



**203:
Sexuality of Children:
Healthy Sexual Behaviors and Behaviors which
Cause Concern**

Standard Curriculum

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**For
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Training Program**

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**Agenda for Sexuality of Children:
Healthy Sexual Behaviors and Behaviors Which Cause Concern**

Estimated Time	Content	Page
60 Minutes	Section I: Introduction	1
30 Minutes	Section II: Continuum of Sexual Behaviors	5
90 Minutes	Section III: Healthy Sexual Behaviors of Children	7
90 Minutes	Section IV: Sexually Reactive Children	14
75 Minutes	Section V: Application of Knowledge	21
15 Minutes	Section VI: Closing and Evaluation	24

203: Sexuality of Children: Healthy Sexual Behaviors and Behaviors which Cause Concern

Section I: Introduction

Estimated Length of Time:

60 minutes

Key Concepts:

- ✓ Allow participants to address their own personal issues and thoughts regarding childhood sexuality

Methods of Presentation:

Lecture, large group discussion

Materials Needed:

- ✓ Name Tents
- ✓ Idea Catchers
- ✓ Markers
- ✓ Masking tape
- ✓ Flip Chart
- ✓ Flip Chart Paper
- ✓ Prepared Flip Charts: (for Walking Around activity)
- ✓ Prepared Flip Chart: WIIFM
- ✓ Prepared Flip chart: Parking Lot
- ✓ Overhead Projector and Screen
- ✓ **Handout #1 (PowerPoint Handout)**
- ✓ **Handout #2 (Competency and Learning Objectives)**
- ✓ **Handout #3 (Training Agenda)**
- ✓ **Overhead #1 (Quote)**
- ✓ **Overhead #2 (Training Agenda)**

Outline of Presentation:

- ✓ Welcome participants
- ✓ Establish ground rules
- ✓ Review agenda and learning objectives
- ✓ Facilitate activity around personal issues regarding childhood sexuality

Step 1:

Trainer Note: Due to the sensitivity of this material, you will want to make sure that you establish your credibility as well as give enough time for participants to begin to feel comfortable with each other. Keep in mind, however, that this is only a one-day training with a lot of material to cover. Therefore, be watchful of the time and try not to exceed the 60 minutes allowed.

Welcome the group and thank the host agency, the system, or any others that have helped make the training possible.

Introduce yourself; give name, education, and any personal experience that might be of interest to those participating in this training.

Provide participants with logistical information concerning restrooms, where they can smoke, local restaurants for lunch, the 15-minute rule and sign-in procedures. Review the Training Program Rules poster on the wall.

Overview of Training: Introduce the workshop by reviewing **Overhead #1 (Quote)**.

Trainer Note: The following Quote can be a good introduction for why this workshop is important. Remember, however, that it should not be read. One suggestion is to place it on the overhead projector and allow a few seconds for participants to read it. Leave it up while you continue with the overview.

Quote: “Sexuality is seldom treated as a strong or healthy force in the positive development of a child’s personality in the United States. We are not inclined to believe that our children are sexual or that they should be sexual in any of their behaviors. Although it is difficult to generalize in our pluralistic society, there is typically no permission for normal child sexual experiences. Children are not taught to understand their sexual experiences or to anticipate sexual experiences as enjoyable. Rather, they are taught to be wary of most sexual experiences, both interpersonally and intrapsychically.” – Floyd M. Martinson

Historically, the American culture has denied the sexuality of children. Children have been deterred or re-directed from sexual exploration and discouraged from seeking sexual information. However, in a 2004 poll conducted by NPR (National Public Radio), the Kaiser Family Foundation, and Harvard's Kennedy School of Government, it is reported that only 7 percent of Americans say sex education should **not** be taught in schools.

As public awareness increased, many professionals were confronted with defining the concept of healthy childhood sexuality. In fact, the “backlash” from the work surrounding child sexual abuse brought into the light, the basic fact that children are sexual beings. We as a society have truly struggled with this recent discovery and to this day are in the

infantile stages of understanding the development and incorporation of sexuality into a child's repertoire.

Step 2:

If the group is less than 25 participants; go around the room and have participants introduce themselves stating their name, what they do and how long they have been with the agency.

If the group is larger than 25 participants, have participants turn to their neighbors and introduce themselves by stating their name and the ages of the children they work with or have in their home.

Inform participants that around the room are several statements. For each statement, ask that they take a marker and put a check mark along the continuum, complete the sentence, or make a comment. Let them know they are allowed to pass, and all responses are anonymous.

Trainer Note: Since this is such a sensitive topic for most professionals to discuss, a "Walk Around Activity" can allow the participants to anonymously address their own personal issues and thoughts regarding childhood sexuality.

Post 7-10 statements on very large paper and hang them on the wall prior to the start of the training. Some of the statements may include, but are not limited to:

- All children are sexual beings.
- Adults should avoid being naked in front of their children.
- Children today know too much about sex.
- Sexual identity is formed by age 5.
- It is typical for children to touch other children.
- Masturbation is morally wrong.
- It is typical for children to insert objects in their private areas.
- Most adolescents engage in sexual relationships before age 18.
- All cultures view the sexuality of children as a taboo subject.
- We should try to encourage heterosexual rather than homosexual experiences for children and/or adolescents.
- Children who have been sexually abused are sexually "ruined" by their experiences.

