



# Examining the ATSA Children with Sexual Behavior Problems: 2<sup>nd</sup> Edition

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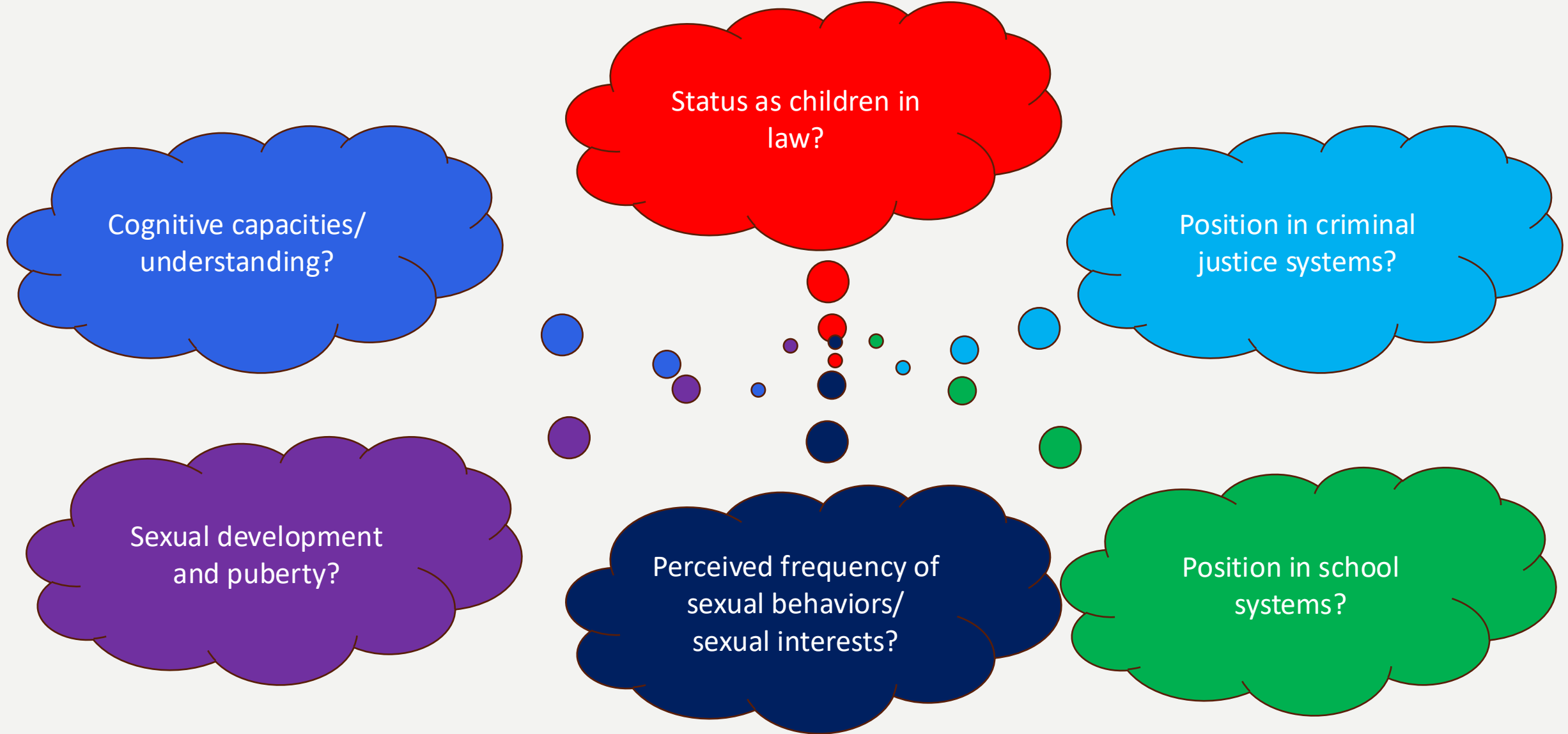
MASOC CONFERENCE 2024

Why consider  
under 12s  
specifically?

