community. To date, the task force is aware of only one prospective study of children with SBP, the results of which suggest that the concerns derived from reasoning backward are exaggerated. Ten-year follow-up data suggest that children with SBP are unlikely to have future arrests or child welfare reports for perpetrating sexual offenses through their adolescence and into early adulthood (Carpentier, Silovsky, & Chaffin, 2006). When given appropriate treatment, as described elsewhere in this report, children with SBP, including aggressive SBP, were no more likely to have future arrests for sexual or nonsexual offenses than a comparison group of clinic children with common nonsexual behavior problems such as ADHD (a 10-year risk of

2%-3% for both groups). Overall and regardless of treatment type, children with SBP may be as likely to be future *victims* of sex crimes as future *perpetrators* of sex crimes (5%-6%) (Carpentier, Silovsky, & Chaffin, 2005). The available data suggest that the vast majority of children with SBP, given appropriate short-term intervention, do not pose an elevated risk for committing future sex offenses. Public policy makers should consider both the overall low level of risk and the fact that risk appears easily modifiable by focused short-term treatment, in crafting sound policies for these children. Public policies should consider the fact that a body of sound research supports using treatment to lower sex offense risk. The risk posed by untreated children with SBP is unknown but may not be insignificant given that 10% of children receiving less effective treatment had future sex offense arrests or reports. Therefore, public policy should promote appropriate treatment where assessment suggests it is needed. Making appropriate treatment available to these children is in the public's interest.

Legal response and culpability. Laws generally set an age below which children cannot be found legally culpable regardless of their behavior. The age at which youths are assumed to understand what it means to break the law and may be adjudicated delinquent varies by jurisdiction. Often there is an age bracket where the presumption of incompetence can be rebutted and the child adjudicated. In other cases, formal legal proceedings may be undertaken against young children more as an effort to ensure receipt of needed services. In some locations, children ages 9 or younger are adjudicated delinquent for sex offense behavior, although this is rare within many other jurisdictions. Recent public outcry and concern about sexual offenders may mistakenly suggest to some that children with SBP are an exceptionally high-risk group and that routine prosecution and adjudication are correspondingly in order. The task force disagrees. The task force does not support the differential application of the normal adjudication decision-making processes for children with SBP compared with children of similar age who may have engaged in other behaviors that would be serious crimes (e.g., assault, theft). Legal authorities routinely make case-by-case judgments about what steps are necessary when children and youths engage in seriously inappropriate or victimizing behavior, and sexual behaviors should not be a special exception to this rule. In some cases, adjudication may be helpful in securing needed services, protecting communities, or as an appropriate response to particularly egregious behavior. However, simply because a child's behavior was sexual in nature should not suggest any unique risk or unique adjudication priority.

Effective policy should recognize that children are naturally less legally culpable than adults. By definition, they lack the experience, education, and wisdom to make decisions in ways that adults can. Furthermore, children's behavior often is highly susceptible to environmental influences. For example, some SBP seem to be in response to witnessing explicit sexual stimuli or a response to sexual abuse or trauma. The link between SBP and abuse or trauma appears far more direct among young children than among other age-groups. For all these reasons, policy makers should take into account that the legal culpability of children is significantly different from that of adults who sexually abuse others.

Best interests of the child with SBP. The public is rightly concerned about sexual abuse in our communities and rightly gives high priority to the interests of victims and to protecting children from risk. Indeed, where SBP involve victimizing other children, protecting other children by stopping the SBP is an immediate concern. The public also is rightly concerned about the interests of children with SBP and their welfare. Effective public policy must protect the long-term development and well-being of *all* children. Public policy always must strike a balance between the interests of the individual and the interests of the community, and among the interests of those posing a risk of harm, those harmed, and those at risk of harm.

Because the long-term level of risk posed by children identified as having serious SBP appears to be manageable, and because children with serious SBP, like all children, merit special considerations, the task force believes that this balance should be far different from the one drawn for adult sex offenders. Consequently, many policies developed for adult sex offenders are inappropriate for children.

Labeling. Adults should take every precaution against policies that label children as deviant, perverted, as sex offenders, or destined to persist in sexual harm. Professionals increasingly use the term *children with sexual behavior problems* because it labels the behavior and not the identity of the child (Chaffin & Bonner, 1998; Chaffin et al., 2002). Given that childhood SBP may foretell little about a child's future behavior and that labeling a child risks creating a self-fulfilling prophecy and social burdens, applying labels such as *sex offender*, *predator*, *perpetrator*, or variants of these terms are injudicious, especially when those labels are likely to outlive any utility or relevance.

