Working with Children Exhibiting Sexual Behavior Problems Washington Edition Participant Guide

Child Welfare Training Institute
at the
University of Southern Maine

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1

Exploring Family Values and Beliefs (Yours and the child you are caring for)

Competencies

1. Understand your expectations and assumptions of providing care for a child with sexual behavior problems.
2. Know your values and beliefs on issues regarding sexuality.
3. Identify the characteristics of foster parents who are effective in caring for children with sexual behavior problems.
4. Know the vocabulary and terms regarding sexual abuse and sexual behavior.
5. Know the relevant legal terms used in the foster family system and criminal justice system.
6. Know some statistics about child maltreatment in general, and about child sexual abuse specifically.
7. Recognize the damaging effects of labeling.

Purpose

This initial unit asks parents to focus on their attitudes and beliefs that will affect fostering a child with sexual behavior problems. Parents should be aware of their own values and beliefs regarding sex, sexual abuse, victims, perpetrators, and other issues so they may accurately assess their own strengths and weaknesses in fostering a child with sexual behavior problems.

This unit also serves to expose the participant to the wide array of new vocabulary they will encounter when they enter into several collaborative relationships with treatment, legal, and other professionals involved with children with sexual behavior problems.

Objectives

1. Meet, "break the ice" and get to know each other enough to create the necessary safety to begin to talk openly about this topic.

2. Explore your values and beliefs on a variety of issues regarding fostering a child with sexual behavior problems through class exercises.
3. Identify terms and abbreviations already familiar to parents.
4. Define new terms and abbreviations.
5. Become familiar with some relevant statistics regarding children in care.
6. Identify instances when children are labeled, and negative effects of labeling.

Unit 1: Exploration of Family Values and Beliefs (Yours and the child you are caring for)

Guiding Principles

1. Children are **more than the sum** of their behaviors and history. Each child is both vulnerable and resilient and possesses strengths upon which interventions are based.
2. There are children who exhibit sexual behavior problems whose behavior **can be safely managed** in the foster family setting.
3. Foster parents are **essential members of the treatment team** and are central to decisions impacting the child.
4. **Continuous open communication and teamwork** in the treatment team are the key to effective therapeutic foster parenting. "When in doubt, bring it to the team."
5. Each child with sexual behavior problems is **unique** and requires **individualized** assessment, treatment and intervention strategies.
6. All children deserve **emotional support and nurturance** that recognizes and responds to their unique needs.
7. **Effective intervention** coupled with meaningful relationships can lead to the safe management and eventual resolution of sexual behavior problems.
8. Children will **adapt and change**, requiring foster parents to adapt and change.
9. The **safety** of children and the larger community is **central** to all decisions and interventions of the treatment team. The ability of the child to sustain change is enhanced by the collaboration between the community and the treatment team.

Sentence Completion Exercise

1. One thing I already know about children with sexual behavior problems is…
2. Some feelings I have when children act out sexually…
3. What I want to know is…
4. If you are fostering a child with sexual behavior problems, how did you first learn of these behaviors?
5. My feelings about children masturbating are…
6. My family taught me ____ about sex, and now…
7. One thing I know about child sexual abuse is…
8. Some feelings I have about child sexual abuse are…
9. I want to know…
10. My greatest fear about fostering a child with sexual behavior problems is…
11. My concerns about impact on my family are…
12. I cope with challenging situations by…
13. I have some questions about my own ability to handle this, but the one that is most important is…
14. The strengths I can offer a child with sexual behavior problems are…
15. My own challenges are…
16. I know that I also need to…

Adapted with permission from Peterson, Cheryl, **Preparing for Success**, Illinois Department of Children and Family Services, 1993

True-False Quiz

1. Approximately 1 in every 4 girls and 1 in every 6 boys are sexually abused before age 18.
2. Children are usually sexually abused by a stranger.
3. Most children tell someone about their abuse.
4. Sexually abused children have both emotional and physical reactions to their abuse.
5. A child who is sexually abused always proceeds to abuse others.
6. Online enticement of children occurs about 10% of the time.
7. Most people who sexually abuse have multiple victims.
8. Growing up in a violent home may lead to sexual behavior problems, even if there was no sexual abuse in the family.
9. Sexual offense rates are higher than ever and continue to climb.

PLEASE DO NOT TURN THE PAGE UNTIL INSTRUCTED TO DO SO.

True/False Quiz Answers:

1. Approximately 1 in every 4 girls and 1 in every 6 boys are sexually abused before age 18.

True

- Nearly 70% of all reported sexual assaults (including assaults on adults) occur to children ages 17 and under.
- An estimated 39 million survivors of childhood sexual abuse exist in America today.

Source: Hopper, J. (1998). Child Sexual Abuse: Statistics, Research, Resources. Boston, MA Boston University School of Medicine.

2. Children are usually sexually abused by a stranger.

False

- 30-40% of victims are abused by a family member.
- Another 50% are abused by someone outside of the family whom they know and trust.
- Approximately 40% are abused by older or larger children whom they know.
- Only 10% are abused by strangers.

Source: US Department of Justice. (1997) and Finkelhor and Ormond. (2001).

3. Most children tell someone about their abuse.

False

- Evidence that a child has been sexually abused is not always obvious, and many children do not report that they have been abused.
- Over 30% of victims never disclose the experience to ANYONE.
- Young victims may not recognize their victimization as sexual abuse.
- Almost 80% initially deny abuse or are tentative in disclosing. Of those who do disclose, approximately 75% disclose accidentally. Additionally, of those who do disclose, more than 20% eventually recant even though the abuse occurred.
- Fabricated sexual abuse reports constitute only 1% to 4% of all reported cases. Of these reports, 75% are falsely reported by adults and 25% are reported by children. Children only fabricate ½% of the time.

Source: Hanson, R.F., Resnick, H.S., Saunders, B.E., Kilpatrick, D.G., & Best, C. (1999). Factors Relating to the Reporting of Childhood Sexual Assault. Child Abuse and Neglect, (23) 559-569; FBI Law Enforcement Bulletin

4. Sexually abused children have both emotional and physical reactions to their abuse.

True

- Children who have been victims of sexual abuse are more likely to experience physical health problems (e.g., headaches).
- Victims of child sexual abuse report more school problems than non-victims.
- Victims of child sexual abuse are more likely to experience major depressive disorder as adults.
- Young girls who are sexually abused are more likely to develop eating disorders as adolescents.
- Children who have been sexually abused are 2.5 times more likely develop alcohol abuse.
- Children who have been sexually abused are 3.8 times more likely develop drug addictions.
- Adolescents who suffer violent victimization are at risk for being victims or perpetrators of felony assault, domestic violence, and property offense as adults.
- Nearly 50% of women in prison state that they were abused as children.

Sources: National Institute on Drug Abuse 2000 Report & Child Abuse & Neglect Study by Arthur Becker-Weidman PhD and National Clearinghouse on Child Abuse & Neglect Information. Long-term Consequences of Child Abuse & Neglect 2005

5. A child who is sexually abused always proceeds to abuse others.

False

There is widespread belief that child sexual victimization leads to sex offending. Often referred to as "The Cycle of Sexual Abuse" this myth is perpetuated in the media, in the courts, and throughout child welfare literature. Does research support this belief? The following comes from the United States General Accounting Office. The GAO found that:

- There was no consensus among the 23 retrospective and 2 prospective studies reviewed, that childhood sexual abuse led directly to the victim becoming an adult sexual abuser;
- Although some of the retrospective studies concluded that childhood sexual abuse may increase the risk that victims will commit sexual abuse later, most of the studies noted that the majority of sex offenders had not been sexually abused as children;

- The prospective studies, which tracked sexually abused children into adulthood to determine how many became sex offenders, studied sample populations that may not be representative of the entire population of childhood sexual abuse victims; and
- The prospective studies found that victims of childhood sexual abuse were not more likely than non - victims to be arrested for sex offenses.

6. Online enticement of children occurs about 10% of the time.

False

- Based on a study of 1,501 teens and preteens, 19% of the young people surveyed received unwanted online requests to engage in sexual activities or to provide intimate sexual information in the last year. In 15% of those incidents (approximately 35 of all the youth), the solicitor attempted to contact the youth in person, over the telephone or by mail, incidents the study called "aggressive solicitations."

- Less than 10 percent of these sexual solicitations were reported to authorities such as a law-enforcement agency, an Internet service provider, or a hotline. Most families do not know where to report Internet offenses.

Source: David Finkelhor, Kimberly J. Mitchell, and Janis Wolak. *Online Victimization: A Report to the Nation's Youth*. Alexandria, Virginia: National Center for Missing & Exploited Children, 2000

7. Most people who sexually abuse have multiple victims.

True

Nearly 70% of child sex offenders have between 1 and 9 victims; at least 20% have 10 to 40 victims.

Source: Bolen, R. & Scannapieco, M. (1999). Prevalence of child sexual abuse: A corrective meta-analysis. *Social Service Review, 73,* 281-313.

8. Growing up in a violent home may lead to sexual behavior problems, even if there was no sexual abuse in the family.

True

There are risk factors other than sexual abuse history. Incidents of trauma to include physical and sexual abuse, neglect, exposure to domestic violence and other experiences almost universally appear in the histories of adolescents who later develop offending behaviors. Risk factors will be the topic of discussion in a future unit.

Source: McMackin, Leisen, Cusack, LaFratta and Litwin, 2002

9. Sexual offense rates are higher than ever and continue to climb.

False

Despite the increase in publicity about sexual crimes, the actual rate of reported sexual assault has decreased slightly in recent years.

- The rate of reported rape among women decreased by 10% from 1990 to 1995 (80 per 100,000 compared to 72 per 100,000). In 1995, 97,460 forcible rapes were reported to the police nationwide, representing the lowest number of reported rapes since 1989.
- More recently, when examining slightly different measures, it appears that rates have continued to drop. The arrest rate for all sexual offenses (including forcible rape and excluding prostitution) dropped 16% between 1993 and 1998. In 1998, 82,653 arrests were logged for all sexual offenses, compared to 97,955 arrests in 1993.

Source: Greenfeld, 1997. Federal Bureau of Investigations, 1997 and 1998.

Impact of Trauma, Abuse and Neglect on Development

The information in this section was adapted from the ***Journal of Traumatic Stress***, written by Mary Harvey.