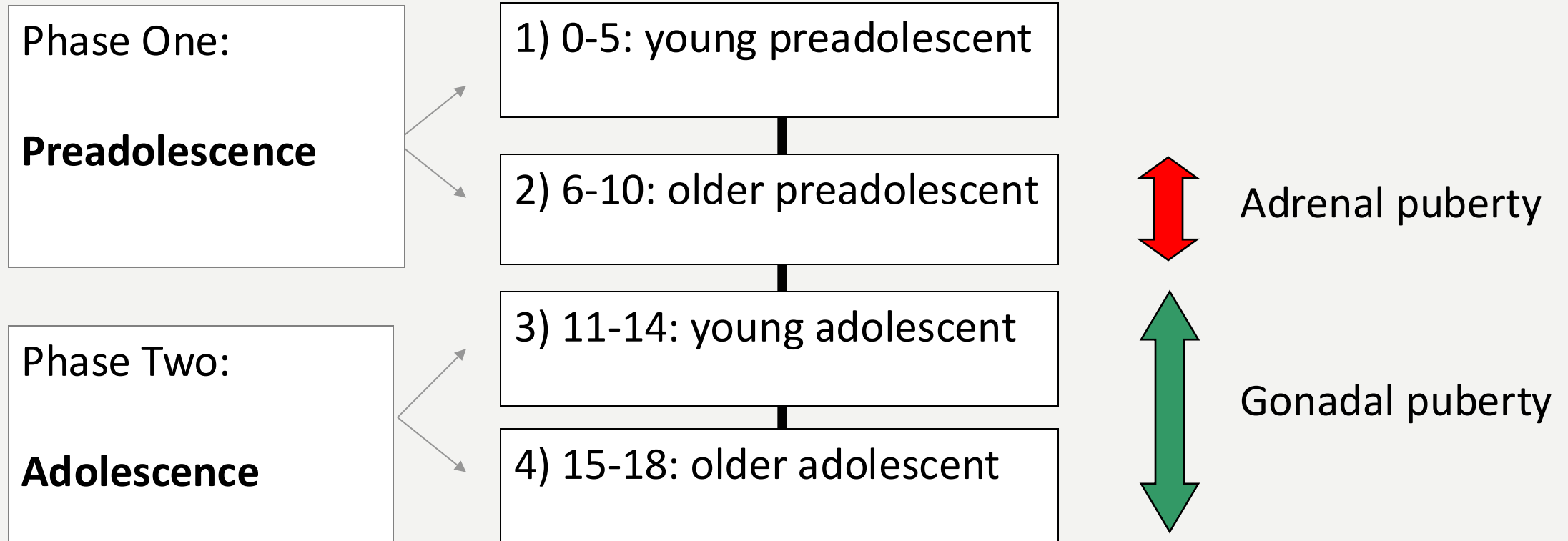
Early practice responses to youth with harmful sexual behaviors were largely based on adult sex offender models, with adaptations for use in work with adolescents.

According to Longo (2003) this 'trickle-down effect' was highly destructive in the way it influenced work with adolescents

# 12 is no hard and fast developmental boundary, but...




# Two phases / four stages of sexual development (Hackett)



# What's the definition?

Children with sexual behavior problems are defined as those aged 12 and younger who initiate sexualized behaviors that are developmentally inappropriate or potentially harmful to themselves or others.

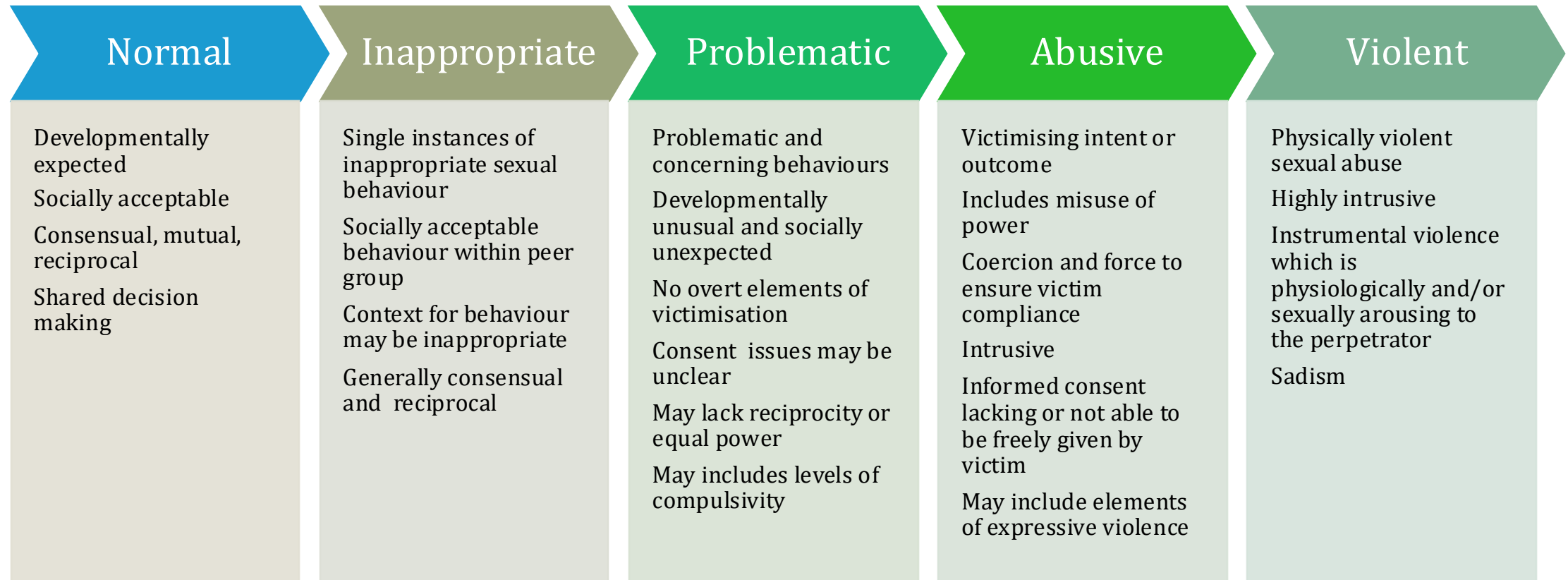


The phrase “sexual behavior problems” encompasses a range of behaviors that can be directed at oneself or directed toward others and that fall outside of acceptable societal limits.