On each piece of paper, draw a continuum from Strongly Agree to Strongly Disagree and have participants walk around and put a "sticky note" where their personal opinions fall on each continuum.

Additionally, create two WIIFM posters with the following statements:

- Why is this workshop important for the work I do with children?
- Something I really want to learn about before I leave today is ...

While they are walking around, ask participants to stop by the WIIFM posters and write a comment on them.

Allow approximately 15 minutes for the participants to walk around the room and respond to the activity

Once participants have had the opportunity to respond, reunite the large group. Read some of the comments aloud and discuss the differences and similarities in the participant responses. Set the stage for the training by summarizing the ideas and thoughts of the large group.

Trainer Note: One way to form a contract with participants is to mark on the WIIFM chart the corresponding item on the agenda that will address the issues. Any items that do not correspond to the agenda can be placed in the “Parking Lot.” These items can either be addressed, if there is time, or passed on to the training coordinator as potential training issues for the future.

Alert the group that the training will focus on a sensitive subject matter. All of the participants need to review their “baggage” that they bring into the training and be mindful of how these thoughts, experiences, etc., affect how they look at and act toward this subject matter. Sexual abuse survivors need to pay particular attention to their strong insights and take good care of themselves throughout the day.

Distribute **Handout #2 (Competencies and Learning Objectives)**. Review this material with participants. Display **Overhead #2 (Training Agenda)** and distribute **Handout #3 (Training Agenda)** in order to review the major topics of the training curriculum. Answer any questions participants may have.

Distribute and review the Idea Catchers and encourage participants to write down ideas they want to remember throughout the course of the day.

Tell participants that in an age when childhood sexual abuse and victimization is increasingly on our minds, it is important for parents (and other caretakers) to understand what is “normal” sexual development and behavior in children and teenagers, and which behaviors might signal that a child is a victim of sexual abuse, or acting in a sexually aggressive manner towards others.

Historically, we have only examined the sexual expression of children in light of “normal” and “not normal”. Society has not readily discussed healthy sexual expression of children. Therefore, any expression at all may have been viewed and labeled as “not normal” or deviant. One way to begin to look at childhood sexual behavior is to see it as a continuum.

203: Sexuality of Children: Healthy Sexual Behaviors and Behaviors which Cause Concern

Section II: Continuum of Sexual Behaviors

Estimated Length of Time:

30 minutes

Key Concepts:

- ✓ Understanding Toni Cavanaugh Johnson's Continuum

Methods of Presentation:

Lecture

Materials:

- ✓ Handout #4 (Johnson's Continuum)
- ✓ Handout #5 (Characteristics of Child Sexual Behavior: A Continuum)
- ✓ Overhead #3 (Johnson's Continuum)
- ✓ Packages of Post It Notes (1 per table)

Outline of Presentation:

- ✓ Review Toni Cavanaugh Johnson's Continuum

Step 1:

In 1993 a book entitled, "Sexualized Children: Assessment and Treatment of Sexualized Children and Children Who Molest" written by Eliana Gil, Ph.D. and Toni Cavanaugh Johnson, Ph.D., began to pave the way for professionals to comprehensively address the sexual behaviors of children. Dr. Gil and Dr. Johnson developed the continuum to assess the sexual behaviors of children and address this issue over a wide spectrum of possibilities, rather than "normal" and "not normal".

Trainer Note: "Sexualized Children and Children Who Molest" by Eliana Gil, Ph.D. and Toni Cavanaugh Johnson, Ph.D. is available through the CMO for use by trainers. If this book is not already a part of your personal library, in preparation for this training, we highly encourage you to borrow it from the CMO or purchase it. This book is also heavily relied upon for the 203 Juvenile Sex Offenders workshop as well as the 522 Supervisory Issues in Child Sexual Abuse: A Training Institute.

Display **Overhead #3 (Johnson's Continuum)** and distribute **Handout #4 (Johnson's Continuum)**. Discuss that this training will focus on the groupings of normal sexual behaviors and sexually reactive behaviors of the continuum. A description of mutual sexual behavior and child perpetrators will briefly be discussed. Other trainings discuss these two points in more detail.

Trainer Note: You may want to have a flipchart prepared that highlights the major points in the Four Areas outlined in Handout #4 (Characteristics of Child Sexual Behavior). This will allow participants to not have to read the entire handout at this time.

Distribute **Handout #5 (Characteristics of Child Sexual Behavior: A Continuum)**. For each section of the Johnson's continuum, highlight points from the **Handout #5 (Characteristics of Child Sexual Behavior: A Continuum)** and give a case example. If unable to come up with your own, case examples are outlined in the book by Gil and Johnson.