Definition of Trauma

"Trauma: a single event or series of events over time, which can tax or overwhelm a person or community's resources and sense of wellbeing."

Most of us have experienced some type of trauma over the course of our lives, and our responses and recovery processes are all different, based upon various factors in our lives.

How an individual reacts to trauma depends on a number of variables in their lives. Three of these variables are:

- The person (their age, ethnicity, gender)
- The event (when it happened, where it happened, were there others around, one time or a series, was a weapon used, threats)
- The environment (where they live, support systems they have, the relationship to the abuser, family response, police response)

None of us is immune to experiencing trauma, however much we may try to protect ourselves. We are differentiated by the specific traumas we experience, the personal

resources we possess, and the context in which we live. For some, trauma results in devastation of the spirit that is never repaired, with or without therapeutic intervention. For others, a similar trauma, while initially devastating, is blended into the person's totality of experience and they recover successfully, with or without therapeutic intervention.

Trauma might show up in people's lives in a number of different ways, which are described briefly below. Remember, that these are just a few of the ways in which people might respond to trauma. Everyone responds to trauma differently, according to who we are and where we have been.

Trauma Principles

- **Feeling of Helplessness**: The feeling of helplessness reorganizes the lives of trauma victims; memories and cues maintain the helpless feeling.
- **Safety**: Trauma destroys the victim's sense of safety; if it happened once, it can happen again. Victims of trauma may expect the worst and view the world that way.
- **Why did it happen?**: A victim of trauma may be driven to search for an explanation of why it happened to them: What could I have done differently? Did I deserve it? Could I have stopped it? Can I prevent it from happening again?
- **Post Traumatic Stress Responses**: Many survivors of trauma develop Post-Traumatic Stress Disorder (PTSD) similar to war veterans - e.g., flashbacks, hyper-vigilance, startle responses, etc.
- **Changes in CNS**: The experience of trauma may temporarily or permanently change the central nervous system; may result in "hyper" behavior seen sometimes in adults and children who have been traumatized.
- **Sensory Experience**: Trauma is primarily a sensory experience.
- **Attachments may be severed**: Trauma can threaten to or actually eliminate attachments; children wonder why the person who is supposed to protect them is hurting them; trust is lost.
- **Shame-based**: Trauma is shame-based; trauma victims feel that they should have been able to prevent it.

- **Contagious**: Trauma is contagious; people who hear details of the trauma may experience similar responses, as though they themselves experienced the trauma; other children may get hooked into the 'post-trauma' play of the child victim.
- **Perspective**: The experience of trauma can be put into perspective; people develop strengths that carry them through life. Therapy may be helpful for many people, but others rely on resources and supports from friends, family, and other types of service providers.

How Severely a Child is Impacted by Sexual Abuse

The severity of a child's reaction to sexual abuse depends on these variables:

- **Abuse** - Depends on the **nature and physical contact** of abuse and frequency (acute, episodic or chronic)
- **Abuser** - Depends on **abuser's age, relationship to child, and how many abusers** (usually more damaging if big age difference between abuser and victim and/ or if a trusted adult or in close relationship
- **Child** - Depends on the **age and developmental age of child** (usually more damaging if emotional age is under age 6 or child is emotionally fragile), family situation, adult and family supports, family reaction to disclosure (more damaging if family rejects or ridicules the child's feelings; disclosure is not accepted by the family; the family is disrupted or dissension is stirred by the disclosure; and/ or the child is rejected or abandoned by the family), child's experience of and emotional reaction to the events (feared for life, participated, enjoyed it)

Selected Definitions

1. **Consent**

   Agreement including all of the following:

   a. **Understanding** of what is proposed based on age, maturity, developmental level, functioning and experience,
   b. **Knowledg**e of societal standards for what is being proposed,
   c. **Awareness** of potential consequences and alternatives,
   d. **Assumption** that agreements or disagreements will be respected equally,
   e. Voluntary **decision**,
   f. Mentally **competent**

   A child cannot give consent (by definition) to sexual activity because of lack of knowledge and maturity.

2. **Compliance**

   Passive action without overt resistance in spite of opposing beliefs or desire. Compliance may occur without consent.

3. **Cooperation**

   Participation regardless of beliefs or desire. Cooperation may occur without consent.

4. **Sexually abusive behavior**

   These behaviors involve **coercion, threats, aggression, secrecy, or developmentally inappropriate (precocious) sex acts** with or between children, or where one participant relies on an unequal power base.

5. **Child with abuse reactive behavior**

   Child who exhibits **a pattern of sexualized and/or developmentally inappropriate sexual behaviors** that persist despite limit setting or redirection and that are in reaction to past or current abuse, exposure to sexual stimuli, and/or a sexualized, enmeshed relationship with an adult. This may or may not involve physical touch with anyone else and isn't necessarily abusive. i.e. excessive masturbation, provocative/seductive interactions.

6. **Juvenile sex offender**

   Term used to describe the child or adolescent who has **engaged in an offensive sexual act** or pattern of sexual acts with a person of any age against the victims' will, without consent, or in an aggressive exploitative or threatening manner. Often overused or misappropriately used to describe a youth with sexual behavior problems. The legal implications for this label are strong and are stigmatizing.

7. **Enmeshed**

   Overly close relationship between people in which at least one person is overly responsive to the emotional life of the other. This term is typically applied to relationships in which this is outside of developmentally appropriate stages or culturally appropriate behavior.

8. **Post Traumatic Stress Disorder**

   A diagnostic label assigned to an individual of any age based on their exposure and continuing **reaction to a traumatic event** (natural disaster, violence, victimization). Some symptoms include: flashbacks, nightmares, dissociation, hyper-vigilance, and reenacting trauma through play or art.

9. **Developmentally Appropriate Behaviors**

Range of **normal or typical behaviors** within a particular stage of development.

10. **Sexual Misconduct**

General term used to describe the behavioral act of engaging in **sexually offensive or abusive behaviors**. (not labeling the person, but describing the behavior)

11. **Coercion**

The act of compelling or **forcing** someone to do something by use of power, intimidation, or threats

12. **Sexual Offender**

A common label used when referring to an individual who has engaged in **sexually offensive behavior(s)**, not a diagnosis. Generally a negative label that evokes strong emotions and implies this offending behavior will continue. Is often used interchangeably with juvenile sex abuser.

13. **Pedophile**

Typically, a **diagnostic label** assigned to an adult (16 or older) with primary or exclusive sexual interest and arousal toward children. **Often misused and cannot be used to describe all sexual offenders.**

14. **Transference**

Having **feelings** awakened or triggered by someone with whom you are interacting based on your past relationships with someone considered significant.

15. **Counter-Transference**

Emotional reaction or feelings of person in a therapeutic role **toward** person he or she is working with that is about their own "stuff" – personal history, past experiences, and relationships. In other words - things that "push your buttons" and are really stemming from your own "issues" and unresolved history and not what the person is really doing.

16. **Ritualistic Abuse**

Bizarre, systematic, formalized, repetitive abuse which is mentally, physically, and sexually abusive. Can be Satanic; such as devil-worship or sacrifices, hypnosis, brain washing, or implanting evil and take place in a cult or other group setting. The sexual abuse is usually painful, sadistic, and humiliating, intended as a means of gaining dominance over the person.

A second definition is abuse (non-satanic) which involves any form of ritual (**defined as a "detailed procedure faithfully or consistently followed"**). The ritual itself may not be abusive but the "anticipatory fear" leading up to the abuse can be equally traumatizing.

Example: *Every Wednesday at 4p.m. Sarah's Uncle Joe comes to the house. Following a brief discussion, her mother leaves for her church group. Uncle Joe then asks Sarah if she'd like to watch TV. She knows that this means they will be sitting on the couch where Uncle Joe will proceed to fondle her. Sarah begins having stomachaches and complains of feeling ill every Tuesday in anticipation of the upcoming ritual leading to fondling.*

17. **Sexual Exploitation**

Purposefully **manipulating, taking advantage** of another person to get sexually gratified, to obtain some sexual benefit, without regard to the person's well-being or consequences.

18. **Pornography**

Writings, pictures, videos depicting **explicit or implied sexual behaviors** intended to arouse sexual desire.

19. **Sexualized Behaviors**

Learned use of sexual behaviors to get nurturance needs met. Using sexual behaviors as the way to relate to people. Everyday behaviors and interactions have a sexual meaning**.**

20. **Psychosexual Assessment**

A specialized assessment that can be requested to address the following problem situations: inappropriate sexual behaviors, sexuality problems, and/ or sexual abuse concerns or allegations. Could involve use of the following instruments: Child Sexual Behaviour Inventory (CSBI) (Friedrich, 1997) and the Child Sexual Behaviour Checklist (CSBCL) (Johnson, 1998c)

Unit

2

Typical Sexual Development and "Red Flags"

Competencies

1. Know the range of sexual behaviors considered typical.
2. Know the ages and stages of typical sexual development.

Purpose

This unit provides information on the typical sexual development of children and adolescents, which usually proceeds in a predictable sequence. To know whether a child's behavior is sexually abusive or simply curious, one needs to understand normal sexual development. This unit teaches participants that there is a wide range of behaviors considered 'normal' or typical. This information is important for participants who are considering a child or adolescent's sexual behavior and determining what is normal behavior.

Objectives

1. Clarify and explore through group discussion the range of sexual behaviors that are considered normal or typical.
2. Present information on the stages of normal sexual development in children and adolescents.

What is typical?

Stages of Sexual Development

Ages 0-6

- **Born sexual** – boys often born with erect penises, girls with lubricated vaginas
- Very **curious** about their bodies
- **Masturbation** is a self-soothing activity, and done in public
- Interested in **looking** at others' bodies
- Interested in **physical differences** and function of body parts
- Assume **different positions** to urinate and copy other positions
- **Bathroom behavior** very interesting to them
- Like to talk about **elimination,** call each other names using bathroom lingo
- Preschool ages, in general:
- **Exploratory touching** of each other's private parts if permitted; respond to limit-setting by adults
- May **show genitalia** to peers; respond to limit-setting by adults
- Become **more modest** and demand bathroom privacy

Ages 5-10

- Continue to **touch** and fondle their own genitals, but **with more modesty**.
- Boys **compare** penis size
- Interested in **sex words** and dirty jokes
- Imitate **seduction** (i.e. flirting or kissing)
- Genital or reproductive **conversations** with peers or similar age siblings

Age 6

- Playing **"Doctor"**
- Question 'Where do **babies** come from?'