Although the term “sexual” is used, the intentions and motivations for these behaviors are multifaceted and could be related to curiosity, anxiety, imitation, attention seeking, self-calming, sexual stimulation, or other reasons

# Hackett (2010)





## Sexual Behavior Is a Continuum



Bonner(1995); Davies, Glaser, & Kossoff (2000); Friedrich (1997); Johnson(2004); Larsson & Svedin (2001)

Work of Jane Silovsky (used with permission)

# What's the state of the evidence on under 12s with sexual behavior problems?

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- Malvaso, et al.'s (2020) systematic review of 78 studies relating to HSB in children and young people, found only seven studies specifically examining PSB in children:
  - Limited prevalence data, no comparison groups
  - Three studies were primarily concerned with how previous experiences of CSA were correlated with PSB
  - Major finding was that significant emotional and behavioral problems were characteristic of children exhibiting PSB



# Campbell and Wamser (2023)

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- 1,011 8-year-olds from the Longitudinal Studies of Child Abuse and Neglect cohort to investigate the links to SBP of a range of types of maltreatment and family functioning factors
- 9.0% of children in the sample had a clinical levels of SBP, and 13.3% had engaged in at least one inter-personal SBP
- The number of maltreatment types children experienced was positively associated with SBPs
- A higher level of maladaptive parental discipline methods was also present among children with higher levels of SBPs

# Allen (2017)

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- 1112 8-year-old children and controls
- Children displaying *general SBP* were significantly more likely than control children to have previously alleged sexual abuse, with also a relationship to other forms of maltreatment (including physical abuse and neglect)
- However, when it came to ISBP (i.e. interpersonal sexual behaviors), only physical abuse was related
- Allen concludes that his findings lend “moderate support for the traumatic sexualization etiological theory for general SBP only...there was no evidence observed that supports [the theory] as a viable hypothesis for the commission of ISBP”

## ATSA (2023)

- No distinct characteristics for children exist, nor is there a clear pattern of demographic, psychological, or social factors that distinguish children with sexual behavior problems from other groups of children (Chaffin et al., 2002).
- Evidence suggests that there are **no qualitatively different subtypes of sexual behavior**. Instead, there are **varying degrees of severity and intensity of sexual behavior problems** overall.
- Children with more frequent and intrusive sexual behavior problems tend to have more comorbid mental health, social, and family problems.

**Adversity, maltreatment, and  
neurodevelopment**

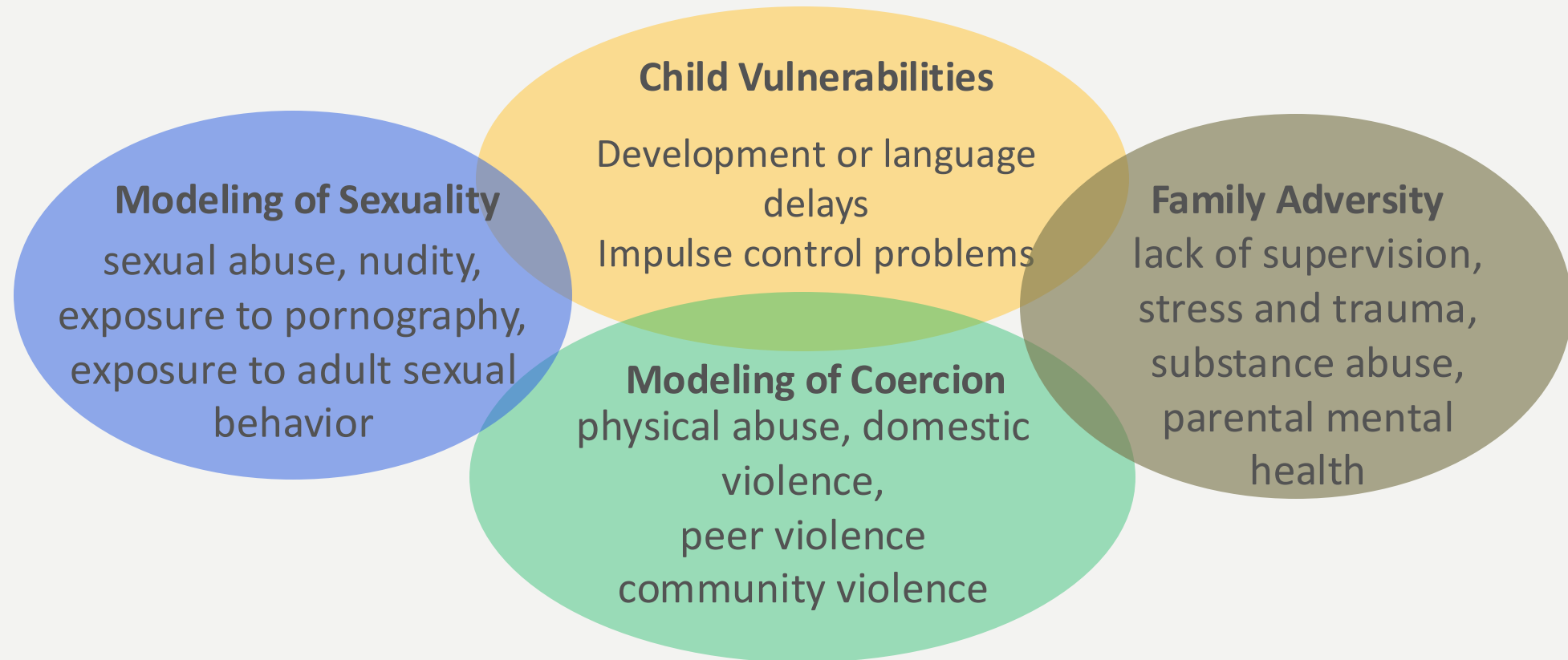
understanding the influence on  
problematic sexual behavior