Recommendations Regarding Specific Public Policies

Registration and public notification. By 2001, more than half of all American states required juveniles adjudicated for sex offenses to register (Trivits & Repucci, 2002). Although the applicable ages, offenses, and conditions under which juveniles are required to register vary by jurisdiction, several jurisdictions adjudicate children as young as age 8 or 9, and some include young children with SBP on public sex offender registries. At the time of this writing, legislation was proposed and passed the U.S. House of Representatives that would mandate lifetime sex-offender registration and public notification for children of any age adjudicated delinquent for sex offenses against other children (Children's Safety Act of 2005). The provisions of this act, in revised form, were passed as the Adam Walsh Act and would require states to practice lifetime public sex offender registration for children 14 and over adjudicated for common sex offenses, and the act would allow states to be more inclusive and less restrictive if they so desire. The task force believes that registering children and publicly labeling them as sex offenders for life risks a number of significant harms. These can range from educational discrimination to ostracism to vigilantism. It is not difficult to see how subjecting children to public stigmatization and possible ostracism, barriers to education, and occasional vigilantism could impede development. Including children under registration and notification policies offers no broad protections to the public because children with SBP simply are not a high-risk group, especially if provided with appropriate treatment. In short, applying these policies to children will likely do more harm than good, and the task force believes this is an onerous policy. It might reasonably be argued that some form of public notification would be helpful in very unusual cases involving highly dangerous children. However, it remains unclear how these few children could be identified with acceptable reliability and specificity, and there is no consensus on what legal procedures would be necessary to assure adequately selective application of these laws to children.

Mandatory reporting of children with SBP as alleged sexual abuse perpetrators. Laws on mandatory child abuse reporting and/or mandatory reporting of sex offenses against minors may vary, and readers should familiarize themselves with their local laws on this matter. The task force believes the decision to file a suspected child abuse report because of SBP between children should be considered carefully. Mandatory reporting laws more directly apply to adult-child and adolescent-child sexual behavior, where reporting decisions are clear-cut. Behavior between or among children may be less clear-cut. Typical or normative sexual play and exploration between children does not merit a report to law enforcement or child welfare authorities. Even SBP that may warrant consulting a professional may not always merit a report to the authorities. In other cases, SBP may be clearly abusive and should trigger reporting requirements. In situations in which the parents or caregivers were informed of ongoing abusive sexual behaviors and failed to intervene or protect the children, a report to authorities is warranted. In addition to local laws, the following principles may be useful to consider when deciding if SBP warrant a report to the authorities. The task force believes reporting is most appropriate where both of the following conditions are true:

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

SBP not meeting both criteria above obviously may still merit adult correction and/or professional attention, even if not meriting a report to the authorities. In some cases, the overall decision to report extends beyond simply considering the child's SBP. For example, where there are reasonable suspicions that the child may have experienced prior or ongoing maltreatment, or where parents or caregivers are neglecting to provide sufficient supervision or care, reporting requirements may be triggered.

Policies Related to Placement.

Placement decisions. Children with SBP are a diverse population with diverse needs, diverse presentations, and diverse circumstances. Because of this diversity, any fixed, single policy or intervention plan may miss the mark for a significant number of children and families. This principle is especially true when it comes to out-of-home placement decisions. The task force believes that children with SBP do not require automatic out-of-home placement, even in cases where a child has sexually victimized another child in

the same home. This decision requires case-by-case assessment. Retaining *all* children in their homes, families and communities should always be the first option considered. However, out-of-home placement should be considered for those cases where retaining children in the home is not viable either because it would cause harm or significant distress to the other child(ren), because of acute needs for treatment or protection (e.g., seriously suicidal children), or because caregivers are not providing an adequate environment (e.g., serious neglect). If placements are required, priority should be given to the least restrictive, closest-to-home placement, where family involvement in treatment can be accommodated.