Age 7

- **Less** interest in sex

Age 8

- **Provocative** giggling and whispering; 'Jake loves Sue' notes passed in class

Ages 9-10

- Seek sex information
- Look for books and diagrams to satisfy their curiosity and explain their bodies
- Swearing
- Greater interest in children of opposite sex

Ages 10-12

- Masturbation continues
- Establishing relationships with peers and may engage in sexual activity like kissing, fondling, whether with same sex or opposite sex
- Interest in viewing bodies of same or opposite sex, usually in publications
- Viewing sexually explicit pictures
- Sexually explicit conversations with peers

Ages 12-18

- Masturbation continues
- Interest in viewing bodies of same or opposite sex, usually in publications
- Viewing sexually explicit pictures
- Body has matured
- Uneven and rapid growth
- Peers more important than family; tests authority
- Sexual desire strong
- Sexual intercourse and/or oral sex
- Impulse control uneven
- Questions about sexual orientation, sexual identity
- Emergence of same sex experimentation
- Sexually explicit conversations with peers
- Cultural and religious standards affect activity

"Flags"

What behaviors may be signs of problems?

Green Light Behavior - Healthy sexual play for children 12 and under is characterized by:

- Exploration with children of similar age and size
- Generally mixed gender friends rather than siblings
- Voluntary, i.e. "I'll show you mine if you show me yours"
- Affect is light-hearted, spontaneous, silly, excited (possible confusion and guilt, but not shame, fear or anxiety)
- Sexual behaviors are balanced with curiosity about other aspects of their worlds
- May still need **limits or intervention** by foster parent, but not considered pathological

Yellow Light Behavior (Cause for **concern/ possible intervention** needed)

- Preoccupation with sexual themes (especially sexually aggressive ones)
- Attempting to expose other's genitals (pulling others' skirts up or pants down),
- Sexually explicit conversation with peers
- Sexual graffiti (especially chronic or impacting individuals)
- Sexual innuendo/ teasing/ embarrassment of others
- Precocious sexual knowledge or language
- Single occurrences of: peeping, exposing, obscenities, pornographic interest, rubbing genitals against others or objects
- Preoccupation with masturbation
- Mutual masturbation/ group masturbation
- Simulated foreplay with dolls or peers with clothing on (petting, French kissing)

Red Light Behavior (**Requires adult supervision, confrontation**, and possible therapeutic intervention)

- Sexually explicit conversations with others of significant age difference
- Touching the genitals of others
- Degradation/ humiliation of self or others with sexual themes

- Forced exposure of others' genitals in the context of hazing (such as pulling down pants or exposing breasts)
- Inducing fear/ threats of force
- Sexually explicit proposals/ threats including written notes
- Repeated or chronic (or with younger children): peeping, exposing, use of obscenities, pornographic interest, rubbing genitals against others or objects
- Compulsive masturbation/ task interruption to masturbate
- Female masturbation that includes vaginal penetration
- Simulated intercourse with dolls, peers, animals (humping) or children with clothes on
- Oral, vaginal, anal penetration of dolls, children, animals
- Forced touching of genitals
- Simulating intercourse with peers with clothes off

Definite Need for Therapeutic Intervention

- Child appears preoccupied with sexual themes for extended periods, often with confused or anxious affect or child appears secretive, anxious, or confused about sexual matters
- Child is angry, violent, or forceful in his or her sexual behavior toward others, is using objects, or is inserting objects or fingers in other children
- Child compulsively engages in sexual behaviors, does not seem to enjoy the activity but keeps doing it, or seems to be unable to stop
- Child is engaged in sexual activity inappropriate for his or her age or sexual activity includes intercourse or oral sex between young children, or child attempts sex with animals
- Child is involved in sexual activity with a child of a large age difference

Based on the work of Gail Ryan and Bernard and Joan MacNamara, ***Adoption and the Sexually Abused Child,*** 1990**.**

Unit

3

Experiences That Can Lead to Sexual Behavior Problems and Their Effects on Children and Adolescents

Competencies

1. Recognize the nature of experiences that can lead to sexual behavior problems in children and adolescents.
2. Know the potential effects of these experiences on development.

Purpose

This unit helps participants to identify the kinds of childhood experiences that are associated with sexual behavior problems and to understand the effects of these experiences on child and adolescent development and how they may vary.

Objectives

1. Discuss the nature of premature sexual experiences and other abusive experiences that can lead to sexual behavior problems.
2. Identify and discuss behaviors of children and adolescents that are delayed, repetitive, or inappropriate for their age level, due to premature sexual and other abusive experiences.

Family Risk Factors for Children Developing Sexual Distress and Sexual Behavior Problems

Certain family characteristics and experiences might lead to sexual confusion, distress, and behavior problems in children. Here are some family risk factors that might lead to a child developing sexual distress and sexual behavior problems:

- sexual abuse, domestic violence, physical abuse
- exposure to adult sexual activity, visual, auditory, or participatory
- access to sexual materials (videos, magazines, 900 phone numbers and some 800 numbers, Internet)
- extreme parental dominance
- not allowing child to have friends; rigid control over friends
- family sexualizes routine interactions
- extremely enmeshed, unhealthy attachment between a parent and child
- secrecy is tolerated and encouraged and is a norm in the family
- unclear family roles and unhealthy relationships allow a parent to involve a child in keeping secrets from other parent, a parent to confide in a child about the other parent and try to get child to take sides, and/or a child to play one parent against the other (triangulation)
- extreme over-protectiveness
- special privileges given to one child over another
- unequal roles, unequal power, devaluing of certain roles, unhealthy sex roles (boys who are expected to be stoic and self-sufficient and not admit feeling powerless or helpless are more likely to re-enact abuse on others; girls who are conditioned to be submissive are more likely to be victims)
- inappropriate adult roles for children; encouraged outside of what is developmentally appropriate
- parent acting jealous of child
- isolated from community and supports
- extreme reaction to sex education or prevention materials
- non-offending parent minimizes abuse allegations, encourages denial

- excessive use of alcohol or drugs
- intolerance of/ denial of/ lack of empathy for feelings
- lack of consequences for sexual behavior problems
- covertly sexualized atmosphere - family's difficulty setting and respecting personal boundaries (examples: sleeping with children without clothes, entering bathrooms unannounced while children bathe, inspecting the developing bodies of pubescent children, confiding in children about sexual and romantic matters and sharing intimate details about their sex lives) reflected in attitudes and behavior about:

  nudity
  privacy
  bathing
  toileting
  bedroom and bathroom doors (when open, when closed)
  masturbation
  sibling sexual activity- viewed by family as incest or not?
  virginity
  sleeping arrangements
  joking about sex
  sexual teasing
  teaching about sex
  punishment for sexual activity

Remember, no one factor deems a family to be predisposed to abuse! It is important to look at the entire family system, not just one risk factor or distorted attitude. All families fall somewhere on a continuum of healthy versus unhealthy attitudes and interactions for promoting healthy sexual development. It is important to determine if families thrive and grow, or whether this behavior or attitude is inhibiting growth and development.

Impact on the Foster Family

Questions for Group Discussion: Keeping in mind the risk factors that a foster child may have encountered while in their birth family,

1. How will a child's experiences in their birth family, impact your family?

2. How will a child's experiences in their birth family impact how you parent that child?

Impact on Development

The Nature of Developmental Delay and Disruption

- Children impacted by abuse or neglect often have significant developmental delays in one or more areas of development.
- Some delays are caused by genetics. Some are the result of prenatal exposure to drugs or alcohol. Some are the result of poor prenatal care or from situations in which children lived after birth.
- Some delays are the direct result of trauma, abuse, and neglect.
- As a result, many children in substitute care will have developmental delays as well as problems with developing healthy self-esteem.

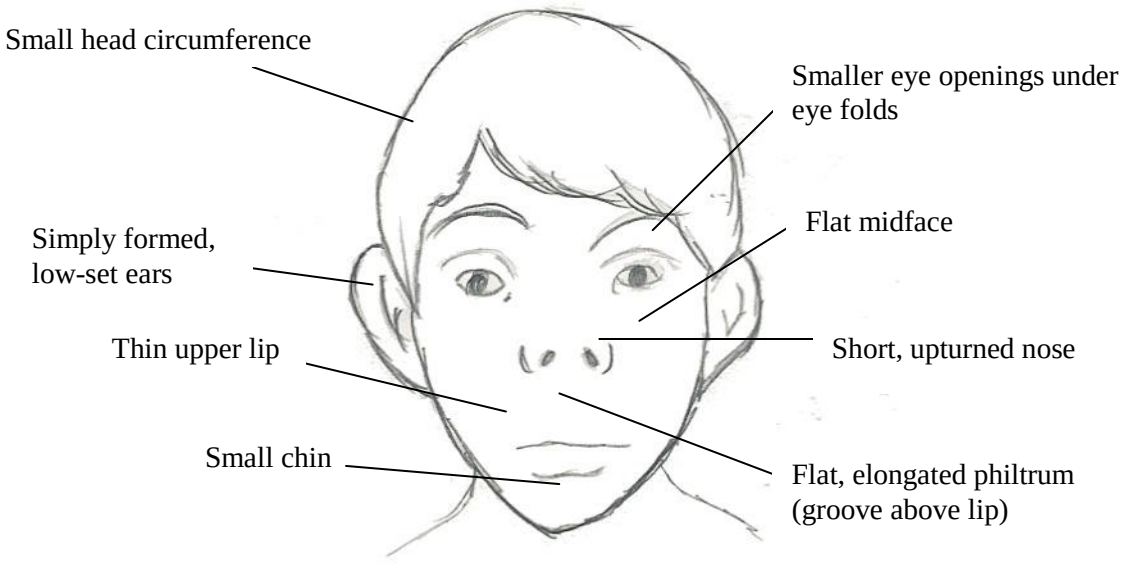
Fetal Alcohol Syndrome (FAS) is one example where the maternal abuse of alcohol impacts many areas of a child's development. FAS is the single greatest cause of mental retardation in this country. Some estimates indicate that as many as fifty to eighty percent of substantiated child abuse and neglect cases involved some sort of substance abuse by the child's parents.