# Childhood Adversity

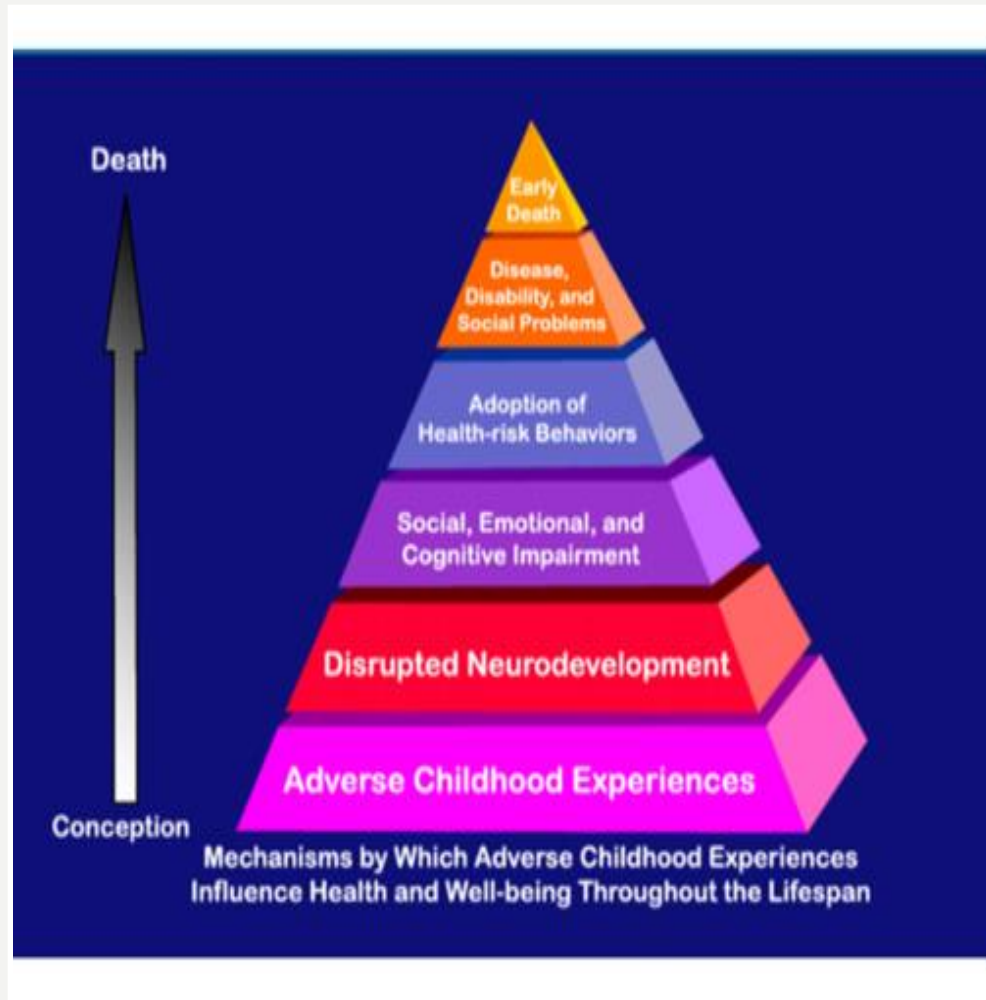
Significant stressors or potentially traumatic events that occur in childhood (ages 0-17).

