THE UNIVERSITY OF CALGARY

Treating Children With Sexual Behavior Problems

by

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A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE

DEGREE OF MASTER OF SOCIAL WORK

FACULTY OF SOCIAL WORK

CALGARY, ALBERTA

JULY, 1995

The University of Calgary

Faculty of Graduate Studies

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ABSTRACT

The primary objective of this study was to explore treatment providers' experiences and views on the assessment and treatment of children who exhibit sexually intrusive behaviors. A qualitative approach was selected as the methodology of choice, consisting of the analysis of nine interviews with treatment providers who had worked with over 350 children ages 12 and under who exhibited sexually intrusive behaviors.

Four main outcomes are highlighted in this study. First, is the importance of incorporating a developmental perspective in the assessment and treatment of children who are sexually intrusive and in understanding the sexually intrusive behaviors of children ages 12 and under. Second, is the importance of parental influence, including other caregivers such as foster parents and child care workers, in the development and maintenance of sexually intrusive behaviors. Third, is the fact that many of the family's experienced other types of domestic violence including the mother being the victim of the child's sexually and physically aggressive behaviors. The fourth main outcome is the importance of addressing ethical issues such as confidentiality and responsibility with respect to informing community agencies of potential risks that these children's behaviors may impose on the community.

ACKNOWLEDGEMENTS

Without belief in self, completing a project such as this would be impossible. Claire, Jean, and all at Homes for Growth, thank you for helping to awaken the hope and belief of self within me that has made this endeavour possible.

Faithfulness, commitment, and love. Leanne these describe how I have experienced your friendship. Every step of the way, you have made your presence known. You are a blessing.

Dan, Syrah and Margaux, I have found your strength and warmth a refuge during this process. You have provided a solid foundation from which I could renew myself and carry on.

Your time and commitment have been treasured Teri as you so freely shared them with me. You helped keep me focused, and continued to remind me that there really is life after thesis. Donna, your desire for truth has been a gift and an inspiration to me. I thank you for your continual prayers. Marg, your gentle comfort and belief in my abilities have sustained me throughout the process. Even over the miles I have felt your presence. To the rest of the study group, Lana, Janice, Keith, and Cathy thanks for your insight and encouragement!

Completing this thesis has been more than learning about the content of the problem area, the process itself has been a rich learning experience. I feel very fortunate to have had this opportunity to work with Dr. Leslie Tutty. Together, your editorial expertise and knowledge in this area have provided a rich and balanced thesis experience.

That which we choose to endeavour is not completed in isolation, it is a combined

effort by those lives who have intertwined with our own, past and present, each offering their unique gift of hope. To those mentioned here and those not, I say 'thank-you' for your gift of hope during the difficult moments along with the celebration of the successes over the past two years.

Hope means to keep living amid desperation

and to keep humming in the darkness.

Hoping is knowing that there is love,

it is trust in tomorrow, it is falling asleep

and waking again when the sun rises.

In the midst of a gale at sea, it is to discover land.

In the eyes of another, it is to see that she understands you.

As long as there is still hope

There will also be prayer.

And God will be holding you in his hands.

-Fr. Henry Nouwen

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PROLOGUE

Over the past 20 years, images of perpetrators of sexual abuse have evolved from men sexually abusing female children to images of male adolescents abusing boys and girls. In more recent years, growing evidence of males as victims and females as perpetrators have challenged the previous images of victims and perpetrators. Unthinkable as it may seem, perpetrators of child sexual abuse have also been found to include children under the age of twelve. Acknowledging that the sexual behavior of young children is also considered to be "perpetrating" behavior can be shocking to not only parents but professionals as well.

My initial interest in this area began when I was employed as a community mental health social worker in northern rural Saskatchewan. In one day I received two referrals from social services. One was to work with a five year old child who had been sexually abused by a teenage boy. The second referral was to see a five year old girl who had been sexually molested by the five year old boy in the first referral. I had rarely heard of children perpetrating sexual abuse, much less worked with them. Thus, my quest for information and guidance on how to approach the situation began. I soon discovered that not only was information difficult to access, but the number of professionals with expertise in the area were also limited. Fortunately, I connected and consulted with a "willing" family therapist in a southern city who had experience treating children with sexual behavior problems. However, I had no idea how complicated these two referrals would become.

As the initial meetings with parents began, it became apparent that we were not

only dealing with two families, but more neighborhood children were involved. We began to uncover more details of the five year old boy's initial abuse by the adolescent boy and learned that other neighborhood children were witness to some of the violent sexual acts committed against the child. A few months later this boy began repeating similar behavior towards same age, but physically smaller girls and boys. These children in turn began acting out sexually with siblings and other children. Work at the individual, family, and community levels became necessary.

The child who engages in sexually intrusive behaviors have multiple issues including fear of what will happen to him/her, possible victimization issues, anger about being "caught", and remorse, and/or confusion over own behavior. The siblings often were confused about what was going on within the family and may have felt left out if the other child received considerable attention. Siblings were also at particular risk to have been the victim of the child's sexually intrusive behavior. The parents presented with a number of reactions: fear of what would happen to their child within the legal and helping systems; denial, and/or ambivalence over their child's molesting behavior; guilt over not being a "good enough" parent; blame and/or shame for their child's acting out behavior; outrage at other parents for reporting such a notion; sadness over the perceived loss of their "innocent" child; confusion as to their current role as a parent and finally; questions as to how best they could help their child. Other families and community people who were peripherally involved needed to deal with their feelings around the shattered myth of living in a "safe" neighborhood. I believe that it is important for parents to band together to address all such related issues stemming from the children's

sexually aggressive behavior. As such, this problem requires the therapist to treat the problem in the context of the family and community.

This thesis begins with a review of the literature divided in two sections which identify the important debates, as well as the areas in which further research is required. Chapter One explores the incidence and prevalence of children under the age of twelve who exhibit sexual behavior problems, the demographic aspects of these children and their families, difficulties with describing the child's behaviors, normal sexual development in children, the etiology of this problem area and preliminary typologies. The second chapter is a description of the literature on the treatment and assessment of children with sexual behavior problems. Chapter Three outlines the methodology employed in the current study, with the results presented in Chapters Four and Five. Chapter Four includes the results which describe the children and their families and the children's sexual behavior problems. The results pertaining to the assessment and treatment of these children are presented in Chapter Five. Finally, Chapter Six includes a discussion on the major themes found in the current study, the implications of these findings on the various roles of social workers involved with this population, and suggestions for future research.

CHAPTER ONE

THE LITERATURE: DESCRIPTIONS AND DEBATES

Introduction

In the past few decades a growing awareness has developed about the surprisingly high number of children who have been the victims of sexual abuse. Typically, victims were female and offenders were primarily male (Courtois, 1988; Finkelhor, 1984), with male victims and female or child offenders practically unheard of (Cunningham & MacFarlane, 1991). This picture changed considerably during the 1980s, when it became increasingly clear that not only were adults offending, but teenagers and young children were as well. During this time, researchers discovered that many adult offenders began their abusive behavior as adolescents (Longo & Groth, 1983). Others reported that some perpetrators began their offending behaviors as young as age seven (Longo & McFadin, 1981).

During the early 1980's, the sexually intrusive behavior of children who were under the age of 12 was only described in the literature as sibling incest (DeYoung, 1982; Finkelhor, 1980; Lorado, 1982; Smith & Israel, 1987). During the late 1980's, studies acknowledging that children under the age of twelve were 'sexually aggressive' and 'child perpetrators' followed (Johnson, 1988; 1989; Friedrich & Leucke, 1988). In spite of this increasing awareness, little is known in the 1990's about the development and maintenance of sexually intrusive behavior in young children and about long-term preventative treatment.

This chapter consists of six sections. The first section is an exploration of the studies on the prevalence and incidence of children with sexual behavior problems. Second, the foundational research describing this population is reviewed. The third section addresses the critical definitional issue that reflects our current understanding of these children. The literature on normal childhood sexuality is reviewed in the fourth section, while hypotheses on the development of sexual behavior problems in children comprise the fifth. The sixth section is a review of the preliminary typologies of children who exhibit sexually intrusive behavior.

Incidence and Prevalence

The extent of the problem of children who sexually abuse other children has yet to be determined. Establishing such estimates is fraught with difficulty. While the scope of the problem is determined by both incidence studies which "attempt to estimate the number of new cases occurring in a given time period" and prevalence studies which "attempt to estimate the proportion of a population" that has experienced a particular problem (Doyle Peters, Wyatt, & Finkelhor, 1986, p. 16), problems in collecting such data arise for several reasons. First, many incidents of sexual abuse go unreported as children find it difficult to disclose abuse due both to their own feelings of guilt and possible threats used against them by the perpetrator. Second, due to the denial and minimization of childhood sexuality, parents, police, and other professionals may adopt the belief that the sexually intrusive behaviors of these children are simply normal exploration. Third, many of these children do not fall within the jurisdiction of either

child welfare or the justice system making data collection difficult (Gray & Pithers, 1993; Hall, 1993a; National Children's Home, 1992).

While no incidence and prevalence data are being systematically collected in Canada on sexually intrusive children under the age of 12, other studies conducted in the United States and in the United Kingdom reveal some indications of the scope of the problem. In his retrospective survey of adults in the United States who experienced childhood sexual abuse, Finkelhor (1979) found that 39.1% of those who abused boys and 33.6% of those who abused girls reported that they were between the ages of 10 and 19 at the time of the initial offence. Another study revealed that, of all sexual abuse investigations in Liverpool (1989-1990), 34.4% of the allegations were made against children between the ages of 7 and 17. Children 8 to 12 years of age made up 35% of these abusers (Horne, Glasgow, Cox, & Calam, 1991). In Vermont during a six year period (1984-1989), approximately 200 children under the age of 10 were identified as having sexually abused another child. In 1991, alone, 100 such children were identified (Gray & Pithers, 1993), indicating a growing awareness of the problem. While the magnitude of the problem is still unknown, such results provide an emerging picture of a significant number of sexually intrusive children who are coming to the attention of treatment providers.

Foundational Research on Children Who are Sexually Intrusive

Only recently have children who exhibit sexually intrusive behavior been identified as an issue of concern. This section reviews the few studies which have become the

groundwork for further research, providing a conceptual description of this population. A brief overview of the related literature on sibling incest follows. Before doing so, a note on the limitations of the small body of research completed to date is warranted. The available studies have several methodological problems: the sample sizes are small, most of the children are receiving clinical treatment which results in a biased sample, and control or comparison groups are non-existent. As well, most of the research published on children who are sexually intrusive originates from one treatment program in the United States, thereby, restricting the generalizability of the results to other programs (Hall, 1993a). In spite of these limitations, the published research provides an emerging description of a serious problem.

Johnson (1988) and Friedrich and Luecke (1988) published the first two studies which identified and labeled children who are sexually intrusive. The articles were published simultaneously although neither had knowledge of the other's work. These two works, with the addition of Johnson's later 1989 study, provide the basis for the review of preliminary findings. The three studies focused on children of a similar age range. Johnson (1988) described 47 boys between the ages of 4 and 13 who had sexually abused children younger than themselves. Friedrich and Luecke (1988) reported on 16 children aged 4 to 10 1/2 years who had been referred for treatment of their molesting behavior. In her study of female "child perpetrators", Johnson (1989) evaluated the molesting behaviors of 13 girls between the ages of four and 13 who were involved in a treatment program for this problem. Importantly, the criteria used to select children for the three studies were comparable, including children who exhibited overt sexual behavior, used

force or coercion to illicite the other child's participation in the behavior, and the children had sexually molested others at least two years younger than themselves.

The characteristics of the children in these three studies were very similar. A large percentage had severe learning difficulties, with many diagnosed with an attention deficit disorder. The most prevalent diagnoses were oppositional and conduct disorders. Oppositional behaviors included stealing, fire-setting, and running away. Although not identified as a major issue, some of the children reported suicidal thoughts.

Many of the children had experienced past victimization. Sexual, physical, emotional abuse, and neglect were significantly common experiences for the children in all three studies. In Johnson's 1988 study, 50% of the boys had been sexually abused and 19% physically abused by someone they knew prior to their own perpetrating behaviors. Friedrich (1988) found that 75% of the boys and 100% of the girls had sexual abuse histories and Johnson (1989) similarly reported that 100% of the girls had been sexually abused.

Descriptions of the molesting behaviors exhibited by the children were reported primarily by Johnson (1988; 1989). The average age at first perpetration for the 13 girls was 6.7 with a range from 4 to 9 years; for the 47 boys the average age was 8.7 with a range from 4 to 12 years. The average age of the victims was 5 years for the girls and 6.7 years for the boys. All of the victims were known to the children with the majority being a sibling or extended family member. The average number of victims was reported in all three studies. The girls in Johnson's study had an average of 3.3 victims ranging from 1 to 15, whereas the average number of victims for the boys was 2.1 ranging from

1 to 7. This compared to Friedrich's report of an average of 2 victims for both boys and girls.

Corresponding data on the parents of the children was reported in each of the three studies. The majority of families were headed by single-parent mothers. Many of the mothers experienced a combination of depression and personality disorders with almost all having experienced prior sexual and emotional abuse. The fathers were often absent, some never known to the child, and many having been emotionally, physically, and sexually abused as children. In Johnson's 1989 study, only two fathers participated in treatment. A high number of grandparents also had experienced physical, sexual, and/or emotional abuse. Substance abuse histories were characteristic of most of the families.

Information about the home environments of these children proved similar as well. The children tended to grow up in unstable homes with emotionally chaotic relationships. Secrets about the birth of other siblings, previous partners, and incarcerations were common. The discipline practices of the parents were described as rudimentary, based primarily on an authoritarian model of parenting. Disciplinary behaviors included criticism and physical punishment.

The families were characterized by highly sexualized parent-child interactions which were considered to be a major factor that sustained the child's sexually intrusive behavior. The majority of the parents were, themselves, victims of abuse and were unable to enforce appropriate sexual boundaries in the home. Such inappropriate behaviors by the parents included walking unannounced into the bathroom while occupied

by the child, or entering bedrooms without knocking. Some parents were overly interested in their child's physical development, frequently inspecting the child's body.

The mother-child relationship was often fraught with conflict, stress, and ambivalence. Frequently the children were blamed or ridiculed by their mothers. Further, the mothers were described as projecting their own negative feelings about themselves, or their hatred toward the child's father, onto the child, making it difficult for the mother to provide support and nurturance.

In addition to these three foundational studies, Cantwell (1988) presented three cases where children who had been abused by other children, in turn, began abusing other children, suggesting a cycle of victimization. She focused on parent education as the means towards prevention of sexual abuse of children by children. Interestingly, the issues that she suggested parents need to be educated about parallel the findings in the previous three studies. These issues include: 1) the importance of reporting sexual behavior in children; 2) the fact that spanking children is not an effective way to stop the sexually intrusive behavior, 3) the fact that the majority of sexual assaults on children occur within their own circle of friends and family, 4) that children should be encouraged to tell if anyone, including a same-age child initiates sexual play, and 5) encouraging parents to consult professionals if there is any confusion regarding what constitutes normal sexual play.

A brief mention of an unpublished paper about sexually intrusive children is also warranted. Powell (cited in Friedrich, 1990) evaluated the behavior of children who were referred to a treatment program for sexually abused children. The children were

followed over a number of years during which time Powell identified 15 who had committed a sexual offense which was generally reported to have occurred when the child was between the ages of 14 and 15. He postulated that the difference between the sexually abused children who did not abuse and those who did engage in molesting behavior was due to two factors: (1) poorer quality parent-child relationships; and (2) the greater severity and extent of abuse experienced by those children. To the extent that these two factors were present it was more likely that the child would abuse others. Both of these factors were similarly found to be characteristic of the children's experience in the research by Johnson (1988; 1989) and Friedrich and Luecke (1988).

Related Literature on Sibling Incest

Siblings comprised the majority of the victims in Johnson's two studies. As mentioned previously, in her first study on male child perpetrators, Johnson discovered that 47% of the boys had sexually abused a sibling (1988). Johnson's subsequent study on female child perpetrators indicated that 77% of the girls had chosen a victim in her family; the remaining 33% of the female perpetrators had no available family members (1989). Unfortunately, Friedrich and Luecke (1988) did not identify the nature of the relationship between the perpetrator and the victim within their study. Nonetheless, the high proportion of sexually intrusive behavior towards siblings suggests the need to examine the literature on sibling incest.

Although sibling incest has been described in literature dating back to the early 1980's (De Young, 1982; Finkelhor, 1980; Lorado, 1982), to date, only two empirical

studies have been conducted (Finkelhor, 1980; Russell, 1986). In general, the literature on sibling incest is comprised primarily of case studies (Canavan, Meyer & Higgs, 1992; De Jong, 1989; Fortenberry & Hill, 1986; Laviola, 1992; Lorado, 1982; Pierce & Pierce, 1990; Smith & Israel, 1987). The average ages of the children who perpetrated sibling sexual abuse in these case descriptions were from 13 to 15 (De Jong, 1989; Laviola, 1992; Pierce & Pierce, 1990; Smith & Israel, 1987). However, all of these studies also include children under the age of 12. In fact, Pierce and Pierce (1990) describe sibling perpetrators as young as four years of age.

The literature on sibling incest appears to both support some of the findings in the literature on children who are sexually intrusive and to describe other potentially relevant issues not yet identified. The supporting characteristics includes similar histories of abuse, parental histories of abuse, and family dynamics. Several studies reported that the majority of children who were perpetrating against a sibling had been exposed to inappropriate sexual behavior, were victims of either intra- or extra-familial sexual abuse, and had experienced physical abuse and neglect (Fortenberry & Hill, 1986; Pierce & Pierce, 1990; Smith & Israel, 1987). In many instances, the parents of the child who had perpetrated the abuse also had a history of sexual victimization as a child (Fortenberry & Hill, 1986; Smith & Israel, 1987).

The descriptions of the family dynamics also appear similar to the findings in the literature on children who are sexually intrusive. Some of the dynamics include distant, inaccessible parents (Smith & Israel, 1987), significant parental discord (Canavan et al., 1992), father-daughter incest (Fortenberry & Hill, 1986; Smith & Israel, 1987),

dysfunctional child-rearing practices and family rules (Canavan et al., 1992; De Jong, 1989; Laviola, 1992; Smith & Israel, 1987), and verbal and/or physical abuse (Laviola, 1992; Pierce & Pierce, 1990).

Three other issues raised by the studies on sibling incest that appear relevant to children with sexual behavior problems but do not appear to have been identified include the underreporting of sibling incest, the prevalence of father-daughter incest preceding sibling incest, and traditional gender roles in families reporting sibling incest. First, incest between siblings is thought to be underreported (Pierce & Pierce, 1990; Canavan et al., 1992). In fact, several authors have speculated that sibling incest is more common than father-daughter incest (De Jong, 1989; De Young, 1982; Smith & Israel, 1987; Thomas & Rogers, 1983), although De Jong (1989) estimated that incest between cousins is at least as common or twice as common as sibling incest. One reason cited for the underreporting of sibling incest is the fact that sexual interaction between siblings is often assumed to be experimental or exploratory and is, therefore, rarely reported (Pierce & Pierce, 1990). As with other types of sexual abuse, the shame and guilt leading to self-blame for the abuse is believed to keep the abused sibling silent (Canavan et al., 1992). When considering children who are sexually intrusive, identical reasons for underreporting could apply as well.

Second, Smith and Israel (1987) discovered that father-daughter incest preceded brother-sister incest in the cases of 32% of the women in their study. Fortenberry and Hill (1986) support this finding in their case report in which they document the history of one young girl who, after her father was removed from the home for sexually abusing

her, began sexual relations with her sister in order to "get my sexual fix" (p. 202). They hypothesized that "the initiation of sibling incest after cessation of father-daughter incest represents a learned sexualization or erotization of interpersonal relationships" (p. 203). This dynamic, however, has not been documented in the literature on children who are sexually intrusive.

The third issue not noted in the literature on children who are sexually intrusive is the gender roles adopted by the parents of these children. Two of the studies on sibling incest identify these as families where the father and mother occupy very traditional roles. Although these studies on sibling incest comprise a very small body of research, the issues appear to be relevant to the understanding of families with children who exhibit sexual behavior problems. In the majority of the women's families in their study, for example, Canavan et al. (1992) identified "strong male domination and passivity in the wives....Rules are made by a powerful male and there may be extreme rigidity of gender role expectations" (pp. 136-138). In her descriptive study of 17 cases of older brother-younger sister incest, Laviola (1992) similarly noted that, "families also held views about men and fathers as superior, controlling, and dominant over women and children" (p. 415).

The studies discussed in the previous two sections provide a preliminary description of a heterogeneous group of children who exhibit sexually intrusive behavior. A wide range of child, parental, and sibling incest characteristics are considered to be related to the sexual behavior problems of the children.

Definitional Issues Regarding Sexually Intrusive Children

Part of the challenge in treating and assessing children with sexual behavior problems is reaching consensus on how best to describe the behavior of these children. The terms that have been utilized to describe these children are many and varied and reflect the difficulties experienced in attempting to describe a complex, sensitive phenomenon. The ten terms that have been found in the literature to date include sexually reactive (Friedrich, 1990; Rasmussen, Burton, & Christopherson, 1992), sexually intrusive (Hall, 1993a; Lane, 1991; Wachtel, 1992), sexually aggressive (Friedrich, 1990; Friedrich & Luecke, 1988; Gray & Pithers, 1993; Henderson, English, & MacKenzie, 1988), child perpetrators (Cantwell, 1988; Johnson, 1988; 1989; Lane, 1991), child-victims (Ryan, 1989), children who molest (Cunningham & MacFarlane, 1991; Gil & Johnson, 1993; Johnson, 1988; 1989), children with sexual behavior problems (Bonner, Walker, & Berliner, 1992; Ryan, 1992), sexualized children (Gil & Johnson, 1993), children who act out sexually (Johnson, 1990), eroticized children (James, 1989; Yates, 1987; 1991) and children who sexually abuse other children (Bagley & Shewchuk-Dann, 1991; National Children's Home, 1992).

The debate about how to describe the sexual behavior problems of the children is critical because the label selected reflects particular assumptions and beliefs about the etiology of the behavior, the seriousness of the behavior, and to whom we attach the responsibility for the behaviors (Hall, 1993a). Although some treatment providers suggest calling these children, "children with sexual behavior problems" (Bonner et al., 1992), Wachtel (1992) suggests that this label conceals the issue and the seriousness of

the problem. At the other extreme, these children are described as abusers, molesters, and child perpetrators (Cantwell, 1988; Johnson, 1988; 1989). While such terms are utilized therapeutically and strategically with adult and adolescent offenders for the purpose of confronting the abuser with denial and minimization, it has not been established that such confrontation is effective with children under the age of twelve (Cunningham & MacFarlane, 1991).