Impact of Fetal Alcohol Syndrome on a Child

- Physical Development
- Cognitive Development
- Social Development
- Emotional Development
- Facial malformations, cleft palate, growth deficiencies
- Mental retardation, learning disabilities
- Intrusive, poor judgment, overly talkative
- Behavior problems, lack of understanding of cause and effect

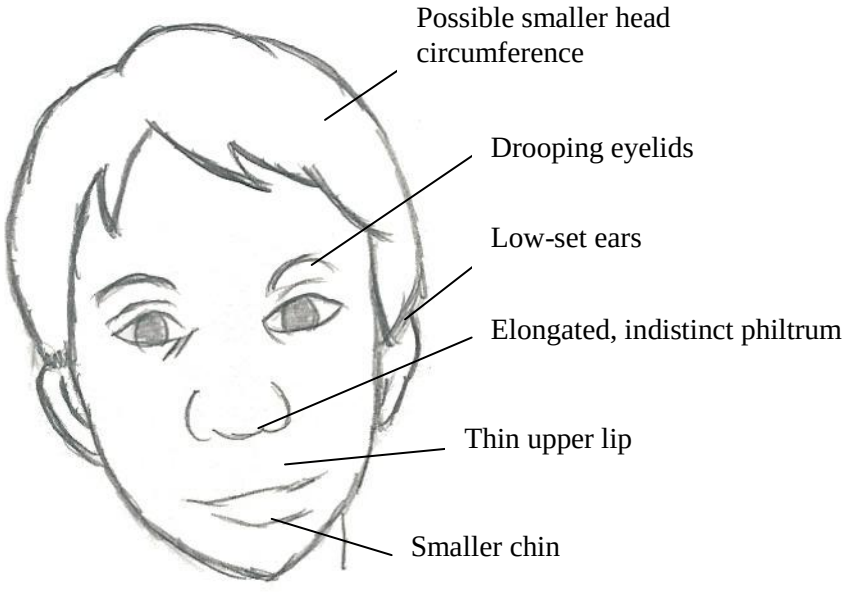
Fetal Alcohol Syndrome

Source: Malbin, 1993



Fetal Alcohol Effects

Source: Malbin, 1993



Effects of Sexual Abuse on Various Developmental Domains

Sexual Behaviors

- public and/or excessive masturbation
- sexual aggression toward children if unsupervised
- sexual gestures toward peers that escalate toward aggression
- lack of impulse control
- unusual interest in sex and sex language inappropriate to age
- seductive behavior
- promiscuous behavior
- inappropriate touching
- exhibitionism
- peeping
- sexual behavior with animals/ toys
- peeing in inappropriate places
- playing with feces

Emotional

- nightmares
- night terrors
- depression
- anger
- anxiety
- phobias
- hyper-vigilance
- lack of affect
- compulsive bathing
- shame and low self-esteem
- guilt
- sexual guilt (guilt derived from sexual pleasure)
- fear of abandonment
- fear of appropriate intimacy
- fear of school or Y changing rooms
- need for (too much) control
- obsessive/ compulsive behavior
- lack of empathy
- bedwetting (enuresis)
- soiling (encopresis)
- loss of innocence

Social

- lack of healthy boundaries with strangers or in dating
- withdrawal from friends and family
- controlling
- fighting
- obsession with being powerful/ tough
- fascination with fire/ gore/ violence
- immaturity
- play with adults or younger children vs. peers
- entrenched defenses
- cruelty to pets
- fire setting
- fear of certain gender
- charming/ flirtatious with adults
- wearing many layers of clothing regardless of weather
- not bathing or compulsive bathing
- weight gain
- making self look unattractive
- promiscuity
- prostitution (95% of teenage prostitutes have been sexually abused)
- higher rates of juvenile delinquency and sex offending
- difficulty with attachment and with authority figures

Intellectual

- School failure
- attention problems/ dissociation
- frequent absence or tardiness (sometimes with excuses/notes from one parent)

Physical

- Injury
- STD's
- Infections
- Pregnancy
- substance abuse (70 – 80% of sexual abuse survivors report excessive use of alcohol and drugs)
- eating disorders
- self-destructive behavior
- don't trust body sensations
- high tolerance for pain or accident prone
- psychosomatic or stress-caused illness

Spiritual

- Loss of hope
- higher suicide rate
- helplessness
- feeling abandoned/ betrayed by God and world - alone and not worthy
- "hole in soul"/ emptiness
- vulnerable to fanatical or cult religions or gangs
- sometimes find sense of higher power and hope through prayer

Be careful not to be overzealous in identifying children with some of these indicators. No indicator alone does not necessarily mean a child has been sexually abused. These are **general** indicators of stress. Severe, extreme and pervasive behaviors may indicate sexual abuse. Verbal disclosure is the best indicator.

Unit

4

Parent's Role in Promoting Healthy Sexuality

Competencies

1. Knows the issues and messages to promote healthy sexuality in children.
2. Provides sex education and can respond appropriately when children and adolescents discuss their sexual experiences.

Purpose

Children with sexual behavior problems and/or children who were sexually abused have confused emotions about sex and sexuality. Sex may have been used (and may be used by them) for power and control over others. Foster parents need to recognize that sex and sexuality are highly charged issues, and they may see reactions in the child. A common myth is that children who have been exposed to sex at an early age know more than the average child does. On the contrary, the child with premature sexual experiences is often more confused. They have heightened awareness of sex and sexuality but not necessarily the correct information.

Objectives

1. Explore the reasons foster parents must talk about sex and sexuality with children.
2. Explore the ways foster parents can talk about sex and sexuality with foster children.
3. Identify the scenarios in which the need to educate children about boundaries and sexuality may occur.
4. Define positive messages to share with children regarding sex and sexuality.

Positive Messages to Children about Sex and Sexuality

- Sexuality is a **normal** part of human development, starting at birth or before and continuing throughout life.
- Feelings, thoughts, and even fantasies about sex are a **part of growing up** as well as part of being a grown-up. Because someone has certain thoughts that excite or scare him/her does not mean that they have to act these out.
- **Everyone**, from infants to grown-ups, has these feelings. Children learn in stages as they grow. When children are abused, their feelings get more confused. They may need extra help in dealing with this and with the world around them.
- Stages of development mean that there are **specific times to learn** certain things about yourself and the world, and specific tasks, or jobs that go with each stage. Children introduced to sexuality at a stage before they are ready can miss other important stages as well as have mixed up feelings.
- Touching yourself is a **normal** part of sexual activity. But if touching yourself brings uncomfortable feelings and memories, you can choose another activity instead of touching.
- There are **responsibilities and obligations** related to sexuality as well as moral decisions influenced by society, family, and religion.
- Children need **clear information** at their own level about names and functions of body parts, sexual identity, puberty, reproduction, birth control, AIDS, and personal safety. Parents can help children get information through talking with them, reading books and watching videos together, and talking to people like doctors, nurses, teachers and therapists.
- **Stereotyped sex roles** sometimes give children wrong information. Children need to know that both males and females can be strong, sensitive, caring and independent people. Being male does not always mean being in control, being the protector, and being macho. Being female does not mean being weak, being natural victims, or being frilly. Children need to know that being victimized does not mean you are damaged or less valuable, gay or straight, helpless or hopeless. Your inner value does not depend on whether you are a male or female or whether or not something bad has happened in your life.
- An important part of sexuality is **knowing** what you feel, want and don't want, need and how to express it. It means having the self-esteem, confidence, knowledge of your boundaries and rights, and skills to say no effectively. Another important aspect is to respect the feelings and boundaries of others.

Suggestions for Prevention Education for Children with Sexual Behavior Problems

- **Teach About Differing Kinds of Touches**

  Even young children understand that some touch hurts (pinching, biting, hitting) and is not allowed. *Some touches feel good and are good to give (such as hugs, kisses, handshakes). Other touches may either hurt or feel good, but are not okay. These include when people touch you in your private places or force you into sexual touch.* This message will be presented differently depending on the age of the child, but it is a good message for all ages. There are many books and videos addressing this topic that will supplement your message. "Sexual touching between kids or between adults and kids is not allowed and neither are touches that hurt others" are house rules that should be repeated often.

- **Role-Play Or Set Up A Safety Plan Around Touching Problems**

  If a child has an on-going problem with touch, help him set up and practice a plan for the next time. Ask them about their feelings and practice a set response (such as "when I feel I want to hit, I will hit a pillow instead." "If I feel I want to kiss, I will come to you and ask if it is okay first.").

- **Use The Idea Of Personal Space To Reinforce Boundaries**

  For young children or children with learning delays, using a concrete exercise may help with the idea of personal space. For example, have the child step into a hula-hoop. "Inside this bubble is your personal space and someone needs to ask permission before they come inside your bubble." Use whatever language works for you and the child to reinforce the learning. "You are in my personal space." Or "Don't go in my bubble without permission."

- **Don't Forget About Regular Sexuality Education**

  Talk with children about changes in their bodies and their sexual feelings. As children change, so will their needs for information and skills, so talk to your children regularly. Make it okay to ask about any sexual matters, (even if you don't know the answer - great chance to role model finding it!)

Reprinted with permission from the self-study course *Dealing with Sexually Acting Out Behaviors in Foster Care* by Aileen McGinnis, Alaska Foster Parent Training Center, Fairbanks, Alaska.

Answering children's questions about sex: "Can of worms"

Guidelines for Responding to Questions About Sex

1. **Answer all** the child's questions about sex and sexuality (unless they are repetitive and you believe the child is becoming over-stimulated by the conversation).
2. Try to **understand what the child needs** to know and at what developmental level (make sure you understand the question or confusion and look for questions behind questions).
3. **Give just the information** they are asking for or demonstrating a need for and wait to see if they want to know more. Give the information honestly, accurately, simply and directly (using correct names for body parts). Let them know by the way you respond that you are open to these kinds of questions on an on-going basis (even if you have some embarrassment) and that sex is a good thing when they are old enough and find someone special with whom to share their intimate and sexual feelings!
4. Your local **Planned Parenthood Center** has great handouts and workshops about this and you can call them for consultation.

Unit

5

Assessments and Treatment: An Overview of Types and Purpose

Competencies

1. Know different types of assessments.
2. Understand the benefits and limitations of assessments.
3. Know different types of treatment.
4. Understand the process of treatment.
5. Advocate for appropriate assessment, treatment and services.