- *Witnessing violence; parent suicide, parent MH problem; parent separation; substance abuse; poverty; homelessness; food insecurity*
- *Physical abuse, sexual abuse, emotional abuse, neglect, bullying*
- **General population: 64% at least 1; 17% report 4+**

# ORIGINS OF SEXUAL BEHAVIOR PROBLEMS

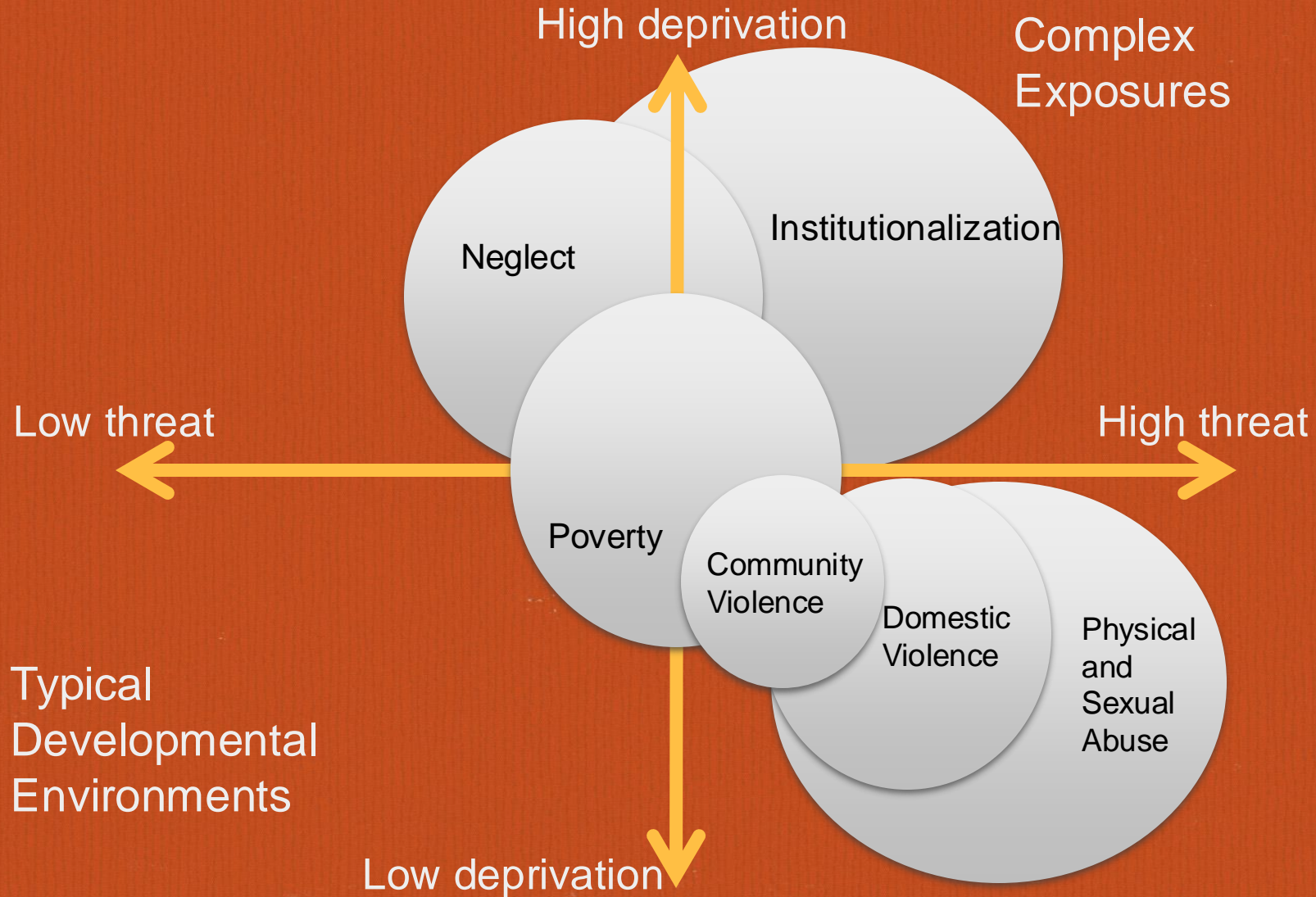


# Cumulative Harm/ACEs



- The experience of persistent stressors throughout childhood has a cumulative effect that increases the likelihood of cognitive, emotional, social and health related problems

(Mc Laughlin & Sheridan, 2016)





# Learning Processes

- **Associative learning:** detect environmental cues associated with threat and reward and shape the emotions, behavior, and neurobiological responses to those cues.
- **Emotional learning** processes
  - fear learning: rapidly detect potential threat and mobilize responses
  - reward learning: track the probability and magnitude of rewards associated with particular environmental cues