While connoting the seriousness of the behavior without labeling the child as "bad", Hall (1993a) notes that the term "sexually aggressive", is problematic in that it suggests that the behavior is always aggressive when, in fact, the child may be grooming the victim without using force. The term, "sexually reactive" suggests that the child is responding to some prior trauma, however, as Johnson (1988) argues, such is not always the case especially for older latency-age children. As well, Wachtel suggests that this term detracts from the child taking responsibility for their behavior by assuming that the behavior is simply a reaction to past life experiences. In contrast though, Rasmussen et al. (1992) report that the majority of the children with whom they work have experienced prior trauma. They propose that, "unless a child has experienced sexual arousal either by being molested or by exposure to explicit sexual stimulation, an offense is unlikely" (p. 38).

Perhaps adding to the debate regarding label appropriateness for children who are under age 12 and are sexually intrusive are developmental differences. The cognitive, physical, moral and social development of children within the age range of 4 to 12 years varies significantly, however, development is an aspect that most authors don't appear

to take into account when describing the sexual behaviors of children. One exception is Rasmussen et al. (1992) who suggest a separation into two groups. For children who are under eight years of age, the term "sexually reactive" is utilized to describe their sexually inappropriate behaviors as they believe that the behavior is in reaction to prior sexual victimization and/or inappropriate exposure to sexual stimuli. For children ages nine to twelve, the authors use the same term only if the child has a documented history of sexual victimization and/or exposure to sexual stimuli.

The term, "sexually intrusive" appears to have gained considerable acceptance (Hall, 1993a; Lane, 1991; Wachtel, 1992). Those who advocate its use suggest that the term describes the seriousness of the behavior without labeling the child as "bad" or necessitating the element of aggression. However, the difficulty with this description, as with all the labels previously suggested, is that no distinction is made regarding the degree and type of sexually inappropriate behavior. From my perspective, it is important to develop clearer definitions regarding the behaviors of these children, a task that should have an impact on treatment strategies.

For the purpose of the current review, however, the term, "sexually intrusive" will be used to describe children ages 12 and under who have engaged in sexually abusive behaviors with other children. This term connotes the seriousness of the behavior encompassing both aggressive and non-aggressive sexual abuse by children. The terms 'children with sexual behavior problems', 'abusive', 'perpetrating', 'offending', 'sexualized', and 'molesting' will be used interchangeably to describe the behaviors of children ages 12 and under who have engaged in sexualized behaviors both intra- and

extra-familially.

Sexual Behavior in Children

As the incidence of sexual molestation perpetrated by children under the age of 12 continues to gain recognition, treatment providers will be confronted with the need to assess and treat these children and their families. However, to understand the sexual behavior of these children we must first be clear about what constitutes age-appropriate sexual behavior in children. Johnson (1990) suggests that, "normal childhood exploration is an information-gathering process of limited duration wherein children of similar ages explore each other's bodies, visually and tactilely" (p. 64). Importantly though, to date, there has not been consensus about what constitutes normal sexual behavior in children (Hall, 1993a). Although some exceptions exist (Goldman & Goldman, 1982; 1985; 1988), relatively little attention has been given to the processes and factors of childhood sexual development. In fact, few studies exist on normal childhood sexuality, "because childhood sexuality seems like a contradiction in terms" (Frayser, 1993).

Bullough (1990) suggests that researchers face barriers when they attempt to examine normal child sexual development, previously a "forbidden area". Furthermore, children have been considered "asexual" (Frayser, 1993). As such, Frayser (1993) identified several obstacles to assessing and treating sexual behavior problems in children. First, the majority of therapeutic interventions rely on verbal accounts of problems, which in this case, is complicated by the fact that there is no acceptable sexual vocabulary available to either child or therapist. Second, any testing completed with the child on

sexuality is open to wide interpretations, to cultural influences, and to therapist bias/background. Third, procedures such as genital examinations may be traumatic to a child who may experience the exam as abusive.

Research on the Sexual Development of Children

Berliner (1991, cited in Wachtel, 1992) has been critical about the lack of research and literature on normal sexual development in children. De Jong (1989) also notes that, "no universally accepted criteria are available for distinguishing between abusive sexual contact and normal sexual exploratory behavior" (p. 272).

Four earlier studies (Kinsey, Pomeroy, & Martin, 1948; Kinsey, Pomeroy, Martin, & Gebhara, 1953; Langfeldt, 1990; Litt & Martin, 1981), examined the sexual development of children. Langfeldt discusses aspects of childhood sexuality based on data gathered from over 100 tape-recorded interviews with children and adults about their sexual development as well as other information gathered from therapy sessions. His study focused on fantasies, sexual interactions, and the frequency, pattern, sensations, and onset of masturbation in children. He concluded that children begin masturbatory behavior in infancy when sexual arousal is usually discovered accidentally. Further, Langfeldt notes that once children begin masturbating they rarely stop, and their pattern remains relatively unchanged through their life.

Litt and Martin (1981) concur with Langfeldt's results, finding that normal sexual behaviors begin soon after birth as the infant develops awareness of the clitoris or penis. Vaginal lubrication and penile erections are also common in infants and by a child's first

year, self-stimulation becomes more purposeful.

The Kinsey Reports were based on case histories detailing the sexual experiences of both men and women, gathered by nine investigators over a period of twenty-five years. The first report, published in 1948, was a study of male sexual behavior based on the case histories of 5,300 white American males. The case histories of 5,940 white females formed the basis of the 1953 report on female sexual behavior. One section of the Kinsey Report focused on pre-adolescent sexual development including sexual response and orgasm, the incidence, frequency and techniques of both heterosexual and homosexual play, and the frequency and significance of pre-adolescent contacts with adult males. The findings of the 1948 Kinsey Report indicate a wide range in the age at which the stages of sexual development are manifested in children (Ernst & Loth, 1948). This range is exemplified by the finding that the earliest phase of sexual activity for most boys is between the ages of 8 and 13. However, for some boys the phase begins in babyhood and for 10% of the boys by the time they are 5 years old. "In childhood as in youth and manhood, the Kinsey Report shows, there is such a wide range of behavior at any age that the word, 'normal' cannot be applied" (Ernst & Loth, 1948, p. 42). Thus, even today it is difficult for parents or professionals to obtain precise information on "normal" childhood sexuality. Nevertheless, the Kinsey et al., (1948; 1953) and Langfeldt (1990) studies have introduced the idea that children, even infants, exhibit sexual behaviors and provided descriptive information on children's sexual development from infancy to adolescence based on reports of both adults and children.

While these few studies on the normal sexual development in children (Friedrich

et al., 1991; 1992; Kinsey, Pomeroy, & Martin, 1948; Kinsey, Pomeroy, Martin, & Gebhara, 1953; Lamb & Coakley, 1993; Langfeldt, 1990), have highlighted sexuality as a part of childhood, there is increasing evidence that sexually abused children exhibit more sexual behavior than children who have not been sexually abused (Cohen & Mannarino, 1988; Deblinger, McLeer, Atkins, Ralphe, & Foa, 1989; Friedrich, Beilke, & Urquiza, 1987; Gale, Thompson, Moran & Sack, 1988). However, the risk associated with this conclusion is that all sexual behavior in children may be viewed as deviant (Ryan, 1990).

Recently, Friedrich, Grambsch, Broughton, Kuiper, and Beilke (1991) studied the sexual behaviors of 880 children aged two through twelve years. They examined the children's sexual behaviors using the Child Sexual Behavior Inventory to standardize parent reports about their child's range of sexual behaviors. Importantly, the sample excluded children with a history of sexual abuse. Of particular interest was that behaviors which were described as being either very aggressive or imitative of adult sexual behavior were rare. In fact, of the 880 children studied, only 10-15% were described as engaging in sexual behaviors such as masturbation, and less than 1% were reported to have either engaged in oral sexual behavior, involved others in sexual behaviors, or used objects for stimulation. Similarly, Cantwell (1988) has proposed that oral-genital contact and penetration be considered "abnormal" sexual behavior in children.

In a later article, Friedrich, Grambsch, Damon, Koverola, Wolfe, Hewitt, Lang, & Broughton (1992) compared the sexual behaviors of the non-abused children used in their previous study to that of 276 sexually abused children. Their findings support the

idea that sexual abuse is associated with families where there are greater levels of distress and fewer financial and educational resources. The authors stress the importance of considering family variables such as life stress and socioeconomic status to determine the degree to which such family variables influence the sexual acting-out of children who are sexually abused.

In another study on abnormal sexual behavior in pre-pubescent children, Pomeroy et al., (1981) studied patient records of children who were referred to a psychiatric department. Ten girls and six boys had a history of sexual problems, with five of the girls and one of the boys having reported being sexually abused. When compared to children with other conduct-disorders, the girls were victims of sexual abuse and were in a home were the father was absent more often than girls in the comparison group. There was little difference between the boys in each group. As a result, the authors suggest the importance of assessing family interactions when children present with sexual behavior problems.

Lamb and Coakley (1993) surveyed 128 women in their study of normative childhood sexual play and games. The majority of the women (85%) reported having experienced a sexual game in childhood. Cross-gender play was reported by 44% of the women, many of whom described the experience as involving coercion, manipulation, or persuasion. The aim of the study was to determine the range of games in which children engage and to determine to what extent aggression or coercion play a part in normal sexual games. The authors developed a typology of six different sexual play experiences including kissing games (6.1%), experiments in stimulation (14.3), exposure

(15.3%), playing doctor (16.3%), other (18.4%) and sexual fantasies (29.6%). Interestingly, 84% of the women reported that the games were mutual and did not involve any persuasion or coercion. Of those that were reported as involving coercion, 13% of the women recalled that they were the manipulator or coercer, and 30% reported having been coerced to play sexually. When religion and home atmosphere were taken into account, Lamb and Coakley reported that women who were from "restrictive" homes were significantly more likely to view their sexual play as abnormal and to report feeling fearful.

Classifying Sexual Behavior in Children

Part of the challenge facing therapists who assess and treat children who exhibit sexually intrusive behaviors is the lack of empirically-validated norms to equip the therapist with a guide of what constitutes developmentally appropriate or inappropriate sexual behavior in children. However, several researchers/clinicians have developed frameworks that classify children's sexual behavior. Four of the more prominent models are presented.

First is a framework developed by Ryan, (1990) which presents sexual behavior ranging from normal, to "yellow flags", to "red flags" to "no question" or abusive behavior. In this model, sexual behavior in children may be exploratory, imitative, or reactionary. When evaluating sexual interactions between children, Ryan suggests that three factors be considered: consent, equality and coercion.

The second model is a definitional framework for appropriate and inappropriate

child sexual behavior (Hall, 1993b). Unlike the models presented by Ryan or Johnson (1991; 1993b) it is unique in that it takes into account whether or not the behavior is self- or other-directed. Hall does not "classify" children as belonging to a particular category but assesses the behavior in terms of appropriateness based on particular criteria. For assessment purposes, if the behavior is self- or other-directed the following criteria are important to consider: nature, extent, frequency, compulsiveness, and the context of the behavior. If the sexual behavior is other-directed, an assessment of additional factors should also be included: unequal power relationship, level of coercion or bribery, consent and secrecy. Another element unique to this model is the consideration of the impulsive and premeditated nature of the sexual behavior.

Based on years of clinical experience, Johnson (1991; 1993a) developed a model that identifies a continuum of sexual behaviors in children ranging from normal sexual exploration (group one) to children who are sexually intrusive (group four) with sexually-reactive and extensive mutual sexual behavior as groups two and three. Children may move from one group to another or may be on the border between the categories. Johnson's model appears to be the most thorough in terms of providing concrete descriptive behaviors within each group. Johnson, like Ryan and Hall, suggests considering equality and coercion when evaluating the sexual behaviors of children but also includes the motivation for the sexual behaviour, the other child's description of the behavior, response to and feelings about the sexual behavior, and the child's level of affect regarding sexuality. However, unlike Ryan and Hall, Gil and Johnson (1993) do not believe that consent is a critical factor when assessing child sexual behavior, stating

that, "young children are clearly not capable of giving informed consent, and assessing whether or not a victimization has occurred based on this variable is totally unacceptable" (p. xvi).

Berliner, Magnus, and Monastersky (1986) have also developed criteria to assess inappropriate sexual behavior in children. This model is different from the previously discussed frameworks in that appropriate sexual behavior is not described. However, like Johnson and Ryan, they conceptualize sexual behavior in children as existing along a continuum with the most severe labeled as "coercive sexual behavior" a category which includes elements of aggression. Coercion is not present in the second level labeled "developmentally precocious sexual behavior". The final level is labeled "inappropriate sexual behavior". At each level, Berliner and colleagues provide behavioral descriptions and criteria to assess the intervention required.

Before concluding this section, a note on age difference as a criteria for assessing sexual behaviors between children is necessary. While Johnson (1988; 1989) and Friedrich and Luecke (1988) used a two year age difference between the child perpetrator and child victim as a criteria in their studies on children who are sexually abusive towards other children, many other authors advocate that age difference is not significant. Rather, size and intellectual differences between children are more important considerations (Berliner et al., 1986; Hall, 1993b; Ryan, 1990; Russell, 1986). In fact, Ryan (1990) states that, "as the age of the perpetrator gets younger, and the age difference becomes less, additional criteria are needed" (p. 6).

In summary, the criteria in all four models are similar with the exception of

consent. Coerciveness appears to be one of the most significant criteria in all the models. Three of the four authors include normal sexual behaviors as part of their framework. The major differences are the organizational framework and presentation of each, reflecting the unique conceptualizations of important variables.

The Development of Sexual Behavior Problems in Children

There is no empirical data which conclusively explains how sexual behavior problems develop in children, yet several hypotheses offer partial explanations. Of these clinically documented factors, prior sexual victimization appears to be the primary factor considered in the development of problematic sexual behaviors in children (Cantwell, 1988; Friedrich & Luecke, 1988; Johnson, 1988; 1989; Pierce & Pierce, 1987). Although prior victimization is acknowledged as a main contributing factor, the mechanisms by which the child will move from being a 'victim' to exhibiting perpetrating behavior are unclear.

Some authors view this victim-victimizer process through a "trauma lense". When a young child has been traumatized s/he may reenact the trauma through play or action, typically referred to as post-traumatic play (Terr, 1990). The reenactment is believed to be an attempt to process the traumatic event (Hall, 1993b; Terr, 1990; Van der Kolk, 1989), and is characteristic in children with post-traumatic stress disorder (PTSD). However, it should be noted that of children who are sexually abused, only 48% are thought to develop PTSD symptoms (Mcleer, Deblinger, Atkins, Foa & Ralphe, 1988). Similarly, Rasmussen et al. (1992) suggest that children who have been sexually

victimized or who have been exposed to inappropriate sexual stimuli, have choices as to how to respond to the trauma, with one of the choices including acting-out sexually towards other children. The inclusion of exposure to inappropriate sexual material is recognized by other authors as well (Berliner, as cited in Wachtel, 1992; Friedrich, 1990; Johnson, 1993a).

Another aspect of the development of sexual behavior problems in previously victimized children, not entirely distinct from trauma, is the child's learning of sexually intrusive behaviors. Both Yates (1991) and Finkelhor and Browne (1986) theorize that sexually abused children often learn sexually inappropriate behavior as a result of sexual victimization. For example, a child may be rewarded by the offender through the exchange of affection or gifts during the time of the abuse. The child may then learn to exhibit sexually intrusive behavior in an effort to meet his/her developmental needs (Finkelhor & Browne, 1986).

Other than learned behavior or responses to trauma, several authors consider power and control to be factors when a child moves from being a victim to a victimizer. Ryan (1989) regards power and control issues as responses to prior abuse and triggers for abusing others. Lane (1991) believes that some victims of sexual abuse will abuse others in an attempt to gain control in order to compensate for the loss of power during their own victimization. Lane and Ryan have both primarily conducted research with adolescent sex offenders, however, their hypotheses are often considered useful by therapists working with children under the age of twelve.

Factors other than prior sexual victimization are also considered relevant to the

development of sexual behavior problems in children (Johnson, 1993a). In his review of the literature, Wachtel (1992) indicated that the victim-to-victimizer hypothesis is insufficient to account for the development of all sexual behavior problems in children. Citing other authors (Berliner, 1991; Finkelhor, 1987; Friedrich, 1991), Wachtel notes that a background of sexual victimization is not always present. Similarly, Yates (1991) believes that some nonmolested children also exhibit "erotic behavior" as such behavior is also influenced by biological and gender variables as well. Further, she states that sexual compulsion, while rare, is another path by which such behaviors can develop.

Many authors consider a range of child, family, and socialization variables that contribute to the development of sexual behavior problems. Considering child variables, Rasmussen et al. (1992) identify four precursors in combination with prior sexual trauma which contribute to the development of sexual behavior problems in children: social inadequacy; lack of intimacy; impulsivity; and lack of accountability. Gil (1993a) identifies specific family dynamics such as poor family cohesion, inadequate parental nurturance, lack of clarity around sexual matters, and inappropriate sexual boundaries as possible contributors to the development and/or maintenance of the child's molesting behavior. Healy, Fitzpatrick and Fitzgerald (1991) concluded that rather than prior victimization, it was the mother's attitudes towards sexuality which contributed to her child's sexual behavior problems. The socialization process that includes the development of empathy and the sexualization of emotional expression, are also considered to be etiological variables (Pearce, 1991).

In summary, none of the hypotheses about the development of sexual behavior

problems have been systematically tested nor do they differentiate between factors that precipitate the behavior and factors that sustain it (Gil & Johnson, 1993). There does appear to be agreement that prior victimization, as a contributing factor, influences the development of sexually intrusive behaviors in children, along with a combination of other family or individual variables.

Typologies of Sexually Intrusive Children

To further our understanding of children who exhibit sexually intrusive behavior, two preliminary typologies have been developed. Rasmussen (cited in Wachtel, 1992) developed a typology primarily defined by the ages of the sexually intrusive children for the purpose of assigning responsibility to specific agencies for their services. Embedded in the typology is the belief that the younger the child, the more likely the behavior is abuse-reactive. Rasmussen describes children aged eight years and under as "sexually reactive" and children aged nine to twelve as "pre-adolescent offenders". Within each category the behaviors are further described as victim, delinquent, or family perpetrator. While the breakdown by age may be helpful with respect to assigning agency responsibility to these children, the categories are confusing for three reasons. First, the children are initially divided into two categories as either sexually reactive or offenders depending on age, followed by three types of "perpetrators" in each category. This raises the question of why the children are viewed as victims or as offenders, which is not clarified in the typology. Second, a "family perpetrator" could also be a victim or delinquent perpetrator, therefore, category placement is not exclusive. Third, a family

perpetrator is defined according to choice of victim, while victim and delinquent perpetrator refer to the development of the sexually intrusive behaviors.

Johnson (1993b) has also developed a preliminary typology of children who are sexually intrusive but for a different purpose than Rasmussen. Johnson's intention was to develop a typology for the purposes of risk assessment, assisting therapists in developing appropriate treatment plans. First, two primary paths by which the sexually intrusive behaviors develop are described based on the child's sexual behavior rather than age. One path suggests that the child is reacting sexually because of prior victimization or because of a sexually confused environment. The child is no longer able to cope, as needs for stability and nurturance are not being met. The second path describes children who are engaging in mutually agreed upon sexual behaviors which progress into sexually aggressive behavior. The second component of this typology is a description of the various "subpopulations" of children which includes detailed information on who the child victimizes and how the child's life experiences contribute to the sexually intrusive behavior. Johnson's typology illustrates that a variety of sexually intrusive behaviors can occur to varying degrees even though the development of the behaviors may be similar.

The deficiencies of these and other typologies (Lane, 1991; O'Brien & Bera, 1992) have been outlined by Hall (1993a). First, all consist of many "non-mutually exclusive categories" (p. 5) and were developed primarily from clinical observations rather than empirical research. Therefore, none have been validated or tested. Second, the majority of typologies other than Johnson's were developed more for the criminal justice and social service systems than for treatment providers, thus, their usefulness in

counselling is questionable. Finally, the typologies are inconsistent and confusing as some are based on the characteristics of offense behavior, others on the offenders's choice of victim or on the variables of the offender's background, or on a combination of factors.

The typologies illustrate both the heterogeneity of the class of sexually aggressive children and the extent and severity of the sexually aggressive behaviors exhibited. Friedrich (1990) believes that the development of a framework is important stating that, "a typology is useful to the extent that it can provide concrete descriptions of behaviors, personality and family correlates, and motivations for each type of offender" (p, 248). While only based on clinical impressions of respected therapists, such frameworks suggest the appropriateness of particular assessment and treatment strategies. Research to validate and refine these typologies is required but, to date, has yet to be completed.

Summary

The foundational research based on both sexually aggressive children and sibling incest studies provide an emerging conceptual picture of both the children and the families who have experienced significant emotional, sexual and physical abuse. Family variables are believed to play a significant role in the development and maintenance of sexually intrusive behaviors in children aged 12 and under. With a number of terms identified for describing the behaviors of these children, the term sexually intrusive was selected for this study as it reveals the seriousness of the sexual behavior, including both aggressive and non-aggressive sexual abuse of children by children.

The recognition of children's sexuality is slowly being elucidated by further

research into children's sexual development. At the same time, frameworks to classify the range of sexual behaviors in children are being developed. Hypotheses to explain the development of sexually intrusive behaviors, while varied and unsubstantiated, suggest that prior victimization and/or witnessing inappropriate sexual material appear to be the central contributing factors. The few typologies of sexually intrusive children provide descriptions of children in extremely negative, inconsistent, and abusive relationships with parents.

Considering the relatively recent interest in researching the current problem area, the initial studies have provided a consistent emerging picture of children who exhibit sexually intrusive behavior and their families. These studies have provided some of the initial groundwork required for further investigation, however, it is important to acknowledge that the studies are scant and are based on the clinical experiences of relatively few authors.