This is a great opportunity for participants to begin drawing on their own experiences. Create four flip charts, label them: (1) normal sexual exploration, (2) sexually reactive, (3) extensive mutual sexual behavior, and (4) children who molest, and hang the flip charts on the wall. Ask participants to individually take a sticky note from the package on the table and write down a scenario where a child they worked with exhibited any kind of sexualized behavior. Then ask participants to share the case example and put the sticky note where on the continuum this child's behavior would fall. Remind participants to use no identifying information other than the age and gender of the child.

203: Sexuality of Children: Healthy Sexual Behaviors and Behaviors which Cause Concern

Section III: Healthy Sexual Behaviors of Children

Estimated Length of Time:

90 minutes

Key Concepts:

- ✓ Understanding age appropriate healthy sexual behaviors of children
- ✓ Understanding some potential signs of sexual disturbance in a child

Methods of Presentation:

- ✓ Large Group Discussion
- ✓ Small group work

Materials:

- ✓ **Handout #6 (Normal Child Sexual Development and Promoting Healthy Sexual Development)**
- ✓ **Handout #7 (Signs of Sexual Disturbance)**

Outline of Presentation:

- ✓ Review normal child sexual development
- ✓ Review signs of sexual disturbance in a child

Step 1:

Trainer Note: To illustrate the areas of child development, draw a “stick man” figure with lines radiating out from the figure and label them: physical, cognitive, social, moral and psychological. For the final line, add sexual.

We do know that children are sexual beings. (Hopefully, the group came to some agreement on this statement during the “**Walk Around**” activity.) Sexual development appears to fall in line with the child’s physical, cognitive, social, moral and psychological development. Sexuality seems to change over time and is affected by and affects the child’s developmental perspective. While parents generally pay attention to the first five areas of development, they need to also be aware and knowledgeable about a child’s sexual development.

Culturally, the issues of childhood sexuality are managed very differently. In equatorial Africa, southern Asia and the South Pacific, adults may stimulate the genitals of children if the children are cross or restless. In the Amish community, sexuality is not a subject that is addressed either with adults or children. In fact, pregnant women often do not venture out in public.

Trainer Note: Ask the group for other examples. Someone may mention “rites of passage” traditions, or the teaching of mutual masturbation to adolescents in some Scandinavian cultures.

Step 2:

The developmental progression of a child’s sexuality can be traced. Trainer should distribute **Handout #5 (Normal Child Sexual Development and Promoting Healthy Sexual Development)**, and trace the sexual development of children from birth to adolescence. It is important to remember that through each developmental stage every child is an individual and will progress through the stages at varying rates and with a slightly different slant than any other child.

Break participants into five small groups and have each group brainstorm (on newsprint) sexual development for one of the following age groups:

Pre-birth-birth-Age 3
Preschool: Ages 3-5,
School-aged: 6-9,
Preadolescence: Ages 10-12,
Adolescence: Age 13+

Post the following questions in the front of the room to help facilitate their discussion:

- a) List some of the behaviors seen in this age group that reflect their sexual development.

- b) What are children this age thinking, doing, saying, that reflect their sexual development?
- c) Are there some “firsts” that happen in this age group that impact sexual development? (i.e., learning parts of the body, puberty)
- d) List 5-10 correct or slang words that you might hear from this age group that describe male and/or female sexual body parts.

Ask each group to select a presenter and “teach the class” the sexual development of the age group they were assigned. Be sure that they highlight or add significant pieces for each developmental stage as found in the handout and following content. After each group presents, the trainer should supplement each group’s presentation with some of the following information.

Pre-Birth: The pre-birth period for a fetus is a period of constant change and growth. Over the course of the last 10-15 years there has been a considerable effort to research and analyze growth that takes place in the womb. Biologically, we know that all embryos are female at the time of conception. Somewhere between the sixth and twelfth week the fetus can be observed to develop a male sexual apparatus. At that time, the pathways are formed from the brain to the mouth, genitals and anus. At six months, the fetus has been observed to touch its mouth and genitalia. Involuntary penile erections have also been observed in the womb. The meaning assigned to these biological actions has not yet been determined. The topic of fetus sexuality is a highly controversial area that has not been totally validated. Although no conclusions can be drawn regarding the intent of fetus behavior at this time, it is safe to state that human behavior is purposeful and often, self-gratifying.

0 – 2: Infants are born with neurological capacity to derive pleasure from their bodies. This includes the genital area. Infants can be observed several times a day engaged in a range of self-stimulating behaviors such as thumb sucking and breast-feeding. At this stage infants learn that touching feels good and that the physical expression of affection is a way to meet their basic needs. At 6-12 months infants can identify their primary caregivers and are able to link the mental image of the caregiver with the affection that they receive from the caregiver through the process of being fed and held. Infants learn to associate pleasurable sensations with the mouth and genital area. By the age of two, children have increased interest in touching their genitals; are intensely curious about sexual differences; and are voyeuristic and exhibitionists.