Purpose

The purpose of this unit is to increase knowledge about different types of assessments and what they can and cannot tell parents about a child. With this knowledge, parents will be better able to advocate for additional or different services based on the results of an assessment, or to challenge the conclusions of an assessment. This unit will also help parents explore expectations, myths and assumptions surrounding assessments and examine the components of treatment and the treatment process.

Objectives

1. List and explore myths and expectations about assessments.
2. Identify and differentiate between several types of assessments.
3. List and explore myths and expectations about treatment.
4. Identify and differentiate between several types of treatment.
5. Learn about the process of treatment for sexual behavior problems.
6. Develop effective and appropriate advocacy skills.

Descriptions of Assessments

1. **Neurological Testing:** An examination to determine whether there is an abnormality in brain and nervous system function, and if so, where the abnormality is located and how it affects the child.
2. **Neuropsychological Assessment:** Standardized techniques that:
    a. identify cognitive deficits
    b. evaluate developmental disorders (like ADHD, PDD) and learning disabilities
    c. identify effects of an illness on the brain, such as cognitive deficits from chemotherapy for brain cancer or depression from dementia.
    d. assess neurotoxic effects like from chronic substance abuse
    e. evaluate the effects of treatment like surgery for epilepsy
3. **Achievement Testing:** An evaluation to assess the attainment of relatively broad educational goals, cutting across subject matter specialties.
4. **Psychological Assessment:** The administration of standardized tests that yield answers that are compared with the responses of a group similar to the individual. The evaluation provides information on patients' intellectual and emotional strengths and weaknesses, on how and why they are in their current situation, and on their prognosis.
5. **Psychosexual Assessment:** A specialized psychosocial assessment with attention to psychosexual history, development, and sexual abuse and misconduct issues. An individual of any age and gender can be referred for an assessment. It is common for a psychosexual assessment to be requested (by DSHS or court) following the discovery of an individual's involvement in sexual abuse of another person, typically a minor. Also, a referral is often made when a child or adolescent is exhibiting a pattern of sexual behavior problems. Generally, the party requesting the assessment is interested in knowing if the client being referred represents a low, medium or high risk of having engaged in the referring behavior and/or for continuing to engage in such behavior.

Treatment types and steps in treatment

Fact Sheet: Treatment

Goals of treatment for sexual behavior problems:

- Help children/youth gain control over their behavior; prevent future sexual behavior problems
- Resolve trauma resulting from child's own victimization

- Help children/youth learn age-appropriate social skills and coping skills

Types of Treatment: Typically children and their families require a multi-modal approach that entails child individual therapy, group psycho-education for the children, and family therapy

- Group therapy provides a place for children to be with other children with similar issues and thus provides opportunities for them to see that they are not the only ones with sexual issues. (can decrease shame, denial, depression, and/or acting out) – usually 5-6 members for 12-18 months and often combined with individual. Curriculums are available to structure and guide group work for sexual behavior problems. Peer influence helps produce behavioral changes
- Behavioral management focused groups can help kids learn appropriate boundaries, respect for authority, rules and limits, and improved self-control.
- Family therapy (under-utilized) can help heal the disconnect brought on by sexual behavior problems and make sure family dynamics encourage vs. inhibit change. Cloe Madanes, a well-known family therapist has developed a step-by-step process to help families deal with sexual abuse that has happened within a family: understand nature of problem, work on apologies and amends, establish consequences and accountability, and restore love and normalcy. Education and support groups help family members get information and hope about recovery, break isolation and work through their feelings.
- Availability and insurance often drive treatment decisions. Groups are often not available. Most common is once a week individual therapy (most often cognitive, focused on talking about thoughts, or cognitive-behavioral, talking about thoughts and practicing strategies for behavior change through assignments). It can be hard with once a week individual to work intensively enough to resolve trauma, break through denial and defenses, and make major behavior change.
- When insurance will only pay for once a week therapy and a child needs more, the child's ability to manage his/her emotions and behavior may result in a need for a more restrictive living situation such as residential treatment.
- Play therapy and other expressive therapies, depending on the ability of the therapist, can help children express and work through non-verbally what they cannot express verbally (and may help them move to verbal expression).
- It can help for treatment to have a set beginning and end time, which structured curriculums and/or workbooks can help provide.

Fact Sheet: Continuum of Care

A range of interventions and placement options that address both the individual's needs and community safety. Assessment is one component that helps determine the most appropriate intervention and placement. Different treatment programs have different philosophies and approaches, so it is important to get this information and choose one that fits for you and your child.

Most continuums have the following levels of treatment:

1. Short-term specialized psycho-educational programs (outpatient)
2. Community based outpatient sex offender treatment programs while the child remains at home
3. Community based outpatient sex offender treatment programs while in foster care or other out of home care
4. Intensive outpatient services (more than 1 hour a week)
5. Day treatment programs
6. Residence-based and short-term placements providing assessments and facilitating readiness for community-based treatment
7. Residential group homes or residential facilities
8. Secure units providing comprehensive, intensive treatment (staff secure is highest level)
9. Psychiatric Hospital
10. Incarceration

Issues:

- Insurance
- Funding

Advocacy and Foster Parent Rights

One of the most important things you as a foster parent can do is to advocate for the children in your care so that they receive the treatment and services that they need.

Knowing what your child needs and what services are available in your community will help you advocate for your child.

Advocacy

In the book *Changing Human Service Organizations: Politics in Practice*, George Brager and Stephen Holloway identify 3 approaches to advocacy: **collaborative, campaign and contest**. One should *always* begin with a collaborative approach (best chances of success) and only move on to the next level if best collaborative efforts fail to achieve what the child needs and careful evaluation leads you to believe a stronger approach makes sense.

Collaborative – find common goal, hear each other's input and concerns, and put minds together to find a way to achieve it that all feel good about

- Open communication and good listening
- Information flows both ways
- Education (sharing information)
- Problem solving (division of tasks – who does what, who has what issues and why)
- Joint Action – tasks together
- Mild persuasion

Goal – Finding best fulfillment for all involved

Parents need to have self-confidence to express what they know about the child and work for successful collaboration as equal team members. Anyone in a group (even if not officially in charge) can take leadership to facilitate this collaborative approach by asking different people what they think; listening, seeking to understand and checking to see if they understand correctly; and saying things like, "We haven't heard from __. What do you think?", "What could we do that would work for all of us?", "What possible solutions might address all these concerns?", or "I like this about your suggestion, but I'm still concerned about __. Can we keep working on it until it addresses all of our concerns?"

It is really helpful to build good relationships with all of the people in the group and to notice and appreciate their caring about the child and positive contributions as often as possible. When people feel heard, respected, and appreciated they are less likely to be controlling – more likely to trust and collaborate as equals. Remember that we are all good human beings working in stressful roles in systems that are over-loaded, under-funded, hierarchical and rule-bound.

Campaign - pushing harder when power is unequal, system problems and people's blind spots are getting in the way of important needs of the child, and **an all-out, honest effort at collaborating is not working**

- Hard persuasion, hard advocating (look at rules, laws, political maneuvering, get advice from special needs advocacy groups, support from influential people)
- Bargaining, negotiating to reach mutual acceptance (continue to treat humans involved with respect and acknowledge their difficulties and needs.)
- Mild coercion

Goal – Getting child's needs fulfilled despite obstacles

People often pose as collaborating when they are really campaigning for their position. They may not even realize it themselves, but this may be blocking successful collaboration. It is very important to develop good collaborative skills, work through old feelings that get in the way of believing collaboration can work, and really try to make it work before moving to campaign.

When campaigning, assertiveness will be much more successful than aggressiveness. Parents need to deal with any feelings a conflict brings up elsewhere and stand up for their child in a positive way - without hostility, intimidation or tearing others down. Aggressiveness breeds resentment and resistance, not cooperation. You can take assertiveness classes.

Contest – last resort when issue is vitally important, power is unequal, and sincere and exhaustive efforts have been made with first two approaches

- Debate
- Protest, demonstrations, sit-ins, boycotts
- Investigative journalism
- Lobbying, referendum

- Court case
- Coercion

Goal – Achieving own fulfillment at all costs

One of the largest barriers to effective advocacy from the perspective of a foster parent is that well-intentioned people who all have the child's best interests at heart can honestly disagree about what the child needs and what would be in the child's best interests.

Unit

6

Safe Family Living

Competencies

1. Teaches and reinforces appropriate limits for privacy and interpersonal boundaries.
2. Knows how to protect others in the home from sexual abuse.

Purpose

Treatment that occurs in the foster home is one part of reducing and/or managing the child's sexual behavior problems. The foster parent's daily role of managing these behaviors involves ensuring safety, setting boundaries and expectations, and enforcing limits. Foster parents should be aware of the importance of offering a safe environment for children with sexual behavior problems, and assuring the safety of everyone in the household.

Objectives

1. Identifies and can practice limit setting and expectations regarding privacy and boundaries.
2. Understand the nature of safety in the home, for the foster child and the entire family.
3. Know the approaches for reducing sexual behavior problems in the home setting.

House Rules

Suggested House Rules for Foster Homes Caring for Children with Sexual Behavior Problems

1. **Family members are treated in a respectful and caring manner** (you will need to model and teach what this means continuously – do not assume a child knows how to do this). Sexual advances toward others are not acceptable.
2. **Supervision**: Children with sexual behavior problems must have continuous eyesight supervision (by an identified, responsible adult knowledgeable about their issues) when they interact with other children. Inappropriate sexual behavior is dealt with at the time it occurs in a respectful, direct and firm manner. During adolescence, adjustment of supervision may be necessary to allow for social activities and peer contact. Teens need to be able to progressively earn freedom by demonstrating responsibility.
3. **Bedrooms**: Children should sleep in their own beds and not share bedrooms. If it is absolutely necessary to share, it should be with a strong, assertive child of similar age or older who has been informed and understands about the sexual behavior problems. Monitors or door alarms should be placed on the bedroom doors of children who have problems staying in their room at night or following safety rules (and/or other children in the house who feel unsafe). A child may be able to earn the privilege of having a roommate or overnight guest or having the monitor removed by making progress and earning trust over time. Except in the case of very young children, family members should knock before entering bedrooms. Care should be taken when tucking children in at night. For children who have been abused in their beds, nighttime may be an anxious transition. Foster fathers may cause anxiety for children, so it may be more comfortable to say good night from the door in the beginning of the placements. Leave lights and doors open for children who are fearful. Playtime with other children should not take place in bedrooms.
4. **Bathrooms**: One person in bathroom at a time (except for adult with a young child that needs help or supervision) – knock to let someone know you need to use the bathroom. Door closed when using toilet or showering. Children wash own private parts.
5. **Privacy**: To help children learn the importance of boundaries, emphasize that everyone has the right to privacy. This may include a private spot or drawer that no one should go without your permission or knocking on the bathroom or bedroom door and waiting for permission to enter. Do not search drawers or read diaries without permission.