CHAPTER TWO

THE LITERATURE: ASSESSMENT AND TREATMENT OF SEXUALLY INTRUSIVE CHILDREN

To date, empirical knowledge regarding what treatment model provides the most effective intervention with children who exhibit sexually intrusive behavior is sparse. The majority of published reports on treatment programs are based on the clinical experiences of the authors rather than research (Cunningham & MacFarlane, 1991; Friedrich, 1990; Gil & Johnson, 1993; Johnson & Berry, 1989; Lane, 1991). In his review of the literature, Wachtel (1992) cited a number of authors who have presented material at conferences on the assessment and treatment strategies presently being utilized with these children (Ballester & Pierre, 1989; Berliner, 1991a, 1991b; Cunningham, 1991; Friedrich, 1991; Gray, 1991a; 1991b, 1991c; Issac, 1986, 1991; Monastersky, 1986; Rasmussen, 1991). Gil and Johnson (1993) have written the first full-length volume containing pertinent theory, practice and networking that is required to best serve children who are sexually intrusive and their families.

This chapter reviews the assessment literature, including the various structured assessment tools presently being used with these children and the central components of assessment. This will be followed by a review of the treatment programs currently utilized with children who exhibit sexually intrusive behavior.

Assessment

As the literature regarding the classification of sexual behaviors in children has been discussed in Chapter One, this section will focus on the literature describing the assessment process of children who exhibit sexually intrusive behavior and their families, followed by a description of two primary standardized instruments used for assessing the sexual behaviors in children.

Johnson (1993d) and Johnson and Berry (1989) outline a thorough clinical evaluation of children with sexual behavior problems and their families, which includes a three part process. First, prior to the initial interview with the parents, Johnson asks the parents to complete several standardized measures to assess their children's behavior and their own parenting skills. The interview with the parents includes an assessment of the parental reactions, feelings, and levels of concern about the child's sexually intrusive behavior. Further information is collected with respect to the child's early history, parents' history, physical violence, family boundaries, religion, and culture. Information is also gathered from other adults or siblings who live in the home as well as from protective services, police, foster or group home providers, and mental health professionals. The second part of the assessment process involves an interview with the referred child, which is detailed and specific to sexuality, as well as to other aspects of the child's life. During this initial meeting, a battery of standardized tests are completed with the child for the assessment of the type and severity of the sexual behaviors. Assessment of these variables is critical to understanding the breadth of the problem, however other aspects of the child's life such as developmental level and the child's view

of self are also important and may be assessed. Finally, in order to assess the family's interactional style, an interview is conducted with the entire family, during which the sexual behaviors of the child are discussed, any questions regarding the treatment process are answered, expectations are clarified, and rules regarding confidentiality are described.

Friedrich (1990) utilizes a similar process, but in less detail and with less focus on standardized assessment instruments. The first step is to determine whether or not the child's sexual behavior is within the "normal" range. Secondly, Friedrich assesses the family's reaction to the child's sexually intrusive behavior and the meaning that they attach to the behavior. Thirdly, it is considered critical to assess the parent's ability to protect the children. In comparison, the family appears to be central to Friedrich's assessment style while Johnson appears to consider a more equal evaluation of parents, child and family. Other authors who specialize in treating sexually intrusive children utilize assessment processes similar to both Friedrich and Johnson (Cunningham & MacFarlane, 1991; Lane, 1991).

Two instruments have been developed primarily to be used to assess the extent and severity of sexual behaviors in children. These measures may also serve to monitor the progress of parents and children throughout the treatment process. These structured instruments are the Child Sexual Behavior Inventory (CSBI) developed by Friedrich and colleagues (1992) and the Child Sexual Behavior Checklist (CSBCL) developed by Johnson (1992). The CSBI is a thirty-six-item measure that assesses a wide range of sexual activities. The CSBCL is an assessment tool that is to be completed by the primary caregiver and contains over 150 sexual behaviors of children ranging from age-

appropriate sexual exploration to behaviors that are indicative of severe sexual problems. These instruments are relatively new and appear to have been used in only two studies by their respective authors.

Treatment

There is little published material regarding the treatment of children who exhibit sexually intrusive behavior. Several publications in which clinicians report their experience of working with children who exhibit sexual behavior problems are available including works by Johnson (1990; 1991; 1993a), Johnson and Berry, (1989), Gil and Johnson (1993), Friedrich (1990), Ryan, (1990) and Cunningham and MacFarlane (1991). This section includes a description of some of the modalities currently being utilized to treat sexually intrusive children, a discussion on the debate between individual and group treatment modalities, and finally, a review of a primary issue regarding the treatment of a child as both victim and victimizer.

Current Modalities

In 1991, Ryan mailed a survey to members of the National Adolescent Perpetration Network (Ryan, 1992) collecting information from those who had treated children with sexual behavior problems. Of the 25 members who identified themselves as having treated more than one child from the ages of 4-11, 19 reported using group as their primary modality. Of these, 15 used group in combination with play therapy or a psychoeducational approach. Eight stated that they used only one primary mode of

therapy (four used group, three only psychoeducation, and one play therapy). These results, in part, reflect the treatment programs described in the literature. Interestingly, family therapy was not reported as being utilized by the respondents, although it is considered an important component by some authors (Johnson & Gill, 1993; Friedrich, 1990). This section will describe four of the most commonly cited treatment programs noting the differences and similarities in treatment modalities.

Lane (1991), Cunningham and MacFarlane (1991), and Johnson and Berry (1989) each utilize group as their chief mode of therapy for children with sexually intrusive behaviors. Johnson and Berry divide the children by gender and into three age group categories: 5-7, 8-10 and 11-13, while Lane divides the children into two groups of 7-8 and 9-10. Cunningham and MacFarlane also separate the groups by gender but do not mention age. The founders of all three programs suggest that a combination of male and female group co-leaders is the most effective. The size of group varies, though, with Johnson and Berry limiting the group to five children, Lane to six with at least two to three therapists, and Cunningham and MacFarlane to eight or nine children. All of the groups are described as highly structured with similar goals, some of which included developing problem solving and social skills, correcting thinking errors, and learning impulse control and perspective taking. Johnson and Berry also report providing groups for parents, the victimized sibling, and for non-victimized siblings. Cunningham and MacFarlane highly recommend that a parent's group be conducted at the same time as the children's meet.

In contrast, Friedrich (1990) considers the management of sexually reactive and

aggressive behaviors of children as most effectively treated within the context of the family rather than by group modality. Using both individual and family therapy, Friedrich draws primarily from social learning, behavioral, and psychodynamic theories to treat these children and their families. He utilizes a family-wide behavioral program and various family therapy techniques such as considering the symptom in the context of the family and reframing the child's behavior. Addressing any parental history of chemical dependency and unresolved abuse is also an integral part of the treatment plan.

In subsequent work, Johnson, with Gil, published a thorough and comprehensive treatment program for children with sexually intrusive behaviors (Gil & Johnson, 1993). Together they describe a holistic approach to treatment that appears to combine the above-described group, family, and individual treatment modes. Although they still consider group therapy to be the "pivotal component of effective treatment" (p. 179), a combination of individual, group and family treatment is offered depending on the outcome of the assessment. Gil and Johnson consider individual therapy for the child to be beneficial for three reasons. First, if group therapy is contraindicated, individual therapy would be beneficial for addressing the treatment needs of the child. Second, it can be used in conjunction with group in that specific issues or concerns that arise in group can be further addressed in individual sessions. Third, once the acting-out sexual behaviors subside, other underlying issues may arise and can be addressed in-depth by the individual therapist.

Like Friedrich, Gil and Johnson view treating the family as critical to the curbing the sexually intrusive behaviors in children. Due to the often problematic nature of the

relationships among families with children who exhibit sexually intrusive behavior, Gil and Johnson complete a comprehensive assessment of the family to determine patterns and interactions that contribute to the maintenance of the molesting behaviors. The assessment is followed by family therapy. Gil states that, "attempts to curtail the behavior must be negotiated within the family system, which has inherently contributed to the emergence and maintenance of the problem behavior" (p. 275). These sessions deal with the family's response to the abuse, how they view the sexual behavior problem, what steps they are willing to take towards prevention of further abuse and what each family member has discovered about their own contribution to the problem. Some of the goals when working with these families include: 1) providing strategies of how to interrupt the patterns that have contributed to the problem; 2) focusing on and tapping into family strengths; and 3) preparing the child and family for an apology to the child victim (Gil & Johnson, 1993).

Individual and Group Treatment Modalities

In light of the treatment programs described, there is a debate regarding the appropriateness of individual and group modalities for children who exhibit sexually intrusive behavior. Group treatment is presently enjoying wide acceptance as an effective mode of therapy (Cunningham & MacFarlane, 1992; Gil & Johnson, 1993; Johnson & Berry, 1989; Lane, 1991) and has been considered highly effective in confronting issues of both isolation and the "damaged goods" syndrome that are so pervasive with children who are both sexually intrusive and victimized (Cunningham & MacFarlane, 1991). As

well, when children who are sexually intrusive choose to act out against another child, it is interactional in context, therefore the group format, which is similarly interactional, allows group members to help each other understand and work on their problems (Johnson, 1990).

However, Friedrich (cited in Gil & Johnson, 1993) cautions treatment providers, "that sexually reactive children are also behaviorally more reactive in group settings, and we owe it to them not to retraumatize them in treatment" (p. xi). Friedrich describes utilizing "pair therapy" with sexually aggressive children and reports better results when using this combination of a structured setting and two children rather than a larger group. He states that including more children, "would have been both overwhelming and invited rejection" (p. xi). Other authors support this view and have gone so far as to completely abandon group treatment, "because they find that the young boys in particular are overstimulated in this context and pose too many management problems" (Berliner, 1991 cited in Wachtel, 1992, p. 26). Interestingly, although Gil (1993b) also believes that the group context stimulates children who are sexually intrusive to act out sexually in the presence of other children, she views this as "a unique opportunity to make interventions with inappropriate behaviors as they occur" (p. 180).

Individual therapy for children is generally considered as an adjunct to other treatment modalities (Cunningham & MacFarlane, 1991; Friedrich, 1990; Gil & Johnson, 1993). However, there are significantly different beliefs as to why the individual modality may be useful. Yates (1987) advocates for a psychodynamically oriented individual therapy approach with eroticized children that relies on the close therapeutic

relationship and transference reactions to promote healing in the child. While stating that individual therapy can be a valuable adjunctive modality to group and family therapy, Johnson (1990) also identifies possible adverse effects, stating that, "individual therapy can be overstimulating and confusing for children with sexual acting out problems. It can create tension and anxiety in these children to be in a closed room with an adult talking about sex" (p. 69). For this reason, Johnson believes that specific discussions of sex and sexuality are handled best in the context of group therapy.

One aspect of treatment that deserves mention is relapse prevention, a self-management model for the maintenance of behavior change in sexual behaviors. While relapse prevention is a major component of adolescent and adult treatment (Gray & Pithers, 1993; Pithers, Kashima, Cumming, Beal, & Buell, 1988) most of the treatment programs described for children with sexual behavior problems and their families do not discuss relapse prevention per se. This may be attributed to the need to rely less on self-management techniques with younger children and to rely more on the child's family for supervision, guidance and limit-setting. Therefore, to ensure the successful outcome of treatment the family must be involved in continued prevention of further abusive behavior. The only authors who have applied relapse prevention techniques in treating sexually intrusive children are Gray and Pithers (1993) who are in the preliminary stage of modifying a relapse prevention model to meet the needs of this population.

Victim-Victimizer Treatment Issues

While treatment providers agree that the reduction of sexually intrusive behaviors is the primary goal when working with this population, there are differences expressed about how to achieve this objective, particularly with treating both the victim and victimizing behaviors. The major questions when working with a child who has been both victim and victimizer, are how and when does the therapist address the "victim" issues.

As previously stated, the majority of children who are sexually intrusive have experienced prior trauma (Johnson, 1988; 1989). The outcome of having been sexual victimized is that it may trigger offender behaviors followed by the emergence of a "dysfunctional response cycle" (Ryan, 1989, p. 329). When children are both victims and victimizers what issue should be dealt with first? Johnson (1993d) suggests that both issues can be addressed simultaneously and throughout treatment rather than dealing with each separately. Her concern with dealing with the child's victimization first is that the child could see their perpetration as a direct result of their victimization and believe that they will always abuse. Conversely they may use their victimization as a way to rationalize their perpetrating behavior. James (1989) supports this view that both victim and victimizer issues must be addressed simultaneously while remaining both "tough and tender" (p. 85) as a therapist. Further, while past victimization may explain sexual offending behavior, the child victim needs to be held accountable for current thoughts and behaviors (Ryan, 1989).

Cunningham and MacFarlane (1991) believe that although these children may have

been victimized, it is not appropriate to include them in a victims' treatment group because the issues for child victims who abuse and those who don't are different. They state that the major treatment goal with abuse-reactive children is the reduction of aggression and anger toward others, in contrast to the major treatment goal for child victims, who may need to be encouraged to express appropriate anger. Rather, these authors suggest offering groups for children with similar backgrounds.

Regardless of treatment modality, most authors agree that treatment must be comprehensive and dual-focused, dealing not only with issues around the current sexually intrusive behavior but also issues regarding past victimization (Cunningham & MacFarlane, 1991; Friedrich, 1990; Gil & Johnson, 1993; James, 1989; Terr, 1990).

Before concluding this chapter, a description of a study currently underway in the United States is warranted. A five-year treatment outcome study conducted jointly by the Department of Pediatrics, University of Oklahoma Health Sciences Center in Oklahoma City, OK and the Sexual Assault Center, University of Washington in Seattle, WA began in 1992 (Bonner, Walker & Berliner, 1992). The treatment consists of a 12-week, one hour treatment group for children ages 6-8 and 9-11 and a separate group for the primary caretakers. Two treatment modalities are being compared: a highly structured cognitive behavioral approach that addresses directly the inappropriate sexual behavior, and a relatively unstructured dynamic play therapy approach that only addresses the inappropriate sexual behavior when brought up by the child. The treatment outcomes will be compared to determine which is more effective.

Summary

This review of the treatment literature reflects the rudimentary state of understanding children with sexual behavior problems. Researchers and treatment providers are only beginning to learn about the development of sexually intrusive behaviors and effective assessment and treatment strategies for these children.

When assessing sexually intrusive behavior, clinicians rely on the parents to provide information on the child's sexual behaviors as evidenced by the fact that the two primary instruments for assessing the extent and severity of sexual behavior problems in children are filled out by the primary caregivers. The assessment of parental variables such as prior history of abuse, boundaries, and parental reactions to the disclosure of the child's perpetrating behaviors are also critical to the understanding of the children's sexual behavior problems.

The treatment literature consists primarily of the descriptions of programs developed by several treatment providers who have recounted their work with this population based on years of clinical experience. While there are varying opinions regarding the efficacy of one mode over the other, the majority advocate using a group modality with individual and family treatment as adjuncts to treatment. Focusing on both victim and victimizer issues simultaneously along with a direct approach to addressing the sexual intrusive behaviors is also recommended. The literature reviewed in this chapter highlights the importance of the family component in treatment with the majority of the authors agreeing that, "sexual victimization and perpetration by children are family problems and should be regarded as such by treatment providers" (Cunningham &

MacFarlane, 1991, p. vi).

Although these chapters have provided as detailed as possible a look at the central issues with respect to identifying, assessing and treating sexually intrusive children, much of the material has been written by only a few authors. Furthermore, the published literature is primarily descriptive. Virtually no research has been conducted to provide guidance to practitioners who are responsible for treating these children and preventing the victimization of others.

Rationale for the Current Study

The knowledge base about children who exhibit sexually intrusive behavior is not extensive. With the growing numbers of children under the age of twelve who abuse other children being brought to treatment providers, further research is needed. Data on the characteristics and treatment issues of these children is sparse. The foundational studies provide an emerging picture of the characteristics of these children and their families, generating even more questions regarding what are the important variables in the development and maintenance of sexually intrusive behaviors, what impact has sexual trauma on the child's development, and how effective are the current treatment methods. The aim of the current study is to contribute to the social work knowledge base of this under-researched problem.

The rationale for collecting data by interviewing treatment providers is threefold. First, access to children and families who would agree to participate was viewed as an obstacle to the study's researchability. Second, it was anticipated that researchability

would be enhanced as access to treatment providers was assessed to be more readily available. Third, because the focus of this study was on the assessment and treatment of children who are sexually intrusive, the treatment providers were judged to be able to provide such valuable information.

The current qualitative study grew out of the recognition that little has been researched or written about children who are sexually intrusive and their families. The aim of the study is to gain insight into the assessment and treatment of these children, based on the expertise of professional treatment providers. Abstracting important knowledge gained from the practice of treatment providers is seen as a viable avenue in which to support the aim of the study. "We have not thought of the practitioner as knowledge builder, yet no social worker is in practice very long before the accumulation of expert knowledge from practice experience" (Lang, 1994, p. 277).

CHAPTER THREE

A QUALITATIVE INQUIRY

"Qualitative research is a craft...The researcher is a craftsperson"
(Taylor and Bogdan, 1984, p. 8).

I have chosen a qualitative approach to explore treatment providers' views on treating children who exhibit sexually intrusive behavior as it is the research question which guides the choice of research methods used (Miller & Crabtree, 1994; Patton, 1990; Schatzman & Strauss, 1973). The fit between the current study and qualitative inquiry is evident for two reasons. First, because qualitative methods are particularly appropriate for exploration, discovery and inductive logic (Patton, 1990), the current study lends itself to these methods since the paucity of research and literature, as described in the previous two chapters, indicates that we are only beginning to discover what are some of the important variables and questions when assessing and treating children who are sexually intrusive. Furthermore, qualitative methods allow for:

> the important analysis dimensions to emerge from patterns found in the cases under study without presupposing in advance what the important dimensions will be. The qualitative methodologist attempts to understand the multiple interrelationships among dimensions that emerge from the data without making prior assumptions or specifying hypotheses about the linear or correlative relationships among narrowly defined operationalized variables (Patton, 1990, p. 44).

Second, an underlying principle of the qualitative method is that the researcher gets close to those people studied (Schatzman & Strauss, 1973) which corresponds with the study's

intent to understand the treatment providers' views, beliefs and experiences with children who exhibit sexually intrusive behaviors.

Several authors encourage us to be our own "methodologist" following guidelines but never rules (Miller & Crabtree, 1994; Patton, 1990; Taylor & Bogdan, 1984; Schatzman & Strauss, 1973). "The field researcher is a methodological pragmatist. He sees any method of inquiry as a system of strategies and operations designed - at any time - for getting answers to certain questions about events which interest him" (Schatzman & Strauss, 1973, p. 7). As a methodologist, I have chosen to follow a generic approach to qualitative inquiry. This approach is clearly outlined by Schatzman and Strauss (1973) serving as the guiding principle in this study.

Some streams of qualitative research, as well as conventional research, make a priori statements of the theories that underpin their study, however, this study will not be aligned with any particular theoretical framework. This decision is supported by Patton (1990), who makes it clear that it is not always necessary to align your study with any epistemological perspective to use qualitative methods. He states that, "not all questions are theory based. Indeed, the quite concrete and practical questions of people working to make the world a better place can be addressed without placing the study in one of the theoretical frameworks in this chapter" (p.89). The decision to avoid any prior commitment to a specific theoretical framework is also encouraged and supported by several authors who do not align themselves with any particular paradigm (Berg, 1989; Glesne & Peshkin, 1992; Lincoln & Guba, 1985; Lofland & Lofland, 1984; Patton, 1990; Marshall & Rossman, 1989; Miller & Crabtree, 1994; Schatzman &

Strauss, 1973; Taylor & Bogdan, 1984).

To ensure a sound research design I will provide a rationale for the following decisions grounded in the methodological literature and the research questions: 1) literature review; 2) sample selection logic; 3) justification for data collection; 4) justification for data analysis; 5) trustworthiness of overall inquiry; 6) consideration of ethical issues; and 7) strengths and limitations of the study. First, the researcher's point of view and ethical issues will be considered.

Researcher's Point of View

Each researcher must bring to awareness his/her own values, attitudes and beliefs in order to confront the issues of objectivity and personal bias (Locke, Spirduso, and Silverman, 1987) while at the same time maintaining a stance of "balance and fairness" (Lincoln and Guba, 1985, p. 192) or "empathic neutrality" (Patton, 1990, p.55).

I bring with me a set of beliefs and values to this research project and will address them here in as much as I am able to see the potential for their influence on data collection and data analysis processes. I have worked as a social worker in varying capacities over the past seven years during which time I have developed a particular set of beliefs about victims and perpetrators of child sexual abuse in general and children who exhibit sexually intrusive behaviors in particular. I believe that children who are sexually intrusive need to be treated within the context of the family. While I believe that the child is responsible for his/her behaviour, I also believe that the caretaker is responsible for providing these children with supervision and protection to minimize the

opportunity for future offending. I must continually be cognizant of beliefs such as these during the research process with hopes of decreasing researcher bias and allowing the data to emerge freely from the informants. While my experiences have the potential to determine what I chose to hear and select as important in the interview and influence my interpretation of what the informants relay to me, the same professional experience may also prove to be helpful as a source for theoretical sensitivity (Strauss & Corbin, 1990). Being familiar with the assessment and treatment of this population assisted me in understanding what the informants were saying and had the potential for providing me with a more meaningful interpretation of the data.

Ethical Issues

"Ethical considerations should always be at the forefront of naturalistic research" (Erlandson et al., 1993, p. 89). There are several ethical obligations that must be met, but first it must be stated that any research should not proceed without respect, sensitivity and integrity for the individuals under study (p. 156). This was demonstrated through notice of informed consent, an acknowledgement of appreciation of their time and commitment by way of a thank-you note following the interview, and continued sensitivity and awareness of the use of their time during interviews and telephone contacts.

Before consenting to the study, all respondents were informed of potential issues regarding confidentiality, the nature of the interview process and informed consent during the initial telephone contact. At the outset of the interview, the informants were

presented with the Consent Form document (see Appendix A) which advised them of the purpose of the research, that no identifying information about themselves or their clients would be included in the written document, that participation in the study was voluntary, and that they could withdraw from the research process at any time. Informally, the respondents were advised of further safeguards for their protection in that all taped interviews would be stored safely within the researcher's home. At the completion of the study, the tapes would be destroyed and any identifying information related to case examples would be eliminated or disguised in the written research. Pseudonyms were used within the text of the study when quoting directly from the respondents.

The ethical standards outlined in the Canadian Association of Social Workers Code of Ethics (1994) were firmly adhered to throughout the research process. All ethical issues mentioned above were addressed and submitted to the Ethics Committee of the Faculty of Social Work, University of Calgary and met with the Ethics of Human Studies (1986) requirements and subsequently approved.