3 – 5: Pre-school children (ages 3-5) are in a developmental stage of intense curiosity. Curiosity serves to educate the child about his/her world. Most child developmentalists believe that most of our learning takes place by the time that we reach age 5. Preschoolers are extremely interested in their own bodies at this time due to their heightened levels of exploration

and emphasis on toilet training. Children are able to recognize the physical differences between boys and girls at approximately age 2 or 3. Caregivers of preschoolers may observe mutual sex play between children of this age which can involve taking advantage of opportunities to look at or touch another child's body. Children may also begin game playing (i.e., playing doctor) where they will show each other their body parts. Preschoolers also develop or repeat words or names for body parts and functions of their private areas. Sexual exploration between children is very typical. Since children may make no attempts to hide their curiosity, adults who encounter mutual sex play between children should handle the situation matter-of-factly. The children should not be reprimanded for their exploration, but should be re-directed in their actions.

Preschoolers also become aware of their parents' relationship, including their sexual relationship. Children do not understand the details of this relationship, but they do understand that physical expression between the caregivers is occurring. Some children may be jealous of this affection since they may not want to share one caregiver with another and may even compete with one caregiver for the attention of the other.

By the age of three, most preschoolers have discovered masturbation and begin to learn it is a behavior to be done in private.

Research indicates that some children will try to put something in the genital or rectum of self or others. (Friedrich). Friedrich's research indicates that, while such acts can fall within the normal range of behavior, it is unusual. Such sexual behavior in a young child requires further assessment, especially if it is an act of attempted vaginal insertion. Children may be exposed to seeing thermometers or suppositories inserted into rectums of small children, babies or family pets. It is less likely, but not impossible, that children may see a caretaker inserting a tampon. In these instances the behavior might fall into the normal range as long as the behavior stops at the point it causes pain or discomfort.

6 – 9: School aged children (ages 6-9) remain very curious about other people's bodies; however, developmentally they have developed a conscience that prohibits them from immediately acting on their curiosity. School aged children become more sophisticated than preschool children and may initiate a situation where they can see and touch someone else's body (i.e., games of strip poker and truth or dare). They may also attempt to utilize pornography as an avenue for exploring the bodies of adults. School age children will vary greatly on how they fulfill their curiosity. Children of this age may develop "puppy love crushes" with fellow classmates or adults (e.g., teachers). Some children may experiment with French-kissing or petting with other age mates. Other children may simply

verbally express their sexual awareness with slang words or sexual swearing.

The increased focus on male and female roles at this developmental level permits the child to identify with one sex or the other. At this point, children typically feel comfortable with their gender and attempt to align themselves with age mates of the same gender. For early school aged children there may be great competition between the boys and the girls. This may be evident by observing 5 or 6-year-old children playing on the school playground. The boys typically play with the boys on one end of the playground and the girls play with the girls on the other end of the playground. As school aged children mature, these harshly drawn lines blend. At 9 to 10 years of age, children attempt to explore their interest in heterosexual or homosexual relationships. Masturbation continues as a primary sexual behavior but the child is more discrete.

- 10 –12:** Preadolescence (ages 10-12) is a stage where pre-teens are concerned with their changing bodies. The onset of puberty for some children will bring about physical, emotional, and cognitive changes. Pre-teens may feel awkward or worried about what is happening to their bodies and confused about how to manage the sudden onset of changes. Pre-teens may compare and contrast their bodies to age mates and worry that they are developing out of sync with others. Preadolescents may become involved in sexual behaviors and relationships that include handholding, kissing, flirting, “making out”, and foreplay. This sexual exploration is conducted with age mates and does not extend to adults or young children.

Developmentally, pre-teens appreciate not only the mechanical aspects of sexuality, but also the emotional aspects of adult sexuality. Preadolescents are cognitively able to solidify their values, cultural influences, and religious standing regarding the expression of their sexual feelings. They should have established “rules” regarding their sexual conduct and developed guidelines concerning their responsibility in a sexual relationship.

- 13 –18:** Adolescents (ages 13-18) are involved in a wide range of sexual behaviors, including kissing, foreplay, simulated intercourse and intercourse. Adolescents are still interested in viewing the bodies of others and still utilize sexual joking and language to express their sexuality. Research states that most adolescents in rural communities and small towns begin to have sexual intercourse between the ages of 16 and 18. In large towns and communities it is likely that the average age drops (Gil & Johnson). A study conducted by Flax (1992) revealed that more than half of all high school students in the ninth to twelfth grades had sex. Black students were more likely than Caucasian or Hispanic students to have

had sex, and boys were more likely than girls to have done so. In addition, it is important to note that Kinsey's research demonstrates that it is common for adolescents to engage in same sex experiences during this period of exploration. Same sex or opposite sex activities are a means for adolescents to establish their sense of self and try on a number of different roles. The utilization of fantasy and sexual materials may also be prevalent for this age group, especially for young males. The research on the role of pornography and the effects that it has on children and adolescents is highly controversial.