6. **Clothing**: It is a good idea to require bathrobes or sweats around your house for all family members. Walking around naked partially clothed or in your underwear may cause embarrassment or anxiety for children. It may also arouse children who are prone to sexually acting out. Identify appropriate dress for different situations as necessary. Children should wear underwear under clothes and not wear clothes that have holes near private parts.

7. **Horseplay**: Reduce or eliminate horseplay such as tickling or wrestling. While these behaviors are not bad in themselves, tickling can be coercive, and wrestling is often the starting point for more intimate behavior. Children with violated boundaries may feel anxious or coerced during wrestling. Other children may use the guise of wrestling as an excuse to sexually touch other children. Sexually abused or acting out children may find wrestling to be quite sexually stimulating. Instead of wrestling, channel kids into lots of physical activities that are appropriate.

8. **Sexual talk**: Monitor sexual talk and gestures between children in the home. Talk openly about sexual matters, but make sure it is developmentally appropriate and respectful (it's important not to treat it as a secret topic). Children who sexually molest others often groom their victims through sexual talk so keep tabs on talk in your house, especially when used as a put down or act of aggression. Keep to a minimum the presence of sexually stimulating materials such as explicit television shows, movies, magazines, music and pornography. Be aware that violent, aggressive and stimulating television shows or video games can raise the tendency toward aggression in children, at least temporarily, and it has been suggested that there is a link to sexual stimulation as well. Talk to children about what is appropriate and supervise children appropriately.

9. **Physical punishment**: Foster parents are not allowed to use physical punishment with a foster child and are not allowed to use punishment that is cruel or humiliating. This includes your response to sexual behavior problems. Do not use pepper, restraining devices, slapping, or humiliating or hurtful consequences when addressing a child's behavior.

Foster parents should review their state's rules and regulations regarding discipline.

10. **Personal touch**: When children first come into your home, be respectful and, even with young children, ask permission to touch. Address immediately any touch that feels uncomfortable to you or that is hurtful. Children need to know what is not acceptable, but they also need to be sensitized to good, nurturing touch. Go slow. Side hugs, brushing hair, pats on the back, tag: all are less intrusive touches that most children can handle. Allow children to say no to touch and don't be hurt or cajole children into touches they clearly are

uncomfortable with. If children need constant touch or contact with you, set limits for the child. Give a child five to fifteen minutes of sitting on your lap, and then you take a break. Schedule these times throughout the day, so the child gets his need for attention met, but learns to respect boundaries. Talk openly and often about appropriate touch safety and boundaries with all children in the family. This will let everyone know that everything can be talked about and sexual touching will not be kept a secret.

11. **Pets**: If a child has any known or suspected history of abuse or neglect of an animal/ pet, there must be a supervising adult within eyesight when he/she interacts with the animal/ pet. (The pet cannot sleep with the child in his or her bedroom, for example.) It will be very beneficial to the child if the adult teaches and models proper care, handling, boundaries and love for animals.

Teaching children about your house rules

- **Young children (4 and under)** – Can tell them rules as things come up
- **Children 5 and above**– Go over rules, and consequences for breaking them, early in placement**. Write** important rules down, discuss in family meetings.

Additional House Rules To Consider

1. **Contribution** – in this family, everyone contributes something.
2. **Open doors** – When more than one person is in a room, the door must remain open, except for parents in their bedroom together.
3. **Curiosity** – It is okay to ask any questions that you want to ask. We will answer every question we can in the best way we can. However, sometimes we may need to answer a question in a different place or at a different time so that we can talk appropriately.
4. **Consequences** – It is important that children understand in advance what the consequences will be if they break a house rule. For many children, severe abuse may have been the response that they received in their birth homes if they broke a rule.
5. **Limits** – It is important to have boundaries and rules around computer and phone usage, as well as parental controls on television and access to pornography.

Preventing False Allegations of Sexual Abuse Checklist

- ✓ **Make sure your behavior is above reproach.** Do not sexually abuse, sexually touch, physically abuse, spank or use suggestive language with a child.
- ✓ **Secure accurate information upon placement of child.** Ask why the child is being placed, ask about behavior problems that are known, and ask about any history of abuse. If a child has been sexually abused, set up an effective safety plan (to be covered in Unit 8).
- ✓ **Use the "rule of three".** If a child has a history of sexually acting out, do not leave alone with another child. Never leave the child in an unsupervised babysitting situation. If a child has a history of false allegations, when possible, do not be alone with the child for a long time. Use the rule of three. That means try to have three people in the room such as a parent and two children or two adults and a child.
- ✓ **Put foster child in own bedroom.** Leave doors open and be within earshot of another parent if you need to talk or be with child in his or her room.
- ✓ **Do not use physical punishment**. Physical punishment is not allowed in foster care and breeds resentment in children.
- ✓ **Be clear about rules of dress, privacy and touching.** Set, explain and maintain clear, firm, concise rules on dress, privacy, touching, boundaries, language, and behaviors. Ask permission to touch. Take special caution around bathroom, bedroom and dressing issues.
- ✓ **Record any sexual acting out in writing**. Send a copy of the report to child's social worker or therapist and keep a copy for yourself.
- ✓ **Reduce your stress**. When you are caring for difficult children, schedule in a regular break for yourself. Take care of yourself! You must monitor your own emotions and own stress and get help when you need it.
- ✓ **Address issues when they happen**. If you are open and confrontative, children will learn that everything can be talked about and secrets about touching are not allowed.
- ✓ **Avoid aggressive horseplay, teasing, suggestive or ambiguous language.** Avoid sexual language, swearing, comments, whistles, things that may be misinterpreted. Keep touches appropriate: kisses on the cheek, short hugs or side hugs. Avoid lap sitting for older children.
- ✓ **Use family and group therapy rather than confidential individual therapy** with the child. The secrecy and isolation of one-on-one therapy may encourage manipulative reporting in a child who has a history of false allegations.

Reprinted with permission from the self-study course Dealing with Sexually Acting Out Behaviors in Foster Care by Aileen McGinnis, Alaska Foster Parent Training Center, Fairbanks, Alaska. Her sources included Kunstal, Frank "Preventing Allegations of Abuse", The National Advocate; Sprouse, Jacob, Defensive Parenting, American Foster Care Resources; and McNamara, Bernard and Joan, The SAFE TEAM Curriculum: Preparation and Support for Families Adopting Sexually Abused Children, Family Resources, 1990.

An additional step that foster parents can take to reduce the risk of false allegations is to develop and maintain a good relationship with your caseworker. Find a communication strategy and schedule that works for both of you and KEEP IN TOUCH!

Unit

7

Intervening with Sexual Behavior Problems

Competencies

1. Examine the nature of sexual behaviors along the continuum from normal to unhealthy as a result of trauma.
2. Discuss and practice appropriate parental responses to inappropriate sexual behaviors.
3. Sets limits effectively on problem sexual behavior in ways that help to decrease them and to foster healthy boundaries, relationships, sexuality, self-esteem and self-control.

Purpose

Effective limit setting is one of the most important components of treatment for children with sexual behavior problems and needs to be done consistently whenever children exhibit the behaviors. Because our society is uncomfortable with many sexual behaviors and with talking directly about sex, most parents need to practice setting limits on sexual behaviors in order to be able to do it directly and specifically in a calm, matter-of-fact way. This unit helps participants identify patterns of sexual behavior on a continuum from normal sex play to sexually reactive or molesting behaviors. Parents can then determine how to address these behaviors using a simple 4 step model developed by Patricia Ryan.

Objectives

1. Examine the nature of sexual behaviors along the continuum from normal to unhealthy as a result of trauma.
2. Discuss and practice appropriate parental responses to inappropriate sexual behaviors.
3. Learn a simple 4-step model for intervening with sexual behavior problems.
4. Practice the model with scenarios to become more comfortable and confident actually doing the 4 steps.

Understanding Different Types of Sexual Behavior Problems

The model we have chosen to utilize in this training was developed by Toni Cavanagh Johnson, Ph.D. Dr. Johnson is considered one of the top experts in this field and has published extensively on materials that assist parents and substitute caregivers in helping children with sexual behavior problems.

Toni C. Johnson's Continuum of Sexual Behavior Problems

GROUP ONE: Normal Sexual Exploration

Children of all ages show normal sexual behavior based on the **discovery and development** of their physical and sexual selves. This may include exploring feelings and genitals, interest in language related to sex, and giggling about bathroom related functions. Children involved in normal sexual exploration may do it solitarily or with friends of similar age and size. They more often explore with friends rather than siblings. These encounters are voluntary and often lighthearted, fun, and silly. They do not often include feelings of deep shame, fear or anxiety. For teens, this often involves intense sexual feelings toward others and sexual exploration in relationships. These behaviors may need limits, guidance, or education, but are not considered abnormal or pathological.

GROUP TWO: Sexually Reactive Behaviors

Group Two exhibits more sexual behaviors than Group One and has **a preoccupation with sexuality**. Many of these children have been abused or exposed to pornography and sexual stimulation. These children have trouble integrating and understanding such stimulation and **express deep shame, guilt, and anxiety about sexuality**. Their behavior focuses mostly on themselves. When they involve other children, the **difference in age is usually not great** and force is not usually involved. These children **respond well to therapy and education**. When the anxiety is reduced or more age appropriate and less sexually stimulating environments are encouraged, the level of sexual behavior tends to decrease.

GROUP THREE: Extensive Mutual Sexual Behaviors

These children often approach sexuality as **just the way they play** and are often more resistant to treatment than Group Two. These children use coercion and manipulation but **rarely resort to violence**. They are characteristically **without emotional affect**, meaning they have neither the lighthearted spontaneity of normal children nor the shame and guilt of the sexually reactive

children. These children often have a history of severe abuse and abandonment. Sex is a way to relate to their peers. These children need an intensive and rigorous **relearning of social skills** and peer relationships. These children will also need **intensive supervision** in the home setting and around other children.