Policies concerning removal and placement should consider the impact of removal and placement on *all* the children affected and strive to balance their respective interests. For example, residential placement may meet several needs for a minority of children with SBP (e.g., safety, supervision, specialized care, intensity of care), but residential placement also can carry distinct disadvantages (e.g., exposure to other children with problem behaviors, disengagement from family, interruption of normal social development, distress, expense). Similarly, removing some children with SBP may offer benefits to the other child(ren) in the home (e.g., protection from a high-risk or frightening sibling, or relief) but in other instances may actually increase the other child(ren)'s distress (e.g., distress over family disruption, distress over separation from a sibling). As a general principle, removing a child should be considered where one of the following conditions is found:

1. *Source of serious distress or need for relief.* Where the presence of the child with SBP in the home is causing current, serious distress to other child(ren), and/or where the other child(ren) would be significantly relieved to be separated from the child with SBP. Current, serious distress and need for significant relief may be gauged either by child statements or behavior. Distress and/or need for relief should be based on a case-by-case assessment and not presumed to be invariably present or absent; *or*

2. *Reasonable, less restrictive efforts have failed to curtail serious SBP.* A less restrictive intervention is being tried and aggressive or advanced sexual behavior involving other children continues to occur; *or*

3. *Lack of reasonable effort combined with serious SBP.* Where, despite efforts, caretakers are unable or unwilling to provide a healthy and stable home environment or to exercise even a minimally sufficient intervention or safety plan in the home, *and* the child persists in aggressive or advanced sexual behavior with other children; *or*

4. *Exceptional circumstances.* In rare cases, there may be risks or behavior so extreme or potentially harmful to self or others that attempting less restrictive solutions is not reasonable and placement should be immediately considered.

The task force believes that in a majority of cases, these conditions will not be found. Many children with SBP targeted at other children in their home do not require removal, either for their own welfare or the welfare of the other children. However, where the circumstances described above are found, action is warranted. Of course, removal and placement may be considered for reasons other than SBP. For example, removal may be considered because of serious maltreatment by caretakers in the home or because of comorbid problems (e.g., suicidal behavior). Or, families simply may opt to place a child out of their home (e.g., to a relative's home) for the sake of convenience or to reduce stress within the family. In borderline cases, where it is not immediately clear whether removal is indicated, short-term removal pending further assessment can be considered. In these cases, assessment and final decision making should be expedited in to minimize the duration of the temporary placement. Where out-of-home placement is involved, less restrictive alternatives, such as therapeutic foster care, should be considered first. Long-term placement in an institution or residential facility, particularly facilities that aggregate children with behavior problems, should be considered a last resort.

Segregated and specialized versus general out-of-home placements. When a child with SBP is placed in out-of-home care, the issue arises whether the child can be placed with other children in a foster home, group home, or residential facility or whether the child should be segregated away from other children in foster care, placed in a special segregated home, or in a special segregated residential SBP unit. Of course, if any child's behavior is out of control or poses an acute and substantial risk for serious harm to other children, a more restrictive and segregated environment is warranted. This general principle also applies to children with SBP. However, some adults perceive risks involving sexual behavior to be necessarily more serious, predatory, and dangerous than risks for other harmful behavior. This fear, and the related fear of liability exposure, may lead some facilities to form policies that segregate all children labeled as having SBP. The task force believes blanket segregation policies are misguided for two reasons. First, inappropriate sexual behavior occurring among children in placement is not merely a concern for children previously identified as having SBP. In fact, undesirable sexual behavior is a broad concern in many types of institutions, facilities, and foster homes. A sensitive, developmentally appropriate plan for discouraging inappropriate sexual behavior among all children should be considered within all

placements. Second, although children known to have SBP do require additional monitoring and attention in this area, experience suggests that the level of additional monitoring and attention required often is well within the capability of many general placements, and the task force is aware of many general foster homes and residential facilities that have successfully accommodated children with these types of behavior problems in their general population.

Accommodating children with SBP within general facilities involves commonsense precautions. For example, the child with SBP may need to have a separate bedroom and not bathe or change with other children. Children with SBP may need adult monitoring when interacting with other children, although this, too, is not an unusual need among children in placement. Selection of appropriate entertainment material and monitoring Internet use may be important. Wrestling, tickling, or similar behaviors may need to be discouraged. These sorts of commonsense precautions often will be sufficient for many children with SBP who are in placement, and they are well within the capabilities of most foster homes or facilities.