Emotionally, adolescents are able to conceptualize the physical expression of sexuality and the issues of intimacy. The adolescent is learning the implications of an emotional commitment in a romantic relationship and is able to take responsibility for his/her actions. Issues surrounding the topics of S.T.D.'s and birth control should be a part of the sexually active adolescent's world.

Ask the group to list some healthy and unhealthy reasons why teens may have sex. Healthy reasons may include physical pleasure and perceived love. Unhealthy reasons may include peer pressure, under the influence of drugs or alcohol, to feel accepted, or to improve their self esteem.

Step 3:

In preparation for Section IV, Sexually Reactive Children, briefly review **Handout #6 (Signs of Sexual Disturbance)**.

Signs of Sexual Disturbance

Toni Cavanagh Johnson, a psychologist specializing in childhood sexual development, lists signs of concern in children up to the age of about 12:

- Children should not be preoccupied with sexual play, and should engage in many other forms of play
- Children should not engage in sexual play with much younger or much older children
- Children should not have precocious knowledge of sex beyond their age
- Children's sexual behaviors and interests should be similar to those of other same-age children
- Children should not be "driven" to engage in sexual activities, and be able to stop when told to by an adult
- Children's sexual play should not lead to complaints from or have a negative effect on other children, and should not cause physical or emotional discomfort to themselves or others

- Children should not sexualize relationships, or see others as objects for sexual interactions
- Children aged 4 and older should understand the rights and boundaries of other children in sexual play
- Children should not experience fear, shame, or guilt in their sexual play
- Children should not engage in adult-type sexual activities with other children
- Children should not direct sexual behaviors toward older adolescents or adults
- Children should not engage in sexual activities with animals
- Children should not use sex to hurt others
- Children should not use bribery, threats, or force to engage other children in sexual play

Trainer Note: As you summarize this section it may be helpful to address the subject of masturbation concretely. It remains a topic of concern for caregivers and Child Welfare Professionals alike. Point out that, within the range of normal sexual development, children learn that touch feels good and as they mature they learn that they have the ability to touch themselves. Children receive a physical and emotional or self-soothing response to touching their genital areas. Preschoolers, as curious children, have not yet incorporated the socialization skills that govern the public display of self-touch. They can not discriminate between touching themselves at home in their room or touching themselves in the supermarket. Thus, public displays of self-touch are common for preschoolers. As children approach school age they have incorporated society's degrading of public displays of masturbation. School age children learn that private masturbation, typically without penetration by fingers or objects, is appropriate as long as you don't get caught! In essence, masturbatory behaviors do not appear to decrease as the child gets older. They only appear to become more sophisticated and governed by the rules of society. By pre-adolescence, masturbation should be very discrete and private.

Note: It is not uncommon for an adult who works in a residential placement center to walk in on several children engaged in mutual masturbation. This situation should be handled by the adult in a matter-of-fact tone, while attempting to redirect the children's activities. Mutual masturbation can over-stimulate highly aroused children and create a potentially vulnerable position for other children or adolescents. If there are any participants who work or have worked in a residential facility, ask them to share examples of what policies their facility used to manage this behavior.

203: Sexuality of Children: Healthy Sexual Behaviors and Behaviors which Cause Concern

Section IV: Sexually Reactive Children

Estimated Length of Time:

90 minutes

Key Concepts:

- ✓ Define sexually reactive child
- ✓ Identify sexually reactive behavior in children
- ✓ Identify strategies to manage sexually reactive behaviors in children

Methods of Presentation:

- ✓ Lecture
- ✓ Small group activity

Materials Needed:

- ✓ **Overhead #3 (Johnson's Continuum) revisited**
- ✓ **Overhead #4 (Sexually Reactive Children)**

Outline of Presentation:

- ✓ Define sexually reactive children
- ✓ Define behaviors of sexually reactive children
- ✓ Suggest ways to manage the behaviors of sexually reactive children

Trainer Note: Revisit **OH #3: Johnson’s Continuum**, and report to the participants that this section of the continuum focuses on sexually reactive children.

Step 1:

Display Overhead #4 (Sexually Reactive Children)

According to Phil Rich, Ed.D, MSW, DCSW, "Sexually Reactive" children are pre-pubescent boys and girls who have been exposed to, or had contact with, inappropriate sexual activities. The sexually reactive child may engage in a variety of age-inappropriate sexual behaviors as a result of his or her own exposure to sexual experiences, and may begin to act out, or engage in, sexual behaviors or relationships that include excessive sexual play, inappropriate sexual comments or gestures, mutual sexual activity with other children, or sexual molestation and abuse of other children.

According to Toni Cavanaugh Johnson, PhD, sexually reactive children can be defined as, “children whose repertoire of sexual behaviors exceed what is expected of their age.” It is a term used to describe a child who has been sexually abused and is acting out sexually as a reaction to the abuse. These children are not “offending” but reacting to their own victimization. These children display more sexual behaviors than the other children in their age group. Their behaviors are not ingrained patterns of sexually acting out. Their behaviors, however, are not as easily re-directed as the inappropriate behaviors of non-abused children. The sexually reactive child’s focus on sexuality is out of balance in relation to their peer group.