Literature Review

Although there appears to be inconsistency within the literature regarding when and how to utilize a literature review in qualitative studies (Glesne & Peshkin, 1992; Patton, 1990), there is consensus among some researchers to complete a preparatory literature review prior to the study (Berg, 1989; Patton, 1990; Chenitz & Swanson, 1986; Glesne & Peshkin, 1992; Marshall & Rossman, 1989; Taylor & Bogdan, 1984; Tutty, Rothery, & Grinnell, in press). This is a logical decision, if it is true, that the research

question, which may in part develop from the literature, guides the research process. The literature review for the current study was completed in the following three steps, each with a particular intent. The first step was a preparatory literature review which served several purposes. First, it served to assist in determining the scope, range and type of research already completed on children who are sexually intrusive. Second, it allowed me to become knowledgeable about related research and the theories that surround and support this study which provided direction during the research process. Third, it served to identify gaps in the problem area that, in part, guided the design of this study. Although the literature review validates the use of qualitative methods for the current study, Chenitz and Swanson (1986) suggest maintaining a, "cautious and sceptical attitude about the literature throughout the study" (p.4). It is important to remain aware of how the previous literature may influence the study at every step of the research process in order to minimize its' influence in how the data is analyzed. Doing so helped to ensure that the coding and analysis process, rather than the literature review, determined the research focus. This is important as the, "literature is conceived of as data and not viewed as inherently 'true'" (Chenitz & Swanson, 1986, p. 45).

The second step was an ongoing review of the literature throughout the data collection and analysis phase to ensure that recent relevant information was included. For example, this process included reviewing the literature regarding children's sexual development and the impact of trauma on children. These issues were identified by the informants as significant throughout the data collection and analysis phase.

Finally, once data collection and analysis was completed a final review of the

literature was conducted to determine if any new literature was available and to present my findings in the context of other work. Towards the end of the study it became evident that many of the children chose siblings as victims which led me to review the literature on sibling incest. This further material added an important dimension to the discussion of the results. As illustrated, there was a return to the literature throughout the study, however, the purpose changed (Chenitz & Swanson, 1986; Marshall & Rossman, 1989).

Selection of Informants

Selecting individuals for a qualitative study is a critical task for the researcher. Erlandson, Harris, Skipper and Allen, (1993) believe that the informant, "should be considered a full partner in the study" (p. 89) and Reason and Rowan (1981) state that, "true human inquiry needs to be based firmly in the experience of those it purports to understand, to involve a collaboration between 'researcher' and 'subjects'" (p. 113). In the current study these individuals will be referred to as "informants". They understand the culture, are reflective of it, and are able to explain the nature of it to the researcher (Merriam, 1988, cited in Erlandson et al., 1993).

Central to qualitative research is purposeful sampling which is the method of choice for the current study. Purposeful sampling includes the task of selecting "information rich cases" (Patton, 1990, p. 169) for in-depth study. Patton (1990) offers several strategies for selecting information rich cases from which snowball or chain sampling and criterion sampling (p. 176) were chosen. Snowball sampling as a strategy

for purposeful sampling aims at selecting key informants who will provide rich information. This sampling strategy is particularly useful when the researcher is "interested in a very special population of limited size and only knows of a handful of appropriate persons from that population" (Seaberg, 1985, p. 145). I began by asking colleagues currently working in the social work field, who were the key treatment providers for children with sexual behavior problems. Some names were mentioned repeatedly, from whom I chose my population of treatment providers. As well, informants also provided me with names of individuals working with this population.

"Criterion sampling" (Patton, 1990, p.176), which requires that the informants meet particular important criterion, was also utilized as a sampling strategy. Prior to beginning the interviews, the extent of the experiences of the treatment providers was unknown and it appeared that expertise with this population was limited. However, to ensure the quality and the richness of cases, it was decided after the first three interviews that only treatment providers who had experience with at least five children and their families would be used. Further criteria included that the informant was a "treatment provider" meaning any professional person who is contracted by a client, or sanctioned by a social service agency (Compton & Galaway, 1989) to provide therapy to children who exhibit sexually intrusive behavior.

The most commonly cited guideline regarding sample size is that, "*There are no rules for sample size in qualitative inquiry*" (Patton, 1990, p. 184, emphasis in the original). However, sample size is guided by three factors: the research purpose; usefulness and appropriateness of size; and feasibility issues such as resources and time.

Lincoln and Guba (1985), however, offer a clearer suggestion in that, because the purpose of qualitative inquiry is to "maximize information" (p. 202), once information starts to become redundant sampling is stopped. As I completed the seventh interview no new themes were emerging. Consequently, I chose to complete two last scheduled interviews for the study, stopping the sampling process at nine interviews. A profile of the informants who made up the sample for this study is provided in Chapter Four.

Data Collection

The unstructured interview was chosen as the data collection method. Also known as open-ended, unstandardized, intensive, or in-depth, the assumptions operant when utilizing the unstructured interview provide my rationale for choosing this method of data collection (Berg, 1989). First, it is assumed that the questions necessary for the interview are not yet known. Based on the literature review an exploratory study was deemed most appropriate as the important variables were not yet identified. As such, a structured or semi-structured interview were not selected. Rather, this study was an attempt to gather information from treatment providers with the aim of understanding their experiences, "without imposing any a priori categorization that may limit the field of inquiry" (Fontana & Frey, 1994, p. 366). The goal, therefore, parallels the goals of unstructured interviews in that this study seeks to discover the informant's experience of the topic under review and rather than determining preconceived ideas, seeks to discover what exists in the first place (Lofland & Lofland, 1984). When using unstructured interviews, "the subjects guide you into their world, the world that you the researcher, need to enter

and examine" (Chenitz & Swanson, 1986, p. 81) A second assumption of the unstructured interview is that the informants may be utilizing different vocabularies (Berg, 1989). This is true in this field of study when, for example, there is little consensus among treatment providers about what constitutes "sexually intrusive" behaviour.

The limitations and strengths of the unstructured interview itself are important to acknowledge. Unstructured interviews are less systematic, thus, leaving room to "miss" important information. Because this type of interview is less systematic, data analysis and organization can be more arduous (Patton, 1990). In contrast, one strength of the unstructured interview is that it is built on the data that naturally emerges from the informant. Secondly, the questions that are asked in response to the information provided by the informant may allow the informant to guide the interview process, allowing for the emergence of potentially new directions and information (Patton, 1990).

The Interview Process

All informants agreed to the audio-taped interview that was scheduled to be completed at their place of employment. Eight of the informants were interviewed once, with the exception of one interview which was interrupted and had to be rescheduled due to tape-recorder malfunction. Each interview was scheduled for one to one and a half hours, although one interview was two and a half hours in length.

The interviews began with introductions and the review and signing of consent forms (see Appendix A). Next, the Profile of Treatment Provider form (see Appendix

B) was completed by verbally requesting the information from the informants. This task assisted in building rapport with the informants. Each interview began with the question, "What is your experience with working with children ages 12 and under who have molested other children and the families of these children who molest?". I generally continued with comments and examples such as, "This is a very general question, please feel free to share whatever you feel is important. This could include your beliefs and ideas about these children and their families, and any issues you face when working with the population".

Probes are discussed in the literature as an important part of the interview process. "Probes are used to deepen the response to a question, to increase the richness of the data being obtained, and to give cues to the interviewee about the level of response that is required" (Patton, p.324, 1990). They take the form of silence or words or sentences (Glesne and Peshkin, 1992), all of which were utilized in these interviews.

Once all of the interviews were completed, further details on the population of children with whom the informants treated were considered important to gather. At the follow-up contact, the information on the demographic form (see Appendix C) was requested.

Data Analysis

There appears to be consensus within the qualitative literature that the researcher develops his/her own way of analyzing his/her data (Berg, 1989; Marshall & Rossman, 1989; Patton, 1990; Schatzman & Strauss, 1973; Taylor & Bogdan, 1984). Patton

stresses that although there are many approaches to qualitative data collection and analysis they serve only as a guide to facilitate the unique and creative design cultivated by the researcher. "Because qualitative inquiry depends, at every stage, on the skills, training, insights, and capabilities of the researcher, qualitative analysis ultimately depends on the analytical intellect and style of the analyst" (Patton, 1990, p. 372). I decided to utilize several strategies for coding deemed appropriate for the purposes of this study. This section is an account of the decisions made regarding data analysis and rationales which support those decisions. In order to present the data analysis process in a clear manner I have used the framework described in the work of Coleman and Unrau (in press) and have divided this section into four parts: establishing an initial framework, the preliminary plan, first-level coding, and second-level coding.

Establishing an Initial Framework

In preparation for the initial framework there are five basic tasks: deciding on analysis method and transcription of data, transcribing and formatting the transcript for analysis and consideration of ethical issues during data analysis.

"The analysis of qualitative data is best described as a progression, not a stage; an ongoing process, not a one-time event...The collection and analysis of the data obtained go hand-in-hand as theories and themes emerge during the study (Erlandson et al., 1993, p. 111). The strategy used for data analysis is the constant comparison method (Glaser & Strauss, 1967) which is the continual comparing of specific data whereby the researcher "refines these concepts, identifies their properties, explores their relationships

to one another, and integrates them into a coherent theory" (Taylor & Bogdan, 1984, p. 126).

I transcribed each of the nine interviews immediately after to within a week of being completed. Transcribing one's own interviews is supported and encouraged as it "stimulates analysis of the data" (Chenitz & Swanson, 1986, p. 77; Lofland & Lofland, 1984). During the interview I took notes of the salient themes that were being presented by the informants which also served as a place to track any important questions to follow up on. Immediately following the interview I utilized what Miles and Huberman, (1993) call a "Contact Summary Sheet" (p. 51). On this summary sheet I reviewed my notes, rewrote them to make them more legible and to become more familiar with the data, included my personal reflections and impressions of the interview, made note of any important questions that I might ask the next informant (Erlandson et al., 1993, p. 114) and made note of any other literature worth reviewing. After transcribing each interview, the verbatim transcript was entered into Word Perfect 5.2, hard copies were made and the initial reading of the interviews began. All interviews were then entered into the computer software package, Ethnograph (Seidel, Kjolseth, & Seymoiur, 1989) for numbering. With the Ethnograph printout which prepared the transcript for coding by arranging it on the left-hand side of the page, categorization of the data according to emergent themes continued. Ethical considerations were acknowledged by utilizing a code number on the printout rather than the informant's name to ensure confidentiality. All of the transcripts were subsequently returned to the informants for consideration of any additions or modifications to the interview. Relatively few changes were made by

any of the informants at that time.

The Preliminary Plan

During the initial stages of data analysis the process is guided by general rules. Two tasks during this phase of analysis includes previewing the data and the use of a journal. Prior to coding the transcripts I became familiar with all of the data by not only transcribing the interviews but by reading them several times while making notes using a reflexive journal. This journal is an account of every decision and the rationale for that decision made during the research process. It also contains a summary of my contacts with the individuals with whom I consulted throughout the study. Within my journal I kept "analytic memos" (Glaser & Strauss, 1967; Glesne & Peshkin, 1992; Strauss and Corbin, 1990) which included accounts of any references or sources quoted during analysis, descriptions of the preliminary categories on the numbered version of the transcript including the beginning general rules that guided this preliminary process, and any thoughts regarding methodology or analysis. These analytic memos were clearly identified as my own thoughts or ideas.

First-Level Coding

Initial coding includes the tasks of identifying meaning units, fitting meaning units into categories and assigning codes into categories. The majority of meaning units were paragraphs, some of which overlapped with other meaning units. I found this to be quite consistent throughout the analysis even as I moved to the second-level coding. The

second step was fitting together those meaning units that appeared similar and tentative category names were assigned. The categorization process was guided by the method of constant comparison. As I identified a meaning unit it was compared with previous meaning units and the distinction between the units determined the categories that developed. Notes were kept about the meaning of each category and the "rules" which guided the process of categorization.

Several sentences or a small paragraph formed the majority of the codes. Some of the codes fit into more than one category, therefore, allowing meaning units to be nested and overlapped. Category labels were then assigned using acronyms for most of the headings. A review of the data and the assigned categories took place prior to moving on to second-level coding. It was at this point that I had a colleague review a transcript to determine the accuracy and appropriateness of category assignment. This was a positive task as our coding systems were very similar with the majority of code assignments to categories being the same. This verification process was also completed in conjunction with my supervisor who similarly reviewed the data analysis process.

After the seventh interview few new categories were emerging. I completed two more interviews and chose to stop interviewing as "category saturation" appeared to have been reached.

Second-Level Coding

The process of second-level coding involves interpreting the meaning of the categories. All of the codes were entered into Ethnograph (1988) which served to

facilitate the analysis of the data within the context of the category rather than within the context of the interview by extracting the segment codes from all interviews into categories. Category comparisons began and the search for relationships between categories emerged from the data. The goal of second-level coding is to "integrate the categories into themes and subthemes based on their properties" (Coleman & Unrau, in press, p. 103). Two main themes with 12 subthemes resulted from this process providing the framework for the presentation of the interpretations described in the two chapters of results.

Assessing Trustworthiness

Findings must prove to be "believable" or "trustworthy" to the reader for any inquiry to be considered valid. "It must demonstrate its truth value, provide the basis for applying it, and allow for external judgments to be made about the consistency of its procedures and the neutrality of its findings or decisions" (Erlandson et al., 1993, p. 29). Together these qualities determine the trustworthiness of the study (Lincoln & Guba, 1985).

The purpose of this section is to demonstrate the trustworthiness of the current study through the use of rigorous strategies guided by qualitative methodology. In order to produce a sound and trustworthy study, qualitative researchers utilize terms such as credibility, transferability, dependability and confirmability. These terms will be discussed in the following paragraphs and replace the traditional criteria of internal and external validity, reliability and objectivity (Denzin & Lincoln, 1994).

Credibility describes how truthful the findings are (Erlandson et al., 1993; Lincoln & Guba, 1985; Marshall & Rossman, 1989). Further, Taylor (1993) states that the truth of these findings has to do with how carefully the analysis was completed. A credible study will examine and report findings and conclusions that both converge and diverge. Credibility is assessed by determining if the findings derived from the study "ring true" (Erlandson et al., 1993) for the informants. Lincoln and Guba suggest many strategies to accomplish this task. I have utilized three of these strategies in this study, triangulation, peer debriefing, and member checks.

Triangulation means that "multiple perspectives are compared" (Coleman & Unrau, 1995). Although there are many forms of triangulation, two methods were used in this study. One method, analyst triangulation, was utilized by having a colleague code a part of the transcribed interview and then compare it to my coded transcript and assess how similar or different the coding was. This process is also known as "intercoder reliability" (Miles & Huberman, 1993, p. 64). The second method was multiple source triangulation, that is validating and corroborating information obtained from informants with information from other sources. The literature review was used to compare the consistency of information obtained from the informants comments with information from the literature.

In order to increase the probability that the findings and interpretations of the current study were credible, the second strategy employed in this study was peer debriefing. Peer debriefing, "is an effective way of shoring up credibility, providing methodological guidance, and serving as a cathartic outlet" (Lincoln & Guba, 1985, p.

243). The person I chose as a peer debriefer had knowledge in the substantive area of my study, had an understanding of qualitative research and is a trusted and empathic colleague. I met with this person on a regular basis throughout the research process for specific reasons. First and most importantly, we met for the purpose of establishing credibility by inviting the peer debriefer to challenge my ideas, biases, questions and when necessary to take the role of devil's advocate. This process kept me focused and encouraged me to continue questioning each step and decision I made. Secondly, I shared with her the struggles of understanding qualitative methodologies as well as the delights of small revelations during the process. This person also served as a partner in the research process in terms of reviewing the coding process as part of triangulation as was previously mentioned. Finally, the peer debriefer served to encourage me when needed and also celebrated with me the small successes along the way.

Member checks are considered to be, "the most crucial technique for establishing credibility" (Lincoln & Guba, 1985, p. 314). A member check is the process of returning to the informants with the interpretations and conclusions of the study. Member checks provide the informant the opportunity to react to the results, correct errors, add information and assess the overall adequacy of the findings. Several member checks were completed at various times throughout the research process. First, member checks were completed during the interview by summarizing the respondent's ideas and statements to ensure I had interpreted them accurately. Second, once the interviews were transcribed, they were sent to the respondents to provide an opportunity for clarification of any ideas and statements made. Finally, a copy of the results and the interpretation

of the results were sent to the informants for their reactions and comments.

Transferability is concerned with the ability to generalize the findings to other groups, places or times which is referred to as external validity in traditional research (Lincoln & Guba, 1985). An important point to make regarding transferability is that the responsibility to ensure that the applicability of one set of findings to another rests not with the original researcher but with the researcher who is making that transfer. However, it is the original researcher's responsibility to provide a sound data base (Erlandson et al., 1993; Lincoln & Guba, 1985; Marshall & Rossman, 1989).

Several strategies for enhancing the transferability of research findings are suggested in the literature and were used in this study. One strategy, referred to as "thick descriptions" (Erlandson et al., 1993, p.33; Lincoln & Guba, 1985, p.316), requires that the researcher clearly define the parameters of the study which includes a description of how the data collection and analysis were guided by particular theoretical concepts and models. Transferability of this study has been enhanced by the detailed account of the selection and profile of informants as well as by the detailed outline of data collection and analysis. Secondly, purposive sampling (Erlandson et al., 1993, p. 33; Lincoln & Guba, 1985, p. 199) was also used to strengthen the transferability of this study. Each informant was chosen based on their expertise with working with this population in order to maximize the range of information gathered.

Dependability accounts for the stability in the study's design, thus holding the researcher accountable to provide evidence that if this study were replicated in a similar context with similar informants, similar findings would result (Erlandson et al., 1993;

Lincoln & Guba, 1985; Marshall & Rossman, 1989). In order to ensure this kind of trackability should a "dependability audit" (Erlandson et al., 1993, p.34) be necessary, I have documented the entire research process regarding methodological choices, data collection and analysis processes in my journal. Contact notes were also included in the journal, assisting in tracking any communication I had with others contact regarding my thesis.

Confirmability suggests that a study is judged by the degree to which the findings are derived from the process of qualitative inquiry and not the researcher's bias (Lincoln & Guba, 1985, p.290). If another researcher uses the same data and same process of analysis the findings of the second study should confirm the findings of the first (Lincoln & Guba, 1985). The dependability audit described above also serves to establish the confirmability of a study. Erlandson et al. (1993) suggest that the researcher must trust in the "confirmability" of the data alone, meaning that the conclusions, findings, and recommendations can logically be tracked to their sources through the audit trail.

Other criteria for assessing trustworthiness were also employed in the current study. "Because the researcher is the instrument in qualitative inquiry, a qualitative report must include information about the researcher" (Patton, 1990, p. 472). It is important to make public any information that may have affected the data collection, data analysis, and interpretation so that readers of this study may make their own judgments about the affect the information may have on the study. In order to minimize the effects of personal bias and beliefs, addressed previously under "Researcher's Point of View", on the data collection and analysis processes, I wrote relevant events in my journal

throughout the study, noting how my own experience might be influencing my decisions or analysis.

As previously noted, there are also benefits to having had prior experience in the field of study. The interviewing skills and techniques developed through clinical experiences were an asset to conducting research interviews. Having had experience with this population clinically and theoretically (via the literature review) allowed me to engage in interviews with other treatment providers with a common understanding of the language of the profession and with a clear understanding of the therapeutic process. This foundation aided in developing potentially more rich and relevant data.

Researcher competence is also necessary according to Patton (1990) and is demonstrated by utilizing the various strategies outlined previously to assess trustworthiness and by keeping a sound, thorough record of the research process. Patton (1990) also assesses the credibility of a study by the researcher's belief in and rationale for using qualitative research and methods. Patton stresses the importance of the researcher's need to be knowledgeable about the debate over the uses of qualitative and quantitative research methods, thus, I have provided a sound rationale for my choice of methods in the beginning of this chapter.

Limitations and Strengths of the Study

Recognizing the limitations of one's study assists in establishing the trustworthiness of the findings (Glesne & Peshkin, 1992). While strategies such as triangulation, peer debriefing and reflexive journaling have been systematically applied

in attempt to strengthen the trustworthiness of this study, further techniques such as prolonged engagement could have been used to strengthen the credibility of the study. Had time permitted on the part of both the informants and the researcher, prolonged engagement such as a pre-interview could have potentially decreased the possibility that some responses of the informants were based on social desirability rather than personal experience (Patton, 1990), thus strengthening the credibility of the findings. However, although this technique may have strengthened the study it would have been far more demanding on the informant's time and possibly increasing the potential of informants refusing to continue their involvement in the study.

My previous experience as a treatment provider working with children who exhibit sexually intrusive behaviors can be viewed as both a strength and limitation. It has been an asset to this study in that it has allowed me the privilege of being familiar with the terminology of this area and knowledgeable of the treatment process. However, the prior experience could also be seen as a limitation as I have brought with me particular beliefs and ideas about the assessment and treatment of these children and families. Having this previous experience, "introduces the possibility of selective perception and bias in the observations" (Patton, 1990, p. 148) which could have influenced the questions I asked, how I responded to their answers and what I deemed as important in the analysis. The more one is aware of their own biases, the more that awareness serves as a safeguard against those biases influencing decisions. One measure to guard against the influence of such biases was to note my own beliefs prior to the data collection phase and at any point thereafter should the need arise. Being aware of the

potential for bias at the outset of the study, I made a concerted effort to approach the interview with an attitude of curiosity. Further, I made a point of not assuming that I understood the meaning for particular words or issues, but asked for clarification frequently.

One of the overall strengths of this study is the step-by-step documentation of all decisions made regarding the research process within the reflexive journal. Doing so allows, "external judgments to be made about the consistency of its procedures and the neutrality of its findings or decisions" (Erlandson et al., 1993, p.29). Some of the techniques utilized in qualitative inquiry that were implemented in the current study to establish trustworthiness included peer debriefing, member checks, reflexive journal, thick description, and purposeful sampling (Erlandson et al., 1993).

Summary

The aim of this exploratory study was to focus on the treatment provider's experiences with treating children who exhibit sexually intrusive behaviors. A generic qualitative approach was judged to be the most appropriate means of capturing and illustrating the experiences of the treatment providers. The flexibility of this approach allowed the research question to dictate the research design. Data gathered by open-ended interviews, and analyzed using the constant comparison method, permitted an in-depth analysis of the treatment providers' views and experiences. The discussion on the trustworthiness, limitations, and strengths of the current study provides the context from which an evaluation of the significance of the results in the following two chapters can

be viewed.