# Learning processes and behavior

- Earlier studies focused on early abuse and conduct disorder
- Recent studies suggest that general learning processes may explain aggressive and oppositional behavior

# Why Associative Learning is important

- *Children exposed to early adversity were less able than their peers to correctly learn which stimuli were likely to result in reward, even after repeated feedback.*
- *These children use information about known rewards in their environments less often.*

Hanson, van der Bos, et al (2017)

# Reward learning

- Children exposed to deprivation show “atypical” reward learning
  - have difficulty with how quickly and accurately they can connect cues to higher rewards

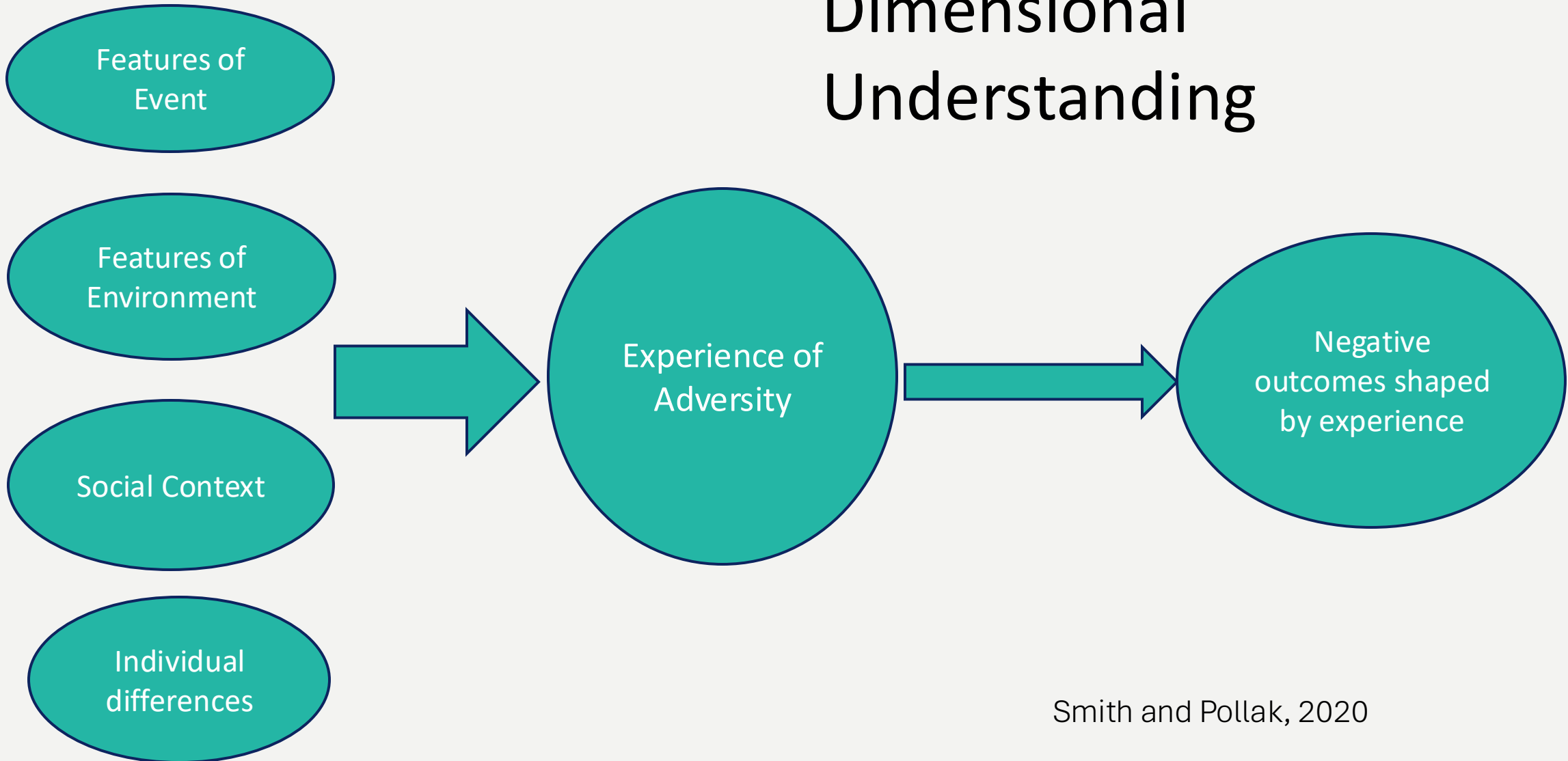
McLaughlin & Sheridan, 2016

# Trauma and Fear learning

- Children exposed to threat demonstrate poor association between threat and safety cues
  - may show the same level of fear response to threat and safety cues
  - may demonstrate broader problems with associative learning

McLaughlin & Sheridan, 2016

# Dimensional Understanding



Smith and Pollak, 2020

# Maltreatment, Development, and Behavior

- Development is best characterized by probabilistic pathways rather than linear causality