Sexually reactive children may be children who have been sexually abused, chronically exposed to explicit sexual materials or children who function in families where the boundaries regarding sexuality are too loose.

1. Sexually abused children are trying to make “sense” of their victimization. The more the child attempts to make “sense” of the victimization, the more confused he/she becomes. Children classified as sexually reactive typically act out shortly following their own abuse or at a point when they feel safe (i.e., foster care).

Ask the group if any of them have had an experience with a child in placement who demonstrated sexually reactive behaviors. If so, how did the caregiver react and what advice did the Child Welfare Professionals give the caregiver.

2. Chronic exposure to explicit sexual materials revolves around the child having access to highly sexualized materials (i.e., children who view unlimited sexual materials or hard core pornography, or children who are encouraged to discuss sexualized thoughts.)
3. Sexually reactive children who come from families where the boundaries are too loose do not fully understand what appropriate behavior is. Children who

come from “crack” homes where the “climate” of the home is too permissive are key examples of the grouping. Another example is a child whose parents engage in oral contact in the front seat while their child is reportedly “sleeping” in the back seat.

The exact breakdown or percentage of each sub-group in this classification is not known. In addition, the age-mates reactions to being on the receiving end of the sexual behaviors are also unknown at this point in time. Research is currently being conducted regarding these two issues.

Step 2:

Ask the large group for examples of specific behaviors that might be exhibited by sexually reactive children in response to their exposure to sexual activities. Record their answers on a flip chart. Be sure to add the following if the group does not capture them:

Sexually reactive children may react to their exposure to sexual activities by:

- demonstrating precocious sexualized activities, gestures, language, and knowledge
- engaging in extensive mutual sexual play with same age or younger children
- engaging in excessive masturbation or demonstrating a preoccupation with sexual activities and ideas
- engaging in sexual behaviors in public, such as sexual exposure, rubbing, or masturbation
- interest in or attempting sexual contact with older children, adolescents, adults, or animals
- engaging in or attempting significant sexual encounters with same age or younger children, including masturbation, oral sex, digital penetration, and intercourse
- sexually molesting other, and especially younger, children

The affect of sexually reactive children is confusion, shame, self-blame, guilt and anxiety. They typically lack anger and aggression. They don't appear to want to coerce or victimize other children nor do they seem to threaten other children into silence. Child victims of sexual abuse falsely assume that they will be able to make sense out of their own victimization by trying to re-enact it with other children; in reality, their sexual “acting out” only serves to add to their feelings of confusion, shame and guilt. They can't contain their feelings; it's too much.

The sexual behaviors of sexually reactive children must be fully addressed. Children identified and assessed as sexually reactive should be confronted with their behaviors

and re-directed to more appropriate behaviors. Since these children's behaviors are not ingrained patterns of secrecy or manipulation, they can respond to limit setting and establishment of boundaries.

Child Welfare Professionals and other professionals need to respect the cultural differences that exist regarding the use of personal space. In every culture there is an invisible boundary regarding how close strangers, friends and loved ones may interact with each other. In many Italian families, for example, one's personal space is very close and a great deal of physical contact takes place within the space. On the other hand, for many families in the German culture, there is a clear distance that exists between strangers and friends. Only very close family members or loved ones are permitted to enter into someone's personal space. Even then, physical contact is limited. The use and limitations of physical touch should be clearly outlined by Child Welfare Professionals, parents and foster parents, so that sexually reactive children can learn that touch is an appropriate and healthy communication when personal space boundaries are respected.

Step 3:

Activity: The trainer should ask participants to break into several small groups to talk about cases where the Child Welfare Professional was confronted with a child who possibly could be assessed as Sexually Reactive. The cases should be discussed in anonymous terms, using no identifying demographic information. The groups should then select a case from their small group for presentation to the large group. The presentation of the case should last no longer than 5 minutes.

Participants should discuss the information that would validate a possible assessment of Sexually Reactive and discuss the behavior management issues of this case. The entire small group should then compile a list of recommendations for managing sexually acting out or reactive behaviors and report out to the large group.

Trainer Note: Circulate to make sure groups are discussing sexually reactive vs. normal or offending behavior. Additionally, when selecting a case for presentation to the large group, be sure that at least one case involves a child in placement and what advice the caregiver should be given when dealing with a sexually reactive child. If any group cannot identify a real case where they were confronted with a child who could possibly be assessed as Sexually Reactive, ask another group who may have more than one case to join the group without a case.

Each small group will compile only one list on newsprint. Have them post it and report out.

Step 4:

Review the following information with participants:

1. **Caregivers will need to make many messages explicit for the child who has been sexually abused. McNamara (1990) gives some of the following examples:**

“I’m your Mom (or your Dad, uncle, grandmother, foster dad). I’m not interested in grown-up touching with you.”

“In this family, children and parents don’t share grown-up touching.”

“That kind of touch is not appropriate; it’s not okay. We only share safe touch.”

“What kind of attention do you think you need right now? How can you get it in safe ways?”