CHAPTER FOUR

RESULTS I

Understanding the Child Through the Eyes of the Therapist

This chapter is divided into three main sections. The first section involves the presentation of the informants, their professional background, theoretical orientation and range of experience with children who exhibit sexually intrusive behavior. The second section includes the presentation and introduction of the 'framework of results' including the themes, sub-themes, and categories that emerged from the data analysis. The framework is divided into two major themes, 'understanding the child' and 'treating sexually intrusive children'. Section three is the detailed presentation of the results with respect to assessment and treatment as told by the informants and analyzed by the researcher. The latter theme is presented in Chapter Five.

Profile of the Informants

I began each interview by asking the informants to provide responses to the demographic information form (see Appendix B) which assisted in providing a description of the treatment provider's professional background and experiences. At the follow-up contact the informants were asked to complete another form on demographic information (see Appendix C) which developed from the interviews to yield a more detailed description of the children with whom they worked. The informants were asked to use their closest approximations regarding the information solicited. Although these numbers

Table 1: Number of Children Treated by Age

Informants	# of children treated	Youngest child Treated	% of children aged 4-6	% of children aged 7-9	% of children aged 10-12
1	15	7	0	33	66
2	30	5	25	25	50
3	40	4	20	40	40
4	50	5	20	30	50
5	7	6	50	50	0
6	200+	4	50	20	30
7	10	7	0	10	90
8	10	8	0	20	80
9	10				

Table 2: Number of Children Treated by Age and Gender

Informants	% of girls treated	% of girls 4-6	% of girls 7-9	% of girls 10-12	% of boys 4-6	% of boys 7-9	% of boys 10-12
1	33	0	0	33	0	33	33
2	10	3	3	4	22	22	46
3	12	2	5	5	18	35	35
4	27	8	9	10	12	21	40
5	14	0	14	0	50	36	0
6	34	25	5	4	25	15	26
7	0	0	0	0	0	10	90
8	0	0	0	0	0	20	80
9							

Table 3: Profile of The Victims

Informants	Average Number of Known Victims	% of victims - siblings	% of victims - extended family member	% of victims - neighbors	% of victims - Other
1	1.5	30	30		40
2	?	70	0	5	25
3	1.5	?	?	?	?
4	1	50	30	20	
5	2	50		50	
6	2	90			10
7	1.5	90	5	5	
8	1.5	30			70
9					

Table 4: Children's Experience of Prior Trauma

Informants	% of children with previous Trauma	Type of Trauma-Sexual	Type of Trauma - Physical	Type of Trauma - Other	Type of Trauma - Combination
1	20	5	5	10	
2	100	80	10	100	
3	75				100
4	90	80	30		
5	100	50	100	100	
6	85	?	?	?	?
7	100	90			10
8	95	80	20		70
9					

were not systematically collected, they do provide an approximate description of the children with whom the informants have worked, including the number of children treated, ages of children, number of victims, and the children's history of trauma. All but one form was returned. The results of this form are provided in Tables 1, 2, 3, and 4. It should be noted that the rationale for categorizing the children by the ages 4-6, 7-9, and 10-12, in Table 1 and 2 was that the categories are developmentally appropriate. Furthermore, several authors have utilized similar categories in detailed developmental charts which describe a range of age-appropriate sexual behaviors in children under the age of 12 (Hall, 1993b; Gil & Johnson, 1993; Sgroi, Bunk, & Wabrek, 1988). The sexual behaviors in children described by these authors are divided into three distinct groups: pre-school; school-age, and pre-adolescence. Based on the information gathered from the two demographic forms, the following details of the treatment provider's professional background, theoretical orientation, experience with sexually intrusive children, and how their work with these children evolved is provided.

Nine treatment providers were interviewed, five of whom were male and four were female. In terms of professional affiliation, six of the treatment providers were social workers (five with MSW's and one PhD) and three were psychologists (one MSc. and two PhD's). Six of the informants worked in private practice, two with a non-profit agency, and one within a hospital setting. Their primary theoretical orientation when working with children who exhibit sexually intrusive behavior was cognitive behavioral (five informants), family systems theory (one informant), humanistic/phenomenological (one informant) and feminist (two informants, with two others stating this as their

secondary orientation). While the majority of the informants identified with one main approach, five informants stated that they also aligned themselves with at least one other theoretical perspective.

The informants' range of experience working with children who molest and their families varied from 4.5 years to 12 years with an average of 7.3. The number of children and their families that these treatment providers worked with varied greatly from 7 to over 200. In total, over 350 children and their families had been treated by the nine treatment providers.

The majority of informants reported working primarily with boys who exhibit sexually intrusive behavior. Of the approximate 367 children treated by the informants, 96 (26%) of the children were female. The youngest reported perpetrator was four years of age. Only two therapists stated that they have only worked with boys. The majority of the boys and girls treated were in the 10 to 12 age range (see Table 1). The average number of victims was 1.5 with the majority of victims being the siblings of the children who perpetrate (Table 3). As illustrated in Table 4, the majority of children treated (83%) had experienced a combination of sexual, physical and/or emotional trauma.

Four of the informants related how they first became involved in treating children who are sexually intrusive. One informant noted that her work with these children and their families developed from treating child victims of sexual abuse who also were experiencing sexual behavior problems. Two other therapists remarked that in their early dealings with this population, the presenting problem of most of the children was aggressive behavior and that the sexual behavior problems were discovered during

treatment. The majority of the therapists began their work treating adolescent perpetrators which evolved into work with younger children under the age of 12. Another informant mentioned that his clientele have become increasingly younger, a process which he viewed positively. One informant had been working in the area of sexual abuse for three to four years when the notion of kids touching kids became more of an issue.

> The number of kids who come and see me who are involved with touching someone else is just phenomenal compared to the first few years I was involved where it was almost the exception...Now we think automatically it is part of our question. The kid has been sexually abused, which is why they were referred to us and one of the introductory questions we always ask is, 'and has there been any indication that they have been touching anyone else (Kevin).

The Framework of Results

The framework presented is the result of a lengthy process of coding and analyzing the data gathered from the nine informants who shared their experience with assessing and treating over 350 children under the age of twelve who exhibit sexually intrusive behavior. The next phase involved a process of identifying themes and reorganizing the data which resulted in the current framework of results including 2 major themes, 12 sub-themes, and 30 categories.

The first major theme entitled, 'Understanding the Child', includes a range of

findings which represent the therapists' views of particular characteristics of children who exhibit sexually intrusive behavior and their families. The second major theme entitled, 'Treating Sexually Intrusive Children', which is presented in Chapter Five, describes the various treatment components, including diverse issues and beliefs which form the essence of the informant's work with children who exhibit sexually intrusive behavior. The complete framework of results is presented in Table 5.

It should be noted that the following presentation of the detailed framework of results includes verbatim segments of data extracted from the interviews. These are included because they capture the authentic view of the informant. The majority of the themes and categories represent the combined experience and/or view of at least two informants. In the cases when only one informant introduced a subject, and it was judged to be important, it was clearly identified as being reported by only one source. In order to maintain confidentiality, pseudonyms were selected for presentation of direct quotations of the informants. The pseudonyms are: Kevin, Jean, Craig, Roy, Glen, Leanne, Karen, Sara and Murray.

Understanding the Child

Based on the informants' professional experiences with children who exhibit sexually intrusive behavior, this major theme is a description of the children and the families with whom they worked. This theme is distinguished by references made by the informants which describe the children's sexual behavior problems and the influence that various family variables have on the child's acting-out behavior. Two sub-themes and

TABLE 5: FRAMEWORK OF RESULTS - UNDERSTANDING THE CHILD

- Description of the Children and Their Victims
  - Terms Utilized to Describe the Children's Behavior
  - The Development of Sexually Intrusive Behavior
  - Difficulties Forming Attachment
  - General Behavior Problems
  - The Victims
- The Influence of Family Variables
  - Parental History of Abuse
  - The Sexual Climate Within the Family
  - The Family's Experience of Violence
  - Method of Child Discipline
  - Father-Child Relationship
  - Parental Response to Disclosure of Perpetration
  - Family Strengths

TREATING SEXUALLY INTRUSIVE CHILDREN

- Assessment
  - Assessment Process and Length
  - Assessing Child and Family Variables
  - Assessment Instruments
- Issues That May Arise in Treatment with the Child
  - Broaching the Subject of Abusive Behavior with the Child
  - Victim-Perpetrator Issues
  - Sexual Issues
  - Suicidal Ideation
  - Dissociation
- Treatment Components for Children
  - Education
  - Empathy, Body and Feeling Work
  - The Apology Session
  - Relapse Prevention
- Issues That May Arise in Treatment with the Parent
  - Parental Motivation For Treatment
  - Parental Response to Disclosure
  - Family Secrets
  - Parental Power Issues
- Treatment Components for Parents
  - Parental Involvement in Treatment
  - Education
- Termination of Treatment
- Treatment Modalities
- Confidentiality and Other Ethical Issues
- Issues with the Therapeutic and Legal Systems
- Future Research

12 categories make up this description of children who exhibit sexually intrusive behavior. This theme provides a backdrop of information from which the second major theme, 'Treating Sexually Intrusive Children', presented in the following chapter, can be understood.

Description of the Children and Their Victims

Under this sub-theme are five categories in which the informants described the characteristics of children who present with sexually intrusive behavior. First, is a report on the therapists' choice of terms to describe the perpetrating behaviors of these children and their beliefs supporting that choice. The therapist's beliefs regarding the development of sexually intrusive behavior are also included, followed by three categories which describe attachment difficulties, general behavior problems other than the sexually intrusive behavior, and the victims of these children.

Terms Utilized to Describe the Child's Behavior

A myriad of terms describing the perpetrating behavior of the children were utilized by the informants. Four informants chose to use the term "sexually aggressive". One of the four was very clear regarding his choice of this term stating, "I either call them perpetrators or sexually aggressive kids...I don't have a problem labeling the behaviors so I label it. You have committed a sexual offense".

Leanne, however, was more cautious stating that, "I don't use a term to describe

them. I do, though, consistently describe what they did as sexually perpetrating and sexually offending against someone else. I don't have a term I don't think". Her concern with using a label involved an issue with ethics in that, "if we label them they will live up to our expectations, live up to their labels so I think that is an ethical dilemma". Sara also stated that she had yet to find her own term, however she would use "children who are sexually inappropriate with their peers". Craig's choice of the term "sexually reactive" reflects his belief that the child's behavior is a reaction to some kind of trauma. Kevin used the term "abuse-reactive" when describing the behavior to parents and "sexual touching" when working with the children. He stated that, "with both parents and kids it is not unusual for me to use a word like 'abuse'. I just say this is abusive behavior, let's be real clear about this". Jean also clarified that depending on whom she is speaking to, she may use a different term. She used "abuse-reactive" and "kids who inappropriately touch other kids" when addressing other professionals but with the children, themselves, she was careful not to label the child but described the behavior as follows, "so in the past Johnny had at times touched other kids".

The Development of Sexually Intrusive Behavior

Each informant identified contributing factors and shared their hypothesis as to how the sexually intrusive behaviors developed. There appears to be agreement that it is not simply one factor which contributed to the development of the behavior, but the culmination of many factors. While prior victimization appears to be an important factor, Glen stated:

> Even with those kids who are sexually victimized there are other factors that have to be in place, some factors have to be there for the kids to act, to repeat what has happened...There are always other issues and other factors that affect that child's behavior other than the victim's issue.

The three most frequently cited contributing factors were prior history of sexual and/or physical abuse, exposure to inappropriate sexual material, and neglect. A range of other contributing factors were also reported.

Most of the informants noted that the majority of children had a prior history of sexual abuse and several also identified physical abuse as a factor (see Table 4). Roy hypothesized that children who are sexually intrusive are modeling or acting out the behavior that they have either experienced or observed, therefore, he/she is "reacting" to some prior sexual abuse. Jean concurred that the acting-out of sexual behavior develops as a result of the child being victimized.

> Preschool children process information by acting it out, it is the developmentally appropriate thing to do. So a preschool child who has been touched inappropriately may or may not be traumatized by the event but whether the child is traumatized or not, the child is likely to act out on another child and that is because they process information by trying things out...I will always assess whether the child has been abuse-reactive because I assume that most kids will act out against other children. I assume that 100% of preschoolers will.

Further, children who have been sexually abused often learn to meet their needs in a

sexual manner. Two informants discussed the "reinforcing and gratifying" (Roy) components of sex in terms of the child meeting his/her needs. Craig stated that, "my sense with the sexually reactive kids is that one of the only ways that they have found pleasure in their lives is by physical pleasure and so they tend to seek that out".

Exposure to inappropriate sexual activity or material was identified by three informants, with one informant also including exposure to physical abuse as a factor. One informant gave an example of a six year old child who had access to his parents pornographic videos without their knowledge. The child proceeded to engage in similarly explicit and inappropriate sexual activities with other boys his age. The behavior stopped once the parents became aware of and prevented the child's access to the videos.

Other traumas that were identified as important by the informants included physical or emotional neglect, witnessing severe violence of mother, and family stress (i.e. separation/divorce of parents, loss of caregiver/parent). Of those identified, the majority of informants noted child neglect as a major contributing factor to the development of sexually intrusive behavior. Three informants hypothesized that, when the child's nurturing needs are not being met, the child learns to connect with others through inappropriate touch to meet those needs. In her experience, Karen has found these children to have developed a stance that says, "I have to do this for myself, I have to be in charge, I have to get what I need". She described the children as experiencing a "jumbled messy pit" of angry, sexual and sad feelings. Roy described two ways in which neglect and rejection can affect children. In his experience with some families he stated that, "we have kids who turn to each other because of the emotional needs not

being met in the family. So the abuse initially starts as comforting one another and then progresses from there". Some children who have experienced neglect and rejection experience a build up of anger and rage and just need to hurt someone else because they have been hurt. "So it is kind of a get back thing" (Roy). Similarly, Murray believes that if the child is scapegoated within the family system he/she may act out this anger sexually as a way of "getting back at people".

Another proposed effect of neglect is a lack of empathy for the victim, regarded by two informants as a possible contributing factor.

> I believe very strongly if kids and young people cannot develop a sense of victim empathy then I believe their risks for offending increases significantly. They have to understand the impact of their behavior not just on themselves but on their direct and indirect victims. And if they can't do that then I think they will offend or reoffend (Roy).

Three informants hypothesized that the need for power is influential in the development of sexual behavior problems in children who have experienced prior abuse. Leanne relayed her belief regarding the children's quest for power stating that, "it was very much based on their own abuse and their own reality of power and how they could get power". Similarly, Kevin stated:

> If kids don't have appropriate power they look for power in less appropriate ways...in my experience what happens when kids touch other kids is that it is about feeling the need to be in control, to have power, to be successful in some way.

Further, several informants believe that part of what supports the child's sexually aggressive behavior are family secrets which Leanne stated:

> Feeds into the powerlessness...there is a powerlessness in terms of knowledge and knowledge is power and so they find some way to be powerful.

Murray referred to the child's lack of personal power as related to the child's low self-esteem stating:

> Some kids who meet with failures in their lives whether it be in the classroom or on the playground, and subsequently experience a real drop in their self-esteem, may engage in sexualized behaviors in order to feel better about themselves, feel more powerful, to identify with the aggressor.

The majority of informants identified the influence of parental factors on the development of the sexual behavior problems in children. One therapist noted that lax discipline methods in the home, with no consequences for the child's inappropriate behavior, reinforces the child's lack of accountability in other aspects of his/her life. Several informants stated that if the parents had been victimized themselves as children they often overreact to their children's sexual behavior and utilize an overly punitive form of discipline. A third informant, Roy, noted that if the caregivers convey to the child that he/she is in any way deviant or perverted, that child may then respond with behaviors that fulfill that label or expectation like a "self fulfilling prophecy". One therapist would assess how the parental interaction supported the child's violence while

another therapist looks at broader relationships such as community, extended family, and nuclear family factors that would contribute to the child's vulnerability. Glen summarized the contributing factors as follows:

> Unfortunately kids who are victimized are vulnerable to abuse because they have poor family relations, are neglected, have family conflict, don't have any friends, may have conduct problems and the risks to this kid becoming an aggressor are the same ones that made him vulnerable; that is family conflict, no friends, neglect.

Difficulties Forming Attachments

Reference was made by four informants to the difficulties that these children experience when attempting to develop secure attachments with others, with one of the informants, Roy, describing in detail how he conceptualized these difficulties. Although Karen pointed out that, "a satisfying nurturing attachment is also the ground work for developing empathies" many of these children have not had the critical attachments to caregivers that are necessary to develop such empathy. Due to these insufficient attachments, issues with male bonding, rejection and abandonment were identified by several informants. Murray stated that:

> Insecure attachments which is probably indicative of a history which is just replete with not only sexual abuse but all sorts of other types of abuse too. And we know these kids later on or earlier have a great deal of difficulty being empathic towards other people.

Similarly, the majority of children that Roy worked with are children in care, living in foster homes, group homes, receiving or assessment homes. Very few were actually living with intact families. Roy further conceptualized the issues into a framework consisting of three distinct groupings of children who exhibit sexually intrusive behavior who experience attachment issues. One group is children who have been heavily involved in child welfare and have never connected to anyone because there have been multiple caregivers. A second group is children where there has been short-term child welfare involvement with the parent, usually the mother who has had multiple partners. The child in this group has never really experienced any connectedness to a significant person in the family. A third group is children who have been abused by their parent(s) and the issues have not been addressed. Violence generally pervades the home, with the child being either a direct victim of the violence or an indirect victim who has witnessed the violence. Such violence inhibits the growth of healthy attachments within the family.

General Behavior Problems

In addition to the sexually intrusive behavior, four informants identified a number of other behavior problems that these children often exhibit. Glen's experience was "that in virtually every case there are general behavior management issues". Two informants noted "conduct disorders" as being common problems with many of the children. Three other therapists described other problematic behaviors including anxiety and attention deficit disorders. Murray explained:

> Certainly a number of the kids that we see presenting with this kind of behavior have been diagnosed with attention deficit, therefore they are somewhat impulsive, they really don't attend or concentrate on cues in their environment, they are more prone to behaving and thinking impulsively, they have very poor social skills, and they don't know how to maintain age appropriate friendships with peers.

The Victims

The majority of the sexually intrusive children in treatment perpetrated against a sibling (see Table 3). However, other children victimized by the child included peers/playmates, other residents in group homes or foster homes, neighbors, or extended family. Glen stated that, "it is who is available, who they play with, who is around. It can be a neighbor kid, sibling, a child that their mother is baby-sitting. It has more to do with availability". Leanne takes the issue a step further by hypothesizing that because these children have witnessed very traditional roles and beliefs such as "women don't have control, women aren't to be listened to, women can't say no or when they do say no it doesn't mean no" the sexual violence in which they then engage is, "just an extension of the perpetration of violence against those with less power. It has not always been female children they have perpetrated against but they have always been younger in somehow a position of less power".

The Influence of Family Variables

The informants described many aspects of parental influence on the child's sexual behavior. The subtheme 'the influence of family variables' consists of seven categories which paint a picture of the typical characteristics of families with children who are sexually aggressive. Secondly, the categories illustrate the intergenerational transmission of violence.

It should be noted that most of the informants agreed that the children, "present with a gamut of problems, there is no homogenous picture, there is no classic pattern of any child or family who has had this problem" (Murray). Another informant stated that, "I don't think there is a typical family. I've seen this happen in all kinds of families". Although there was considerable variability, the seven categories provide an emerging picture of factors that appear to be shared amongst many of the families with children who exhibit sexually intrusive behaviors. Identifying these characteristics highlights the importance of the family's influence with these children.

Parental History of Abuse

The majority of the informants reported on the fact that the parents were often victims of childhood abuse. Three of the informants stated that the child's acting-out behavior appears to serve as a trigger, bringing up childhood memories of abuse for the parent. Kevin found that of the parents he has worked with, approximately 50% of caretaking mothers had been sexually abused as children. He is unsure how many of the fathers have a history of abuse, as it is typically the mothers who bring in the child.

Even when the fathers are involved, they have usually not disclosed abuse, yet Kevin has discovered that often it is not uncommon for the mother to disclose that the dad had also been sexually abused. In her experience, Leanne noted that it has been primarily the mother who raised abuse issues, she described how she works with the mom around the confused feelings that the mother may experience towards her child that get in the way of the family's healing.

> I often then meet with moms by themselves to help deal with their sexual abuse and their feelings towards the offender and how different that is from the feelings towards their son. Towards the offender they usually have hatred and often towards their son there is that whole mixed bag, 'This is my son and I love him and this happened to him' and they almost can't let themselves get angry with him or can't let themselves say this is not okay and they are afraid they will hate their sons.

Similarly, the child's sexual acting-out behavior often has been a trigger for the parent with the abuse history. "They feel that their child is just recapitulating what their own offender did to them and again that often elicits a lot of old memories and old pain for them as well" (Murray).

The Sexual Climate Within the Family

Sexual climate was referred to by many of the informants as a family's interactional style which appears either highly sexualized or sexually repressed. These two examples of sexual climate are commonly noted in families with a child who

exhibits sexually intrusive behavior. Sara commented that, "there are families who are highly sexualized and interact in sexualized ways" which is further described by Glen as including:

> Privacy, language, role boundaries, that is that in some families children have much too much freedom and it isn't that the child is breaking the rule, but that they are allowed to get into a lot of the parents' things in terms of like magazines or even discussions about sex in a more sexist way.

In contrast, the restrictive influence of religious beliefs were reported by two informants as characteristic of a repressed sexual climate in some of these families. Murray experienced having to work very closely with some families, "who will not tolerate any kind of sexual expression in their children in terms of normal masturbation. It's just forbidden given religious beliefs or moral beliefs". Roy described a similar difficulty when working with certain religious groups who are very closed to sexuality because, "you are fighting their perception of God and their interpretation of the testament".

The Family's Experience of Violence

Violence in different forms was identified by several of the informants as being part of the family environment. Leanne described them as, "families who have had violence almost inclusively...very actively abusive families". The violence she has seen within these families is both physical and psychological:

> The physical abuse takes place in the context of the family only. A real sense that this is our business and you people have no right into it. Thus the child, if not being abused directly, is witness to the physical abuse.