## Questions:

- what experiences place a child on one pathway vs another
- what limits the individual from altering those pathways
- what developmental periods or circumstances offer the best opportunity for change

(Pollak, 2015)

# Origins of PSB

Chouinard-Thivierge, et al (2021)  
Canadian study looking at 340 cases  
(158 cases childhood onset; 182  
adolescent onset)

- children referred for PSB were already known to Child Protective Services:
  - 10% had 1 referral
  - 30% had 10 or more referrals



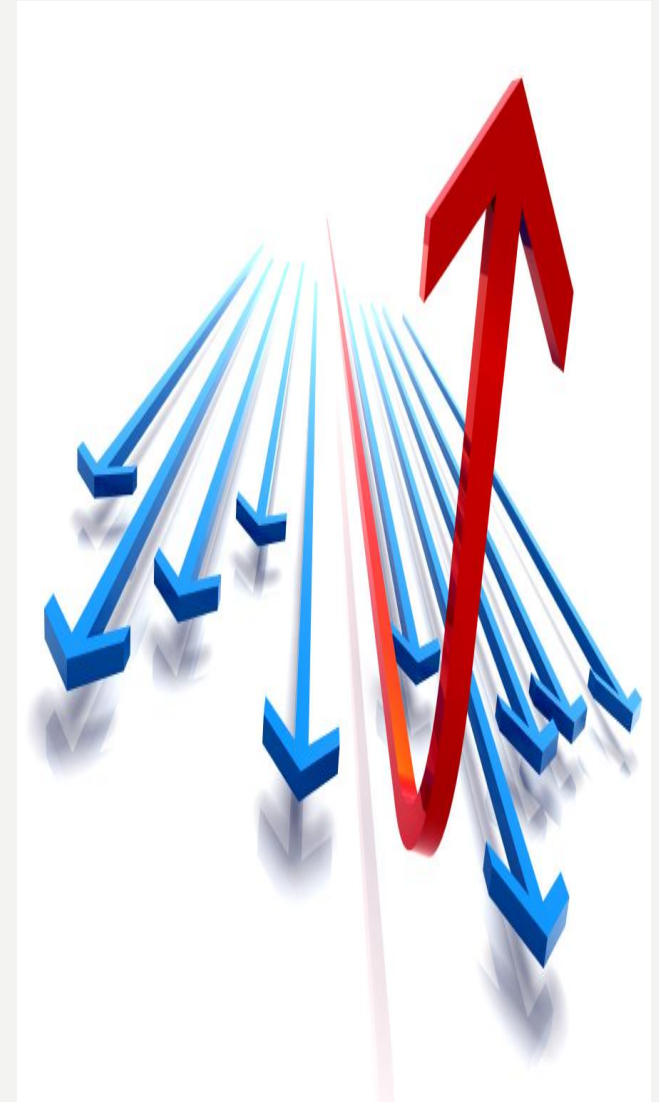


# Development periods

*infancy: 0-2; preschool: 2-5; late childhood 5-11;  
adolescence: 12-17*

Numbers of abuse experiences increased over time and most of these were correlated with the presence of PSB

Being exposed to **domestic violence** correlated to PSB in all 3 childhood periods



# Origins

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Psychological abuse in late childhood correlated with PSB continuing into adolescence

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History of placement and parental neglect correlated with continuing PSB

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Experiencing sexual abuse in late childhood correlated with continuing PSB into adolescence

# **Influence of domestic violence, physical abuse**

- Physically abusive parents tend to be some combination of impulsive, emotionally volatile, and inconsistent in their parenting, and less verbal in discussing/explaining emotional states with their children



# Protective factors

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Safety (protection from harm, stress, trauma)

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Positive relationship with a caring, engaged adult

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Consistent guidance and supervision

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Positive relationships and activities with peers

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Positive connection with school

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Healthy boundaries

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Adaptive coping skills

# Technology Safety Plan

- Live like it is 1989
  - Technology plugged into a wall, in a public space, no headphones
- Utilize safety measures available
  - Apps
  - Restrictions on technology device
  - Restrictions on routers/wifi
- We require youth to practice driving, yet we give them an unprotected cell phone....