“Are you feeling bad right now? We can talk about it and share a safe hug.”

2. **The caregiver needs to identify the problem and offer alternatives.**

Trainer Note: Bullet the following on a flip chart as the steps to dealing with a child that may be exhibiting sexually reactive behaviors: **Label/React, Monitor, Confront/Prohibit, Refer**

Gail Ryan (*Sexual Behavior in Childhood*, 1990) recommends that parents first **label** the behavior (what you see, what you hear.) This helps to provide the language needed to discuss the problem.

“I see you touching Johnny’s penis.”

The initial reaction should be non-judgmental and used to help the child develop empathy.

“It makes both me and Johnny uncomfortable.”

The second response would occur if the behavior continues. Reinforce the initial label and **reaction** with a rule.

“I see you touching his penis and he feels uncomfortable. You need to stop doing that.”

It is important to **monitor** continually not only to help in the re-education of this child but also to prevent any victimization of others. In some cases, the seriousness of the behavior prevents you from waiting for a second occurrence. Your response to the child may need to be within a few minutes.

“I am very concerned that you tried to put a stick in your brother’s bottom. Sticks can hurt bottoms. You must not do that again.”

3. Make sure that you have **removed sexual stimuli** from the home that may increase sexual feelings or confusion. Monitor your family's language; the TV they are watching (several authors have noted that sexually reactive children share that daytime soaps are confusing or stimulating to them); the jokes that are told; etc. Even catalogues that advertise underwear can be sexually stimulating to some children.
4. **Confront/Prohibit:** Help the child learn which behavior is **appropriate in public and in private**. For example, if the child is masturbating in the living room remind him/her that this is a private behavior and concretely help him/her identify a private time and place.

However, if masturbation is compulsive and the child is preoccupied, it should be discouraged altogether. Caregivers can manage this type of masturbation by the substitution of other behavior. Help the child to reduce his/her masturbation by redirecting him/her to other activities, or allotting time for private masturbation that is gradually reduced (Cavanaugh Johnson, 1990). For instance, "Sheila, you are touching your genitals again. There are other ways to help you feel better. How about going for a bike ride? (or reading a story together?)" Some children are unaware of their behavior. It can be helpful to establish, with the child's input, a cue that the parent can give when the child is engaged in the behavior. This should be done in a supportive, private manner. For example, a parent and child can agree that when the parent pats his/her nose, it means to stop the behavior.

5. **Refer:** Ignoring problematic behavior does not help the child recover. Close observation and monitoring are necessary to enable the child to learn about what precipitates their sexualized behavior and identify other ways to express those feelings. If the caregiver cannot manage the problematic behavior, a referral to a professional may be necessary.

Step 5:

We have already discussed masturbation in the healthy and normal developmental context.

However, masturbation is also listed as a behavior indicator of sexual abuse on many indicator lists. There is no legal definition of "excessive" masturbation and only recently has a clinical definition been offered. Sgroi defines "excessive" as, "when a child is older than 3, the child can do little else (compulsive), the activity occurs in public, the child avoids other childhood activities and the child persists in inserting objects in the rectum or vagina without regard to pain or self-injury." Johnson describes "excessive" masturbation as, "when children don't seem to have any control over their behavior, are focused on the activity to the exclusion of other activities, or have hurt themselves."

Masturbation is a behavior that must be managed. You can tell children, “You are in charge of your penis and it’s yours to touch. You must touch it only at the right times and in the right places.” (Hewitt) It is important that Child Welfare Professionals and caregivers acknowledge that this behavior is common for sexually reactive children and that it can be controlled and managed. Child Welfare Professionals should assist parents in re-directing the masturbating behavior, substitute the masturbatory behavior with more appropriate behavior and explain to the child that the behavior is a private rather than a public behavior.

Friedrich provides a 4-step approach to managing this behavior:

1. Assess parents’ attitudes and behavior related to masturbation.
2. Positive shaping of child’s non-masturbatory time.
3. Create a time and place for child to masturbate.
4. Deal with the child’s victimization, if necessary.

On the other hand, we must be very careful not to sanction the child’s use of his/her body to solve their problems. Sexually reactive children must learn that there are people available who can help them with their problems and that they can reach out for support and nurturance. Masturbation is an activity where appropriate boundaries must be observed. Sexually reactive children should learn not to associate their sexual identity with a self-soothing activity. Thus, “excessive” masturbation without limit setting can lead to further confusion.