Four of the informants identified that children who exhibit sexually intrusive behavior are often physically and sexually violent towards the mother, presumably as a result of witnessing the father's violence towards the mother. Kevin noted that, "75% of these children have physically acted out, typically toward the primary caregiver which is usually mom". Jean supported this experience stating that, "if the child is sexually abusing other children as a result of witnessing the dad sexually abusing other people including mom, well then you can pretty well guarantee that the child is going to be violent towards mom". Similarly, a third informant, Leanne, noted that:

> In probably all of the cases there has been physical acting out by the son who has been sexually aggressive towards mom...to the point where mom comes in fearful of the child, really fearful of the kind of violence he has done to her.

Further describing these dynamics, Karen also reported the effects of the child witnessing the physical abuse of the mother stating:

> The father had sexually assaulted the mother and it looked like the kid was reenacting the father's role with the mother. And so we did some work with the mom around that, and she was able to recognize that, which helped her become more of a mother to her son as opposed to a victimized wife.

Characteristic of the majority of families with whom she worked, Leanne also described the families as assuming very traditional family roles resulting in an imbalance of power within the family system. The ten families with whom she had worked, were, without exception:

> Families who have bought into stereotypical roles for men and women in the family...the man is in charge, the man is the one who makes the decisions, the wife deflects to him, the wife leads the very traditional wife role, nurturer, caregiver.

Method of Child Discipline

Several informants described inappropriate discipline practises by parents with children who exhibit sexually intrusive behavior. Sexual behavior problems were viewed by some as just another behavior problem that is not dealt with using appropriate consequences. Murray stated:

> The family's laxity or the family's difficulty enforcing limits around sexuality is just symptomatic of parenting difficulties in general. They are not only lax about the kid doing homework, they are lax about the kid getting up in the morning...so it may be just one example or one symptom of a parenting style that is very inadequate.

Glen also addressed the issue of inadequate parenting style stating:

> So if a kid has a history of slipping out of being responsible, being accountable as to how he is feeling, they lie and they steal and are able to

> tell their story to parents and they are able to weasel their way out of it...Sexual aggression is no different...usually that pattern is a pattern that isn't new...it is the parent who will be persistent enough to do something about general behavior.

On the other extreme is the parent whose reaction to the sexual acting out behavior is "overly punitive" (Murray) which generates anger in the child. An example of such a reaction that has potentially traumatic implications for the child is described as follows:

> One of the methods of disciplining at the age of three, and this was in front of adult friends, was having the child parade around in the nude putting pepper on his penis so he wouldn't touch his penis. In that situation itself there could be certainly enough trauma for the child at three or four to internalize it and have very negative attitudes around sexuality (Craig).

Father-Child Relationship

Three informants raised issues regarding the relationships between the father and child including, "attachment, trust, communicating, openness in the father-son relationship" (Leanne). Craig reported that, "I have never had a situation with younger children where there has been the natural father and the natural mother. There has always been a tremendous inconsistency especially with the paternal side of it". He continued to describe the father as generally "absent, distant emotionally or physically or is never known by the child". In contrast, Karen's experience was that the children,

"usually know who their dad is but the contact has been really minimal, really unpredictable...the fathers are not involved and have disappeared, so they've really been disappointed by their dads".

Parental Response to the Disclosure of Perpetration

Parental response was another major variable that was reported and expanded on by the majority of the informants. Most respondents identified a range of parental reactions to the disclosure of the perpetration, including self-directed, child-directed or other-directed reactions. Examples of self-directed reactions reported were shock, minimization, guilt, powerlessness and defensiveness. Reactions of shock and disbelief were reported by several informants. "When a parent's child molests another child, the parents are horrified usually. They are usually in denial or they are so horror stricken they are beside themselves. Their ability to cope decreases" (Jean). Five respondents reported that minimization and denial follow the initial shock. Leanne stated:

> They have disbelieved it and disqualified everyone else who has brought it out in the open, even if the child is admitting to it. Or they will down-play the significance of it, it was just play, it was just sex play, it was normal, healthy.

Roy similarly commented that, "the one thing the parents will do too is once they get over the initial shock they start to minimize the behavior".

Three therapists reported that the parents often respond to the disclosure of the child's abusive behavior with guilt.

> When the parents march their kid through the door they are feeling like they are on trial. What did I do wrong?...these parents are defensive about their parenting. They are concerned about being blamed. Their whole lifestyle is under the microscope. Their role as a parent might be scrutinized (Glen).

Reactions directed toward the child could be seen as supportive or non-supportive. Only one therapist, Sara, talked about the importance of supportive parental reactions towards the child, stating:

> My experience has been if the parents find out that the kid has been molesting another kid and they respond to the child in a supportive, interested, motivated way that the kids are much more forthcoming with information. If the parents are very blameful and angry and hostile with the children after discovering them sexually involved with others, then I find that the kids are usually more reticent to provide information and it is tougher to do the assessment, it takes longer.

Non-supportive reactions such as distancing themselves from the child were reported by two therapists. "They just stopped talking to him. They have been treating him like he was diseased...they have said things like, 'You are a monster and we want nothing to do with you'" (Leanne). Karen noted a similar pattern stating that, "there is like this distancing thing, like they put their kid at arms length after that and it's like they are so horrified that they can't get close again...They want to punish and they want to reject".

One therapist described the parents as being overvigilant with any part of the

child's sexual behavior, even sexual behavior that was age-appropriate. Three other therapists reported that the parents appeared to be frustrated and exasperated by the child's behavior. "Frankly the parents are frustrated, they don't know what to do with their behavior, because there is a general conduct problem and they're just exasperated" (Glen).

The majority of informants noted that the parents were both concerned and fearful about the child's future. "My experience with most of these parents is that they are very very worried that if their child does not stop this kind of behavior he is going to become an adult offender" (Murray). Other-directed reactions reported by three informants included either anger towards the child welfare system or anger towards the child welfare worker. "These families are typically very angry because Child Welfare has often brought them to my attention" (Leanne).

Family Strengths

Although some of the informants found strengths difficult to identify, the majority noted that such families have significant strengths. These families were regarded as "survivors" (Craig) and were perceived as people who were committed to problem resolution. Several informants found them very open to experimenting with new behaviors and open to learning. One informant commented that the families are very concerned for their children and another, Murray, noted that, "admitting that their child has a problem takes real courage and coming in here and essentially saying that they need help I think for anybody is a real act of courage".

Summary

The majority of children treated by the informants of this study were boys between the ages of 10 and 12, with most of the children perpetrating against a sibling. Terms such as sexually aggressive and abuse-reactive were commonly used by the informants to describe the sexual behavior problems exhibited by these children. A number of factors contributing to the development of sexually intrusive behaviors were described, including numerous child and family variables, with the three most commonly cited factors being the child's history of sexual and/or physical abuse, exposure to inappropriate sexual material and parental neglect. The parents of these children are characterized as having their own histories of abuse with their current home environments marked by either sexual oppression or sexually overt or covert parent-child interactions. Violence is typically part of their lives, in the form of spousal abuse, child abuse, or the child perpetrating physical and/or sexual violence against the mother.

CHAPTER FIVE

RESULTS II

TREATING SEXUALLY INTRUSIVE CHILDREN:

THE THERAPIST'S VIEW

This second major theme represents the informants' views about the treatment process with children who exhibit sexually intrusive behavior. This theme was recognized in the data as descriptions of issues, topics, strategies and components related to the therapeutic experience with sexually intrusive children. All informants addressed the majority of these and clearly identified them as related to assessment and treatment issues. This major theme consists of 10 sub-themes, and 18 categories.

Assessment

The informants discussed assessment as the first step in the development of a treatment plan for the child who is engaging in sexually intrusive behavior. "The treatment components will depend on my assessment so it's very difficult to talk about treatment unless I have an assessment in front of me" (Jean). The sub-theme, assessment, is made up of three categories including a description of the assessment process, what important variables require assessment, and the various formal and informal assessment instruments that are presently utilized by the informants. As Glen stated:

(Assessment) is like a jigsaw puzzle for a primary kid where there is only

> maybe six or eight pieces and so you are trying to find how this all fits together and if a kid has been sexually victimized that is just one piece, that is not the whole picture. It never is.

Assessment Process and Length

Many of the informants reported that assessment can be conducted in various combinations, including interviewing the parents together, then separately, seeing the child individually and with the family. The primary purpose of utilizing the various combinations when interviewing for assessment is, "to see various interactions and giving people opportunities to say certain things that they may not feel free to say with their partner (Glen). While an assessment is required at the beginning of treatment, it does not end there. Several informants viewed assessment as, "often on-going...in reality every session you are getting additional information, the assessment process really never stops" (Roy). Of those informants who commented on the number of sessions required for formal assessment, the range reported was from three to six.

Assessing Child and Family Variables

All of the informants discussed the importance of assessment and taking the time to understand not only the child's sexual behavior, but also other aspects of the child's life. As Glen stated:

> Assessment is a broad assessment, not just looking at the offending or alleged incidents or the sexual behavior concerned, but also looking at the

total child. Looking at their strengths and weaknesses, looking at the family relationships.

The majority of informants identified a range of child and family variables that needed to be addressed during the assessment phase of treatment. Completing a "comprehensive holistic kind of assessment looking at different variables at all sorts of different levels" (Murray) was agreed to by many of the informants. Many child variables that are considered critical to assess were identified, but only one was described in detail.

The child variables that were highlighted briefly by the informants included examining the child's social relationships, academic progress, developmental history, and the child's ability to form secure attachments. Further, the majority of the informants reported on the importance of assessing the contributing factors (presented earlier) that increase the child's vulnerability to perpetrate abuse which included, for example, the child's history of victimization.

The one child variable that was expanded on by seven informants and viewed as central to the assessment of children who exhibit sexually intrusive behavior, was to determine what sexual behavior is considered the norm and what is considered to be inappropriate for children. Kevin suggested that when assessing normal sexual behavior in a child it is important, if possible, to explore what meaning that behavior has for the child. He stated, "It is more than just the behavior. It is the meaning of the behavior, the cognitive process that goes along with the behavior". Whether or not the sexual behavior is mutual or coercive is also part of the assessment, as reported by two

informants. Karen stated that, "if it is two kids who are both willingly engaged, that's not so much of a problem". One informant takes into consideration the age differential between the children, while another suggested that the children's developmental level is more important to assess.

Three other criteria for assessing normal sex play were reported, each by only one therapist. The first is whether or not the child's sexually intrusive behavior diminishes in response to adult intervention. Secondly, whether or not the behavior is trauma-related is also assessed.

> When I treat pre-school children or young children I am always very careful to assess whether their sexually acting-out behavior is due to a traumatic event or whether it is just due to them having had an experience which was not traumatic because the treatment is different (Jean).

Finally, another criteria for assessing normal sex play is whether the sexual behavior was carried out in a light fun manner or whether it had a compulsive element.

> With kids who may be reenacting their own abuse the behavior can be quite compulsive and the fun part of it goes out and when the other child says they want to quit now, they may not be able to quit (Jean).

Three informants concurred that the family's values and beliefs determine, in part, what is normative or non-normative sexual behavior. Thus, the family need to be assessed with respect to how they influence the child's sexually intrusive behavior. "There is such a range of what is appropriate behavior. Families have different belief systems, cultures, religious groups have different belief systems" (Sara). Craig related

that he works with the family to, "try and figure out whether this behavior is normative or non-normative". Analogous to this belief, Kevin added that, "it is also the family's reaction to the child's sexual behavior. It is very hard to tell a family that believes that masturbation is a sin to let the child masturbate". Murray commented that as a therapist, "there are situations where one may not agree at all with a family about what constitutes normal sexual behavior in little children and one may have to refer out to a different therapist" (Murray).

The majority of the informants reported, but did not expand on the importance of assessing family variables such as the parent's attitudes regarding sexuality, family relationships, parental response to the disclosure of perpetration, and parental discipline practices. Two variables that were described in more detail included the family's sexual boundaries and parental history of abuse. An assessment of the family's sexual boundaries were described as central to the assessment by three of the informants and were discussed on a continuum from "loose" and "wide open" (Murray) to "rigid" and "closed" (Craig). With respect to the assessment of the parental history of abuse, a difference in the approach of two therapists was noted. Leanne reported that in her assessment she would, "always check if anyone in the family has been sexually abused. It has always been the mother at this point". In contrast, Sara explained that she will address parental history of abuse:

> Only if it is relevant. I don't seek it out necessarily, but we will deal with it if it is a vulnerability factor that makes the kid or other children in the family vulnerable to offending or to be abused again.

Assessment Instruments

The use of both formal and informal assessment instruments were described by five of the informants with four informants using a combination of the both formal and informal processes. The informal assessment methods included the use of play assessment techniques such as the sandtray, and art based assessment tools including painting and paper drawing. The formal assessment tools included the Child Sexual Behavior Checklist, Child's Anxiety Scale, the Children's Depression Inventory, and the Children's Personality Inventory.

Summary

According to the informants, the initial assessment determines the direction of the treatment phase and is on-going throughout the therapeutic process. Assessing a range of child variables such as the child's academic progress, developmental age, sexual development and the child's ability to form secure attachments were reported. The influence of family variables were reported as a critical aspect of assessment, particularly when assessing the sexual behavior of the child and the influence of parental variables on the development and maintenance of such behavioral problems.

Issues That May Arise in Treatment with the Child

This sub-theme includes five categories that the informants describe as issues that children who exhibit sexually intrusive behavior may experience which may require

attention in treatment. The categories include the mediums that the therapist found useful for addressing relevant issues considering the child's developmental age, how to address the topic of the child's abusive behavior with the child, and what issues should have priority. Furthermore, the informants described a number of maladaptive ways in which the child may deal with their experiences such as suicidal ideation, dissociation, and excessive masturbation. This section consists of practical advice for therapists regarding effective ways to approach certain issues, a description of those issues, and what to expect when dealing with children who exhibit sexually intrusive behavior.

Broaching the Subject of Abusive Behavior with the Child

How the therapist addresses the subject of the child's abusive behavior with the child is a sensitive issue deserving much thought and attention on part of the therapist. Jean stated:

> One of the things about sexual abuse and particularly about abuse-reactive behavior is that kids will not voluntarily speak about it. You need to bring it up in some form. If you bring it up directly, chances are the child's defenses will go up and therapy will be significantly slowed down. But if you do it in a non-direct way then it's very non-threatening, it's very easy for the child to talk...so therapy can be done very quickly, very efficiently using indirect methods such as bibliotherapy.

The informants shared various mediums, which they referred to as "indirect methods", that they found effective when approaching the child regarding his/her abusive behavior.

Many informants acknowledged the importance of understanding the child's developmental level when assessing the appropriateness of such mediums for any particular child.

Of the eight informants who reported on the various mediums they utilized with children who exhibit sexually intrusive behavior, the majority appeared to agree with Craig who stated that:

> With the younger children, I use strategies around providing sexual information in a play way...more play around what is sexually appropriate and not appropriate, story telling, more metaphorical work, obviously younger children relate more to storytelling as opposed to reality...a lot of puppet play, sand trays, play therapy and a lot of metaphorical work.

Another informant discovered the use of board games as an effective strategy with some children who have difficulty discussing their abusive behavior. The more traditional "talk therapy" methods were simply not effective for addressing sexual behavior problems with young children:

> The kids love the game and they don't mind telling you all of the abusive stuff they've done as long as it is part of the game and yet if you sit there and you say 'Can you tell me a bit about what happened', they say they don't want to say any more.

The child's age, cognitive abilities, and other developmental needs were important factors for many of the informants when choosing appropriate mediums with which to address sexual behavior problems with a child in the most effective way. Jean described

using bibliotherapy in treatment and how she would use the same book for children of different ages stating, "Are you familiar with 'No-No The Little Seal'?...How I would use this book would depend on the child and the child's developmental age. So with a 3 year old I would shorten the story and with a 7 year old and up I would read it in its' entirety". Craig acknowledged the importance of adapting the methods of treatment to the changing developmental needs of the child as he/she matures:

> If the ground work is laid it would probably be easier as the youth proceeds developmentally to introduce more of the cognitive aspects of victim empathy and the consequences of his behavior, and I guess the consequences can be introduced with younger children as well but it has to be done in a different way.

While the majority of the informants discussed the use of indirect methods as effective when addressing the child's abusive behaviors, only Roy reported being more direct with children with an emphasis on developing rapport:

> I will confront and be pretty direct but I can be pretty goofy...it is finding ways to try and reach these kids. I will get on the floor with them, play games, go for walks, go and shoot pool, whatever we can do to try and connect with them. This is real important.

Victim-Perpetrator Issue

While there was agreement that both victim and perpetrator issues needed to be addressed, there appeared to be some discrepancy as to whether to begin treatment with

a focus on victim issues or perpetrator issues. Leanne reported that she began with the victimization but, "very quickly move into the offense and the sexually aggressive behavior and really challenge them". She recognized the need for the therapist to be aware of the tendency of the child and parent to want to deal with the victimization rather than the perpetrating behavior. Three therapists, including Leanne, agreed that working at both issues simultaneous is important. In terms of how they would work with both issues, two informants noted that they connect the child's own victimization to their perpetrating behavior. However, Glen took a more provisional stand:

> It depends on the degree of victimization and the degree of sexual aggression...Every situation is different, yet both issues of being victimized and being a victimizer need to be dealt with. How much and when each one is dealt with depends on the situation and depends on how much sexual aggression has been going on and whether there is a high risk.

Disclosure of Perpetration

When treating children who exhibit sexually intrusive behavior, three of the informants agreed that it is not necessary for the child to disclose every incident of perpetrating behavior in order for treatment to be successful. Roy admitted that, as a therapist, he is never really sure if the child has disclosed everything, stating, "you are hoping that what you do know and the treatment you are giving the kid relative to what is disclosed can be generalized to the other offending behaviors as well". Karen

reported a somewhat different aspect of the child's disclosure stating:

> I don't want to give them a chance to lie, because then I have to deal with the lie, so I'm not seeking their disclosure about their abusive behavior, I just let them know that I know about it and that it's something important for us to talk about.

Sexual Issues

Six therapists described sexual issues that they had addressed in treatment with children who exhibit sexually intrusive behavior. Three described addressing chronic masturbation and one therapist, who worked primarily with children ages 10-12, reported addressing the child's questions regarding his sexual orientation. Three informants had addressed the child's sexual fantasies about perpetration in treatment. Glen acknowledged that, "you don't get sexual fantasies in the beginning. Kids don't like to admit that they thought about it at all", yet he will indirectly ask the child how "they made sure that nobody was around when they called the kid downstairs or how they set the alarm in the middle of the night". Another informant routinely addresses sexual fantasies in treatment, attempting to discover what led up to the child's decision to abuse another child. In terms of dealing with the sexual fantasies that are abusive, Leanne has the child, "write them down, track them, show them to other people, therapists and group people, acknowledging that this is part of them and they can have this fantasy but they don't have to act on it".

Suicidal Ideation

Three therapists reported dealing with children's suicidal ideation. Karen found that of the seven sexually aggressive children from ages 4-9, with whom she has worked, that, "when they talked about it(suicide) they've meant it, like they really wanted to die. They feel really bad and they feel like they are bad". In contrast, Jean, who has worked with over 200 children who exhibit sexually intrusive behaviors, found that it was primarily the older children from ages 10-12 who became suicidal, "when they find themselves compulsively engaging in sexually abusive behavior and they promise themselves they are going to stop and they can't stop". Kevin described a different experience reporting that the topic of suicide is raised by about 20-25% of the children he sees, however, none had actually attempted suicide. He stated that, "What I am finding with kids this age is that saying I want to kill myself is mostly pretty light. It might mean I want to go hide in my closet".

Dissociation

Many informants suspected that because of the severe neglect and abuse experienced by these children, they learned at an early age to dissociate or disconnect from their feelings. Craig reported that because of "very severe trauma" the child may become "highly dissociative", while Leanne included witnessing abuse as traumatic for children. She described her experience and understanding of children who exhibit sexually intrusive behavior and dissociate from their feelings as follows:

I find that these kids have dissociated from their feelings pretty early on,

> and that can be because they have been sexually abused and had no control over it or it is often because of being a helpless little child listening to mom being hit at night and not being able to do anything about it, but they have really cut themselves off from feeling sadness or anger or despair.

Another aspect of why some children dissociate is described as the child's "attempt to cope with the feelings that come with hurting another child" (Karen).

Treatment Components for Children

The majority of informants reported on the components they typically include in the treatment of children who exhibit sexually intrusive behaviors. Some of the major components include teaching sexual abuse prevention skills, assisting with developing empathy, teaching how to recognize and express feelings, preparing for an apology to both direct and indirect victims, and developing a relapse prevention program. The consideration of developmental stages, such as the child's learning of empathy, was reported in the discussion of the various components. Components that were identified but were not expanded on included developing problem solving skills and trauma resolution. In contrast, Jean reported that it was difficult to identify treatment components as that would depend on her assessment of the individual child.

> My treatment of the child varies greatly. I don't believe in imposing a treatment methodology on children. I think that's brutal. I think they are all individual and I think we need to tailor our treatment.

Education

Three informants identified several types of educational components to treatment. Teaching sexual abuse prevention skills to children was considered an educational component according to one informant. Addressing power issues with the child was considered another type of educational component by two informants. "If kids don't have appropriate power they look for power in less appropriate ways and one of the treatment components is to re-orient them to appropriate power" (Kevin). Two informants described the need to address aggressive behaviors by teaching problem resolution skills so that the child will have the experience of solving their problems in constructive ways. Leanne shared her beliefs regarding the development of the child's aggressive behavior and how to intervene at that level stating:

> When children have come out of very traditional families of power and control, the psychoeducational piece is about teaching other ways of being, teaching other definitions of power, teaching personal responsibility, choices, teaching that violence and abuse is never okay but anger is and how can you be angry without being abusive. Some very basic teachings, recognizing that this child's teaching has been by role model in his family...so he needs to see and very clearly be taught another way of being..to learn how to be angry and frustrated in a non-abusive manner.

Further, she defines sex education in terms of the child's responsibility for his/her behavior, therefore exploring, "where the child learned what they have learned and believe it was okay to make someone else do something that they wanted them to do...so

I really try and take it out of the specific sexual context all the time".

Empathy, Body and Feeling Work

All three of the areas of empathy, body, and feeling work were considered by the majority of informants to be important components is the overall treatment of children who exhibit sexually intrusive behavior. Four informants referred to empathy work as a process of teaching the child to acknowledge the feelings of those children whom they abused. Two therapists viewed empathy through a developmental lens acknowledging the natural development of empathy in children according to their developmental age. Craig believes that victim empathy is a major component in treatment with older and younger children, but with younger children he stated that, "it is very difficult in so far as developmentally not having the capacity or the cognitive ability to understand right or wrong". Similarly, Karen related that her experience had been:

> (That these children) don't have any compassion or any empathy at all for who they are hurting...in part there's a developmental aspect to this as well. Younger kids just don't have a sense of what another person feels, so while it is partly developmental it is a process that can still be taught even though they're young.