GROUP FOUR: Children Who Molest

The children in this category go far beyond developmentally appropriate play. They are **obsessed with sexual thoughts** and engage in a full range of sexual behavior that becomes a **pattern**, rather than solitary incidents. These children need intensive and specialized treatment. These children often link sexual acting out to feelings of anger, rage, loneliness, or fear. Children with severe offending behaviors **choose vulnerable and younger victims**. They lack compassion for their victims and feel regret in getting caught, not with hurting another child. Most of these children have severe behavior problems at home and at school and have few friends. For some of these children, their behavior borders on compulsive behavior. **Compulsive behavior** means the child has lost control over it and has a very difficult time not repeating actions, even when punished or when trying to stop. These children need therapy, strong intervention, combined at times with medication to control these impulses.

Examples

1. Four-year-old Jenna climbs into the laps of men she doesn't know and snuggles up against them. She tries to stick her tongue into the mouth of people who kiss her and makes sexual sounds. She also spends hours sitting on the couch masturbating against her stuffed animals. Jenna is being raised in a very sexualized environment. She lives in a one-bedroom apartment with her 18-year-old mother and her mother's boyfriend. Her mother treats her as a girlfriend, not as a daughter. Frequently, her mother lets Jenna wear makeup and watch soap operas all day long. She has no age appropriate toys in the apartment and plays with no same-age friends. She sleeps on the sofa bed that her mother and boyfriend have sex on after they think Jenna's asleep.

GROUP _____

2. Frank is an 11-year-old boy who is in residential care and who often bribes younger children into sexual activity, including oral sex and forced penetration of a child's vagina or anus with his fingers. He can turn quite threatening with a vulnerable victim, threatening to never talk to him again or hurt him while he is sleeping some night. Once when he was caught sodomizing a younger child, he angrily yelled at the residential worker that he wasn't doing anything.

GROUP _____

3. The staff at an elementary school was thrown into a frenzy when a teacher discovered three ten-year-old boys playing together in the bathroom with their pants down. The boys were attempting to identify which of them could stand farthest from the toilet bowl and still hit it with a stream of urine.

GROUP _____

4. Todd and Joey are 9-year-old boys who have been in foster and residential care almost all their lives. They are constantly trying to have mutual and willing sex with each other. These behaviors include sexual touching and oral sex. The group leader has to provide constant supervision and separation of the boys in order to stop the behavior. Even nighttime hours need to be monitored because the boys will sneak out of their bedrooms and climb into each other's beds.

GROUP _____

Patricia Ryan's 4 Step Model of Intervention

Attitude: <u>Separate the child from the behavior</u>. Know they are behaving inappropriately because they have been hurt and have not gotten the modeling, guidance and limits they need – not because they are bad. They may not understand that what they are doing is wrong or may have difficulty controlling themselves.

<u>Strive to teach, not punish or shame</u>. Use words that describe behavior such as "not O.K." or "against the rules" instead of words that judge the person such as "bad" or "misbehaving" or "nasty". Stay calm, use simple, direct and few words, set limits firmly, and help child feel your support.

Patricia Ryan, Ph.D., has developed a simple technique for confronting children's sexual behavior problems

1. **Stop** the behavior – tell child to stop, remove child's hand, separate the children, have them pull up pants, etc.
2. **Define** the behavior – describe **specifically and clearly** what the child is doing that is not okay. The more specific and clear, the better opportunity the child has to change or relearn his behavior. If we react with general anger, the child may interpret our anger as "I'm bad" instead of "What I'm doing is wrong". Instead of "Stop that!" or "Don't do that!" or "That's bad!" try "You are poking Billy's private parts and that's

not okay." Or "You are being sexual with the dog and we already talked about how it is not okay."

3. **State** the house **rule** or expectation about this behavior - Don't lecture; state matter-of-factly with as few words as possible. "In this house…", or "The rule is…" or "We expect everyone in our family to…"

4. **Re-direct** the child (let him know what you expect him to do) **and/or enforce** the **consequence** – For younger children you can redirect the child to more appropriate behavior. End the encounter on a positive note and praise the child when he/she acts in the way you suggest. If the child is older and this behavior is repetitive, you may wish to set up a consequence and enforce it matter-of-factly and consistently.

Intervention Skill Building

Situation 1: You are reading to John, a boy of six, and he begins to rub your breast.

Step 1: Stop the action. Remove the child's hand from your breast and move slightly away.

Step 2: Define the behavior. Look him in the eye and say, "John, you are touching my breast."

Step 3: State the rule: "My breast is private and it's not okay for you to touch it. In this house, it's not okay for kids and adults to touch each other's private parts."

Step 4: Re-direct the child or apply a consequence. "I like reading with you and will continue if you can sit here next to me without touching my breast."

Other ideas: For this young child, get a book on good touching and bad touching from the library and set aside some time to read it several times. Find times to restate the rule throughout the day, including noticing good touches that are okay. Ask the child for permission to touch to reinforce the idea of privacy and control. For a child who is easily stimulated, take care when having him sit on your lap or sitting next to you in a way that his face is at breast level. Keep some space between you or sit on the floor with him.

Situation 2: You hear giggling in the bathroom. When you open the door, you find 5 year old Lori rubbing her vagina up against 4-year-old Sandy's buttocks as she brushes her teeth. Both are laughing.

Step 1: Stop the Action. Tell the girls to stop what they are doing and separate them. Put one on either side of you and get down to their level.

Step 2: Define the behavior. "Lori, you were rubbing up against Sandy's buttocks with your vagina and that's not okay."

Step 3: State the rule. "An important rule is no sexual touching and what you were doing, rubbing up against Sandy's buttocks with your vagina that way is sexual touching. That is not okay."

Step 4: Re-direct the children or apply a consequence if this is not the first time the behavior has occurred and the girls are both aware of the rule and the consequence for breaking it. "Come on, Lori. The rule is one person in the bathroom at a time. We'll let Sandy finish brushing her teeth and then let's find something fun to do before bed that's okay for kids. We will talk more about this later."

Other ideas: Later, you may want to repeat the rule while remaining calm. Talk about concern for privacy and safety. Also remind the girls that there is only one person in the bathroom at a time. Emphasize that both girls need to follow and enforce the rules. Increase your supervision of the girls and leave the doors open when children play. Document the incident and communicate to your caseworker.

Situation 3: Paul, a six-year-old who is very emotionally immature, is watching television with the family. He puts his hands down his pants and begins to masturbate while the family members look on in embarrassment and discomfort.

Step 1: Stop the Action. Ask Paul to stop touching himself and to come sit next to you. Or you may wish to have him follow you out of the room to talk privately.

Step 2: Define the Behavior. "Paul, you were rubbing your penis in a public place."

Step 3: State the Rule. "Touching your penis is a private thing to do and you should do that only in the privacy of your bedroom."

Step 4: Re-direct the child or apply a consequence. "Next time I'll remind you if I see you, but remember the rule. Now, why don't you wash your hands and help me pop some popcorn for the rest of the family."

Other ideas: Children should not be punished or shamed for masturbation. In young children, it is natural that they should discover their genitals feel good and they should feel good about their bodies. However, there are some clear limits on this behavior and children should be taught that it is a private activity. If it seems to be a self-soothing activity, you can suggest alternatives, such as play with play dough, sand, water or art

materials; stroking a pet; being rocked or swung in a hammock, or having their hair brushed. If a child seems to focus on masturbation to the exclusion of other activities, masturbates constantly, seems distressed while doing it, or is compulsive and cannot seem to stop, he or she will need therapeutic intervention to deal with the causes behind the behavior.

Situation 4: You discover four-year-old Lucy is hidden in the closet and is pushing a small plastic action toy in and out of her vagina.

Step 1: Stop the action. Tell Lucy to put down the toy and pull up her panties. Ask her to wash her hands. (Using gloves, pick up the toy and dispose of it after you have talked with Lucy following these steps.)

Step 2: Define the Behavior. After she has washed her hands, hold her hands gently to show your concern and say in a calm voice, "Lucy, you were putting these toys up inside you, in your vagina."

Step 3: State the rule: "It's not okay to put things in your vagina because you will get hurt and you might get an infection."

Step 4: Re-direct the child or apply a consequence. "Now lets go back into the play room and find something safe to play."

Other ideas: Later, when tensions have calmed down, talk to Lucy again. Ask why she was playing with her toys like that and listen carefully to the answer. Perhaps it was because she had seen this behavior, or she has an infection and it itches or it felt good, or an adult did something similar to her. This may give you a clue how to handle the situation. With compassion, but firmness, let her know that you care about her and you know she wants to do right. Repeat the rules about not putting things inside your vagina and talk about more appropriate ways to use the toys. If the child has been abused, you may want to ask her if she has any hurts in her vaginal area. Remember to call your caseworker as soon as you can do so with an assurance of privacy. Document the entire incident as completely as possible.

Situation 5: Your fourteen-year-old foster daughter and twelve year old foster son are wrestling and tickling each other on the living room floor.

Step 1: Stop the Action. Tell the kids to stop and ask them to stand up.

Step 2: Define the Behavior. "You kids are wrestling in the living room."

Step 3: State the rule. "In this house, wrestling and tickling are not allowed. It might be fun, but it can also lead to hurtful touch or even sexual touch and that is not allowed in this house."

Step 4: Re-direct the children or apply consequence. "Let's brainstorm some ideas for something physical you two can do together that's okay." (examples: a game with paddles and ball or tether ball)." Or if a recurrent problem, "You knew the rule and broke it, and you know the consequence is…"

Other ideas: Teens need plenty of opportunities to talk about feelings and relationships, but they may be hesitant to ask questions about sexual matters. So make the time and bring the topic up, emphasizing boundaries, responsible behavior and respect for others. Make it a topic of a house meeting about respecting privacy and use the example of wrestling as something that invades privacy. When taking in teenagers who have been sexually abused, foster parents should consider taking in either boys or girls, but not both. Mixed sex foster homes often bring more challenges in supervision and safety than do single sex foster homes.

Situation 6: Your fifteen-year-old foster daughter sits next to you (her foster father) as you read the paper and presses her thigh and breast into you as she leans over to read with you.

Step 1: Stop the Action. Move away and face her.

Step 2: Clearly state what he is doing. "The way you were acting by getting too close to me and touching me felt like a come-on."

Step 3: State the rule. "That made me feel uncomfortable. I am your foster father and that seemed like flirting behavior. I don't want you to act like that to me."