203: Sexuality of Children: Healthy Sexual Behaviors and Behaviors which Cause Concern

Section V: Application of Knowledge

Estimated Length of Time:

75 minutes

Key Concepts:

- ✓ Identify necessary dynamics to consider when evaluating the sexuality of children

Methods of Presentation:

- ✓ Lecture
- ✓ Small group activity

Materials Needed:

- ✓ Handout #8 (Dynamics of Sexual Play vs. Problematic Sexual Behavior)
- ✓ Handout #9 (Sexual Play vs. Problematic Sexual Behaviors Case Examples)
- ✓ Overhead #5 (Dynamics of Sexual Play vs. Problematic Sexual Behaviors)
- ✓ Trainer's Guide to Small Group Activity: Dynamics of Sexual Play vs. Problematic Sexual Behaviors

Outline of Presentation:

- Review the Dynamics of Sexual Play vs. Problematic Sexual Behavior

Step 1:

The trainer will discuss the characteristics that help Child Welfare Professionals and other professionals assess healthy sexual behaviors of children from potentially problematic behaviors. The trainer should remind the participants that no characteristic stands by itself, or alone is indicative of sexual abuse. A complete assessment should be conducted by a qualified professional; however, the following characteristics can assist Child Welfare Professionals in beginning to assess these children and develop appropriate case plans, as well as treatment goals for the child.

Display **Overhead #5 (Dynamics of Sexual Play vs. Problematic Sexual Behavior)** and **Handout #8 (Dynamics of Sexual Play vs. Problematic Sexual Behavior)**, and discuss:

- **Age Difference** – Age difference between children is one factor that must be considered. Sex play between children who are peers and hold a 3-year or less age span is acceptable by most experts. This is lower than the 4-year span previously considered by the professional community. It should be noted that neither a 3 nor 4 year age span is a legal or clinically validated number. **Note:** Some professionals working with youthful offenders have noted that some of these children are offending 3 to 5 years older than themselves.
- **Size Difference** – The size difference between children involved is another factor that must be considered. For example, one child may physically tower over another child or use his/her physical stature to threaten or dominate another child.
- **Difference in Status** – If one child is in a position of authority or placed in a position of power (i.e., babysitter, temporary caregiver) over another child, then she/he may be able to compromise another child's ability to make decisions. Intelligence and/or developmental level can also be a variable of status.
- **Type of Sexual Activity** – Historically, the professional community has always assessed a child's sexual behavior based solely on this criterion. For example, if a child engaged another child in observing his/her private areas we would have determined this to be sex play. If the child touched another child, however, we have viewed this as problematic sexual behavior. The type of sexual activity is an important piece in assessing the child's sexual behavior, but not the only one! Remember that sexual interest and activity may vary depending on the cultural, moral or religious values/beliefs of the family and child.
- **Other Factors to Consider Include:** (Groth & Laredo, Sgroi)
 - a. How the sexual contact takes place (on the playground)
 - b. How persistent it is (was re-direction attempted)

- c. Evidence of progression in regard to nature or frequency (sex play is not progressive in nature)
- d. Nature of fantasies that accompany or precede sexual behavior (fantasy usage is closely related to sexual offending behavior)
- e. Distinguishing characteristics of persons targeted (patterns of victims may indicate sexual offending behavior)
- f. Behavioral indicators (indicating stress or trauma for victim)
- g. Ritualistic or sadistic behaviors (indicating trauma for victims)
- h. Secrecy (Sexual abuse exists in secrecy so that the behavior of the offender can continue and so that he/she will not be discovered or held accountable for his/her actions)

Step 2:

The trainer should distribute **Handout #9 (Sexual Play vs. Problematic Sexual Behaviors Case Examples)**. The participants should be divided into 3 small groups and each group should be assigned (2) case scenarios to assess using the criteria listed above. Using, **Handout #8 (Dynamics of Sexual Play vs. Problematic Sexual Behavior)**, the groups should classify each scenario as healthy or problematic and discuss the characteristics that determine the classification. One group member should record the problem-solving process and one group member should be ready to report on the group's decisions. The trainer should reunite the large group and provide ample time for discussion surrounding the small group's discussion.

The trainer should use the enclosed **Trainer's Guide** by Eliana Gil to emphasize the important characteristics of each case scenario. Participants may not agree with Gil's analysis of the scenarios as presented in the **Trainer's Guide** and should be encouraged to express their views with an explanation of why they came to the conclusions that they did.

203: Sexuality of Children: Healthy Sexual Behaviors and Behaviors which Cause Concern

Section VI: Conclusion

Estimated Length of Time:

15 minutes

Key Concepts:

- ✓ Action plans assist the trainee with transferring their learning into practice

Methods of Presentation:

- ✓ Individual reflection and group sharing

Materials Needed:

- ✓ **Handout #10 (My Action Plan)**
- ✓ **Handout #11 (References)**

Outline of Presentation:

- ✓ Complete Action Plan
- ✓ Complete training evaluation

Step 1:

We need to acknowledge that we live in a culture where children are exposed to messages in the media, which appear to glorify sexual exploration and even violence. It is important that children learn appropriate boundaries and limitations as defined by caregivers/parents.

Ask participants to look over notes and review newsprints posted on the walls and think about what they learned today that was especially helpful. Ask participant to complete **Handout #10 (My Action Plan)** to document the some knowledge they have gained and how they might apply that knowledge when they return to their jobs.

Ask for volunteers who would be willing to share their thoughts with the group.

Distribute **Handout #11 (References)**, which provides resources that participants can obtain if desired.

Step 2:

Thank the group for their participation and ask them to complete the evaluation.