Two informants reported that part of their strategy when teaching empathy is to reflect the children's feelings back to them as a way of helping them become aware of how they feel and how others feel. Roy stated that two major issues he faces when teaching the children empathy skills is to first help them, "understand what aggressive behavior is"

and secondly, to help them "understand the impact of their behavior" on their victims. His approach is to work on their own victimization and to understand how it triggers certain feelings that influence them to act out towards others.

Working with the child's body was described by two informants as a component of treatment, with each informant describing a different rationale for its use. Karen used body work to help the child recognize their own "warning signs" that they need to be aware of and in turn assisted them with learning "how other's feel". Kevin focused more on labeling body parts, body privacy, and respecting other peoples' boundaries with the notion that by doing this, "knowledge of the body gives mastery over the body which is another area of empowerment for the child".

Three informants reported introducing work with the child's feelings, with two of the informants focusing specifically on anger. Karen reported using the child's body to assist with the work on anger with these children. She stated that, "we do lots of physical stuff around anger by shouting and stomping with all this done in play". Rather than for the purpose of catharsis, Karen viewed this as an awareness exercise, a way of teaching that, "you have choices when you're mad". Karen also believes in teaching the child to identify the reason they are angry stating that, "it is not just that I'm mad but I'm mad because...". Similarly, Kevin believes in teaching the child to learn how to "resolve the anger in appropriate ways" by learning what to do when they are angry and what the anger is all about. Leanne discussed feeling work in a more general context. She believes that, "these kids have dissociated from their feelings...and really cut themselves off from feeling sadness or anger or despair". As such, she initially works with the child

on identifying a whole range of feelings by doing exercises followed by teaching them to, "take responsibility for what to do when they have feelings" and work on strategies to help them with the process.

The Apology Session

Three informants acknowledged "the apology" by the child to their victim(s) as a central component to treatment. Considering the child's developmental level, Sara noted that with an older child she may have him write a letter to the victim and with a younger child she may have the child draw a picture that indicates he is sorry. For the older child between the ages of 10 to 12, "restitution is a piece of the plan in that the kid has to do some volunteer work or some other kind of work to take responsibility for his offense" (Sara).

Two informants described the process and purpose of the apology. Leanne stated that together with the child they prepare for the apology which not only includes the perpetration of sexual abuse but also includes, "apologizing for the physical abuse they may have perpetrated against their mothers, their siblings and any other abuse of power". Roy identified the need to apologize to both direct and indirect victims. He stated, "Usually we always have access to indirect victims, mom and dad for example, brother and sisters. We don't always have access to direct victims because it is not always the person in the family that the kids has offended and the external family unit may not want you involved". In preparation for the apology the child must first understand the impact of his behavior on mom, dad, siblings, and others involved. According to several

informants this is done by preparing the child individually for the apology and preparing the parents individually to hear the apology. In her experience, Leanne found that the parents also need to apologize for how they were supporting the child's behavior but keeps the session from becoming a "mutual apology" as the child needs to recognize that, "what he did was his choice and it was wrong. So one apology does not blank out the other ones". Roy viewed his role during these sessions as a "referee" who will facilitate a positive experience for all involved.

Relapse Prevention

Three informants reported including relapse prevention as a treatment component. Including the parents as important supports for the child in terms of preventing further abusive behavior was identified by several informants. Sara reported that she would train the parents to be aware of the possible problems that may arise and to return to therapy if needed, stating, "I think the best relapse prevention is a good follow-up program".

Roy delineates a more detailed picture of the relapse prevention component, which includes having the parent involved:

> The kid presents his program to his parents and I have the parents sign a contract with the kid and me present, saying they are going to help him monitor his program, they are involved with the design of the program and with the follow up and monitoring. They have to assume that kind of role. I mean I'm not naive, shit, my involvement with a kid might be an hour or hour and a half a week, so it is the parents, the caregivers who

have to follow through with what I am trying to do with the kid, hence they are involved right from the beginning.

Issues That may Arise in Treatment With the Parents

This sub-theme includes four categories that the informants describe as issues with parents that need to be addressed in treatment. Each category includes a description of the issue with the majority providing some direction as to how the issue could best be addressed in treatment. The first issue described provides some understanding as to how parents bring their children to therapy. The second issue offers guidelines when working with parents with respect to the disclosure of the child's abusive behavior. Issues with family secrets and parental power issues were also identified by informants as potential inhibitors to successful treatment outcome if not addressed.

Parental Motivation for Treatment

Although many parents sincerely wanted help for their child, external pressure by child welfare authorities was identified by many informants as the key motivating factor for the parents to seek treatment. Some level of external pressure was required in order for the parent to bring the child to receive treatment. Regardless of whether the referral was from child welfare or was a private referral, Glen stated:

There is always external pressure. At minimum it would be from another parent. They may say, 'We're not going to let our kid play with your kid

> any more unless you get help'. Or the parents might have a relationship that has become very strained unless the parents show some responsibility and follow through.

Several informants witnessed parents' genuine concern for their child's future. "I think mostly they don't want their kid to grow up to be an adult offender. They don't want their kid in jail, they don't want their kid to hurt other people" (Roy).

Parental Response to Disclosure of Perpetrating Behavior

Three therapists related the importance of normalizing the parent's feelings in response to the disclosure of their child's sexually intrusive behavior. In the case when parents were thought to be over-vigilant, one therapist advocated for normalizing some of the child's age-appropriate behavior. Another therapist suggested anticipating what feelings the parent may experience and advising them to expect that feeling, while at the same time confronting any denial or minimization of the child's sexually aggressive behavior.

Family Secrets

Only one informant reported the significance of family secrets as playing a role in sustaining the child's sexually intrusive behavior. Other informants addressed the specific types of family secrets, such as the parent's history of abuse, but not in the context of secrets. For Leanne, addressing family secrets in therapy was very important as:

> There are layers of secrets with these families. Typically things like mom's sexual abuse, family violence...it just feels like it is peeling away layers of secrets with these families. I go in now with sort of an anticipation that there are going to be secrets that will be disclosed along the way, but they are not all going to come clean right to begin with because their whole way of operating has been, 'If we keep it secret we are going to be okay' or 'It is not anyone else's right to know'.

Leanne viewed the family's keeping of secrets as a way of:

> Continuing the climate that allowed the sexual abuse to happen in the first place by being secretive which keeps the child from facing that part of himself that made that choice and deciding how he can never make that choice again.

Thus, Leanne's strategy was to bring to light the family secrets that she believes, "feed into that powerlessness and support the child's eventually being sexually aggressive".

Parental Power Issues

Several informants reported on the need to address any power issues between the parents in therapy. Such issues were primarily focused on the imbalance of power between parents.

> Most of the time mom has been usurped of any of her parenting power by dad in those traditional stereotypes...so often I work with the mom because she doesn't have much of a voice when I first meet her and then

> I meet with them as a couple and try and challenge their beliefs and values or to help them see how their interaction has supported their child's violence...so perpetrating or sexual violence is just an extension of the perpetration of the violence against those with less power (Leanne).

Treatment Components for Parents

The key to successful treatment was considered to be parental involvement throughout treatment. This sub-theme consists of two categories. First is a description of the therapist's beliefs about why and how parental involvement is critical to treatment success. The second category is made up of the "how to's" of involving parents in treatment with their children. Educating parents on the development of the child's sexually intrusive behavior is considered a primary aspect of treatment.

Parental Involvement in Treatment

The majority of informants viewed the parents' involvement as "critical" to "treatment success". Sara stated:

> I don't believe one should treat children without parents, so to me parents involvement is really critical to the treatment here. It is my belief that parents are the best therapists for their kids, not external professionals.

Further, Sara reported that it is the parent who is the primary client. Many of the therapists believe that, "the success rate seems to be much higher simply because the

family is involved (Roy). Glen concurred stating that, "parents are critical, in fact the kid probably won't follow through unless the parents are involved". Two informants agreed that the parents need to work as a "team" and be "united" on how they want to work together so that the child is accountable for his/her sexually intrusive behavior. Further, Murray believes that, "if parents aren't consistent with limits and expectations then kids are probably going to continue their acting out behavior". Craig discussed what he believed a successful scenario would look like reporting that, "the ideal situation would be to work with the parents or the caregivers to devise a program in appropriate methods in intimacy, trust, formulating trust and that sort of thing".

Education

Six informants discussed providing education to the parents as the major component of treatment. More specifically five informants discussed educating parents about the development of normative and non-normative sexual behavior in children, and eight informants reported on teaching the parents specific strategies to assist their child in stopping further abusive behavior. Considering a different aspect of education, one informant reported encouraging the parent to do advocacy work as another component of work with these families.

Five of the therapists agreed that, "You have to help the parents become educated about the child's sexual aggression, how it likely developed, how it's been maintained and what they can do about it" (Glen). Two informants stated that they first begin by learning what the parent views as appropriate or inappropriate sexual behavior:

> We go through books together, we might see videos, together and then we pick what they are going to do with the children. What books they might read to the kid, what videos they might show, how to monitor their behavior, how to award them for non-sexually offending behavior (Sara).

In contrast, Roy began with the parents or caregivers by, "describing for them what is normal sexual behavior or boundaries for kids".

Educating parents by providing very specific, practical interventions for home was reported as central to the treatment of these children. The majority of the informants encouraged parents to take on strict "supervisory" roles at home.

> If a child is really quite sexually intrusive you have to talk about monitoring and supervising that child even to he extent of that child not being left alone to play with other kids without an adult supervising those kinds of interactions (Murray).

Along with strict supervision, many informants advised parents of other "practical" rules that may be useful to assist the child with stopping the sexually intrusive behavior. The rules suggested were no babysitting, no sleepovers, separate bedrooms, and whatever other house rules were necessary. Kevin made the distinction between rules and structure:

> The parent's role is not to control kids. It's about setting up a structure for kids...I think it is really important for a child's sense of empowerment because what happens with rigid rules is children become disempowered with rigid rules but if you have a structure and a pattern they become

empowered because they are prepared for the future.

As part of the educational component, Craig believes in "sensitizing" the parents to sexual issues prior to treatment. He stated that, "sensitization is being willing to talk openly about sexual issues. Having knowledge about how sexually reactive children express themselves in a sexual way, talking about exposure, chronic masturbation".

A variety of other interventions that involve the parent's participation were identified. Several informants suggested that advising the parent to cue the child about particular problem behavior was effective.

> We involve the parents in setting up cues for the kid, so the kid knows when the parent looks at him in a certain way or gives him a certain look as a cue that they are recognizing his behavior is starting to escalate or is placing himself in a situation that he might be at risk so they get involved in that context which is very important (Roy).

Two informants related encouraging parents to address sexual issues that are age-appropriate. "I teach parents to tell kids about sex, even at a young age" (Karen). Another strategy was to reinforce non-offending behavior. "My emphasis is on the non-offending behaviors to increase the non-offending behavior and to decrease the offending behavior. If the offending behavior is really out of control then we need to consequence" (Sara). Glen stressed the importance of intervention that includes education of the parents, "to develop limits to help the kid understand limits and boundaries on general and sexual behavior".

Leanne believes that part of her role as a therapist is to encourage the parents to

partake in some kind of "advocacy work" as a piece of the treatment. She has found that the parents have a lot of energy to challenge society stating:

> (The parents) often become real advocates for challenging pornography or challenging stereotypical behaviors in the media...they have a very vested interest in the world changing because they have been there, they have seen the effects of those messages. It has happened to their family.

Termination of Treatment

Five informants reported how they would evaluate whether the child was ready to terminate therapy. The therapists addressed issues with the child, the family and with the school.

The criteria included the following: 1) Has the sexually intrusive behavior stopped? 2) Have they reached the goals set out in therapy? 3) Do they have a good relapse program in place? 4) Has the child acknowledged what they have done and have taken full responsibility for the behavior? 5) Has the child apologized? 6) Is the child able to talk about the sexually intrusive behavior, associated feelings and precipitants? 7) Are the parents more supportive? 8) What are the school reports regarding the child's ability to manage his/her sexually intrusive behavior?

Put simply, treatment is finished, "whenever the kid is symptom-free and you have nothing to talk about. The kids are doing fine and the parents are doing fine. The parents say there is nothing to talk about with respect to the kid" (Sara).

Treatment Modality

The majority of the informants discussed the process of treatment as including a combination of individual, family, group and play therapy. The cognitive-behavioral model of therapy was the most widely noted model used in the treatment of children with sexually behavior problems. Each informant treated the children utilizing various combinations of modalities, but their decision about which method to emphasize was contingent upon the needs of the child, the family, and the particular circumstances. Craig stated that, "each child will certainly dictate what the treatment approach will be". Glen shares a similar belief stating that, "your mode of therapy depends on what your goals are and sometimes family therapy is appropriate for a phase, then individual, perhaps couple work".

Several informants begin with family therapy, then move to individual work with the child and/or work with the parents on parenting and couple issues. Leanne stated:

> I typically get the whole family in first of all and try and get every one's sense of what has happened, what are the contributing factors, what they see as the problem, what they want to have changed and what the issues are for the family.

Similarly, Craig reported having also experienced, "getting everybody in initially" as a good approach and then using, "play therapy or more free flowing forms of therapy" with the younger child.

Five informants reported believing that group therapy is effective for some children.

> It (group) is often a very validating experience in the sense of attenuating some of the feelings of stigmatization and self-blame...and it gives kids experience right there and then to experiment with healthier ways of relating to other kids...another good thing about group is that kids get exposed to different ways of solving these kids of problems around sexual behavior and how you express sexual feelings (Murray).

Leanne concurred stating that, "the peer challenging of the group therapy for sexually aggressive boys is really needed".

The cognitive-behavioral approach to treatment was cited by the majority of informants as the model of choice. Many agreed that although research on treatment efficacy is lacking, there is no conclusive evidence suggesting that one mode of therapy is more effective than another. Nevertheless, Murray stated that, "I think we all have hunches that equipping children with specific skills and abilities to handle their sexual feelings or urges more appropriately is probably the route to go, therefore, one would probably rely on cognitive-behavioral strategies".

While many therapists have found the cognitive-behavioral approach most useful, several therapists who work primarily with the younger children found this approach frustrating. Kevin noted that while the cognitive oriented therapies assisted in his own understanding of the important treatment issues, they are not, "very helpful when you have a seven year old in front of you. Now how do I get this notion of the cycle of offending behavior across to a seven year old?". Jean believes that the treatment approach must be tailored to the developmental age of the child as she expressed her

frustration with the cognitive therapies for young children stating:

> I'm not very happy with the resources out there. They seem to be very cognitively based. It seems to me people have taken a lot of the things the people have used for adult or adolescent offenders and are trying to use them with kids and I think that is inappropriate.

Confidentiality and Other Ethical Issues

Several ethical issues relevant to work with sexually intrusive children were identified, including confidentiality, decisions regarding the parameters of appropriate sexual behavior in children, and the risk to community versus responsibility to the client. Three informants reported a rational for their approach to confidentiality. Many consider the secrecy of individual therapy as a parallel to the secrecy of perpetrating behavior. Leanne remarked that:

> If you are just doing therapy individually, it is a very secretive little thing and it copies the same thing the family is doing, 'Well, we will just keep it secret here amongst ourselves'. But there is a whole system that you can include and I let them know that other people in their helping system need to know things. So I let them know that I will tell them when I am going to talk with them but they don't have any choice in the matter of what I tell.

Several informants asserted that they share information with parents, social workers,

probation officers, psychiatrists, psychologists, nurses and child care workers to "break away from the secrecy" (Roy) that is part of the defensive pattern of offending.

Five informants identified several ethical concerns related to the treatment of children who exhibit sexually intrusive behaviors. Boundaries regarding who has the responsibility to tell others about the child's offending behavior was questioned by three therapists. These questions were associated with assessing the risk that these children pose to society. Leanne also reported that, "the ethical issue is about who should know that this child is high risk for offending". Craig queried, "who do you tell...where does the ethical boundaries lie...who do you let know or do you have a responsibility to let anybody know". Roy had similar questions, asking, "where is my responsibility to community? Where is the responsibility to my client? To the family?". Yet he very clearly stated that his responsibility to the community overrides issues of who to tell as, "I work with kids who potentially are very dangerous kids...so I have less problem with that".

Another ethical issue identified by several informants is who decides what is appropriate child sexual behavior. "There is such a range of what is appropriate behavior. Families have different belief systems, cultures, religious groups have different belief systems" (Sara). Murray identified that this issue is a "value judgment" and questioned, "the danger of treating the child so intensively that the child may have a very adverse reaction to any kinds of sexual feelings" (Murray). He further warned that we are "not to go overboard and inadvertently convey the message that all aspects of sexuality are bad or harmful or exploitive, because clearly they are not".

Leanne questioned the ethics of labeling of the child, stating:

> How do they not brand their child in a way that this label is going to follow them the rest of their life and yet at the same time how do they take it seriously enough to give the child the message that this is wrong and this is really serious.

Finally, another informant was concerned with, "the ethics of keeping kids in therapy just to do stuff that you think is important when you have no proof that it is".

Issues with the Therapeutic and Legal System

Issues with the larger system, namely the therapeutic community and the legal system, were addressed by several informants. First, concerns with the lack of professional training for therapists and foster parents alike were identified. The informants related that, in general, therapists are not seen as being adequately educated to identify the appropriate issues with children's sexually acting out behavior.

> I think a lot of these children have been misdiagnosed in the past. People have not been trained and a couple of the kids I am seeing now at 9, 10 or 11, these behaviors had started at 5 or 6. Nobody really knew how to approach them (Craig).

The informants suggested that therapists must work cooperatively with foster parents. Craig noted that foster parents have not been adequately prepared for working with the range of behaviors that these children present with. He stated:

> It was almost like a kid in the candy store...he just had the run of the place, performing cunnilingus on little girls, at that time he was probably about five and a half, forcing boys to perform fellatio on him, a wide number of paraphilia (Craig).

The second larger systems issue, reported by five informants, addressed the need to involve the legal system when, for example, parents are not taking their child's behavior seriously. While rarely utilized, mandating treatment through child and family services was considered by several therapists.

> The only time I think these cases need to be mandated are when the parents don't see this as serious...so if the parents don't see this as serious and needing of treatments or needing of counselling or mediation, then we don't have a child available to us (Sara).

Leanne stated that, "sometimes I really think we need the law to get them hooked into treatment and to help look at the seriousness of what it is they have perpetrated". Using the Child Welfare Act to motivate families to bring their children for treatment was recognized as a viable option by three therapists.

Future Research

Assessing and treating children who exhibit sexually intrusive behavior is "still in it's infancy" (Craig). In fact, Murray went so far as to state, "the answers, I don't think we even have many of the questions at this point". Many of the informants shared their

beliefs about the areas that require further research and ideas about what variables to further explore. Karen suggested that, "attachment theory could shed a lot of light on the dynamics around sexually aggressive behavior", while Craig highlighted the need for further work in the area of dissociation stating, "Why does a child who dissociates or shows symptoms of dissociation, why is sexuality or highly sexualized or non-normative sexual behavior why is that a factor in dissociation". With respect to further work with these children, Roy suggested "things like fetal alcohol syndrome and what affect does that have...there are some brain issues and brain damage issues that effects memory...multiple personality...chemical stuff". Two informants referred to the role of biological factors. "What do these kids look like hormonally compared to other kids who don't act out sexually...Is there a difference in biology? Physiology...are these kids any different neuropsychologically" (Murray). Another area identified is the need to research what constitutes effective treatment, questioning if, "their chances of growing into adult offenders decreased by having treatment? What happens if they don't have treatment...the real questions will be answered if you can do a longitudinal prospective study" (Murray). Jean added a different direction for research stating that, "I would like to see more attention paid to children's developmental level in relationship to their behavior and their response to trauma".

Summary

The theme, 'Treating Sexually Intrusive Children', includes a wide range of issues related to the therapeutic process with children who exhibit sexually intrusive behaviors. Although assessing the whole child is important, specific child variables were identified with the most significant one being the need to assess the sexual behavior. The family's influence is also important to consider when assessing the problems experienced by the child. In fact, the findings related to parental influence in the development and maintenance of sexually intrusive behaviors, as well as parental involvement in the therapeutic process, suggest the importance of involving parents in every step of the assessment and treatment process. A range of treatment issues and components were identified for both children and parents. The informants offered practical guidelines for therapists who work with these children, including how to address the child's abusive behavior with the child, and how to increase the parent's involvement in treatment to help the child stop the abusive behavior. Related issues with the therapeutic and legal systems and ideas for further research were also included.

CHAPTER SIX

DISCUSSION

The research that addresses children who exhibit sexually intrusive behavior is limited, and even less has been conducted on the treatment process. As such, it is hoped that the findings of this study will contribute to the social work knowledge base with respect to preventing the victimization of children. Highlighted in this chapter is a discussion of the major findings from the current study which contribute to the understanding and assessment and treatment of children who are sexually intrusive and their families. The chapter is organized into four sections. First, the limitations and strengths of this study will be briefly reviewed, followed by a discussion of the four major outcomes of the study. The third section reviews the implications of the research findings for social work practice. Finally, directions for future research will be considered.

Limitations and Strengths of the Current Study

When evaluating the significance of the results, it is important to view these in the context of the study's limitations and strengths. While some limitations were previously described in the methodology chapter, further became apparent as the interviews and data analysis were conducted.

Additional contact with the informants might have provided richer data. Lengthier interviews and second interviews are two methods by which this process could have occurred, however, time constraints on both the part of the respondents and the

interviewer meant that this was not feasible.

While conducting open-ended interviews allowed themes to emerge that would likely not have been raised if a semi-structured or structured interview had been used, this format did confuse some of the informants. For these, the open-ended format seemed too vague and lacked sufficient direction which created the risk of important data not having surfaced. With the open-ended format somewhat different material emerged in each interview. The un-structured format also resulted in a more arduous coding and data analysis. These processes were not only very time consuming, but also left more latitude for the researcher to make her own interpretations, thus creating more opportunities to threaten the validity of the findings. A semi-structured interview could have provided sufficient guidance for the respondents, as well as a more efficient framework for coding and data analysis.

The fact that I have previous experience as a therapist with this population meant that I had developed particular values and beliefs which may have biased the questions asked, my responses to the informants' comments, and the interpretation of the data. In an attempt to redress such possible influence, I followed the lead of the informant as closely as possible during the interview.