Step 4: Re-direct or apply a consequence. "I care about you and like being with you, but I do not like that kind of behavior. If you want to sit here and read the paper with me, sit next to me, but not on me."

Other ideas: Again, older teens need lots of open communication about sexuality and appropriate behavior. This situation warrants further talk with the girl about what she wants to happen and how her behavior may elicit an abusive or unexpected response. When you feel uncomfortable with touch, do not hesitate to address it in a firm assertive way. Do not yell, punish, or name-call. Use I-messages. You are modeling how to protect yourself. Don't be surprised if teens get defensive or angry. That's okay. You

still need to talk with them. (Don't get drawn into a battle.) Also, with teens, have reasonable curfews, lots of family and supervised peer activities and structure. Bored and unsupervised kids spell trouble.

Examples reproduced with permission from the self-study course *Dealing with Sexually Acting Out Behaviors in Foster Care*, developed by Aileen McInnis for the Alaska Foster Parent Training Center – many of the examples came from the video *"Establishing the Psychologically Safe Environment: The Sexually Abused Child"* produced by Patricia Ryan, Eastern Michigan University.

Unit

8

Safe Living at School and in the Community

Competencies

1. Understands the issues involved in balancing confidentiality with right to know.
2. Develops strategies to increase safety of others in the neighborhood, at school and at extra-curricular activities.

Purpose

Parents may find that conflict arises when trying to balance confidentiality and the public's right to know. What do you tell the school, neighbors, and extended family about your foster child and his/her behavior?

Supervision is a necessary component to assure the safety of others, since the child with sexual behavior problems may be over-stimulated if left alone with other children. Participants will examine supervision and other strategies to keep others safe.

Objectives

1. Explore issues involved in balancing confidentiality with others' need or right to know through class exercise.
2. Explore the issues involved in balancing confidentiality with the school's need or right to know.
3. Create strategies to ensure the safety of others.

WA DSHS Confidentiality Rule

WAC 388-148-0130

What information may I share about a child or a child's family?

1. Information about a child or the child's family is confidential and must only be shared with people directly involved in the case plan for a child.
2. You may discuss information about the child, the child's family and the case plan only with:
   a) A representative of the department, including staff from DCFS and DLR; department of health and the office of the state fire marshal;
   b) A child-placing agency case manager assigned to the child;
   c) The child's assigned guardian ad litem or court-appointed special advocate; or
   d) Others designated by the child's social worker.
3. You may check with your child's social worker for guidance about sharing information with the child's teacher, counselor, doctor, respite care provider, any other professional, or others involved in the case plan.
4. Child-placing agencies and the department must share with the child's care provider any information about the child and child's family related to the case plan.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0130, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0130, filed 8/28/01, effective 9/28/01.]

Balancing Confidentiality and Right to Know in Schools

School can be the **arena for the most conflict** for this issue. School staff (administrators, teachers) may want to know more than you and the treatment team deem necessary to disclose.

Usually, the caseworker, you and the treatment team will **share with the school safety recommendations** for the child, not the entire case history and assessment. The guiding question is 'what does the school need to know to keep kids safe?'

Potential problems arise if you are caught in this conflict with the same school your birth children attend. What if the school wants to know more than what you and the treatment team

agreed to disclose? You want to maintain good relations with the school and are now caught in a conflict. What do you do? Ask if anyone has had success managing this conflict and how.

Safety planning in the school and community

School

The school setting is a place in which there is often much confusion and uncertainty regarding the need to inform the school of the child's special safety and supervision needs versus the child's right to confidentiality. **The child's right to confidentiality must be balanced with the school's right to know information that will help them do their job of keeping other children safe.** As a general rule, the more serious the child's safety problem, the more it is likely that the school may need to know. Add to this the issue of a child who will seek ways to manipulate his/her way around the rules; then the responsibility to properly inform the school is even more compelling.

For some children, and more likely with adolescents, there may not be a need to restrict any activities in the school setting, even if there are restrictions within the home setting. In this case, the school would not need to be informed of anything.

If the clinical assessments and the child's current behavior indicate that there may be a risk of the child involving other children in sexual behavior (other than normal, healthy sexual exploration), then the following safety precautions should be considered:

1. Inform the caseworker and coordinate with him/her to request a meeting with the appropriate school official, such as a guidance counselor, assistant principal or principal. Ensure that the proper release of information forms have been signed by the caseworker to disclose confidential information. Document this meeting.
2. Let it be known that the child has a safety plan that should be followed in the school. Have a copy of the plan as it relates to the school setting. This usually involves creating a separate document for this purpose. Make sure the plan is in writing. Have the plan appear to fit into the general routine of the classroom.
3. It is not necessary to provide a copy of a comprehensive psychosexual/psychological assessment for the school, even if they request this. A copy of the safety plan is sufficient. A copy of the recommendations from the assessment may also be provided to the school, if considered appropriate by the guardian.
4. It is usually sufficient to indicate that the child has a safety plan due to problems with impulsivity, boundaries, or keeping their hands to themselves. If it is useful or necessary to

be more specific, then proceed to indicate that the child has a touching problem, is sexually reactive, has been sexually abused, or engages in inappropriate sexual behaviors (diagnostically, this could range from ADHD, PTSD to ODD). Do not tell the school that your child is a sexual offender, as this is a label and not a diagnosis.

5. Based on the safety plan for the child, it may or may not be necessary to have specific activities limited or restricted. Again, this must be determined on a child-by-child basis. For example, children with more serious problems will likely need the following limits or restrictions: eyesight supervision (which may translate into a one-on-one support person being assigned to the child); modification of gym class, such as not changing clothes with other students, if no adult supervision is available; and modification of bathroom time, such as using a private bathroom used by staff, or being escorted to the bathroom with an adult waiting outside. These modifications are generally easy to implement within the elementary settings, and more difficult to implement in middle school and high school.
6. If your child has a safety plan that is being monitored by the school, and this plan involves certain limits or restrictions, request regular review meetings (check-in points) so progress, or concerns, can be properly documented and adjustments made to the plan. This will most likely be beneficial to everyone involved, especially the child. Also, the school needs to know that the parent remains active and interested in the child's participation and progress within the school setting. This is an issue that cannot just be given to the school to deal with in isolation from the rest of the child's life.
7. Build a relationship with key people at the school and maintain open and frequent communication.

Community

Children participating in the community are typically supervised, particularly if they are in a foster care placement. Even still, many children eventually earn the progressive privilege of being in the community during times of little to no supervision either prior to or by adolescence. Children with special needs requiring a safety plan need to have their participation in this setting adjusted in a manner consistent with their participation in other settings. Limits in one setting generally lead to limits in other settings as well. In fact, it is quite likely that as the child makes progress in one setting, this may extend to other settings. For other children, each setting may need to be managed in a different way.

As a general starting point, children who are new to a foster home placement, and who need a safety plan, would most likely have the same rules apply to all settings, until this can be adjusted or refined later, based on trust and progress.

Situations that arise in the community that need attention and problem-solving relative to safety management and supervision would be, for example: social activities such as school dances; social and recreational clubs; sports activities; and scouting.

Developing Safety Plans

How To Create A Safety Plan, by Carrie Craft, www.About.com

1. Define the issue or problem. Be precise and clear with the definition.

   Max inappropriately touches himself while watching television in the family room. This occurs daily.

   Sally leaves the home whenever Mom turns her back.

2. Be clear about who you need to protect.
   - the child
   - other children
   - pets
   - property

   Max's behavior is inappropriate for the other children and family members in the home.

   Sally could become lost or injured in the street.

3. Pinpoint when the behavior occurs, if possible and predictable.
   - When bedroom doors are shut while others are in the room.
   - Left unsupervised.
   - When told no or when limits are set.
   - Before/after visitation with family
   - While doing mindless activities.
   - At night.
4. Determine who is involved in the plan.
   - Determine which adult is doing what action.
   - Remember to share the plan with all caregivers, including short term babysitters.

Mom or Dad will redirect Max by giving him a stress ball whenever he starts to inappropriately touch himself while watching television.

Dad will supervise Sally while Mom cooks dinner.

5. Set a time limit for the plan.
    - How long will your plan be in place?
    - How often will you reassess your plan?
    - What change are you looking for within the child or behavior?
6. What if the plan fails?
    - If your preventative measures don't work, have a list of crisis numbers to call.
    - Consider a therapist or close friends/family to be on this list.
    - Be prepared to report the incident to the proper case workers if your child is a foster placement and the offense is severe enough.
    - If the child's behavior is a crime against another person or property, you may have to call the police.
7. Re-evaluate and ask yourself some questions.
    - How did your plan fail?
    - When?
    - What can you do better tomorrow?
    - What did you overlook?

Example: Bill, who is 9, has a history of having been sexually abused. He has made sexual advances to other children when not closely supervised. Bill has not forced himself on other children and has always stopped when another child says no.

a. What would Bill's safety plan look like?

b. What else would you add?

c. What evaluations/assessments would you like to see with Bill?

d. What other information would you like to have?

Some Helpful Characteristics of Foster Parents of Children with Sexual Behavior Problems

The foster parent:

- Possesses or learns the **attitudes and skills** necessary to be an effective therapeutic foster parent.
- Is willing and able to **work as a team** with other treatment team members (express his/ her concerns and viewpoint, obtain information, listen well to other viewpoints, come to agreements about recommendations and consistently carry out treatment plans). This may sometimes mean accepting and implementing recommendations that differ from his/her beliefs.
- Can **accept** the child's attachment to birth family/ abuser.
- Is **aware** of her/ his own experiences, history, and triggers, and how these may clash with a child's experiences, history and triggers.
- Addresses the **emotional impact** of parenting challenging children.
- Is willing to **ask for help**.
- Identifies and practices ways to **relieve stress**.
- **Recognizes** which interactions (and when) may not be healthy for the child.
- **Talks** about controversial issues such as sexuality.
- Recognizes and accepts **the special needs** of the child.
- Is **non-judgmental,** patient, flexible, and empathetic.
- Knows that healthy sexuality for children is not absence of any sexuality but **moving toward healthy behaviors**.
- Can **remain calm and able to think** (!) when children act out sexually, set limits firmly and re-direct behavior without shaming.
- Creates a **safe, structured home** for the whole family.

THANK YOU FOR ALL THAT YOU DO.