# Best Practices

# Best practices

- Treatment concepts to include
  - boundaries, impulse control, problem solving, coping skills, healthy emotional expression and emotional regulation skills, social skills and peer relationships, developmentally appropriate sex education, and sexual behavior rules
  - child recognizing that their behavior was inappropriate and the impact of their behavior on others
  - individually based to address additional items to include trauma as needed and can be incorporated into the treatment of sexual behaviors

# Best practices

- Not all children need all areas to be addressed
- Coping mechanisms based on child's age and developmental status
- Due to not being cognitive mature, better to stick to simple rules



# Include Family/Caregiver

- **Within the Assessment**
  - Therapist is non-judgmental as youth and family might be hesitant to talk about behaviors, embarrassed, or don't believe the behavior is unhealthy
  - Helping family understand that understanding the past behaviors is far less important than assessing current and future factors
  - Addressing safety at all times
  - An ecologically focused assessment; identifying all aspects of the family's environment

## In the Assessment

- Ecologically focused assessments strive to identify not only problems and factors that trigger or maintain sexual behavior problems, but they also identify strengths, protective factors, and resources that might be developed to overcome the problems.
- If the child is currently in a non-relative, out of home placement (e.g., foster care, residential), but the long-term plan is reunification with their biological family, assessment and treatment planning should focus on both living situations

# Therapy Modality

- Individual
  - ✓ Allows for focus on trauma, developmental behaviors, and specific needs of the home environment
- Family
  - ✓ Allows for role-play scenarios; specific home environment; skills/situations specific to family
- Group
  - ✓ Advantage and disadvantages; must have behavior management within the group setting; must keep a consistent flow of referrals

# Include Family/Caregiver

## Within Therapy/Interventions

- Evidence from both clinical and research literature emphasizes parent involvement in treatment (Johnson, 1989; Johnson, 2004; Silovsky et al., 2006)
- To effectively intervene, the home environment should be stabilized and contributing factors managed
- This includes biological parents, foster or kinship care parents, or other caregivers, with consideration given to both current caregivers and likely future caregivers.
- Efforts need to be made to engage the parents/caregivers in the treatment process, not only because it supports their active involvement but also impacts their child's involvement in treatment.

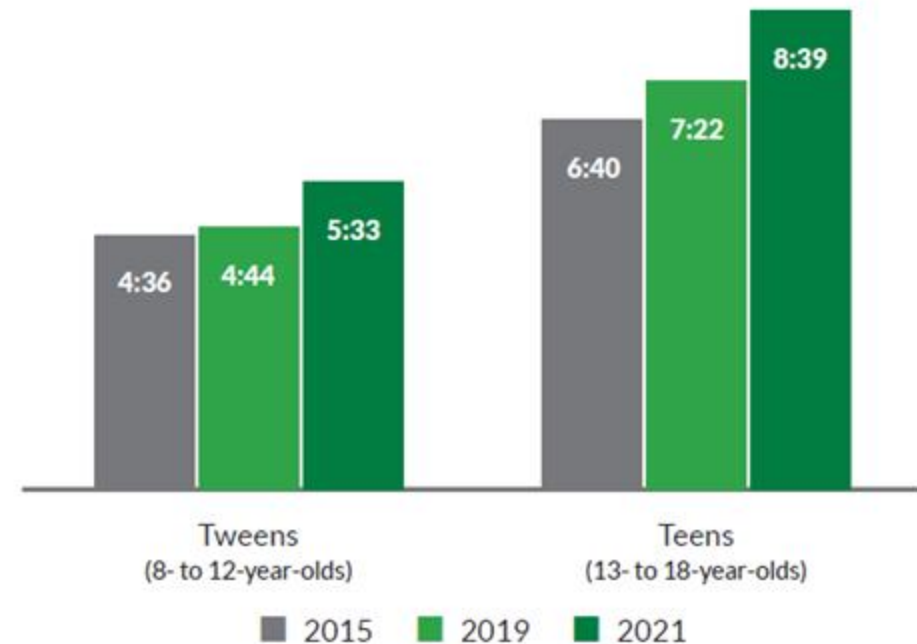
# Family/Caregiver Treatment Components

- child development (including sexual development),
- general behavior issues,
- age-appropriate sex education
- strategies for preventing and addressing sexual behavior,
- increasing their comfort in addressing these issues
- helping their child be safe in the multimedia and technology world
- treatments must seek to address underlying issues as well as the presenting sexual behavior problems

# Technology

- 38% of 8-12 y.o, have a social media account - yet most of these apps have a minimum age of 13
- Young children are being given smartphones – often with no restrictions

FIGURE A. Total entertainment screen use among tweens and teens, per day, 2015 to 2021



Common Sense Census, 2021

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# Placement Decisions

- Children with SBP do not require automatic out of home placement, even if children are all in the same home
- Case by case determination focusing on the assessment
- First priority with safety in mind is to sustain all children in the home, family, or community





# Placement Decisions

- Out of home placement considered when:
  - Child causes harm or significant distress to other children
  - Acute needs for treatment
  - Safety / protection
  - Caregivers can not provide a safe and adequate environment
- Priority given to least restrictive setting, closest to family in order to keep family involved in treatment

# If Removed From Home Environment

- Sensitive, developmentally appropriate plan for reducing risk of SBP among all children should be established
- Consider individual sleeping arrangements, changing clothes, extra monitoring when around other children
- Appropriate boundaries enforced
- Discouraged from using segregation from others

# ATSA

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## Practice Guidelines Available Now