Nevertheless, it is virtually impossible to remove one's biases. Other authors recommend acknowledging one's personal values and beliefs throughout the research process (Van Maanen, 1988). I did so by making a written statement of my personal biases in the introduction of the thesis and by continuing to acknowledge such biases throughout the research process by verbally discussing them with my peer debriefer and

in written form in the audit trail.

Although generalizing the findings of this study to other populations or settings is not at issue because qualitative research is concerned with transferability rather than generalizability, Lincoln and Guba (1985) maintain that research must provide a thick description allowing an interested person to make a transfer of the findings and decide whether this is possible. As much as possible, I have provided a sound data base, which is the researcher's responsibility, leaving the assessment of the transferability of the findings up to the individuals who will read this thesis.

The Four Major Outcomes of the Study

Four significant outcomes emerged from the results of this study. These include the importance of incorporating a developmental perspective in the assessment and treatment of children with sexually intrusive problems, the centrality of parental influence in the development of sexually intrusive behaviors and parental involvement in the child's treatment process, concurrent issues of family violence and finally, significant ethical issues with which therapists may contend when treating these children. Such issues became significant as they were highlighted by the informants as central to their work with these children, with seemingly more emphasis than in the literature. Some of the main themes had only been touched on in the literature, however, I believe that these need to be emphasized as important for therapists when treating children who exhibit sexually intrusive behaviors.

Inclusion of a Developmental Perspective

The importance of considering child development issues in the assessment and treatment of children with sexual behavior problems and in understanding these children became apparent throughout the analytic process. However, more questions than answers arose, particularly with regard to the impact of a child's developmental level on assessment and treatment.

The therapists varied in the age-groups that they treated, with the majority working with children ages 10-12 and several working only with children ages 4-6 and 7-9. This distinction, however, has not been previously highlighted in the literature. While some clinicians have stated that their treatment program should be adjusted to the child's developmental level (Cunningham & MacFarlane, 1991), they have not specified how to accomplish this. Other clinicians write that they take developmental issues into consideration when assessing the appropriateness of placing the child in group treatment (Johnson, 1993e). Thus, if a child's emotional or cognitive developmental levels are significantly below in actual age, placing a child in group therapy with peers of their chronological age may introduce further complications.

Another aspect of child development that has only been touched on in the literature is considering the child's age with respect to the degree to which the child and/or the parent is responsible for stopping the sexually intrusive behavior. Some of the clinically-based literature suggests that the younger the child, the greater the need for parental involvement, including an increase in stressing parental responsibility for controlling the child's sexually intrusive behavior and to keep the child safe (Bentovim,

Vizard, & Hallows, 1991; National Children's Home, 1992).

The findings in the current study support this view and clarify the importance of further research that takes developmental levels into consideration. The treatment providers who worked primarily with younger children appeared to draw on treatment components which emphasized body and feeling work, with a major focus on parental responsibility for supervision and limit-setting with these children. In contrast, the treatment providers whose experience was primarily with children aged 10 to 12 reported integrating treatment components such as the apology session and relapse prevention that are derived from adolescent models of intervention and suggest increased responsibility on part of the child. Implicit in these treatment provider's focus is the belief that the older the child, the greater the expectation for that child to take personal responsibility for his/her own sexual behavior. While parental involvement is important for all these children, the importance of parental involvement understandably increases as the child's age decreases. Thus, the child's ability to understand the consequences of his/her sexual behavior and his/her intent varies with age and should dictate the balance of parental/child responsibility.

The impact of trauma on the child's developmental level is also of interest. There appears to be consensus in the literature that children with sexual behavior problems have often experienced prior trauma (Cantwell, 1988; Dann, 1987; Johnson, 1988; 1989; Friedrich & Luecke, 1988). The findings of this study support this belief, as the majority of children with whom the treatment providers worked had experienced prior sexual trauma. However, no one has answered the question, what influences some children who

are sexually abused to perpetrate against other children? The effect of the child's age at the onset of trauma and its impact on the child's later functioning also require further investigation (Freidrich, 1990).

While some previous research has been conducted to establish what constitutes normal sexual development in children (Friedrich et al., 1991; 1992; Kinsey, Pomeroy, & Martin, 1948; Kinsey, Pomeroy, Martin, & Gebhara, 1953; Lamb & Coakley, 1993; Sgroi, Bunk & Wabrek, 1988), a number of questions remain. For example, do children's level of understanding about sexuality affect how they choose to act sexually towards another child? Is the action considered by the child as sexual? How is sexual arousal in children understood? Do they view their sexual behavior as harmful?

The need for a developmentally-based treatment program for children with sexual behavior problems was highlighted in this study. Some therapists noted that utilizing cognitive-behavioral approaches to treat young children seemed inappropriate as they are based on complex ideas and notions regarding the sexual offense that do not fit the cognitive abilities of very young children. Further developmental research with respect to normal sexuality and trauma could provide insights into how the child is affected by trauma and neglect. Such research could suggest what approach would be most appropriate given the child's developmental level. Another avenue would be to investigate which, if any, of the adolescent and adult treatment approaches might be tailored to meet the needs of the very young children who act out sexually. However, one might also question whether treatment approaches to adolescent and latency age offending behaviors can be meaningfully scaled down for younger children or whether

an entirely different approach is warranted.

The central questions remain; when are the sexual behaviors of children considered abusive and when are they considered to be within normal limits? When are children referred to as 'perpetrators' and when are they considered to be 'abuse-reactive'? Is it appropriate to label children who may or may not know that what they are doing is wrong or harmful to others? At what age is it appropriate to refer to them as offenders if their level of moral development or comprehension of intent is considered? The issue of understanding the child's sexual behavior within the context of child development has not been clarified in the literature, yet is important and clearly requires further investigation.

In summary, the theme of child development ran throughout the entire study, particularly throughout the findings on treatment. While the literature on assessment and treatment is scant, developmentally-based research is even more rare. It is this writer's belief that the range of developmental levels of children from the ages of 4 to 12 are so distinct that treatment must be developmentally-based for each level.

Parental/Caregiver Influence

The second major theme that emerged in the current study is the significance of parents/caregivers to the understanding of the sexually intrusive behavior of their children. Although I refer primarily to "parental" involvement, this term also includes caregivers such as foster parents and child care workers. While parental/caregiver influence has been previously acknowledged in the literature (Canavan et al., 1992;

Courtois, 1988; Dann, 1987; Johnson & Gil, 1993; O'Brien, 1991; Smith & Israel, 1987), the respondents in the current study appear to place considerable emphasis on the parent/caregiver's involvement throughout the assessment and treatment process.

First, in order to understand a child who is perpetrating sexual abuse, one must understand her in the context of the family environment. It appears to be widely accepted that sexually intrusive behaviors do not develop in a vacuum, but rather, there are many factors which contribute to their development such as prior trauma and witnessing abuse (Biddell, 1993; Dann, 1987; Johnson, 1988; 1989; Friedrich & Leucke, 1988). While the importance of multiple factors was also confirmed in the current study, the respondents emphasized the role of the parent's history of sexual, physical and emotional abuse and neglect in contributing to the development and maintenance of sexually intrusive behavior. In particular, these factors were thought to influence how the parent will respond to the disclosure of their child's perpetrating behavior. The informants emphasized the notion that the child's response to intervention will vary according to the parents' willingness to support the child in treatment and their ability to accept responsibility for helping the child manage the sexually intrusive behavior.

Further, while parental response to the disclosure of the child's perpetrating behavior has been addressed briefly in the literature (Johnson & Gil, 1993), the informants expanded this description and connected it to the impact that parental response has on the maintenance of the sexually intrusive behavior. The parental responses included self-directed reactions such as guilt, minimization, and powerlessness; supportive or non-supportive child-directed reactions including anger and distancing themselves from

their child; and, finally, other-directed reactions such as anger towards the child welfare worker. A more complete description such as this, can assist therapists in alerting parents to the possible range of emotional responses that they may experience. Further, parents can consider how they might handle such reactions so that they do not contribute to the maintenance of the child's sexually intrusive behavior. For example, if parents are minimizing the effect of the child's offending behavior it will be difficult to encourage the child to take responsibility for his/her behavior. The importance of family involvement in the treatment of sexually intrusive behaviors which may include family therapy, support and/or treatment groups for parents, and parent-child dyad sessions has been highlighted as part of the second major outcome of this study.

Second, the connection between parental involvement in treatment and treatment success was strongly emphasized by the respondents. Such parental involvement could range from simply ensuring that the child attends treatment, to individual therapy for the parents, to participation in family therapy. Regardless of how the parent is involved it was highly emphasized that the parents adopt strict supervisory roles. The parent's role in treatment is primary and appears to have been emphasized far more in this study than in the treatment literature which focuses on individual and group treatment for children (Cunningham & MacFarlane, 1991; Johnson & Berry, 1989; Lane, 1991; Ryan, 1992). This difference in emphasis could be due to the fact that many of the programs described in the literature are for institutionalized children where parental access is not readily available. In contrast, the majority of informants in the current study provide treatment to children in a community out-patient treatment model.

In summary, the respondents highlighted the importance of parental involvement throughout the study. While the literature describes the parents' influence on the development of sexually intrusive behavior in children, in the current study there was a significant emphasis on parental involvement in the assessment and treatment process, including the need for caregivers, such as foster parents and child care workers, to be involved in the healing process.

Violence Within the Family

The third major outcome focuses on family issues beyond the sexually intrusive behavior, including the violence and power issues that are experienced within many of these families. Some of the families experienced physical, sexual and emotional abuse, issues which have received parallel attention in the literature (Canavan et al., 1992; Johnson, 1988; 1989; Friedrich & Luecke, 1989; Smith & Israel, 1987). The aspect that appears to be novel in the current study is the commonly-mentioned fact that many of the children exhibited sexual and physical violence towards their mothers. The informants speculated that as a result of witnessing the father's violence and/or sexual abuse of the mother, the child appeared to be copying the paternal abusive role. Such behaviors contribute to the range of possible risk factors of which treatment providers must be aware and ready to address in treatment.

Of interest was the emphasis that several informants placed on issues of power and control including the power imbalance within the parental subsystem, the adoption of stereotypical gender roles, and the child's quest for power when engaging in perpetrating

behavior. Each has implications for how treatment is conducted. While these issues were not highlighted within the treatment literature on sexually aggressive children, they have been addressed within the literature on sibling incest which has identified such families as highly patriarchal. As such, the siblings are exposed to male domination and female passivity as their primary relationship models (Canavan et al., 1992; Laviola, 1992; Wiehe & Herrings, 1991). Although power issues were addressed by only three informants and gender issues were addressed by only one, these were judged to be important and in need of consideration because the norms and values of society play a large part in the development of sexually intrusive behaviors (Johnson, 1993a; National Children's Home, 1992). Interestingly, the issues raised in this major outcome, emerged from the treatment providers who practice from a feminist perspective.

Ethical Considerations

Ethical issues comprised the fourth major outcome that emerged from the current study. It is interesting that not a single ethical issue was raised in the published literature on sexually intrusive children. Perhaps this is due to the implied or universal nature of ethical issues in general, however, a discussion of such issues is considered imperative for therapists.

A notable finding was the informant's rational for including others in the assessment and treatment process. It appears that the need for intervention at various levels overrides the child's right to confidentiality. Teachers, relatives, or other professionals were commonly included to help deflect the shroud of secrecy that is the

nature of abusive behavior. For example, teachers were seen as part of the treatment team due to the high degree of contact that they have with the children, and their access and ability to observe them in the context of play with other children. The teacher's involvement would increase opportunities for intervention and prevention of further abuse of other children by working closely with the therapist and parents by monitoring the child's behavior through supervised play and reporting on the child's academic progress. The informants noted that the process of conducting individual therapy with the child can, in effect, mimic the secrecy of the problem. Thus, including more people in the therapy, as described above, appears more appropriate.

Who to tell within the community and who not to tell are particularly important questions for therapists working with children. Generally, there is no required police involvement with this age group. However, the therapists in the current study questioned their responsibility for alerting the community in general to the possible risks posed by their clients. The children in treatment were primarily attending community schools where the possibility of further offending behavior should be considered. Who is responsible for informing community agencies of the child's offending behavior and the possible risk to reoffend appears to be unclear, however, one suggestion is that these issues should be addressed by those treating the children.

Summary

The four major outcomes of the study, including a developmental perspective for the assessment and treatment of children with sexual behavior problems, importance of

parental/caregiver involvement in the child's healing, issues of family violence and ethical issues, expand the current knowledge base of the problem area and highlight gaps in the literature. These themes are central in the following discussion of the implications for social work practice and suggestions for future research.

Implications for Social Work Practice

Limited research has been conducted on the assessment and treatment of children who sexually abuse other children. Although the current findings are based on an exploratory study, they are judged to make a contribution to the social work knowledge base for therapists working with this population. The majority of the findings support what is presently known of these children based on the literature, while some of the findings suggest new directions with respect to the assessment and treatment of children who are sexually intrusive. This section reviews the implications of the findings of the current study for social workers as therapists, child protection workers, and child care workers, including foster parents.

Social workers who treat these children may find the current study useful in four ways. First, the findings can provide therapists who have little experience working with this population with a solid knowledge base about the characteristics of these children and their families, as well as practical information on assessment and treatment processes. For therapists already working with children who exhibit sexually intrusive behaviors, the findings may affirm their treatment directions or provide them with new information

that may challenge preconceived notions or add to their repertoire of treatment strategies.

Second, several issues are emphasized in this study that have not previously been highlighted as related to sexually intrusive behaviors in the literature. Such issues include the prevalence of comments regarding developmental and ethical issues, the importance of assessing a child's violent behavior towards the mother and the inclusion of parents and caregivers in assessment and treatment. Emphasizing these issues may alert the therapist to explore these matters with the child and his/her family.

Third, it is important that we, as therapists, examine our own beliefs and reactions to children who are sexually intrusive and are comfortable in dealing with both child and adult sexuality. A knowledge of children's sexual development is critical for working in this area. The therapist may also be required to assess and address abuse histories on part of both the parent and child. Understanding the family's sexual climate which could range from sexually repressed to highly sexualized interactions is also imperative. An awareness of one's own personal issues is essential to help prevent such issues from interfering with the treatment of these children and their families.

Fourth, an implication of the current research for therapists who are involved in developing sexual abuse prevention models is that such programs should include examples of incidents of children abusing other children. Current sexual abuse prevention models have only recently begun to move away from traditional stranger-danger ideas to include abuse that is perpetrated by familiar adults. However, notions that abuse may also be perpetrated by children their own age have yet to be introduced.

The findings of this study also have implications for social workers in child

protection agencies. Child protection takes on new meaning when we consider that children as young as age four may be perpetrators of sexually intrusive behavior. Recognizing that the majority of these children have experienced prior sexual trauma and are likely to choose siblings as victims must alert child protection workers of the dangers of intrafamilial abuse and the need for early intervention and the mandating of treatment when necessary.

The current results have implications for residential child care workers and foster parents who care for sexually intrusive children in three primary ways. First, while parental influence and involvement in the assessment and treatment process was highlighted within the study, this can also be applied to child care workers and foster parents. As much as possible, child care workers and foster parents should be educated about the significance of their response to the child's perpetrating behavior, and the possibility of suicidal ideation, particularly with the older children. Child care workers and foster parents must see themselves as part of the treatment team, as they are likely to be responsible for providing strict supervision of the child's play, as well as involved in setting up a solid follow up program to treatment.

Second, foster parents and child care workers should be alerted to the fact that sexually intrusive children choose their victims from the children with whom they have most contact, such as siblings or other children in residential group homes. Learning how to effectively intervene with such sexual behaviors is essential to all who are involved in their care.

Third, the findings with respect to confidentiality have particular implications for

foster parents and child care workers. Confidentiality has been addressed in this study in terms of 'breaking the silence' that shrouds the issue of perpetration of children by children, soliciting parental/caregiver involvement from the perspective of prevention rather than focusing on individual rights of confidentiality. Understanding of this rationale of their involvement may also contribute to their understanding of the particular issues around the secrecy of this problem area.

Future Research

There is no question that further research on children's sexual development and intervention outcomes would expand our understanding of the development of sexually intrusive behaviors in children. Further research on the incident and prevalence of this problem would be beneficial in order to more accurately estimate the number of children who engage in sexually intrusive behaviors. Based on the work of the nine treatment providers in the current study who have assessed and treated over 350 children ages 12 and under, is evidence that a large number of children are coming to the attention of professionals. However, in order to provide a more systematic overview of how many children require services, data collection systems must be developed and studies conducted.

The results of the current study could provide a framework from which a survey could be conducted with a larger number of therapists experienced in treating such children. Questions could address the characteristics of children who are sexually intrusive and their families, which variables contribute to the development and

maintenance of sexual behavior problems, and which treatment models have been found to be most effective and appropriate when taking into consideration the developmental level of the child.

Although prior sexual trauma appears to contribute to the development of sexually intrusive behaviors (Johnson, 1988; 1989), further research into other variables which contribute to the development and maintenance of such behaviors is warranted. The majority of authors suggest that children who are sexually aggressive have experienced sexual abuse, but not all children who have been sexually abused go on to perpetrate abuse (Friedrich et al., 1988; Friedrich, 1990; Hall, 1993a; Johnson, 1989). It would be interesting to study the differences between these two groups of sexually abused children. Considering the current thinking about the significance of family variables on the development and maintenance of sexual behavior problems, one hypothesis is that children who have been sexually abused and come from neglectful family environments will have a higher incidence of developing sexually intrusive behaviors than children who have been sexually abused and come from supportive family environments.

Further research on children's sexuality is also required. What constitutes "normal" sexual development in children? When is sexual behavior in children considered 'abnormal' or 'deviant'? In addition to this, in order to understand the behaviors that sexually intrusive children exhibit, further research clarifying a typology of children with sexual behavior problems could be conducted. While the comprehension of the children appears to be most clearly understood when conceptualized on a continuum of sexually intrusive behaviors, it is difficult to know about whom we are

talking when researchers/clinicians use different terms and criteria for children's sexual behaviors.

Outcome studies on treatment efficacy also should be a priority in future research, particularly with respect to the appropriateness of current models with very young children. In an attempt to answer some of the previously stated questions, longitudinal research which follows the sexually intrusive behaviors in children would provide important information regarding the effectiveness of different treatment models and insight into the development of sexually intrusive behaviors.

Another aspect of treatment outcome research would be to determine the appropriate balance of offender and/or victim focused treatment for these children. The majority of children who exhibit sexually intrusive behaviors have a known history of sexual abuse (Cantwell, 1988; Dann, 1987; Johnson, 1988) which raises questions regarding the balance in treating the victimization and victimizing experiences of these children. In the current study, some informants approached the child's victimization issues first, while others addressed the child's perpetration behaviors. Some authors suggest that it is important to confront the perpetration behavior first so that they could not use their own victimization as an excuse (Bentovim, et al., 1991). However, there appears to be little consideration of the child's developmental level when describing which issue is dealt with first, when, and for how long. Is offender-focused treatment appropriate for younger children? Further, as with most aspects of treatment effectiveness with this population, there is little evidence suggesting that one approach is more effective than an other.

EPILOGUE

This exploratory qualitative study employed generic methods for analyzing the data gathered from interviews with nine treatment providers who together had experience assessing and treating over 350 children, under 12 years of age, who exhibit sexually intrusive behavior. The findings of the current study which support the literature, clearly identify a need for therapists to acknowledge the seriousness of the sexual intrusive behaviors of children. Although it may be easier to label the behavior as normal exploration, as professionals, it is our responsibility to identify and address problem sexual behaviors, and to educate ourselves so that further abuse does not occur.

With such a large number of sexually intrusive children also having a history of prior sexual abuse, there is clearly a need to intervene with sexually abused children with hopes of preventing the perpetration of further abuse. Although it is not understood why some children who are sexually abused perpetrate similar behavior against other, it is known that the majority of these children choose children with whom they have the most access, such as siblings, foster children, other group home children, as their victims, alerting professionals of these potential risk factors.

Children who exhibit sexually intrusive behaviors clearly represent a complex phenomenon that requires further evaluation and research. It must be emphasized that this new generation of young "perpetrators" require intervention at not only the individual level, but that intervention at the family level may be even more crucial for these young children. More than with any other group of offenders the familial context is critical.

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APPENDIX A

CONSENT FORM

I agree to being a participant in this study about my experiences in treating children under the age of twelve who molest other children and the families of these children. The study will be conducted by Carmen Richardson, M.S.W. student at the University of Calgary.

I understand that all of my responses will be kept confidential and that no identifying information about myself or my clients will be included in the written component of the research.

I understand that my participation in this study is completely voluntary and that I may withdraw at any point during the research process.

Signature_____

Date_____

APPENDIX B

TREATMENT PROVIDER/PRACTITIONER PROFILE

1) What is your professional identity?

M.D.____ Psychiatrist____

Nurse____ Social Worker____

Psychologist____ Other (please specify)_____

2) Please identify your profession degree:_____

3) How many years have you been working in the helping profession?

____

4) Please indicate the type of agency you work for:

Child Welfare____ Parole/Probation____

Family Service Agency____ Private Practice____

Hospital____ Public non-profit____

Other (please specify)_____

5) What would you perceive as your primary theoretical orientation to treatment? (Please check only one)

Behavioural____ Feminist____

Cognitive Behavioural____ Humanistic/Existential____

Family Systems____ Psychodynamic____

Other_____

6) How long have you been treating children who molest and their families?

____

7) How many children who molest other children and their families have you worked with?

____

8) In your experience, what is the average length of treatment for this population?

____

THANK YOU FOR YOUR TIME!!!

APPENDIX C

DEMOGRAPHIC INFORMATION

1.a)Approximately, how many children, ages 12 and under who have molested other children, have you treated?

b)How old is the youngest child you have treated? Boy or girl?

2.Of those children you have treated, what percent would fall into the following age groups?

4 - 6 ____%
7 - 9 ____%
10 - 12 ____%

3.What is the gender of those children and in what category would they be?

4 - 6 ____%(boys) ____%(girls)
7 - 9 ____%(boys) ____%(girls)
10-12 ____%(boys) ____%(girls)

4.a)What would be the average number of victims that one of these children would have?

b)What percent of the following groups did these children choose as victims?

siblings ____%
extended family ____%
neighbors ____%
other ____% (Please identify)

5.What percentage of these children have experienced prior trauma?

6.What type of trauma:

sexual ____%
physical ___%
other ____% (please specify)
combination ____% (please specify)