The needs and best interests of children with SBP also must be considered in decisions about segregation. In general, the task force believes that foster homes, agencies, and facilities should be discouraged from forming policies excluding children with SBP, as a class, from their services. The idea that children with SBP, as a class, *must* be placed only in segregated SBP or sex offender facilities may unnecessarily exclude these children from needed services and impose needless placement and service disadvantages. It also may needlessly label and stigmatize children. This policy is especially problematic when children are excluded from services based on long-past SBP that have not reoccurred. The task force believes that the best policy is for children to have open access to all needed placements and services and to exclude children from a placement or service only in the event that a careful individual assessment suggests unmanageable risk to other children.

Information sharing with placements. When a child with sexual behavior problems is placed out of home, it is good policy to fully inform the placement about *all* of the child's needs and problems, including SBP. For example, foster parents or group homes should be fully informed that the child has had SBP and that some special supervision needs will apply. On occasion, workers may be reluctant to share this information with foster parents or facilities for fear that the foster parent or facility will reject the child. This may be related to misinformation surrounding children with SBP. Consequently, foster and kinship caregivers, as well as residential staff, should be educated about children with SBP before a child is placed in their care. Foster and kinship caregivers should be strongly encouraged to participate in any SBP therapy, along with the child.

Sharing information about a child's SBP with foster or kinship parents should be done in a child-sensitive, nonjudgmental, and matter-of-fact manner. Often, it may be wise to share some more limited information with other children in the home, in a way that does not stigmatize the child but informs the other children. Sharing details of the sexual behaviors with other children is unnecessary. Knowing that the other children are aware of the problem and will alert the caregiver if problems occur may improve self-control. The child with SBP also can be informed about relevant problems among the other children in the placement so that there is reciprocity in the process and the child does not feel singled out. This discussion can be done jointly with all of the children and caregivers present.

Information sharing with schools or other organizations. The task force believes that most children with SBP can and should attend school with other children, unless their behavior is unusually severe and unmanageable. When children with SBP attend school with other children, the question arises of who, if anyone, at the school needs to be informed. As with other questions, a policy of individual assessment-driven decision making is suggested. The task force believes that notifying schools about all cases of SBP is unnecessary, especially where the behavior problem has not previously occurred in school settings, where the child is receiving help for the problem, and where the behavior is not persisting. However, in those cases where children are assessed as posing a high risk, or where the SBP have occurred in school or school-like settings, or where serious SBP are persisting, it is appropriate to inform school personnel. Often, parents or caregivers may provide helpful input about who at the school would be best to approach. Teachers or school administrators may have little factual information about children with SBP or may have been exposed to misinformation. Consequently, it is important to provide accurate information along with practical commonsense recommendations. For example, in cases where notifying the teacher is indicated, recommendations might include providing a somewhat higher-than-normal level of monitoring during interactions with other children, restricting contact with significantly younger children at the school, or structuring individual bathroom breaks.

The task force believes that any formal process for informing other children at school about the child's SBP is usually unnecessary and risks stigmatization.

Interagency Collaboration

The task force believes that collaboration among involved agencies, authorities, and providers is important during all phases of a case and consequently recommends that policies be developed that allow and promote collaboration. This is a general good-practice principle, not limited to children with SBP. Collaborations can include but are not limited to treatment providers, child welfare workers, foster parents, parents, schools, child care providers, juvenile justice staff, and courts. The extent of collaboration and who may need to be included can be expected to vary considerably across cases. Collaboration should follow applicable laws, policies, and ethical principles governing information sharing. This includes obtaining voluntary authorizations for sharing protected health information, executing any necessary data use or collaboration agreements among teams of collaborators (e.g., confidentiality agreements among multiple party planning or coordination groups), and maintaining appropriate records of what information is shared and with whom.

Information regarding the safety of the child and other children, current and planned services, and overall intervention progress is shared among treatment provider teams so that services can be coordinated and evaluated, and duplicated or incompatible services and actions avoided. In complex cases where multiple service systems are involved, it may be useful for a coordinator or case manager to organize collaborative efforts. Systems-of-Care or similar formal structures in place in many communities may be useful in complex cases where multiple agencies are involved (surgeon general's report; U.S. Department of Health and Human Services, 1999).

Including parents and other caregivers as full partners in coordination, service planning, and decision-making meetings is recommended, and including the child in some or all of the decisions should be considered to the extent the child's development and status permits. A main purpose of coordination and information sharing is to define consensus goals, to articulate a clear plan and timetable of specific tasks needed to reach those goals, to identify who on the team will be responsible for each aspect of the plan, and then to evaluate plan implementation and goal attainment.

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